Sent by: generalmanager@mhaps.org.nz

To: <MentalHealth&AddictionContracts@moh.govt.nz>,
cc:
bcc:

12/01/2017 11:21 a.m.

Subject: Nga Hau E Wha Contract

Ngā mihi mahana ki a koe,

Hoping this finds you well and refreshed after the Christmas / New Year break.

Please find attached the 6 monthly documentation for Nga Hau E Wha comprising the narrative and financial reports.

With all best wishes,

Nāku, nā

Sue

Sue Ricketts
General Manager
MHAPS – Mental Health Advocacy and Peer Support

826 Colombo Street, Christchurch, 8013
P.O. Box 33332, Barrington, Christchurch 8244
Phone: 365 9479
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www.mhaps.org.nz

2016 July to December report NHEW.xlsx June - Dec 2016 MOH Report. Final VGJ.docx

Nga Hau E Wha
"Championing Many Voices"

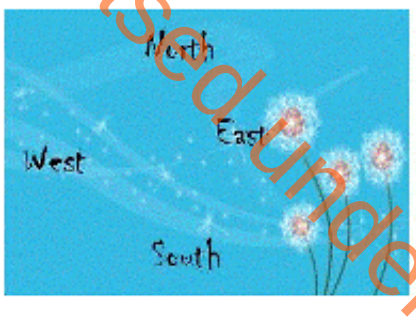
MHAPS
Mental Health
Advocacy and Peer Support
Together on the road to wellbeing

HALF YEARLY FINANCIAL REPORT

REPORTING DATE:	11th January 2017
PERIOD DATE:	1st July 2016 - 31st December 2016

EXPENDITURE ITEM	**BUDGET (12 month)**	**ACTUAL (6 month)**
Travel (airfares, taxis, shuttles)	$ 18,800.00	$ 6,971.89
Accommodation	$ 4,800.00	$ 2,332.94
Venue hire, catering and other meeting costs	$ 6,400.00	$ 942.95
Administration allocation	$ 3,880.00	$ 1,068.58
Meeting fees	$ 6,120.00	$ 3,490.00
Overheads (MHAPS' fee)	$ 8,000.00	$ 4,000.00
TOTAL	**$ 48,000.00**	**$ 18,806.36**

Please note $1364.35 are for airfares for the February meeting. The taxi charges can be very late coming through as it is dependant on when the taxi company puts there claim through.



Nga Hau E Wha

"Champion many voices"

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Ngā Hau e Whā

June to December 2016

Report to Ministry of Health

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Page number

2.2 Meetings Held During Reporting Period

Present	Victoria Roberts (Central) (Chair)	Julie Whitla (Vice Chair) (Southern)	
	Tui Taurua (Northern)	Kieran Moorhead (Northern) By phone	
	Grant Cooper (Southern)	Guy Baker (Midland)	
	Jak Wild (Central)	Vacancy Midland)	
Present	Victoria Roberts (Central) (Chair)	Julie Whitla (Southern) (Vice Chair)	
	Guy Baker (Midland)	Grant Cooper (Southern)	
	Kieran Moorhead(Northern)	Tui Taurua (Northern)	
	Jak Wild (Central)	Vacancy (Midland)	

In the six months from June 2016 Ngā Hau e Whā has hosted the following guests:

- Dr John Crawshaw - Director of Mental Health – Ministry of Health
- Emma Tonks Fund Administrator – Ministry of Health
- Kevin Allan – Mental Health Commissioner
- Grant O'Brien - Health and Disability Commission
- Rod Bartling – Group Manager Mental Health Improvement
- Suzy Stevens – Partnership Works

See the embedded minutes for the January/May 2016 meetings for more information in regard to these visits.

Currently we have the following people waiting to attend our meeting:

- Dr John Crawshaw - Director of Mental Health - Ministry of Health
- Caro Swanson - Te Pou
- Kevin Allan Mental Health Commissioner
- Emma Tonks -Ministry of Health

Ngā Hau e Whā is now receiving regular requests by organisations and individuals to attend meetings. This is due to **Ngā Hau e Whā** becoming more widely known and the quality of work improving.

Membership Updates

January 2016 – June 2016

- The Central Region has had one vacancy for about 3 years and this was recently filled by Jak Wild who has extensive networks throughout the north of the Central Region.
- The Waikato region has one vacancy which we are hoping will be filled by the Midland Regional Network.
- All other positions are currently filled.

Ngā Hau e Whā has had stable representation now in the majority of positions for the past two years. Some members of Ngā Hau e Whā are in paid employment and their work is often done with the support and at the discretion of their employers. It is to their credit those members are still able to do the work and produce the reports that they do. Some members are not in paid employment and there has arisen for these members some difficulties with accessing the means and the resources needed to complete the tasks associated with being a member of the group.

1.7 Ngā Hau e Whā Strategic Plan 2016-2020

Victoria Roberts

In October Ngā Hau e Whā undertook a complete revamp of our Strategic Plan. This was the first rewrite of the Plan since the first one was completed in 2013. During that time the Ngā Hau e Whā Strategic Plan document had been updated with appropriate language as per the strategic plan goals. A Strategic Planning meeting was planned for November 2015. This was to update the Strategic Plan as per the schedule. Because of uncertainty regarding the funding for Ngā Hau e Whā this was delayed and the Strategic Plan has been rolled over to late 2016.

In October 2016 Ngā Hau e Whā contracted with Suzy Stevens of Partnership Works Ltd to revise the plan to include the variations which we have added to our portfolio. We are continuing to work with Suzy to the goal of having our new Strategic Plan by early January.

4. Compliance

People

No.	Objective	Indicator
1.	*Increase and strengthen local, regional and national relationships*	**NHEW is working collaboratively with individuals who are receiving services and other groups locally, regionally and nationally** ▪ **Ngā Hau e Whā** continues to work collaboratively with many individuals, groups and organisations. ▪ The National DHB Family and Whānau Advisors Mental Health and Addictions are continuing to liaise through network meetings and email. The two groups will be working together to ensure a family and whānau perspective is included in **Ngā Hau e Whā** work. They have contributed their up to date statements to this report ▪ **Ngā Hau e Whā** continues to share with the networks any useful information in regard to issues that affect people with lived experience and the group is pleased to be of assistance to our peers and colleagues. Our distribution list continues to function well. ▪ Requests continue to come in from organisations who would like to have time at **Ngā Hau e Whā** meetings. ▪ The email network continues to grow and **Ngā Hau e Whā** is always looking to increase the contacts which include individuals using services, as well as advisory groups, peer groups, and service providers with a specific focus on peer led services. People have been approaching Ngā Hau e Whā to be included in this network.
2.	*Be a recognised and respected conduit for the people's voice*	**There is an increase in the level and quality of feedback on issues for people receiving mental health services.** ▪ Current members have large networks that contribute to the information that is reported to the Ministry. The quantity and quality of feedback continues to improve. ▪ Individuals and groups with lived experience approach **Ngā Hau e Whā** with items that they would like the Ministry to know about. Ngā Hau e Whā continually works on increasing its profile. ▪ Commissioning Framework for MH & Addictions. **Ngā Hau e Whā** represented on the steering group by the Chair ▪ NZ Health Strategy was commented on by individuals from **Ngā Hau e Whā** ▪ Mental Health and Addiction Workforce Action Plan was to be reviewed and feedback was provided by 20 January 2016. The chair has been working with the Sector Leaders Group on the Plan. ▪ **Ngā Hau e Whā** was part of the Fit For the Future and submitted ideas for evidence based interventions ▪ **Ngā Hau e Whā** collated the ideas of service users at 2 forums for the Disability Strategy rewrite. ▪ National Organisations request attendance at **Ngā Hau e Whā**

No.	Objective	Indicator
		meetings, to use the **Ngā Hau e Whā** network and to provide consultancy. ▪ Three members of **Ngā Hau e Whā** were part of the Draft Suicide Mortality Review (SuMRC) Feasibility Study Report which has been reported back this year by the Health Quality Safety Commission.
3.	*Champion the use of appropriate language in all major documents.*	**Newly written documents contain appropriate language.** ▪ **Ngā Hau e Whā** endeavours to use appropriate language in all minutes, letters, reports and other documents it produces. The wording in the **Ngā Hau e Whā** Strategic Plan and Terms of Reference has been revised so labelling language isn't used and all language is appropriate. ▪ The contract document between MOH, MHAPS and **Ngā Hau e Whā** is still to be reviewed to ensure appropriate language. ▪ **Ngā Hau e Whā** continues to advocate for appropriate use of language in any feedback on documentation that it provides.
4.	*Initiate projects and promote leadership forums.*	**There is an increase in leadership and initiatives.** ▪ **Ngā Hau e Whā** led the recruitment for the New Zealand Police National Mental Health Project. We continue to follow and receive reports ▪ **Ngā Hau e Whā** was well involved in The Fit for the Future run by the Ministry. ▪ **Ngā Hau e Whā** has also been working within the Mental Health and Addiction Workforce Planning producing written feedback and workshop attendance. ▪ **Ngā Hau e Whā** attended forums and gave significant feedback to the Draft Disability Strategy ▪ **Ngā Hau e Whā** has plans to become an Incorporated Society with the aim of achieving Disabled Persons Organisation status with the United Nations Convention on the Rights of People with Disabilities (UNCRPD).

Performance

No.	Objective	Indicator
1.	*Fulfill contractual obligations to the Ministry of Health and be in a strong position to negotiate for the future.*	**The Ministry of Health demonstrates that it values Ngā Hau e Whā, and funding is increased.** ▪ **Ngā Hau e Whā** continues to build its capabilities to ensure that the Ministry of Health has access to a strong lived experience perspective, whether that comes from within the group or is sourced from the network. ▪ The Ministry of Health has requested consumer input from **Ngā Hau e Whā** members during this reporting period.

No.	Objective	Indicator
2.	*Connect with the grass-roots and collate issues and common themes.*	**Ngā Hau e Whā has increased the mechanisms for providing and receiving information.** ▪ Due to **Ngā Hau e Whā,** now nearly having almost full membership an increase in information is expected. ▪ Regular forums are being held to gauge the priorities and the mood of the consumer movement ▪ Most meetings and forums are attended by an **Ngā Hau e Whā,** member in each region.
3.	*Be a useful and valued commentator on mental health and addiction service issues.*	**Reports and submissions are timely and well-received.** ▪ Informed and comprehensive reports by members in regard to their region are received quarterly. ▪ Ministry of Health reports are delivered on time. ▪ **Ngā Hau e Whā** provides feedback to a number of organisations.
4.	*Have strong and effective representation in NHEW from the four regions*.	**Ngā Hau e Whā is well-known in each of the four regions and representatives are well-supported.** ▪ One vacancy remains at present in Midland ▪ Midland Region is supported by He Tipuana Nga Kakano (Midland Region Consumer Network). ▪ Northern Region is supported by Changing Minds. ▪ Southern is supported by Incite and Awareness. ▪ Central is supported by Kites Trust and the Oasis Network ▪ Positive feedback from members of the network has been received.
5.	*Improve communication processes.*	**Ngā Hau e Whā produces a regular bulletin, has a website and Facebook page.** ▪ A new website has gone live. www.nhew.org.nz – see later in this report ▪ The new website has been further developed to improve our online presence. ▪ **I**t includes various ways for people to make comment and to connect with their local representatives and networks. People are already contacting us via the new website. ▪ The email network is continually expanding and the website will help drive this expansion further. ▪ A Facebook page will continue to be worked on though at present the capacity and capability for this is limited. ▪ Business cards have been developed and are being used by members

Strategies

No.	Objective	Indicator
1.	*Become familiar with service user demographics in our regions and identify where we need to in-crease our visibility.*	**Ngā Hau e Whā has undertaken some market research and applied the findings.** ▪ Still to complete
2.	*Maintain the budget and administrative support to ensure our business processes are efficient.*	**Business processes are working well. A financial report is provided regularly.** ▪ Mental Health Advocacy and peer Support (MHAPS) forward an updated expenditure report for each **Ngā Hau e Whā** meeting. ▪ All administrative tasks including organisation of travel, accommodation, venue, refreshments, are provided. ▪ **Ngā Hau e Whā** would like to acknowledge Shelley Englebretson for her admin support.
3.	*Review our strategic plan and objectives regularly.*	**Strategic objectives are addressed and plans in place for the next strategic plan (2016 - 2020)** ▪ The Strategic Plan for 2016-2020 was revised in November 2016. The final draft of the Plan should be ready for distribution by mid-January 2017. ▪

Terms of Reference

The **Ngā Hau e Whā** Terms of Reference is in the process of being updated to coincide with our new Strategic Plan and will be available for distribution early in the new year.

Service Specification Deliverables

1.7 Overview of National Issues or Challenges in the Mental Health and Addiction Sector

National issues: Discussions with Ngā Hau e Whā members and their networks have identified that aside from the perennial issues such as housing, employment and mental health service providers as serious concerns for service users there is also a vast array of single issue areas which service users' battle with on a daily basis. So we have chosen to focus on these in this report.

1. **Mental Health Services:**

Grant Cooper – Otago

Attitudes: There is still so much variation in staff attitudes and values within mental health from face to face workers to managers, planners and funders. Mental Health services would generally agree that the service user is at the centre of all the work they do yet actions speak louder than words. For example the peer workforce is still only 2% of the mental health workforce (source: Adult Mental Health and Addiction Workforce 2014 Survey of Vote Health funded services). If the service user was truly at the centre of all the work, would not their experiences be more valued not only as paid peer workers but more paid advisors for example in co-design of services.

Note writing: Another example is the lack of collaborative note writing. Mary O'Hagan the former Mental Health Commissioner in an interview with Radio New Zealand in June 2016 commented about acute inpatient units that have " Staff who spend more time in the office than talking to the patient." She also talked about "solutions that are driven by reason and compassion rather than by fear and risk management."

Language and values: The values and attitudes expressed in mental health strategic plans, policy documents and mental health training seem to be watered down at the coal face running of services. Some of these issues are around funding however feedback from service users is still strong as to the variability of attitude of staff towards service users with some positive practices and those contrary to recovery.

Emergencies: Issues still arise with the wait time at Emergency Psychiatric Services. Staffing levels seem to be a significant issue.

A number of people would like to have more crisis options available to them. One idea that has had success in London is a crisis café which people could go along to instead of going to the Emergency Department of the hospital for a coffee and a chat during the night. Over a 6 month period admissions to A&E went down 33%. See the story at: https://www.theguardian.com/society/2015/dec/01/mental-health-problems-late-night-cafe-not-a-and-e

A number of people who access mental health services would like a similar service here in Dunedin for after-hours support.

Access to talking therapies is an ongoing issue with waiting times of concern.

Medications: A number of people are concerned about the level of medication and the length of time they are on it. Feedback includes feeling "numbed" and not been able to feel the emotions he once did as well as memory issues for example not being able to remember the chords on his guitar.

Complaints: Issue for some people of the cost of challenging the mental health system for example getting a lawyer as well as the length of time complaints can be worked through.

Feedback from peers is that the Raise Hope Mental Health Strategic Plan rollout has been dragging on for a long time.

CTO's: There is still a concern over the high number of people under the Mental Health Act. This concern is expressed nationally as well. Of particular concern is the numbers of Maori on CTO's especially in the north of the country.

Sharon Gutsell – Consumer Advisor – PACT Southland
Peer support:
Lack of peer support and peer advocacy services in Invercargill and Southland.
No training opportunities in Peer Support.

Carron Cossens – Waitaki:

Supporting people bereaved by suicide: Issue exists around finding support for people traumatised by attempts to rescue another person: doesn't really fall under ACC descriptors as far as I can identify. This is particularly important when the rescue is unsuccessful- flashbacks, recriminations etc. Risk of PTSD if not dealt with in early stages.

An ongoing concern is support for children impacted by a suicide death. Child services in Dunedin will only respond if a mental health issue is apparent and my argument is that careful management post incident following the death will prevent mental health issues from developing later in life.

Health education: Issue that more and more health pamphlets are now no longer in print- people are referred to websites for material. Government initiative that I think is short-sighted.

Staffing: A developing concern for us is service provision for Palmerston South. Currently Brief Intervention service is only provided out of Dunedin. We don't think this is adequate, and have asked for the service to be resumed based in Palmerston.

Julie Whitla - Christchurch

Counselling: A person with complex issues has been told that they cannot access the free Brief Intervention Counselling more than once a year by their GP.

There has been a noticeable increase of people accessing the drop in at MHAPS which is open at the weekend due to housing difficulties.
Outcomes identified by people with mental health and addiction needs are:

- Homelessness with debts for storage to HNZ for new WINZ issued washing machines and fridges.
- Families living in cramped conditions with inadequate number of bedrooms in huge complexes with limited outdoor space for their children.

- Complexes are busy and for some people the stress of the noise, people coming and going has not been suitable for people with mental health issues.
- *"I called the police because after weeks of abuse, intimidation such as him putting security cameras pointed on my property I"*
- *" The police said I can't get a protection order as I live at a HNZ home and I feel my housing manager is out of her depth with facilitating a solution"*
- Physical health needs were not considered in my application *"Although I have a flat from CCC, My flat is damp and I have to wipe condensation off the windows every day, I am awaiting a lung transplant and have been hospitalised five times in the last two years and still there is no word from the city council"*
- *My HNZ flat is nice but I have low vision eyesight problems and the stairs are not safe. My housing manager said they have done everything they can to make them safe but will not fill in the stairs or transfer me to a suitable unit.*

The WINZ Linwood office in Christchurch no longer has paper applications for benefits and you have to ask the manger for an application. The expectation is to complete applications on line. It causes delays in people receiving benefit entitlement in a timely manner. People who have identified with mental health issues who were placed in HNZ or city council housing during the earthquakes have been seeking housing transfers or have been evicted due to not fit for purpose housing.
(Please see the article – Internet as Disability/Health Issue)

Housing:

- At the moment there is no single person accommodation available in Christchurch.
- There are a number of people in the acute wards who could leave if there was a place to go.
- Purapura Whetu is now partnering with Comcare for family housing.
- People who have identified with mental health issues who were placed in HNZ or city council housing during the earthquakes have been seeking housing transfers or have been evicted due to not fit for purpose housing.

Awareness Consumer Group - Canterbury

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- People have raised concern at Awareness about Lifeline losing their funding as it is an established name in the community where as many consumers do not know anything about the new tele health providers.

- Suicide rate in Canterbury is still high and there has been little change in the numbers. It is of concern to the network as so many initiatives and focus of the whole region has been on mental health since the earthquake including substantial Health Promotion campaigns on well-being.

- One person fed back that they were not given any choice about where to meet at Specialist Mental Health Services except in an old de-commissioned seclusion room and were made to feel blamed when they didn't want to meet there.

2. **Whanau/ Family**

Corinda Taylor Otago

"As a family we were excluded from the care of our loved one right from the start when our family member was placed under the mental health act. In 1999 Parliament made an amendment to the Mental Health Act that required clinicians to consult family/whānau at particular junctures of a person's compulsory assessment and treatment under the Mental Health Act. However this requirement is rarely observed and families are regularly excluded from the care process. We know our loved ones best and can provide valuable information that can aid the clinical evaluation processes.

The privacy act also prevents clinicians from sharing valuable lifesaving information such as the person being suicidal. If families are expected to care for their loved ones in the community then they need to be well informed and well supported by the system since we are not trained mental health workers.
Lack of collaboration with family, lack of transparency and collaborative note writing with the person under their care can seriously hinder the care of the person.

Families struggle when their loved ones become mentally unwell and when they visit their loved one in the hospital setting it becomes a frightening experience. Mental health clinicians do not communicate well with the families who are in shock when it is their first experience with mental health and services. There is no support for families and there is no information on where to seek help.

The first time we became aware of Otago Mental Health Support Trust was well after our son's suicide. This service could have provided us with much needed support and this could have saved our son's life. If the Southern DHB mental health services do not want to support the families then they need to at least provide information as to where families can seek support.

We wish to see an independent family support person AND an independent consumer support person available on the mental health wards specifically dealing with this issue. This person MUST be independent from the Southern DHB.

Navigating the mental health system is complicated which most people find hard. An attitudinal change can go a long way.

