



Waitemata
District Health Board

Best Care for Everyone

Our Health in Mind.

Growing wellbeing for our community

A Five-Year Strategic Action Plan 2016-21

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Foreword

The *'Our Health in Mind'* action plan has been commissioned to drive a major shift in the traditional model of mental health care in the Waitemata district. It is bold in its aims and proposes courses of action never before seen in New Zealand.

It is driven by a determination to do more to help people in need of mental health support and to provide help earlier where possible before illness progresses.

We know that the existing mental healthcare system does a good job of managing those with the most complex and acute needs, traditionally viewed as the top three percent of patients.

But the reality is that getting comprehensive help for those outside this high-threshold group may be more difficult to achieve.

They – and their families and whānau – are often left to traverse a system that is, at times, not well-connected and does not support people to become well as effectively as they could or should.

We need to change this. We must find new ways of reaching more people more effectively.

If unsupported, it's likely only a matter of time before their health needs escalate, with the resulting negative impact on themselves and their families and communities.

We need to concentrate on more 'upstream' interventions that keep people well and better-supported to live their lives in their communities.

We know that our primary care partners can experience difficulty in managing the needs of those with mental health concerns. *Our Health in Mind* aims to give them more support and more options to help them help their patients and whanau. This is backed by significant additional funding from Waitemata DHB to support the shift we are seeking to make.

The greatest inequalities in health outcomes are found in mental healthcare. People with the poorest outcomes overall are usually mental health patients with known risk factors and/or chronic conditions.

When these patients are Maori or Pacific, life-expectancy can be reduced by 10 years or more compared to the rest of the population. We need to tackle these trends and invest in new ways of supporting people to be well.

Our Health in Mind draws on a wide range of clinical experience and is our roadmap for improvement over the next five years. I thank those who have contributed their expertise so that people in need – and those close to them – may have a brighter future.



Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board

Mihimihi

E nga mana, e nga reo, e nga karangaranga maha o Te Motu.

Tenei te mihi ake ki te hunga kua raru i a "mate", ratou kua wahangu ki runga io tatou kainga/marae maha, ratou kua wheturangi hia, haere, haere, haere oti atu. Ratou kia ratou, kia hoki ake ki a tatou nga mihi.

He Hau Ora, He Mauri Ora. No reira whaia te hau ora hei korowai whakatupu ake i nga whanau, nga tini hapu, me te Iwi-Nui-Tonu.

Whakaaro Hia to Tatou Ora
Our Health in Mind

Whaia te oranga i roto i te Iwi-Nui-Tonu
Our wellbeing in the community

Acknowledgements

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To the people who generously contributed their personal stories and experience about Waitemata district's primary and community mental health services, your wisdom has helped shape this plan.

To the sponsors and advisory group, thank you for your expertise, energy and enthusiasm.

Sponsor	Dr. Dale Bramley	CEO
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Thank you also to the contributors, who - in the form of ideas, facilitation, supervision, writing, feedback, resources, research and thematic analysis - brought the plan to fruition. (Please see Attachment 1)

A special thank you to Naida Glavish, Chief Advisor Tikanga, and Kaunihera Kaumatua Roopu.

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Gwendoline Smith	Karen Fielding
Jay O'Brien	David Todd
Jean Wignall	Sue Johnston
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Sir Mason Durie	Selena Griffith
Professor Tony Dowell	Dr Allan Moffitt
Dr Mike Ang	

Executive Summary

Purpose

The purpose of this plan – ‘Our Health in Mind’ Action Plan (2016-2021) is to:

- Outline a direction of travel towards a whole-of-systems approach to improving health outcomes in the Waitemata health district.
- Provide evidence about why this direction is critical.
- Propose an action plan to guide investment.
- Respond to the growing burden of disease in mental health and addictions.

This plan has been developed for several reasons, including:

- Making a more-substantive shift towards the objectives of *Blueprint II* and *Rising to the Challenge*.
- Responding to current and future needs of service-users and their family/whanau.
- Responding to providers, in particular GPs’ feedback.
- Meeting DHB imperatives – Dr Dale Bramley, Chief Executive Officer, initiated a programme of work in September 2015 to develop a five-year action plan for population and primary mental health and addiction as part of health services planning to 2025.

The scope of the action plan is across the lifespan and whole service system. This incorporates, but is not limited to, what we currently call ‘primary mental health care services’. The plan has a specific focus on the contribution and development of primary and population mental health approaches and services to better meeting the needs of local people, families and communities. The diagram below illustrates this broad scope.

Figure 1: The context for this action plan



Source: Dahlgren and Whitehead (1991)

Meeting the Waitemata promise and the Board's aim

Waitemata DHB's promise is "best care for everyone". The DHB's values are:

- Everyone matters
- With compassion
- Connected
- Better, best, brilliant

This promise and these values are the foundation for the action plan.

'Our Health in Mind' aligns with the Board's purpose to promote wellness, relieve suffering, prevent, cure, ameliorate ill-health for people (and their family/whānau) who experience mental health and substance misuse.

To meet the DHB's promise and aims in the area of mental health and wellbeing is ambitious - and so is this plan. The plan's wider systems-improvement focus shifts the lens from being provider-centric to being more people and their family/whānau-centric. Waitemata DHB, local partners in primary care and NGOs are ideally placed to lead this shift in focus that will be required by all DHBs. We have the skilled people and ability to make it happen.

Who's the plan for?

At its broadest, the plan is for the Waitemata community so people can understand the direction and aspirations for their mental health and wellbeing and addressing substance abuse. The actions are inclusive of many community stakeholders, including service-providers, other government agencies and NGOs. In essence, though, the plan will primarily guide Waitemata DHB's investment and approach to improving the mental wellbeing of the Waitemata community.

Developing the plan as one team

This plan has been developed with providers, service-users and their family/whānau. It was overseen by an expert advisory group (see page 6 for a list of advisory group members).

The plan is also informed by evidence from international and national sources, including research, quantitative and qualitative data, policies and published guidelines (see page 15 for more information about the methodology for this work).

We need to transform

The current health system was designed in a century with different health imperatives. It was not designed to meet the health needs of this and future populations. For example, the World Health Organisation and World Psychiatric Association have identified stigma as the single most-important challenge to mental health reform.

The global burden of disease indicates that mental health disorders will be among the top-three most-common disorders in the next 10-15 years. That burden will be greatest in high-prevalence disorders such as depression and anxiety and substance misuse in the 'mild-to-moderate' range of severity. The response to this will need to be within the primary health sector, with contribution from specialist services. The historical configuration of mental health services in New Zealand has been around low-prevalence disorders in the moderate-to-severe range of severity. In the past 10 years, more attention has been paid to developing primary mental health and addiction services, with some on health promotion. The time is right to move to the next phase and have the services more connected.

Although this plan focuses on the community part of the system, an integrated mind/body approach is essential for hospital-based services, too – especially for long-term conditions. A King's Fund report

examining the cost of co-morbidities (Naylor et al 2012) highlights that people with long-term physical health conditions also have mental health problems which can lead to significantly poorer health outcomes and quality-of-life. Interestingly, the report also pointed out that the total health care costs increase by at least 45% for people with a long-term condition and a co-morbid mental health problem (King's Fund, 2012).

In the New Zealand context, Blueprint II confirmed the mismatch between the configuration of current services and predicted service-need. It identified that the combined impact of several factors would require the health and disability sector to increase access to organised mental health and addiction responses over the next 10 years. These factors are:

- The personal impacts of poor mental health are higher than any other group of diseases and the societal impacts reach far beyond just the affected individual or the health sector.
- The personal impacts of mental health and addiction disorders are significant: they are the leading cause of disability and result in significantly reduced life-expectancy. It is estimated that people with severe mental illness live an average 10-15 years less than people without mental illness.
- We have one of the highest rates of youth suicide in the developed world.
- Mental health and addiction outcomes for Māori and Pacific people prevent them experiencing the same levels of wellbeing as the rest of the population.
- Early recognition and treatment of mental health and addiction issues can significantly reduce the negative impact on people, their families and whānau, communities and wider society.
- The mental health and addiction sector has a role to play in forming strong links and partnerships with agencies that are addressing broad government objectives where mental health and addiction issues play a significant role - for example, reducing sickness benefits.

Within the Waitemata community, evidence suggests there are people missing out on access to primary mental health care due to historical under-resourcing. They are falling between the gap of primary and secondary care. In some cases, this is about limited capacity. However, it's also because people are not seeking help or leaving it until they are very unwell. The reasons for this are many and varied and include stigma and shame about accessing services, availability of services and cost of services. This means a lost opportunity to avoid preventable distress, illness and the subsequent burden for the person and their family/whānau. Ultimately, this results in the need for more specialist and costly mental health services down the line.

GPs in the Waitemata district have voiced concerns about primary mental health care including:

- Limitation of availability of treatment programmes.
- Difficulty seeking better support from specialist services (access to advice and access to services).
- Difficulties knowing what's available and how to access it, including from NGOs and broader community.
- Building confidence and skill in meeting rising demands.

The proposed whole-of-system approach

To better-meet the current and future mental health needs of the Waitemata population, we must think and do things differently. This shift to a people and their family/whānau-centric approach highlights the gaps in the current system.

This co-developed action plan provides the basis for meeting current and future mental health and wellbeing needs. The plan describes how a population and primary health-informed approach focused on promotion, prevention and early intervention can contribute to the objectives of the DHB in its roles as a commissioner, provider and key local constituent as an employer, influencer and enabler. The overall

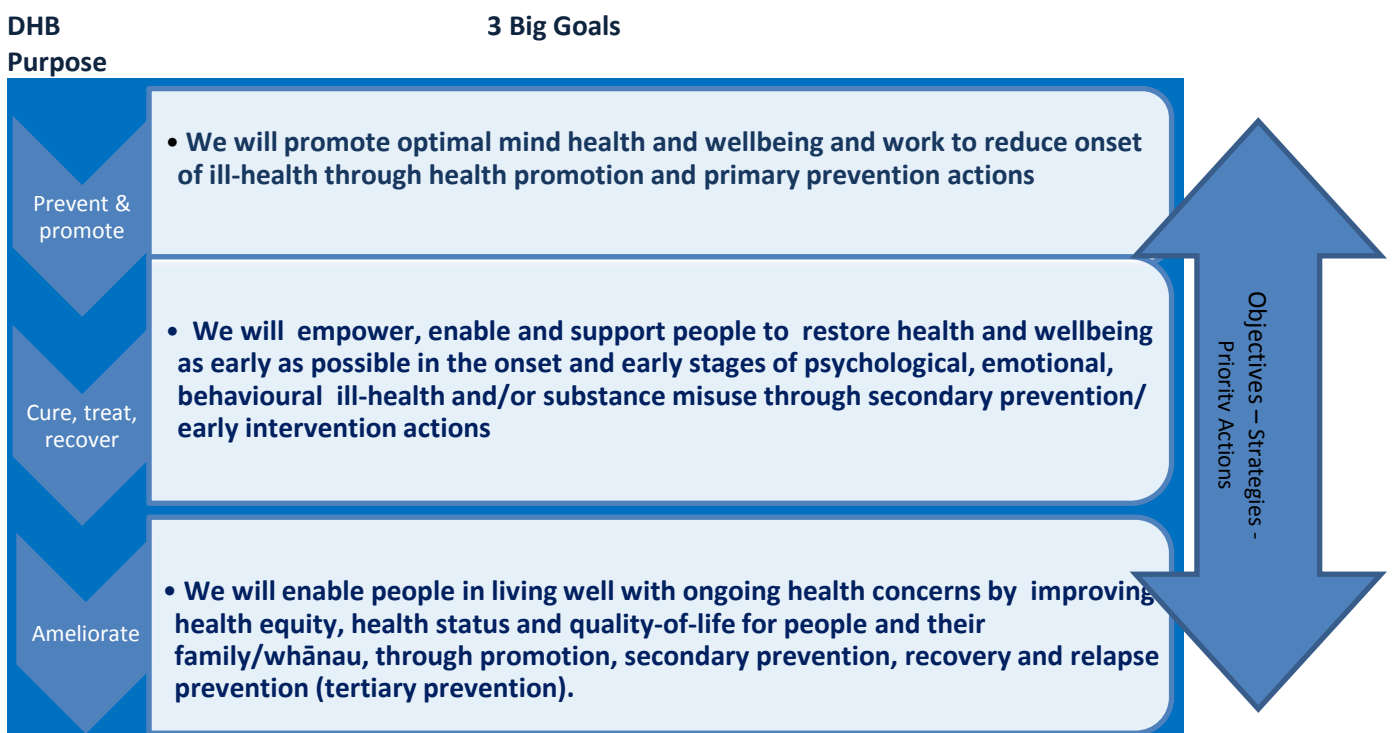
intention is to meet the needs of local people, families and communities earlier, locally, respectfully and compassionately.

The overarching principles for the actions in the plan are:

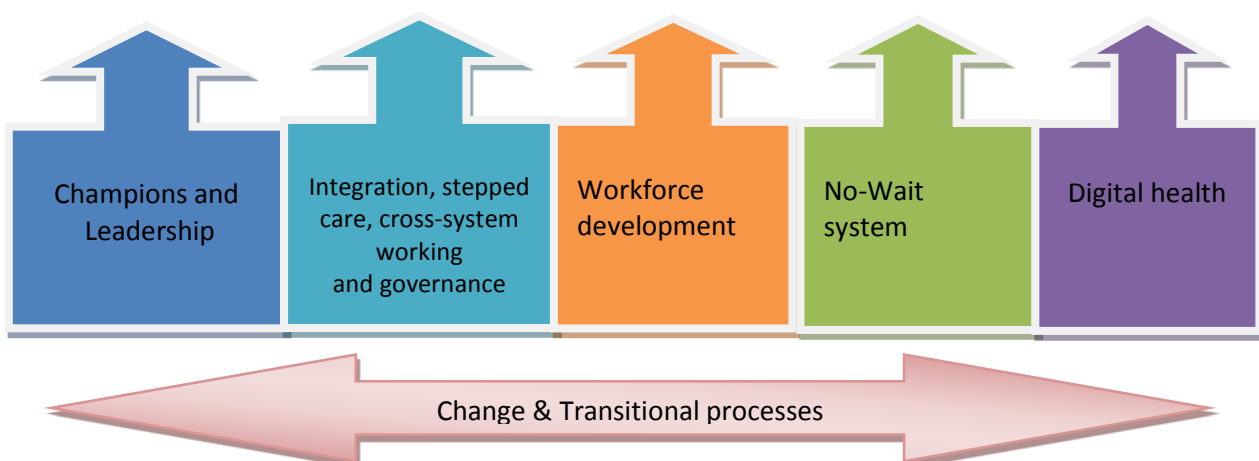
- People and family/whānau-centric.
- The earlier the better (in life course and when help is sought).
- Our health includes mind, body and (for many) spiritual needs.
- Address differences in health and life outcomes for some population groups.
- Take a strengths-based approach.
- Build on existing capability.
- Integrate programmes where it makes sense to.

The diagram below illustrates the framework for the action plan.

Figure 1: Framework for the 'Our Health in Mind' Action Plan



Whole of system enablers, to help achieve the 3 Big Goals



For each of the goals and whole-of-system enablers, the framework includes:

- Objectives (what needs to improve)
- Strategies (how to make things happen)
- Priority actions (where we will start). See pages 38-59 for more detail about the plan.

Priority Actions

Goal 1: We will promote optimal mind health and wellbeing and work to reduce onset of ill-health through health promotion and primary prevention actions.

Priority actions

1. Strengthen and promote existing resources as options for improved navigation (tele-health via Homecare Medical) and Raeburn House (but needs a broader remit for the whole district).
2. Mental health literacy and cultural competency for health workers is a priority to reduce experience of stigma and differential response, support early help-seeking and timely access to appropriate sources of help and support.
3. Use a positive pregnancy test result as a trigger to identify early opportunities for improving support, strengthening support networks where the woman is known to be in a vulnerable situation (via maternal and LMC network – Te Aka Ora), teen pregnancies.
4. Focus on potential harm from alcohol misuse, particularly in women with positive pregnancy tests, young people, and Māori and Pacific communities. Implement national guidelines - for 2015, of 7383 births: 6663 no alcohol (90%), 40 some alcohol (0.5%) and 680 unknown (9%), so some improvements in screening could occur.
5. Work in partnership with local employers and schools to:
 - a. Normalise psychological distress, along with physical ill-health and establish core wellbeing and health-promoting thinking and behaviour habits.
 - b. Support/promote access to existing tools for resiliency building.
 - c. Promote help-seeking by individuals and families/whānau – with need defined and determined by them through people they know, online.
6. Allocate resource to commission culturally relevant resources and tools with utility for Pacific and Māori communities for promotion, addressing stigma, navigation and suicide prevention (including budget allocation to suicide prevention programme).
7. Workforce - fund senior clinical and youth leadership roles for fixed-term to lead development and implementation of promotion and prevention (and Goal 2) for youth and young people for Pacific and Māori communities.

Also see digital health for safe use of media.

See Attachment 10 for the strategies related to Goal One.

Goal 2: We will empower, enable and support people to restore health and wellbeing as early as possible in the onset and early stages of psychological, emotional and behavioural ill-health and/or substance misuse through secondary prevention/early intervention.

Priority actions

1. Invest in additional access to talking therapies, self-management programmes and mindfulness on an individual basis and prioritise more group provision at primary health system level. This should include:
 - a. Revising how these programmes are funded and the most cost-effective contracts.
 - b. Promoting and extending the use of existing digital and tele-health tools, plus building access over time to other options.
 - c. Accessing social support through NGOs.
2. Initiate a programme/needs assessment project to quantify and describe actual unmet need.
3. Prioritise and potentially incentivise screening and brief interventions for alcohol.
4. Make available by June 2016 access to specialist advice to GPs from:
 - a. Psychiatrists for specific medical decision-making on treatments and diagnosis via phone, e-referrals.
 - b. Ensure all GPs are aware of the existing GP helpline from Community Alcohol and Drugs.
5. Build capability and capacity for early identification and treatment, with evidence-informed effective interventions, including medication where indicated.
 - a. Prioritise access for practice nurses to credentialing programme.
 - b. GPs to develop general skill and knowledge base via CME sessions, peer review, peer consults via phone, email, etc.
 - c. Increase availability to primary care of specialist multi-disciplinary expertise – psychology, nursing, psychiatry, social work, occupational therapy – (see also integration).
6. Encourage and increase use of extended consults for practice nurses who have been through credentialing programme or already have appropriate skills and support.
7. Broad approach through training and creating connections across the health, social, education and emergency services system – the ability to understand and respond to distress and screen for early signs of “disorder.”
8. Invest in building capability and capacity in West Auckland for Māori and Pacific child and youth responsiveness shaped by positive youth development approaches.
9. Speed-up implementation of regional health pathways to support this goal.

See Attachment 10 for the strategies related to Goal 2.

Goal 3: We will improve the health equity, health status and quality-of-life for people and their family/whānau, living with enduring health issues.

Priority Actions

1. Endorse and implement actions for first 12 months (to 2017), to identify and resolve barriers for access to care for physical health issues for people with longer-term mental health and substance misuse needs – focus on agreeing opportunities and models for integrated responses.
2. Quantify the size of the opportunity accurately and identify people for urgent integrated collaborative care.
 - a. Complete audit process in Mental Health & Addictions provider arm.
 - b. Undertake audit in LTC programmes in primary care of detection of MH problems and adequacy of access to psychological treatments).
 - c. Undertake identification process to answer the following question – ‘where are the differential responses in the health system to people who typically have an established “psychiatric” diagnosis’?
3. Commission a review of current contracted primary mental health programmes for adequacy in supply (capacity) and consistency in model (quality) of self-management programmes (individual and group). Develop a plan to resolve accordingly.
4. Build on existing work in the area of metabolic monitoring in DHB provider mental health services and in primary care, with particular focus on building capability in practice nurses in this area.
5. Establish clinical/quality improvement fellowship role that will provide academic and practical hands-on service improvement support.

See also workforce, integrated services and digital health for further related actions.

See Attachment 11 for strategies related to Goal 3.

PART A: SETTING THE SCENE

Real experience narrative: Craig's story

Craig works in an IT support role in education.

I suffer from work-related stress and had an incident 2-3 years ago when it all became too much for me. I wasn't sure then who to turn to, where to get help from. I called the Crisis Team, "leave a message and someone will get back to you" the message said - it wasn't the help I needed. I did try to engage with them but felt they failed me, I was better off trying to sort out my own problems.

Time went on and I thought I was coping - but I wasn't. I went back to the GP and saw someone else who understood me. I had to complete three tests to see if I fulfilled the criteria for help. Luckily for me, I did. A few days later, someone from Comprehensive Care contacted me to set up three 1:1 sessions. Looking back, this wasn't enough. I really do think six sessions should be the minimum. It was suggested I also attend a focus group for 13 sessions, two hours-a-week. This was to learn strategies for coping. This isn't for everyone but it helped me. The only downside is that if you miss any sessions for whatever reason, you can't add any on at the end. Also, smaller groups would work better. It is quite daunting walking into a room with 8-12 other people when you are feeling anxious and some people would struggle engaging with that many in a group. A refresher course is offered but only if you pay for it. I can afford to do that but a lot of people can't.

I think WDHB could do better. All GPs need to be offering the same helpful advice and know what to do when someone comes to them for help. They need educating. The Crisis Team are good individually but no one communicates with each other and the support offered varies so much in regards to day and night staff. I think the website should have an obvious "I need help" button to click where it then asks what sort of help you need. Getting information, phone numbers, who to contact for different issues is so difficult to find, most people suffering from stress find it more stressful trying to find help. Make it easy.

New Zealand men are particularly bad at asking for help. My advice to others is to try and get the support you need as soon as you are starting to feel low. I wish I had persevered three years ago when I first needed help. I wish it was easier to get help.

My message to staff is to communicate better with each other and your patients, make it easier for everyone to know how and where to get some help. If you come across a person who is struggling and they reach out, don't mess it up as they are not going to bother again. Don't give false expectations.

It would be good to educate school students in recognising the signs of stress so they know what is happening to them and where to get help should they or their friends and family need it in the future.

1.0 Introduction and Background

1.1 Purpose of the document

The purpose of this primary mental health plan – *'Our Health in Mind' Action Plan (2016-2021)* is to:

- Outline a direction of travel for using a population health approach, alongside growing primary health provision for substance misuse and mental health issues in the Waitemata district.
- Provide evidence about why this direction is critical.
- Propose an action plan to guide investment.

1.2 Methodology

The methodology for developing this plan was based on two main principles:

1. The plan must be developed with service-user and provider input.

The primary focus of the plan is deliberately on services at this stage. It has been informed by the views, wisdom and experiences of people who experience ill-health either directly or indirectly as a family member, friend and partner. People who are part of providing services in primary care, NGOs, community agencies, health agencies have also actively contributed.

Three separate co-production processes were used to develop a more detailed understanding of what is important - or front of mind - for people locally. A total of 22 interviews and focus groups were undertaken.

- (a) A series of focus groups with people who currently or recently attended primary mental health programmes.
- (b) A brief survey to a wide range of contributors – GPs, family members, people with lived experience, advisory group members, primary care and DHB staff, NGOs and stakeholder groups, with 42 responses.
- (c) A series individual focus group sessions or attending existing forums. See Attachment 1 for a full list of co-production activities.

