APPENDIX ONE: UPDATE MENTAL HEALTH AND ADDICTION INTELLECTUAL DISABILITY SERVICE

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa; HUTT VALLEY DHB; Capital & Coast District Health Board Ūpoko ki te uru hauora	**HAC INFORMATION PAPER**
	Date: July / August 2015
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Endorsed By	Debbie Chin, CE, Capital & Coast DHB
Subject	**MHAID Service 3DHB Report for Hospital Advisory Committee (HAC)**

RECOMMENDATION

It is recommended that the Committee **NOTES** the contents of the report

Establishment of MHAID Service 3DHB

In January 2014, the Executive and Senior MHAIDS leaders from the respective DHBs met and a decision was made to consider further integration of the mental health services for the 3DHBs. All of the leaders saw this as a potential way of ensuring the collective resources are used to provide the most effective services and in many ways, this was seen as a natural evolution of the already close working relationship that existed across the sub-region in the mental health and addictions areas. In April 2014, a concept of alignment and integration was taken a step further when, on consultation with a proposal for a single lead for MHAID Service 3DHBs, was the creation and subsequent appointment in July 2014 of a General Manager position across the 3DHBs.

Subsequently, the General Manager oversaw the engagement process (through August 2014 and September 2014 there were 20 focus groups across the region with staff and unions) and the consultation on the proposal with around 106 individual and group submissions received with the vast majority supportive of the proposed leadership model and positions. There were also submissions that suggested adaptions to the proposed model and some of the service groupings were adapted to consider the suggestions and points raised.

On February 9, 2015, MHAID Service 3DHB was launched. The launch occurred at Ratonga Rua Hospital, the Hutt Hospital and finished with a powhiri at Wairarapa Hospital. The new structure for MHAID Service has six service groupings. An example is the Younger Persons & Addictions group will now take clients up to 25 years of age (previously 17 - 19). The approach has been to establish a new integrated service with no boundaries so clients can access the service that they need, irrespective of where in the sub region the service is.

1 *Balanced Score Card*

The Balanced Score Card for MHAID Service 3DHB is attached. We have been finalising this and some of the challenges have included the different way in which the data is collected in the 3DHBs. The Score Card is colour coded so it is clear which of the factors are the National Benchmarking KPI programme, national health targets, Health Quality & Safety Commission KPIs, Mental Health & Addictions Services targeting Ministry of Health Performance measures, and our own targets. Key indicators that the Committee might focus on are the 28 day acute re-admission rate and the post discharge community care.

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2015 Balanced Score Card - July.doc

a. The average 28 Day readmission rate nationally for comparable DHBs is 15% and the national KPI target that we have also adopted is 10% which we are moving towards.

b. Wellness plan (%) has a few data quality issues but it is a performance measure that we are focusing on for 2015/16.

c. HONOS (%) has been declining in utility over the years resulting in MoH considering dropping the measure to evaluate performance. The measure has not gained favour with the DHBs clinicians too.

d. Seclusion - differences in unit configuration and data capture methodology account for the difference in numbers between the two acute units.

e. Adult Inpatient Occupancy - we are over the desirable target of 85% due to increasing demand on acute beds from the region. National KPI target is set on 85%.

f. Post Discharge community care is the latest measure that is being added onto the BSC and other than a few data quality issues remains to be a concern for the service. The target for the service is the same as the National KPI which is 90-100%. The national average currently sits at 62% amongst comparable DHBs. This is a focus for the service this year.

g. Consumer related time (Adult) – at 20% with the national average being 30% amongst comparable DHB's. The Service has initiated several time and motion studies within the community mental health teams and the contact time has been increasing gradually over the last few months. Changes to data capture and accurate recording of activity by the clinicians has contributed to the accurate capture.

2 *Acute Day Service (Te Wharu Ahuru)*

The project for closing the Acute Day Service at Te Whare Ahuru and opening a new community based day service with a new provider has been on target. This has been a joint initiative between SIDU and the MHAID Service 3DHB. The new service is run by Pathways (who were selected following an RFP process) and is based in Queens Drive, Lower Hutt. The Service opens on the 14 September 2015.

3 *New base, CAMHS Porirua*

Monday, 10th August was an auspicious occasion for the Child, Adolescent and Mental Health Service in Porirua. The Service moved to new accommodation - Level 3, BNZ Tower is now the new address for CAMHS, joining the Porirua Adult Community Mental Health Team (level 8) and MHAID Service 3DHB management (level 11) in the BNZ building.

4 *Crisis Resolution Service*

In March this year we began an engagement process with staff looking at the way we work across the Crisis Resolution Service and in particular how to work with the changes to Police process, the Emergency Department needs and also the needs of clients in the communities. We have held workshops with staff and sought their input into possible model changes that will ensure we are meeting our client needs. A consultation document is out with staff (and unions). The proposal is to have one integrated Crisis Resolution Service across Hutt Valley and CCDHB, with mental health crisis staff based in the Emergency Departments, the new Police hub, and the community.

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5 *Rangipapa Reconfiguration*

Rangipapa is one of the forensic mental health units at Ratonga Rua Hospital, Porirua. It is a mixed gender 13 bed facility. Women who require mental health care and treatment in secure settings are a highly vulnerable group, with complex challenges and differing needs from their male counterparts. The Unit is being reconfigured to provide a small, women-only facility as part of the Rangipapa inpatient unit. This will provide increased privacy and safety for women

Once commissioned, Rangipapa will be the first for the country.

6 *Purehurehu Refurbishment*

Purehurehu is another regional forensic unit, built in 1992, and located at Ratonga Rua Hospital in Porirua. Little upgrade maintenance work has been undertaken since the building opened. A capital spend was recently approved to scope the maintenance, compliance and reconfiguration works in order to inform a business case for a capex project.

7 *Te Whare Ra Uta*

Te Whare Ra Uta is located on the Kenepuru Hospital site. It is a 16 bed psychogeriatric unit (a service for CCDHB and since March providing 4 beds for HVDHB). Work is underway to ensure the design and layout of the seclusion area is compliant and we are also building a new de-escalation area. This work has been approved.

8 *Te Whare Ahuru*

The security access and the fire safety systems are currently being upgraded at Te Whare Ahuru, the acute inpatient unit at Hutt Hospital. There is approval to install a much needed emergency lighting system as well as minor building works in the safe care of the unit to make the area pleasant for clients and staff alike. That work includes relocating/ reconfiguring the staff base and also relaying the flooring. This work has been approved and due to start this month.

9 *Clinical Governance*

There has been on-going discussion at the DHBs level about developing a 3DHB clinical governance model. This is particularly significant for 3 DHB clinical services (including MHAID Services). Clinical Governance focuses on patient safety, minimising risk to consumers, and monitoring and improving the quality of clinical care. A 3DHB clinical governance structure is being drafted.

10 *Wellington Hospitals Foundation*

The Rangatahi Adolescent unit received support from the foundation which provided an iPod Touch and a portable Bluetooth stereo speaker.

11 *CAMH Service (Wairarapa)*

This is an important community based service. With increasing demand on the service, the limitations of the current facility has become evident and the Property Team has been engaged to look for alternative community based options.

12 *Intellectual Disability Service Audits*

The ID Service has been subject to two external audits over the last two months commissioned by Disability Services Quality and Performance Group from the Ministry of Health. These audits are randomly commissioned. The first audit, a quality review against service specification, ran in June/July. The findings have come in this month. Overall there were some recommendations for improvements, but no corrective actions. Generally, a very positive audit. The second audit, a claims audit against invoicing, is in process currently with results expected in October. The expectation from

the auditor is a favourable outcome. The service has now been notified that they are also part of the upcoming ACC Partnership Programme Audit. This service has now been robustly audited since the MHAID Service 3DHB integration.

13 *MOH Site Visit to Nga Taiohi – the national youth forensic unit under construction*

Ministry of Health and National Health Board officials were very pleased with what they saw and the progress in the construction of the facility. The draft Model of Care document for Nga Taiohi has been circulated widely. Work is underway developing the Operational Manual and the programmes and activities. We have undertaken to coordinate rationalising the Youth Court forms so there is national consistency.

14 *Research*

There are a number of pieces of research being undertaken in MHAID Service 3 DHB. A NZ study on Members of Parliament experience of being stalked/harassed has recently been completed and received considerable publicity. This is by Drs Susanna Every-Palmer and Justin Barry-Walsh. Another research project about to commence is a joint undertaking with the Department of Psychological Medicine (Otago University) looking at the effectiveness of our forensic mental health service.

15 *Restraint Advisory Groups (RAG)*

A Restraint Advisory Group (RAG) has been set up for Wairarapa DHB. It met for the first time in August and is chaired by GM, MHAID Service. Similarly, the RAG for Hutt DHB has been reconstituted, which is also chaired by the GM, MHAID Service. This is about monitoring incidents, approving staff training in various restraint minimisation techniques and ensuring to the standards, primarily to protect staff and our patients.

Nigel Fairley
General Manager

APPENDIX TWO: Equity Dashboard for Sub-Regional Mental Health & Addictions Services (DRAFT)