Services need to understand that not all families are bad and that we are not the enemy. Work with us to help the person to avert tragedies and let it become a life full of hope."

I am not aware of any new initiatives or developments in our region since all family involvements and feedback are discouraged by Southern DHB services. The last time I was invited to participate

in a survey from the Early Intervention for Psychosis services in 2012 I was told that the survey results were ignored as they had a poor return of only 20% of participants. 20% of people bothered to respond and their feedback which included my own was valuable information that was discarded. Perhaps the truth in those surveys can bring about much needed change.

DHB Family and Whanau Advisors:

Co-Chair Leigh Murray

DHB Family Whānau Advisors continue to provide guidance on working with families and whānau to mental health and addiction workforce via Handover nursing newsletter & Te Pou website. Latest article is 'Moving from Individuation of risk to a shared safety agenda' written by DFWA co-chair Leigh Murray. http://www.tepou.co.nz/news/moving-from-individualisation-of-risk-to-a-shared-safety-agenda/810

- Family Whānau Advisors are looking forward to their annual national meeting Nov 3-4 in Christchurch. This is a great opportunity to feed into & be updated about key projects as well as share best practice ideas 'kanohi te kanohi'. There is a full agenda with all 4 workforce centres, MH Foundation, MoH & HDC Mental Health Commissioner taking up slots. Unfortunately some of our key family advisors won't be there due to travel restrictions currently in place for some DHBs. We are hoping to link them in via video conference.
- DFWA recognises there is probably not a widespread understanding/appreciation of the systemic advocacy family whanau advisor role across NZ. This may be a contributing factor to family advisor vacancies that are of several years duration in a few DHBs. We appreciate that this might also be the case for some consumer advisor positions. Currently there are 22 family advisors in post which equates to 17.87 FTEs nationally.
- We also note that the importance of family, whānau perspective and participation is increasingly mentioned in MH & addictions though this does not always seem to translate into tangible ways of ensuring that the whanau voice is present or included.
- To end on a positive note DHB Family Whānau Advisors contributed significantly to the successful TheMHS pre-conference family & whānau forum held in Auckland on August 23rd with 65 attendees. At the start of the day we demonstrated our commitment to the theme of 'Building Authentic Relationships' with our own whānau by presenting the consumer forum delegates with the gift of a peace lily, a fun fruit face & chocolate with good wishes for an inspirational, fun and learning day.

3. Internet Access as a Disability / Health Issue

Victoria Roberts - Chair

This issue has previously been raised in earlier reports but with the current rewrite of the Disability Strategy it is useful to revisit the matter. There is a need for robust discussion and sound policy formulation around internet access as a health issue.

There is also a need for the current working group whose brief is to align the Mental Health Act with the UNCRPD to take note of this. Other Government departments need to be engaged to ensure that this is progressed (e.g. MSD; ODI)

Internet access is widely available in New Zealand. In 2013 according to Statistics NZ 4 out of 5 homes in NZ have access to the internet[i] and two thirds of rural households had a broadband connection.[ii] This survey showed that for two thirds of those households not connected to the Internet, concern over cost was the reason for them not being connected.

Some of the poorest people in New Zealand are long term beneficiaries and especially those who are unable to supplement their benefits by working such as those on Supported Living Payments (formerly Invalids Benefits) and Job seeker support – with medical deferment (formerly Sickness Benefit). Many of these are people with lived experience of mental illness and/or addiction. The Ministry of Social Development who administer Work and Income (WINZ) do not keep statistics on the numbers of people receiving these benefits who have diagnosed mental illnesses.

Currently, there hundreds of people receiving Disability Allowances in Aotearoa NZ. Beneficiary advocates know that of these a very small number will have persuaded WINZ to pay them an allowance to cover the cost of Internet even if a large number will have a telephone covered as an 'essential' need.

Day-to-day living: The internet has many practical applications and it is widely used for entertainment purposes; reading; games; accessing music, videos and movies. As well connecting with friends' online, chatting, skyping, social networking are all new ways of social interactions that have become the norm and that now hold across all age groups and most socio economic demographics.

For many people with lived experience not having the ability and the right to use this modern day facility because of having inadequate income is unfair and debilitating. When public spaces are too overwhelming and scary due to noise lights and stimulation and online peer support is your only option, then that is when public policy should champion the right to an adequate income to enable that to happen. Some situations are such that people are confined to their homes and the internet becomes their link to the outside world.

E-therapy: Modern medics too are using the internet to provide mental health supports like recent e-therapy tools such as the Sparx e-therapy for young people which was launched 28th April 2014 – a CBT technique in a youth friendly game to teach young people how cope with negative thoughts and to think more positively. There are other mental health tools available on the Internet – John Kirwan's Depression.org.nz; Through Blue; and any number of positive thinking websites. Even the ability to distract is invaluable for someone who is alone and vulnerable. But as detailed above without sufficient resources these sites and such diversions are not be available to all those who could benefit from them.

Employment: The internet has become the first port of call for most job seekers. Job listings, job alerts, employer alerts, are all posted on the internet. So for many people with lived experiences of mental distress, who are seeking employment, many of whom are either unemployed or underemployed, access to the internet is of vital importance. Also there is an increase in the availability of "from home" and online job vacancies. Working from home via the internet may be the only option for some job seekers. Work can be shown to be therapeutic in and of itself.

It has already been demonstrated by others that to be in the workforce or to be looking for work is also to be experiencing discrimination if one has lived experience. Therefore to have an added hurdle of not having instant and easy access to the internet decreases the odds of the much sought employability.

Disability costs: The Internet is also a vital connection to anyone with restricted mobility including those who experience mental distress that makes it difficult to leave their home. However it is not included by the *Ministry of Social Development* when assessing Disability Allowance costs. It is so rarely, as to be almost never included as an allowable cost of disability even though as shown quite clearly above it can quite reasonably be demonstrated to be so. The Ministry of Health may be able to offer guidance in this regard.

International obligations: The UNCRPD underscores the need for disabled persons to be able to communicate freely, and access things they need and having internet in the home undoubtedly facilitates this. The *Ministry of Social Development* appears to be deliberately obstructing applications for the inclusion of internet as part of disability costs. WINZ facetiously make the claim that "most households have internet access and therefore it is not a cost that is due to a

persons' disability. However it is not true that most of the households which have people with disabilities that require internet access actually have it.

Article 9 Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, **States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others,** to the physical environment, to transportation, **to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:**

(b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures:

(g) **To promote access for persons with disabilities to new information and communications technologies and systems, including the Internet**;

We at Ngā Hau e Whā respectfully suggest that the Ministry of Health might assist the Ministry of Social Development to understand its obligations and responsibilities to people living with distress and addictions or the after effects of these to enable them to counter stigma and discrimination that many of us experience at the hands of other people and regrettably at the hands of other government departments as well. Enshrining obligations into the newly rewritten Disability Strategy will be a good way of signalling to everyone a decent way to go.

1. Household Use of Information and Communication Technology: April 2012

1.8 Overview of areas of best practice in the Mental Health and Addictions sector

Corinda Taylor Otago

I would have liked to put something in this section since I am a very positive person and like to find positives in services but unfortunately cannot find one positive at this stage. I do hope that feedback will in time be able to improve this.

Projected best practice in future would be:

- Inform family of what is happening every step of the way so that we can best support our loved ones
- Inform family if loved one is suicidal and the risk factors
- Consult with family to get a full clinical history
- Collaborative note writing
- Keep the service transparent to keep people honest
- Phone calls to be well recorded with parental or family concerns
- Record keeping to be electronic as current handwritten notes can be tampered with after a serious adverse event since there would be no evidence of it
- Inform family/whanau of **all** the other agencies in their district so that they can make their own decisions as to where to seek additional support
- Provide real time feedback from people and their families/whanau so that services can know immediately where their failures are it and can be addressed/rectified immediately

Kia Noho Rangatira Ai Tatou:

Jak Wild Central Region North

- Kia Noho Rangatira Ai Tātou is a unique education programme that puts the human rights of disabled people and the UNCRPD into a New Zealand cultural context. This two day workshop has an applied focus which will help ensure that disabled people's human rights are upheld. The Disabled Persons Assembly and Te Pou o te Whakaaro Nui have worked together to develop this programme which examines human rights and the United Nations Convention on the Rights of Persons with Disabilities (Disability convention). Workshops are being held throughout New Zealand with attendees of the most recent workshop in Napier, Hawkes Bay giving positive evaluation feedback

From Julie Whitla - Christchurch:

- **Acute Wards**
  Occupancy (midnight census) of the adult acute inpatient service has remained at 93% for a second consecutive month. There were 17 sleepovers required in July 2016.
  Canterbury are exceeding Ministry of Health targets with respect to wait times for adult services. The targets are 80% of people seen within 21 days and 95% within 56 days. 97.4% of people referred to the Adult Community Service were seen within 21 days, and 100% seen within 56 days for July 2016. The percentages are 92.9% and 98.8%

respectively when other adult services i.e. Specialty, Rehabilitation and Forensic are included.

Seclusion

- The CDHB focus on reduction of seclusion in Te Awakura (acute inpatient service) continues. Two consumers experienced seclusion during July 2016 for a total of 6.75 hours. There is strong and effective nursing leadership and staff dedication and commitment to maintain the focus of reduction.
- There was discussion around the steeply dropping seclusion rate – this has decreased from 800 hours in April 2012 to 1 hour in the last month commendations to the CDHB for doing this. Awareness (Canterbury Consumer action Group on Mental Health and Addiction) are to be thanked for helping instigate this focus on seclusion reduction and elimination. Debbie Selwood mentioned the DHB is talking much more about seclusion elimination now, rather than just reduction. There is much more of a focus on upskilling staff to be able to provide talking therapies, not just assessment. Mental health staff are also being supported to upskill around supporting people with alcohol or drug problems as well as mental illness.
- In June there was only **one hour of seclusion** recorded in the acute wards. Though rates are going up in other parts of the country, likely as a back lash from some bad media and incidents, the efforts of staff in Canterbury have been excellent. There is anxiety among staff over changes in policy and the increase in assaults on staff. Some feel they are at risk but are still de-escalating patients.

From Sharon Gutsell – Consumer Advisor PACT Southland

- Working on a new referral protocol for people to receive community support services without the need for a needs assessment, removing this barrier to people receiving support services.

Lisa Perniskie, Peer Support, Mirror HQ, Ōtepoti

- Within my team I have been working on how to collaborate and spent time recently on developing a process for our internal referrals to my role.
- With our taiohi it works well to have a mihi whakatau process with myself, taiohi and the clinician to clarify for them what support I can offer and what the clinician will be working with. The taiohi is given the opportunity to discuss what they would like support with.
- It is very isolating for me being in Dunedin as there are very few peer support workers here. I have had a lot of support from OHMST and would like to thank Grant for his ongoing support of my role.
- I would like to participate more in best practise within the southern area and find out more about what is happening in our area- Te Wai Pounamu.
-

Changes or developments that have come out of Rising to the Challenge

Rising to the Challenge

Kieran Moorhead - Auckland

Rising to the Challenge

Health outcome: Reduce morbidity and mortality for people with mental illness

What are we aiming for in 2016/17? (Our measures)

Key measures

- At least 95% of child and youth clients discharged from community mental health and addiction services will have a transition (discharge) plan
- 80% of 0-19 year olds referred for non-urgent mental health or addiction services are seen within three weeks and 95% within 8 weeks.

Other measures

- Access targets for mental health and addiction services: 3.1% (4.4% for Māori) for 0- to 19-year-olds, 3.4% (7.6% for Māori) for 20-to 64-year-olds, and 2.1% for those aged 65+ years
- 95% of older adult service users meeting the criteria will have a current relapse prevention plan.

How will we achieve this?

- Providers will be reliably and consistently collecting social outcome indicators by June 2017.

Actively using our current resources more effectively

- Continue roll-out of a new model of community acute response in Rodney and West Auckland, following the successful North Shore pilot, by June 2017
- Participate in regional plan activity – High and Complex needs, Eating Disorders, Substance Addiction (Compulsory Assessment and Treatment) Bill, Māori workforce development plan, framework for suicide prevention training, review of child and youth services, offender health, and forensics (youth and adult) - ongoing
- Mental Health and Addictions NGO sustainability - with the Mental Health and Addictions sector, implement the agreed work plan and complete 2016/17 objectives by June 2017
- Utilising a co-design process, develop a Shifting Services plan across DHB Provider Arm and NGO services to deliver the right care, in the right place, at the right time, by the right people. Plan to be completed by June 2017
- Continue to work collaboratively with Police to identify and implement initiatives that will improve the experience of people with mental distress who come to Police attention. Ongoing.
- Actively participate in the development of the Commissioning Framework and develop an implementation plan once the final Framework is published by June 2017.
- Maintain regular meetings and communication with key stakeholders from the Ranui Social Sector Trial to develop, agree and implement a transition plan. June 2017

Integration between primary and specialist services

- Plan and implement integration of General Practice and NGO support services based on the

model(s) developed within the Tamaki Mental Health and Well-being Initiative, prioritising Whānau House and Totara Health, by June 2017

- Further develop primary mental health integration with Totara Health based on the evaluation (evaluation due March 2016) by June 2017
- Improve the interface between the Community Alcohol and Drug Service and primary care – ongoing
- Design access for primary care clinicians to advice, information and screening from provider arm clinicians by June 2017

Resilience and recovery

- Develop an Equally Well action plan for the Waitemata and Auckland DHBs to improve the physical health of service users. The initial stages of this plan will include the ability to record physical health status and development of baseline data, to be completed by June 2017
- Evaluate clinical processes around assessment and treatment of Māori under community treatment orders by June 2017
- Monitor and analyse section 29 Mental Health Act treatment orders for Māori. Ongoing
- Run focus groups with non-Māori clinical staff to better understand perceived differences in assessment and treatment of Māori under CTOs (Section 29), identify gaps in current service delivery to Māori and recommend steps for improvement by June 2017
- Ensure reliable collection of seclusion and restraint use data for Māori, and analyse the data to understand differential rates of use for Māori by June 2017
- Māori and Pacific service users have the highest physical health comorbidities. Ensure routine metabolic screening for secondary service users, with priority focus on Māori and Pacific clients by June 2017
- Deliver 2016/17 actions of the Auckland and Waitemata DHBs' Suicide Prevention and Postvention Action Plan (2015-2017). The plan and the actions will be guided by the Advisory Working Group and Inter-Agency Advisory Group, and will prioritise at-risk populations (e.g. youth/rural/Māori). Activities in 2016/17 will include developing community resources, wellbeing and resiliency; training community members and health providers to identify and support at risk individuals; and develop pathways between primary and secondary care providers – to be completed by June 2017
- Implement the priority actions identified from Everyone's Business: a mental health and employment strategy for the Auckland and Waitemata DHB regions by June 2017
- Support Parents Healthy Children (COPMIA) – all services to develop action plans, and establish routine data collection and service champions by June 2017.

Delivering increased access

- Implement the 2016/17 actions of the Waitemata Stakeholder Network Service development Plan (2015-2020). Actions to be completed by June 2017 include increasing access to Child and Youth services in Rodney, delivering the first Incredible Years course in Chinese and Korean languages, and utilising service user feedback in Older Adult service planning and evaluation
- Continue development of shared care between secondary and primary services for aging population between Services for Older Adults and primary care. Ongoing.
- Increase access to alcohol and drug services through improved relationships with education, justice, health and child protection services by June 2017

Impact of Ngā Hau e Whā

Victoria Roberts – ~~Central Region North~~Chair

The Information Provided by Ngā Hau e Whā to the Ministry of Health

- **Ngā Hau e Whā** work supports the Ministry of Health (MOH) to respond to the issues people receiving mental health and addiction services face in a timely manner. This information is directly from people using services and includes NGO's and their clients and so cannot be sourced from the reporting District Health Boards. Because it is sourced from people with lived experience it is invaluable.
- MOH is able to use the information provided by **Ngā Hau e Whā** to inform policy, procedure and new developments. **Ngā Hau e Whā** gives the ministry an insight into what matters to the people who are affected by the decisions made at ministry level.
- **Ngā Hau e Whā** reports are distributed throughout the ministry and sent to the Director of Mental Health's office.
- The integrity of **Ngā Hau e Whā**'s work means that the group is a ready resource for gaining the viewpoint of people with lived experience for example: the external reference group for 'Rising to the Challenge' and for ministry interview panels. Also quarterly reports keep the ministry in touch with what is happening in service user's daily lives.
- The MOH sees worth in the work that **Ngā Hau e Whā** is doing. Especially the networking of groups such as **Ngā Hau e Whā** with SF, Platform and other service user interest groups.
- Many opinions and standpoints, give the Ministry a more rounded picture of what is happening for people with lived experience in the sector.

E-Network

The **Ngā Hau e Whā** E-network continues to grow. Requests are now coming in for **Ngā Hau e Whā** to send out information through the network on behalf of others. Members are utilising their business cards as a means of growing the network. **Ngā Hau e Whā** has no way of knowing how far and wide the E-network reaches. Work will continue on increasing the network and sharing information.

Website

Ngā Hau e Whā Website June 2016 <www.nhew.org.nz>

The new Ngā Hau e Whā website is completed and has gone 'live', replacing the old website hosted by Midland Health. Ngā Hau e Whā sees this as a bold step that indicates the importance that independence and autonomy brings to our work.

We see the website as key to helping to build, educate and connect the sector networks, both locally and nationally.

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The website is based on the previous design, but has much greater capability for modifications and further development, with Ngā Hau e Whā 3 representatives forming a sub-group as administrators and developers of the site, including the person who was contracted to re-host, re-design and build the new site.

The website is designed in a way that it's content, functioning, and design is 'open', flexible and simple for administrators to manage, allowing the site to remain in the hands of the Ngā Hau e Whā representatives into the future, rather than having limited funds go to professional developers and a third-party host. Previously the website was overseen by third-party developer, Black Sheep who were contracted by Midland Health.

Further work is being undertaken so that the website will manage the entire Ngā Hau e Whā networking capability, such as the distribution list, feedback and comment, and promotion of our stakeholders and network communications, and most importantly a blog and links to Facebook and Twitter.
It is expected this new arrangement for our website and online and social media presence will bring about a considerable cost benefit to Ngā Hau e Whā. This saving will be presented in the next report, once we are better informed as to the previous specific costs associated with Midland Health hosting the website.

It is expected this new arrangement for our website and online and social media presence will bring about a considerable cost benefit to Ngā Hau e Whā. This saving will be presented in the next report, once we are better informed as to the previous specific costs associated with Midland Health hosting the website.
Jak Wild Website Design.

Bulletin

Ngā Hau e Whā has intentions to produce a regular bulletin of highlight items from the minutes and regional reports which are of specific use to those in our networks. The intention was to send out to e-networks and place on the website. Unfortunately our human resource does not have the capacity to do this work currently. Minutes from **Ngā Hau e Whā** meetings will continue to be posted on the webpage and sent out via the network.

Regional Reports

Nga Hau E Wha

"Champion many voices"

Member: **Tui Taurua-Peihopa**

Region: **Northland**

Meeting: **7/8 September 2016 3/4 November 2016**

1. Issues/challenges identified by people in your region

Hui to discuss the Mental Health and Addiction Framework

- 40 attendees including the Northland Ngā Hau e Whā representative.
- Lots of discussion around choice, partnership, and communications

Prescribing of medication

- Issue around prescribing in the region. There is only one psychiatrist who is able to prescribe medication and an alternative provider is not available to tangata whaiora and this causes problems when a person s requires daily prescribing.
- If a person does not want to use a particular pharmacy or they can't, then it is about an hour to Kaikohe.

Not all tangata whaiora have GP's and are reliant on the psychiatrist to prescribe. Without a nurse or other clinician people have too little choice.

Security at WINZ

- Up to 4 security guards are being stationed at each of the WINZ offices which claimants report they find intimidating with a feeling of being judged and watched. A report from one Maori security guard is that he "felt he was being used against his own people

Maori Consumer advisor

- Reports from clinicians that there is a need for a Maori consumer advisor in the region. Issues also raised around the need to have face to face contact rather than over the phone which raises challenges due to the remoteness of the Northland region

Communications

- A report of a letter from the Kaikohe Community Mental Health team to a service user was sent out without the name of the psychiatrist the person that the person was due to be seen by. The person had an hour drive to attend the appointment but the psychiatrist was sick but no one had attended to informing the service user not to attend.