An expert advisory group was also established to provide input into the plan. See Attachment 2 for more detail about the advisory group members.

2. The plan must be based on best evidence, with well-researched and documented approaches.

International and local research has been reviewed and applied to the development of this plan, including:

- Research, academic knowledge, qualitative and quantitative data/information to provide a range of evidence-informed objectives, strategies and priority actions.
- Policy, guidelines and published documents/reports from New Zealand and internationally, including the NZ Health Strategy, Ministry of Health plan for mental health and addictions – *Rising to the Challenge, Blueprint II*, Productivity Commission review of health system capability and capacity, On Track - Co-Creating a mental health and addiction systems New Zealanders want and need, workforce reports, Making a difference for Rangitahi, etc.

See the references section for a comprehensive list.

1.3 Why the plan?

This plan has been developed because we need to plan now to adequately meet the health care needs of our community in the future. In particular, the plan:

- Makes a more substantive but staged shift towards the objectives of *Blueprint II*.
- Responds to service-users and their family/whānau's current and future needs.
- Responds to providers, in particular GPs' feedback.
- Meets DHB imperatives – Dr Dale Bramley, Chief Executive Officer, initiated a programme of work in September 2015 to develop a five-year action plan for population and primary mental health and addiction in the Waitemata district.
- Contributes to health services planning to 2025, which is required to prepare for the future surge in population size, the changing make up of that population and to manage the affordability of health care into future through alternative approaches.

The 'Our Health in Mind' Action Plan builds on the current lens of a primary care focus to a broader population and primary health-informed approach focused on promotion, prevention and early intervention. The overall intention is to meet the needs of local people, families/whānau and communities earlier, locally, respectfully and compassionately by:

- Assisting in achieving better outcomes for the Waitemata population and families.
- Improving the experience of people who seek help from our services.
- Preparing for the future (2025) in terms of population growth, providing services we can afford.

“The single-largest challenge facing Waitemata over the next 10 years is the substantial increase in demand on facilities and services that are currently fully utilised and requiring refurbishment. In the next 10 years, WDHB will serve a population of approximately 700, 000,” Health Services Planning Board report Nov '15

The Waitemata DHB's promise, purpose and values (see Figure 2), along with outcomes framework form the foundation for this action plan. A copy of the DHB outcomes framework is attached as Attachment 3.

Figure 2: Waitemata DHB's promise, purpose and values



“Mental health problems, such as depression, anxiety, and alcohol and drug abuse, are among the most common and disabling health conditions worldwide. They often co-occur with acute and chronic medical problems and can substantially worsen associated health outcomes. When not ... effectively treated... impair self-care, adherence to treatments to medical and mental health treatments and are associated with increased morbidity and mortality, increased health care costs and decreased productivity.” (Patel et 2013)

We are increasingly clear on the impact our mental health and/or having an addiction can have on our physical health and well-being, vice-versa and on how long we live. Overall, the evidence suggests that at least 30 percent of all people with long-term conditions also have a mental health problem (Cimpean and Drake 2011) in Naylor et al (2012), pg four.

- People with diabetes are two-to-three-times more likely to experience depression than the general population and a similar level for people with cardiovascular disease. This has not been well-recognised or responded to, with the physical and health systems being so separate. People have needed to find their way around multiple different systems and providers. (Naylor et al (2012). Sartorius (2014)).
- New Zealanders who experience mental ill-health and/or an addiction have more than twice the mortality rate of the general population. This rises to three-times the general population rate for people with a psychotic disorder. (Te Pou, Equally Well [www.tepou](http://www.tepou.govt.nz))

2.0 The challenges we face

The global burden of disease indicates that mental health disorders will be among the top-three most-common disorders in the next 10-15 years. That burden will be greatest in high prevalence disorders, such as depression and anxiety in the ‘mild-to-moderate’ range of severity. The response to these will need to be within the primary care sector, with support from specialist services. The historical configuration of mental health services in New Zealand has been around low-prevalence disorders in the moderate-to-severe range of severity.

2.1 A global epidemic

Evidence in respect of global burden of disease indicates that mental health disorders will be among the top three in the next 10-15 years. This action plan helps take the sector in the direction of being able to respond to that – and, to some extent, help avert it. Figures vary internationally; however, around 40% of primary care workload has been suggested as having a mental health and/or addiction component. This can be:

- A condition in its own right, most commonly depression, anxiety and/or substance misuse problem (around 40%) (Dowell et al 2009).
- Part of, or a contributor, to other medical conditions, especially long-term conditions, such as asthma, diabetes, cardiac health, COPD, obesity.
- A feature in symptoms that people describe experiencing with no clear medical explanation.

See Attachment 4 for The World Health Organisation’s 10 facts on mental health.

In the New Zealand context, *Blueprint II* confirmed the mis-match between the configuration of current services and predicted service need. It identified that the combined impact of several factors would

require the health and disability sector to increase access to organised mental health and addiction responses over the next 10 years. These factors are:

- The personal impacts of poor mental health are higher than any other group of diseases and the societal impacts reach far beyond just the affected individual or the health sector.
- The personal impacts of mental health and addiction disorders are significant: they are the leading cause of disability and result in significantly reduced life-expectancy. It is estimated that people with severe mental illness live an average 10-15 years less than people without mental illness.
- We have one of the highest rates of youth suicide in the developed world.
- Mental health and addiction outcomes for Māori and Pacific people prevent them experiencing the same levels of wellbeing as the rest of the population.
- Early recognition and treatment of mental health and addiction issues can significantly reduce the negative impact on people, their families and whānau, communities and wider society.
- The mental health and addiction sector has a role to play in forming strong links and partnerships with agencies that are addressing broad government objectives where mental health and addiction issues play a significant role; for example, reducing sickness benefits. See Attachment 5 for Blueprint's eight priorities.

We know that Māori and Pacific people do less well than other New Zealanders in some important mental health statistics. However, more Maori are seeking help from mental health services than in the past. (Mental Health Foundation, 2014).

2.2 The impact of mental wellbeing on life outcomes

“When I think about it, I just wish that my GP had sent me for the extra help. I played things down a bit when I went to see him and I wonder - if I had got the help - if things would have been easier for me.”

One of the biggest and toughest impacts of experiencing mental illness and/or an addiction is the impact it has on social identity, connectedness and participation in the person's desired life and often on their families. This is fundamentally a health issue, while not treated medically.

Connectedness with culture and social networks shape identity and are fundamental to flourishing, growing and sustaining our wellbeing. Being able to positively contribute to, participate in, and gain succour from the cultural, spiritual and social realms of life are fundamental human needs. All can be interrupted by health and particularly by our mental health. Advances in neuroscience can physically show that the experience of disconnection, isolation or exclusion is felt acutely and are equal to physical pain in the brain. A body of thought in neuroscience is that we are “hard-wired” to be social beings and when that is impacted by isolation, difficulties in being with other people, etc., we wilt.

‘Social isolation and loneliness in adults affects health: people with adequate social relationship have a 50% greater likelihood of survival – equivalent to the effects of quitting smoking... Inequalities and social disadvantage affect health, wellbeing and life expectancy ...’(Crisp, 2016)

The impact of social determinants on health is well-documented. We do not need to undertake separate approaches to tackling social determinants. The determinants of poverty, nutrition, living conditions,

employment, social and cultural inequalities and isolation are fundamental to a healthy mind, and healthy body (Allen et al 2015).

Waitemata DHB has a vital role in contributing to the social capital of its district. This is demonstrated in the way it develops and commissions services, influences and participates in broader collective action alongside other community, government and business sector agencies.

The top three areas where strategic and ground-level partnerships can make a very real difference to the health and wellbeing of the mind are:

- Housing - affordable, safe, comfortable.
- Education - staying with it, literacy and skills for life.
- Employment - having a job and an income and being in a job that sustains health and wellbeing.

People and their families/whānau have to contend with the well-documented adverse lifetime impacts if issues are not responded to early and with access to best-available responses (treatments, supports). These can include interruption to usual development as a child/young person, impacting on school, learning, family and social relationships, broader health and, sometimes, their survival. Internationally, research indicates that of adult mental health issues, 50% begin to show early signs by age 14/15 and 75% by the early 20s.

Moving on into adulthood and as older people, experiencing an addiction and/or poor mental health can have further negative effects on protective factors that help them ride through the troubled times in life.

- Educational and training achievements.
- Employment opportunities and being able to have some economic independence.
- Living in, being an inclusive part of and contributing to their own families, (however family/whānau is determined for people).
- Enjoying and contributing to supportive and enriching relationships.
- Socially and culturally connected.

The King's Fund report on long-term conditions and mental health highlights that people with long-term physical health conditions also have mental health problems which can lead to significantly poorer health outcomes and quality-of-life. Interestingly, they also pointed out that the total health care costs increase by at least 45% for people with a long-term condition and a co-morbid mental health problem (King's Fund, 2012).

The impact of stigma and shame

"He [the GP] kept saying how well I was coping and that made me feel ashamed that I was not coping, almost like I was a failure..... I cried a lot and felt alone with my secret. I didn't know anyone else who had had this happen to them."

The World Health Organisation and World Psychiatric Association have identified stigma as the single-most-important challenge to mental health reform (Stuart et al, 2012). Stigma gets in the way of people seeking early access and getting the help they need. A NZ survey of 1,135 people found:

- 57% reported hiding their mental illness from others moderately or a lot.
- 37% stopped themselves having close relationships through anticipated discrimination.
- 33% stopped themselves from applying for work through anticipated discrimination.
- 24% stopped themselves from applying for educational courses through anticipated discrimination. (Phoenix Research, 2011).

"If I could do it again, I would have been more open about it, too, as I didn't do myself any favours by keeping it to myself."

Real experience narrative: Karen's Story

My experience with WDHB started when I fell pregnant at 17. I started to feel unwell, something was wrong and I felt no one was listening to me. I knew my own body, surely it wasn't all in my head. I felt stupid and discriminated because of my age. I ended up having an emergency caesarean and the lack of aftercare contributed to my already-anxious state. I didn't know where to turn. I was made to feel the only option was anti-depressants, which didn't work. I drank bottles of Coke every day, which resulted in me feeling full of energy, then having no energy, then putting on weight. It was a vicious circle and I still felt anxious and stressed all the time. As time went on, I learnt to somehow cope. I met my husband, who gave me the support I needed and I felt happy at last.

It was the same story with the second baby, no one listened. I felt I was labelled as just being over-anxious with anxiety problems. The birth was terrible; I thought I was going to die. I was still having pain and still no one was listening. After my GP persisted on my behalf, I was admitted on Christmas Eve to NS hospital and, as my baby was only three weeks old, I was told that it wasn't possible for her to come into the hospital with me. But there was someone there with a two-week-old. Why was I being treated like this? I thought 'what is wrong with me, why aren't I allowed to be with my baby?' I was missing Christmas with my family and it shouldn't have been like that. If only someone had listened to me weeks ago and not discharged me.

As time went on, I was hardly coping. I was obsessed with cleaning and rarely went out. Cleaning took up all my time. I did this as I felt if my children get sick, it would be my fault. It was having a massive impact on my life. I fell pregnant with my third baby, who was born by emergency caesarean at 32 weeks and the baby was taken to SCBU. I became more and more obsessed with cleaning - the house, the children, myself. I spent most of my time thinking I wasn't a good enough person and was anxious to the point of not wanting to go out, worrying about what might happen. Eventually, this spiralled out-of-control and I would only leave the house if I absolutely had to. I woke up one morning and suddenly realised that I need my life back, my behaviour isn't fair on my kids and family.

I went to my local GP, who offered me anti-depressants and gave me some pamphlets in regards to getting some counselling. But all this cost money, which we didn't have. I eventually went back and saw another GP at the same practice. They understood - someone was listening at last. This was a huge turning point in my life. I was put in touch with Comprehensive Care in Albany and was offered four sessions 1:1 with a counsellor. This was the first time in 10 years I had been offered any proper help and support and the first time someone had listened to me and understood that I had a problem. In conjunction with my 1:1 sessions, I attended a focus group, which consists of 13 sessions for two hours once-a-week. I have struggled a bit with this as it's hard to be sociable sometimes. I see a psychologist in Paramount Drive - that place is amazing and I can't believe that it's

just down the road from me and I knew nothing about it. The staff are fantastic - so friendly, they make you feel "normal", they don't judge you.

Although I am grateful to be getting help at last, it has been a very difficult journey. Help isn't readily available and I feel angry and sad that if I'd have been listened to 10 years ago, I wouldn't be like I am now. I would have been so much further on with my life, having already gone through my further education and already achieved my goals. I feel let down by the whole system.

My message to the mental health team is to somehow get rid of the stigma that comes with having MH problems as I worry that it will follow me the rest of my life. The adverts on the TV aren't real, that's not how it is living with mental health issues. It is not easy to get help, make GPs more aware and give them some understanding on what to do when faced with a patient like me.

My message to others who are suffering the same is to get help early, find a supportive GP and keep persisting until someone listens. Tell your friends and family and get their support. It is not something to be ashamed of; you can't help feeling like you do.

The world still scares me and I don't want to feel this way.

2.3 Addressing local demand for services

People and their experiences

"I went to my local GP, who offered me anti-depressants and gave me some pamphlets in regards to getting some counselling. But all this cost money which we didn't have."

Listening to the personal stories people share of their experiences of health and ill-health and the impact that this has on their lives - and those close them - is a stark reminder to us all. They are inspiring stories of personal courage and tenacity, not of weakness or deficit. The story starts long before a person turns up at their GP, of which a small percentage then may get referred on to another service, often a secondary specialist.

"I cannot praise the MMH team enough for the support they provided me. In particular, the CBT course was so very helpful in allowing me to understand that it was an illness that could be managed. Also, the mental health crisis team were what got me through those first terrifying few weeks. On more than one occasion, I told my partner it was either our son or me, one of us had to go. They came to my home during several panic attacks, often late in the evening, and talked me down."

The word cloud (see Figure 2), essentially shows the 'top 20' themes that emerged from the qualitative data transcribed from the interviews and focus groups (see Attachment 1). The three most-commonly referred to themes, considered to be the most important issues or priorities for improving population and primary mental health and addictions, in Waitemata DHB are:

- **Better communication** (e.g. between primary-secondary interface; navigator; listening to family/friends)
- **Workforce and training** (e.g. training in mental health for LMCs; compulsory mental health training for GPs; enhancing the practice nurse role)

- **Improving access to services** (e.g. getting advice in the interim, better/wider range of programmes; self-management resources).

See Attachment 6 for more detail from focus groups. See Attachment 7 for thematic analysis from surveys.

Figure 3: Top 20 themes from Waitemata interviews and focus groups.



“This time, though, I recognised what was happening and called for help, which was there right away. They were fantastic and I cannot thank them enough for what they did for us all. I started treatment straight away and was feeling normal again within a week or two. I stayed on the treatment for six months, when I came off as I was pregnant again! I am still under MMH and just knowing they are there just in case is very reassuring. I hope that the same thing doesn’t happen again but, if it does, at least there is a solution that works.”

Understanding local demand for services

Within the Waitemata community, there is evidence that suggests that there are people that are missing out on access to primary mental health care services. They are falling between the gap of primary and secondary care. This means a lost opportunity to avoid preventable distress, illness and the subsequent burden for the person and their family/whānau. Ultimately, this results in the need for more specialist and costly mental health services down the line.

GPs in the Waitemata district have voiced concerns about primary mental health care including:

- Limitation of availability of treatment programmes.
- Difficulty seeking better support from specialist services (access to advice and access to services).
- Difficulties knowing what’s available and how to access it, including from NGOs and broader community.
- Building confidence and skill in meeting rising demands.

Mental ill-health and addiction accounts for 11% of the total burden of disease in New Zealand, measured in disability-adjusted life years lost. The biggest contributors are anxiety and depressive disorders (5.3% of loss), alcohol use disorders (2.1% of loss) and schizophrenia (1.3% of loss). We can estimate from the NZ Mental Health Survey and from other research that one-in-five (around 133,000) residents of Waitemata DHB experienced some mental health or addiction issue in 2015. Not all of these require face-to-face contact with health services in order to recover. There are a range of self-help publications and

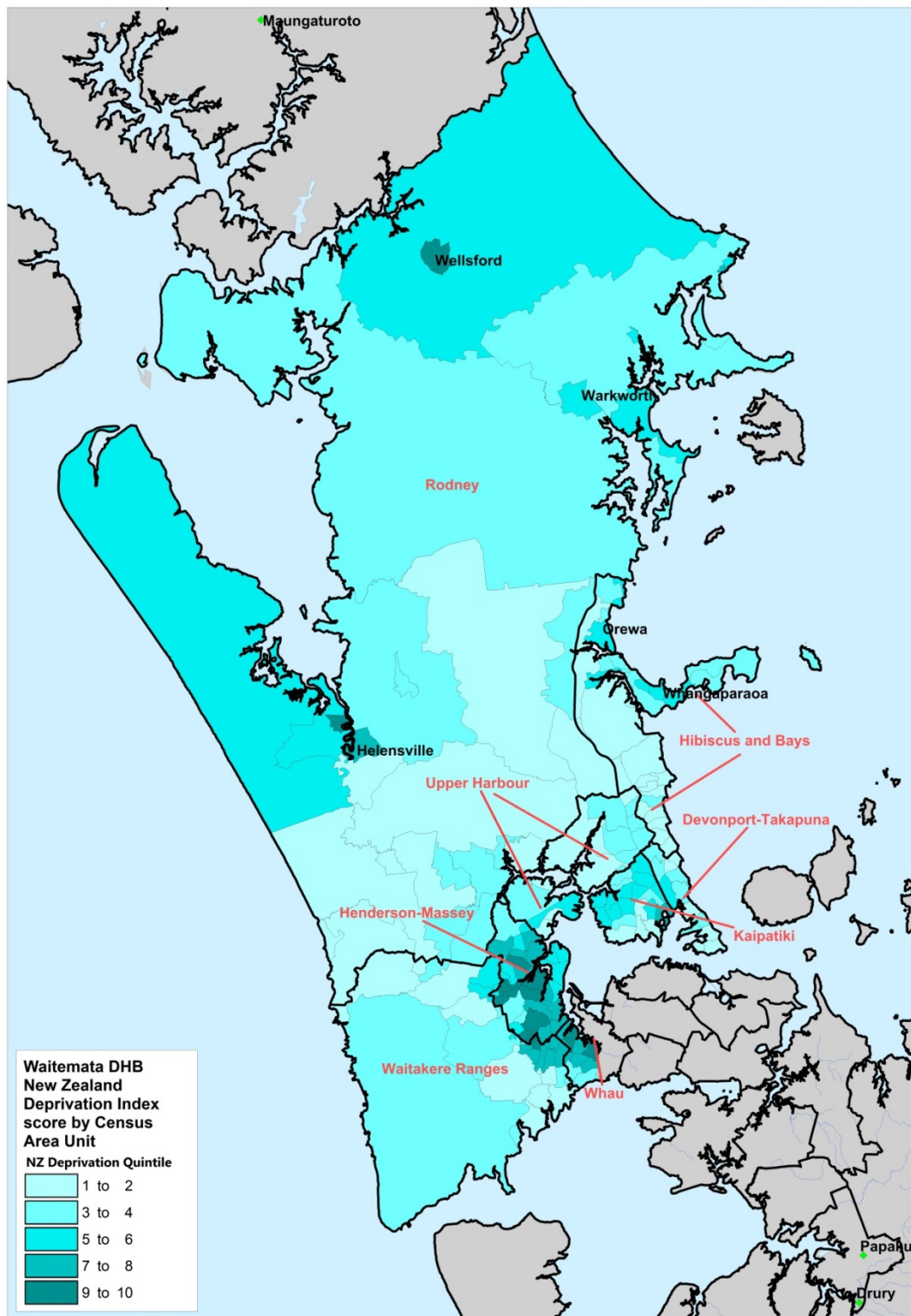
websites available and some people will recover with support from family and friends. Around 20,000 with more-severe illness receive help from the DHB's secondary services. DHB-funded primary mental health services saw around 7,500 young or high-needs people and NGOs helped 4,000 people in 2015. There were 5,600 people living on benefits because of mental health problems. But these numbers overlap, as the same patient may access a range of services and, crucially, we do not know how many people receive help from their GP or from private services.

Our population is diverse, and spread over a wide area, which presents challenges in delivering services. Poverty and deprivation are known risk factors for mental ill-health and some geographic areas have much higher levels of deprivation than others. The map below shows the geographic distribution of areas with higher levels of deprivation, as measured by the NZ Deprivation Index. The low-quintile (deciles 1-2) are the most-wealthy areas. The most-deprived areas are concentrated in West Auckland.

Our population is growing rapidly and, by 2025, the numbers with mental health or addiction issues will be around 158,000 (146,000), an increase of about 20% (10%) on current numbers. There are whole new suburbs developing, for example in the Hobsonville, Whenuapai, Albany, Silverdale and Lynnmall areas. As services expand to meet population growth, the geography of service delivery will need to change as well, in order to match the changing distribution of population.

As well as geographic changes, our population is changing in terms of ethnicity. By 2025, 25% of our people will be Asian, compared with 20% now. The Asian population in Waitemata DHB is predominantly young migrants of student and working age, with few old people, but many children aged under-five. Within the Asian population, there is a mix of cultures, mostly Chinese, Indian and Korean.

Figure 4: Geographic spread of deprived areas, Waitemata DHB

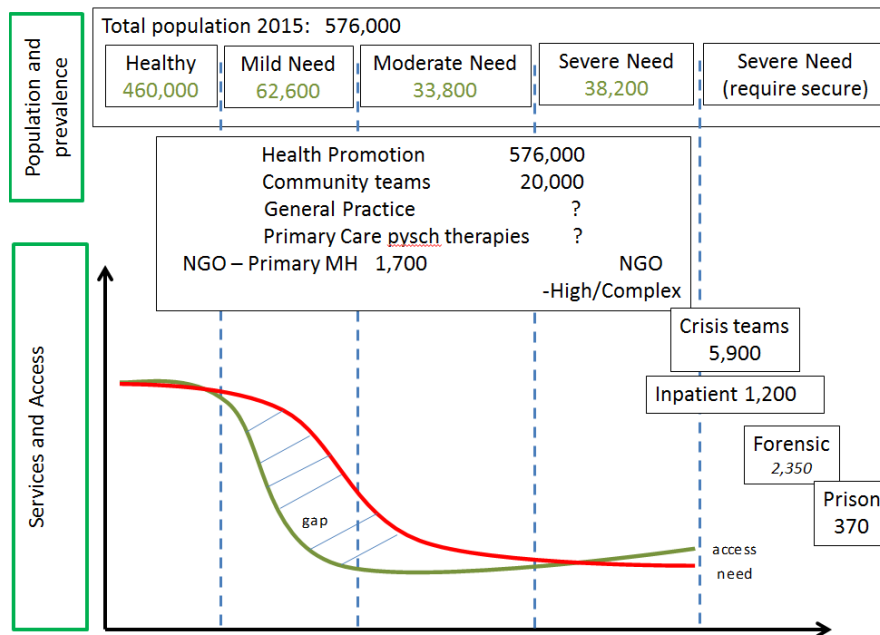


How do we know if services are meeting current demand?