	Name of Measure	Access	Experience of Care	Health Literacy	Description	Rationale	Source	Data Definition	Targets	Availability	Comment
Equity for Priority Groups that use MH&A Services Parameters: **Maori↔Pasific↔Other** **Wairarapa↔HV↔C&C**	Age Profile	✓			Distribution of all people accessing secondary MH&A services across 5 year age groups	Service response to needs of children and youth is equitable across populations	PRIMHD	PP6 unique service users grouped by 5 year age band	N/A	report currently available	no target but useful to view differences between ethnic groups and domicile
	Community DNA Rate	✓		✓	Count of DNA activity codes as a proportion of total activity	Higher DNA rates for specific populations could indicate issues related to accessibility of services	MHAID balanced scorecard	Count of DNA activity records divided by total count of activity recorded	N/A	report currently available	Is already part of the MHAID balanced scorecard
	New Referrals Admitted	✓	✓		People new to secondary mental health services that were admitted to an acute inpatient unit under the MH Act	Accessibility and early engagement can mitigate need for admission or placing under a section of mental health act	PRIMHD	New Report to be developed	N/A	data currently available for a report to be developed	Is able to be developed from currently available data in PRIMHD
	Primary Mental Health Services	✓			Numbers utilising Primary MH by age & ethnic groups	Engagement with Primary MH services is equitable across populations	Primary MH Quarterly Reporting	Breakdown of youth and adults using Primary mental health services by ethnicity and DHB	N/A	data currently available for a report to be developed	data available but needs to compiled manually from PHO quarterly reports
	Readmission		✓		Adult acute inpatient rates of readmission within 28 days	Continuity of care between inpatient and community services is equitable across populations	MHAID balanced scorecard/national KPI framework	Total discharges from adult acute unit that were followed by an admission with 28 days divided by total discharges in the period	10%	data currently available for a report to be developed	Is part of the 3DHB balanced scorecard but the data would need to be further broken down by ethnicity OR could be taken from national annualKPIs
	Days of Life Disrupted		✓		Number of days of the period spent engaged with either community or inpatient based acute services as a proportion of total days	Indicator of quality of life for people with long term and complex conditions - keeping well enough to maintain without acute intervention	PRIMHD	New Report to be developed	N/A	data currently available for a report to be developed	Needs definition of which group of service users would be reported on. E.g. service users with long term and complex conditions only?
	Family/Whanau involvement		✓	✓	Number of service users who have had family involved in contacts with community mental health services	Family/Whanau involvement increases chances of recovery	PRIMHD	New Report to be developed	N/A	data currently available for a report to be developed	Comparison of total activity time involving family/whanau
	Seclusion Rates		✓		Number of individuals that experienced seclusion per 100,000 of population	The evidence that seclusion is a therapeutic tool is weak. Seclusion may contribute to a negative experience of care	MHAID balanced scorecard/national KPI framework	Service users secluded per 100,000 population	N/A	data currently available for a report to be developed	Is part of the MHAID balanced scorecard but the data would need to be further broken down by ethnicity. National KPI framework is developing a new KPI for seclusion which will provide targets and will be stratified by ethnicity
	Continuing Treatment Orders		✓	✓	Number of users of community services that were compulsorily treated under S29	Higher Rates of compulsory treatment may indicate populations that are less engaged with mental health services	Local DHB's Data	As per the Maori Health Plan	N/A	data available but some quality issues to be resolved	MHAID has been working on a Legal Status data quality project since the beginning of 2015
Equity for Users of DHB and NGO MH&A Services as a group Parameters: **Wairarapa↔HV↔C&C**	PHO Enrolment	✓		✓	Number of service users who are enrolled with a PHO	Equity between MH users and general population	PHO register/PRIMHD	The proportion of total current users of secondary services that are currently enrolled with a PHO	N/A	data currently available for a report to be developed	can be produced from current data
	Regular Physical Health Checks	✓	✓		Number of service users enrolled with a PHO whose last consult was within the last 12 months	Equity between MH users and general population	PHO register/PRIMHD	The proportion of total current users of secondary services enrolled with a PHO with a last consult date within the last 12 months	N/A	data currently available for a report to be developed	can be produced from current data
	Smoking Cessation			✓	Number of users of MH&A services that are smokers and have been offered support to quit compared to the general population	Disproportionate number of service users are smokers, contributes to a higher rate of long term conditions and shorter life expectancy	Smoking Cessation data/pharmacy data	Proportion of MH inpatients discharged that were offered cessation support compared with general hospital inpatients	N/A	data currently available for a report to be developed	can be produced from current data for inpatients only. Community data is a work in progress
Measures on hold as data is not currently available	Service User Feedback		✓	✓	Data from service user responses to the questions in Feedback Online	Includes indicators of satisfaction and whether service users feel they have been given enough information to manage their own illness	Feedback Online	Data collection and analysis to be establish across the sector	N/A	data not available	A cross sector strategy needs to be agreed before the survey is implemented across the 3DHB area and data is analysed. A national dashboard is being developed
	Long-term Conditions		✓	✓	Number of enrolled service users who are coded as having a long-term condition	Equity between MH users and general population	PHO Data/PRIMHD	MH service users enrolled with a PHO that have an LTC compared with non-MH service users	N/A	data not available	Requires an agreement between DHBs and PHOs to share data and match NHIs of users of secondary MH services with data held by the PHOs
	Community Wait Times	✓			Average number of days from the day a referral is received to the day the person is first seen	Longer wait times could lead to DNAs or people otherwise failing to access services earlier	MOH PP8 wait-times/MHAID balanced scorecard	Days from the date referral recieved to first face to face activity	80% < 3 weeks 95% <8 weeks	data available but some quality issues to be resolved	MOH produces national data based on new referrals only, but there is inconsistency related to the different service configurations between the 3 dhbs.
	Co-Existing Disorders	✓			Proportion of all secondary MH&A service users that were seen for both Mental Health and Addiction issues	Indicates whether prevalence of CED is different for some priority groups	PRIMHD	Proportion of all people seen by any secondary service that were seen by both addictions and MH services	N/A	data available but some quality issues to be resolved	Diagnosis data is not useable. Different service configurations means results across the 3 DHBs would be inconsistent

Equally Well

Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction

A consensus position paper

This consensus position paper is based on the findings of an evidence review undertaken by Te Pou (2014)[1] and has been written in consultation with representatives from the following organisations:

Matua Raki Consumer Leadership Group
New Zealand Medical Association
New Zealand Nurses Organisation
Nga Hau e Wha National Service User Group
Platform Trust
Royal Australian and New Zealand College of Psychiatrists
Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc
Te Pou

[1]Te Pou o Te Whakaaro Nui. 2014. *The physical health of people with a serious mental illness* and/or *addiction: An evidence review.* Auckland: Te Pou.

11 September 2014

Introduction

People experiencing challenges with mental health and/or drug and alcohol use also often experience physical health problems. The associations between mental illness and/or addiction and relatively poor physical health outcomes have been well-established over many decades. However, these issues and the people who experience them have not yet been formally acknowledged as a priority.

Platform[1] and Te Pou[2] have been working together over the past year to develop **Equally Well**, an informed, collaborative response to this challenge. **Equally Well** aims to draw on expertise and knowledge across the health and related sectors to translate the available evidence into action.

The first phase of **Equally Well** was a call for New Zealand evidence and a review of published research from here and overseas to understand the physical health issues, contributing factors to poor health, and effective interventions. This review has brought together overseas and national data on the extent of the issue here, and what local services are doing to address it.

Equally Well now calls for a concerted and sustained effort by all those who can effect change including policy makers, academics, and the whole health workforce particularly primary care and mental health and addiction treatment services in partnership with the people who experience these challenges. Together we seek to make the necessary changes at policy, service delivery and individual levels[3].

This consensus position paper is supported by organisations and representative bodies committed to working together to influence change in order to support better physical health outcomes for people affected. The signatories to this paper recognise there is an urgent need for coordinated action that will contribute to improved life expectancy and physical health. The driving principles of the **Equally Well** collaboration are that people who experience mental illness and/or addiction need:

- To be identified as a priority group at a national policy level based on significant health risks and relatively poor physical health outcomes
- To have access to the same quality of care and treatment for physical illnesses as everybody else, and in particular to have a right to assessment, screening and monitoring for physical illnesses
- To be offered support to make the connection to how they are affected physically and guidance on personal goals and changes to enhance their physical wellbeing.

We acknowledge Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand, and the rights of all New Zealanders to reach their full health potential.[4]

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[1] (www.platform.org.nz) The peak body for mental health and addictions non-government organisations

[2] (www.tepou.co.nz) A national mental health workforce development centre which incorporates Matua Raki, national addictions workforce development centre

[3] The definition used in the evidence review of 'people who experience serious mental illness and/or addiction' includes those who have been diagnosed with schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder and/or addiction with the primary focus on alcohol, cannabis and methamphetamine addiction. However, it is likely that many people with other mental health conditions and/or addiction face similar challenges.

[4] In accordance with Te Tiriti o Waitangi principles, Aotearoa and New Zealand are used interchangeably in this document.

Evidence review findings: mortality and morbidity

The situation in New Zealand is very similar to other relatively wealthy countries. People who experience serious mental illness and/or addiction die much earlier than their counterparts in the general population, with a two to three times greater risk of premature death.[5] [6] Two-thirds of this premature mortality is due to cardiovascular disease, cancer, and other physical illnesses.

Māori who experience mental illness and/or addiction have a higher mortality rate than Māori in the general population (one-third greater) [1].

This group also have significantly higher rates of physical illnesses including metabolic syndrome[7], viral and oral health diseases, respiratory diseases, diabetes and cardiovascular disease [2,3,4,10]. A significant association has been found between anti-psychotic use and risk of diabetes [5]. The evidence is mixed regarding the prevalence of cancer; what is clear is that the outcomes for this group are much worse, indicating that timely access to diagnosis and effective treatment is problematic [1,5].

Alcohol use is causally related to more than 60 different medical conditions including gastrointestinal and liver diseases, central nervous system effects, a range of cancers, coronary heart disease and sexually transmitted diseases [23]. It is estimated that a quarter of alcohol-related deaths in New Zealand are due to cancer and a further quarter to other chronic diseases. Alcohol-related deaths for Māori are over four times the rate of non-Māori [22].

The physical health effects of illicit substance use vary according to the specific substance, method, frequency and level of use. For example, intravenous drug use has a number of health risks including transmission of blood-borne viruses [23]; methamphetamine addiction is linked to oral health disease, heart disease, and cerebrovascular complications [25,26]. The most probable effects of chronic cannabis use are bronchitis and impaired respiratory function, respiratory cancers and cardiovascular disease [23,28]. High rates of hepatitis C have been found among people who inject substances including those in opioid treatment [29].

There are notable gaps in research relating to, for example, Māori and Pacific populations as well as people with a dual diagnosis of mental illness and intellectual disability, and people with a dual diagnosis of substance use and mental illness.[8]

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[5] Premature death is defined as dying before the age of 65.

[6] These data include people with a primary diagnosis of substance use who had premature mortality rates over two and a half times that of the population as a whole

[7] **Metabolic syndrome** is a disorder of energy utilization and storage, diagnosed by a co-occurrence of three out of five of the following medical conditions: abdominal (central) obesity, elevated blood pressure, elevated fasting plasma glucose, high serum triglycerides, and low high-density cholesterol (HDL) levels.

[8] Although there is a growing evidence base for responding to co-existing mental illness and addiction, much of the research tends to focus on either one or the other. We acknowledge the work going on at a service delivery level to better meet the treatment needs of people with co-existing problems [31].

Evidence review findings: factors contributing to the disparity

The links between socio-economic status and mental health have been widely reported both in terms of the effects of socio-economic status on mental health and vice-versa. **Mental illness and/or addiction can further compound the disadvantages associated with low socio-economic status**, for example, through increased exposure to risk factors [24].