- Lack of communicating appointments e.g. Appointment contacts; little or no advancement acknowledgement appointments
- One psychiatrist for Far North; changing of psychiatrists up to every six months.
- Lack of choices when requiring a change of psychiatrist.
- Mental Health persons being bullied on the streets.
- Children and poverty; young children seeking funds through using criminal tactics as have no food at home; parents are using money for their alcohol and drug needs.

We need to develop a Peer Support Service using Maori Models of Practice.

2. Best Practice according to people in your region

Intra-muscular prescribing

- Reports of inconsistency between clinicians around aspects of holistic health at Kaikohe health center. A new clinician gave an excellent assessment and education around all aspects of holistic health which had not ever happened with previous clinicians

- We need to develop a Peer Support Service using Maori Models of Practice.

3. New Initiatives /Developments in your region

Te Haurahi te Pounamu – Maori pathways

- This is the name of the newly formed national Maori network
- Northland Ngā Hau e Whā representative attending a hui in Nelson to support Iwi to reconnect with each other.

Kia Noho Rangatira Ai Tatou:

- Kia Noho Rangatira Ai Tātou is a unique education programme that puts the human rights of disabled people and the UNCRPD into a New Zealand cultural context. This two day
- workshop has an applied focus which will help ensure that disabled people's human rights are upheld.
- The Disabled Persons Assembly and Te Pou o te Whakaaro Nui have worked together to develop this programme which examines human rights and the United Nations Convention on the Rights of Persons with Disabilities (Disability convention).
- Workshops are being held throughout New Zealand. Workshops in the Northland region so far have included one for Disability Support Services in Whangarei last month, with another

- planned for Disabled persons later this month. Attendees have reported very favourable on last month's workshop.
- Human Rights Workshop October 2016 Whangarei by Te Pou Auckland:

Attended this workshop with my team of Maori. Very good workshop provided by Jak Wild; Hee Barnett and Vicki Terrell.

An evaluation of the workshop was provided to Te Pou by my team.

We evaluated the Te Tiriti o Waitangi presentation.

We were clear that as members of Nga Puhi we were not happy with the presentation thus far. From this evaluation, we had a phone conference with Frances Anderson, Bill Hamilton and Kaumatua Peter Mason.

We had an in-depth discussion which would be included they coming back to us when completed their process.

Staff Recruitment

A belief of a Tangata Whaiora Maori Workforce: re Ngā Hau e Whā and Te Rau Matatini
One psychiatrist for Kaikohe; lack of choices

Distribution List

Over next three months will develop a distribution list for Northland. I will make contact with people who may be interested in being on this distribution list.

Rural Community

Work on proposed 'Framework to improve Mental Health and Addictions Outcomes in Rural NZ.' The Kaikohe rural group met in September and they have run a workshop that 500 or so people responded to. A draft proposal has been completed and a second meeting on the 16th November to discuss this draft.

Northland Issues pending -

1. Prisoners and Mental Health: Nga Wha Prison
2. Veterans and Post Traumatic Stress Disorder, Depression, Suicide, Physical Health due to Agent Orange (Wai Claims)
3. Mental Health Act and the Marae
4. Suicide Prevention Action Plan
5. Seclusion Numbers
6. Respite

Relationship Building Expectations

- Te Rau Matatini
- Te Huarahi o te Pounamu (Maori National Tangata Whaiora Roopu)
- Te Pou
- Rural NZ
- Maori Networks
- Nelson Consumer Networks
- Maori Networks
- United Convention Human Rights
- NGO Governance Group, Northland

Tui Taurua-Peihopa
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s 9(2)(a)

Nga Hau E Wha
"Champion many voices"

Representative ~~Name~~: **Guy Baker**

Region: **Midland**

Meeting Date: **8-9 September 2016**

1. Issues or Challenges in the sector as identified by people receiving services in your region

TAIRAWHITI – Guy Baker

Consumer Advisory Group (made up of service users, meeting held second Monday of every month)

- Still a lot of discrimination being experienced by those under the Mental Health Act. Gisborne District Council Councillors reported in the Gisborne Herald their desire to rid beggars, whom they termed as mental health sufferers, from the streets of Gisborne. This was followed by a covert survey by Heart of Gisborne (Business Collective) asking retailers if "beggars" were sitting outside their premises or if they were aware that "beggars" were outside other premises, if they supported this and if so why? Some Councillors were of the opinion that they should be prosecuted through the courts.

Feedback gleaned from support workers, peer support worker, whanau ora workers, and others providing services in the Tairawhiti region:

- Suicides continue to be prevalent. Although hard statistics have yet to be confirmed by the Coroner's office for recent periods the numbers that services have been involved in suggest that rates continue to climb. An 8-day period in August saw four completed suicides alone where services attended post vention incidents.
- Housing respite services being placed under increasing pressure as there are not enough beds to cope.
- Lack of emergency and social housing continue to be a struggle for all workers alike.

TARANAKI UPDATE- Nic Magrath

- The Taranaki Consumer Advisory Groups still struggle to encourage people to attend.
- Ombudsman Report highlighted the appalling state of the environment in Te Puna Waiora. This has been on the risk list of Taranaki District Health Board for a number of years and the inpatient unit awaits much needed refurbishment.

EASTERN BAY OF PLENTY – Arana Pearson

- Workloads are peaking with varied and challenging circumstances.
- Lack of supportive accommodation adding to continuing social issues that impact mental health needs. Wait lists are long.
- Several male clients have been victims of violence and robbery.
- Transport remains a problem in the area as many do not have driver's licenses, no vehicle or access to public transport despite efforts to alleviate.

LAKES – Susan Freeman

- Difficulties for consumers to access emergency housing. Life wise hold the contract however referrals are only accepted through two providers.
- Very limited free counselling available in Rotorua. Salvation Army are no longer offering free counselling services.
- Emergency food grants are increasingly becoming difficult to obtain through MSD and are often declined. Only recourse is through Salvation Army who are still willing to provide food parcels.
- Taupo Consumer Group is difficult to get up and running.

2. Best Practice according people in your region.

TAIRAWHITI – Guy Baker

- Feedback Informed Treatment data is providing valuable indicators however progress is developing in this area with the knowledge that wider use and increased data will only enhance current services
- Consumer Engagement Strategy has been completed and wider consultation workshops are to be held this month.
- Peer debriefs for those currently being placed in seclusion continue to support initiatives for ending seclusion.
- Consumer Advisory Group (CAG) continues to be very active despite the wintery months. This monthly meeting of consumers has had a number of different guest speakers including Psychiatric Ward Manager, Health & Disability, Budget Advice and even a previous Consumer who related benefits they have had after successfully completing a smoke cessation programmes following 14 months of continuing to be smoke free etc.

- A submission to the Minister of Justice, Amy Adams, is currently being prepared to advocate for marae based mental health hearings.
-

TARANAKI – Nic Magrath

- Real Time Feedback is now available through Alcohol & Drug, Adult Community outpatients, across the three acute services and with community teams. A review of this is yet to be conducted.
- Telemedicine (consultations via video conference) through the South Taranaki MH Service have been found acceptable but staff are disappointed that it hasn't yet equated to more appointment slots as promised.

EASTERN BAY OF PLENTY – Arana Pearson

- Peer support and advocacy groups meet weekly and provide on-going programme delivery to participants.
- Support of local dentists to access urgent dental care has been outstanding and tangata whaiora have been able to obtain urgent appointments.
- Good collaboration with WINZ staff have been particularly helpful.

LAKES – Susan Freeman

- Focus Groups are underway for YouthNav, a new addition to WebHealth.
- Monthly Consumers Groups continue to be held.
- VIP (Consumer) Group, Rotorua, trial run a consumer led facilitation and participation workshop.

3. New initiatives / developments in your region.

TAIRAWHITI – Guy Baker

- A collaborative Post Vention Suicide Group has been formed bringing together an array of services (Police, Victims Support, Hauora Tairawhiti Mental Health & AOD, NGO Mental Health & AOD providers etc.)
- Developments occurring as Hauora Tairawhiti works towards "ending seclusion". Funding has recently been granted to refurbish a current seclusion room into a low sensitive environment. Training for staff is also being planned.
- Revelations of occurring themes continuing to be identified in SAC1 incidents have prompted further investigations into the effectiveness of initiatives to address the gaps and the recommendations and whether these have actually been fully incorporated.
- Dr. Di Rangihuna (ICAMHS Psychiatrist) and her Whanau Ora Pakeke husband Mark Kopua continue to develop their Mahi-a-Atua programme, that delivers a holistic approach to instill "purakau" (Maori Atua stories) to enhance a consumers well-being, by training of mataora (practitioners) to facilitate workshops on this practice.

TARANAKI – Nic Magrath

- Suicide Prevention and Postvention Coordinator has been appointed to this new role that is being supported by Tui Ora
- Recovery Action Plan (RAP) has now been rolled out but faces challenges in its implementation.

EASTERN BAY OF PLENTY – Arana Pearson

- Partnership between the Peer Group and Centre 401 (consumer run service) has developed confidence, participation and enthusiasm for continued peer run experiences and events.
- An opportunity to work with mental health clients from Opotiki in partnership with CMH Whakatane is being welcomed.

LAKES – Susan Freeman

- Representation has been gained on Lakes DHB MH&AS Clinical Governance (via Consumer/ Whanau Representative) and on the SPHC working party at Lakes DHB.
- Linkage to commence a peer led LGBTI group

4. Addiction

TAIRAWHITI – Guy Baker

- AOD Review of Hauora Tairawhiti has commenced with an initial stocktake of services and meetings with a myriad of stakeholders including services, managers, stakeholder organisations, consumers and whanau. This review and final reporting will conclude in December 2016.

TARANAKI – Nic Magrath

- An OST programme survey coinciding with an external audit was completed. A work plan has been developed to address the recommendations given.

5. Family and Whānau

TAIRAWHITI – Guy Baker

- A Family and Whanau Consult Group has been established to ensure family and whanau are provided with an opportunity to have input into local, regional and national mental health and addiction service provision and that their views contribute to the ongoing development and quality.

LAKES – Susan Freeman

- With Linkages new service development input from consumer and family is a priority.

Nga Hau E Wha

"Champion many voices"

Representative: Jak Wild

Region: Central North

Meeting date: 8/9 September 2016 3 /4 November 2016

Introduction:

This is the writers' first report after recent selection for the Central (North) representative role. The role had been vacant for some time with contact details not readily available for the previous representative, resulting in their not being a handover of the role. Therefore, communications with stakeholders and networks will take some time to build up, hence the limited information in this report, with reporting relying mainly on information from local media and online networks

Networking

Contact and communications with the Central Region (North) stakeholders and networks has been slowly progressing, with new persons identified to include in our local distribution list.

Face to face meetings with numerous services has resulted in communications with relevant persons for ongoing liaison including: Whatever it Takes Team Leader, Emerge Aotearoa Consumer Advisors and GM, Salvation Army Consumer Advisor and Lieutenant Colonel, Dalcom Health Care GM and Consumer Advisors, Supporting Families National Coordinator and Manager, Te Hauora Runago O Wairarapa Consumer Advisor, Wharenikau Consumer Advisor.

Although there has been only small number of reports from stakeholders for this quarters report, the expectation is there will be increased information for the next report based on the new contacts made over the last two months

1. Issues/challenges identified by people in your region

1. Mental health services:

Opposition parties, trade unions and special interest groups have been highlighting many issues of concerns nationally in Mental Health service delivery over the last 6 months. Local Media has culminated reporting on calls for a public inquiry with special mention of waiting lists for youth in the region. Up to June 2016 Whanganui DHB had 35.6% of young people waiting more than three

weeks to access mental health services. Hawkes Bay DHB reportedly reduced their waitlists for youth of 3 weeks or more from 32.6% to 13.9%. The national target is 20%.

2. Crisis services

Ward 21, Mid Central DHB's Palmerston North inpatient unit continues to raise concerns in the media including a recently released Ombudsman report under the Crimes of Torture as well as a recent report by the Counties Manukau, chief medical officer, Dr. Gloria Johnson. Reporting to MidCentral DHB's quality and excellence advisory committee Dr. Johnson noted that the ward design was "*very unsuitable... the intensive care unit still looks and feels intimidating and imprisoning, rather than therapeutic*". The 2015 Ombudsman Crimes of Torture report noted *"incomplete seclusion and restraint records and ….call bells in seclusion rooms that did not register….and a ward design not conducive to providing safe effective mental health care".* The parents of a woman who suffered a self-inflicted death at the ward have appealed for the MidCentral District Health Board to get on with a rebuild.

Star 1, Mid Central DHB's 15-bed elder care ward including mental health service users also had a concerning 2015 Ombudsman's Crimes of Torture report noting *"Service Users were being subjected to prolonged and excessive use of mechanical restraints, specifically having a device called a 'T-Belt' used on them for up to four hours at a time".*

The recently released 2013 Ombudsman Crimes of Torture report into Whanganui's inpatient unit Stanford House, noted night safety orders still being used (e.g.; service users being locked in their rooms at night, effectively being an unrecorded seclusion event). It is currently not known whether night safety orders are continuing at Stanford House.

3. Housing

Local media has continued to highlight the problems of homeless ness particularly in Palmerston North. A recent inquiry into homelessness led by the Labour, Green and Maori parties reported on research that found each person living on the street in New Zealand cost the Government around $65,000 a year. Getting them off the streets and into secure housing could cost as little as $15,000.

The Salvation Army reported New Zealand's housing crisis is having a devastating impact on the most vulnerable families and individuals. With housing and living costs now at an all-time high, one in 100 Kiwis are classed as homeless because they are living in unsafe or unsuitable locations.

An overnight event in October in Palmerston North titled "14 Hours Homeless" had a good turn out with people joining hundreds of other Kiwis around the country who slept out in a car, on a couch or on cardboard to raise funds to help New Zealand's homeless population.

4. Legal Challenge

Local peers have attended the past months high court hearing in Wellington brought by human

rights lawyer Dr. Tony Ellis. The case involved three men with intellectual disability and mental health issues (two also have autism). Dr. Ellis said the treatment of all three had caused them to become institutionalized describing their treatment as 'warehousing'.

Allegations include arbitrary detention, solitary confinement (seclusion), restraint and injury, over-medication and a denial of access to family, friends, advocates and lawyers, and a denial of access to possessions. These incidents are alleged to have happened over many years while the three men were in forensic health facilities, where two still remain. They were all committed as special patients after coming before the courts more than 10 years ago. They are suing the Government for more than $800,000 for the years they have allegedly experienced ill-treatment. The men did not appear in person with video interviews shown to the court instead.

Dr. Ellis reported that the case is significant because *'the rights of the intellectually disabled are rarely, if ever, litigated ... this case becomes important because of that'.* The court has heard from DHB clinicians, Ministry of Health staff and others who work in the field. The abusive treatment, if proved, would contravene the NZ Bill of Rights Act and the UN Convention on the Rights of Persons with Disabilities including Article 14, liberty and security of disabled people.

Link to Herald article containing Ombudsman's Reporting on Torture in NZ

http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11676336

Mental health services:

Media

Mental health continues to be a major focus in the local media since our last Ngā Hau e Whā report. Concerns raised, focus on service access and availability, staffing levels, the increased suicide rates, availability of and misuse of methamphetamine, seclusion and restraint (especially in schools and dementia units), homicide in the context of mental health distress, and policing issues (including mechanical restraints such as Spit hoods and the increased crisis calls to regional police forces)

Many of these media stories increase debate in our communities and concerns that can at times fuel additional stigma and discrimination. Service users have commented on the lack of positive discrimination initiatives such as the Like Minds media campaigns in years gone by.

Places of detention

The Ombudsman has recently released their 2015/16 Annual Report which is available on their website. Pages 40 and 45 - 49 of the report has the specific detail related to Health and Disability places of detention but there is also other relevant comment to people who have lived experience of a psychosocial disability elsewhere in the report.

A summary of the concerns specific to mental health facilities are as follows;

- Some adult inpatient units being “unfit for purpose”

- Older persons being arbitrarily detained

- Prolonged and excessive use of mechanical restraints

- Complaints policies not being readily available

- Incomplete and missing seclusion records

- Seclusion rooms used as long-term bedrooms

- Lack of restraint training for staff

- A service user found still in seclusion after being seriously assaulted despite requiring surgery 10 days prior

- 'Informal service' users being "environmentally detained" in locked wards and then being concerned they would be committed if they wanted to leave

- Service users not being able to access the minimum entitlement to daily fresh air

- Night Safety procedures continuing

WINZ Beneficiaries

Around the country the Ministry of Social Development has introduced a type of app for smartphones and computers (requiring very little data cost) called “My MSD”. It is a user friendly app and provides a lot of information individuals need about checking payment details, declaring income, changing bank accounts, managing appointments, reporting job search, re-applying for job-seeker support, change of address, updating contact details.

Social Services “One Stop Shop” in a rural location has reported a number of their clients don’t live in cellphone range and don’t own a computer or afford data for their phone. They noted these clients are always out of credit for phone calls and texts. Even establishing a “RealMe” login is challenging for many, which is a requirement for pre setting up the MyMSD login. It is reported that many Social Service providers have despaired at setting up the Government’s RealMe identifier. It can be quite a stressful experience, particularly for the elderly and those who already experience stress in their lives.

2. Crisis services

Spithoods

Statistics released by police under the Official Information Act show Spit hoods were used 316 times between August 2014 and July 2016. In just over a quarter of those times, the hoods were

used on people who were 18 years old or younger. Concerns have been raised in the media about the impact especially on vulnerable adults such as persons with mental health issues which it could be particularly distressing for.

New Zealand Police acknowledge Spit hoods are "an intrusive mechanical device" with Amnesty International UK warning the hoods "could restrict breathing and create disorientation, and could be dangerous".

Mid Central DHB inpatient services

STAR 1 (Elderhealth) the 15 bed ward that provides services for the treatment, assessment and rehabilitation of older people (over 65), including those with mental health issues is again reported on by the Ombudsman, this time in their annual report. Mention is highlighted of evidence that some service users are being arbitrarily detained without documentation, and some service users were being subjected to prolonged and excessive use of mechanical restraints.

Mid Central's Ward 21 is a 24 bed ward with dedicated wings for both men and women. The High Needs Unit (HNU) is a secure, 6 bed unit for clients under the Mental Health Act experiencing more traumatic symptoms of mental illness. Crimes of Torture Inspectors found that the ward design, in particular the HNU, was not conducive with providing safe and effective mental health care. Also the DHB's complaints policy, and information on access to the District Inspectors, was not readily available in the ward. The seclusion and restraint registers were incomplete and some seclusion records were missing.

Visits to STAR 1 and Ward 21 in December 2015 resulted in 19 recommendations by the Crimes of Torture Inspectors across both facilities.

2. Best Practice according to people in your region

Fielding Integrated Health Centre

MidCentral DHB has opened its latest integrated family health center in Fielding. The new center is a multi-million dollar facility that houses many of the health services a person needs including mental health and all other general practices, as well as radiology and a pharmacy.

Integrated family health centers (IFHC) are a goal across the MidCentral region so as to provide central health hubs for communities which are more than just health centers. They will bring services closer to home, allow for more specialist services, and work to strengthen communities. IFHCs around the district include Te Waiora in Foxton and now Feilding, with a further IFHC nearing completion in Palmerston North. Once the Palmerston North facility is completed, around 60 percent of the MidCentral regions population will be covered by an IFHC."

Kites Trust

- Kites are continuing to undertake 3DHB funded action research looking at peer advocacy work. The work will continue until the end of December 2016 and is proceeding very well.

- Kites Trust have successfully received new contracts, including additional contracts for their Buddies Peer support service which will now extend to Hutt Valley DHB's inpatient unit, in addition to the pre-existing contract with CCDHB, a new Youth Advocacy Project - Peer Tree, and a successful collaboration with Te Korowai Whariki with the Intentional Peer Support contract.