Figures collected by one PHO suggest that 15% of patients referred to community MH teams are declined service. This indicates that GPs are being left to manage patients whom they assess as requiring more

support. Moreover, the Adolescent Health Survey 2012 found that 11% of secondary school pupils had difficulty getting help with emotional worries. There is a gap in provision for people with illness that does not require secondary care but is not being met by primary services. However, we struggle to quantify the size of this gap. We can roughly represent what we know about levels of need and the relationship to access but we are missing much of the detail.

Figure 5: Estimated current service demand in Waitemata



We need to improve our understanding of service demand. This would be considerably assisted by the collection of additional information.

We need to improve our understanding of service demand and our ability to measure outcomes. This would be considerably assisted by the collection of additional information. Six suggestions are summarised below.

1. The New Zealand Mental Health survey is now 10 years old and services and funding have changed considerably over that period. To gain a clear view of the need in our population, the ideal option is to carry out a local sample survey and directly collect up-to-date information. This would be a large undertaking but might attract funding from research groups.
2. In order to improve our knowledge around primary service provision, we recommend undertaking a sample of general practices that have a particular interest in mental health. This would involve either a retrospective review of records or prospective data collection over a short period to capture a full picture of the numbers and proportions of patients receiving help with mental health issues in primary care. Such a survey could also measure referral rates to other services and overlaps between primary and secondary services. This exercise could also inform a decision on whether it was practicable to collect this information systematically in future as a means to measure improvements in provision or whether we will need to rely on a repeat survey at a later date. The outcome of this exercise would be to give an estimate of the rates at which people are accessing primary care for

mental health issues, which could then be compared with illness reported in the Mental Health Survey and the NZ Health Survey to estimate gaps in provision. It could also provide a measure of the numbers and types of cases where GPs required more support. The information would provide age, gender, ethnicity and illness information. It would be particularly helpful in assessing whether young people were getting help, as we know that half of mental ill-health arises before the age of 15 and early intervention is effective in preventing years of ill-health.

3. Changes and extensions to current data collections could improve our understanding of the numbers of people receiving services. For example, schools funded to provide health services could be asked to count the number of pupils seen for mental health issues, rather than the number of contacts. This would allow a comparison with the reported rates of secondary pupils who have clinically significant depression or who have problems accessing help with emotional problems to identify gaps. The data for primary mental health services could be extended to include a census of service-users, which, again, would allow for a comparison of estimated need with provision of service.
4. The DHB could adopt a universal health scoring tool, to be used in the system. This would need to be simple enough to use at every contact, whether in primary or secondary care or in schools, NGOs or other providers. This would give the ability to monitor outcomes and, hence, the effectiveness of interventions.
5. The DHB could also consider paying for more detailed analyses of existing surveys; for example, using the NZ Health Survey to estimate the proportion of patients with mental distress who have problems accessing primary care due to cost or transport issues. It would also be useful to know the proportion of people reporting multiple risk factors for mental illness rather than having each measured separately with little information about the amount of overlap. Useful indicators to count would be hazardous drinking, chronic pain, physical ill-health (stroke, diabetes, medication for high blood pressure and high cholesterol), low physical activity, poor diet, obesity and children experiencing physical punishment. This would help to estimate the proportion of the population at lower and higher-risk of mental ill-health and the likely impact of interventions to modify any single risk factor. The NZ Health Survey is run each year, so it can provide information about changes over time and new questions about mental health will be added to it in future.
6. It would be helpful to survey other sectors to understand the support that is provided by employers, schools and community pharmacists.

3.0 The way forward

To better-meet the current and future mental health needs of Waitemata's population, we must think and do things differently. Fortunately, we have evidence of treatments, approaches and supports that have measurable evidence to show beneficial effect. However, we do not consistently implement them, or have a level of access to them that has wide reach. That will require systemic change with multiple partners, which is tricky, slow and challenging to achieve. Those changes and incremental movements are not improbable or impossible if invested in, utilising good improvement processes, including a transitional phase.

The systemic change has the following features:

- A turnaround in thinking, intentions and efforts as people, families/whānau, communities, practitioners and services move towards a focus on being healthy, flourishing and staying well rather than primarily on treating ill-health. Our system is set-up to respond and treat people once they are already quite unwell – described by some as the ambulance at bottom of the cliff, rather than the fence at the top helping us to stay well.
- The *slogan* – 'no health without mental health' is a reality and we don't separate in unhelpful ways the mind, body and - for many – the spiritual realms of being human. This applies equally to being well as well as what helps when unwell.
- People have the experience of being taken seriously when they seek help. The first door knows how to get them to other doors if that is useful for them and then through those other doors.
- People have the experience that they are the centre of orbit for services, there is an organised and co-ordinated response which may be centrally co-ordinated but they access it locally.
- Where what matters most to the person and family/whānau at that point in time is asked about and, where possible, is attended to first.

3.1 *Person and family/whānau led service design and delivery*

When we have a person and family/whānau-centric look at the impact of ill-health, the lens moves to a whole-of-system view. From that view, we can more-easily recognise the gaps and areas for improvement. We need to improve delivery of person and family/whānau-led service design and delivery if we are to achieve better outcomes. Service-users and their family/whānau consistently express the need for stronger partnerships with them, better information and involvement as the key to better experience and outcomes. Studies have demonstrated significant benefits from partnerships between health services, health professionals and service-users, their families and whānau. Such partnerships benefit clinical quality and outcomes, the experience of care, and the business and operations of delivering care (including reduced costs) (*Blueprint II*, 2012).

3.2 *Getting the basics right*

Well-researched and documented approaches are now giving us some clear indications of benefit gained from access to effective practical support, role of peers in recovery and self-management, key therapies, and when medication works and when it doesn't. This also includes various models of care looking at better interface, integration, shared care for mental health in primary care. Informed wisdom and expert opinion are active in this sphere and, again, don't necessarily agree. Noted below is where research, lived experience and informed evidence provide some direction. Consistent implementation and having a locally relevant, skilled and responsive workforce is critical.

Universal basics

- Consistently encouraging and promoting the role of enough sleep, good level of exercise, benefit of healthy nutrition, feeling safe at home – these are the life-giving fundamentals of healthy mind, health body.
- Addressing the practicalities in life – housing, financial, loss - it can be very hard to engage in therapies if the things that matter most for people are not being attended to.
- Healthy thinking. Learning to regulate our emotions and the impact they have on how we think, perceive and respond to a situation has a big role in what happens.
- Self-management - knowing how to pick things up early, what to do, where to go for help and support and acting earlier rather than later.

Providing accessible and effective responses, support and treatment

“I can easily write a prescription that isn’t necessarily the best option for my patient. I can’t write a prescription for CBT which is an evidenced-based treatment because there isn’t the funding.” - GP

The treatment and supports noted in this plan have either high-level research efficacy e.g. systematic review and/or supported by strong qualitative feedback from people benefiting and providing them. An example of this would be the use of groups. Researchers have given more attention to individual interventions than group-based programmes. There is some evidence of the tangible benefits of groups, such as the role of sharing among peers, not feeling alone in the experience, ongoing support of others, shared learning and accountability. The other opportunity that groups and/or workshops offer is the opportunity to reach more people, so from the organisation’s perspective they are an efficient use of access to limited resources for more people.

3.3 Responding earlier with evidence-informed interventions

“For me, the thing that would have made a difference would have been if I could have treatment that wasn’t with drugs. I just didn’t like the thought of them going through to my baby. If I could do it again, I would have been more open about it, too, as I didn’t do myself any favours by keeping it to myself.”

We know that responding earlier to peoples’ health needs leads to better outcomes.

A menu of non-pharmaceutical responses and treatments with high-level research support is noted below in Figure 6. Most can be provided collectively within the primary health system context, some co-working with specialist-trained staff in the first instance or ongoing. A family/whānau group could be run jointly with practice nurses and occupational therapists from the DHB mental health services.

Figure 6: Non-pharmaceutical responses and treatments with high-level research support

1. Talking therapies packages – individual, group, delivered via GP, Practice Nurse, Primary MH programmes in PHOs, NGOs, collaborative primary care and secondary care staff, digital tools, including:
 - CBT (group and individual) brief (four-session brief intervention package – standard -; 8-12 sessions (for assisting with more complex issues)
 - ACT – acceptance commitment therapy
 - MBCBT – mindfulness-based CBT
 - Motivational interviewing
 - DBT light skills programmes.

2. Brief interventions for alcohol, substance misuse.
3. Self-management coaching and psycho-educational.
4. Peer workers/health coaches.
5. Appropriate safe prescribing of medicines, including support from community pharmacies.
6. Groups – including managing mood, mindfulness, ongoing peer support and self-run support groups.
7. Family support and family intervention where indicated.
8. Social support - access to community support workers (CSWs), social workers at primary care level. Need to ensure getting optimum benefit from currently funded CSWs within primary care. This may be the priority before starting groups where it can be challenging to take on new learning or treatment until some of the basic needs are met.
9. Clear process for managing delay - if there is one – tele-health, regular phone follow-up from practice, interim support and/or self-management.

References for evidence base can be found in reference section page 88.

3.4 Dealing with distress and screening for disorder

“New Zealand men are particularly bad at asking for help. My advice to others is to try and get the support you need as soon as you are starting to feel low. I wish I had persevered three years ago when I first needed help. I wish it was easier to get help.”

The action plan encompasses two distinct but related dimensions of mental health – distress and disorders. Early intervention practitioners in NGOs and general practices will frequently encounter people who are mentally distressed but are not necessarily suffering from a mental disorder. Instead, the distress is a normal (often intense) response to a challenging situation. Practitioners will also encounter people who are in the early stages of a mental disorder that may not be readily attributed to a single situational crisis.

The distinction – between mental distress and mental disorders – will require a frontline workforce that can alleviate distress as well as being able to detect the early stages of a mental disorder. Their tasks will be to manage distress and refer people who have signs of a mental disorder to a treatment service. (Sir Mason Durie, 2016)

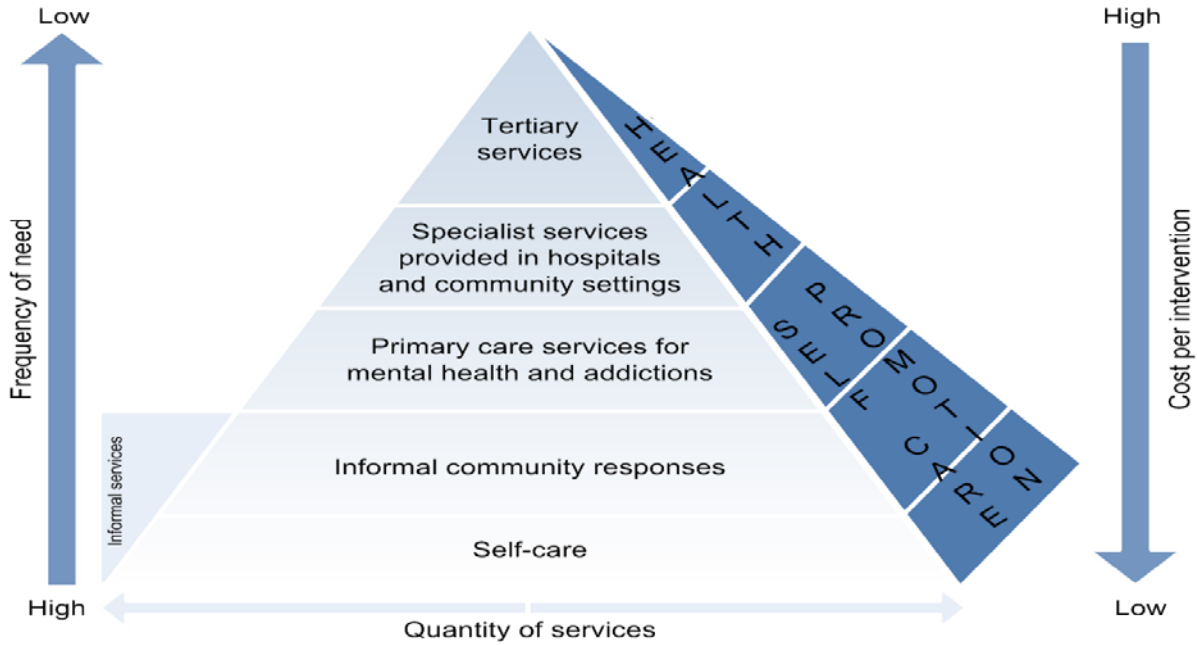
3.5 Mental health integration with primary care services

Primary care plays an important role in the delivery of mental health services. *Blueprint II* recommended that the mental health and addiction sector fully implement the stepped care approach – i.e. intervening in the least intensive way to get the best-possible outcomes. Features of a stepped care model are:

- Using the least-intrusive treatment required to meet presenting need.
- Access to interventions with differing levels of intensity.
- Matching people’s need to the level of intensity.
- Entry and exit at any point.
- Using robust tools to collect outcomes data to support people’s journey into, through and out of services.
- Having clear referral pathways between different levels of intervention
- Supporting self-care as an important aspect of managing demand across primary, community and specialist care settings.

The diagram below illustrates a stepped care model.

Figure 7: The stepped care model.



The World Health Organisation has recommended 10 ways to integrate mental health in primary health care. See Attachment 8 for more detail.

3.6 Digital health

Digital health opens the doors to innovation and reaching more people, and more people being able to reach resources that can help. It is an area for a somewhat cautious approach and requires effective governance and safety processes, given the digital world is also unregulated and open to misuse. Youth and young people live in it - it's business-as-usual to them, so we have to take up those opportunities it provides.

The advancement and potential of digital health gives very real opportunities to extend reach for people to access information, tools, resources, therapy, peer support, and taking a central role of managing our own care through portals to health records, self-assessments, etc. There is growing research activity and innovation in this area. Sadly, it can take a very long time to translate research into routine daily practice (some say 17 years). This will not work in the digital health area. The rapid nature of digital development struggles to keep-up with the even more-rapid rate of technology changes and consumer-driven preferences – Apps and social media, for example, are highly affected by market popularity. Given this, we may need to feel more comfortable with not having the full randomised control study before we feel confident it provides benefit.

PART B: THE ACTION PLAN

A fundamental principle of this action plan is to promote health, wellbeing and resilience, alongside prevention and intervening earlier in the onset, course and adverse impact of mental ill-health and addiction issues. The ability to continue to “treat” ill-health continues to be essential but we need to balance and shift some focus to enable different outcomes and experiences. A simple analogy would be – currently, the majority of our eggs are in the ‘treat ill-health’ basket, with resources primarily focused on people once they become unwell/very sick. We must invest some eggs in the other basket that supports not getting unwell and experiencing the level of distress that goes with that.

We do have some existing assets on which to build this plan. They are summarised below.

4.0 Existing Assets

4.1 Community Assets

The Waitemata district’s three main areas of West Auckland, Rodney and North Shore, the associated electoral wards and localities, have an eclectic mix of social and community development initiatives. We will not note them all here but the communities in those areas have a range of networks, groups, and collectives informal and formal where people who care put energy, time and resource into building “communities”. This is not intended to make a statement that there is enough but to indicate the foundations are there. New suburbs are popping up rapidly. Older, more rural communities have strong foundations for the way in which formal organisations and NGOs work together – for example, the Helensville community, while communities like Whangaparoa have fewer community networks and support systems. Health workers describe how knowing each other makes it easy to work across organisations to practically support people. A full community asset-mapping process has not been undertaken but would be extremely useful.

4.2 Non-Government Organisations

Waitemata has a thriving and vibrant NGO sector providing community support, funded primarily for people who are, or have recently been, linked with DHB provider arm community mental health services. They are not age-specific but are more-developed in the area of adults, where the majority of resources have been directed over the past 20 years. Partnerships with clinical teams are, on the whole, working but do vary. The capability and capacity of NGOs to provide a diverse range of services and supports for people has grown over the years but in a limited way for primary care. In the past year, it has been agreed to progressively move towards 10% of the NGOs’ current contract being available for access directly from primary care.

The Shared Vision forums set up over the past 15-20 years have been grass-roots networks with a particular interest in mental health and addictions. People in our communities come forward to work together and support each other. West Auckland, North Harbour and Rodney shared visions link into the Waitemata Stakeholder network (WSN). This network has been active in collaborating across NGOs, community networks and DHB provider arm services for mental health and addictions. The WSN recently updated their stakeholder plan. The ‘*Our Health in Mind*’ Plan has attempted to incorporate, or reinforce where relevant, those activities. The networks are keen to resolve issues relating to knowing who to go to, where and finding their way around the various community, NGO, primary care and DHB resources. Many in North Shore see Raeburn House as a key holder of that information. Their new App as a directory is a great resource that could be widened further.

The Youth Health Hub is primarily located in Henderson and has an outreach centre now open in Glenfield. The hub was developed with an integrated model in mind where young people could access a range of health care resources. For mental health and addictions, they received the bulk of funding with a tag for youth initiatives, including the Prime Ministers Youth Mental Health Initiative. The DHB Child and Youth mental health teams and CADs – Altered High have strong working partnerships. The hub is now a point of access to those services and assists as a point of triage into the specialist teams (as part of the choice and partnership model).

NGOs are beginning to develop collaborative initiatives with primary care – the main one being Odyssey House, providing support into Totara House. Pathways have also expressed an interest in this. All NGOs are keen to work actively as part of a primary health system and could take a more prominent role in supporting people over time who do not require full access to specialist mental health teams but do require access when needed.

4.3 Primary Care

Waitemata PHO / Comprehensive Care Ltd offer primary mental health programmes for their collective of practices. Populations are funded by the DHB through specific funding tagged for primary mental health. East Tamaki Healthcare, while under the umbrella of ProCare, provides their own programmes. Funding also enables extended consultations for the GP and/or practice nurse. The reality is that it is not used much for practice nurses.

The total funding pool for primary mental health and addictions, for current population of 597,500:

General	\$2,113,938.
Youth initiatives	\$1,099,395.

DHB funding path total **\$3,213,333.00**

Funding is prioritised, with a methodology for funding allocation to PHO and then to practices by population demographics – i.e. Māori, Pacific and Decile 5. Variation in access levels to these programmes is a reality, just as we have variation in referrals within practices. Waitemata PHO experienced a significant shift in funding away from the PHO at the beginning of the funding year 2014/15, restricting GPs' ability to refer to the lifestyle options programme. Some just don't refer now. We have not been able to identify if PHOs add additional funds to the programmes they provide.

Most recent full-year reporting (2014-15) on primary mental health contracts is shown in Figure 8.

Figure 8: Number of people where the service is begun or delivered in the Quarter

Overall client info. People seen in total	Q 1	Q 2	Q 3	Q4
Age 12-19				
Females	336	244	170	96
Males	255	165	126	73
Total	591	409	296	169
Age 20+				
Females	929	742	891	1,350
Males	521	374	423	754
Total	1,450	1,116	1,314	2,104

Ethnicity total by Q Full table by Age (12-19 and (20+) in Attachment XX				
NZ European	1,051	841	800	1,266
Māori	568	391	413	522
Pacific Island	186	120	114	192
Asian	98	87	85	133
Other	141	102	146	154

The elements purchased are:

- Extended consultations: of the total 4,221 extended consults for the year
 - 32 of them were by practice nurses, of which 27 were in Q4.
 - 176 were for 12-19-year-olds
- Brief intervention counselling (BIC) usually 1-2 sessions – 1,249 (people but not necessarily distinct individuals as the reporting describes number of BIC started and delivered in the reporting quarter)
 - 51 were for 12-19-year-olds
- Alcohol brief interventions (ABI) - 618 (reporting as above)
 - 418 were for 12-19-year-olds
- Group therapy: a total of 794 group sessions started and completed in the quarter
 - 270 sessions for 12-19-year-olds, with average number per group of six
 - 524 sessions for 20 years-plus with average number per group of 6.5
- Packages of care – doing a care plan with client and plan involves series of interventions (such as CBT, medication reviews, counselling and other psychosocial supports not covered above)
 - 1,151 Packages of care for 12-19-year-olds with average number of sessions as five
 - 1,969 packages of care for 20 years-plus with average number of sessions as 6.5

Quantifying the treatment gap has not been possible. Qualitatively, from individuals and families, GPs and primary mental health programme provider teams, there is a clear pattern in the feedback of a number of people needing access to programmes but not getting it. This is for a variety of reasons:

- They don't meet criteria established in the contract measured often by Kessler score – so, either not sick enough or too unwell. But then they are described as not getting into secondary services, either.
- GPs have stopped referring.
- Diagnosis is often not recorded in primary care notes due to concerns about stigma and impact on health care insurance.

4.4 Primary and secondary care collaborative working.

The pilot in New Lynn (Totara Integrated Health Centre - TIHC) initially evolved from discussions with ITHC Pro Care and the Waitemata provider arm about developing a stepped care model. The pilot was then initiated with the appointment of Dr Lyndy Mathews in April 2014 and starting in practice in October. The New Lynn Integrated Family Care Centre has 14 GPs. The core element of this has been 0.1 of psychiatrist, 0.2 mental health Nurse and 0.1 OT. An evaluation is due to start in the next month.

Figure 9: Psychiatrist Clinic Findings: Preliminary finds from pilot

Note: Six people were seen by both the psychiatrist and mental health nurse

	Number of people referred	Number of people seen	Number of people that did not attend (DNA)	Number of people seen twice
Psychiatrist	100	94	6 (6%)	6
Mental health primary care liaison nurse	89	72	17 (19%)	3
Total	189	166	23 (12%)	9

- The 94 people seen by the psychiatrist (Dr Matthews) were for an average of one session, primarily for brief assessment, advice to person and to GP. Dr Matthews provided a telephone advice line to the 14 GPs. During Oct 14-Oct 15, the number of calls received was 10. Diagnosis, medication and management advice was the most common reason for GPs referring to Dr Matthews. Being physically based alongside GPs and using their clinical records system is a critical success factor to date. 47% of presentations seen by the psychiatrist presented with depression/anxiety. 12% of presentations were for psychosocial stress only. 10% presented with bipolar affective disorder. 7% presented with alcohol or drug issues.
- Of the 72 seen by a nurse, (mental health primary care liaison nurse), 53% of people presented with depression and anxiety. A number of GPs were referring to the mental health nurse for psychosocial stress and these referrals often led to referrals to NGO support services. 82% of people remained under the care of the referring GP. 13% of people were referred to the anxiety group which is run by the Waitemata DHB occupational therapist. 5% of people were referred to secondary services.
- The occupational therapist provided on-site group work (later in partnership with practice nurse). The anxiety and depression group was attended by people from primary care and secondary care team referrals.

(Source: Preliminary (Quantitative) Findings of the Waitemata DHB Mental Health Services Pilot Within the New Lynn Integrated Family Care Centre – Jan '16. S Griffith)

A separate full report on this pilot is available from the DHB provider arm.

This model is highly valued by the GPs in the centre. Dr Peter Woolford, one of the lead GPs, reports very positive feedback from the GPs and has observed an increase in learning and confidence in the GPs and

practice nurses as a result. Alongside a range of other DHB services, a child and youth psychiatrist also provides a clinic.