The socio-economic consequences associated with mental illness and/or addiction can have a serious impact on the physical health of people affected. Consequences include restricted access to employment, social stigma and isolation, poverty and poor housing [7]. However socio-economic status does not fully explain the disparities in health status or outcomes [6].

People who experience mental illness and/or addiction have a greater exposure to risk factors associated with physical illnesses such as tobacco smoking, poor nutrition, reduced physical activity, and higher levels of alcohol use [3].

'Within group' variations have also been identified such as high levels of alcohol abstinence as well as alcohol dependence. Therefore, there is a need to avoid generalisations and stereotyping [3,4].

Smoking prevalence for people who experience mental illness has been estimated at 40-50 per cent, three times the general population rate [2,3] with many people also being heavy smokers [8,9,10]. There is also evidence that many are trying to quit and/or would like help to quit and can be effectively supported with no detrimental impact to their mental health [10,11,12].

Recent systematic reviews have identified a **negative impact of psychotropic medications on physical health** due to their contribution to obesity, cardiovascular disease, poor oral health, and type II diabetes [8].

Access to healthcare can be problematic for people with serious mental illness and/or addiction, due to stigma and discrimination, financial constraints, and practical issues such as lack of transport [14]. Stigma and discrimination by health professionals has been identified as a key barrier in accessing adequate healthcare for people who have an addiction to an illicit substance [29]. Systemic issues such as the physical separation of physical and mental health and addiction services are also barriers to access.

There is a lack of clarity over health professional roles and responsibilities for the physical health needs of people who experience mental illness and/or addiction. This appears to be contributing to the disparity [15] as well as to inconsistent assessment, monitoring and documentation of physical health status.

There is a growing body of research examining the quality of health care received by people who experience mental illness and/or addiction with stigma and discrimination being a key factor along with diagnostic overshadowing. The quality of medical care received can be compromised, particularly in relation to general medicine and cardiovascular care, but also for cancer and diabetes care [6,13,16].

Evidence review findings: promising interventions

There is an emerging body of literature on effective strategies and interventions for improving the physical health of this group. Interventions need to occur at the level of the individual and at a systemic level, with a core aim to reduce exposure to known risk factors as well as the impact of psychotropic medications.

Systems level changes

It is clear that people who experience mental illness and/or addiction should be **identified at a national policy level as a 'priority' health group** across the whole health system, who require specialised and properly-resourced interventions in relation to their physical health [16].

Policies that can reduce health inequalities amongst groups most affected by social exclusion, vulnerability, and disadvantage should be drawn on to improve physical health outcomes for this group. These include addressing the *'causes of the causes, i.e. the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to them'* [17]. Universal approaches to public health need to be tailored to people at a level and intensity proportionate to need. It is important to avoid focusing on the individual attributes and behaviours of people who are socially excluded [17].

Changes are needed in the way health care services are structured and funded to improve integration between mental health, addiction and physical health care services, particularly in developing shared care arrangements between primary and secondary care. Methods of integration should be adapted to local needs and capacities [18] and can include:

- all relevant parties endorsing the need for linked services at a senior level, and supporting this at all levels of the service
- planning and accountability at both local and regional levels e.g. through PHOs and DHBs
- ensuring people who experience mental illness and/or addiction are at the centre of care, around which services collaborate
- promoting models of clinical collaboration such as practice nurse or GP liaison with psychiatric services, or vice-versa with psychiatry liaison into primary care
- identifying and responding to the training needs of all health professionals regarding the physical health care of people who experience mental illness and/or addiction [19].

Clinical guidelines are needed to clearly identify roles and responsibilities of all health professionals in relation to the monitoring and ongoing management of the physical health care of people who experience mental health problems and/or addiction.

Reducing exposure to risk factors

Personal interventions

Identifying and making changes can be supported by combinations of personalised support for smoking cessation, increasing physical activity, nutrition, and general wellbeing. Those based on good evidence, which are service-user directed and work towards achieving long-term sustainable lifestyle changes, have been shown to be successful at a personal and small group level [20,21]. However no simple or single approach has demonstrated long-term effectiveness. Findings from evaluations of diet and exercise programmes indicate that the following characteristics are likely to facilitate greater success:

- Build on existing therapeutic alliance
- Incorporate both cognitive and behavioural strategies
- Combine exercise, dietary counselling and health promotion
- Specific, realistic and measurable goals identified by the person seeking change and supported by the therapeutic alliance
- Are flexible in accommodating individual needs and differences and are culturally appropriate
- Are long-term and provide ongoing support beyond the initial intervention
- Include support through participation in a group and/or social component
- Acknowledge and address wherever possible the barriers faced by people participating in such programmes
- Have an active peer support component alongside health professional support [20, 21].

Conclusion

Addressing the inequalities that lead to and arise from mental illnesses and addiction is a key part of a sustainable health strategy; it is also a key part of the work of healthcare professionals in primary and secondary care, and of colleagues in other professions such as public health and government [24].

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Appendix Four:
Table 1: Summary of all Primary Mental Health Innovations and Initiatives funded by Wairarapa, Hutt Valley and Capital Coast (including Adult, Youth and Alcohol Intervention):

Provider	Contract Name	2014/2015 Value
HVDHB		
Te Awakairangi Network Trust	PMHII Adult	$838,329.00
	PMHII Youth	$180,000.00
	Alcohol Interventions	$34,136.00
Hutt Valley Youth Health Trust	PMHII Youth	$78,082.00
Total		$1,130,547.00
Capital and Coast DHB		
Compass Health - Wellington	PMHII	$972,673.59
	PMHII Youth	$371,156.00
	Alcohol Brief Interventions	$54,090.89
Total		$1,397,920.48
Karori Medical Centre Limited	PMHII	$104,696.00
	PMHII Youth	$17,938.00
	Alcohol Brief Interventions	$3,152.00
Total		$125,786.00
Ora Toa PHO Limited	PMHII	$146,961.00
	PMHII Youth	$54,709.00
	Alcohol Brief Interventions	$2,766.00
Total		**$204,436.00**
Well Health Trust	PMHII	$293,499.41
	PMHII Youth	$55,001.00
	Alcohol Brief Interventions	$3,026.64
Total		**$351,527.05**
Wairarapa DHB		
Compass Health	PMHII Adult	$273,932.00
	PMHII Youth	$70,474.00
	Alcohol Interventions	$11,741.00
Total		$356,147.00

APPENDIX FIVE

Perinatal, Maternal and Infant Mental Health

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

HUTT VALLEY DHB

Capital & Coast District Health Board
Ūpoko ki te uru hauora

Perinatal, Maternal and Infant Mental Health

Summary Document

Prepared by Karin Isherwood
Senior Consultant Clinical Psychologist
Service Integration and Development Unit

PERINATAL, MATERNAL AND INFANT MENTAL HEALTH STRATEGY DEVELOPMENT for 3 DHB (Summary Document)

BACKGROUND:

Over the last twenty years New Zealand professionals working with young children and their families in health, early education, and social services have increasingly recognised that intervening early is the key to mitigating longer term problems. As a result of the growing awareness of the importance of the first three years of life (including pregnancy), the parent-child relationship and child mental health in general, there is increasing attention on early intervention, infant and maternal health, parenting and cross agency working in several government strategies.

In 2012 the Government released **Healthy Beginnings** *Developing perinatal and infant mental health services in New Zealand*[1] to provide guidance to district health boards, and other health planners, funders and providers of perinatal and infant mental health and alcohol and other drug services, on ways to address the mental health and AOD needs of mothers and infants. Joining *Healthy Beginnings* in 2012 were *Rising to the Challenge*[2] (Government's direction for mental health and addiction service delivery) and *Blueprint II* [3] (advice and guidance from the Mental Health Commission). Both these papers take a life course approach and advise early intervention and a focus on infant and maternal mental health and wellbeing.

These two documents also support the idea that mental health is everyone's business and integration between primary and specialist services is needed. There is also encouragement to develop programmes and infrastructure that support families to increase their resiliency and ability to provide for themselves, and acknowledgement that one size does not fit all and some families will need access to more direct support services.

Additionally, there has been increasing expectation that primary care and Well Child / Tamariki Ora practitioners take a greater role in recognising perinatal mental health issues, attachment and early relationships difficulties, child abuse and neglect, and incidents of family violence. The publication of the 2013 Well Child / Tamariki Ora Practitioner's Handbook[4] supports providers to screen families in these areas and engage with a variety of support services.

The development of a Perinatal, Maternal and Infant Mental Health strategy is very much in line with the government direction for district health board annual planning and service development, and the actions and activities outlined in the Children's Action Plan[5]. Underpinning the strategy is early identification of risk and difficulties, early intervention using evidence based activities, support for expectant women and their families, and agencies working together across sectors using a joined up model

1 Ministry of Health. 2011. Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand. Wellington: Ministry of Health.

2 Ministry of Health 2012. Rising to the Challenge The Mental Health and Addiction Service Development Plan 2012-2017. Wellington: Crown Copyright

3 Mental Health Commission. 2012. Blueprint ll: How things need to be. Wellington: Mental health Commission.

4 Ministry of Health. 2013. Well Child / Tamariki Ora National Schedule 2013. Wellington: Ministry of Health.

5 Minister of Social Development. 2012. The White Paper for Vulnerable Children. Wellington: New Zealand Government. There are four parts to The White Paper for Vulnerable Children: Volume 1 contains the Government's plans for getting better outcomes for our most at-risk children. The Children's Action Plan is setting out actions and timeframes. Volume II contains the evidence and the detailed rationale for the plans. Summary of Submissions is covering the nearly 10,000 received on the Green Paper for Vulnerable Children.

of service delivery. What we know is that there is currently a number of services working with expectant mothers and those with young children, unfortunately they do not always know about one another, nor how to access each other's services and the 3 DHBs do not yet have an identified continuum of care.

To this end the Service Integration and Develop Unit for Wairarapa, Hutt Valley and Capital & Coast DHBs has developed the Perinatal, Maternal and Infant Mental Health Strategy. The strategy takes into account a cross sector, stepped care approach to working with expectant families and those with young children. The development is informed by a Steering Group with representatives from a variety of services, and a Reference Group with members from over 35 agencies working with expectant mothers, families, and young children.

VISION:

The high level vision for the strategy is 'All children with 'early risk indicators' thrive, belong and achieve through an easily identifiable array of services for children under school-aged and their families, which reaches across the spectrum from supporting emotional well-being and responsive caregiving to engaging in therapy with the infant and primary caregiver'.