Whirlwind

- Whirlwind men's mental health support networks are popping up around the region. They have a website (www.whirlwindstories.com) and facebook page. A monthly male-only dinner get together is held at Hightide Café, Paraparaumu Beach.

3. New Initiatives /Developments in your region

Kia Noho Rangatira Ai Tatou:

- Kia Noho Rangatira Ai Tātou is a unique education programme that puts the human rights of disabled people and the UNCRPD into a New Zealand cultural context. This two day workshop has an applied focus which will help ensure that disabled people's human rights are upheld. The Disabled Persons Assembly and Te Pou o te Whakaaro Nui have worked together to develop this programme which examines human rights and the United Nations Convention on the Rights of Persons with Disabilities (Disability convention). Workshops are being held throughout New Zealand with attendees of the most recent workshop in Napier, Hawkes Bay giving positive evaluation feedback

Mental health Awareness week:

- The region is gearing up for this year's Mental Health Awareness week from 10th to 16th October with this year's theme being on connecting with nature. Previous years has seen many events organized in the region with this year expecting to be no exception.

Campaign to review the mental health system:

- Over the next 3 months in the lead up to Mental Health Awareness Week in October, campaign group Action Stations is inviting New Zealanders to share their experiences of the public mental health system. Their aim is to promote public pressure to initiate a review of the mental health system.

  Titled 'The People's Review of the Mental Health System" it is designed to allow anyone involved with mental health in New Zealand – from mental health professionals to those with either personal or family experience of the system – to tell their story via a purpose-built website, publicmentalhealthreview.nz.

Review of the Disability Strategy

- Ngā Hau e Whā representatives attended Disability Strategy review meetings. Based on group discussions at the Wellington and Manawatu region Hui's a report was drafted on behalf of Ngā Hau e Whā and submitted as part of the consultation specific to psychosocial disability.

Peer Tree

- Kites Trust is developing a Youth Peer Support Programme for young people who experience mental distress. This project has been made possible through funding by the Todd Foundation.

  The program is for young people (18-24 years old) who are experiencing mental distress. The groups will be facilitated by young people with lived experience of recovery, trained in the Intentional Peer Support model.

Buddies

- Kites agreed to extend its Buddies service to the Hutt Valley DHB in-patient service Te Whare Ahuru. The new Buddies service will be based on the current CCDHB Buddies service at Te Whare O Matairangi. Volunteers are being recruited and a coordinator has been employed.

New Hawkes Bay mental health unit

- Hawke's Bay's new mental health unit was officially opened earlier in the year and has just won an accolade for its design. The new $22 million unit, Ngā Rau Rākau, is on the grounds of the Hawke's Bay Hospital. It is a 23-bed unit made up of 16 inpatient beds and seven sub-acute beds. However, the Improvements to the mental health unit were reported in the media to have "blown out the MidCentral District Health Board's budget with the DHB forecasting a deficit expected to be $2.7m"

Rural Mental Health

- New rural health national initiatives continue to generate local interest especially in the Wairarapa. This includes new initiatives such as Farmstrong who have a series of North Island Woolshed music events in October and November. Also DairyNZ introduced the GoodYarn initiative in February and has run more than 30 workshops nationally including in our own region, helping more than 600 farmers and rural professionals. The East Coast rural Support Trust have created a resource "*Feeing Down on the Farm"*

3. New Initiatives /Developments in your region

Kia Noho Rangatira Ai Tātou:

The Kia Noho Rangatira Ai Tātou education programme that puts the human rights of disabled people and the UNCRPD into a New Zealand cultural context continues to be held around the

county. This two day workshop has an applied focus which will help ensure that disabled people's human rights are upheld.

The Disabled Persons Assembly and Te Pou o te Whakaaro Nui have worked together to develop this programme which examines human rights and the United Nations Convention on the Rights of Persons with Disabilities.

Workshops in the Central region so far have included one for Disability Support Services and one for Disabled Persons in Whanganui, one for Disabled Support Services in Hawkes Bay, with another due in Wellington the end of November. Attendees have reported very favourably on the workshops to date.

Mental Health Awareness week (MHAW):

The region held many events and initiatives in celebration of Octobers Mental Health Awareness week. The theme was connecting with nature with initiatives including:

- Mental Health services at Mash Trust having a series of special events on including bush walks and arts projects linked to nature.
- 'State Highway 48' was a musical that toured the North Island throughout Oct as part of MHAW. Good turnouts were seen for the Central Region shows including shows in Napier, Palmerston North and Whanganui. The musical tracked the life and times of an everyday family and their friends as they navigate the road of middle age with a reminder about what's important; the dangers of not facing up to depression and a celebration of the everyday.
- The New Zealand Association of Counsellors had a series of public lectures in Hawkes Bay as part of MHAW including topics such as Reducing stress with Beachcombers Q&A's, Causes and Tools for Managing Anxiety, and Holistic Wellbeing
- Other events included Palmerston North's 'Gentle Stroll around the Esplanade' followed by morning tea, Whanganui Regional Health's team Shared Picnic Kai, and various bake and cake events in Manawatu, a week-long series of talks in Whanganui by various service user and services, and a series of guided walks throughout Manawatu.
- Unfortunately there was no reports of any events being held in the Wairarapa region

- **Review of the Disability Strategy**

  Embedded with this report is the submission that the Ngā Hau e Whā Central Regions representatives drafted for the Disability Strategy review. The submissions was based on group discussions at the Wellington and Manawatu regions hui's, with the focus on the consultation that was specific to psychosocial disability.

- **Tahatū Rangi Symposium**

  Both Central Representatives attended the Te Pou / Platform Tahatū Rangi Symposium on behalf of Ngā Hau e Whā. The two day symposium was an opportunity for sector leaders

and their allies to come together to collectively re-imagine the mental health and addiction system. New liaisons were forged as well as meeting up with numerous people we have worked closely with in the past. The outcomes from the two days were captured creatively in this poster presentation. (Note the Lived Experience section on the photo that NHEW reps ensured was highlighted throughout the two days!)

- **Ombudsman 'Experts with Experience'**

  The Ombudsman Office was successful with an application for funding from the UN's Optional Protocol - Crimes against Torture. The funding is for training and monitoring skills to a group of people who have personal experience of using or caring for someone who uses mental health services in New Zealand. Termed *'Experts by Experience'* they will assist the Ombudsman Crimes Against Torture Inspectors to undertake visits to places of detention.

  The writer was successfully selected for the initiative and will report back on progress with the project in next month's report.

- **Wellington Regions Suicide Prevention and Postvention Leadership Group**
  This new wider Wellington region initiative aims to reduce suicide and minimize the impact of suicide across Wairarapa, Hutt Valley and Capital Coast DHBs populations. Both Central Region representatives are applying to join the group on behalf of Ngā Hau e Whā.

4. Addictions

New Wairarapa Gambling service

- The Salvation Army has been contracted to provide a new problem gambling services in the Wairarapa -- including counselling support for those struggling with a gambling addiction, as well as family members, partners and others affected by someone else's gambling.
- Public Health services are also delivered, aiming to reduce the harm that gambling can cause, help agencies to develop policies around gambling and raise awareness of problem gambling in the community.
- Counselling for problem gamblers in Wairarapa was previously offered by Wairarapa Addiction Services and then Care NZ, until the Salvation Army picked up the contract recently. Since then, the service has seen new clients, including family members, who range from professionals to beneficiaries.

5. Whanau/family services

New links with Family Whanau Services

- New links were forged at recent Hui's with staff from both Manawatu and Whanganui 'Supporting Families in Mental Illness' organisations.

- Manawatu Supporting Families report they are finding that people that are experiencing depression and anxiety are finding it hard to access GP's because of the cost. Therefore they become more unwell and the challenge is getting people assessed at Community Mental Health as they are asked to see their GP for a referral. It becomes a never ending circle and people are running up debits at GP practices. Because of this people are presenting more acutely unwell at services.

6. Maori services

Advice will be sought around making links to Iwi, and Maori networks and stakeholders so progress will be noted in the next report

- Both Central Representatives are due to visit a local Maori respite crisis service (Te Waka Whaiora). The new liaison will help us continue to extend Nga Hau e Whā's regional communications and liaison with other Maori services throughout the Central Region
- The Emerge Aotearoa Consumer Advisor is helping us engage and liaise with his own pacific networks
- The Kia Noho Rangatira Ai Tatou education programme that is being presented around the country for disabled people (including persons with psychosocial disability) and Disabled Support Services (not including psychosocial support services) is partly presented by either a regional or National Kaumatua. The programme has a strong focus on presenting Te Tiriti o Waitangi from a human rights perspective.

Nga Hau E Wha

"Champion many voices"

Member: **Kieran Moorhead**

Region: **Northern - Auckland**

Meeting date: **8/9 September 2016 3/4 November 2016**

1. Issues/challenges identified by people in your region

CHAMP – Counties Manukau Peer Potential Project – Cassandra Laskey

Counties Manukau Mental Health and Addictions Partnership (CHAMP) commissioned the Peer Potential Strategic Action Plan (2016 – 2021) to develop the mental health and addiction peer support workforce funded by Counties Manukau Health in both the DHB and NGOs.

There is a growing international trend towards a peer workforce in mental health and addictions, therefore it is timely to discuss and analyse the peer workforce in NZ:

Counties Manukau (CMDHB) has the largest funded peer workforce in NZ – 69.0 FTE.

CMDHB has three fully peer-led services, the rest of the peer workforce operate in Multi-Disciplinary Teams.

Over 130 people participate in Peer Employment Training (PET) in CMH but only 12% of the people go on to employment as peer support workers. This could be because of the lack of growth of peer support roles in CMH over the past few years.

Recommendations:

- Reconfigure the PET course into three levels – personal recovery, informal peer support with open entry and formal peer support with limited places for people who want to work in peer support.
- Clarify the respective roles of the two PET providers.
- Encourage the development of more peer support positions.

Next part of the Peer Potential Project 2016/2017:

- A fully established Peer Support Governance Group to drive and monitor the implementation of the Action Plan.
- Complete evaluation of peer support in the CMH district.
- Redesigned peer support workforce development opportunities with a clear pathway for progression for peer support workers.
- Redesigned and accessible training for colleagues on peer support and recovery.

2. New Initiatives /Developments in your region

Feedback from Waitemata DHB CAMHS:

Respect – **4.5 / 5**

"The majority of you feel that you are respected by people here"

Communication – **4.5 / 5**

"Most of you feel that staff work as a team and support each other to ensure you get the best care"

Support – **4.5 / 5**

"We're glad most of you feel safe here. If you've been here a little while and still feel unsure about stuff, talk to your keyworker or write the consumer advisor a letter"

Appointments – **3.2 / 5**

"This is one we are pretty worried about. We've implemented CHOICE teams to get through appointments quicker as our demand increases!"

Plan Reviewed – **4.5 / 5**

"Treatment goals should be reviewed consistently – even if it's just to say 'Yep all good'."

Decision Making – **5 / 5**

"Clinicians ask you what you want for yourself"

"We're committed to this, so we are happy to see this result"

Recommend – **4.3 / 5**

"Most of you would recommend us to friends/family"

Family/Whanau – **4.5 / 5**

"The majority feel their family is encouraged and informed"

Culture – **4.5 / 5**

"You feel that we acknowledge your cultural needs"

"Many NZ Europeans did not answer this question – please do!"

Rodney working party is scoping out some locations for a permanent building in Whangaparoa – we're also looking for a few rooms in Warkworth and Wellsford.

New Clinicians – Our Choice Team in the North will be filled by some clinicians from Youth Health Hub, and an experienced Eating Disorders Clinician will be joining the Liaison Team in September.

CMDHB Health – Mental Health and Addictions Integration update:

Progressing the implementation plan

An implementation plan for the roll-out of the integration agenda was presented to a meeting of CM Health's Exec Leadership Team on 8th November. The plan put forward an approach for enabling integration through proposed changes across specialist mental health provision, specialist addiction provision and NGO provision. The plan recognised the excellent contribution that each component part has to make in delivering an enhanced experience for people using our services, and to the gains in their overall health outcomes and health equity. ELT endorsed the plan to be progressed to a meeting of the Community and Primary Health Advisory Committee (CPHAC) on 21st December and the February 2017 meeting of the CM Health Board. Subject to the outcome of those discussions, we commit to update the sector with clear next steps and timescales after the February meeting of the Board. Recognising the significance of this agenda, the timescales for progressing implementation will ensure that sector partners receive maximum notice of any proposed changes.

Franklin Integrated Care Locality Team (ICLT)

The Franklin Integrated Care Locality Team (ICLT) was formally established within the Franklin Locality on Monday 21st November. The first members of the team are providing the initial presence and will be joined by colleagues, including our NGO and specialist addiction partners. The initial team includes two nurses and an OT with combined experience across child and youth, adult, and older adult mental health. The team is enhanced with dedicated psychiatrist time, and support from a CAMHS nurse practitioner and an adult mental health clinical nurse specialist. The team has a base at Pukekohe Hospital alongside other DHB community healthcare teams and will be working with those teams in a multi-disciplinary team model. This approach will enhance our capability in relation to a 'whole of health' approach to people's wellbeing. In the coming days and weeks, the team will be engaging with primary care, offering a range of ways to work together through consult liaison, shared care, care planning, assessment and advice. The work of the ICLT will be in addition to the existing referral pathways.

We are excited about the progression of this initiative and see it as the first step towards an integrated model of care across all of Counties Manukau. The team will be working with an improvement advisor from Ko Awatea to assess the impact and benefits through PDSA cycles,

learning and developing as we go. This initial step is the first of many moving forward and we are excited about enhancing the team with NGO and specialist addiction capability.

Integrated Mental Health and Addictions Leadership Group

The Integrated Mental Health and Addiction Leadership Group was established in April 2015 to help guide and inform progress towards an integrated model of care. Members were selected for their experience and expertise across mental health and addictions and the broader health and care system. The membership provided perspectives from Māori, Pacific, primary care, NGO, specialist mental health, specialist addictions, and locality community services. The group met earlier this month and gave their reflections and contributions on the implementation plan due to be presented to ELT and the next steps for the programme.

Subject to feedback from CPHAC in December and the Board in February 2017, the work programme will move into a defined implementation phase. With the expectation that this phase will involve a procurement process to deliver locality services, it was recognised that clear consideration needed to be given to any conflicts of interest moving forward and how best to provide the necessary sector-wide leadership within that context. Members agreed that it would be appropriate to disband the group, with no further meetings under the current membership. The group has been an invaluable resource in progressing the agenda, providing insight and challenge. Moving forward, we will look at what leadership is required to support the implementation at both a governance and operational level.

CMDHB Inpatient Unit Tiaho Mai re-design update: The architect leading the re-design of Middlemore Hospitals Tiaho Mai acute mental health unit provided an update. Construction has already begun on the grounds of Middlemore, and the foundations and walls are being laid currently. The design of the unit utilised a co-design process with people who use the inpatient services, as well as overseas experts from Australia. The new Tiaho Mai will have 76 individual rooms each with its own bathroom, separated into two areas, High dependency and Low dependency. Feedback from CHAMP NGO network was to be wary of language used as high dependency and low dependency might not be appropriate, there was also a room labelled 'Judge's Room' which CHAMP asked to be changed as that is not language we wish to use anymore. There are 5 grass and concrete courtyards inside the unit and each room has a view into one of these courtyards which was based on feedback from people currently using inpatient services. There are no labelled seclusion rooms but there is an area which has been labelled 'low stimulus' and it has its own room, bathroom, and lounge area which can be kept separate from the rest of the unit. It was mentioned that this area may not be for people deemed 'too at risk' but could be for say mothers who have children or families to stay together in.

Housing First Initiatives: There is new Housing First Initiatives beginning across Auckland, which are working with CORT social housing provider to get vulnerable people into housing, and not

using the requirement of being in accommodation a barrier for receiving support. One initiative discussed is a mental health initiative that houses four women who have historically been categorized by the mental health system as 'dysfunctional' or 'uncooperative'. The aim is to have the women in safe, reliable housing where there is no expectation for them to leave any time soon, and for mental health services to provide support for the women when and how they want it. There is also a desire for the women to provide informal peer support for each other as might occur in a flatting situation.

Consumer/Mental Health Promotion Event: A group of ADHB providers including Changing Minds are planning an event for 2017 that aims to bring public awareness about mental health and provide ways of seeking information and support. The group are currently speaking to the organisers of Pasifika Festival, a large public event held in Western Springs annually, and they are keen to partner and have a large public mental health attraction at Pasifika. The attraction will be experiential, for all ages/families/whanau, and there will be information, resources and support available.

Collaborative research:

Optimising treatment outcomes for depression in primary care (OptiMA3-NZ)

Richard Tranter is a consultant psychiatrist at Nelson Marlborough DHB with honorary appointments at NMIT and the University of Otago. His research in the UK was focused on improving outcomes for depression in primary care settings. He has experience of being a principal investigator on large clinical trials and has developed successful primary care networks for recruiting to clinical trials.

Dr. Jacquie Kidd *Nga Puhi*, is a Senior Lecturer at the School of Nursing, University of Auckland. She has experience in qualitative research with Māori communities, and has led two significant kaupapa Maori projects focusing on palliative care and prostate cancer respectively, with a strong focus on health literacy. Jacquie will be involved with study design, data analysis, dissemination and stakeholder partnerships for the Māori arm of the project and for the nurse led aspect of the intervention.

Varsha Parag is the lead biostatistician at the National Institute for Health Innovation at the University of Auckland with 16 years' experience in epidemiological studies and clinical trials. Varsha will provide statistical oversight of the trial in relation to study design, and conduct the data analyses.

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Aim

- To evaluate the clinical effectiveness and economic benefits of a nurse led intervention, assisted by an online system, Psynary, to optimise existing treatments for depression in primary care.

Primary hypothesis

- **For new presentations of depression to GP practices utilising the "blended" Psynary assisted nurse practitioner health care pathway there will be a significant increase in patients achieving complete remission from their depressive symptoms after three months of treatment compared to GP practices following their usual care pathways.**

Exploratory aims

- Acceptability and accessibility of the online system to patients and practice nurses will be explored using semi-structured interviews and framework analysis. There will be particular focus on the impact of the "blended" nurse led health pathway on accessibility to interventions for Māori health consumers.

Centres and Participants

- A consortium of five schools of nursing will act as the research hubs for conducting the clinical trial. Each hub will recruit and coordinate three - six GP practices. Practice nurses will be the lead points of contact with the research team.

- All patients presenting to the trial GP practices with a suspected diagnosis of depression over a 12-month recruitment period will be invited to participate in the study.

- Patients who verbally agree to take part will be registered on to the Psynary system by the practice nurse. When patients log on to Psynary for the first time they will be presented with information about OptiMA3-NZ, available in English or Te Reo Māori.

- Patients will then complete the online consent form. Only if they consent to all the items will they be able to proceed with the Psynary baseline assessment (detailed below).

- The initial part of that assessment involves a diagnostic algorithm for ICD-10 mood and anxiety disorders. Only those patients meeting criteria for a moderate or severe depressive episode will be included in the intervention or Treatment As Usual arms of the trial.

- Practice nurses will keep records linking patient identification, including NHI number, to the anonymous Psynary username. These records will be stored at the GP practice and will not be shared with the research team. These records will be used by the GP practice to identify patients as part of their routine clinical use of Psynary, and for adverse event reporting to the research team.

Interventions

Description of the online support system: Psynary

- Psynary is an anonymous web-based system that assists non-specialist clinicians and patients in the assessment of mood and anxiety disorders, treatment planning, monitoring and optimisation.
- Patients are registered on to the system by their clinical team and are allocated an anonymous username (a colour and a number) and a temporary password.
- Patients are then able to complete a detailed baseline assessment in their own time, in a setting of their choice.