The primary care liaison nurses in the West Auckland mental health teams are linked to a range of practices and, to date, this has received positive support. In Rodney, the relationships vary with primary care and, while in physically close proximity, the level of integration is of a different nature than the New Lynn experience.

Proximity is not an indicator of experience of support and collaborative working. There are a number of psychiatrists providing access by phone and some doing more clinics in GP practices.

CADS provide an advice line to GPs provided by a GP who is now dually trained in addictions. While the presence of the advice line was widely communicated, it did not appear to be well-known about or used. Mental health services for older adults noted an improved relationship with primary care, with frequent communication. There is some sense of variation of referrals within and across GP practices.

This is just a very high level and brief account of some of the developments to build relationships and infrastructure from secondary mental health and addiction services to primary care.

5.0 Key components of the action plan

The structure of the action plan's framework has been developed to align with the WDHB Outcomes framework. It is also informed by public health frameworks for improving health outcomes, through focus around promoting health and prevention – primary, secondary and tertiary - these are outlined earlier in the document but essentially they focus on: (Byrne & Rosen 2014)

Promotion – approaches that build optimal wellbeing, health and resilience, through increased awareness, knowledge and skills to live well, stay well and for everyone and for those more at-risk of becoming unwell and for those who have already developed health issues, to support their recovery to stay as well and possible (in all areas below)

Primary Prevention – actions and strategies that look to prevent ill-health occurring in the first place, to strengthen protective factors and our resilience that help us get through adversity that we come across in life, or part of our make-up (genetics) and to mitigate risks we may be exposed to. One of the key high level aims of primary prevention is to reduce incidence. Primary prevention is usually approached at three levels

- Universal – for whole population
- Selective – for what is described as at risk sub-groups of population
- Targeted – specific cohorts or groups

Secondary Prevention – synonymous with early intervention: looks to restore health and wellbeing as early as possible in the onset of ill-health/symptoms. It aims to recognise early signs of ill-health, so that provision of support, responses, treatments known to work, can be provided before illness/experiences create suffering, harm and adverse life-time impacts and/or longer-term compromising of health.

Tertiary prevention – attention is on retrieving, alleviating and/or reducing adverse impact of an existing longer-term health issue on a person's wellbeing, health status, life roles and social

connectedness. It is a key element of “recovery” and living in the presence and/or absence of ill-health.

The overarching principles for the actions in the plan listed below.

- People and family/whanau-centric.
- The earlier the better (in life course and when help is sought).
- Our health includes mind, body and (for many) spiritual needs.
- Address differences in health and life outcomes for some population groups.
- Take a strengths-based approach.
- Build on existing capability.
- Integrate programmes where it makes sense to.

5.1 Three goals aligned with DHB purpose

The three goals for the action plan are listed below.

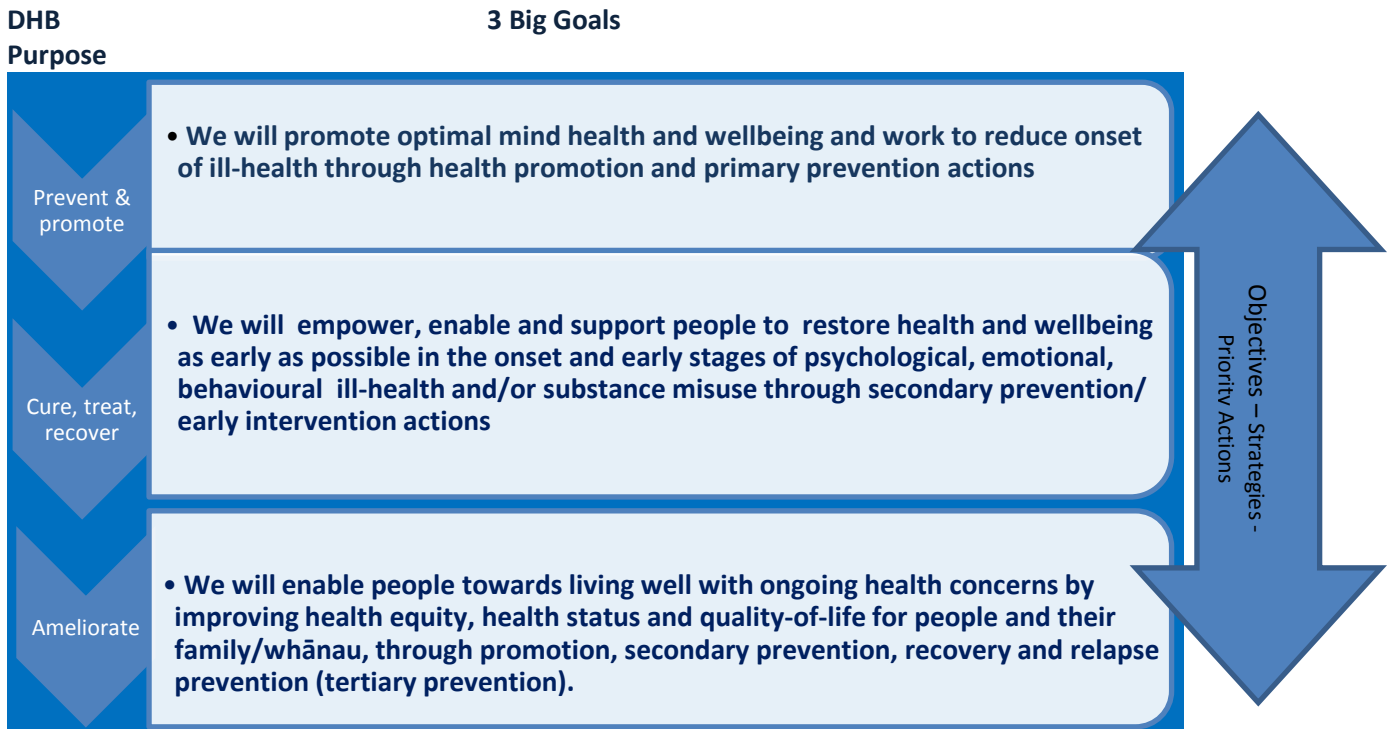
1. Promoting optimal mind health and wellbeing and to reduce the onset of ill health through health promotion and **primary prevention**.
2. Reducing harm, suffering and adverse lifetime impacts associated with substance misuse and high-prevalence mental health conditions through **secondary prevention** and early intervention.
3. Improving the health equity, health status and quality-of-life for people and their family/whānau who live with enduring health issues through **tertiary prevention**.

5.2 Five whole-of-system enablers to drive the system

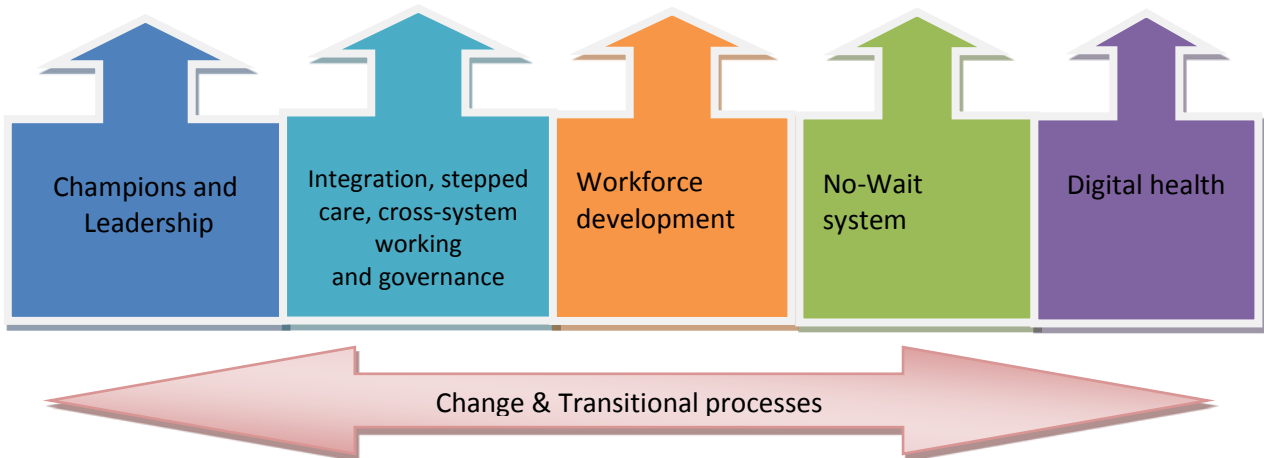
Five whole-of-system enablers have also been identified:

1. Champions and leadership
2. Integration, stepped care, cross-system working and governance
3. Workforce development
4. No-wait system
5. Digital health

Figure 10: The action plan framework



Whole of system enablers, to help achieve the 3 Big Goals





5.4 Goal One - We will promote optimal mind health and wellbeing, and work to reduce onset of ill-health through health promotion and primary prevention actions

Ten-year Objective - By 2025 we will “reduce onset, incidence and duration” of mental health and addictions problems in the population of Waitemata DHB.

Our Health in Mind. What needs to change?	Objectives 2016-2021	By When	Resource Comments
We will simplify navigation to, around and through the system of services by building on existing resources and better connections e.g. Raeburn House, national tele-health services provided by Homecare Medical, Healthpoint, role of NGO and primary care health support and cultural support workers.		2017	Full business case will determine details Who / Leads Tbc once plan agreed Build on existing with additional resource.
We will achieve enhanced and, where appropriate, integrated health promotion activities and programmes. <ul style="list-style-type: none"> a. For youth and children. b. For Māori and Pacific communities. This will include with primary care, PHOs, DHB child health services, DHB CAMHS and Altered High services, and NGO providers to young people, Alternative Ed, and school based health services – to avoid duplication, mixed messages and reinforce integrated mind, body and spiritual health.		2018	Collaboration across existing entities and some new resource.
We will actively support local implementation of national programmes and/or design where needed of up to three selective primary prevention programmes to strengthen protective factors that help lessen or resolve problems when life gets really tough and we may experience the known risk factors for developing distress and/or disorders. This needs to include addressing and challenging misunderstandings and stigma. <ul style="list-style-type: none"> a. Children (3-13), youth and young people (14-24), through schools, community organisations including churches, sports and youth clubs. b. Parents. c. Māori and Pacific communities with culturally relevant programmes (one for each). <ul style="list-style-type: none"> i. This will include development health promotion (mental health literacy, dealing with distress, whānau resilience) that integrate mind, body, spiritual approaches in language that has resonance. Access via social media .eg Facebook page, Apps. ii. For youth, it will follow youth development model – to focus on their potential and skills 		2019	Some existing resources and skills locally. However, likely to require investment of new resources, including \$ and people, to get to level suitable for <i>selective</i> approach.

<p>for living e.g. Te Kete Whanaketanga—Rangitahi (Simmonds et al 2014).</p> <p>d. Programmes for Asian communities in mind and body health promotion, health literacy, including as relevant - substance misuse, mental health, navigation, dealing with distress, De-stig. (in relevant formats, language).</p>		
<p>We will identify and complete minimum of five indicated primary prevention programmes, including specific screening, self-management resources, (digital and paper) and building resilience and protective factors (or ensure access to if they are already available).</p> <p>a. Positive pregnancy test to result ensure primary provider (Lead Maternity Carer - LMC, GP, family) receive appropriate advice, information and knowledge for protecting health and wellbeing, especially for those who may not be consistently in contact with a health care provider.</p> <p>b. Screening and action for alcohol use in pregnant women (see Foetal Alcohol Spectrum disorder guidelines).</p> <p>c. Pre-natal and post-natal: enhance support for people with existing/known mental health and/or substance misuse issues.</p> <p>d. Children and young people with parents who have lived experience of mental health and/or substance misuse issues.</p> <p>e. People, their partner and family/caregivers with recently diagnosed long-term medical conditions, including dementia.</p> <p>f. People who have experienced trauma and/or loss i.e., loss from suicide, loneliness as a result of death of life-partner, refugees and asylum seekers.</p> <p>g. People caring for a partner with age related conditions and loss of function i.e. dementia, cognitive impairment and stroke.</p> <p>h. Exposure to violence and/or abuse in the family/home (e.g. elder, child, women) – while screening is occurring may need to ensure people have access to resilience and protective factor and prevention resources.</p>	<p>2019</p>	<p>Review existing national and international programmes to build on.</p> <p>New and collating for specific groups so it is acceptable, has utility and is accessible in terms of language and medium of delivery.</p>
<p>We will be able to accurately measure and describe how widespread issues relating to positive and adverse substance misuse, mental health and wellbeing are for the population living in Waitemata district (prevalence) - with an agreed approach to:</p> <p>a. Supplement use of annual NZ Health Survey Data with additional localised activity.</p> <p>b. Bid for research grant to undertake two population prevalence studies. Sample i) to be completed in Dec 2016 and ii) Oct/Nov 2021. We describe prevalence within sub-populations and show the differences from December 2016 in mind, body, and for many, spiritual well-being.</p>	<p>2021</p>	<p>Existing people and work together to agree common measure of wellbeing.</p> <p>Make bid for research grant.</p>
<p>We will have worked with communities, health promotion groups, schools and employers to make sure that</p>		

<p>district wide universal health promotion and literacy programmes are available and can be useful to all communities. This will include:</p> <ol style="list-style-type: none"> Addressing and challenging misunderstandings, and stigma. Programmes that will raise awareness and equip people, families/whānau, with the knowledge and skills in staying well, keeping well and getting well (Five Ways to Wellbeing). Approaches to tackling and/or lessening harm from substance misuse. What to do when you notice things are not quite right (bad head space), how and where to go to seek help early, and practical strategies in self-management. 	2021	<p>Material is mostly available from health promotion agency, Mental Health Foundation, digital, etc.</p> <p>Resource would be to promote those tools and assess level of utility of them by specific groups.</p>
<p>75% of staff, in health-funded organisations serving the population of the Waitemata District, will have had access to training in a suitable programme that equips them in promoting positive mental health and use of substances, how to navigate the system, what to do in crises, tackle stigma and seek help for others or themselves.</p>	2021	<p>Review which existing programme to use, may need to adapt it.</p> <p>Support for one-day training.</p>
<p>WDHB Board and Executive will influence and support the roll-out of programmes in wider organisations serving the Waitemata District. (Govt agencies e.g. Justice, emergency services (Emergency planning), MSD, etc.).</p>	2021	<p>Existing people in roles with leadership influence.</p>
<p>Sponsor programmes in schools and workplaces generally on promoting positive mind health, stigma reduction and help seeking options.</p>	2021	<p>Assess need for specific sponsorships and work with Well Foundation potentially to support this.</p> <p>Some workplaces link into existing programmes.</p> <p>School-based programmes developing NZ and internationally.</p>
<p>Priority Actions – Where we will start. DHB has the role as influencer, collaborator, funder, promoter, integrator and facilitator of programmes.</p>		
<p>Priority Action Goals 1.1-12</p> <ol style="list-style-type: none"> Strengthen and promote existing resources as options for improved navigation (Tele-health via Homecare Medical) and Raeburn House (but needs to broader remit to whole district). Mental health literacy and cultural competency for health workers is a priority to reduce experience of stigma and differential response, support early help seeking and timely access to appropriate sources of help and support (any door is the right door). Use positive pregnancy result as a trigger to identify early opportunities for improving support, strengthening support networks where the woman is known to be in vulnerable situation (via 		<p>Existing and new resource.</p> <p>Integrate, promote and train.</p> <p>Integrate screening where not already consistently</p>

<p>maternal and LMC network Te Aka Ora), teen pregnancies</p> <p>11. Focus on potential harm from alcohol misuse, particularly in women with positive pregnancy test, young people, and Māori and Pacific communities. Implement national guidelines (Ministry of Health (2015)). (For 2015, of 7383 births: 6663 no alcohol (90%), 40 some alcohol (0.5%) and 680 unknown (9%), so some improvements in screening could occur).</p> <p>12. Work in partnership with local employers and schools.</p> <ol style="list-style-type: none"> Normalise psychological distress, along with physical ill-health and establish core wellbeing and health-promoting thinking and behaviour habits. Support/promote access to existing tools for resiliency building. Promote help-seeking by and with individuals and families/whānau – need defined and determined by them: through people they know, online. <p>13. Allocate resource to commission culturally relevant resources and tools with utility for Pacific and Māori communities for promotion, addressing stigma, navigation and suicide prevention (including budget allocation to suicide prevention programme).</p> <p>14. See workforce enabler - fund senior clinical and youth leadership roles for fixed-term to lead development and implementation of promotion and prevention (and Goal 2) for youth and young people: for Pacific and for Māori communities.</p> <p>See also Digital Health enabler for safe use of media. See Attachment 9 or the strategies related to Goal One.</p>	<p>done.</p> <p>Potentially joint-quality improvement programme.</p> <p>Identify someone or people to do this (new and or existing). Ensure resources are widely available. Specific initiative – new health promotion /community development.</p> <p>New – funding for people, production, then integrate into existing programmes and providers.</p> <p>New funding for fixed term, agree who employs/takes lead for the district and system.</p>
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<p>5.5 Goal 2 - We will empower, enable and support people to restore health and wellbeing as early as possible in the onset and early stages of psychological, emotional, behavioural ill-health and or substance misuse through secondary prevention/early intervention actions</p>		
<p>Ten Year Objective: By 2025, we will reduce the duration of untreated ill-health, work to minimise harm and enable people to stay in their job, school, or life roles to remain in and/or return quickly to healthy, socially connected, active and productive lifestyles.</p>		
<p>Our Health in Mind. Objectives 2016-2021</p> <p>What needs to change?</p>	<p>By When</p>	<p>Resource Comments</p> <p>Full business case will determine details Who / Leads Tbc once plan agreed</p>

<i>“When I realised I was totally broken from years of avoiding getting help.”</i>		
<p>Complete implementation of specific project to quantify and describe what is required to close the gap between current services and programmes for “Missing Middle” (across all ages) - who this is, how many are not accessing timely help, support and treatment, what are the barriers, their specific treatment and support needs and ensure access to appropriate level of treatment packages through collective actions of primary and secondary services.</p> <p>This needs to include the following:</p> <ol style="list-style-type: none"> People who could be described as “hard to reach” as their health and/or social issues make it extremely difficult for them to get to or have face-to-face contact with health providers, support workers e.g. mobility, social phobias, extreme anxiety issues, homelessness, poverty. People who are assessed by services as “not sick enough” or “too unwell/acute” for either primary care programmes or secondary services. Low and often late access by Māori, Pacific and Asian communities. Affordability issues. 	End of 2017	Existing and time-limited new resource for specific project to help determine unmet need.
We will minimise and reduce unexplained variation in screening, detection, treatment and referrals from GPs, practices nurse to primary care and NGO-delivered treatment (for all people but with a particular lens on group with known higher-risk factors).	2019	Links with Health Pathway implementation: better communication and connections.
Primary Care and ED staff will meet agreed targets for consistently implementing existing healthy lifestyles package for reducing harm associated with substance misuse , alcohol and cannabis.	2019	Look at use of ABC approach - widely used and good knowledge about it – for smoking cessation – not as suggested for other substances – such as alcohol. Whanganui Regional PHO GP Dr John McMenamin has developed a computer programme which makes screening for alcohol problems and the provision of follow-up support easier within a primary mental health context.
Implement the Waitemata Stakeholder Network (WSN) Employment strategy “Everyone’s business” , ensuring equitable return to paid employment for Māori and Pacific people being supported in mental health and addiction services (DHB, NGO) and primary care programmes.	2019	Existing Plan In DAP 16/17 and seeking some resource for implementation.
<p>Provide evidence of improvement in shift towards focus on early intervention in life course (age, developmental level) and onset of ill-health and substance misuse indicated by:</p> <ol style="list-style-type: none"> Integrated screening in ante-natal and post-natal programmes (early detection) and full implementation of health pathway for maternal mental health. Support and enable parents, youth-based organisations and schools to do more, earlier. 	2019	<ul style="list-style-type: none"> Existing and implementation support. Parenting programmes, community

<p>c. Increased focus on young people and families with (30-40% increase access to organised responses across the system – digital and tele-health, school-based programmes, primary care, NGO, community and DHB specialist services).</p> <p>d. Implementation of priority pathways (described in regional health pathways), early detection, intervention and recovery (be well, stay well and get well) for 4-13 years and highest points of age of onset (14-24 years) - youth based services</p> <p>e. Improvement in development goals for young people measured through age and culturally appropriate tools – Pacific and Māori youth: e.g. Te Kete Whanaketanga—Rangitahi.</p>		<p>linkages with youth groups and schools – agree some priority actions with them.</p> <ul style="list-style-type: none"> Existing and enhanced resources. System support for pathways development and implementation. Development role previously noted. New and existing.
<p>We will be able to measure the reduction in delay to treatment from an established baseline to be done in year one (2016/17) to an agreed half-way target – aiming at minimum of 5-10% improvement by years two and three (2018/19) and 15-20% years four and five (2020/2021).</p> <p>i. Reduce the delay from first onset of symptoms to first point-of-contact with health professional (all ages) – particularly for Pacific and Māori.</p> <p>ii. Reduce delay from first point-of-contact with health professional to starting appropriate treatment options (all ages).</p> <p>iii. Reduce delayed and under-treated ill-health for all ages and enhanced for indicated groups (to note for each of the below):</p> <ul style="list-style-type: none"> Depression and anxiety Alcohol and substance misuse Psychosis - prodromal phase and early detection. 	<p>2021</p>	<p>New resources that assist with:</p> <ul style="list-style-type: none"> Earlier help-seeking (already noted) Improving responsiveness to youth and particularly Maori and Pacific whānau/ Fono Assisting us to develop a measure for delay at various points (not just secondary care) and measure this consistently. Providing more access to young people through schools, youth groups, youth NGO provision and promoting their use of primary care. Earlier detection of prodromal symptoms in primary care and then fast access to specialist advice and contribution.
<p>Reduce the intervention gap by 50% in five years and in two years by minimum 20% for organised responses (once established) to improve access to subsidised and affordable levels of known effective treatments, group programmes, support packages and where person/families level of need/presentation matches the evidence for good outcomes.</p>	<p>2021</p>	<p>New</p> <p>Increase access to funded and subsidised access to treat programmes and NGO support.</p> <p>When intervention gap is properly quantified, can agree investment plan (see above).</p>
<p>Reach equity in outcomes through equity in access to brief interventions, self-management and talking therapies for Pacific and Māori youth and families. Objective in 10 years is to achieve level outcome through access to treatment and support relative to prevalence for those population groups – with a focus on positively contributing to the development of youth.</p>	<p>2021</p>	<p>Existing and new as noted previously.</p> <p>Needs to include increasing availability of Māori and Pacific providers with demonstrated track record of improving access and health outcomes for these</p>

