

Continuum Project

Taranaki Adult Mental Health and Addiction Services

Adult Mental Health and Addictions Continuum Project – Background and Context Document

Version Three

Prepared by Deirdre Mulligan & Jenny James

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Glossary of Acronyms

AOD	Alcohol and other Drug
CAG	Consumer Advisory Group
CAMHS	Child Adolescent and Mental Health & Addictions Services
CEP	Co-Existing Problems
DHB	District Health Board
DOD	DHB of Domicile
FTE	Full Time Equivalent
GM	General Manager
IDF	Inter District Flows
KPI	Key Performance Indicators
MAG	Maori Advisory Group
MDT	Multi-disciplinary Team
MHA	Mental Health and Addictions
MHSOP	Mental Health Services for Older Persons
MOH	Ministry of Health
MSD	Ministry of Social Development
NASC	Needs Assessment and Coordination
NGO	Non Government Organisation
NSF	National Service Framework
PHO	Primary Health Organisation
POC	Package of Care
PRIMHD	Programme for the Integration of Mental Health Data
TDHB	Taranaki District Health Board
TLAG	Taranaki Local Advisory Group
WFD	Workforce Development

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Steering Group

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The Steering Group would like to thank those representatives that have provided valuable input and a commitment to participating in the work streams and workshops as part of phase two of the project. Acknowledgement in particular to the following organisations:

- Taranaki DHB Mental Health and Addictions Services
- Tui Ora Ltd
- Te Kokiritanga o Te Rau Pani
- Te Whare Puawai o Te Tangata
- Tu Tama Wahine o Taranaki
- Te Ihi Rangī Trust
- Mahia Mai o Whaitara
- New Progress to Health
- Healthcare New Zealand
- Pathways Health
- Midlands Regional Health Network
- Mt View Residential Trust
- Workwise
- Linkage Trust
- Likeminds
- Schizophrenia Fellowship
- Ngati Ruanui Health

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Executive Summary

The Adult Mental Health and Addictions Continuum Project aimed to assess, review and address the key aspects of the continuum of service delivery through a client and family/whanau centred approach. The process sought to lead the sector to more cohesive and responsive services for all NGO/Iwi and Mainstream Providers.

This Background and Context document for the Project is a result of a commitment from the Mental Health and Addictions (MHA) sector who provided expertise and guidance in developing preliminary recommendations and a supporting action plan in order to better meet the needs of service users', tangata whaiora and their families and whanau who access mental health and addictions services in Taranaki.

In June 2010, the sector came together for a workshop to describe the current adult continuum and identify initial gaps. This Background and Context document builds on the key themes from that workshop as well input from a range of key stakeholders via additional meetings and information sharing. It is also supported by a high level Summary Overview document that summarises the key points, and should be used as a quick reference guide.

A fundamental aspect of this project was to articulate a short, medium and longer term direction for services for Taranaki Mental Health and Addictions services, and to develop a corresponding Action and Implementation Plan for how services will be delivered now, and into the future. The project included a wide consultation process that sought views and perspectives from:

- Service users', tangata whaiora and their families and whanau
- The Primary Care Sector
- TDHB Provider Arm Mental Health and Addiction Services
- Non Government Organisations (NGOs).

In addition to a number of national directives and other core strategic policy documents, this Background and Context document has been informed by a number of other key sector projects and initiatives including:

- The National Mental Health and Addictions Services Framework
- Midland Regional Strategic Planning Activities (including Workforce Development)
- Midland Needs Assessment Project
- Midland Review of NASC Services
- The TDHB Acute Mental Health & Addictions Pathway Service Review
- Mental Health Pathway for Mild to Moderate Mental Health Services Report.

It has become quickly apparent that the service mix and pathways are multi-tiered and complex and a number of challenges have been identified if we are to achieve seamless, consistent and integrated service access for service users', tangata whaiora and their families and whanau. Additionally, reflecting the full range of contracted services and cross sector agencies (including voluntary and social services) proved to be difficult, due to the range of funding streams and complicated nature and variability of the types of services available.

The range and mix of Governance structures and sector forums, both nationally, regionally and locally meant that there is no one clear reporting structure or centralised decision making function across services, which often makes communicating clearly, planning collaboratively and working effectively in partnership a challenge.