Psynary does not collect any personal identifiable information, such as names, date of birth or addresses. The baseline assessment covers the following domains:

- Demographic information
- ICD-10 mood and anxiety diagnoses
- Past psychiatric and medical history
- Family history
- Current and past psychiatric medications, including dosages, duration, compliance and side effects
- Psychological interventions
- Depression symptom severity
- Anxiety symptom, avoidance and impairment severity
- Pregnancy, breast feeding and contraceptive status
- Alcohol and drug usage
- Cognitive functioning
- Patient identified goals for recovery
- Patient treatment preferences

4. Addictions

Counties Manukau Health - AOD Collaborative:

Peer Group Project:

We know that when we broadly target teenagers and young adults, we don't tend to reach and engage the young people who need support the most. This project used Rescue's Peer Crowd Discovery methodology, which has been successfully implemented in the USA and other countries, to segment the New Zealand teenage and young adult population into specific "peer crowds" with similar interests, attitudes, lifestyles, and behaviours.

This was used to explore the relationship between these peer crowds, alcohol, and other risk factors. These findings will make it easier to engage diverse teen and young adult populations, and break down barriers by making peer influence easier to understand and to be incorporated in interventions. We focused on the multifaceted Counties-Manukau area, and tested whether these findings were generalizable to another New Zealand region.

"We've got an international expert in behaviour change marketing, Jeff Jordan (President and Executive Creative Director | Rescue | The Behaviour Change Agency), coming to New Zealand, and we'd love for you to join us as he presents. The most exciting part is that a group of health and social support organisations have been working with him and his company to get information on New Zealand teenagers and young adults. He will be sharing what we have learnt about our youth, with alcohol as the main risk factor, and it will be a great opportunity for you to reflect on how this can inform your work!"

LookUp Auckland DHB Youth Event – Wellbeing and AOD:

Official number of attendees: 230 – 110 young people – 14 schools

Auckland DHBs Youth event co-created by young people and delivered by a collaboration of young people and DHB + NGO organisations.

1. Balance and Connect

- Youth line interactive workshop to create support trees.
- Pocket pick-me up (box art) designed with Toi Ora that reflects on your life and identity.

2. Know Better, Do Better

- Auckland Sexual Health Service workshop on consent, including the viral video on the 'tea' analogy and scenarios.
- St John's Cadets teaching some basic first aid skills for situations involving alcohol and other drugs.

3. Brave Conversations

- Odyssey House have giant traffic lights on the floor and a bunch of scenarios – what would you do if your mate was in trouble with alcohol or other drugs?
- Altered High is also running an activity that reflects on the tough stuff that can happen when alcohol and other drugs are involved.

4. Making a Difference

- Come and participate in a community action workshop with CAYAD about how to make a difference to an alcohol or other drug problem.
- Hear a panel of young people speak about their involvement leading youth health programs – including young people from St John's Cadets, Mental Health Foundation's POD, Affinity Youth Advisor Group, Peer Sexuality Support People, Rainbow Youth, and School Health Councils.

ADHB Providers DHB/NGO:

Substance Abuse Compulsory Treatment Bill: Cate Wallace from the shared Funding and Planning team at WDHB/ADHB provided an update on the new Substance Abuse Compulsory Treatment legislation that has recently had its third reading at parliament, with the bill set to become law next year (2017). Cate said that the legislation applies to people who are at the extreme end of substance abuse for example people experiencing Korsakoff Syndrome from alcohol misuse. Cate and the rest of the funding team are in conversations with the Ministry of Health about how many people the legislation may apply to, which was originally around 200 but this estimate has increased to 500 people. The funders are also negotiating funding for the people who will require services under the new legislation, which the Ministry of Health initially costed at $500,000, but Cate estimates they will probably be looking at closer to $1 million.

TheMHS Conference August 2016

Keynotes:

- Arthur Evans from Philadelphia spoke about public health approach to mental health and wellbeing and showed off some emotive and visually impressive murals that have been done across Philadelphia to highlight some of the health and social problems and encourage people to work together to be a part of the solutions to these problems.

- Robin Youngson an anesthatologist emphasised the power of being compassionate, taking the time to listen to people that you encounter in your work life, clinical or non-clinical and the resounding impact that your compassion has on others and the evidence-base that supports this.

- Joe Macdonald spoke on the final day, about people as not just discrete entities to be catalogued by a system and treated, but as people who live in a context with a story, and motivations and struggles, and how our systems do not cater to this variation.

TheMHS Conference - Coercive Community Treatment:

- Discussion on the readiness to end coercive community treatment practices.

- Clinicians argue that CTOs enable people to reliably access treatment in their community.

- Some questions were raised asking why we can't have reliable and effective services without CTOs.

- In the context of reviewing NZ's mental health legislation, someone who works for the Ministry of Health commented that there is the fear that we are currently living in a more socially conservative time and any changes to our legislation could result in more coercive practices.

Whanau and Family

Waitemata Stakeholders Network:

Supporting Parents Healthy Children: To mandate MHS & Addiction services to work in a family focused way to help parents achieve the best for their children.

- Risks related to parental mental health and addiction issues, e.g. poor outcomes, increased risk of MH and/or addiction issues, children taking on care giving responsibilities for their parent.
- There is growing international evidence for effective interventions to improve short and long term outcomes for children.
- What is needed:
    - Data on the number of children in NZ affected
    - Services to routinely identify children of parents
    - Adult services to recognise and respond to people as parents and develop family/whanau focused practices
- Where are we up to:
    - Supporting Parents Healthy Children Leadership Group underway since 2013
    - Review and dissemination of resources, auditing, development of an implementation of guidelines across the services, building relationships, reviewing policy, developing pathways (DHB/NGO)
    - COPMIA full days training, 3 x in 2016
- Data – regional group undertaking work to identify and agree the data collection regionally.
- Next steps – seek further representation by Adult Clinicians and managers, agree and progress actions in implementation plan, socialise and train.

Nga Hau E Wha

"Champion many voices"

Member: Victoria Roberts

Region: Central South

Meeting date: 8/9 September 2016 3 /4 November 2016

Issues/challenges identified by people in your region

1. Mental health services:

Oasis Network

Te Whare Ahuru HVDHB

- Staff in mental health wards need to be trained to be non-aggressive
- Long term services users do not get a fair go.
- In the inpatient unit there are no discharge plans; informed consent does not happen at all; no wellness plans
- Service users need more advocacies around their rights.
- Most agencies will only pick up new clients if they are suicidal or threatening harm to themselves.
- Person reported that while they were in TWA (Te Whare Ahuru – inpatient ward) they were refused permission to call a lawyer.
- There are no services funded especially for the elderly: this makes it hard for them to get to Oasis; maybe there is a need for an elderly peer support group?
- The staff bullies the patients and treat them like children. (Tell them to go to bed at 8pm.)
- The staff are heavy handed and frequently threaten the people in the ward with the lock up if they object to what is being demanded from them. (Not obeying staff directions)
- "The staff throw their weight around" it is a hierarchical system and people using the ward are well below the staff.
- It is a power and control issue with ward staff.
- There is some worry about the soon to begin frozen meals they will be made in Christchurch and Auckland and sent frozen to TWA. They have concerns about people's health and want the current great meals to continue.
- There is no counselling available at Te Whare Ahuru (TWA)

2. Communication:

Oasis Network

A well-known Hutt Valley DHB (HVDHB) service user went missing recently and the people at Oasis said they would have welcomed immediate input from clinical services.

- Clinical services should reach out to service user groups who are at the forefront of supporting service users especially at times of emergency.
- Clinicians should have realised that there would be a lot of strain and grief within peer services.
- They could have designed some information/education about how people in Oasis might be feeling; what to notice about people who are grieving;
- They should also realise that people who use mental health services often have lots of other past unresolved grief; even having a diagnosis of chronic illness can cause grief.
- People would like to hear from speakers: mental health services in the community; the DHB could be invited to talk about hospital services and functions.

3. Crisis services

Oasis

- CATT takes too long to respond – if they respond at all.
- They seem to be overworked and underfunded
- They have heard that CATT has been restructured by don't know how.
- People don't know when to ring Te Haika (crisis line) or who they will get and would like some education from them.
- There is a need for a crisis service for mothers and babies.
- Respite services in the Hutt are operated by PACT and EmergeAotearoa
- There is no instant access/emergency housing in the Hutt.

Mental Health Services

<u>Crisis Service CATT</u>

- Aggressive clinicians; interactions create large misunderstandings
- If you ring up CATT you are always put on hold and you are sometimes just cut off after waiting for a while.
- It's hard to get CATT to see you when you need help.

<u>Knowing my rights</u>

- "I need to know my rights around the Mental Health Act. Who can put me under the Act?"
- "If I go to the Wellington and Hutt Valley Community Law center can I request a man (or a woman) to talk to?"

Consumer Leadership Development Fund

- This is needed for all consumers especially those who are unemployed.
- It would be a training fund that people could apply to, to be upskilled.
- It should be administered by peer workers from several different services in the region.

Medication issues

- Why can't people who have been stable on clozapine for years be monitored by their GP? It could also be overseen by a trained nurse or nurse practitioner.
- The same issue with Opioid Substitution Treatment - why can they not transfer to a GP?
- Some people have been on anxiety medications for many years and they are now being taken off these cold turkey. People have major changes made to their medication and do not receive adequate notice, advice or support. This is dangerous practise and sadly it is the consumers and their loved ones who face the consequences.
- There needs to some professionals who can assist people to gently taper off medication
- Given that there are many side effects (physical) of psychotropic medications many people are keen to reduce the use of these medications – a professional to assist would be valuable. People trying to reduce these medications are often seen as non-compliant and punished.

The medical model which says that there is a chemical imbalance is losing ground. It says medication will be needed forever in spite of the knowledge that the medications used are causing brain damage. A biosocial model that privileges the developing complex neuroplasticity knowledge is preferred. Our brains can and do, heal.

4. Housing

Oasis

- Clinical staff have a far too high tolerance for homelessness
- Homelessness can be linked to wellness because people who are even slightly unwell can make bad choices.
- Some mental health funding should be ring-fenced for housing.

5. Civil defence

Oasis

- Many service users are just not financial enough to put aside emergency supplies for 2-3 days. It takes time, money and space which many people do not have,
- Medication supplies for 2-3 days – what do other people do?
- Civil defence helplines should be tied into peer support lines and numbers

6. Service user fund

Oasis

- There should be a dedicated fund (government funding required) for peers to apply to.
- This could fund: first aid training; governance; civil defence and others as well.

Linkage

Rex Delaney

- Dairy owners have been letting people accrue debts and then demand to take their cards off them. In one case the debt was up to $1,000 and the person had to go to a loan agent to repay the dairy and get his card back.

- Some dairies are selling people single cigarettes (around $1 each). This is totally illegal. If anyone hears about this practice please let the community constable know.

- The Mental Health Foundation has met with the Wellington City Council (WCC) and there is to be a project focused on isolated men in the community

PATHS Wellington

- This service was provided by Cap Coast DHB and MSD to assist people on sickness and invalids benefits into work. The funding has been cut and the service closed down.

Feedback from Oasis Network's Regional Consumer Forum 8 November 2016

- Given that there are many side effects (physical) of psychotropic medications many people are keen to reduce the use of these medications – a professional to assist would be valuable. People trying to reduce these medications are often seen as non-compliant and punished.

- The medical model which says that there is a chemical imbalance is losing ground. It says medication will be needed forever in spite of the knowledge that the medications used are causing brain damage. A biosocial model that privileges the developing complex neuroplasticity knowledge is preferred. Our brains can and do, heal.

Community Mental Health Team (CMHT):

Requests to change clinicians

- There have been several requests for people to have a change of doctor and/or nurse or social worker. These came from people who have not made these requests before. These requests are routinely declined.

- There is no reply to these offers

Homelessness

- There is a very high tolerance within mental health services of homelessness. It is known that people who are delusional or suffering from PTSD find it hard to maintain a home.
- It is common for people being released from prison to end up being homeless and living under a bridge. Rimutaka Prison is quite near. On release people only get $360 – Steps to Freedom.

Local PHO

- Has reduced funding of 15% This means many community services have had to be cut e.g. Women's Centre groups
- But it appears that funding to Youth groups may have increased

People under the Act

If you are not under the MH Act you do not have access to District Inspectors even if you are in the ward. And we all know there are ways for people to be kept in the ward without using the Mental Health Act (like threatening to use it). There is not legislative or paid ability for a DI to see people not under the Act.

Housing New Zealand

- HNZ is evicting people for drug use and with P there can even be just a low reading. This may not even be the fault of the tenant being evicted.
- There appears to be a policy by HNZ not to upgrade their houses if people have been in them a long time. No repairs or renovations are being done and some people have shabby wall paper and paintwork.

Men's Support

There is a need for men who have been given six- day no contact orders by police to be given some place to stay. Many are broke, have nowhere to stay and often go home with their partners consent because she feels sorry for them. Then the cycle of violence restarts.

All specific anger management programs have stopped running. There is a need for these for men and women.

Best Practice according to people in your region

Oasis Network

- A question was asked: When you first make contact with Ambulance, Police or CATT do they routinely ask if you affected by drugs, alcohol or gambling? The group agreed that they did.

- A nurse from Ward 27 (Wellington Hospital) told a person that the first thing she asks for when a new person is admitted is whether or not they have an Advance Directive.
- Warmline is excellent and Samaritans are a good support. A suggestion was made for a list of all available support services.
- Oasis is a great community support. People are not sure why there is no money for food at Oasis because the DHB always has plenty of money for food at their events and meetings.

Vincents Art Workshop

- Vincents is open to the whole community in the spirit of inclusion. Different to Pablo's is that they are more like an art school.
- Vincents is now involved in Peer Advocacy work and has a contract along with Te Ara Korowai, Newtown Union Health and Kites. The work is going well and there has been a 6-month extension from CCDHB to 31 December 2106.
  Suzy spoke about the peer advocacy work and how the numbers of people seeking it is steadily increasing.

Linkage

Rex Delany

- The Mental Health Foundation has met with the Wellington City Council (WCC) and there is to be a project focused on isolated men in the community.

Hutt Valley

- "I find that people are more accepting of me than they were. Retailers and people like that"
- "I was not sleeping and needed some help. I was asked if I wanted to go to respite or go into the ward. I said respite of course and it was the best thing ever. It had curtains and I got some much needed sleep. I was there for five days for assessment. After that I was okay to go home."

Kaibosh – a food rescue group has been giving Oasis Network (as well as other groups) some food.

Buddies Peer Support has now started in the Hutt Valley. They are based at MIX.

Housing New Zealand (HNZ) now has a regular forum with Oasis Network. This supports HNZ to support their tenants with mental health or addiction issues.

There are now men's and women's support group running at Oasis every week. These are excellent.

Amigos Wellington

The Joy of Improvisation.
Discover your creative potential and enjoy improvising scenes and stories in a safe, positive group environment.

- Explore roles
- Create dramas
- Learn about performing
- Gain more understanding about human life together

These classes will resume again on **Wednesday 12th October** 2016 and run weekly until 14th December 2016 only. Sessions run **2pm** to **4pm**. Once again, our wonderful tutor will be Ali Little.

Venue is Newtown Hall in Daniell Street Newtown, and is wheelchair-accessible.
People found these sessions fun and non-intimidating. Free to people who are, or have been mental health consumers.

Oasis Network Program – an excellent format.

Advocacy group: Tuesdays 1–2:30

- These groups cover self-advocacy and systemic advocacy. We discuss our rights and responsibility to honour other people's rights. In October we learn about what our Annual General Meeting is for and how to make informed voting decisions.
- Tuesday 4th - Guest speaker:" Vicki - Salvation Army, Oasis. Gambling
- Tuesday 11th - AGM: What do our board members need to know?
- Tuesday 18th - AGM: Checking out the candidates
- Tuesday 25th - AGM: Understanding the voting process

AGM: Thursday the 27th October from 5:30. Please let staff know if you need a ride home.

Healing Voices movie: Wednesday 19th October at 12: 45pm at Pathways. There are only a few tickets so book with Sue.

Recovery Art Journaling: Wednesdays 1– 3.00

- Recovery journaling continues this month.
- We will continue trying new techniques and recording thoughts and feelings in creative ways. Please book in as this is very popular.
- Wednesday 5th — Creative self-care
- Wednesday 12th— Stop sabotaging self-care
- Wednesday 19th - 8 artsy self-care projects
- Wednesday 26th—Easing anxiety

Kai time on Fridays

- Would you like to eat a hot meal on Fridays at Oasis?
- Add your name to the whiteboard near the kitchen on Friday morning.
- When we have three volunteers' we will start cooking.
- NB: Volunteers may do a Food Handling course in the future.

Members meetings every 2nd Friday 1- 2:30

- Friday 7th October 1-2
- Friday 21st October 1-2
- We encourage members to attend your members' meetings.

Men's group

Runs Thursdays from 1– 2:30

Mental Health Awareness week:

- **Friday 14th 11– 3**
- River walk : leaving Oasis at 11
- Lunch at Oasis: 12 –1
- Mindful river stone art 1-3

Recovery group: Fridays 10:30-12

- Friday 7th
- Friday 14th - Mental Health Awareness week: walk and lunch
- Friday 21st - Work focus – who can help me find work?
- Friday 28th - Work focus – who can help me find work?

Study Buddies: Wednesdays 10 - 12

- We are really excited to see so many members are studying.
- If you want to find out about courses or are studying you are welcome. Sue is here to support your study or help you apply for courses.

"It does not matter where you go and what you study,

what matters most is what you share with yourself and the world."
Santosh Kalwar

Women's group -Thursdays 10 -12

Life style and substance addictions

We have great caring and sharing and learning happening in Women's group. During each group we touch on a topic women have chosen. We also integrate relaxation and sensory techniques into each session.

During October we will be discussing addictions and or misuse of substances etc.

- Thursday 6th October— Problematic substance use: Rosemary Casey HALT Services
- Thursday 13th October—Components of Addiction: Rosemary Casey HALT Services
- Thursday 20th October 2016—Who can help:
- Thursday 27th October 2016—The quit cycle: Lisa Phillips, Salvation Army, Bridge.

- **Women's group peer mentors and volunteers**
- Thanks again to our three wonderful volunteers for your contributions to the Women's Group. We all appreciate your help and support.

New Initiatives in your region

Buddies Are Coming To Lower Hutt!

- For a number of years now, people have been asking for Buddies to come to Lower Hutt and as we have been successful in securing a contract with HVDHB, we are now able to extend our service to the Hutt.

- We will be providing peer support at the inpatient unit Te Whare Ahuru, and are delighted some of the current and past Buddies living in the Hutt Valley will be joining us there. We are also looking for new Buddies for Lower Hutt, so if you are keen to volunteer or know someone who is, let us know as soon as you can!

- For those who meet our volunteer requirements, training will be held late November in Lower Hutt. We have already interviewed a few people and are looking for some more—that could be you! We are looking for peers who are far enough along in their own recovery and are willing to give some of their time for a visit each week or once a fortnight. We are really looking forward to getting to know the team at TWA and plan to start with 2 visits each week and increase these as we increase our volunteer team capacity.

- We already sprang into action with the set up phase from 1 September, and this has included the training and induction of the new coordinator (read more about Candice on the next page). She is amazing and has already hit the ground running and finished the Buddies Induction training this week.

- For Wellington, we were also be busy recruiting and training new Buddies for Te Whare o Matairangi (TWOM), who will be ready to start ward visits soon—they are an awesome bunch of people and we look forward to them being a par

Training and Development Opportunities for Buddies

- Buddies give so freely of their time and energy and it takes great courage to share their personal stories. They are the face of our service and we acknowledge the importance of the work they do. It is only natural that we want to support them to be the best they can be.
- New Buddies all go through 4 days of intensive training, spread out over 2 weeks and we cover a wide range of topics including recovery concepts, communication, listening and feedback, diversity and stereotypes, as well as discrimination and stigma. We also cover the operational side of the service, what it is like to be a Buddy, stress and self-care. Confidentiality and professionalism are also on the training agenda.

- To support Buddies with their ongoing development, training is provided once a month as part of their team meeting. This generally covers topics the Buddies are interested, in as well as networking and visits from other local service providers.

- In addition to the main support we provide for Buddies like pastoral care and supervision, we have been exploring how we can add value to the Buddies by offering a wider range of training and development opportunities. This is optional for those who wish to develop their skills further in different areas relating to Peer Support, as well as building on work skills for those who want to return to the paid workforce.