<p>Reach target of halving the suicide rate in five years and zero suicide in 10 years by 100% implementation of currently agreed suicide prevention (there is considerable debate on this)</p> <p>a. Focus in next five years is on halving rate of complete suicide of people who have points-of-contact in the past month, leading up to an attempt/completion (GP, Emergency Department, Specialist Mental Health Services).</p>	<p>2021</p>	<p>communities.</p> <p>Existing Plan and programmes.</p> <p>Investment into suicide prevention programme (priority actions) that already exists and updating this after 2017.</p>
<p>Priority Actions</p>	<p>Comment</p>	
<p>Priority Action Goals 2.1-2.12</p> <ol style="list-style-type: none"> 1. Invest in additional access to talking therapies, self-management programmes and mindfulness on an individual basis and prioritise more group provision at primary health system-level. This should include: <ol style="list-style-type: none"> a. Revising how these programmes are funded and most cost-effective contracts. b. Promoting extending use of existing digital and tele-health tools and building access over time to other options. c. Including access to social support through NGOs. 2. Initiate programme/needs assessment project to quantify and describe actual unmet need. 3. Prioritising and potentially incentivising screening and brief interventions for alcohol. 4. Make available by June '16 access to specialist advice to a GP. <ol style="list-style-type: none"> a. Access to a psychiatrist for specific medical decision-making on treatments and diagnosis via phone, e-referrals. b. Ensure all GPs are aware of existing GP helpline from Community Alcohol and Drugs. 5. Build capability and capacity to identify early and treat early with evidence-informed effective interventions (more than but including medication where indicated). <ol style="list-style-type: none"> a. Prioritise access for practice nurses to credentialing programme. b. GPs to increase general skill and knowledge-development via CME sessions, peer review, peer consults via phone, email etc. (just-in-time learning), c. Increase availability of direct in-reach to primary care of specialist multi-disciplinary expertise – psychology, nursing, psychiatry, social work, occupational therapy – (see also integration) 	<p>Increase current investment by 20% by 2017/2018 budget year.</p> <p>Review commissioning process to ensure best value for money.</p> <p>Review capacity for increasing access to NGO community support.</p> <p>Joint needs assessment initiative across agencies started by July/Aug '16.</p> <p>Consistent implementation of existing programmes and investigate other models nationally.</p> <p>Already underway. Need to formalise and make consistent, promote with primary care.</p> <p>Needs some attention and focus with:</p> <ul style="list-style-type: none"> - Prioritised investment for continuing and extending credentialing programme for practice nurses in Waitemata District. - Work with existing programmes of CME and peer review - Existing in some areas - agree timeline and development programme for in-reach with cluster of GP practices where they are small-medium size 	

<p>6. Encourage and increase use of extended consults for practice nurses who have been through credentialing programme or already have appropriate skills and support.</p> <p>7. Broad approach through training and creating connections across the health, social, education and emergency services system – the ability to understand and respond to distress and screen for early signs of “disorder”.</p> <p>8. Invest in building capability and capacity in West Auckland for Māori and Pacific child and youth responsiveness, shaped by positive youth development approaches.</p> <p>9. Speed-up implementation of regional health pathways to support this goal.</p> <p>See Appendix 10 for the strategies related to Goal 2.</p>	<p>and possibly different approach for larger integrated health centres to achieve economies of scale.</p> <p>Existing and new with training and support needs.</p> <p>Link with general roll-out of an existing MoH-funded programme or with adaptations / additions</p> <p>New.</p> <p>Existing programme. Need to clarify what requirements are for effective implementation.</p>
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<p>5.5 Goal 3 – We will improve the health equity, health status and quality-of-life for people and their family/whānau who live with enduring health issues.</p>		
<p>Ten-Year Objective: By 2025, we will close the gap in health equity, health status and quality-of-life for people living with enduring co-occurring physical and mental health issues and that of their family/whānau.</p>		
<p>Our Health in Mind. Objectives 2016-2021</p> <p>What things need to change?</p>	<p><i>By When</i></p>	<p><i>Resource Comments Full business case will determine details Who / Leads Tbc once plan agreed</i></p>
<p>We will have resolved barriers for access to care for physical health issues for people with longer-term mental health and substance misuse needs.</p> <p>a. We will have integrated approaches and provision where required through shared care/collaborative care arrangements:</p> <ul style="list-style-type: none"> • Determined by negotiation with the person and family/whānau. • Relative to need, acuity and complexity. 		<p>Existing programme of work but needs specific funding. Number is around 2000 people with funding for up to five extended consults and linking into existing long-term conditions programmes where pertinent.</p> <p>Link with developing models for integrated</p>

b. For the people who have lived with a co-occurring issue for more than two years.		care and shared governance.
Health care pathways for long-term conditions will be explicit , as a component of standard care, about the process for meeting the emotional, behavioural and mental health aspects of those conditions.	2018	Integrate into existing programmes. Need to audit and then track detection and access to appropriate treatments already funded in those programmes - may need to assess whether this is right level of funding or not.
We will reach appropriate level for a consistent approach across primary and secondary health providers of funded programmes service delivery programmes for access to, and content of, self-management programmes, both individual sessions/coaching and/or group programmes for improved mind/body health.	2018	Establish commissioning and quality review process across providers that asks the question: 'What should be the rationale that guides difference and/or consistency between programmes? Where should they be different and for what groups?'
We will identify then resolve barriers that may exist for people with long-term physical health conditions accessing known treatments that work, within long-term conditions programmes, for their psychological and emotional health care needs.	2018	
All people with current and emerging long-term conditions (physical and mental health) will have had the opportunity for referral and participation in self-management programmes (group and/or individual).	2019	Need to identify numbers and pathways to most relevant provider.
<p>People with longer-term mental health issues who do not require the current level of specialist secondary service support will have:</p> <p>a. Their main source of ongoing support, monitoring, and core health/medical care needs met and based within NGOs and primary care.</p> <p>b. Rapid (just-in-time) access to specialist assessment and treatment will be available via specialist in-reach into primary care and/or referral back to secondary services.</p> <p>c. Agreed phased transition by service and practice e.g. start with Pacific service, services/practices and teams where partnerships already have solid foundation.</p>	2019	<p>Link with existing WSN plans, provider arm planning.</p> <p>Needs clear transition-planning that is centred around the person and family/whānau.</p> <p>Can be supported by NGO and primary care capacity – assess any resource implications.</p>
<p>All people with long-term conditions will have access to:</p> <ul style="list-style-type: none"> Information programmes and treatment aimed to prevent the onset of mental health problems (wellbeing focus) via their workplace, healthcare provider and community groups. Advice, education and interventions that promote wellbeing, optimum health and prevent onset of further mental health and/or physical health issues including exercise, nutrition, sleep, social 	2019	Resource impact for existing and new resources requires assessment.

connectedness (integration approach to health and wellbeing).		
<p>Promoting optimal health and prevention (also noted in goal one)</p> <p>Early in the onset of long-known long-term conditions, people and their family/whānau will receive advice, education and interventions that promote wellbeing, optimum health and prevent onset of further mental health and/or physical health issues including exercise, nutrition, sleep, social connectedness (integration approach to health and well-being).</p>	2019	Noted previously.
<p>We will reduce the gap in equity of health and life outcomes for people with enduring mental health and enduring physical health conditions through timely access to appropriate physical and/or mental health treatments as measured through an improvement in scores for:</p> <ul style="list-style-type: none"> • Individual health outcomes using an agreed tool e.g. EQ-5D • Carer measure • Symptom measures • Qualitative measures of experience and satisfaction • Measure of wellbeing, employment/education, (for those of working age). 	2021	<p>Existing and new.</p> <p>Need to develop a specific programme of work with allocated resource (e.g. Fellow) to do proper evaluation process, including:</p> <ul style="list-style-type: none"> • Measure met and unmet need • Agreeing tools for measuring different areas. <p>Supporting programmes that help achieve all above relevant objectives.</p>
We will show a reduction in health inequalities that exist for Māori and Pacific Whanau/Fono in this area.	2021	As above.
Priority Actions		
<p>Priority actions 3.1- 3.5</p> <ol style="list-style-type: none"> 1. Endorse and implement actions for first 12 months (to 2017) with a focus on agreeing opportunities and models for integrated responses. 2. Quantify the size of the opportunity accurately and identify people for urgent integrated collaborative care. <ol style="list-style-type: none"> a. Complete audit process in Mental Health and Addictions provider arm. b. Undertake audit in LTC programmes in primary care of detection of MH problems and adequacy of access to psychological treatments. c. Undertake identification process to answer the following question: “Where are the differential responses in the health system to people who typically have an established “psychiatric” diagnosis?” 3. Commission a review of current contracted primary mental health programmes for adequacy in supply (capacity) and consistency in model (quality) of self-management programmes (individual and group). Develop plan to resolve accordingly. 4. Build on existing work in area of metabolic monitoring in DHB provider mental health services and in primary care with particular focus on building capability in practice nurses in this area. 		

<p>5. Establish clinical/quality improvement fellowship role that will provide academic and practical hands-on service improvement support.</p> <p>See also workforce, integrated services and digital health enablers for further related actions.</p> <p>See Appendix 11 for strategies related to goal three.</p>	
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5.6 Whole of system enablers 2016-2021

5.6.1 Leadership

<i>Objectives – what needs to change?</i>	<i>By When</i>	<i>Strategies – how</i>
<p>1. We have identified leaders (formal and informal) who collectively and individually, promote, develop and resolve sustainability of improving responsiveness to and population health in the Waitemata District.</p>	2019	<p>Identify someone whose job it is to make this happen – not just a part of many people’s roles.</p> <p>Establish early, a leadership development process.</p> <p>Establish transitional roles for whole system to lead and enable transition for key areas over three-to-five-year period (not necessarily based in DHB but need to not be restricted by geography or who employs them to effect change).</p>
<p>2. We have invested specifically in supporting:</p> <p>a. Cross-system leadership for Māori and Pacific populations, for child (families) and youth and for people who live with enduring health conditions.</p> <p>b. Personal leadership for people with lived experience which may result in providing support, coaching and navigation to others or entering other roles in system.</p>	2018	<p>Create opportunities for building personal leadership of individuals who are seeking help.</p> <p>Models for joint-leadership and governance arrangements with the accountability and responsibility for shared outcomes, performance targets and process changes will be researched, with a preferred option being agreed by DHB and PHO Executive for implementation from July 2017. Governance will include Consumer and whānau/family leadership, Māori, Pacific, Asian and youth leadership.</p>
<p>3. Leadership across a system that fosters partnership and collective impact across services, providers and agencies, despite/in-spite of the different clinical and business models.</p>	2018	
Priority Actions	Comments	
<p>Appoint Programme Director – accountable to DHB and PHOs for delivering programme (pending process and phasing of development).</p>	<p>New resource or agreed secondment.</p> <p>Joint agreement with stakeholders on remit, scope and who hosts the role.</p>	

Establish joint leadership and governance group.	
<p>Initiate linking current leadership programmes to support changes, including with senior advisor in health leadership, programme lead, PHO and DHB-identified leads that will, in the first instance, define:</p> <ul style="list-style-type: none"> • What leadership means in this context – clarity of language. • What we need leadership for. • Nature of leadership that is needed by way of issues to resolve the aims. • How to increase/improve and identify leaders. 	<p>Review availability and capacity of existing programmes for provider leadership.</p> <p>Likely to need to invest in developing options for personal leadership of individuals seeking help.</p>
<p>Invest in and appoint transitional clinical fellowships/leadership roles:</p> <ol style="list-style-type: none"> a. 0.5 FTE Child and Youth Clinical Lead three-to-five years provider leadership, service development for primary care early intervention and integration. b. Clinical Quality Fellow for long-term conditions. c. Development and integration lead for Pacific responsiveness' (possibly a secondment) and development and integration lead for Māori responsiveness – fixed-term. 	<p>New, shared roles and reliant on phased process of development.</p>
Each PHO Chief Executive and DHB CEO to actively promote and campaign for positive action for primary and population mental health and addictions.	<p>Need to agree reporting and accountability to who and where and to what degree PHO and NGO CEOs can promote, given they have a broader geographical remit and development strategies linked to other DHBs and own boards.</p>

Whole of system enablers 2016-2021		
5.6.2 Integration, cross system working and Governance		
Objectives – what needs to change? “The step, step, leap experience...”	By When	Strategies – how
<p>We will work collectively to describe and put in place models and local working arrangements to support achieving objectives in Goal 2 and Goal 3</p> <p>a. Recommend actions towards resolving the barriers for some, to primary care mental health and addiction programmes arising from nature of business models (affordability) and competition between providers to enable collaboration.</p> <p>b. Identify clear priorities for a way forward on a range of options in the continuum of shared and integrated care models, for example:</p> <ol style="list-style-type: none"> i. Single provider fully integrated programmes (if that is appropriate for an area or population group). ii. Shared care programmes (for particular groups). iii. In-reach by specialist services multi-disciplinary team staff for advice assessment and brief intervention packages. 	<p>July 2017 To agree models</p> <p>By 2021 to fully implement across the district</p>	<p>Keep as top priority being focused on people and their families seeking better outcomes and experiences rather than professional, organisational and process issues – what matters most.</p> <p>Establish a transitional process that sees a shift in balance of resource and investment in early intervention, more routine triage assessment and early treatment in primary care settings – provided by both generalists and specialists of all disciplines.</p> <p>Learn and refer to pre-existing literature described in NZ, Australia, UK and US to develop best local options, linked with local context i.e. size of practices, other resources in the area, demographics.</p> <p>Provide strategic and practical support and give the joint leadership and governance group the responsibility to:</p> <ol style="list-style-type: none"> a. Work through the development of models of care/ways of working. b. Design change processes. c. Implement transition programmes that achieve their agreed models. <p>Joint-governance and leadership group will need to identify existing data collections processes that could assist this, agree on new measures and processes for collection, collation and sharing.</p> <p>Look at potential of customer rating systems used in commercial sector so that the person/people in receipt of the improved process has a voice in evaluating and that is made public (at the four levels).</p>
<p>Qualitative and quantitative measures will demonstrate improvement in communication, measured annually with agreed criteria to address concerns noted in Attachments 6 & 7 by:</p> <ol style="list-style-type: none"> i. People seeking help and support (e.g. knowing who to contact, where to go, navigation). ii. Family/whānau and clinical staff (e.g. being included, informed). iii. Between primary and secondary clinicians/services (e.g. timely access to treatment advice, sharing of care plan, changes in plan) between NGOs and primary care (navigation, knowing what to access, how, processes). 	<p>Start from Oct/Nov’16</p>	
<p>Consumer/service-user/patient feedback/evaluation processes (real-time feedback and/or ‘In Your Shoes’ (clarify process for NGOs and primary care) will start to progressively show improvements in their experience of services overall but also specifically in relation to:</p>	<p>Starting late 2016</p>	

<ul style="list-style-type: none"> i) Communication. ii) Being taken seriously. iii) Ability to lead and determine need and response. iv) Early access to relevant information, support and treatment. 		
Priority Actions	Comments	
<p>Start process for scaling-up agreed level presence of, and access to, specialist advice into primary care as described in each goal – priority – Pacific, Māori, child and youth, and phone/e-referrals access to adult/older adults.</p>	<p>Build on current strengths, complete New Lynn evaluation and agree which practices/localities for feasible scale-up over six-month groupings (May – Oct'16), then following six months (Nov '16-April '17), etc. Existing and small investment of new resource.</p>	
<p>Set-up joint governance arrangements required to enable and support necessary changes – in particular, need to address issues raised by staff re accountabilities when work in different environments and role (consult liaison, provision of treatment when person has a medical health care 'home' with GP and staff delivering are employed by NGOs and/or DHB secondary services).</p>		
<p>Identify areas to start to build on and scale-up (within primary care, NGOs and secondary services) - foster sharing of knowledge and experience.</p>		
<p>Establish a virtual library of resource.</p>	<p>Started. Needs IT solution to making it widely available within district.</p>	

care and across primary and secondary care linked to regional health pathways programme.	
Invest in strengthening access to digital (including tele-health), self-management and peer-supported tools and approaches.	New to enhance capacity of existing resources.
Ensure there are links in resources for clear navigation and information on resources in digital format, in libraries, community and church groups, health care providers, with other agencies e.g. Education, MSD services, Police, council community development programmes.	Links with navigation in Goal 1.
Start in next three months to build on existing strengths – some phone access to psychiatrist already in place, CADs advice line in place, New Lynn, Luckens Road, Ranui practices started formal in-reach, Youth Health Hub started joint triage with Child and Youth Services.	Existing.

Whole-of-system enablers 2016-2021		
5.6.4 Workforce development		
Objectives – what needs to change?	By When	Strategies – how
<p><i>Parity proposition</i> - Every health professional in this district will understand their contribution and that of their colleagues to good mind, body and, for many, spiritual health.</p>		
<p>The overall health and wellbeing people is core business for all:</p> <ol style="list-style-type: none"> I. Understanding the impact of mental wellbeing on themselves and their colleagues – self-care, supervision, burnout session. I. Encouraging and promoting a healthy (mentally and physically) workforce and workplaces. I. With core competency in physical and mental health, every health professional and NGO staff member in this district will understand their contribution and that of their colleagues to good health, including physical, psychological, mental and addictions health. (For many, also spiritual and cultural paradigms and their impact on “health”). V. Knowing how to easily and quickly access (and provide) support to each other so that the right level of support and/or advice can be accessed early for individuals and families/whānau regardless of location of service. V. Developing high trust system including skills in cross-system leadership. 	<p>2021 Phased in from 2016</p>	<p>Build on existing and/or Commission an approach to enabling health promotion and a recognised agreed literacy/first aid training to achieve parity proposition in the workforce.</p> <p>Link with existing and new national workforce plans (and agencies) to leverage a workforce plan to support <i>Our Health in Mind Action Plan</i>.</p> <p>Invest in building capability in practice nursing workforce so that each practice has at least one practice nurse with knowledge and skills in the area of integrated mind and body health.</p>
<p>Current workforce initiatives are expanded to extend capability, co-working and in-situ shared skill development:</p> <ol style="list-style-type: none"> a. Nurse Practitioner Credentialing Programme: Every practice will have at least one nurse who has been credentialed in mental health = circa 95. b. Enabling GP trainee placements in primary and secondary mental health environments. c. Current primary care, NGO and secondary mental health workforce take up opportunities to share: <ol style="list-style-type: none"> i) Group work. ii) Share training. iii) Stronger linkages with CME and peer-review processes to share skills and build trust and collegial relationships (generalists have some specialist skills and specialists have some generalist skills). 	<p>2021 Phased in from 2016</p>	<p>Invest in recognised self-management training for peer health coaches</p> <p>Whole-of-system workforce action plan that supports the workforce as a whole to build:</p> <ul style="list-style-type: none"> • Understanding of and, where appropriate, adoption of Whānau Ora concepts, values and world view. • Understanding issues for Pacific people – especially with families who have mixed family culture of Island way and NZ way – born-and-bred in NZ. • Embedding cultural competency across all services. • Working from positive youth development

d. Staff in secondary mental health and addiction services learn how to work in the very different environment of primary care.		understanding and framework – particularly for Rangitahi and Pacific Youth.
We will collectively develop the workforce mix to ensure we utilise effective skills of peer workforce (as health coaches, peer support) and health psychology.		Workforce that is well-equipped to respond to people in distress and at least one person in each NGO who knows how to recognise when it maybe something more serious.
We have a workforce across the system, that understand issues for Pacific people – especially with families who have mixed family culture of Island way and NZ way – born-and-bred in NZ.		
Continue to build capability and capacity in primary health system of working with youth (school-based, primary care practices and centres, NGOs for example) alongside initiatives in secondary care.		
Priority Actions	Comments	
Commission capacity in practice nurse credentialing programme to enable 96 places over the next three years in the Waitemata district.		
Establish workforce training plan that increases the number of people trained as health professional or peer health coaches to enable delivery of programmes across primary health and in secondary services, as noted in Goal 3.		
Develop new peer health coach roles for working in primary health environments.		
Roll-out agreed health promotion training. For example, to 75% health care staff (one-day) over next five years.		

Whole-of-system enablers 2016-2021		
5.6.5 Digital Health		
Objectives – what needs to change?	By When	Strategies – how
Make better use of available technology and be leaders in implementing new options		
We will establish a digital health special interest group to support implementation of this action plan across primary, NGO and DHB – to coordinate effort, achieve greater synergies.	In 3 months (May 2016) ,	Build from a stocktake of existing tools and resources. Establish process and framework for increasing availability in liaison with national and regional agencies.
We will be able to clarify and promote what is currently available in digital health solutions to support this plan.	End 2016	Build on strong and growing Apps culture, blogs and safe use of social media - youth love it and live there – they strongly advocate for digital platform as part of meeting their needs.
We have an agreed Kawa on the safe use of social media ready to share with whānau.	By beginning of 2017	Build familiarity and comfort of primary health system staff in using digital-supported approaches.
We will have a process underway to socialise the collective workforce on how best to use digital health, promote it and enable the people/families/whānau they see to use it.	End 2017	Develop clear role for digital health for: <ul style="list-style-type: none"> • Navigation. • Literacy and health promotion. • Advice. • Self-management tools. • Self-assessment. • Credible delivery of ultra-brief, brief interventions and longer clinician-supported talking therapies (primarily CBT) where evidence supports its use.
Tele-health and e-health options with have started to be in place for the population of Waitemata district for no-wait access to advice, navigation, options for self-management and sign-posting to other sources of help.	2017	Be active in research area of developing evidence base in digital health approaches.
Priority Actions	Comments	
Clarify and promote/signpost what is currently available and has evidence to support it but is under-used.	Collating existing knowledge.	

Up-skill health and NGO staff on what's available, credible and has known best-evidence.	
Set up digital health special interest group to guide and support enhancement of existing and development of new resources.	Co-ordinate involvement of range of participants with interest, skills and experience.
<ul style="list-style-type: none"> a. Develop Kawa (for Māori) for safe use of social media - with community leaders, whānau etc. b. Use of Facebook specifically for Māori and one for Pasifika – (see Goal 1). Promotion and prevention actions. c. Develop a Pacific App: use of social media – for literacy, navigation, self-management, possibly via the Pacific Health Science Academy. 	<p>New resources</p> <p>These are specific recommendations from the advisory group for Maori and Pacific Health Leadership group as their priorities.</p>
<p>Provide clear medico-legal advice on:</p> <ul style="list-style-type: none"> a. Use of digital tools. b. Recording of clinical notes in electronic records (primary care, HCC in secondary services – mainly secondary mental health services staff working into primary care settings and for NGO staff working primary care settings). 	Needs collective governance view.