As a result of this project a number of high level recommendations have emerged that, once implemented, will result in changes to various aspects of the delivery of Mental Health and Addictions services in Taranaki. These are noted below and described in more detail in Section 3: Preliminary Recommendations.

overarching recommendation

The project identified the need for an Action Plan that demonstrates best practice clinical and cultural models of care which would focus on prioritised pieces of work as part of the next phase of implementation. This includes improved referral pathways and protocols and reducing the barriers to access to services and service gaps when service users', tangata whaiora transition in and out of the services and across providers.

recommendations

The project participants considered the extensive issues identified throughout the project and prioritised the pieces of work into red flag areas, medium and longer term which would form the basis of implementation of change in the next phase. These included:

Recommendation One

Developing formal agreements on how providers work together to support consistent practice in the care of service users', tangata whaiora and their families and whanau, shared duty of care¹; minimum standards for service delivery are agreed across the sector; and caseload levels and consistent policies, procedures and practice, regardless of where services are delivered geographically.

Recommendation Two

¹ Health and social care professions have in common the concept of a 'duty of care' toward their users. This means that the wellbeing of the service user should be central to their work. All treatment given must have a therapeutic benefit to the user or must be essential for saving life.(www.mind.org.uk)

Increased accountability from MH&A providers across the sector in the planning and delivery of services for service users', tangata whaiora through:

- review of and agree NASC roles in access management, prioritisation and discharge planning;
- future proofing population needs through improved understanding of specific cohorts of service users', tangata whaiora e.g. ageing population, longer term clients requiring residential care, complex health needs;
- gaining consistency in service delivery models e.g. mix of residential beds, AoD services, crisis respite, ensuring value for money and contemporary practice followed;
- improving outreach service provision with emphasis on collocation options.

Recommendation Three

A stronger focus on clinical leadership at the governance level, acknowledging the value of leadership in supporting and creating a sustainable and inclusive sector. This includes formalising and regularly evaluating clinical oversight arrangements; allocation of Psychiatrists to providers; and the establishment of a cross sector Mental Health and Addictions Clinical Governance Board and other relevant cross sector forums. The structure of regional and local networks will be reflective of strong clinical leadership and evidenced through all Advisory Groups and other stakeholder boards and forums.

Recommendation Four

Workforce training and development will be reflected across all provider activity and service reviews / developments across whole of sector. This will be monitored against regional and local plans and reviewed and signed off through Taranaki Local Advisory Group. There will be a continued emphasis on maximising the national workforce agency and regional training opportunities by ensuring information is shared sector wide.

Based on these recommendations, an Action Plan has been developed to support this Background and Context document, which will be used as a guide for further enhancing and developing services in the sector. It is also intended that the above recommendations will assist us in streamlining services, integrating these where possible, and also focus on reducing duplication, increasing efficiencies, and ultimately lead to improved health outcomes for service users', tangata whaiora and their families and whanau.

Any specific changes to enhance service provision will need to be incremental and prioritised carefully in terms of short, medium and longer term actions. Some recommendations can be realised within existing resources (subject to a commitment to make available dedicated capacity and time), and some service enhancements may require a reconfiguration of current services for a more flexible approach to service delivery. Additionally, re-investment may also be required for increased service levels in some areas.

Section One: Project Background

Mental health is a priority health area for the Government, as reflected in the *New Zealand Health Strategy* (Minister of Health 2000) and *New Zealand Disability Strategy* (Minister of Disability Issues 2001), and as set out in *Te Tahuu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005). Achieving positive outcomes for the population will depend on whole-of-health and whole-of-government efforts across primary secondary and tertiary continuum.

Significant progress in improving mental health and addiction services has been made over the past 15 years. However, mental health disorder and addiction continue to present major public health challenges equal to heart disease, diabetes and cancer.

*The New Zealand Mental Health Survey*² 2006 reported that:

- 47% of the population were predicted to meet criteria for mental disorders (including alcohol and other drug related disorders) at some stage in life.
- 40% of the population had already experienced a mental disorder.
- Over 20% of the population experiences a mental disorder in the last 12 months.
- 4.7% of the population met criteria for a severe mental disorder in the past twelve month period.

Maori rates of hospitalisation for mental health disorder were 80% higher than those of non-Maori³. In 2005, Kingi noted that mental health remained the single most significant threat to contemporary Maori health development⁴.

Co-existing mental health and addiction problems are common. Of people attending community alcohol and drug services in New Zealand, 74% met the criteria for mental disorder⁵. Of people diagnosed with a serious mental disorder, 30-50% reported also having problems with their use of alcohol and drugs.