- New Buddies volunteer alongside experienced ones for up to 6 months to ensure they are confident in providing peer support on the ward and "know the ropes" of how we do things. At this point they are then "Graduated" and are able to visit the ward with other new Buddies. Regardless of being new or experienced, our Buddies always visit in pairs and keep each other in line of sight.

- One of our new initiatives has been a 3 part introduction to mentoring training for the experienced Buddies who want to take on a mentoring role for new Buddies. This programme is still being reviewed and further developed and builds on the induction training the Buddies receive. It is optional for Buddies to attend as they do not have to take on a formal mentoring role for new Buddies, however we would like the training to be beneficial for all Buddies and build on their skills and knowledge.

- For new Buddies, being able to volunteer alongside a more experienced Buddy is a valuable experience for both, so we look forward to how this evolves over the coming months, and will be inviting the current Buddies who would like to be involved, to collaborate and contribute to the revision and further development of the training.

- We have other ideas too and are keen to hear what other training and development opportunities Buddies would like. We have talked about how being a Buddy has been a pathway to employment for some and this is an area we are also keen to support for those who wish to pursue it.

BUDDIES I Peer Support Service I Level 6, Education House I 178 Willis Street I WELLINGTON
(04) 384 3303 I buddies@kites.org.nz I www.kites.org.nz

New Initiatives /Developments in your region

Oasis

- Kuranui Marae has started a kaupapa Maori group called Bereaved by Suicide that is based on the training delivered by Skylight Trust
- Hutt Valley Day Service is now operated by Pathways after the closure of the HVDHB day hospital. It is a very limited budget and not many resources; it is only a short term service.

CATT

- Crisis Assessment and Treatment team in Wellington (CATT) is undergoing a restructure. In the future it will be Crisis Resolution Service – CRS.
- The CATT restructure plan is for it to be more proactive and less reactive. Less assessment. Staff will aim to see people where they are rather than expecting them to get to a clinical center. Staff will be closer to places like Police station, ED, more GP practices. The service will be available in the CCDHB and Hutt Valley DHB areas. It may be up and running by 1st November 2016, providing some of the issues holding it up are resolved.

Homeless Women's Shelter

- There is a new service in Wellington
- It is for women alone (no children)
- There has been a Homeless Men's shelter in Wellington for many years and this new service is long overdue.
- There is to be a fundraiser and awareness-raising event. It's the 14 hours homeless campaign. People will be sleeping in cars, boxes, on couches in Wellington on the 7th of October

Mosaic

- Mosaic, is a new support group for male survivors of sexual abuse. There are also Men's Sheds.
- There are issues with the Porirua Council around not supporting initiatives in their city.

- There is currently a need for more anger management services.

Collaborating with DPA

Central reps have begun a new relationship with DPA which is centered in Wellington. Attached is the Disability Strategy submission that was submitted by DPA. We will be spending time regularly as this relationship matures.

Addictions

Oasis Network

- There is no Peer addiction support or recovery group in the Hutt.
- AOD services in Hutt include: Welltrust, Care NZ
- Problem is knowing what exists, how to access it and being able to afford it (e.g. transport)
- Alcohol is a depressant and the use of illegal drugs is not helpful but the group would like more wellness information and information about harm reduction.
- Also education regarding the interaction between medications and street drugs.
- Before people can get into rehab they have to have been abstinent for 2 weeks. It was stated that if you could be abstinent for two weeks on your own then why would you need rehab? This requirement also makes it impossible for many people to access rehab that otherwise would.
- Detox is mainly done in people's homes or in police cells. Home detox is okay but hospital would be the best.
- The Smoke free work is creating stigma and discrimination for smokers. Mental health services "should not back smoke free. They should back wellness and some people need to smoke to be well."

Whanau/family services

DHB Family and Whanau Advisors:

Co-Chair Leigh Murray

DHB Family Whānau Advisors continue to provide guidance on working with families and whānau to mental health and addiction workforce via Handover nursing newsletter & Te Pou website. Latest article is 'Moving from Individuation of risk to a shared safety agenda' written by DFWA co-chair Leigh Murray. http://www.tepou.co.nz/news/moving-from-individualisation-of-risk-to-a-shared-safety-agenda/810

- Family Whānau Advisors are looking forward to their annual national meeting Nov 3-4 in Christchurch. This is a great opportunity to feed into & be updated about key projects as well as share best practice ideas 'kanohi te kanohi'. There is a full agenda with all 4

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workforce centres, MH Foundation, MoH & HDC Mental Health Commissioner taking up slots. Unfortunately some of our key family advisors won't be there due to travel restrictions currently in place for some DHBs. We are hoping to link them in via video conference.

- DFWA recognises there is probably not a widespread understanding/appreciation of the systemic advocacy family whanau advisor role across NZ. This may be a contributing factor to family advisor vacancies that are of several years duration in a few DHBs. We appreciate that this might also be the case for some consumer advisor positions. Currently there are 22 family advisors in post which equates to 17.87 FTEs nationally.
- We also note that the importance of family, whānau perspective and participation is increasingly mentioned in MH & addictions though this does not always seem to translate into tangible ways of ensuring that the whanau voice is present or included.
- To end on a positive note DHB Family Whānau Advisors contributed significantly to the successful TheMHS pre-conference family & whānau forum held in Auckland on August 23rd with 65 attendees. At the start of the day we demonstrated our commitment to the theme of 'Building Authentic Relationships' with our own whānau by presenting the consumer forum delegates with the gift of a peace lily, a fun fruit face & chocolate with good wishes for an inspirational, fun and learning day.

Atareira Family Whanau Services Wellington

- Atareira provides a multidisciplinary team: whanau/family workers; counselling
- Atareira has a COPMIA worker and support group.
- Atareira was formerly SF in this region.
- Oasis Network is going to offer a family / whanau workshop in December. We hear very good feedback about Atareira family/whanau workers.

Child Youth and Family

Reports are that they discriminate early with people with experience of mental distress. This means they assume because of the people's history that they are not able to give birth and parent their children so the babies are being taken off people who just need good ongoing support. Then the parents are not given any support or education once their children have been taken from them

Maori services

More Maori than ever are visiting and returning to Oasis Network which they are really happy to see.

Wellington Community Law just launched '**Ngā Rerenga o Te Tiriti**, a new resource for community organisations changing and engaging with the Treaty of Waitangi. Highly recommended.

Kuranui Marae (Hutt Valley) has started a kaupapa Maori group called Bereaved by Suicide that is based on the training delivered by Skylight Trust but focuses on tikanga.

Te Paepae Arahi

- Te Paepae Arahi in the Upper Hutt is a kaupapa Maori service that supports a multidisciplinary practice.
- They have a social worker, counsellor, a regular visiting GP and operate a peer support

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Nga Hau E Wha

"Champion many voices"

Members: **Julie Wilia and Grant Cooper**

Region: **Southern**

Meeting: **7/8 September 2016 3 /4 November 2016**

1. Issues/challenges identified by people in your region

Carron Cossens – Waitaki:

Issue exists around finding support for people traumatised by attempts to rescue another person: doesn't really fall under ACC descriptors as far as I can identify. This is particularly important when the rescue is unsuccessful- flashbacks, recriminations etc. Risk of Post-Traumatic Stress Disorder (PTSD) if not dealt with in early stages

Issue that more and more health pamphlets are now no longer in print- people are referred to websites for material. Government initiative that I think is short-sighted

Lisa Perniskie, Peer Support, Mirror HQ, Ōtepoti

Kia ora Koutou

For those of you who do not know me

Ko wai au

Ko Hereweka te maunga

Ko Rees te awa

Ko Kotimana te iwi

Ko Airihi te hapu

Ko Perniskie rātau, ko Gray, ko Bartlett, ko Munro nga ingoa ōu tipuna

Ko Felix te pāpā, ko Isla te whaea

Ko David toku hoa rangatira

Ko Hollie taku tamahine

Ko Sam raua ko Jasper aku tama

No Ōtepoti au.

Kei te Kaiawhina taku mahi

No reira,

Nga mihi mahana ki a koutou

Tēna koutou, Tēna koutou, Tēna koutou katōa

I work with taiohi (youth) with co-existing issues.

Our age group is from 12-22 years.

We offer a multi-disciplinary team including a whanau therapist, myself, a psychiatrist and all clinicians are CEP trained. One of the issues the young people I work with is finding suitable housing at an affordable house. I do a lot of advocacy with our youth so they are not taken advantage by landlords and property managers.

Adequate resourcing for youth as our service now has a waiting list.

Addressing stigma relating to young people with addiction issues

Grant Cooper –Otago

Issues still arise with the wait time at Emergency Psychiatric Services. Staffing levels seem to be a significant issue.

Access to talking therapies is an ongoing issue with waiting times of concern.

A number of people are concerned about the level of medication and the length of time they are on it. Feedback includes feeling “numbed” and not been able to feel the emotions he once did as well as memory issues for example not being able to remember the chords on his guitar.

Issue for some people of the cost of challenging the mental health system for example getting a lawyer as well as the length of time complaints can be worked through.

Feedback from peers is that the Raise Hope Mental Health Strategic Plan rollout has been dragging on for a long time.

Brief Intervention Counselling

A person with complex issues has been told that they cannot access the free Brief Intervention Counselling more than once a year by their GP.

Housing in the community

People who have identified with mental health issues who were placed in Housing New Zealand (HNZ) or city council housing during the earthquakes have been seeking housing transfers or have been evicted due to not fit for purpose housing.

There has been a noticeable increase of people accessing the drop in at MHAPS which is open at the weekend due to housing difficulties.

Outcomes identified by people with mental health and addiction needs are:

- Homelessness with debts for storage to HNZ for new WINZ issued washing machines and fridges.
- Families living in cramped conditions with inadequate number of bedrooms in huge complexes with limited outdoor space for their children.
- Complexes are busy and for some people the stress of the noise, people coming and going has not been suitable for people with mental health issues.
- "*I called the police because after weeks of abuse, intimidation such as him putting security cameras pointed on my property I"*
- *" The police said I can't get a protection order as I live at a HNZ home and I feel my housing manager is out of her depth with facilitating a solution"*
- Physical health needs were not considered in my application *"Although I have a flat from CCC, My flat is damp and I have to wipe condensation off the windows every day, I am awaiting a lung transplant and have been hospitalised five times in the last two years and still there is no word from the city council"*
- *My HNZ flat is nice but I have low vision eyesight problems and the stairs are not safe. My housing manager said they have done everything they can to make them safe but will not fill in the stairs or transfer me to a suitable unit.*

Work and Income expectations of on-line applications

The WINZ Linwood office in Christchurch no longer has paper applications for benefits and you have to ask the manger for an application. The expectation is to complete applications on line. It causes delays in people receiving benefit entitlement in a timely manner.

The advocates in Christchurch have found there are still many people with addiction/mental health issues who do not have email addresses, internet and internet devices, data on their mobile phones.

- Still a concern over the high number of people under the Mental Health Act. A concern that is expressed nationally as well

Carron Cossens – Co-ordinator – Peer Support Group Oamaru

- A developing concern for us is service provision for Palmerston South. Currently Brief Intervention service is only provided out of Dunedin. We don't think this is adequate, and have asked for the service to be resumed based in Palmerston.
- An ongoing concern is support for children impacted by a suicide death. Child services in Dunedin will only respond if a mental health issue is apparent and my argument is that careful management post incident following the death will prevent mental health issues from developing later in life.
- We continue to need a peer support worker based in Oamaru/Waitaki

Sharon Gutsell – Consumer Advisor – PACT Southland

- Lack of peer support and peer advocacy services in Invercargill and Southland.

No training opportunities in Peer Support.

Housing for people with mental health issue

Julie Whitla - Christchurch

At the moment there is no single person accommodation available in Christchurch. There are a number of people in the acute wards who could leave if there was a place to go.
Purapura Whetu is now partnering with Comcare for family housing.

Acute Wards

• Occupancy (midnight census) of the adult acute inpatient service has remained at 93% for a second consecutive month. There were 17 sleepovers required in July 2016.

• We are exceeding Ministry of Health targets with respect to wait times for adult services. The targets are 80% of people seen within 21 days and 95% within 56 days. 97.4% of people referred to the Adult Community Service were seen within 21 days, and 100% seen within 56 days for July 2016. The percentages are 92.9% and 98.8% respectively when other adult services i.e. Specialty, Rehabilitation and Forensic are included.

Best Practice according people in your region.

Lisa Perniskie, Peer Support, Mirror HQ, Ōtepoti

Within my team I have been working on how to collaborate and spent time recently on developing a process for our internal referrals to my role.

With our taiohi it works well to have a mihi whakatau process with myself, taiohi and the clinician to clarify for them what support I can offer and what the clinician will be working with. The taiohi is given the opportunity to discuss what they would like support with.

It is very isolating for me being in Dunedin as there are very few peer support workers here. I have had a lot of support from Otago Mental Health Support Trust (OHMST) and would like to thank Grant for his ongoing support of my role.

I would like to participate more in best practise within the southern area and find out more about what is happening in our area- Te Wai Pounamu.

Julie Whitla - Christchurch

Canterbury District Health Board Specialist Mental Health Services September 2016 (SMHS)

Occupancy of the adult acute inpatient service decreased from 95% in August 2016 to 91% in September 2016. There were 32 sleepovers required in September 2016, of which 29 were for patients waiting to be formally admitted to the Seager Inpatient Rehabilitation Unit of (a recovery based programme to enable people with mental health issues to live in the community), or Tipuna units (24 hour care and support in a home-like environment with the aim of assisting people who have ongoing mental health issues to work towards finding a suitable place to live in the community).

STAFF RECRUITMENT

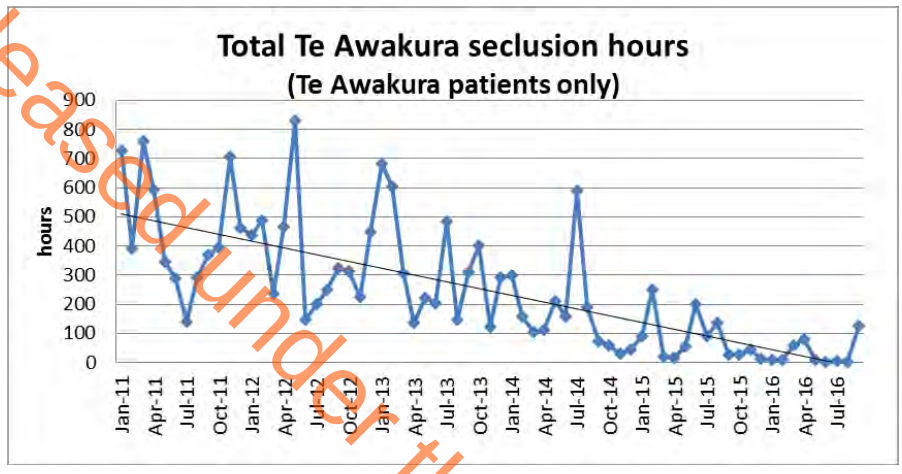
The CDHB are also experiencing challenges recruiting Specialist Medical Officers into mental health. There are a number of vacancies and locums across Specialist mental Health services. Recruitment into Crisis Resolution is currently challenging putting additional pressure on an already busy team.

CRISIS RESOLUTION SERVICE

Demand for Crisis Resolution remains steady. There was a slight decrease from 219 new crisis case starts in August 2016 to 196 in September 2016. New crisis case starts require an assessment within a day of referral.

SECLUSION

A total of 126.8hours.



Acute Inpatient House Emergency Solution Labour Weekend

Over labour weekend there were more people needing beds than were available at Hillmorton Hospital at the inpatients unit. A respite house was made available by Stepping Stones Trust and 6-8 people were cared for in the community instead of the hospital with a Registered nurse. The people were close to discharge or were on day leave were moved to the house, with support of a RN. The initiative was a step down approach back to the community in a more homely environment. Another respite provider Pathways took the people who were getting respite.

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Brief Intervention Counselling

A person with complex issues has been told that they cannot access the free Brief Intervention Counselling more than once a year by their GP.

Housing in the community

People who have identified with mental health issues who were placed in HNZ or city council housing during the earthquakes have been seeking housing transfers or have been evicted due to not fit for purpose housing.

There has been a noticeable increase of people accessing the drop in at MHAPS which is open at the weekend due to housing difficulties.

Outcomes identified by people with mental health and addiction needs are:

- Homelessness with debts for storage to HNZ for new WINZ issued washing machines and fridges.
- Families living in cramped conditions with inadequate number of bedrooms in huge complexes with limited outdoor space for their children.
- Complexes are busy and for some people the stress of the noise, people coming and going has not been suitable for people with mental health issues.
- "*I called the police because after weeks of abuse, intimidation such as him putting security cameras pointed on my property.)"*
- *" The police said I can't get a protection order as I live at a HNZ home and I feel my housing manager is out of her depth with facilitating a solution"*
- Physical health needs were not considered in my application "*Although I have a flat from CCC, My flat is damp and I have to wipe condensation off the windows every day, I am awaiting a lung transplant and have been hospitalised five times in the last two years and still there is no word from the city council"*
- *My HNZ flat is nice but I have low vision eyesight problems and the stairs are not safe. My housing manager said they have done everything they can to make them safe but will not fill in the stairs or transfer me to a suitable unit.*

Work and Income expectations of on line applications

The WINZ Linwood office in Christchurch no longer has paper applications for benefits and you have to ask the manger for an application. The expectation is to complete applications on line. It causes delays in people receiving benefit entitlement in a timely manner.

The advocates in Christchurch have found there are still many people with addiction/mental health issues do not have email addresses, internet and internet devices, data on their mobile phones.

2. Best Practice according to people in your region

From Sharon Gutsell – Consumer Advisor PACT Southland

- Working on a new referral protocol for people to receive community support services without the need for a needs assessment, removing this barrier to people receiving support services.
- Consumer Advisor has been appointed for Pact Southland, whose responsibilities include individual and systemic advocacy, and peer support.

- Extending "Giving Tuesday" (community art event held at Southland Museum and Art Gallery for Mental Health Awareness Week); to a full day programme building on the success of last year's event.

- **Carron Cossens – Waitaki:**

- The Men's Wolfpack support group are setting up headquarters as a drop in centre in Oamaru. They are currently doing renovations.

- Youth line Otago is now established in the Waitaki.

Acute Wards in Christchurch:

• Occupancy (midnight census) of the adult acute inpatient service has remained at 93% for a second consecutive month. There were 17 sleepovers required in July 2016.

• We are exceeding Ministry of Health targets with respect to wait times for adult services. The targets are 80% of people seen within 21 days and 95% within 56 days. 97.4% of people referred to the Adult Community Service were seen within 21 days, and 100% seen within 56 days for July 2016. The percentages are 92.9% and 98.8% respectively when other adult services i.e. Specialty, Rehabilitation and Forensic are included.

From Grant Cooper –Otago

- Raise Hope SDHB Strategic Plan is still in development. A lot of behind the scenes work is going on and hopefully some concrete proposals will be able to be released for wider release.

From Carron Cossens – Co-ordinator – Peer Support Group Oamaru

- The Wolfpack (Men's mental health peer support group) are looking at finding premises so they can meet with those needing support every evening. Funding is an issue with this of course. They are now a charitable trust.

- The Men's Wolfpack support group are setting up headquarters as a drop in centre in Oamaru. They are currently doing renovations.

- Youth line Otago is now established in the Waitaki.

- Artsenta 9mental health art group) are re-establishing in Oamaru on a monthly basis for ten people at a time. I hope to have secured funding for room rental through the Waitaki District Council but won't know for a while.

Seclusion

Julie Witla Christchurch

Our focus on reduction of seclusion in Te Awakura (acute inpatient service) continues. Two consumers experienced seclusion during July 2016 for a total of 6.75 hours. There is strong and effective nursing leadership and staff dedication and commitment to maintain the focus of reduction.

There was discussion around the steeply dropping seclusion rate – this has decreased from 800 hours in April 2012 to 1 hour in the last month commendations to the CDHB for doing this. Awareness was thanked for helping instigate this focus on seclusion reduction and elimination. It was mentioned the DHB is talking much more about seclusion elimination now, rather than just reduction. There is much more of a focus on upskilling staff to be able to provide talking therapies, not just assessment.