6.0 Attachments

Attachment 1: Engagement and Co-Production - Face-to-Face

Groups & Individuals		
<p>Engagement & Briefings</p> <ul style="list-style-type: none"> • Craig Murray, Neil Kemp, Bev Monahan, Ajay - Comprehensive Care, • ProCARE – Johnny O’Connell, Julian Reeves, Shelley Willet. • Jean McQueen, Rachel Calverly • WSN Stakeholder meetings x 3 and community event • David Codyre, Kate Baddock, • Lyndy M / Selena G – New Lynne; Jamie Speeden • MHSB Governance Group & each CD /Mgr. Ana, Alex, Megan, Wayne Miles, Vicki MacFarlane, Susannah G, Andrea OT, • Rob Butler, Sue , • Tim Wood. Stuart, Murray P, Debbie H, Simon Bowen, Ruth B, • Karen Fielding, MH Funding Team, Patricia Bolton, Stacey H, Jay O’Brien, Karina M, Hilary Carlisle, Robyn Whittaker, Martin Orr • Ruth Williams, Rob Warriner, • Suicide Post-vention steering group • Sonya Russell (MoH) Rod Bartling MoH • Orewa Practice Nurses peer review • Child Health – Steph. Doe, Tim Jelleyman, • Youth Health Hub • Health Services Plan workshop day and providers • Sarah Hyder – Health Pathways • North Harbour Shared Vision • Rees Tapsell (Waikato), Ian Soosay, • Gwendoline Smith • Ariel Hubbert (Pharmacist) • Whaea Naida Glavish, Aroha Haggie, Karl Snowden • Raeburn House team • Perinatal Depression network evening event – mostly women with lived experience • Practice Nurses Credentialing group • Anna Birkenhead – Metabolic screening • WDHB Board and Senior Management Team 	<p>Co-Production specifically</p> <ul style="list-style-type: none"> • Attendees of three primary mental health programs - Health Lifestyles group participants – Snell’s Beach & Albany, Youth Health Hub West Auckland. • ProCARE Psychological Services (PPS) team • Comprehensive/W PHO GP Peer reviews x 5 • Comprehensive Primary Mental Health team • Pro-CARE Forums - 16th Dec & 20th Jan • East Tamaki Healthcare Mental Health team • Luckens Road / GP Peer Review Group West Auckland (mix pro-CARE & W PHO) • Waitemata PHO – GP Peer review forums x 5 and CME session • Soalaupule – Pacific Network incl NGOs, Fono, Police, consumer leadership, WDHB • Te Pae Herenga Ora – Maori MH & A network- NGOs, Police, Te Puna Haiora, WDHB • WSN Adult work stream – (Provider Exec Group) NGOs, Housing rep, PHO rep. WDHB • Asian Mental Health Governance Group • Funders group • Mental health division Leadership – CD Dr Murray Patton & GM Ian McKenzie • Pacific health leadership group • Mental health services older adults: Executive group and Richard Bohmer leadership group • Health Older People Stakeholder Group • Waitakere Adult MH teams - Primary Care Liaison staff, Locality Manager, co-ordinator, • Rodney Locality : Warkworth Mental Health Team – Tohu Wairoa, Helensville & Red Beach Primary care liaison staff 	<p>Advisory Group - Māori Sir Mason Durie, Dr Hinemoa Elder, Moe Milne, Dr David Jansen, Ana Sokratov, Aroha Haggie, Karl Snowden</p> <p style="text-align: center;">Attending Kaunihera Kaumatua 23 Feb’16</p> <p>Pacific Health Leadership Group</p> <p>Advice & contributions from others external to WDHB Wellington Tony Dowell, Professor of Primary Health Care and General Practice Dr Alison Masters, Dr Aaron Culver, Tony Littlejohn – Capital Coast DHB</p> <p>Professor Bruce Arroll - Elaine Gurr Chair of General Practice and Primary Health Care, Director of the Goodfellow Unit; Department of General Practice and Primary Health Care. University of Auckland</p> <p>Dr Hamish Howie - GP Liaison SMO, Youth Health, Youth Mental Health, Centre for Youth Health. Whirinaki Youth Mental Health. Counties Manukau DHB</p> <p>Phillip Gandar, Synergia (Australia) David Todd, Synergia (NZ)</p>

Attachment 2: List of advisory group members

Co-Chairs

Prof. Max Abbott

Max Abbott is Pro Vice-Chancellor and Dean, Faculty of Health and Environmental Sciences, at Auckland University of Technology, New Zealand, where he is also Professor of Psychology and Public Health, Co-director of the National Institute for Public Health and Mental Health Research and Director of the Gambling and Addictions Research Centre and the Centre for Migrant and Refugee Research Centre.

Previous positions include Clinical and Community Psychologist with the North Canterbury Regional Mental Health Advisory Service, National Director of the Mental Health Foundation of New Zealand and President of the World Federation for Mental Health. He is currently the Federations Senior Consultant. He is a Waitemata DHB Board member and was Deputy Chair for nine years. He serves on a variety of governmental and NGO boards, committees and advisory groups

Dr Lynne Lane

Former Mental Health Commissioner at the Health and Disability Commission, Dr Lane has held a number of senior positions within the public sector, including Chair Commissioner of the Mental Health Commission, Director of Public Health at the Ministry of Health and Acting Chief Executive of the Central RHA.

In the private sector, Dr Lane owned and developed an innovative general practice before specialising in public health medicine. Since specialising, she established and managed a multi-million-dollar company which achieved the goal of significantly reducing the costs of medicines in New Zealand. She has also undertaken a wide range of consulting assignments for Government-funded organisations, the World Health Organisation, the World Bank, NGOs and private companies.

Dr Lane is currently a Management Consultant to ACC, and holds several directorships, including Board Member of the CHT Charitable Trust, Director of HHL Group, Managing Director of Affordable Healthcare and Zygal International Limited, and Chair of the Advisory Board of the Turanga for Research into Tobacco Control, University of Auckland.

Project Sponsor

Dr Dale Bramley, Chief Executive Officer

Dr Bramley is the CEO of Waitemata DHB, the largest DHB in New Zealand, serving a population of 580,000. Prior to this, he held several senior management and clinical roles within the DHB, having been with the organisation since 1999. He has a medical degree from the University of Auckland, a Master's Degree in Public Health (first-class honours) and a Master of Business Administration from Henley, United Kingdom. He is currently the New Zealand chief examiner of the New Zealand College of Public Health Medicine and an adjunct professor at AUT University. He is also a Fellow of the Australasian Faculty of Public Health Medicine and a Fellow of the New Zealand College of Public Health Medicine. A recipient of the Harkness Fellowship, Dr Bramley has had over 40 published papers in peer-reviewed medical journals internationally. He has previously served on the National Health Committee and the National Ethics Committee. Dr Bramley is of Nga Puhī descent.

Project lead

Helen Wood

Helen brings extensive senior service development, project and operational leadership, established over a 35-year public sector career in mental health and addiction sector both in the UK and New Zealand. Her breadth and depth of knowledge, experience and skills are the result of working in a variety of roles from

front line clinician for 16 years (occupational therapist and assertive outreach case manager), professional and clinical leadership roles, through to senior management and national service development and leadership roles. Ninety-five percent of her working career has been non-hospital-based.

Helen has contributed in national-level policy development and leadership in the UK and NZ, more recently as part of the project team that developed *Blueprint II*. She pro-actively seeks and nurtures successful stakeholder working relationships. Up until September '14, Helen worked at Waitemata DHB in leadership roles in mental health services. She then took a year out to undertake full-time study of MSC Global Mental Health in London. This is her second Master's degree in mental health and will add depth to her knowledge and skills in public mental health, epidemiology, research skills and the global challenges in mental health care.

Helen's primary goal is to reduce the inequalities in health and life outcomes that many people with mental health and or addiction issues experience. She has her own experience of living with depression over more than 20 years, managed at primary care-level alongside very proactive self-management and family members who experience the significant life impacts of psychosis.

Advisory group

Mary O'Hagan

Mary O'Hagan was a key initiator of the mental health service user movement in New Zealand in the late 1980s and was the first chairperson of the World Network of Users and Survivors of Psychiatry between 1991 and 1995. She has been an advisor to the United Nations and the World Health Organisation. Mary was a full-time Mental Health Commissioner in New Zealand between 2000 and 2007. Mary has written and spoken extensively on recovery and user/survivor perspectives in many countries. Mary is now an international consultant in mental health and runs a social enterprise that has developed PeerZone – peer-led workshops in mental health and addiction. She is also leading the development of Swell – an online recovery toolkit for people with mental distress and the people who work with them. Mary has written an award-winning memoir called 'Madness Made Me'. She was made a Member of the New Zealand Order of Merit in 2015.

Dr Kate Baddock

Kate is a full-time rural GP and has been practising in Warkworth and surrounds for the past 27 years. Kate is a member of a large teaching practice, with 13 doctors, including registrars and post-graduate doctors as well as medical and nursing students. Kate has been involved at a regional-level in health organisations and on the board of Waitemata Primary Health Organisation for the past decade. Nationally, Kate sits on the executive board of General Practice New Zealand, is the Chair of the GP Council of the New Zealand Medical Association, the Deputy Chair of the New Zealand Medical Association and is a member of the General Practice Leaders' Forum. She also sits on the Medical Council of New Zealand and is a member of the Medicines Classification Committee.

Dr Karina McHardy

Dr Karina McHardy graduated from the University of Auckland's Faculty of Medical and Health Sciences in 2005. Following two years of clinical practice, Karina worked with Auckland's Medical Programme Directorate as a Clinical Medical Education Fellow. In 2008, she moved to the United Kingdom to pursue an MSc in Global Health at the University of Oxford as a Commonwealth and Clarendon Scholar. After her Masters, Karina undertook doctoral research through Oxford's Department of Public Health as a Clarendon, Wolfson and Departmental Scholar. Her research focused on childhood obesity and international public health surveillance systems. Karina has worked with the WHO Regional Office for Europe and has published in the areas of population medicine, medical education, global health, quality and safety, health workforce and healthcare IT.

After completing an Advanced Trainee Fellowship in Health Leadership with Counties Manukau Health and Health Workforce New Zealand, Karina joined Waitemata DHB in a new role as a Senior Advisor in Health Leadership in September 2014.

Hugh Norriss

Hugh has over 20 years' experience in managing not-for-profit and government organisations with responsibility for mental health, social and housing needs and promoting wellbeing in communities and workplaces. He has held a range of leadership positions in the mental health field, including Group Manager of Mental Health Services and Mental Health Planning and Funding Manager at Capital Coast Health 2005-2009 and Chief Executive of Wellink Trust from 1997-2005.

Hugh joined the management team of the Mental Health Foundation in 2009 after serving as a Board member for several years to develop and lead programmes aimed at increasing mental wellbeing for all New Zealanders.

Tania Wilson

Tania is a registered clinical psychologist. She has been working in the health sector for 30 years across a number of settings, including maternal mental health, youth forensic and child and adolescent mental health. She has held several leadership roles and most recently worked as the Senior Advisor for the Werry Centre for Child & Adolescent Mental Health, leading various national projects, providing advice to the Ministry of Health and working with DHB services across the country. Tania is currently Clinical Director of the Waitemata district-wide Youth Health Hub, *HealthWEST*. Tania is a member of the Advisory Group for Child & Adolescent Mental Health postgraduate programme at the University Of Auckland School Of Medicine and a member of the Psychology Workforce Group (PWG), a national representative group to address workforce issues impacting on the psychology profession. Tania has also recently embarked on doctoral research focusing on primary health care for children and youth. Tania's passion is ensuring children and youth, particularly the "hard-to-reach" have access to youth-friendly health services which meet their needs. She strongly believes that young people, with whanau support, must be provided with choices enabling them toward a healthy future.

Vicki Macfarlane

Dr Vicki Macfarlane is of Te Arawa descent and is a Fellow of the Royal College of General Practitioners and Fellow of the Australasian College of Physicians Chapter of Addiction Medicine. She has more than 15 years' experience as a general practitioner and five years' experience in addiction medicine. During the last four years, Dr Macfarlane has worked as the lead clinician for the medical detoxification services of CADS Auckland, a role that includes clinical leadership for the service and liaison to both primary and secondary care.

William Ranger

William is a public health physician with a background in health services planning, funding and management. He has had a variety of senior roles in the health sector and has a particular interest in mental health and wellbeing. William was the foundation President of the New Zealand College of Public Health Medicine.

Rachel Calverley

Rachael Calverley has over 20 years of registered nursing experience. She currently works for an Auckland primary health care organisation in the role of director of nursing and workforce development. She trained in the UK, where she received an honours degree and worked predominantly in intensive care units and coronary artery bypass surgery, followed by over 10 years' clinical experience in primary health care, clinical general practice and education in New Zealand. Rachael holds a Masters in Philosophy of Nursing and has a commitment to nursing leadership. She is an energetic and passionate person dedicated to working with others to improve comprehensive health outcomes and support people in

reaching their potential (both patients and staff). She is experienced in strategic planning approaches, project leadership, driving new workforce direction and framing change pathways to enable improved service delivery.

Rachael has gained further expertise from the regional and national exposure she has had in leading an executive committee and strategising with a variety of audiences. This has enabled her to develop strong relationships and connections locally, nationally and internationally. In 2013, Rachael was awarded the National Service Award for her nursing endeavours by the New Zealand Nursing Organisation (NZNO). In 2014, she received an award from NZNO for strategic leadership. She has recently been appointed as the northern lead for the national group, Nurse Executives New Zealand. She continues to be committed to communicating the nursing voice.

Dr Stuart Jenkins

Stuart is currently Clinical Director – Primary Care, Planning and Funding, Waitemata and Auckland DHBs. He is also a GP and practice-owner at the Apollo Medical Centre, which he developed as part of the Apollo Health Park. Stuart has previously been an elected Board member at WDHB and, over recent years, has taken on an operational role at the DHB with the aim of bringing positive change to the health sector. Prior to embarking on a career in medicine, he worked in marketing and a range of other roles. This helped to inform his view that health is no different to other service industries. He wants to see a Copernican shift in health, with services being developed around the patient journey. He has a particular interest in seeing improved access to primary mental health services as part of a seamless model-of-care involving other social determinants of health.

Jean Wignall

Jean has been a health service data analyst for most of her career. She spent a number of years working in the NHS before returning to New Zealand and working in Auckland DHB for 12 years. She joined Funding and Planning a year ago as Health Outcomes Analyst and is enjoying the change of focus from hospital services to population health and outcomes.

David Codyre

David is a psychiatrist with 30 years' experience working in the community mental health sector in New Zealand, in a range of clinical and leadership roles. He has spent the past 13 years leading development of primary mental health programmes and advocating at a regional and national level for strengthening of primary mental health capacity, along with better support for primary care from secondary mental health services. David currently works with East Tamaki Healthcare, a network of clinics providing team-based primary care services to populations in high-needs areas of Auckland.

Philip Grady

Philip Grady has been CEO of Odyssey for over four years and sits as Co-Chair of the National Committee for Addictions Treatment (NCAT) and NGO Sponsor for the National Mental Health and Addiction KPI Project (Youth stream) as well as holding several other roles within sector groups. Previous to Odyssey, Philip held senior planning and funding roles within district health boards, such as group funding and primary care manager at WDHB and senior portfolio manager at CMDHB. Leading strategic initiatives on sector and workforce development as well as development of innovative programming has contributed to positive changes in the mental health and addiction sector. Trained as a mental health nurse, he worked as a clinician for many years and is currently pursuing his MBA.

Dr Lyndy Matthews FRANZCP

Dr Lyndy Matthews is a general adult psychiatrist, seeing people from teens to older age and working with their families and friends. Currently, Lyndy is employed in a lead role for primary mental health with Waitemata DHB and as the clinical lead for MH&A at a regional level (NRA). She has worked across all

three Auckland DHBs and for an NGO Maori mental health service. Lyndy worked in Maori mental health for 10 years to 2013 and has held service clinical director roles in community mental health services. As a past Chair of the New Zealand Branch of the Royal Australian and New Zealand College of Psychiatrists (2007-11) and of the Council of Medical Colleges of New Zealand (2010-14), Lyndy contributed to a number of national initiatives, including the *MHC Blueprint II* and the Health Workforce New Zealand; Mental Health Service 2020 Review. She has experience with e-health initiatives including depression.org.nz and, most recently, as lead psychiatrist for the National Tele health Service. Lyndy is particularly interested in looking at how we can change how we work; promoting health literacy and improving timely access to effective mental health care.

Robyn Whittaker

Dr Robyn Whittaker is a public health physician working in innovation for the corporate office of Waitemata DHB. As such, she has been involved in setting-up the Leapfrog programme of strategic projects and the Centre for Health IT & Creative Design (of wards that work with industry and academic partners to try out new technologies and models-of-care). She also leads the Health Informatics & Technology programme at the National Institute for Health Innovation, University of Auckland. She has developed and trialled several health interventions for delivery via mobile phones including for smoking cessation, depression prevention, diabetes self-management and others. She works as a consultant for the World Health Org/International Telecommunications Union on their 'Be Healthy Be Mobile' global initiative.

Ruth Bijl

Ruth is the Funding and Development Manager, Child, Youth and Women for Auckland and Waitemata DHBs. She has been in her current role for over two years, prior to which she was part of the Auckland DHB planning and funding team. Previous roles include senior management roles in the NGO sector, Ministry of Health and in research. She has a first-class honours degree in political science and a post-graduate qualification in public health. Ruth is passionate about improving outcomes for women, children and young people and sees mental health as integral to their health and wellbeing.

Sonya Russell

Sonya Russell has a background in psychology, management and service development. In her current role as Senior Project Manager with the Ministry of Health, she has project-managed the development of a Commissioning Framework for Mental Health and Addiction and is the lead for Primary Mental Health and the Perinatal and Infant Mental Health service developments for the North Island. Sonya has broad experience across the health sector, having worked in an NGO, district health board (DHB) and currently Ministry of Health environment. Her academic and professional qualifications include a BSc in Psychology & Biology, PGCertHS Mental Health Development, and PGDipSc in Psychology. Sonya is an experienced health manager and has led the development of a range of services, including maternal crisis respite, adult crisis respite, perinatal and infant mental health services, parenting programmes, youth respite, youth development programmes and youth primary mental health initiatives. Sonya lives in West Auckland with her husband and two sons and is committed to improving the health and wellbeing of communities with a particular focus on mothers, babies and their whānau.

Julian Reeves

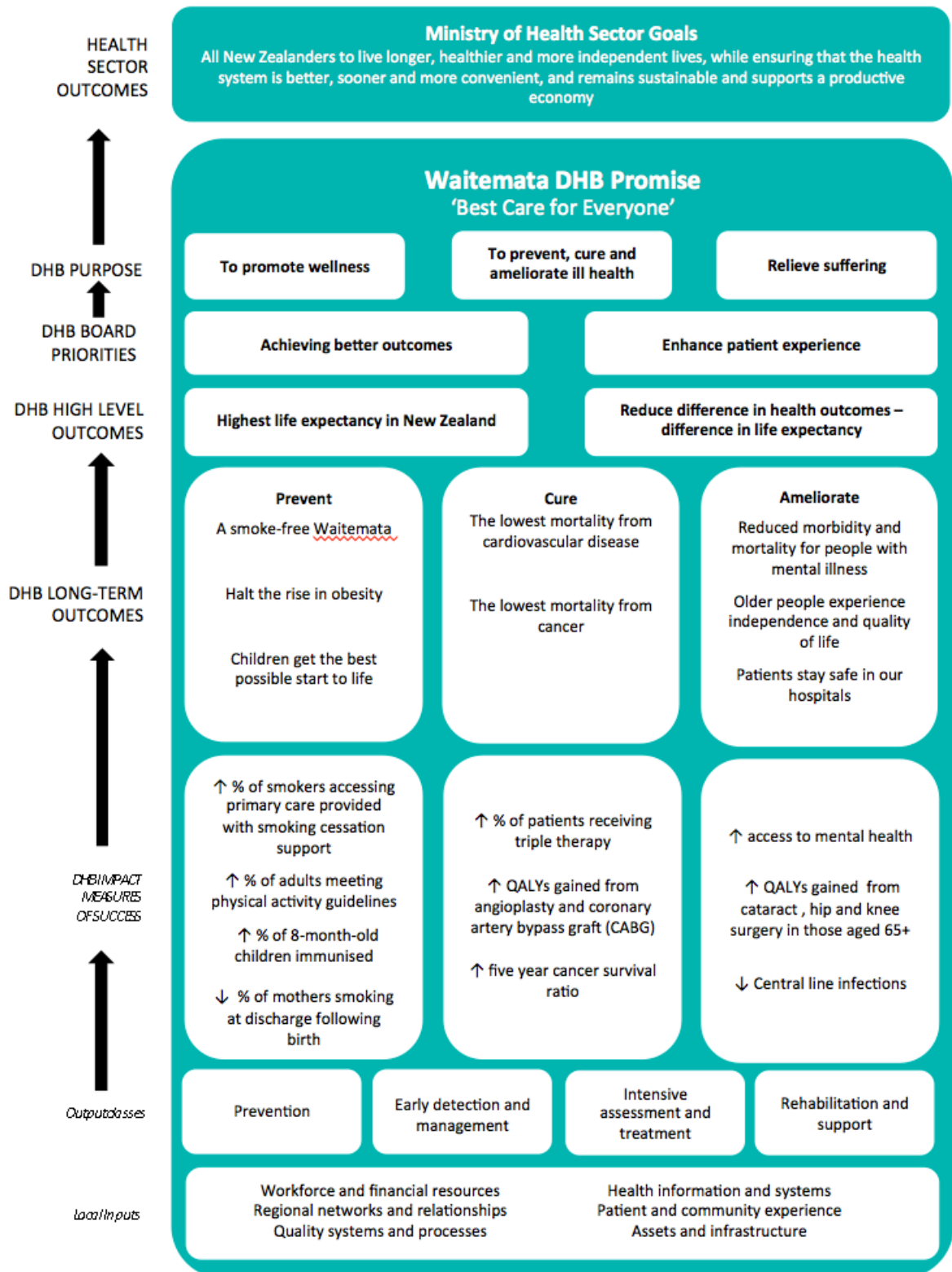
Julian is a Fellow of The New Zealand College of Clinical Psychologists and a former President of the College. Julian works with a range of psychological referrals but has special expertise in dealing with depression and anxiety disorders. He works for Auckland District Health Board in the area of health psychology and as Clinical Director of Procure Psychological Services. He also offers relationship counselling. He has an Honorary Appointment in The Department of Psychological Medicine at The University of Auckland School of Medicine. He also works with emergency service personnel dealing with trauma and its sequelae (particularly Post-Traumatic Stress Disorder) and consults on work stress cases.

Key modalities include Psychodynamic psychotherapy, Cognitive Behavioural Therapy (CBT) and Positive psychology. Qualifications B.Sc., P.G.Dip Sci. (Psychol) (Otago) F.N.Z.C.C.P.

Susanna Galea

Dr Susanna Galea is the CADS Service Clinical Director and a consultant psychiatrist. Susanna has worked in the addiction field for a number of years. She provides clinical leadership to the largest drug and alcohol service in New Zealand. Susanna has been contributing to the scientific knowledge of addiction through involvement and facilitation of research projects, training of various disciplines and publications, such as book chapters and peer-review journals. Her main interests are in multi-morbidities related to addiction, alcohol-related harm and use of substances in special populations.

Attachment 3: Waitemata DHB Outcomes Framework



Attachment 4: Ten Facts on Mental Health – World Health Organisation (WHO)

Fact 1: Around 20% of the world's children and adolescents have mental disorders or problems. About half of mental disorders begin before the age of 14 (up to 75% by age 24). Neuropsychiatric disorders are among the leading causes of worldwide disability in young people.

Fact 2: Mental and substance-use disorders are the leading cause of disability worldwide. About 23% of all years lost because of disability is caused by mental and substance-use disorders.

Fact 3: About 800,000 people commit suicide each year. Over 800,000 people die due to suicide every year and suicide is the second leading cause of death in 15-29 year olds. There are indications that, for each adult who died of suicide, there may have been more than 20 others attempting suicide.

Fact 4: War and disasters have a large impact on mental health and psychosocial wellbeing. Rates of mental disorder tend to double after emergencies.