MODEL:

The public sector has scarce resources and it is difficult, but necessary, to re-focus the lens from the intervention/treatment programs and services to more health-promoting models that would reach children at younger ages and their families before difficulties become too entrenched and intractable. If the 3DHBs and sector partners want to make a real difference it will take a concerted effort across the government sectors and occur at all levels including:

Promotion: Services that recognise the central importance of early relationships on brain development, learning and the emotional and social well-being of all young children. These services include a focus on positive parent-child and primary caregiver relationships within the home, at kindergarten, crèche, kōhanga reo and other service settings for young children and their families. The focus is on competence and wellbeing and empowering people to help themselves.

Prevention: Services that mitigate effects of risk and stress and address potential early relationship challenges or vulnerabilities that have a documented impact on early development. Specific intervention strategies are designed to nurture mutually satisfying parent-child relationships and prevent the progression of further difficulties. Health and developmental vulnerabilities; parenting difficulties; domestic violence, family discord and other major child and family stressors may warrant the delivery of preventive intervention services in a variety of settings. People need to be aware of potential difficulties that affect family well-being and refer to targeted supports as necessary.

Selective Prevention and Targeted Support: Early identification, assessment and intervention for vulnerable individuals and populations. Often these families and children will have an identified need, or complex presentation.

Treatment or Complex Care Management: Services that target children and families in distress or with clear symptoms indicating a mental health disorder. They address attachment and relationship problems and the interplay between the child, parent and other significant caregivers that jeopardises early mental health and

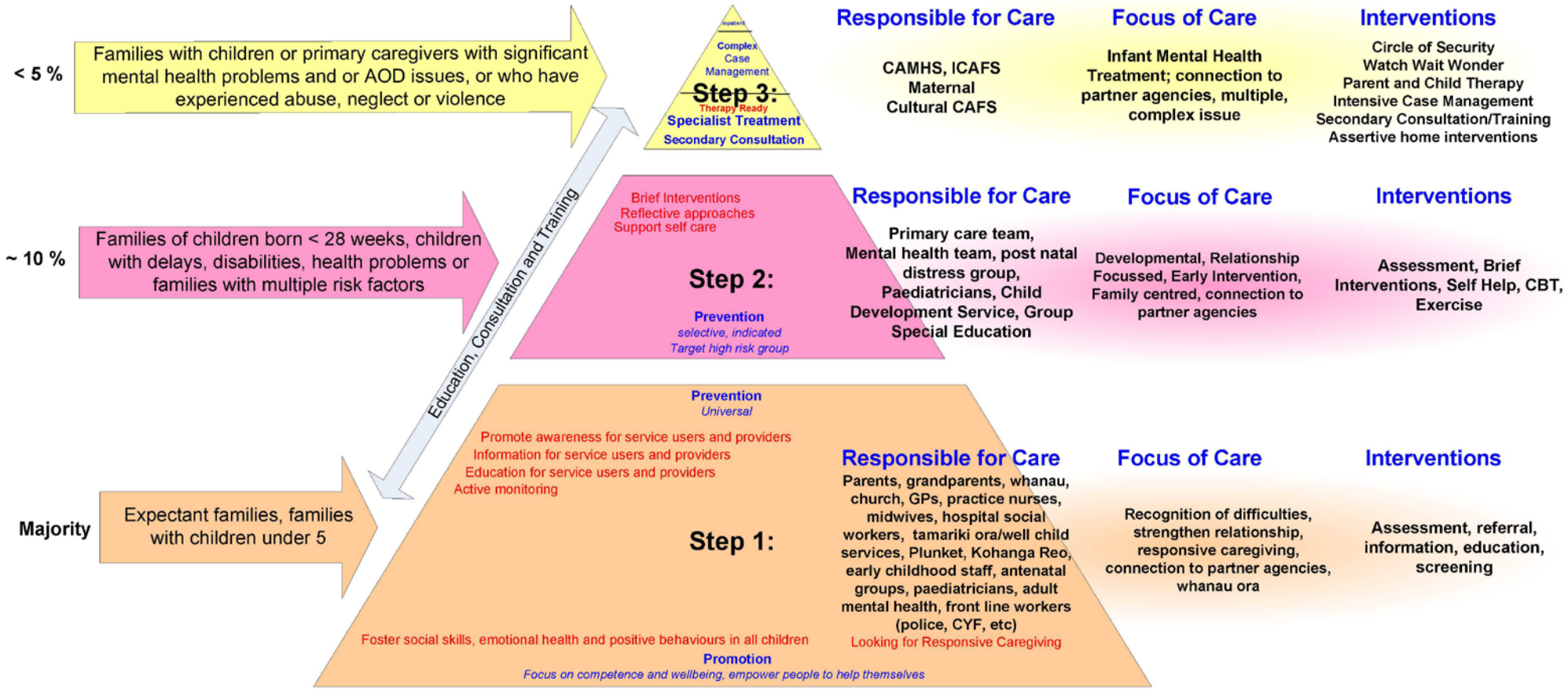
early emotional and social development. Specialist early mental health services focus on the parent-child dyad and are designed to improve child and family functioning and the mental health of the child, parents and other primary caregivers.

Please see below for a model of the stepped care approach (Figure 1) and an array of services[6] (Figure 2) available across the spectrum of care. Both models are in draft and changes are made as new information comes available.

6 The services came from a Reference Group workshop held 9 November 2012, where participating agencies were asked to place where on the model their work fit. They each had three stickies to place on the model. As more services are identified they can be added to the map.

Figure 1 G:\Karin Isherwood\Stepped Care Model v2 DRAFT

Stepped Care Approach to Perinatal, Maternal and Infant Mental Health

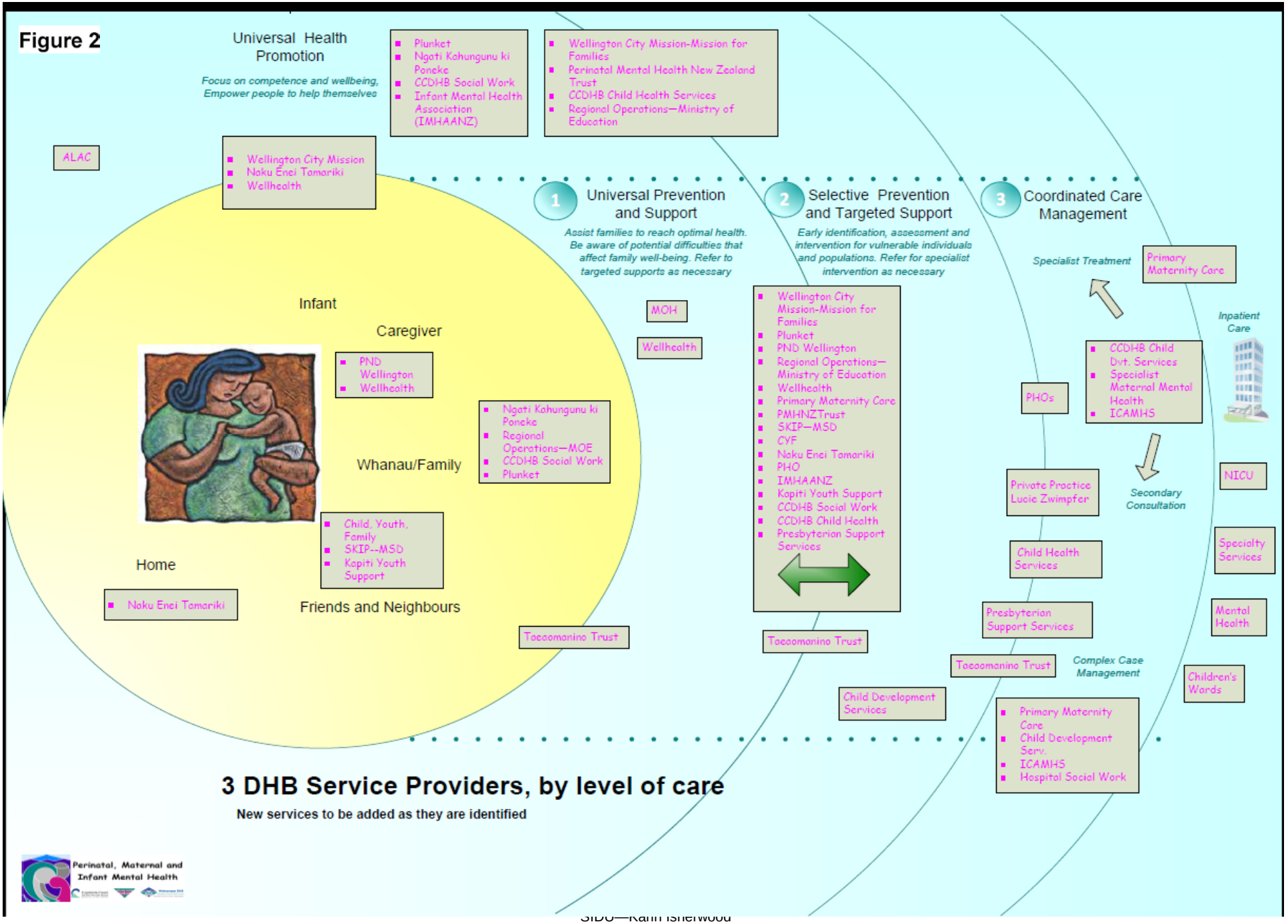


Infant Mental Health refers to the healthy social and emotional development of children from birth to school aged and the health of the relationship between the infant and the primary caregiver, known as the attachment relationship

Perinatal Mental Health refers to the emotional, psychological and social aspects of health during the time from preconception up until two years post birth. This period is the highest risk time for women to develop mental health problems with a varying range of severity and impact upon functioning.

Perinatal, Maternal and Infant Mental Health

Figure 2



3 DHB Service Providers, by level of care

New services to be added as they are identified

Perinatal, Maternal and Infant Mental Health

STRATEGY:

For a majority of women from preconception to after birth Primary Health Care will have the responsibility for universal screening, assessment, determining vulnerability and strengths, care planning at appropriate levels, care coordination and follow up. Alongside primary care, there will be a comprehensive network of services to assist and support families where mental health concerns or psychosocial issues are identified.

Conception and pregnancy

In New Zealand all resident women and families are entitled to maternity care through their GP, midwife or hospital based service. Generally a pregnancy is confirmed by the GP and a lead maternity carer (LMC) is chosen. Lead Maternity Carers can be midwives, GPs with a diploma in obstetrics or obstetricians. Since a change to the Health and Disability Services Act 2000, the majority of maternity care is provided by community based midwives often using DHB facilities for delivery. In cases where women and families have difficulty accessing community care, the 3 DHBs each have a hospital based primary care LMC team. In addition, there are also High Risk teams that work with women when health and social factors may increase risk during pregnancy, and Hutt Valley and Capital & Coast DHBs have developed care pathways for vulnerable pregnant women and their unborn babies. There will also be a number of women who do not access care for a variety of reasons, and they may not come to the attention of health or social services until there is a significant need.