Mental health staff are also being supported to upskill around supporting people with alcohol or drug problems as well as mental illness. In June there was only **one hour of seclusion** recorded in the acute wards. Though rates are going up in other parts of the country, likely as a back lash from some bad media and incidents, the efforts of staff in Canterbury have been excellent. There is anxiety among staff over changes in policy and the increase in assaults on staff. Some feel they are at risk but are still de-escalating patients. (This may be what is reflected in unpleasant anonymous comments that follow media articles.)

Individualised Funding TRENDS

Discussion about viability of increasing number of IFA requests (from a cost perspective), which must be balanced with right of individuals to live in the community (in so far as possible).

Agreed that Planning and Funding team will draft a discussion/analysis paper covering the issues, options etc and circulate for further consideration.

Stigma and Discrimination

A recent literature review prepared by CDHB, Commmunity and Public Health – *Impacting stigma-related inequalities among those who have been diagnosed with a mental illness* , particualrly from within maori, pacific and CALD populations.

The main research question was: *what policies, interventions or programmes work to reduce stigma/self-stigma amongst those who have been diagnosed with a mental illness?* The importance being that self-stigma can negatively impact on health i.e. barrier to seeking treatment, poorer health outcomes expected and the "why try" effect contributes to ongoing diability/social withdrawal.

Key findings included:

- there are 3 types of stigma: stuctural, public and self;
- mental illness stigma varies accross cultures – stigma does **not** operate in a similar way for everyone;
- in the study period maori and pacific people had a higher prevalence of disorder/serious disorder but were less likley to seek treatment;
- reasons for not seeking treatment included racism and stigma;
- there are 3 types of racism: institutionalised; interpersonal and internalised; and there are parallels with the 3 types of stigma;
- maori, pacific and people from asian communities were more likely to access culturally specific health initiatives;
- culturally appropriate health frameworks can reduce inequality;
- reducing stigma needs a "whole of system" approach;
- reducing stigma should be focused for different population groups, reflecting diversity of needs;
- reducing stigma needs to be tackled from a policy level;
- psychological first aid may help in reducing stigma;
- cultural responsiveness should be improved by incorporating cultural competency training at a structural level;
- self-stigma programmes should be delivered by relevant providers e.g. kaupapa maori providers for maori populations;
- KPI's for programmes should be orientated at achieveing equity; and
- evaluation should be built in to programmes.

The aim of the report/findings is to support/inform mental health providers to reduce self-stigma in priority populations, to inform initiatives and policies etc.

Lisa Perniskie, Peer Support, Mirror HQ, Ōtepoti

I have been in discussion with Sue Paton from DAPAANZ and some peer support workers from Auckland and Christchurch. DAPAANZ is the membership association representing the professional interests of practitioners working in addiction treatment.

There are some new categories being discussed for the Peer Support role with the DAPAANZ organisation

Grant Cooper Otago

Mental Health Awareness Week initiatives in Dunedin with a number of events. The largest was a picnic in the Octagon in Dunedin with over 200 people with more than 15 community and mental health providers with interactive displays and activities including yoga, tai chi and mindfulness

Julie Whitla - Christchurch:

Acute Wards

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From Sharon Gutsell – Consumer Advisor PACT Southland

Working on a new referral protocol for people to receive community support services without the need for a needs assessment, removing this barrier to people receiving support services.

Lisa Perniskie, Peer Support, Mirror HQ, Ōtepoti

Within my team I have been working on how to collaborate and spent time recently on developing a process for our internal referrals to my role.

With our taiohi it works well to have a mihi whakatau process with myself, taiohi and the clinician to clarify for them what support I can offer and what the clinician will be working with. The taiohi is given the opportunity to discuss what they would like support with.

It is very isolating for myself being in Dunedin as there are very few peer support workers here. I have had a lot of support from OHMST and would like to thank Grant for his ongoing support of my role.

I would like to participate more in best practise within the southern area and find out more about what is happening in our area- Te Wai Pounamu.

3. New Initiatives /Developments in your region

Psychosocial Committee

Julie Whitla Christchurch

There was an update on the work of the Psychosocial Committee, led by CDHB for 9 months now (previously CERA):

The committee meets monthly and meetings continue to be well attended

The committee are responsible for the shared programme of action (**SPOA**)

SPOA is comprised approx. 90 services working together to achieve the shared goal of recovery in Canterbury.

Two thirds of the services are engaged and committed to working together. A review of SPOA is underway and will be completed by 2017. The intention is that future iterations of SPOA will be split between services for recovery (past) and reactive services (future).

The committee are working with MBIE (and other relevenat agencies) around what services are still required for the 6500 households with outstanding EQC claims. Emphasised that there are other vulnerable people that may require ongoing assistance e.g. households who have cash settled and are managing complex/stressful rebuilds by themself and/or managing re-repairs due to defective EQC works. Both of the latter groups are still under stress capable of affecting wellbeing/mental health.

It was noted that as well as a wind down of some services that the funding environement is changing: Red Cross funded social workers in schools funding has ended; it's unclear what the $1million allocation to CCC (from additional mh funding) will be used for; and likewise MSD residual funding (approx $800K). It is hoped that the CCC and MSD funding will be targeted at high need groups e.g. people with disabilities; people with outstanding EQC claims and people with health conditions.

A recent evaluation of All Right? found that:

- 75% of people were aware of All Right? (compared to 49% awareness of *Push Play* the most visible/expensive public health campaign)
- 83% said it was valuable
- 71% had a greater awareness of taking care of self
- 75% had a greater awareness of taking care of others
- 74% had done something different as a result of the campaign

On the whole, the signs are that population wellbeing measures are rising. The WHO – 5 score has risen from 15.4 (in 2013) to 16.2 (2016). At the next meeting Lucy will provide an update on the latest reuslts from the Canterbury wellbeing survey, which will have been published by then.

PRIMARY HEALTH

Work is commencing with the primary mental health providers to consider where the opportunities are to increase responsiveness to the community and provide more support for General Practice to manage people with complex issues.

Meetings are being held with groups of providers to illustrate how their routine reporting can be collated to provide useful data for system planning. This is generating useful discussions about the development of KPIs that reflect local priorities and add context to national reporting.

Primary Mental Health Discussion Paper

Background

Primary Mental Health Services (PMH) are a highly valued and an essential part of the Canterbury mental health system. The clinical work force is highly skilled in delivering services to those with mild to moderate mental health and AOD conditions. PMH Services are provided by the, Christchurch, Rural Canterbury and Pegasus PHO's.

Current Primary Mental Health Service

Role	Brief Description	Resource
Brief Intervention Counselling/Co-ordination (BIC)	BIC offer up to 5 counselling sessions for people with mild to moderate mental health and AOD issues referred from their General Practice. In addition to the 3 main PHO providers St John of God Waipuna have 1.75 FTE specifically for youth BIC in Primary Mental Health	**23.16 FTE**
General Practice Liaison	GPL are to provide clinical interventions and supports for those with enduring mental illness but no longer require specialist services or those who have a more serious episode of mental illness but it is deemed appropriate to manage their needs within Primary Care	**5.2 FTE**
Intensive General Practice Liaison (IGPL) *Being recruited at the time*	While these new roles will increase the capacity in PMH of the standard GPL role, it is expected that this role will include a range of different	**8 FTE**

of writing this paper	interventions such as group work, family work, support for those post a suicide and strengthen the integration with Specialist services	
Senior Clinical	Provides clinical supervision to staff and clinical expertise required to deliver services that meet best practise requirements	**2 FTE**
Extended Consultations	Allows for double the time for the General Practitioner to spend with an individual who is presenting with a mental health /AOD issue	**5919 sessions per annum**

Brief Summary of Current Model of Service Delivery

Each of the PMH teams receive referrals from the PHOs affiliated General Practices with the exception of 5 Practices who transferred from Rural PHO to Pegasus in July 2014, for those Practices RCPHO continue to provide the PMH services.

Each PMH team has a Senior Mental Health Clinician to triage the referrals and allocate appointments based on urgency and availability of staff. Prior to the allocation of the additional 8 FTE IGPL roles, eighty percent of the FTE's in PMH are BIC workers, who deliver up to 5 sessions of brief intervention counselling sessions to patients. Brief Intervention Counselling is provided to youth and adults

GPL provide support and education to General Practice Teams and also work with mental health consumers who require episodic and on-going monitoring and support for those with more severe and enduring mental illness. In RCPHO and CHPHO the GPL role is delivered by a clinician employed specifically for the GPL role. In Pegasus PHO the GPL role is part of the BIC role, rather than a separate FTE.

IGPL is a new role which is envisaged to expand the GPL role to include family and group work, more capacity to work with those with enduring mental illness and to include working with youth. The role is specified and is not to be used to expand BIC capacity.

The General Practice is the 'health home' for the mental health consumer and as such when discharged from the PMH service, the General Practice team receives a summary of the engagement with the service. While there is some variation for individual circumstances and between PMH teams, consumers are given information on other services available for on-going support or when assessment with Specialist services is required this will occur via the General Practice.

Service Performance

Data is taken from the quarterly reporting from the 3 PHOs.

Total referrals for Brief Intervention Counselling (BIC) combined for 3 PMH services are on average between 750 and 900 referrals per month.

BIC services worked with 1,000 12-19 year olds in 2014/15 and 7,505 adults aged between 20 and 64 years.

This reduced in 2015/16 to 444 12 – 19 year olds in 2015/16 and 5,509 adults aged between 20 and 64 years.

There is no information provided for the 2,000 per annum plus referrals not seen in BIC services.

Average number of BIC sessions per individual is 3 sessions. This is unchanged despite reports from PMH teams that this has increased with the number of people needing interventions for their complex needs.

There is no discharge information as providers refer back to the General Practice and there is inconsistent reporting on the numbers referred onto Specialist Mental Health.

While no clear conclusions can be drawn, the data in Table 1 and 2 has been obtained by cross checking SMHS and Primary Care reporting for 2015/16.

Table 1:

2015/16

Count of SMHS NHI also seen by Primary M H Teams

2015/16	**Count of NHI By Age Group**			
Ethnicity	**0-19**	**20-64**	**65+**	**Grand Total**
Maori	37	144	2	183
Other	226	897	97	1220
Pacific	1	17	1	19
Grand Total	**264**	**1058**	**100**	**1422**

Table 2:

% of SMHS NHI also seen by Primary Mental Health Teams

Ethnicity	0-19	20-64	65+	Grand Total
Maori	4.51%	9.07%	3.28%	7.41%
Other	7.55%	11.65%	4.21%	9.39%
Pacific	1.04%	7.76%	3.85%	5.57%
Grand Total	**6.75%**	**11.13%**	**4.18%**	**8.99%**

There is inconsistent reporting for the GPL role therefore it is not reported here.

Extended Consults

Yr 2014/15	5,834
Yr 2015/16	4,947

Where some of the opportunities might lie?

- PMH services provide services to those who have mild to moderate mental health conditions. While these people make up the majority of people seen, in reality PMH services work with people who are experiencing psychosocial distress through to those with severe and enduring mental illness. Are we seeing the right people? Are services configured in a way that meets peoples' needs? Are there barriers for people getting the services they need in a primary care setting?
- New ways of working adopted in the NGO sector and SMHS, such as the youth collaborative provided by 3 NGO's for those with mild to moderate mental health conditions and centralised referral points, needs to be considered for their applicability to PMH.
- Could the Service model be adapted so that there was direct flow of information from PMH to NGO and SMHS e.g. does the referral pathway and discharge processes lead to an integrated system? How could IT systems support this?
- Over the last 5 years an increasing number of Mental Health NGO services have accepted referrals from General Practice. The majority of these services are non-clinical and they rely on the General Practice for their clinical support when working with a consumer referred from General Practice. How could PMH increase their involvement with mutual consumers in the NGO sector?

- How can PMH, work together to provide packages of care, group work, etc. in collaboration with and for other parts of the system.
- The additional 8 IGPL FTE from MOH, BIC 3 FTE from Red Cross and MSD and Community Connector are all time limited agreements from between 12 -36 months. Without this resource services across the mental health sector are at capacity. Looking to 3 years ahead, are we making the best use of the resources we have?
- Are there opportunities to move work to other parts of the health and social service system e.g. telephone consults, e-therapies, MSD services. Who decides?
- There is variation across the 3 PMH services, what needs to happen to provide equitable services? Why aren't more Maori accessing BIC services?
- PMH undertake Alcohol Brief Intervention Counselling, are we doing enough in Primary Care for people with alcohol and other drug issues

Consumer Thoughts

Will the Intensive GPS be free?

Will there be adequate choice of Intensive GPS?

Seeing people in their homes is a great idea.

Crisis Service Resolution Service

Demand for the Crisis Resolution remains steady. In July 2016, there were 185 crises new case starts. This was a slight decrease from the 215 new case starts in June. Crisis new case starts require an assessment within a day of referral. In July 2016, 28 initial assessments occurred in the consumer's home.

Consumer Thoughts Below is a Consumer Satisfaction Report of Crisis Resolution services as the Crisis has undergone a shift in model of care and its good practice to look at what people who are using the service think of it.

Satisfaction with Crisis Resolution: Consumer, family and referrer perspectives

Project Information Sheet

Satisfaction with Crisis Resolution: Consumer, family and referrer perspectives

Name and address of service/department/organisation

Name: Clinical Research Unit, Specialist Mental Health Service, Canterbury District Health Board

Address: Terrace House, 4 Oxford Terrace, Christchurch 8011

Contact person

Name	Job Title	Email
Frances Carter	Clinical Psychologist/ Scientific Officer	frances.carter@otago.ac.nz
Address:	Terrace House, 4 Oxford Terrace, Christchurch 8011	
Telephone:	03 3720400 extension 86440	

Please tick the category you think best fits your project

Improved quality, safety and experience of care	✓
Improved health and equity for all populations	
Best value for public health system resources	

(Please note Assessors make the final decision)

Full list of project investigators

Frances Carter (Clinical Psychologist (Scientific Officer, Senior Clinical Lecturer); Joan Taylor (Clinical Liaison, Nurse Consultant); Steve Duffy (Consultant Psychiatrist); Robert Green (Consultant Psychologist), Teresa Quigley (Consumer Advisor); John Beveridge (Nurse Consultant-Informatics); and Maddie Weston (Interviewer).

ABSTRACT

Overview

In 2014, the ways that help was provided to people with urgent mental health needs in Canterbury was changed. Prior to the present study, only anecdotal evidence existed about how people who use the new Crisis Resolution services, experience them. Almost by definition, having an urgent mental health need is a highly stressful time for consumers, family and potentially referrers. We wanted to understand the perspectives of all of these key stakeholders.

Aim

The broad aim of the study was to evaluate the service satisfaction of consumers, their families and referrers, for consecutive people discharged from Crisis Resolution over a five week period.

Goals and objectives

Specifically, the study sought to do the following:

- Evaluate **global satisfaction** with Crisis Resolution;
- Evaluate satisfaction with **specific aspects of care** that the service was striving to achieve (e.g., ease of access, efficiency and effectiveness);
- Compare service satisfaction amongst different **demographic groups** for consumers;
- Assess how participants think that the service could be **improved**, and which aspects of the service were especially **helpful or good**.

The ultimate goal of the study was to improve Crisis Resolution for all key stakeholders.

Results

75 consecutive, eligible and consenting consumers, 22 family and 16 referrers completed structured interviews. High levels of satisfaction were found amongst consumers, family and referrers with Crisis Resolution for global satisfaction and most specific aspects of care. If consumers were dissatisfied with care, they were more likely to be 25-34 years of age. Staff manner and having effective treatment of sufficient duration were the most important issues discussed by participants on open questions. A diverse range of specific suggestions were made by participants.

Conclusions

High levels of satisfaction were found with Crisis Resolution. Staff manner and having effective treatment of sufficient duration were the most important issues for participants.

INTRODUCTION AND BACKGROUND

What is the health care context in which this project occurred?

In 2014, the ways that help was provided to people with urgent mental health needs in Canterbury was changed. The new model of care involved a Crisis Resolution function being built into the existing four geographical mental health teams. The aim of the new model of care was to provide care that was easy to access, efficiently delivered and highly integrated. For example, because consumers were now dealing with the same team for different needs, it was hoped that meeting new staff and undergoing unnecessary assessments would be minimised, and the transition between outpatient and inpatient care would be improved. An emphasis was also placed on trying to see consumers where they wanted to be seen, such as in their own home, where feasible. Prior to the present project, only anecdotal evidence existed about how the people who use Crisis Resolution, experience it.

Why was it important to understand how people receiving help from Crisis Resolution, experienced this? Who was it important to ask?

Almost by definition, needing help from Crisis Resolution is a highly stressful time for consumers and their families. These situations may also be difficult for referrers, such as General Practitioners, who are trying to organise urgent and appropriate help for people in crisis. Mental health guidelines and commentaries note the importance of consumers having the best possible *experience* of care [1], recognise that carers are vital partners in the provision of care [2], and advise that Crisis Resolution services need to work closely with other care providers [3]. Surprisingly, no previous study has systematically evaluated the service satisfaction of all key stakeholders (consumer, family and referrer) for the same case, when somebody has an urgent mental health problem.

PLANNING

Aims

The broad aim of the study was to evaluate the service satisfaction of consumers, their families and referrers, for consecutive people discharged from Crisis Resolution over a five week period.

Specifically, the study sought to do the following:

- Evaluate **global satisfaction** with Crisis Resolution;
- Evaluate satisfaction with **specific aspects of care** that the service was striving to achieve (e.g., ease of access, efficiency and effectiveness);
- Compare service satisfaction amongst different **demographic groups** for consumers;
- Assess how participants think that the service could be **improved**, and which aspects of the service were especially **helpful or good**.

The ultimate goal of the study was to improve Crisis Resolution for all key stakeholders who use the service.

Links to planning principles and service priorities

The project was consistent with the Canterbury DHB (CDHB) ideals for "our way of working" [4] as follows:

- Understand and respond to the needs of populations;
- Make decisions based on where services are best provided, including "what is best for the patient?" and
- Use information to plan and drive service improvement.
-

The project linked with the following SMHS priorities [5]:

- Crisis Resolution development;
- Collaborative care;

- Family safety and wellbeing, communicating with (listening to) family and supporting family;
- Technical support with service improvement (evaluation); and
- NGO integration with SMHS (i.e., seeking General Practitioner's views).

Team process

Originally a broad range of people expressed the view that it would be desirable to evaluate Crisis Resolution, such as clinical staff, Consumer and Family Advisors and service management (SMHS). Following an initial 'expression of interest' meeting involving around twenty people, a smaller working group was formed consisting of people with the key skills, knowledge and experience needed to undertake an evaluation (e.g., research skills, knowledge on the original goals of Crisis Resolution, clinical expertise, data base expertise, and consumer advisory expertise). This working group then critically examined which evaluation questions were important and which were feasible to examine. We then agreed on roles and responsibilities for the project, identified key tasks (e.g., obtaining funding, gaining ethical approval, employing and training the interviewer and developing a recruitment plan) and established a timeline for completing these tasks.

Collaboration

This project was collaboration between SMHS and the University of Otago, Christchurch (UOC). The latter provided funding via the Summer Studentship programme for an interviewer to be employed for three months, support and advice regarding (research) data bases, statistical advice and paid for the telephone calls that were made by the interviewer.

Sensitive issues identified in the planning phase

Privacy issues

We became aware that privacy concerns had the potential to jeopardise the project. In particular, concern was expressed by the Research Committee (SMHS) about us contacting consumers to ask them if they would like to participate in a service satisfaction survey. We spent a considerable amount of time talking with the Complaints Officer at Hillmorton Hospital and the Office of the Privacy Commissioner about how privacy issues could be managed. This input enabled us to come up with a research design that the Research Committee (SMHS) and the University of Otago Human Ethics Committee were satisfied with, and that was still valuable from a research perspective. Specifically, we developed a study protocol that ensured that consumers had "no surprises" about the study, and that they had multiple opportunities to indicate that they did not wish to be contacted about the study. In addition, we recommended to management (SMHS) that an addition be made to the Initial Treatment Information Form for all consumers, explaining the integral nature of quality improvement in health care and clarifying that consumers may be contacted for these purposes. This suggestion was accepted and implemented.