Fact 5: Mental disorders are important risk factors for other diseases as well unintentional and intentional injury. Mental disorders increase the risk of getting ill from other diseases such as cardiovascular disease, diabetes and vice-versa.

Fact 6: Stigma and discrimination against patients and families prevent people from seeking mental health care. Misunderstanding and stigma surrounding mental ill-health are widespread. Despite the existence of effective treatments for mental disorders, there is a belief that they are untreatable or that people with mental disorders are difficult, not intelligent or incapable of making decisions. This stigma can lead to acute rejection and isolation and exclude people from health care or support.

Fact 7: Human rights violations of people with mental and psychosocial disability are routinely reported in most countries. These include physical restraint, seclusion and denial of basic needs and privacy.

Fact 8: Globally, there is huge inequity in the distribution of skilled human resources for mental health. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low and middle-income countries. The rate for psychiatrists in high-income countries is 170 times higher and for nurses is 70 times greater.

Fact 9: There are five key barriers to increasing mental health services availability. In order to increase the availability of mental health services, there are five key barriers that need to be overcome:

- The absence of mental health from the public health agenda and the implications for funding.
- The current organisation of mental health services.
- Lack of integration within primary care.
- Inadequate human resources for mental health.
- Lack of public mental health leadership.

Fact 10: Financial resources to increase services are relatively modest.

Attachment 5: Blueprint's eight priorities

Blueprint II identifies eight priorities to give effect to the vision and principles:

Providing a good Start: Respond earlier to mental health, addiction and behavioural issues in children and young people to reduce the lifetime impact.

Positively influence high-risk pathways: Provide earlier and more effectively for youth and adults with mental health and/or addiction issues who are at-risk or involved in the criminal justice system.

Supporting people with episodic needs: Support return to health, functioning and independence for people with episodic mental health and addiction issues.

Supporting people with severe needs: Support return to health, functioning and independence for those most severely affected by mental health and addiction.

Supporting people with complex needs: Support people with complex combinations of mental health issues, disabilities, long-term conditions and/or dementia to achieve the best quality-of-life.

Promoting wellbeing, reducing stigma and discrimination: Promote mental health and wellbeing to individuals, families and communities and reduce stigma and discrimination against individuals with mental illness and addictions.

Providing a positive experience of care: Strengthen the culture of partnership and engagement in providing a positive experience of care.

Improving system performance: Lifting system performance by improving outcomes while at the same time reducing the average cost-per-person. (pg. 7 & 23)

To put the principles into action, we must:

1. **Respond earlier and more effectively** to mental health, addiction and behavioural issues.
2. **Improve equity of outcomes** for different populations.
3. **Increase access** to mental health and addiction responses.
4. **Increase system performance** and our effective use of resources.
5. **Improve partnerships** across the whole-of-government. (pg. 13)

We need goals that:

- *Increase screening* for people and families/whānau at high-risk of mental health or addictions issues.
- Reflect the effectiveness of *providing organised mental health and addiction responses across primary and community settings as well as specialist services (stepped care)*.
- *Ensure that no one is turned away.*
- Foster effective *partnerships with inter-sectoral partners* and recognise their contribution to meeting the mental health and addiction needs of our population.
- Are embedded within a *whole-of-system framework that drives for sustainability* by making the best use of all the resources we have available, *including those within wider general health and those that our inter-sectoral partners contribute.*
- *Help drive changes* in how we respond to need across the life-course.

All text directly from Blueprint II - how things need to be.

Attachment 6: Qualitative Data from Interviews and Focus Groups - Word Cloud

The qualitative data from 22 interviews and focus groups was transcribed and put into a table format for analysing. A summary of key words and phrases from each interview was then compiled from the text-based data set. These key words and phrases were then analysed to look for 'themes' (codes) to help categorise the data.

The coding phase involved generating succinct labels (codes) that identify important features of the data that might be relevant to answering the research question. It involves coding the entire dataset and, after that, collating all the codes and all relevant data extracts together for later stages of analysis.

The most-commonly-referred-to themes, in order of frequency (highest-to-lowest), are noted in table below:

Top Ten	
1. Communication	6. Service integration
2. Workforce (and training) issues	7. Screening
3. Access to Services	8. Longer consultations needed
4. Referrals	9. Building 'resilience'
5. Funding	10. Technology
And Next	
11. Better planning	16. Health literacy
12. Depression	17. Community pharmacy
13. Changing perceptions (de-stigmatising)	18. Information quality
14. Local solutions	19. Psychological treatments
15. Over prescription	20. Co-morbidities

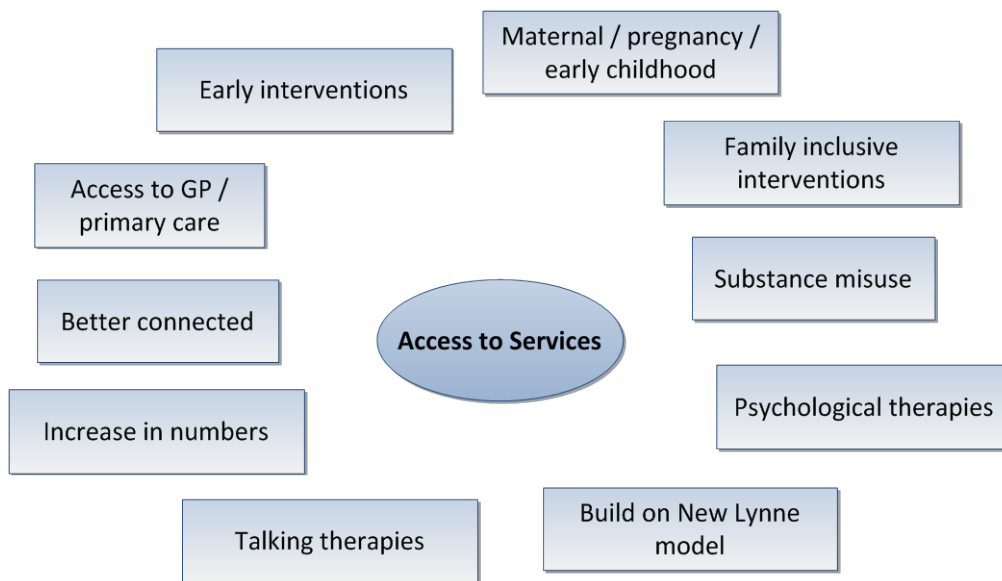
The next step was to run the data through an online 'word cloud' tool, which works in a simple way - the more a specific word appears in a source of textual data, the bigger and bolder it appears in the word cloud. Giving greater prominence to the themes that appear more frequently from the interviews and focus groups can help to immediately convey crucial information in a more visual way. The online tool used was <http://www.wordclouds.com/>.

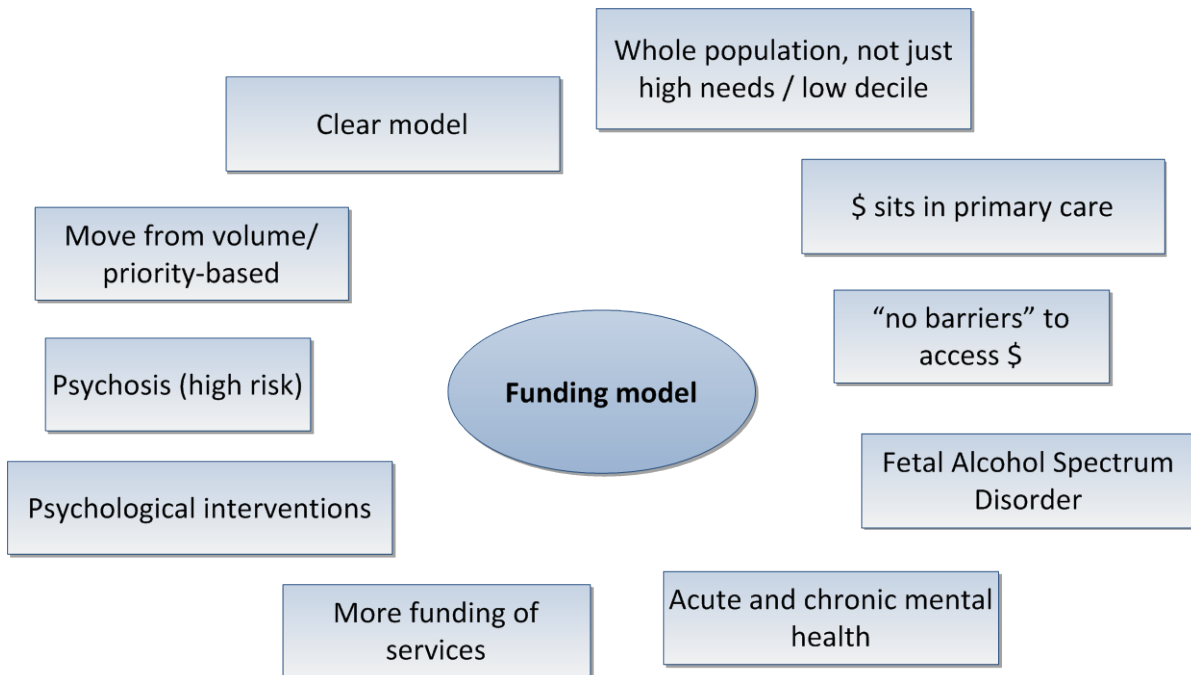
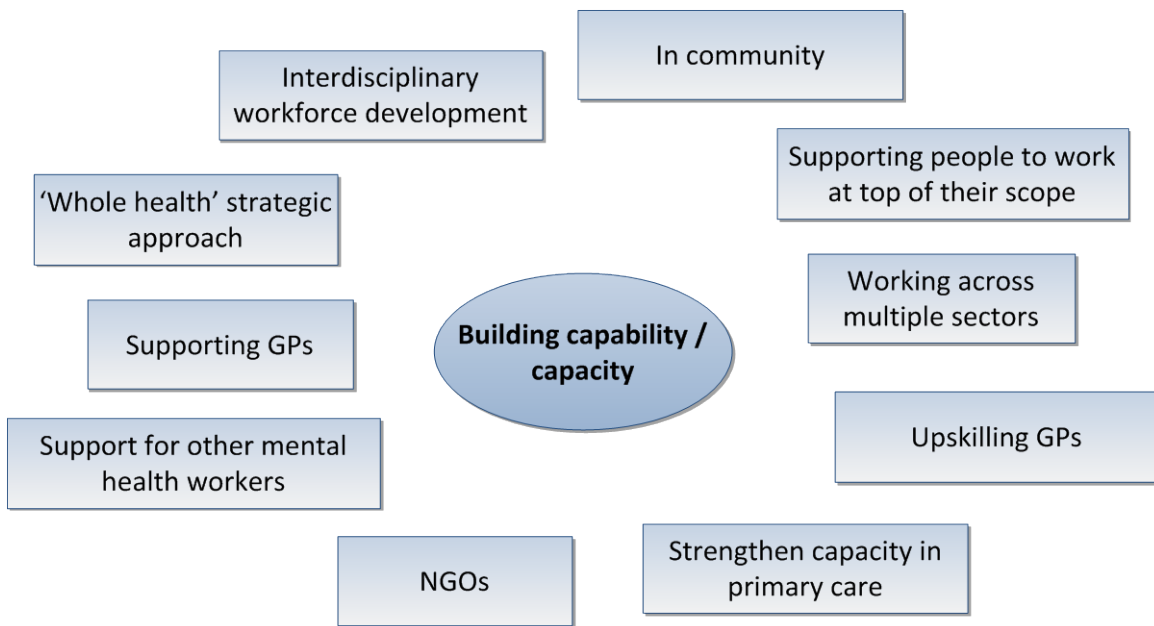
The word cloud (see figure below), essentially shows the 'top 20' themes that emerged from the qualitative data transcribed from the interviews and focus groups. The three most-commonly-referred-to themes – considered the most important issues or priorities for improving population and primary mental health and addictions - in Waitemata DHB are:

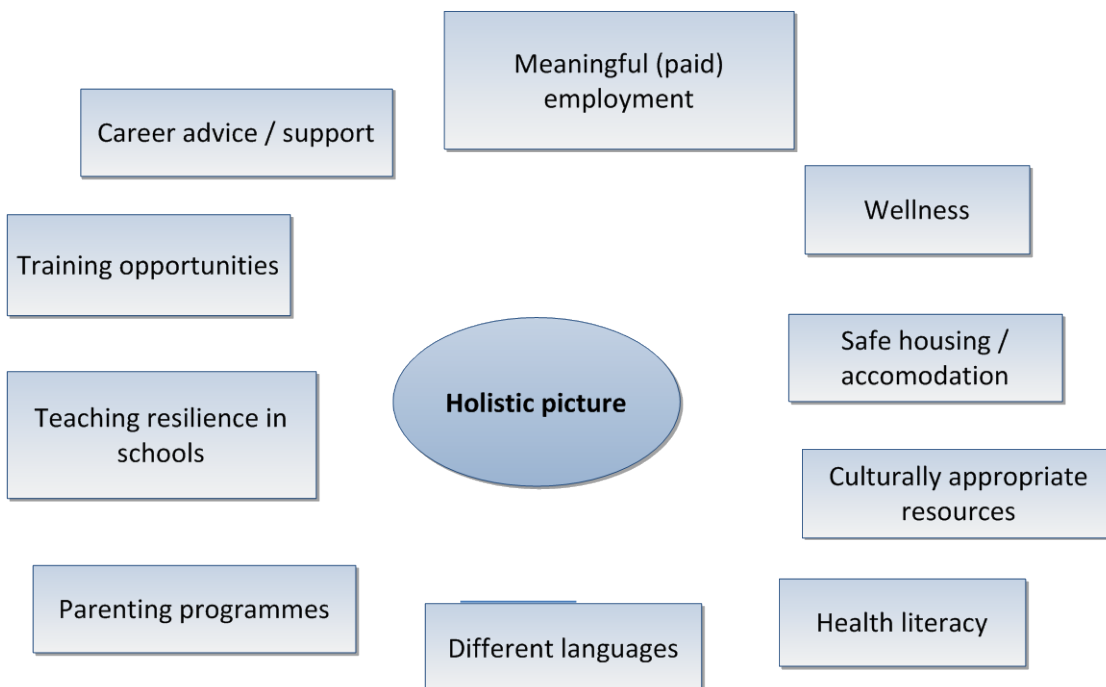
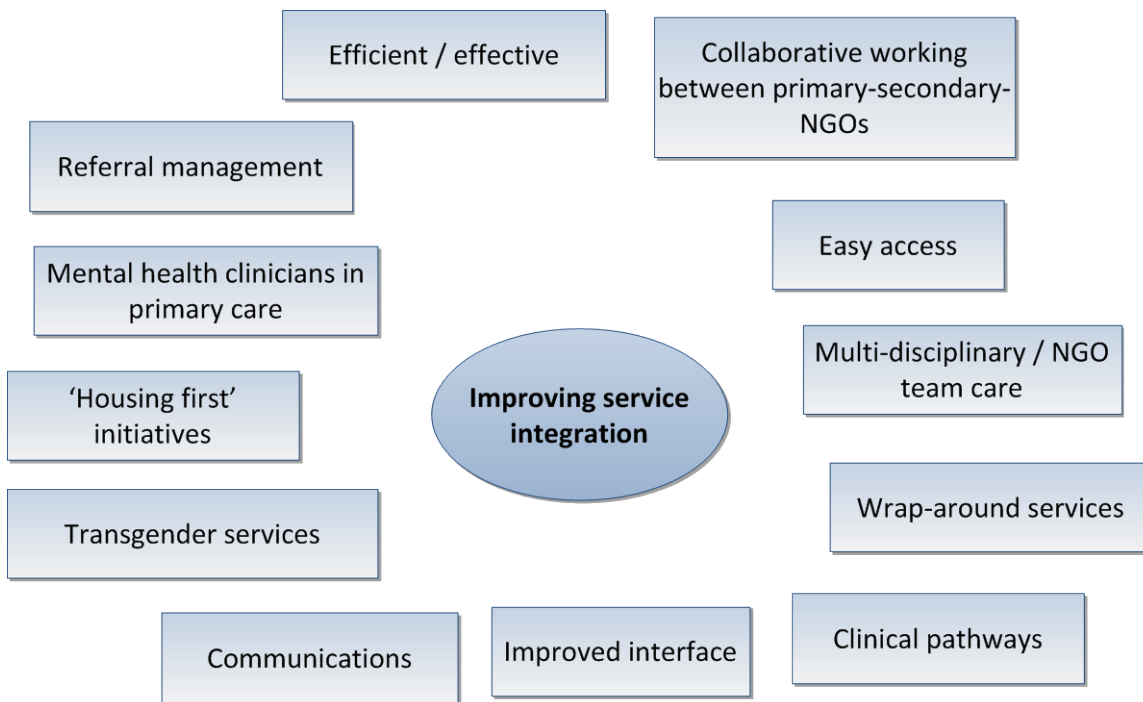
- **Better communication** (e.g. between primary-secondary interface; navigator; listening to family/friends).
- **Workforce and training** (e.g. training in mental health for LMCs; compulsory mental health training for GPs; enhancing the practice nurse role).
- **Improving access to services** (e.g. getting advice in the interim, better/wider range of programmes; self-management resources).

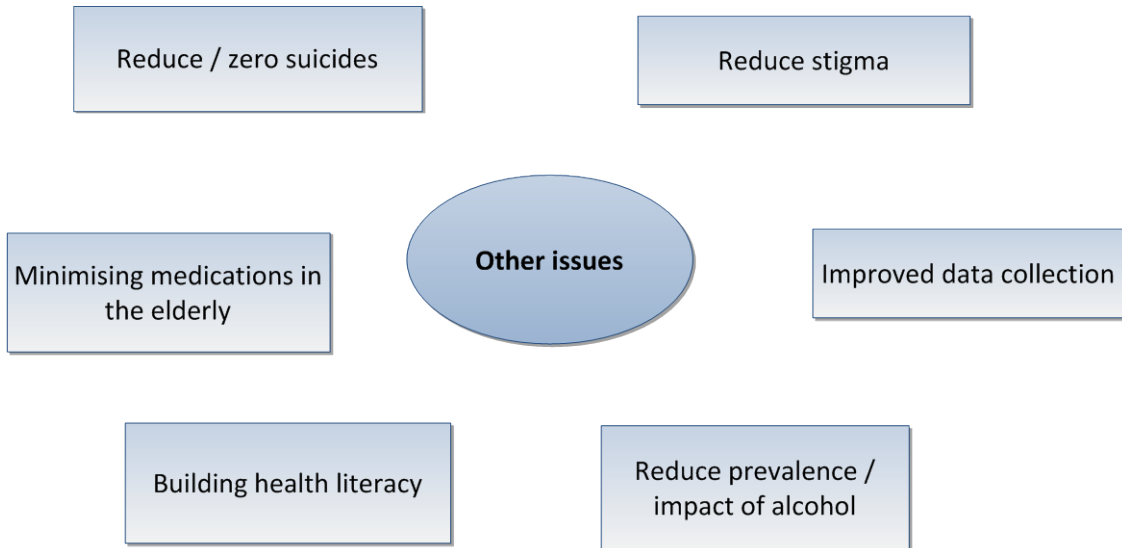


Based on the data highlighted in the above table, the following key themes (codes) are identified below, with some of the sub-themes included as examples:









Attachment 7: Summary from Survey - Thematic Analysis

This section summarises the results from a two-question survey circulated by email to 110 key stakeholders in advance of an Advisory Group workshop on 27 October 2015. The purpose of the survey is to (1) gauge what the key perceived ‘big goals’ should be for the five-year strategic plan and (2) identify the main problems/issues that need to be ‘fixed’ (either at Waitemata DHB-level or wider). By the closing date of 23 October, 42 respondents had completed the survey (a response rate of 46 percent).

The survey questions were as follows:

Q1) From your perspective, experience and knowledge, what would you promote as your pick for top three “big” goals that should inform the Strategic Plan and that we could measure progress toward attainment on 27 October 2020. These can relate to either or both - improved experience/better outcomes.

Q2) What things would you most like to get fixed: (1) in order of priority (1 = most important), (ii) preferably within WDHB but, if you are not local, your thoughts regionally or nationally.