The strategy proposes all women are screened using evidence based screening tools (e.g. Edinburgh Post Natal Depression Scale-Antenatal[7]) for the detection of risk factors or developing mental illness. A psychosocial assessment will be undertaken to identify additional risk factors. If appropriate, fathers, partners and other caregivers may also be screened for mental health issues and their risk factors will be included in the psychosocial assessment. Screening may be completed by the GP, practice nurse, midwife or other professional (i.e. mental health practitioner) that has contact after conception. Following the screening the screener will provide information about ante and post natal distress and how to access support if needed. Should risk or distress be present at any time a fuller assessment may be necessary and a Wellbeing Plan is developed with the family and support people. Ideally the initial screening will be completed by whoever has first knowledge of the pregnancy and if risk is identified then a Wellbeing Plan will follow.

GPs, practices nurses, midwives and Wellchild/Tamariki Ora providers are some of the people working with expectant families and those with young children as part of universal service provision and there are many natural opportunities for screening, and in some cases this is already part of their work. However, currently screening is not happening consistently with a recognised screening tool and while a birth plan is developed between families and LMCs, it may only cover to the birth of the baby.

Following the screening, if mental health issues and risk factors are not identified, then these women and families have access to universal health promoting activities that focus on competence and well being. Activities include classes for pregnant women and their partners, maternity health care and information about nutrition, breastfeeding, exercise and emotional wellbeing.

[7] Cox, J. & Holden, J. 2003. *Perinatal mental health: a guide to the Edinburgh Postnatal Depression Scale (EPDS)*. The Royal College of Psychiatrists; Gaskell, London.

When risk or stressors are identified, then it may be appropriate to bring together a Wellbeing Team including primary care, mental health, LMC etc. to develop Wellbeing Plans and engage services as necessary. The important thing is that there is a clear pathway of what happens when risks are identified and the continuum of care will be dependent on the type of risk identified.

Birth

After birth, women and families should be given information by LMCs or hospital staff regarding the social and emotional development of babies and how to recognise the signs of post natal distress. This information should include what to do if there are concerns in any of these areas. Often, the time following birth and discharge from hospital is quite chaotic and all of the bio-psycho-social changes mean that it may be difficult for new families to take in information. Over the course of the LMC postnatal visits information regarding postnatal distress should be revisited in an appropriate manner. Other professionals, such as GPs, practice nurses and mental health practitioners, who come into contact with women and families may also provide this information.

Home and early childhood

After giving birth, many women feel strong enough to go home soon after and have the support of their partner, family, midwife, friends, GPs, Wellchild/Tamariki Ora providers etc. Some women may not feel ready to go home, however are encouraged to leave hospital due to demand for beds. Other women benefit from staying in the hospital a few days and receive support from lactation specialists, hospital social workers, maternity carers, etc along with friends and family members. If risk factors are identified at this time or at any stage earlier, a Wellbeing Plan can be developed to mitigate risk.

When babies are born with particular conditions or with disabilities, specialist services may be asked to meet with the family prior to leaving the hospital in order to provide information and/or education. Often a plan is made to follow up with families when they are settled at home, or some babies will need support to be at home. The service providers are part of the Wellbeing team and have a responsibility to recognise when a family needs additional support and intervention and will know how to access this.

For some women, the pregnancy and birthing go well, however distress develops over the following weeks or months. Often these women will be in contact with a variety of people such as those listed above and as in the earlier stages there is a responsibility to screen for developing mental illness and/or the presence of risk factors or psychosocial stressors. When risk is identified, the person who identifies the risk can bring together a Wellbeing team and develop a Wellbeing plan. The members of the team are decided with the woman and her family.

Every child and family is entitled to Well Child/Tamariki Ora visits and there is an expectation that along with physical health, the emotional well being of the child and family will also be assessed. When difficulties are encountered providers will be able to refer children and families to appropriate services identified on a continuum of care.

Ideally GPs would refer pregnant women to an LMC before the 10th week of pregnancy and the LMC would care for the child and family until about 6 weeks after

birth when care is transferred to a Well Child/ Tamariki Ora practitioner and back to the GP. Due to our universal maternity care policy LMCs are well placed to screen for post natal depression and assess for psychosocial risks.

In situations where risk factors are present, the transfer to the Well Child/Tamariki Ora practitioners can begin at 2 weeks post birth and may include a Wellbeing team gathering so everyone can meet and discuss the Wellbeing Plan. Ideally, families would re-engage with their GPs at this time, and practice nurses can also monitor wellbeing and screen during immunisation and breastfeeding clinics and refer as necessary. In any case, GPs and Well Child / Tamariki Ora practitioners benefit from receiving a thorough discharge summary from the LMC.

In the course of developing this strategy, an area in need of attention has been the handover from the LMC to the Well Child/Tamariki Ora practitioner. This happens within 6 weeks of birth, and there does not appear to be a standard practice across LMCs, with inconsistent referral forms and transitioning processes used. The handover from the LMC to the Well Child/Tamariki Ora practitioner is a crucial part of good care, however can be complex. Often the LMC has built a strong relationship with a woman and her family over period of time, and while sharing personal information is imperative for continuity of care, it is not always comfortable to pass over information that was shared in confidence.

Before school

In order to promote school readiness many children have access to early childhood education in the form of crèche, kindergarten and kōhanga reo. Teachers or caregivers are well aware of child development and what is needed help children develop the social and academic skills necessary to begin school at five years old. Teachers and caregivers are well placed to note the relationship between the child and parent and may recognise when there are significant difficulties.

The last Well Child/ Tamariki Ora visit is the B4School Check. In this check, as well as screening hearing and vision, parents and pre-school teachers are asked to fill out a Strengths and Difficulties Questionnaire (SDQ). The SDQ is a brief behavioural screening questionnaire about 3-16 year olds and covers 5 areas: emotions, conduct, peer relationships, hyperactivity/inattention and pro-social behaviour. If the score on the SDQ is in the 'clinical' range, then referrals can be made to appropriate services such as the Child and Adolescent Mental Health Services, paediatricians, parenting programs and NGO counselling.

Currently there are not a lot of referrals for emotional or behavioural services following the B4School Check and the reasons for this need further investigation.

Services

There are a range of services available to work with expectant families and those with young children and there is increased government focus on identifying and assisting vulnerable children and families.

According to the recently updated Well Child/Tamariki Ora (WCTO) National Schedule 2013 [8] at every core contact the WCTO practitioner will initiate or review a health needs assessment and develop a care plan. Maternal wellbeing, family health

8 Ministry of Health. 2013. Well Child / Tamariki Ora National Schedule 2013. Wellington: Ministry of Health.

and wellbeing and PND screening are included in the assessment, as are questions regarding child abuse, neglect and family violence.

To assist the practitioner in carrying out these health needs assessments, the Ministry of Health released the *Well Child/ Tamariki Ora Programme Practitioner Handbook 2013*[9]. There is a link between these assessments and the Children's Action Plan[10] with the expectation that a needs assessment and care plan will be developed with the family. However, the *Common Needs Assessment* is still under development by the Ministry of Health and the Children's Action Plan project team, and it unclear what process is currently used.

The developing Children's Teams and Common Needs Assessment as part of the Children's Action Plan, in concert with the just released Well Child / Tamariki Ora Handbook[11] outlining a variety of mental health and bio-psychosocial assessments, provides a mandate for services to work together and share information about families at risk.

Perinatal Pathway of Care

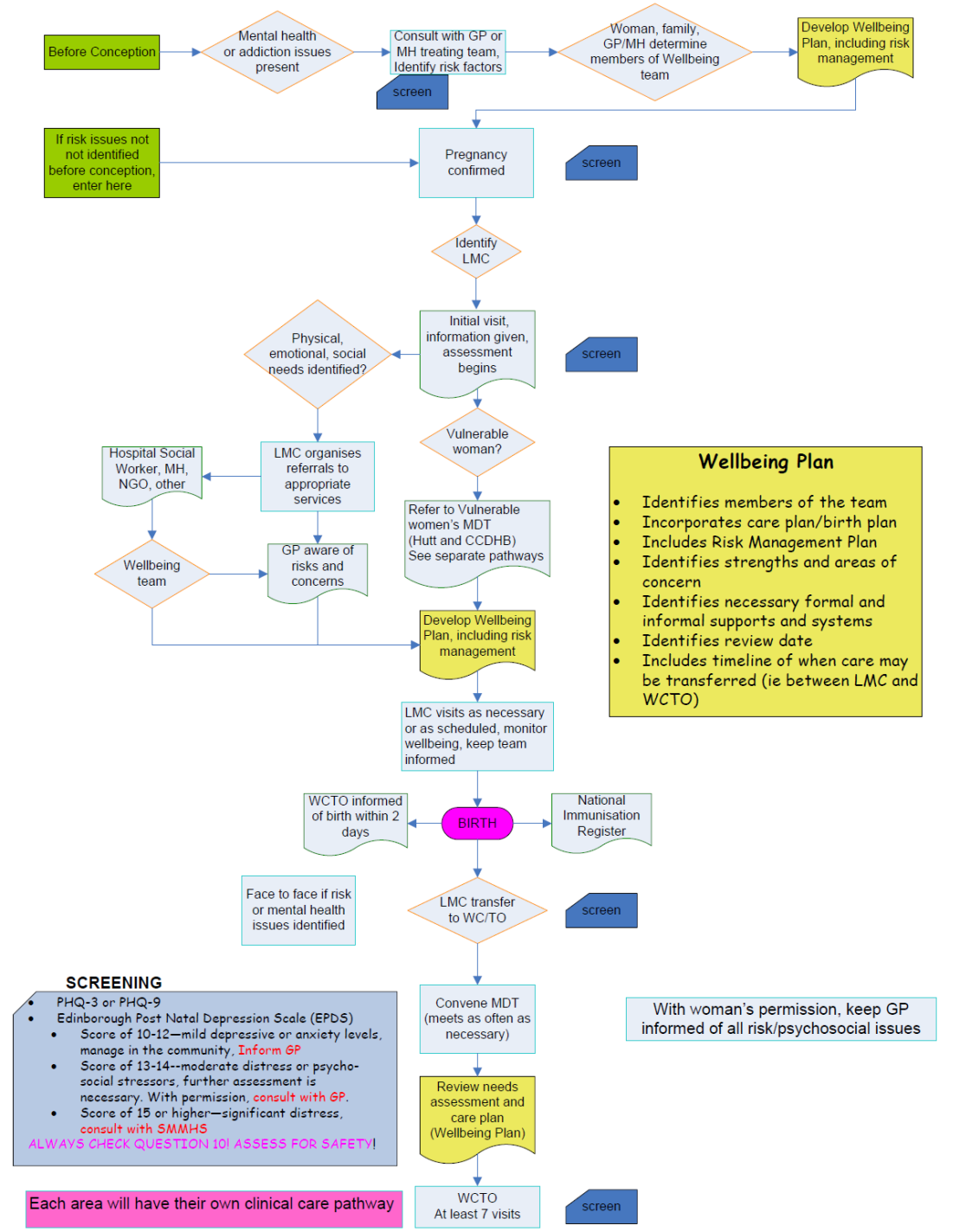
Please see below for the Perinatal Pathway. The top horizontal line of the pathway demonstrates what happens for a woman who has identified risk factors, or a mental health problem, and makes a conscious decision to get pregnant. Alternately it could be used when a woman is already using services and the team involved want to pre-plan in case of pregnancy. For example some medications can interfere with a developing fœtus, and a Wellbeing Plan can identify increased risk; or some women may become more emotionally vulnerable when pregnant and early planning may mitigate some risk.