Vulnerability

By definition, people with a "mental illness" are "vulnerable" according to the National Ethics Committee Guidelines. Therefore, there is (appropriately) an even greater expectation on researchers that the study question under investigation is important, and that the study is carefully designed and implemented to ensure that no harm is done to anybody through participation in the study. This consideration influenced our planning of the study in numerous ways. For example, we only included consumers who had been recently *discharged* from Crisis Resolution (i.e., judged by their clinician to be well enough to be discharged). We also set up systems so that we identified anybody who might have been put at risk or made worse through participation in the study (e.g., people who may be put at risk of family violence if letters or phone calls from the CDHB were intercepted, or people with delusions about being spied upon). The Clinical Liaison (Joan Taylor) personally screened consumer notes and liaised with clinical staff around this issue.

Avoiding unwanted communication following loss

Sadly, it seems likely that consumers who have recently had an urgent mental health problem (and needed to use Crisis Resolution), are at increased risk of suicide. We were mindful of this, and were keen to ensure that we did not inadvertently add to the distress of families in this situation by sending letters to consumers who had deceased or phoning their homes. Therefore, we enlisted the help of staff within SMHS who manage information of this nature, and set up a system for them to inform the Clinical Liaison of situations where consumers who had used Crisis Resolution were deceased.

Consultations

Conducting structured interviews

Professor John Horwood from the Christchurch Child Development Study (UOC) provided expert advice on how to form questions for use in structured interviews. He recommended asking participants to provide words as opposed to numbers, to keep the response options to a minimum, and to use plain and simple language wherever possible (e.g., good/bad/ok).

Maori

We consulted with the CDHB Maori consultation committee regarding the project, and liaised with Henare Te Karu (Pukenga Atawhai at Hillmorton Hospital) about how to ensure that the interview process was accessible to Maori.

Crisis Resolution staff

We met with staff and outlined the purpose of the study, sought their ideas and addressed their concerns. This was done on three occasions to ensure that staff from all geographical teams on a range of shifts had the opportunity to participate.

Training

The interviewer received comprehensive training on a range of issues including how to manage potentially difficult scenarios with participants, and relevant protocols were developed.

Ethical approval

The study was approved by the University of Otago Human Ethics Committee.

IMPLEMENTATION (METHOD)

Participants

Consumers

Consecutive individuals discharged from Crisis Resolution (from any of the four geographical SMHS teams) over a five week period (last week of October 2015 until the end of November 2015). For participation in the study, consumers were required to meet the following criteria.

Inclusion criteria Individuals had been newly discharged from Crisis Resolution. Specifically, they needed to meet the following criteria:

- Had face to face contact with Crisis Resolution within the previous six weeks;
- Discharged from being a Crisis Resolution 'case' within the past seven days. Individuals were suitable for participation. Specifically, they needed to meet the following criteria:
- 18-65 years of age;
- Contact information available for participant (address and phone);
- Currently residing in New Zealand;
- Able to adequately participate in the structured telephone interview (e.g., sufficient English language, adequate intelligence)
- Able to provide informed consent (e.g., not too unwell);
- Consent provided for participation in the study.

Exclusion criteria

Consumers needed to not meet any of the following criteria:

- Consumer refused contact with SMHS;
- Consumer opted out of being contacted about participation in the study;
- Participation in the study deemed to be potentially distressing, unhelpful or harmful to the consumer as judged by either their treating clinician and/or the Clinical Liaison.

Family

'Family' was broadly defined to include any people who had been involved in the consumer's recent care with Crisis Resolution in a non-professional capacity (e.g., partner, friend, Pastor,

neighbour who facilitated the consumer's involvement with Crisis Resolution, or supported them while they were under the care of Crisis Resolution).

Referrer

'Referrer' was broadly defined to include any people who had been involved in the consumer's recent care with Crisis Resolution in a professional capacity (e.g., General Practitioner, Psychiatrist or Counsellor who facilitated the consumer's involvement with Crisis Resolution, or worked alongside them while they were under the care of Crisis Resolution).

Measures

Brief structured interviews were conducted via telephone with participants. Questions were designed to assess global satisfaction with care and satisfaction with specific aspects of care, and involved nine forced choice questions and two open ended questions. The specific questions that were asked are outlined in the results section of this report (together with responses), for economy of space. Consumers and family were asked all eleven questions. Referrers were asked the first four questions, plus an additional question addressing communication (How would you rate the communication that you received from Crisis Resolution about this patient? good/ok/bad/don't know). Consumers were also asked brief demographic questions assessing age category (18-24, 25-34, 35-44, 45-64 years), ethnicity and gender.

RESULTS

Who participated?

Figure 1 summarises recruitment for the study. Of the 123 consumers who met inclusion and exclusion criteria, 75 participated (response rate = 61%). This rate compares favourably with other similar studies that have recruited consumers who have recently had an urgent mental health problem [3]. Briefly, consumers were roughly evenly split by gender (51% female), were most likely to be aged 18-24 years, and most commonly identified as being New Zealand European (81%), followed by Maori (14%), Samoan, Indian and other (each ≤ 1%). The demographic characteristics of the consumers interviewed were broadly consistent with those of people who use CR. This means that the findings from this study can be generalised to people who typically use Crisis Resolution.

What did participants say?

Forced choice questions [1]

[1] To ease interpretation, only summarised responses are presented. 'Satisfied' includes response categories such as 'good' and 'ok.' Response categories such as 'not applicable' or 'unsure' were excluded.

Would you recommend the Crisis Resolution Service to family and friends if they needed similar care or treatment?

Consumer = 92% satisfied, Family = 86% satisfied, Referrer = 93% satisfied.

How would you rate the care you received from the Crisis Resolution Service?

Consumer = 96% satisfied, Family = 91% satisfied, Referrer = 91% satisfied.

How easy was it for you to access the Crisis Resolution Service (e.g., find out how to contact them, get someone on the phone and make an appointment)?

Consumer = 86% satisfied, Family = 88% satisfied, Referrer = 91% satisfied.

Were you seen and helped quickly enough by the Crisis Resolution Service? Consumer = 88% satisfied, Family = 77% satisfied, Referrer = 93% satisfied.

Were you given a choice about where you were seen (at least some of the time)?

Consumer = 65% satisfied, Family = 57% satisfied

Were you asked if you wanted family involved in your care? (e.g., maybe to attend appointments with you, or for staff to talk to them)?

Consumer = 84% satisfied, Family = 79% satisfied.

How straightforward was it for you to meet with staff, tell your story and develop a plan?

Consumer = 86% satisfied, Family = 83% satisfied.

Were your needs met by the Crisis Resolution Service (either by them, or did they suggest somebody else who could help)?

Consumer = 81% satisfied, Family = 81% satisfied.

How respected did you feel by staff at the Crisis Resolution Service?

Consumer = 93% satisfied, Family = 91% satisfied.

How would you rate the communication that you received from the Crisis

Resolution Service about XX?

Referrer = 81% satisfied.

Who was more likely to feel dissatisfied?

If consumers felt dissatisfied with care on global measures, they were significantly more likely to be aged 25-34 years.

Open questions

Participants were more likely to offer comments on what they thought was especially helpful or good about the care (approximately 3/4 commented), than about how the service could be improved (approximately 1/2 commented). The same themes were identified for both the positive and negative questions, as follows: staff issues, access to the service, where consumers were seen, the interventions provided or facilitated, involvement of family, communication/liaison/record issues and transport.

Overall, participants were most likely to comment on the manner of staff and the treatment that had been received. For staff manner, it was important to participants that staff were: warm, interested, empathetic, respectful, not rushed or dismissive, that they listened well, treated people as individuals, and were positive and reassuring. For treatment, it was important to participants that they received effective treatment of sufficient duration.

A diverse range of specific suggestions were made about how the service could be improved, including the following:

- Better publicity about the existence of the service and how to contact them;
- The 111 service suggest use of Crisis Resolution as an option, rather than necessarily using the Police;
- Access to the service at a "non-crisis level;"
- Somewhere private to sit and be looked after if experiencing an anxiety attack in the waiting room;
- Better options for managing intoxicated people needing crisis care;
- Improved security for staff; and
- Not being discharged "too soon."

In terms of what was especially good or helpful about the service, many people made general comments about how grateful they were that the service existed, how appreciative they were of having someone to talk to and listen to them (or their family member) at a difficult time. Specific aspects of care that people commented favourably about included the following:

- Being seen quickly;
- Having the option of being seen at home;
- Being given a "minder" while in hospital;
- Receiving "good respite care;" and
- Receiving "good follow-up.

EMBED, SUSTAIN & FUTURE DIRECTIONS

The findings have been presented in person and in writing to both the front line Crisis Resolution staff and to clinical leadership teams on several occasions. Open discussions have occurred with these groups about what can be learned from the results, and what the implications may be for service delivery. The present research is also informing a working party looking at improving Crisis Resolution services. A complimentary piece of work has been conducted by Dr Charlie Whan (SMHS) on **staff** perspectives, and is also contributing to the working party. By taking all perspectives into account, meaningful improvement will occur within Crisis Resolution services and changes will be more likely to be consistently implemented and maintained.

Of concern, the present project identified that 19% of referrers were not satisfied with the communication that they received from Crisis Resolution. Work is currently underway looking at how SMHS and General Practitioners can work together better, including improving communication. It is not clear why consumers who were aged 25-34 years may have been more dissatisfied with the care they received (global ratings). This finding highlights the importance of collecting demographic data in the future, so that it can be seen if this finding is replicated. In the event of this, further in depth investigation would be warranted.

A manuscript detailing this study is presently under consideration with a peer reviewed journal (BMC Psychiatry). If successful, publication would mean that this project contributed to the international literature on this topic, as well as helping to improve local services.

Finally, one of the key, ongoing benefits of the project has been the addition that has been made to the Initial Treatment Information Form (SMHS) as a consequence of our consultations with the Office of the Privacy Commission, as follows:

I understand that…

- *CDHB aims to continually improve the quality of care that it provides. Therefore I may be contacted and asked about the quality of care that I have received. I understand that I have a right to decline to participate, and that this will not adversely affect the care that I receive in the present or in the future, nor will it adversely affect the quality of the care I receive.*

This addition will help clarify for future consumers how their contact information may be used and what they might expect when receiving care from SMHS. Importantly, it will also mean that future Quality initiatives within SMHS should be more straightforward to undertake, and be more clearly consistent with expectations around the management of information collected in a health context.

CONCLUSIONS

High levels of satisfaction were found with Crisis Resolution. Staff manner and having effective treatment of sufficient duration were the most important issues for participants.

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3. Lloyd-Evans B, Johnson F. Crisis resolution teams: how are they performing? Ment Health Today 2014;18-19.
4. Canterbury District Health Board. "We need the whole system to be working for the whole system to work". 2012.
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New initiatives / developments in your region.

Home care Health lines and Spark Home care health line have a new app that they have developed for mobiles and devices; they are currently in talks with Spark about making the pp free for people to access when they have no data!! Come on Spark help our people.

Child, Adolescent and Family Changes:

Reducing wait times has been a key focus for CAF services. The number of case starts for September 2016 was 239 compared to 293 in August.

The service has undergone significant growth over the past 15 years, which accelerated after the quakes. In recent years, it has become apparent that the individual components of the service that developed, somewhat independently of each other, need to be drawn closer together to ensure smooth clinical and administrative processes and efficient utilisation of resources. The first stage of implementing the Direction of Change got under way in September, which has involved co-locating staff that are part of the integrated community teams into *North* (Hillmorton) and *South* (Princess Margaret Hospital campus). The idea being the services will be closer to the communities and the people that are using them.

The School Based Mental Health Team

The Team continues to engage with a large number of schools across Canterbury and at end September 2016 were working with 112 schools. The ongoing focus is to help schools to identify the mental health support needed for their population and to meet these needs through workshops, pastoral care meetings, learning and development activities for staff, and liaison and engagement with other agencies. Families in the community have found the educational presentations that were provided in the evenings at local schools or community halls such as to be very helpful after the earthquakes. Presentations were on anxiety and children, E- Devices Safety etc.

Awareness Mental Health Consumer Network October

Awareness celebrated mental health awareness week by having a picnic in the Christchurch Botanic gardens. A cake donated by the Mental Health Foundation plus a carrot cake provided by Awareness was a great starting point for conversations around mental health.

Please check out the Facebook page.

People have raised concern at Awareness about lifeline losing their funding as it is an established name in the community where as many consumers do not know anything about the new tele health providers.

Suicide rate in Canterbury is still high and there has been little change in the numbers. It is of concern to the network as so many initiatives and focus of the whole region has been on mental health since the earthquake including substantial Health Promotion campaigns on well-being.

Minutes attached to Southern Regional Report

Minutes of the Awareness: Monthly Meeting

Monday the 8th August 2016, 12.30pm-2.00pm

SPEAKER Debbie Selwood: SERVICE MANAGER

Debbie Selwood presented on the new model of care in Specialist Mental Health Services (SMHS) has been implementing and the impact it is having on the services. Debbie summed up the major issues that people were experiencing in the system about three years ago. These included: lack of flexibility, multiple assessments meaning people needed to tell their story over and over, delays in non-urgent assessment leading to some people waiting eight weeks, delays in transitioning people into other services that would be helpful, overcrowding in the acute inpatient units, an inpatient service with a high number of locked beds, and high seclusion rates.

After consultation with people who have used services and families, the services made a plan to increase consumer choice, reduce wait times, prevent the use of seclusion, and increase community teams' face to face time with people. The new model has reduced waiting times for initial assessments, home visits increased, community case manager's caseloads decreased to be able to work more with people, increased capacity to support an extra 600-700 people following the earthquakes and dramatically reduced seclusion.

ISSUES One person fed back that they were not given any choice about where to meet at Specialist Mental Health Services except in an old de-commissioned seclusion room and were made to feel blamed when they didn't want to meet there.

Mental Health Awareness Week: *Naturally Happy*

At the last meeting we talked about holding a Mad Hatters Ball to celebrate mental health awareness week. Since then the exec has thought about the logistics of this and are considering smaller events or activities. This could be a poetry night if we bring this forward for October, a music event, a film screening, or even doing some positive chalking around the city. The theme of the week this year is "naturally happy" which may also help inform what we do.

Fundraising

A friend of Awareness started the first Depressed Cake pop-up Shop. It is happening at "First Thursdays" market at The Colombo Shopping Complex.

It is about reducing the stigma of depression and mental illness, and all the proceeds are going to MHAPS. They have cakes and cake shops from all over Canterbury (as far down as Ashburton) contributing to the fundraising. All cakes were grey on the outside, and had rainbows in the inside!

The Chair of Awareness meets with the General Manager of Specialist Mental health service, Toni Gutschlag bi-monthly for the membership to directly ask pertinent questions and for Toni to update them on

1/ How do you ensure transgender people are represented accurately and that their need get meet? For example, when a Trans person fills out a form can they put their gender down accurately and then have their choice of pronouns used? One consumer noted "As a Trans person I find it hard to accurately fill out forms in a way that represent my gender because there is normally only a female and male box. Neither describes my gender. When I tried to change my prefix to Mx it got change but when I went there again it got change back to Ms. I feel this does not meet my need of my gender being recognized." Another example Trans people have experienced is a practitioner needing to lie for them to get access to trans health care such as Hormone Replacement therapy.

This hasn't been fully worked out yet so the question is timely. This would be a good issue to take to the Consumer Council as it is a concern across all health. In a recent form she noted that they offered Male, Female and Agender as options. Darryn did mention this at the Consumer Council meeting and they will look at it as well. Toni will follow up with Wayne at Planning and Funding.

Toni Gutschlag acknowledged that there needs to be more engagement with the transgender community. Has Ngā Hau e Whā been discussing this? Have Pacifica leaders? Toni will raise this with the Ministry of Health to see how other DHBs are handling it. As far as she is aware there are no guidelines available yet. Her expectation of services is that someone's personal needs will be met with sensitivity. If this doesn't happen, please note the concerns to the CDHB and use and advocate or the Human Rights Commission for support.

2/ Collaborative note writing – where is this at in services? This is a huge thing for members of the network, especially people who struggle with having their experiences reworked or reframed
The CDHB doesn't have a policy at this point. Anyone can ask to see their notes and can correcting or amending them is encouraged. Again, you can seek advocacy support if needed.

3/ Are there any opportunities for patients in the inpatient units to meet all together to provide feedback on how the units are administered? There are some inconsistencies members have noticed between the different units. *Yes, there is likely to be but Wendy Lowerson and Steve Duffy would know how to also, those going in to do peer support could pass information or concerns on.*

4/ A member of the network has recently had difficulties with her family accessing support through specialist mental health services. Her family member has been denied further support from SMHS on each occasion after a number of referrals. When the family see staff at crisis resolution, or talk to SPOE staff the focus has been on the Awareness member's previous mental ill health, and their family member, who is seeking help has only had their depression and anxiety explained by SMHS staff as being in relation to the Awareness member's prior mental ill health experience, or "family relationship issues" and then been referred back to their GP. 5/How does the mental health system work when a family or couple have multiple people who have mental illness? What should the process be for staff to provide support in this situation? What should be happening to prevent one family member's previous diagnosis becoming the lens through which all other family members' struggles are perceived?
This is a concern. Toni would want every referral to be considered on its own merits. She encourages taking an advocate. Perhaps a second opinion would help. The staff have training available for family support and being aware of individual needs.
Making a complaint can help. Each first goes to the Quality Manager, then to the Leadership team (as do all serious incident reports) where they are assessed for any clinical changes needed. Then they go to Toni for any final support required. Complaints can be made anonymously if needed.

5/ There have been disparities in what members of the network have been offered in terms of support following a contact with Crisis Resolution, for example, one member was contacted every day for a week following being in touch with CR where staff checked how they were doing. Another member was told the only options would be a medication change or inpatient stay and if they didn't want an inpatient stay then their GP could just as easily oversee medication change so further SMHS or CR support would not be needed. Why does this discrepancy occur? Should consumers be given the full range of options for support and be able to choose what feels best for them?
These issues can be taken to Joan Taylor as she is developing clinical pathways right now. It may help people to know that they are short of Doctors right now and there has been a lot of staff change. Thankfully the request for services has levelled off and isn't still increasing. It has stabilised at a very high level though.

6/ Some comments from presumably mental health staff (not necessarily from CDHB) have been posted on a Stuff article and show incredibly negative views. Does the CDHB require staff to not comment publicly in this kind of way? It's hard knowing that health professionals can talk about consumers like this on a public forum. (Examples were given)
Yes, the CDHB has a policy that staff may not make public comments, can't say they work in a particular part and are not meant to criticise their employer or breach the privacy of patients or colleagues. Especially on facebook or any other social media. No one can control anonymous comments though. We don't have the same support from a Mental Health Commission as we used to. The Mental Health Foundation should be able to offer some leadership here. We also have the right to write to Fairfax Media to express our concern re lack of balance or moderation.

7/ Do you have plans yet for Mental Health Awareness Week? Would you like to work with Awareness to put on an event?
Yes, a broad project could be good though cost has to be a concern. We could talk to Cathy King who runs projects and conferences for the CDHB. Toni would support a project if there were enough people to help. The 150th Commemoration Family Picnic went well but it also required a great deal of time and co-ordination.

8/ We read in the paper that Hillmorton will go Smoke Free again. What is the plan this time?
They have been moving toward reducing and eliminating smoking since the last temporary cancellation .They have a group who is establishing a good time frame and good systems, and further cessation supports.

Toni's (Gutschlag) Items

At a previous meeting Toni said she would talk to the Christchurch co-ordinator of Child, Youth and Family. She wanted us to know that she was on leave then they were on leave but she is still following this up within the next 2 months.
The changes at CYF will be important to the CDHB. In about 2 years' time a percentage of the CDHB's Child/Youth funding will be given to CYF (or their equivalent organisation) to give out to providers. There is grave concern that the providers won't understand clinical needs and the governance required to support clinical programmes. As it is there isn't enough funding to cover services requested?
One advantage for Mental Health in Christchurch is that there has been such good work done with keeping older persons healthy in their home that the hospitalisation rate has reduced. The funding freed up has come to mental health.