Question 1: Top 3 Big Goals

A summary of the respondents’ feedback to Q1, including the associated themes identified, is shown in the table below:

ID	Goal 1 – Summary	Goal 1 - Theme	Goal 2 – Summary	Goal 2 – Theme	Goal 3 – Summary	Goal 3 – Theme
1	Specialist care linkage with primary care	Access to services	Access on same day + care plan in place	Access to services	Achieving access targets in BPPII, particularly e-b prevention / early intervention	Achieving access targets
2	Building capacity in community	Building capacity / capability	Service integration/development – <i>maternal and early childhood</i>	Access to services	Reduce the prevalence and impact of harm from alcohol consumption	Reduce prevalence/impact from alcohol
3	Clear funding model for common MH conditions	Funding model – whole population and within Primary Care	Development primary care nurse role	Building capability	Easier access systems - no/low wait for Psychiatrist	Referral management - Primary/secondary care interface
4	Access to services - <i>pregnancy</i>	Access to services	Increase access to parenting programmes	Improved access to evidence-based information/resources for the public	Reducing stigma	Reducing stigma
5	General Practice – effective/efficient service delivery	Improving service integration / capacity	Improved interface between community and IPU	Referral management - Primary/secondary care interface	Service user satisfaction	Patient satisfaction
6	GPs focus on psychological and physical health	Recognition and detection of MH in primary care	Community feels empowered to address mild-moderate MH issues	Building mental health literacy and understanding	Better services in communities through co-design, physical locations and relationships with community	Improving service integration / capacity Access to services
7	Safe housing / accommodation	Holistic picture - Safe housing /	Meaningful (paid)employment	Holistic picture - employment	Supportive school environments –	Holistic picture -

		accommodation			teaching resilience	schools
8	Safe housing / accommodation	Holistic picture - Safe housing / accommodation	Training opportunities to their preferred work	Holistic picture - employment	People are able to get and maintain work, incl. career advice & support	Holistic picture - employment
9	Behavioural change programme of action normalising early intervention into mental wellbeing	Access to services – early intervention	Easy access to community based MH&A service delivery and assessment	Access to services	There is no “wrong door” to accessing wellbeing	Building mental health literacy and understanding
10	Accurate data collection on psychological health	Improved data collection and impact analysis	Training and support for primary care professionals – psychological distress	Building capability	Work across multiple sectors; to socialise mental wellbeing strategies/risk reduction strategies into local/regional institutions	Collaborative working / multi-disciplinary / NGO team care
11	Primary Care screening tools – identifying patients with MH needs	Early detection / screening	Access to providers of services to assist identified patients	Collaborative working / multi-disciplinary / NGO team care	Clinical pathways for primary care	Referral management - Primary/secondary care interface
12	Access to services – substance abuse disorders (child/teenager/ young adults)	Access to services	Improve access to substance abuse interventions for adults with young children	Access to services	Improve access to family inclusive interventions	Access to services
13	Improved access to psychological therapies (PT)	Access to services	Developing relationships with primary care	Communication - Collaborative working / multi-disciplinary team care	Build on work at Health New Lynn. More options needed in wider West area and for cross-boundary access	Access to services
14	Building capability – support people to work at top of scope	Building capability	Enhance service integration and relationships	Seamless transfer of care - Improved information/data and shared resources across primary/secondary/NGO interface	Early identification and intervention; improved health literacy	Early intervention Health literacy
15	Reduce suicide rates	Reduce/zero suicide rates	Reduce acute admissions	Referral management - Primary/secondary care interface	Increase primary care enrolment and shared care	Seamless transfer of care / shared care
16	Reduce suicide rates	Reduce/zero suicide rates	Reduction in secondary care presentations	Referral management - Primary/secondary care interface	Successful schooling	Successful schooling
17	Improved joint-working between primary and secondary care	Collaborative working / multi-disciplinary team care	Psychiatrist blending-working with primary care	Seamless transfer of care - Improved information/data and shared resources across primary/secondary interface	Interdisciplinary workforce development; ascertaining capability for future	Workforce development and building capability
18	Enhanced MH literacy - User-	Building mental health literacy	Making it easy to get advice before reaching	Improved access to evidence-based	Reduce by 40% the duration of untreated	Reduce untreated

	friendly language and positive messages	and understanding	a point of entering the system	information/resources for the public	psychosis	psychosis (early detection)
19	Transfer funding to primary care and cover whole population, not just high needs	Funding model – <i>whole population</i> and funding sits within Primary Care	Strategies and processes needed to ensure ease of access and flow through system	Improved clinical and service integration	Acknowledge other high needs communities (i.e. LGBT) within planning phase	Consultation and inclusion of LGBT in planning
20	Young primary prevention; substantial increase for young people accessing MH services and funding moved accordingly	Access to services – early interventions	Employment specialists and improve accessible access to services	Access to Services	Reduce homelessness (and trial ‘housing first’ initiatives - whereby people with MH&A are provided housing and services wrap around them to provide access/support/wellbeing)	Reduce homelessness
		Funding for preventative / early intervention activities				Wrap-around services
21	Primary care – mild-to-moderate depression	Access to services – depression & early detection	Better integration of primary / secondary care / NGOs	Improving service integration	Move from volume-based / priority based funding – to a model where there are no barriers for accessing mental health services	Funding model – <i>no barriers</i> for accessing mental health services
22	<i>Talking Therapies</i> – increased access in primary and secondary care	Access to Services	Establishment of a service for ultra-high risk – psychosis	Funding of psychosis – ultra high risk	Increased numbers accessing care	Access to Services
23	Transgender services – collaboration/service integration across medical/social/surgical services	Improved clinical and service integration	Fetal Alcohol Spectrum Disorder (FASD) – diagnostic services and linkages with disability, education and social welfare	Funding of FASD	Resiliency training in youth; improving self-management	Building mental health literacy and understanding
24	Wider availability of funded <i>counselling and support</i>	Access to Services	Greater spending on acute and chronic MH	More funding of services	Legalisation of cannabis; greater policing of other drugs of abuse	Legalisation of cannabis
25	No funding – Fetal Alcohol Spectrum Disorder (FASD)	Funding of FASD	Transgender service / clinic	Improved clinical and service integration	Behavioural support service	Access to Services
26	Identifying depression in the elderly – upskilling GPs	Building capability - Upskilling GPs	Improve communication between GPs and Mental Health Services Older Adults (MHSOA)	Communication / Collaborative working / multi-disciplinary team care	MHSOA PP6 to increase from 2% to 3% [i.e. Improving the health status of people with severe mental illness through improved access]	More funding of services
27	Dementia – early detection and referral	Access to services – early detection and screening	Improved diagnosis and treatment of mild depression by GP and availability of PT	Building capability - Upskilling GPs	Minimising medications in elderly	Minimising medications in elderly
				Access to Services - PT		
28	Better	Access to Services	Allow the primary	Building capability	Culturally appropriate	Resources -

	connected/more timely/accessible MH services in primary care		mental health and addictions workforce to expand out to work with culturally diverse patients/refugees	and capacity	resources in multiple languages	multiple languages
29	Knowing where to seek help early & no stigma	Access to Services – early interventions	Subsidised access to more than medication e.g. talking therapies, helps with returning/staying to work/education	Improved access to evidence-based information/resources for the public	Reduce by 50% early preventable mortality	Reduce mortality
30	Increased psycho-social integration – impact analysis regarding early detection/intervention strategies	Improved data collection and impact analysis	Closer co-operation and collaboration between the sectors of primary, NGO and secondary care to facilitate earlier intervention of psycho-social disorder	Improved clinical and service integration	Mental health clinicians based within primary care	Improved clinical and service integration
31	Improvement in access to GP services and more support for GPs	Access to Services	Improvement in assessment and early management of substance use disorders	Access to Services – early assessment / management	Reduction in stigma	De-stigmatisation
32	Greater accessibility to MH services within primary care	Access to Services	Development of electronic resources for clients to access after discharge	Improved access to evidence-based information/resources for the public	Greater input from clients regarding experience and needs (via surveys)	Patient-led focus
33	Improved linkage of families to e-b parenting programmes	Improved access to evidence-based information/resources for the public	Improved pathways and packages of support for neuro-disability	Improved access to evidence-based information/resources for the public	Early intervention for addiction	Early intervention for addiction
34	Strengthen the capacity and responsiveness of primary care services	Building capability - Upskilling GPs	Increase capability of primary care workforce to respond to MH&A issues across lifespan	Building capability	Develop a whole health strategic vision and plan – shared & integrated funding approach	Whole of health strategic vision Funding model – whole population and funding sits within Primary Care
35	Funding to reflect whole community not just high-needs/low-decile populations	Funding model – whole population	Appropriate funding for psychological interventions that is safe for consumers	Funding model – psychological interventions	-	-
36	Significantly reduce primary care referrals to secondary care; more seamless access for primary/secondary interface	Referral management - Primary/secondary/tertiary care interface	A zero target for suicides	Reduce/zero suicide rates	Wrap-around service for consumers, with more holistic support	Improved clinical and service integration
37	Identify and treat issues that	Improving outcomes and	Specific referrals to tertiary services	Improved access to evidence-based	Wellness focus groups available in primary	Access to Services –

	restore functioning	Improved data collection and impact analysis		information/resources for the public	care	wellness groups
38	Holistic approach to understanding patients' needs (comorbidity)	Recognition and detection of MH in primary care	Developing primary health pathways (including education of resources, increased access to psychologists and NGOs)	Access to services – early interventions	Patient/whānau input into recovery pathway	Patient/whānau input
				Referral management - Primary/secondary/tertiary care interface		
39	Primary/secondary transfer of referral information and data – more seamless / timely / relevant	Seamless transfer of care - Improved information/data and shared resources across primary/secondary interface	Physical health care – importance of access to appropriate (early) interventions	Access to Services – early interventions	Reduction in suicide	Reduce/zero suicide rates
40	Prioritise building MH literacy across all agencies (e.g. police, school, work & income)	Building mental health literacy	Building capacity and capability of NGOs	Building capacity & capability - NGOs	Transformational programme – resource/capability/capacity/social determinants	Building capacity & capability
41	Clear-cut continuum of care with goals and processes	Seamless transfer of care - Improved information/data and shared resources across primary/secondary interface	Improve clinical liaison between primary and secondary care	Seamless transfer of care - Improved information/data and shared resources across primary/secondary interface	Promoting wellness – clear, shared goals	Promoting wellness – clear, shared goals
42	Significantly reduce suicide rate (and stigma)	Reduce/zero suicide rates	Reduction of stigmatisation of MH conditions, especially by psychiatrists	Reduce stigma associated with MH	Increase in support for GPs to manage mental health in community; increase in support for mental health workers	Building capability - Supporting GPs
						Supporting the primary care mental health workforce
43	Improved early identification of 'at risk' individuals and families	Early detection / screening	Linking them with services	Service integration	Improved co-ordination of services	Access to services – improved coordination

Attachment 8: Ten ways to integrate Mental Health in Primary care (WHO)

1. **Policy and plans need to incorporate primary care for mental health.** Integration can be facilitated not only by mental health policy but also by general health policy that emphasises mental health services at primary care level.
2. **Advocacy is required to shift attitudes and behaviour.** Time and effort are required to sensitise political leadership, health authorities, and primary care workers about the importance of mental health integration.
3. Adequate **training of primary care workers is required.** This includes training of medical student and recent graduates but also experienced family doctors. **Collaborative or shared-care models**, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing ongoing training and support.
4. **Primary care tasks must be limited and do-able.** Initially, each health system needs to **look at the capacity of their primary care workforce** and then the **functions of primary care workers can be expanded over time as practitioners gain skills and confidence.**
5. **Specialist mental health professionals and facilities must be available to support primary care.** The integration of mental health services into primary care must be accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and, when required, supervision.
6. Patients must have **access to essential psychotropic medications in primary care.** Countries need to review and update legislation and regulations to allow primary care workers to prescribe and dispense psychotropic medications.
7. **Integration is a process, not an event.** Even where a policy exists, integration **takes time and typically involves a series of developments**, including training, appropriate staffing and adequate funding.
8. **A mental health service coordinator is crucial.** Unexpected problems can sometimes threaten a programme's outcomes or even its survival. Mental health coordinators are crucial in steering programmes around these unexpected challenges and driving forward the integration process.
9. **Collaboration with other government non-health sectors, non-governmental organisations, village and community health workers, and volunteers is required.** These organisations can play an important role in supporting primary care for mental health. Community-based non-governmental organisations can provide great ancillary support to people with mental health problems.
10. **Financial and human resources are needed.** Although primary care for mental health is cost-effective, financial resources are **required to establish and maintain a service. Training costs need to be covered** and **additional primary and community health workers** might be needed, as well as **additional mental health specialists to provide support and supervision and specialist consultation.** As we better meet mental health needs, demands for services will increase and cannot be met by expecting existing services to cope with increased demand.

Attachment 9: Strategies for Goal One

Strategies – how to make things happen

- Endorse and mandate mental health promotion and primary prevention activity with clear points of accountability for leadership and implementation – who oversees it as a cohesive campaign (to avoid ad-hoc and sporadic activity). Promotion and primary prevention programmes should be designed and focused-on.

a. Strengthening Individual and family protective factors

Ability to cope with stress	Ability to face adversity
Adaptability	Autonomy
Early cognitive stimulation	Literacy
Exercise	Feelings of security
Feelings of mastery and control	Good parenting
Positive attachment and early bonding	Positive parent-child interaction
Problem-solving skills	Pro-social behaviour
Self-esteem	Skills for life
Social and conflict management skills	Socio-emotional growth
Emotional regulation	Stress management
Social support of family and friends	

(Ref WHO 2004 Prevention of Mental Disorders, pg. 23.)

b. Working with communities, NGOs and government agencies, public health partners on macro-strategies to reduce risk and improve quality-of-life.

Improving nutrition	Improving Housing
Improving access to education	Reducing economic uncertainty
Strengthening community networks	Reducing harm from addictive substances

(Ref WHO 2004 Prevention of Mental Disorders, pg. 24-26.)

c. Reducing stressors and enhancing resilience through existing and new programmes

- ✓ Promoting a health start in life – including home-based support, pre-school educational and parenting interventions
- ✓ Reducing child abuse and neglect
- ✓ Coping strategies with parental mental illness
- ✓ Enhancing resilience and reducing risk behaviour in schools – addressing bullying, general skills-building programmes, changing the school ecology
- ✓ Response to job loss and unemployment
- ✓ Supporting refugees
- ✓ Ageing mentally healthy, including exercise interventions, enhancing social support, early screening in primary care, long-term conditions, suicide prevention, prevention/delaying onset of dementia
- ✓ Practical and psychological Support for Care givers

(Ref WHO 2004 Prevention of Mental Disorders, pg. 27 -37.)

d. Implement known evidence for primary prevention actions - universal, selective and indicated

Conduct disorders, aggression and violence
Depression and depressive symptomology
Anxiety disorders
Substance related disorders
Psychotic disorders
Suicide

(Ref WHO 2004 Prevention of Mental Disorders, pg. 38 -51.)

- Build on existing strengths in the system of people and resources at a local, regional and national level where there is measurable evidence to support programmes as effective and cost-effective (quantitative and/or qualitative).
 - a. Review existing local health promotion and health gain activities to seek out opportunities to leverage, strengthen and integrate appropriate information and actions.
 - b. Provide additional financial resource and support to existing suicide prevention and post-vention programme.
 - i. Suicide Prevention for Māori community;
 - Work with community leaders and Whānau, Te Pae Herenga Ora & Māori planning and funding team to improve awareness of suicide risk among young Māori men and facilitate the development and implementation of a prevention-focused strategy. There are more male fatalities but more women attempt suicide and rate of increase for completed suicides in females is growing.
 - ii. Suicide prevention and post-vention within the Pasifika community; work closely with Pasifika community and Soalupule, towards building resilience and connectedness and to raise awareness of support and referral options. This could include:
 - Providing training to leaders in the Pasifika community on mental health, suicide prevention and treatment availability (La Va suicide prevention resources).
 - Providing resources to the Pacific community (Social Media, App).
 - iii. Provide training for mental health and primary care services, community organisations and ED services to recognise and respond to suicidal ideation and behaviour. Using SafeTALK, QPR and QPR on line, ASSIST training.
 - c. Target and support roll-out of existing awareness campaigns at community events, through media, integrate and build on health awareness-raising campaigns through existing media and communications of healthy mind healthy body mindset.
 - d. Facilitate consistency of use and availability of self-management/self-care resources through developing digital health options, promoting existing resources and group programmes and building on resources/literature within primary care settings, diversifying workforce e.g. practice nurses, health psychologist, peer health coaches, NGO staff.
- Invest in enabling new/enhanced levels of evidence-informed universal, selective and indicated access to mental health/addiction health promotion, literacy and wellbeing resources where that is determined to be required, particularly for cultural utility and responsiveness.
- Support and invest in the development of peer support networks and roles.
- Incentivise and establish targets to:
 - a. Improve consistent use of screening and brief interventions to agreed priorities e.g. alcohol use and maternal health.

Attachment 10: Strategies for Goal Two

Strategies - how to make things happen

- Broad approach through training and creating connection, building capability broadly in primary health system, emergency department and other front-door government and non-government entities – the ability to understand and respond to distress and screen for early signs of “disorder”.
 - Within primary care:
 - Review use of Kessler as an access measure to funded primary mental health treatment programmes – while useful as measure of distress, it is very changeable within 24-48-hour period.
 - Add nurse time to extended consults.
 - Broaden options for use of tele-health, groups, self-management, e-based supports, peer support and ensure encompass selection of talking therapies plus mindfulness. (Via PHO programmes and via GP, Practice Nurses etc.).
 - Explore, review, commission and evaluate contracting and delivery models for primary mental health and addiction programmes to achieve best experience, best outcomes and best value-for-money.
 - Commission more than current 10% access to NGO contracts:
 - To enable delivery of promotion, prevention, treatment programmes, social and/or cultural support as part of primary health network and to primary care, building on some existing examples e.g. Odyssey House programmes in Totara House, Raeburn House community groups /classes, pathways support to Totara House.
 - Schools:
 - Support existing programmes provided by CADS’ Altered High, CAMHS and NGOs into schools – identify areas to improve.
 - Review school-based health programmes and integrate, if required, more mental health programmes for resilience, emotional regulation, mindfulness, stigma reduction, etc.
 - Work with schools/education for further investment, particularly in addressing bullying, enabling flourishing mental health in children and adolescents, early detection of children and youth who are “languishing” due to poor health.
 - DHB secondary mental health and addiction services (specialist community):
 - Establish transitional resource to enable a three-to-five-year completion process for the sustainable shift of expertise and community support resources, creating greater direct availability at front door of health system.
 - Build and shift resources to enable primary care and NGO service levels to be in alignment with shift in focus of secondary services through Bohmer programmes in DHB services to a more acute, complex needs-focus.
 - March – October 2016 - Start with transitional programme to scale-up from existing experience and practice:
 - i. Scale-up and/or start increased direct time spent by mental health and addictions specialists based in primary care settings (GP practices, community agencies and school-based programmes).
- Priority – phased - achieve 30% (TBC) shift in time and service-provision in year one.**
- Takanga a Fohe.
 - Whitiki Maurea in Whānau Ora centres North Shore (Puna Hauora) and West Auckland. (Whānau House) – Whānau Whai I Te Ora – Families in pursuit of Health.

- Integrated not solely co-location of a clinic. Models to be agreed by participants.
 - ii. With an agreed level by practice population or shared across a cluster of practices.
 - iii. Build on and strengthen existing examples, such as New Lynn, Luckens Rd practice, Helensville, Whānau House. However, being close-by or even in the same building does not create the experience of direct support, access and integration.
 - iv. Agree timelines and phased approach for both transitions, with agreed targets with measurable change in place by July.
 - v. Will require some resource subsidy to primary care entities for space rental and/or ability of the DHB to tolerate duplicate facility costs.
- Strengthen partnership in working with Ngati Whatua, Marae, Police, community leaders to support their strategies for alternative action – points of difference in responding to Māori, particularly at points of imminent crisis.
 - Identify credible service access options 24/7 and in particular early evenings (after-work, family meals, tele-health and face-to-face options) to promote access for Pacific and Māori.
 - i. *“Need to make it not such a big leap into relationships that are completely alien – many whānau find ‘clinical’ services an alien culture”*- personal quote (Dr HE)
 - ii. Tackle service and whānau assumptions:
 - Do you/I want to tell people my “stuff”?
 - If it’s coming from your mind or feelings, it’s far less important.
 - Must exclude physical cause first – need to do both.
 - Understand and find options for resolving barriers for seeking help:
 - i. Resistant to spending money or don’t have the money.
 - ii. Concern/fear of being judged.
 - iii. For women, consequences with CYFs, Mental Health Act.
 - iv. For Asian / immigrant communities – fear impact on visa/immigration status.
 - Implement key workforce development strategies as noted in foundational goals e.g. strengthen existing knowledge, skills and use of common tools for routine screening and early detection of issues (via CME, shared peer review processes,) enhancing role of practice nurses (additional credentialing fund), shared provision of groups.
 - Integrate into existing processes where feasible and relevant i.e. Well Child check, Before School checks, ante and post-natal checks/screens, routine health checks and/or registration with new GP/ practice.
 - Investigate and invest in new models for growing community hubs, youth centres/one-stop shop, NGO provision, peer support, expert patients.
 - Focus on health education (psycho-education), building confidence and skills in self -management and support increased autonomy in self-management peer support.

Attachment 11: Strategies for Goal Three

Strategies - how to make things happen

- Empower and enable people with enduring (long-term) health conditions to commission and incentivise services/practitioners, so their physical, biological, psychological, psychiatric and spiritual needs are met earlier and “focus” on measurable improvements in their:
 - Ability to self-manage symptoms and recovery journey.
 - Outcomes that minimise impact on being able to do things for themselves and others, reduce number of times of being acutely unwell and/or need for hospital admission and risk of early death.
 - Quality-of-life by being able to remain active in employment (paid and unpaid), productive in workplace and/or education, social connectedness, community engagement and home-life.
 - Reduce emotional, social and financial burden of caring – by family and/or other carers (not part of a formally funded provider).
 - System cost-effectiveness by reducing cost of care across primary and secondary care.

- Make this the joint responsibility (and thus jointly accountable) of mental health funders and providers, of PHOs/primary care providers, DHB funders and providers, linked with long-term conditions.

- Establish joint-clinical governance process with focused one-year work plan that will deliver on the actions (MH, PC, Older adults).

- Appoint a joint-primary care DHB quality improvement programme-enabler role (clinical/quality improvement fellow allocated for three-to-five years).

- Within 12 months:
 1. Agree core pathways for models of integrated and collaborative care (no one model is likely to fit all people and/or all practices).
 - Single organisation as lead provider of primary and specialist mental health services.
 - Share care arrangements with mental health staff embedded (employed, seconded, sessional).
 - Facilitated referral approach with lead care manager for co-ordinating care but not necessarily with physical co-location.
 2. Agree prioritisation and timing of actions with levels of need.
 3. Agree “case-finding” process.
 4. Ensure that regional health pathways for LTC have appropriately explicit expectations and processes for meeting co-occurring needs.
 5. Make broader use of wellness recovery action plans (WRAP) that normalise and integrate physical, emotional, psychological, behavioural and social aspects of wellbeing.

Agreed timeline and incentives, linked to quality improvement process.

Agreed process and timeline for future further integration of services/programmes for people with long-term conditions (inclusive of long-term mental health problems).

Example of people finding and establishing levels of need and responses:

- Undertake process to identify people at three streams of need over the next five years.
 - a. People who currently have lived with co-occurring mental health and physical health conditions for more than two years and/or their health and quality-of-life is already assessed as being compromised - (rehab, recovery and amelioration of impact).

- b. People who have a diagnosis of long-term condition and mental health condition that is either depression, anxiety and substance-misuse (high-prevalence) – and not likely to require care co-ordination and longer-term support and vice versa (secondary prevention).
- c. People who have had recent diagnosis and would benefit from health promotion interventions to prevent co-occurring issues developing to preserve best health possible (primary prevention, early intervention).

- Establish shared understanding between primary care teams and secondary mental health services (all ages) of who is living with more than two co-occurring conditions across physical and mental health and how the current active care plan for those people meets core standards of best practice for those conditions.
 - Shared “case” registers and case-finding.
 - Planned and share audit/quality-improvement cycle.
 - “Disease” registers for long-term conditions to include information on co-morbid mental health problems.

- Invest in quality and service-improvement programme over three years that will:
 - Commission and conduct ethnographic research of experience of long-term conditions.
 - Audit long-term conditions programme activity and resource-utilisation to determine baseline information by ethnicity, age and gender on:
 - i. Screens done for depression, anxiety, substance misuse.
 - ii. Access levels/utilisation of existing resources for meeting psychological needs in LTC programmes.
 - iii. “In Your Shoes/In Our Shoes” processes.
 - Build on existing strengths and programmes of work in primary and secondary systems:
 - i. Bohmer project in provider arm mental health and addiction services. Complete audit and recommendations process with DHB mental health and addictions provider arm long-term conditions project.
 - ii. East Tamaki Healthcare – SME groups, health coaches and peer coaches.
 - iii. Metabolic programme.
 - Evaluate impact of contract expectations for NGOs and others to implement equally well.
 - Audit the long-term conditions programmes to measure adequacy of access to psychological treatment resources within current tagged funding i.e. within diabetes stream, etc. – complete assessment of met v unmet need (detection, diagnosis and treatment of depression).
 - Enhance health and quality-of-life outcomes for people by integrating mental health treatments, expertise and approaches into “chronic disease-management programmes”- through:
 - Documentation in clinical guidelines in the health care pathways.
 - Accurately measuring prevalence of depression and anxiety and/or alcohol to ensure it is detected, diagnosed and recorded.
4. People who experience longer-term mental ill-health and/or substance misuse issues will have greater confidence in and access to material resources enabling them to have easy and appropriate access to primary care to:

- Attend to basic physical health care needs.
- To access supports for the management of other chronic diseases that have arisen as a direct and/or indirect/unintended consequence of symptoms and treatment of their mental health condition.

Develop partnerships with workplaces to influence and ensure health promotion, workplace wellbeing initiatives are integrated - in particular, promotion of psychological and emotional health as key for people with early-stage and existing long-term conditions.

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