In 2006 Taranaki DHB undertook a review of its Mental Health Residential and Respite services. As a result of the review, the DHB sought expressions of interest in delivering services in a new and more effective way. Arake Consultants were successful and undertook a Community Supported Living project to work with the sector to gather information and provide recommendations in a business case, which was never formally signed off. The current environment has changed considerably, and the original scope of the project was too narrow and did not cover the broader continuum of care for Adult Mental Health and Addictions Services.

² MA Oakley Browne, JE Wells & KM Scott (eds), 2006, *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health

³ B Robson, R Harris (eds), 2007. *Hauora: Maori Standards of Health Iv: A study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare.

⁴ T Kingi, 2005. *Maori Mental Health: Past Trends, Current Issues, and Maori Responsiveness*. Wellington: Massey University

⁵ I MacEwan, 2007. *Mental Health and Alcohol and Drug Co-existing Disorders: An Integrated Experience for Whaiora*. Wellington: Matua Raki.

This project builds on some of the work that has been completed to date, and has been guided by the following key principles:

- The DHB values ongoing relationships with providers and the other sector agencies in creating a robust viable sector for consumers.
- The sector values a continuity of services and needs to ensure this continuity for clients.
- The sector values open and transparent processes around decision making.
- The future planning of services will be outcome driven by best practice models, Kaupapa best practice and modern mental health and addictions care and support methodologies.
- The model of care will continue to focus on internal and community integration and seamless service delivery across all continua.

project goals and objectives

The following goals and objectives were agreed at the initial stage of the project.

- Development of a core vision and values that provides overarching direction how the sector will work together.
- Robust project management and governance structures established, stakeholders engaged and participating in the process, and project milestones met in accordance with project deliverable timeframes.
- Identification of workforce development needs across the sector that translates into a workforce development plan.
- The processes and resultant model of care will reflect the guiding principles of the Treaty of Waitangi, partnership, protection and participation.
- Models of care that has removed access barriers to services for service users', tangata whaiora and their families and whanau.
- Providers have greater awareness and understanding of each other's services and operate in an environment that is mutually supportive and able to provide a seamless service for service users', tangata whaiora and their families and whanau accessing Kaupapa Maori and Mainstream care.
- A shared duty of care across the continuum within a holistic model of care that balances the cultural and clinical paradigms.
- Through consultation perspectives mental health and addictions sector, and service users', tangata whaiora and their families and whanau have informed the development of an implementation action plan.
- The project acts as a flagship for collaborative processes, outcomes and models of care across the primary / secondary interface and across multiple work streams.
- Sector wide support for an implementation plan which includes, but is not limited to:

- ❖ an agreed continuum of care in an approach that is outcome driven by clinical and cultural best practice models and modern mental health care support methodologies
- ❖ clearly defined governance structures and roles, functions and accountability for enable successful implementation.
- ❖ schedule of activity, goals and objectives for implementation in an approach that is outcome driven by clinical and cultural best practice
- ❖ a focus on internal and community integration and seamless service delivery across all continuums.

assumptions

The following assumptions underpinned the development of this Background and Context document.

- That service users', tangata whaiora and their families and whanau are at the centre of the service model.
- The Steering Group was the recommendation making body in providing direction for the project.
- All stakeholders agreed to be engaged and provide ongoing support to the projects' progression.
- Relevant national, national and regional strategies and frameworks would be adopted as part of the service continuum.
- Any changes in the service delivery model will be within the future funding budgets for Mental Health and Addictions services.
- Any identified gaps in services would be considered through Taranaki DHBs prioritisation process annually.
- That service delivery does not impact on a provider's ability to deliver other services as part of core business.
- Planning for services must be outcome driven by clinical and cultural best practice models and modern mental health care/support methodologies.