Following the pathway down, shows potential times for screening for mental health difficulties and when risk or psychosocial difficulties are identified a Wellbeing team can be brought together and a Wellbeing Plan developed. The success of the team and the plan is dependent on primary secondary integration and shared communication.

9 See footnote 1, page 2

10 Minister of Social Development. 2012. The White Paper for Vulnerable Children. Wellington: New Zealand Government. There are four parts to The White Paper for Vulnerable Children: Volume 1 contains the Government's plans for getting better outcomes for our most at-risk children. The Children's Action Plan is setting out actions and timeframes. Volume II contains the evidence and the detailed rationale for the plans. Summary of Submissions is covering the nearly 10,000 received on the Green Paper for Vulnerable Children.

Perinatal Pathway



Wellbeing Plan

- Identifies members of the team
- Incorporates care plan/birth plan
- Includes Risk Management Plan
- Identifies strengths and areas of concern
- Identifies necessary formal and informal supports and systems
- Identifies review date
- Includes timeline of when care may be transferred (ie between LMC and WCTO)

SCREENING

- PHQ-3 or PHQ-9
- Edinborough Post Natal Depression Scale (EPDS)
  - Score of 10-12—mild depressive or anxiety levels, manage in the community, Inform GP
  - Score of 13-14--moderate distress or psycho-social stressors, further assessment is necessary. With permission, consult with GP.
  - Score of 15 or higher—significant distress, consult with SMMHS

ALWAYS CHECK QUESTION 10! ASSESS FOR SAFETY!

When and how we provide support

Kings Crescent Community Day Service will be open Monday to Friday 8.30am to 5pm. Our day programme sessions will usually run between the hours of 10am and 3pm, although this may vary.

We can also provide support in the evenings and weekends if required. This service is provided by Pathways' Community Mobile team, who can provide support in partnership with the Community Day Service, clinical teams and your family/whanau.

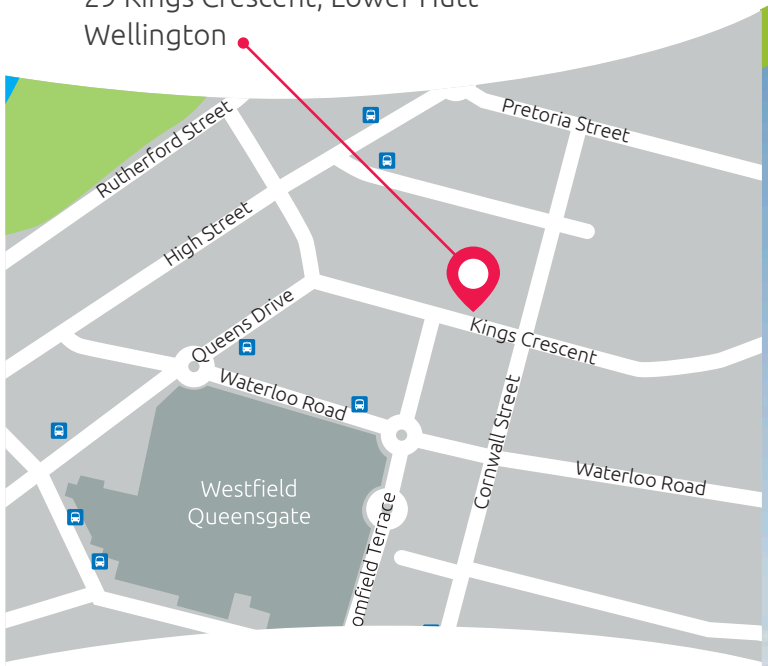
Access to the Community Day Programme

Access to the service is via referrals from Hutt Valley DHB secondary mental health and addiction services.

When you discuss your referral with your Hutt Valley DHB clinician, they will send the referral to us. We'll then get in touch with you to make arrangements for you to meet with us and develop your personalised recovery transition plan.

Contact Details

The service is located at
29 Kings Crescent, Lower Hutt
Wellington



You can contact us at:
HuttDayProgramme@pathways.co.nz
Ph: XXXXXXXXX Web: www.pathways.co.nz

Kings Crescent Community Day Service

Empowering you in your mental health recovery journey.

The Community Day Service provides support during times of mental distress. We're about helping people live well, long beyond their time of distress.

What the service offers

Most people will attend our recovery focused service for up to four weeks. During that time we'll focus on assisting you with:

- developing skills that increase your ability to
  - manage your own mental health and wellbeing
  - achieve life goals
  - develop positive relationships
- making a smooth transition to living well at home and in the local community
- connecting with educational and employment opportunities.

Personalised recovery transition plan

Everyone's needs are different. So when you join the Community Day Service, we'll work with you to create a personalised recovery transition plan. We'll also involve your family/whanau as much as you are comfortable with, so you have support in the process.

We'll discuss suitable activities and learning opportunities for your needs. Then we'll record these in your plan for the time you're with us. We'll also include in your plan other key supports and activity you wish to access, so you can keep track of your wider wellbeing needs.

Our environment

We hope you experience our service as a welcoming wellbeing environment. We want it to be a retreat-like place where you feel safe, relaxed and open to new experiences.

Our people

You'll work alongside peers (staff with their own mental health/addiction experience who have had specific peer training) and clinicians, who can support you in achieving your goals.

Our programme

We'll provide engaging activities and learning experiences facilitated by a range of wellbeing activity specialists. Activities could include things like yoga, healthy cooking and nutrition, art, music and physical exercise.

Wairarapa DHB — Wairarapa District Health Board — Te Poari Hauora a-rohe o Wairarapa
HUTT VALLEY DHB
Capital & Coast District Health Board — Ōpoko ki te uru hauora

Te-Upoko-me-te-Whatu-o-Te-Ika
Mental Health, Addictions & Intellectual Disability Service 3DHB
Balanced Score Card: July 2015
FY 2015/16

Patient Experience	Target	Local/Sub-Regional Service: WDHB	HVDHB	CCDHB	Te Korowai-Whāriki: Forensic & Rehab	ID Services	MHAID 3DHB: Jul-15	Total YTD
28 Day acute readmissions rate - adult acute units (%)[1]	10%	NA	14%	14%	NA		14%	14%
Long-term consumers with a current wellness plan (%)[2]	95%	NR	79%	38%	37%	43%	NA	NA
Better help for inpatient smokers to quit (%)	95%	NA	97%	83%	75%	No D/C	90%	90%
HoNOS compliant inpatient discharges - matched pairs (%	80-100%		58%	30%	0%	No D/C	36%	36%
HONOS compliance - Community (%)	80-100%	77%	68%	33%	13%	11%	45%	45%
Consumer death by suspected suicide (n)		0	0	1	0	0	1	1
SAC 1& 2 (n)		0	0	2	0	0	2	2
All reportable events (n)	No Target	0	58	182	165	109	514	514
Medication errors (n)		0	2	5	4	2	13	13
Complaints (n)		0	2	20	4	3	29	29
Complaints resolved within 30 days (%)[1]	100%	100%	100%	45%	0%	100%	56%	56%
Health & Disability Commission Complaints (n)		1	1	2	0	0	4	4
Compliments count (n)		0	0	0	0	0	0	0
Personal restraints count (n)		0	7	23	5	14	49	49
Consumers subject to undergo MH (CAT) Act assessmen		4	33	99	20	1	157	157
Consumers subject to CTO (n)	No Target	33	106	232	58	0	429	429
Consumers subject to CTO - Maori (n)		17	30	77	38	0	162	162
Seclusion hours per 100,000 pop			408.6	72.1	0.0	254.7		
Seclusion hours per 100,000 pop - Maori		NA	285.7	43.8	0.0	6.0	NA	NA
Seclusion hours per 100,000 pop - Pacific			0.0	0.0	0.0	0.0		

Healthy Workforce	Target	WDHB	HVDHB	CCDHB	Forensic & Rehab	ID Services	Jul-15	Total YTD
Staff turnover (%)[1](Headcount)	8-10%	2.2%	1.6%	1.1%	1.2%	0.0%	1.1%	1.1%
Sick leave (%)[1]	2-4%	3.0%	3.7%	3.1%	3.5%	5.0%	3.3%	3.3%
Staff with annual leave > 200 hours (n)[1]	No Target	7	0	150	90	57	304	304
Physical assaults on staff (n)		0	1	21	17	18	57	57
Performance appraisals completed (%)[1]	100%	22%	13%	35%	44%	48%	35%	35%

Financial	Target	WDHB	HVDHB	CCDHB	Forensic & Rehab	ID Services	Jul-15	Total YTD
Operating (actual) costs ($'000)		408	435	4413	2150	1195	8601	8601
Personnel including outsourced ($'000)		304	1601	4014	1933	1090	8942	8942
Overtime hours (%)	No Target	1.2%	3.1%	3.0%	3.1%	6.3%	3.5%	3.5%
FTEs - actual		37	183	502	265	161	1147	1110
FTEs - vacancies[1]		1	10	18	8	14	50	N/A