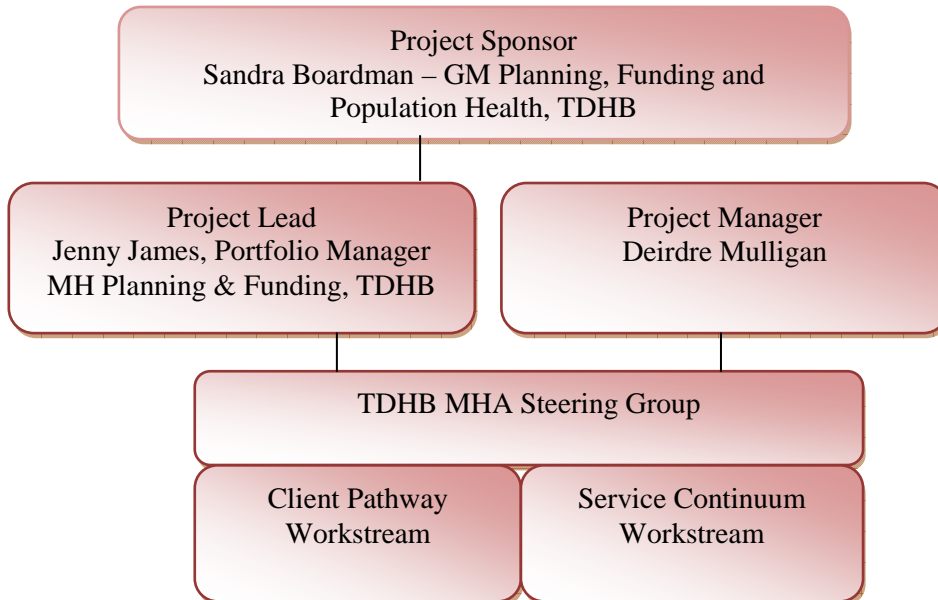
constraints

The following constraints were considered in the development of this Background and Context document.

- The current political and funding environment impacts on the ability to create longer term sustainable services by restricting opportunities to increase resources.
- Logistics of current provider configuration in enabling a seamless continuum of care for clients.
- Unrealistic community and wider sector expectations.
- Conflicting information being obtained.
- Incomplete reporting information being readily able to be accessed via PRIMHD resulting in questions related to the accuracy of data.

project structure

The overall Project sponsor, responsible for sign off is Sandra Boardman, GM Planning, Funding and Population Health, TDHB. A Steering Group was established and two key workstreams were convened. Details of membership of the Steering Group and Workstreams are noted in Appendix One.



approach

The approach to this project was based on professional relationships with clear and concise communication with all parties. The parties included representatives of DHBs Provider Arm services, Iwi and NGO providers from across the continuum of care.

A Project Steering Group was established to provide clinical and cultural governance to the project and provide strategic advice and leadership. A communication plan was developed and highlighted key messages about the project to be shared with the sector and interested parties, via the Midland regional network website. Additionally a Risk Mitigation plan was developed and continually reviewed throughout the project.

Building on initial themes from the workshops in June and December, it was agreed that two workstreams in particular were a priority. They were the Service Continuum Workstream and Client Pathway. Further detail on the activities and focus of each workstream is described in Section Two below. Refer to Appendix One for membership of the Steering Group and Workstreams.

vision and values

The following Vision and values were agreed to guide the project.

Vision

“Ehara taku toa I te toa takitahi, He toa takatin Ke’

My strength does not lie in working alone. Rather my strength lies in working with others

Mission Statement

‘Kia mahi tahi ai, tatou kit e hapai ake te whanau ora o nga tamariki, rangitahi, whanau’

Working together to strengthen the health and wellbeing of people and their families and whanau

Combined Key Values

- **Quality/Tika**
Minimise the risk by understanding and developing clinical and cultural boundaries
- **Flexibility/Whanaungatanga**
Building and maintaining relationships that can make the appropriate decisions with respect and dignity for all concerned
- **Evidence based models/Mana**
Employing evidence based treatment models. Harmony and balance of the individual and the collective. Respect and trust towards each other’s clinical and cultural models of care
- **Duty of Care & Accountability/Ko te Putake o te kaupapa nei ko te mana whakaritea**
A joint collaborative partnership that encompasses Duty of care (clear lines of responsibilities, accountability, transparency, systems and processes and clearly defined roles)
- **Workforce Development/Akona nga mea tika o runga, o raro, o roto, o waho kia noho mataara ai tatou**
Supporting and empowering the workforce towards individual and organisational growth, self sustainability (professional development) and quality improvement
- **Communication/Takatoranga**
Building relationships between each other, across the service and with family/whanau that is recovery focused, builds resilience and weaves us together as one people
- **Clinically and Professionally Competent/Tikanga, Tika, Pono**
Formal processes, learnt knowledge and personal and social integrity
- **Respect**
To practice with mana and respect
- **Advocacy**
To awahi tangata whaiora to enhance their wellbeing