Productivity	Target	Local/Sub-Regional Service: WDHB	HVDHB	CCDHB	Te Korowai-Whāriki: Forensic & Rehab	ID Services	MHAID 3DHB: Jul-15	Total YTD
Access rate (%)[3]	3%	4.4%	4.3%	3.3%	NA		3.7%	NA
Acute Adult Inpatients ALOS (days)	14-21		17	26			21	21
ALOS Adolescent Unit (days)				50	NA			50
ALOS Psychogeriatric Unit (days)				41				41
ALOS Eating Disorders Inpatient Unit (days)			156					156
ALOS Regional Rehabilitation Units (days)	No Target	NA			1153		NA	1153
ALOS Adult Forensic Inpatient Units (days)					137			137
ALOS Adult Intellectual Disability Unit (days)						No D/C		0
ALOS Youth Intellectual Disability Unit (days)						No D/C		0
Adult Inpatient Units Occupancy (%)	85%		104%	96%			100%	100%
Adolescent Unit Occupancy (%)		NA		80%	NA			80%
Psychogeriatric Unit Occupancy (%)				91%				91%
Eating Disorders Unit Occupancy (%)			26%				NA	26%
Regional Rehabilitation Units Occupancy (%)	No Target	NA			99%			99%
Adult Forensic Inpatient Units Occupancy (%)					96%			96%
Adult Intellectual Disability Unit Occupancy (%)					NA	73%		73%
Youth Intellectual Disability Unit Occupancy (%)						100%		100%
Pre-admission community care (%)[1]	75-100%	NA	64%	90%	NA		78%	78%
Post-discharge community care (%)[1]	90-100%		45%	46%			46%	46%
Consumer related time - child and youth (%)[1]	30-40%	NR	NR	26%	7%		22%	22%
Consumer related time - adults (%)[1]	35-40%	NR	NR	20%	4%	17%	16%	16%
Community treatment days per quarter (days)[1]	10-20	NR	NR	3	2	4	3	3
Wait-time < 3 weeks - child and youth (%)[3]	80%	79%	46%	51%	97%	NA	55%	
Wait-time < 8 weeks - child and youth (%)[3]	95%	97%	88%	86%	99%	NA	89%	NA
Wait-time < 3 weeks - adult (%)[3]	80%	86%	82%	86%	93%	100%	86%	
Wait-time < 8 weeks - adult (%)[3]	95%	98%	97%	94%	97%	100%	96%	
Community DNA rate (%)[1*]		8%	12%	10%	2%	1%	10%	10%
Community DNA rate - Maori (%)[1*]	No Target	10%	20%	13%	1%	0%	13%	13%
Community DNA rate - Pacific (%)[1*]		0%	15%	13%	1%	NA	12%	12%
Case load w consumer participation in last 90 days (%)		NR	90%	74%	67%	49%	79%	79%

Key

- Mental Health & Addiction Services Benchmarking Programme KPI
- National health target
- Health Quality and Safety Commission KPI
- MoH performance measure or Maori Health Measure
- Key Issue
- Alert
- Good News
- Under development

[1] One month lag
[2] Different measures so not comparable
[3] Rolling year, 3 month lag (MoH Report)
[NR] Not reported, under development
[NA] Not applicable
* Not comparable with 3DHB measure

Balanced Score Card Inpatient Units, Community Teams and Indicator Definitions

The MHAID Service 3DHB is comprises two main parts:

- The local/sub-regional mental health and addiction services.
- Te Korowai-Whāriki which consists of adult rehabilitation and forensic (mental health and addiction) and intellectual disability services.

A range of age specific community and inpatient services are delivered to meet population needs.

Eleven inpatient units provide service and age specific assessment and treatment for the most severely unwell consumers. Services are either local, sub-regional regional or national (see table 1). The balanced score card inpatient measures are divided by DHB for the local/sub-regional services. For Te Korowai- Whāriki the inpatient measures split is by Forensic & Inpatient Rehabilitation and Intellectual Disability. There is additional split by age-based facilities for forensic and intellectual disability services.

Table 1. MHAID Service 3DHB Inpatient Units

MHAIDS 3DHB	Group	Provision*	Service & Age Focus**	Hutt Valley DHB	Capital and Coast DHB
Local / Sub-Regional	Intensive Recovery Sector	Sub-regional	Mental Health - Adult	• Te Whare Ahuru	• Te Whare o Matairangi • Managed Withdrawal Service beds
		Central region	Mental Health - Adolescent		• Regional Rangatahi Acute Inpatient Unit
		Sub-regional	Mental Health - Psychogeriatric		• Te Whare Ra Uta
	Younger Persons Community & Addictions	Central region	Eating Disorders - Mixed	• Central Region Eating Disorder Service	
Te Korowai-Whāriki	Forensic & Inpatient Rehabilitation	Central region	Regional Rehabilitation - Adult		• Tawhirmatea • Tane Mahuta
		Central region	Forensic - Adult		• Puraehuraehu • Rangipapa
		National	Forensic - Youth		• Nga Taiohi *Build in progress*
	Intellectual Disability Services	Central and South Island	Intellectual Disability - Adult		• Haumietiketike
		National	Intellectual Disability - Youth		• Hikitia Te Wairua

* **Sub-Regional** *Wairarapa, Hutt Valley, Capital and Coast DHBs;* **Central** *Sub-Regional DHBs plus Mid-Central, Hawkes Bay, Wanganui DHBs plus Tairawhiti DHB;* **National** *All DHBs*

** **Youth** *Population aged 12 – 18 years;* **Adult** *Population aged 18 – 65 years;* **Psychogeriatric** *Population aged 18 – 65 years;* **Mixed** *Population aged 16 plus years*

There are 61 community based provider arm teams (see table 2). The majority are local or sub-regional services providing primarily assessment and treatment. Some teams also provide consultation liaison and education services. The balance score card community indicators report performance for these teams. Given varying indicator definitions not all teams are reported in all the measures (MHAID Service 3DHB, 2015).

Table 2. MHAID Service 3DHB Community Provider Arm Services

MHAIDS 3DHB	Group	WDHB	HVDHB	CCDHB
Local / Sub-Regional	Younger Persons Community & Addictions	• CAMHS[a]	• *CAMHS teams:* Child Speciality Service and Youth Speciality Service[a] • Intensive Clinical Service Team[b] • Central Region Eating Disorder Service – Community[C]	• *CAMHS teams:* Kapiti, Porirua, Wellington, Primary Liaison Service, Pasifika and Maori[a] • Early Intervention Service[b] • Specialist Maternal Mental Health Service[C]
	Adult Community & Addictions	• Adult CMHT[a]	• *CMHTs:* 1, 2, 3 and 4[a] • Detox[a] • Older Persons Mental Health Service[a]	• *CMHTs:* Kapiti, Porirua, South and Wellington, Adult Maori, Adult Pasifika[a] • Co-Existing Disorder Service[b] • Community Alcohol and Drug Service[a] • *GP Liaison:* Kapiti, Porirua[a] • GP Opioid Service[b] • ECT[a] • Managed Withdrawal Service[b] • Psychogeriatric team[a] • Opioid Treatment Service • Regional Personality Disorder Service[C]
	Intensive Recovery Sector		• Acute Day Service[a] • CATT[a] • Consultation Liaison[a]	• CATT[a] • Consultation Liaison[a] • Home-based Treatment[a] • Rangatahi Day Service[a] • Rangatuhi Day Service[a] • TACT[a]
	Operations Centre		• Intake Team[a] • MH NASC[a]	• Te Haika[a] • Service Coordination[a]
Te Korowai-Whāriki	Forensic & Inpatient Rehabilitation			• Adult Forensic Community Service[C] • Regional Adult Forensic Community Service[C] • Youth Forensic Community Service[C]
	Intellectual Disability Services			• Co-existing Mental Health & Intellectual Disability Service[b] • Behavioural Support Service[b] • National Intellectual Disability Care Agency[d]

[a]**Local:** Primarily delivered to respective DHB population. [b]**Sub-Regional** *Wairarapa, Hutt Valley, Capital and Coast DHBs (some services only contract delivery to Hutt Valley and Capital and Coast DHBs);* [c]**Central** *Sub-Regional DHBs and Mid-Central, Hawkes Bay, Wanganui DHBs (some contracts also include Tairawhiti DHB);* [d]**National** *All DHBs*

Table 3. MHAID Service 3DHB Balanced Score Card Indicator Definitions

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
1.1	28 day readmission rate *(Adult IP units only)*	Target - 10% Alert - ≥20%	Total number of in-scope overnight referral closures by the participant's acute mental health and addiction services inpatient unit during the reference period that are followed by a readmission within 28 days to the organisation's acute mental health and addiction services inpatient unit. Excludes transfers, deaths & readmissions from same day event (Northern DHB Support Agency, 2010).	Unplanned readmission to an inpatient service following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective or that follow-up care was inadequate to maintain the person out of hospital.	WDHB: N/A as no IP unit.
1.2	Long-term consumers with current wellness plan (%)	95%	The percentage of long-term consumers with a wellness plan. Long-term consumers are adults and older people (20 years plus) whose episode of care is two or more years, and children and youth whose episode of care is for one or more years. The episode of care is measured from the inpatient admission or primary community referral start date (Ministry of Health, 2014a).	A proxy measure for quality of care. Wellness plan (relapse prevention plans) identify early relapse warning signs of clients. The plan identifies the support required by the tangata whaiora/consumer to promote resilience and recovery when early warning signs are present. Each client will know of (and ideally have a copy of) their plan.	WDHB: manual quality audit HVDHB: Report on current electronic risk plans CCDHB: Report on electronic wellness plans
1.3			*Held for indicator under development*		
1.4	Better help for inpatient smokers to quit	95%	The percentage of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and percentage of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking (Ministry of Health, 2014b).	There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.	WDHB: N/A as no IP unit.
1.5	HoNOS compliant inpatient discharges - matched pairs	≥80%	The percentage of in scope discharges that have both an admission and discharge HoNOS. In scope discharges: LOS >3 days and the consumer was discharged routinely or to another healthcare facility OR to other service within the same facility. The consumer was not discharged to another psychiatric inpatient unit or an accident and emergency service (Northern DHB Support	Provides information about the effectiveness of inpatient treatment in aiding recovery by measuring if change occurs between the admission and discharge HoNOS.	WDHB: N/A as no IP unit. HVDHB: Snapshot CCDHB: New measure – covers the reference period. Data validation still required.

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
			Agency, 2010; Te Pou, 2012).		
1.6	HoNOS collection compliance - community	≥80%	Number of community consumers with a current HoNOS collection. In-scope collections are within the current episode of care. For new referrals the collection must be within 14 days of the first face-to-face appointment. Thereafter a 91 day review is required. The 91 day reviews are required to be completed within 14 days either side of the review date (Te Pou, 2012).	Provides information about the effectiveness of community treatment in aiding recovery by measuring if change occurs overtime.	WDHB/HVDHB: Snapshot CCDHB: New measure – covers the reference period. Data validation still required.
1.7	Consumer death by suspected suicide (community and inpatient)	N/A	Count of suspected community suicides by current mental health consumer within 28 days of contact with service and all suspected suicides as inpatient (Health Quality and Safety Commission New Zealand, 2012).		
1.8	Severity 1 & 2 (Confirmed SAC 1&2)	N/A	Count of the number of SAC 1&2 events that have been reviewed and reported by the CCDHB Patient Safety Office per month (Health Quality and Safety Commission New Zealand, 2012).	Serious Adverse Events are events which have generally resulted in harm to patients. When adverse incidents occur, it's important these events are reported, investigated and reviewed so we can learn from them and improve the way we do things. Systematic review of and learning from adverse events should see a reduction in serious adverse events over time, reflecting improved safety for people using services (Mental Health Commission, 2014).	
1.9	All reportable events	N/A	Count of the number of all reported events reported in the reportable events database prior to any review.		
1.10	Medication errors (n)		Count of the number of all medication errors reported in the Reportable Events system.		
1.11	Complaints (n)		Count of the number of complaints received and recorded per week by the Quality & Risk team and reported in the reportable events database.		
1.12	Complaints resolved/closed within 30 days	100% complaints resolved	The percentage of all complaints that were received in the reference period and resolved in 30days. This excludes HDC complaints or where the complainants		

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
	(%)	within 30 days	have been notified within 10 working days that an extension is required by the DHB which received the complaint (HDC Code of Health and Disability Services Consumers' Rights Regulation 1996, n.d).		
1.13	Health & Disability Commissioner Complaints		Count of all HDC complaints in the reference period and year to date		
1.14	Compliments (n)		Count of the number of compliments received and recorded per month by the Quality & Risk team in the reportable events database.		
1.15	Restraints (n)		Count of the number of all restraints reported in the Reportable Events system.		
1.16	Consumers required to undergo MH Act assessment		Count unique consumers required undergo assessment subject to sections 11 or section 13 or section 14(4) of the Mental Health Act during the reference period. Consumers transferred between sections in the reference period are only counted once. If section 11 has occurred more than once in the reference period, the person is counted twice.		WDHB: Manual data All DHBs: Data quality issues that each DHB is working on may impact numbers. Data quality project underway.
1.17	Consumers subject to compulsory treatment order		Count of unique consumers subject to an inpatient or community compulsory treatment order during the reference period. This includes extensions and indefinite orders. Consumers transferred between sections in the reference period are only counted once. For example an inpatient treatment order transferred to an outpatient treatment order or when an order is extended or made indefinite. Per the national health target and DHB Maori Health Plans, this indicator also reports the number of Maori subject to section 29 community treatment orders (Capital and Coast District Health Board, 2014; Hutt Valley District Health Board, 2014; Wairarapa District Health Board, 2014).		As above

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
1.18	Number of seclusion hours		Count of the hours that are attributed to seclusion activity in the reference period. This measure excludes the hours attributed to an event that occur before or after the reference period. The divisor is DHB catchment projected population divided by 100,000. Also report by Maori and Pacific ethnicity.	As above	
2.1	Access rate		The average total number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for the projected population of the DHB region (Ministry of Health, 2014c).	This indicator will provide a means of monitoring rates of access to assessment and treatment services and to compare these with what is known about the distribution of mental disorders and what is aimed for in policy and in funding agreements. It is known that there are significant levels of unmet need in mental health and addiction. A measure Is required to monitor population treatment rates and assess these against what is known about the distribution of mental disorders in the community (Mental Health Commission, 2014).	Ministry of Health data, incudes NGOs. Rolling year, 3 month lag (PP6).
2.2	Average length of acute inpatient stay (days)	14-21 days Alert - ≥30 days.	Total number of inpatient bed nights for discharges that occurred in the reference period – excludes transfer, deaths and leave days (Northern DHB Support Agency, 2010).	Mental health & addiction services aim to provide care in the least restrictive environment. This KPI provides some information about the extent to which this is being achieved and promotes a more complete picture of an organisation's overall model of care (Northern DHB Support Agency, 2012).	
2.3	Inpatient occupancy	85%	Average level of occupancy in acute inpatient units managed by the mental health and addiction service over the reference period (Northern DHB Support Agency, 2010).	Most acute inpatient units run at or close to 100%. Experience suggests that acute inpatient units operating above 90% occupancy on an ongoing basis are stressed, compromising the provision of optimal care during the inpatient period including discharge planning. Benchmarking will help to understand variations between DHBs, the drivers of high occupancy, and may support movement toward lower occupancy rates (Mental Health Commission, 2014; Northern DHB Support Agency, 2010).	

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
2.4	Pre-admission community care	75%	Number of in-scope acute inpatient referrals to the mental health and addiction service organisation's acute inpatient team, occurring during the reference period for which a face-to-face community mental health contact was recorded in the seven days immediately preceding that admission by community care services managed by the organisation (Northern DHB Support Agency, 2010).	Provides a measure of the quality of care, efficiency of resource use and the extent to which a service has engaged with consumers and attempted to support them within their natural environment (Northern DHB Support Agency, 2012).	HVDHB/CCDHB: New measure. Data validation still required
2.5	Post-discharge community care	90%	Number of overnight referral closures from acute inpatient units to the organisation's community catchment during the reference period for which a community mental health contact with client participation was recorded in the seven days immediately following that discharge (Mental Health Commission, 2014; Northern DHB Support Agency, 2010).	A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (Northern DHB Support Agency, 2012).	Refer to comment 2.4.
2.6	Consumer related time	30-40%	The percentage of recorded community clinical activity that is attributed to paid direct-care clinical FTE in the reference period. The numerator is the total recorded clinical activity for both consumer participation time (telephone & face-to-face) and non-consumer participation time (liaison/care coordination with other agency or family contact without the consumer present). The denominator 'paid direct-care clinical FTE' is all paid hours for staff (excludes support and management/administration staff) minus any recorded leave (Northern DHB Support Agency, 2010).	Number of contact hours with service user participation plus the number of contact hours without service user participation (Northern DHB Support Agency, 2012).	WDHB/HVDHB: Indicator under development.
2.7	Community treatment days per quarter	10-12 days	Total number of community treatment days provided by the mental health and addiction service organisation's community mental health and addictions services within a three month reference period. (A treatment day is a day on which a service user received some clinical input; it could be one contact or many). This is a three monthly average (Northern DHB Support Agency, 2010).	Provides a measure of the intensity of treatment within the community (Northern DHB Support Agency, 2012).	WDHB/HVDHB: Indicator under development.

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
2.8	Wait-time to first face-to-face contact	80% < 3 weeks 95% < 8 weeks	Measures Wait-time from the referral received date to the first face-to-face appointment. The MHAID 3DHB calculation differs slightly to the MoH PP8 measure as we measure the wait-time for all referrals. The MoH calculation measures wait times for those consumers who have not access MH&AS in the past year.	Provides a measure of service efficiency (Ministry of Health, 2014c).	Ministry of Health data, Rolling year, 3 month lag (PP8).
2.9	Community DNA rate		Count of DNA activity. The count divided by all DNA activity plus all face-to-face activity in the reference period provides the DNA rate. Note: In MHAID mental health & addiction services did not attend activity (DNA) is mainly collected as an activity, rather than an appointment as used by the 3-DHB general outpatients measure This means that the general out patients and MHAID measure is not comparable.	Provides a measure of the quality of care (safety and risk for consumers who do not attend) and efficient use of community FTE resource.	HVDHB/CCDHB: New indicator.
2.10	Caseload with consumer participation in the last 90 days (%)		All unique community consumers at month end, with an episode of care 90 days or over, that have had a service user participation contact recorded during the previous 90 days.	An indicator of service delivery timeliness and proxy measure to consider if active treatment is being delivered to consumers accessing community teams (Mental Health Commission, 2014).	New indicator.
3.1	Staff turnover (%)	8-10%	Number of employed staff who voluntarily resign from mental health and addiction services within the reference period (Northern DHB Support Agency, 2010).	Provides an indicator of the effectiveness of staff recruitment, orientation, engagement and support. Overall it is generally seen as an indicator of the health of the organisation (Northern DHB Support Agency, 2012).	
3.2	Sick leave (%)	2-4%	Total number of sick leave hours claimed by all employed mental health and addiction staff during the reference period (Northern DHB Support Agency, 2010).	Provides an indicator of a healthy, sustainable workforce (Northern DHB Support Agency, 2012).	
3.3	Number of staff with annual leave > 200 hours (n)	0 (Coop, 2006)	Total number of MHAID staff who have annual leave owing greater than 200 hours during the reference period (Coop, 2006).	Provides measure and control on annual leave liability. Staff are encouraged to take leave for their better wellbeing, in turn this reduces the liability carried by	

No.	Measure	Target	Definition	Purpose and utility of indicator	Reporting capability
				the organisation (Coop, 2006).	
3.4	Physical assaults on staff		Count of assaults.		
3.5	Percentage of performance appraisals completed	100% (Coop, 2006)	Percentage of performance appraisals completed in the last year excluding causal, fixed term, medical.	This indicator signals the significance of staff career development and progress towards high quality service delivery (Coop, 2006).	CCDHB: Under development
4.1	Operating (actual) costs ($'000)		Total MHAID costs including personnel, outsourced, clinical costs, infrastructure costs and recharging during the reference period (Coop, 2006).	Provides measure on total cost over total revenue. In general a good indicator to have some controlled measures by percentages etc.	
4.2	Personnel including outsourced ($'000)		Total MHAID personnel and outsourced costs during the reference period (Coop, 2006).	Provides an indicator of personnel costs and outsourced costs percentages to total revenue. Good indicator to measure performance on budget.	
4.3	Overtime (total hours versus overtime hours)		Total overtime hours costs over total hours of personnel costs (Coop, 2006).	An indicator of total overtime hours spent compared to total personnel hours costs. This gives a good picture on the use of overtime hours and puts control measures as percentage to total hours. In general a good tool to control overtime costs over budget.	
4.4	FTEs - actual		Total MHAID personnel and outsourced FTE's (contracted), excluding vacancies during the reference period (Coop, 2006).	Measure the performance vs budget.	
4.5	FTEs - vacancies		Manual count of vacancies provided on a monthly basis, one month lag.		

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