Section Two: Project Activity

Building on initial themes from the workshops in June and December 2010, it was agreed that two workstreams were a priority. They were the Service Continuum Workstream and Client Pathway. Concurrent activity included a stock take of existing local and regional Networks and Governance groups, in order to map out and gain an understanding of the range of forums within the sector. Further detail on the activities and focus of each workstream is described below.

service continuum workstream

The aim of this workstream was to describe the service types, models and mix/range of services to ensure that a comprehensive and full range of appropriate, contemporary, evidence based , high quality, targeted and effective services are available as part of a seamless set of options for people with mental health and addiction problems in Taranaki. *The overarching intent was to:*

- Discuss and understand the range of services (both contracted and delivered via other agencies) across the continuum and consider additional types of evidenced based and contemporary practice options that may be applicable to Taranaki DHB.
- Map existing models of service against the National Service Framework (NSF), and based on known data, evidence and benchmarks, identify service gaps and potential areas for development.
- Propose, advise and recommend a range of key activities that will inform the development of an Action Plan aimed at a seamless service delivery across the Adult Mental Health and Addictions continuum within an agreed model of care that ensures:
 - A holistic approach to care, demonstrating cohesive and seamless pathways across various levels and providers of care
 - A range of services are delivered that achieve the best possible health and well-being outcomes
 - Provision of care where and when it is needed, avoiding unnecessary admission to services
 - Sustainability within the current fiscal environment.

Figure 1: Process Mapping the Service Continuum

Workshop Existing Models of Practice	Mapping	Implementation Plan
<ul style="list-style-type: none"> • Contracts and non-contracted services • Needs of the TDHB population 	<ul style="list-style-type: none"> • Existing models against NSF • Gap Analysis • Future population needs 	<ul style="list-style-type: none"> • Recommendations • Transition approach • Potential risks and Mitigation • Evaluation

Workstream membership was confirmed and a Terms of Reference was developed and endorsed (Refer Appendix Two). Members of the workstream met regularly and were asked to Process map what service types, models & mix/range of services were currently in practice across the continuum.

The following approach was followed:

- Workshop models, mix, types of services as they currently are (local, regional and national)
- Understand service gaps and future needs
- Review innovative practices and potential opportunities
- Develop recommendations and implementation plan/approach (ensuring sustainability and within existing fiscal constraints)
- Review through Steering Group mechanism and broader consultation as agreed.

Additional activity included:

- A high level review of relevant local, regional and national reports and reviews that guide contemporary practice
- Workshop opportunities for innovation and creativity
- Evidence base and outcomes reviewed (including PRIMHD data and KPI information where available)
- Stakeholder interviews and focus groups
- Case scenarios – completed by workstream members, and summary attached in Appendix Two.

Emerging themes from the case scenarios are noted at the end of this section, and have been reflected in the preliminary recommendations.

client pathway workstream (including family and whanau)

The aim of this workstream was to describe responsive and effective recovery focused pathways **in, through and out** of services for service users', tangata whaiora and their families and whanau. The overarching intent was:

- “Any door is the right door”
- Improved journey for all service users', tangata whaiora and their families and whanau
- Commitment to workforce development – a capable and competent workforce
- Commitment to operating in a collaborative manner across multi-agencies & MDT's
- Strengths based, recovery and wellness focus, and treatment is offered that is inclusive and holistic
- The needs of the service user, tangata whaiora, families and whanau will be recognised in the way we deliver our services
- Clarity around duty of care, including clinical risk and accountabilities

Workstream membership was confirmed and a Terms of Reference was developed and endorsed (Refer Appendix Three). Members of the workstream met regularly and were asked to Process map what currently occurs in practice at the following stages of the service user, tangata whaiora journey within each service, and based on analysis of the pathway/key themes; identify strengths and areas for improvement.

Figure 2: Process Mapping the Client Pathway

Pre-entry	Entry	Exit
<ul style="list-style-type: none"> Referral pathways Referral process (incl. Triage) Response (how, when, whom etc). 	<ul style="list-style-type: none"> Assessment Treatment planning 	<ul style="list-style-type: none"> Discharge Planning & execution Follow up

The following approach was followed:

- Workshop “pathways” as they currently are
- Utilise findings from the Acute Services Review, Primary Mental Health Project, CAMHS and Maternal Mental Health Projects, Midland NASC Review, Midland Needs Assessment Project.
- Agree base level responses (timing, communication channels, assessments, reviews etc)
- Develop recommendations and implementation plan/approach
- Review through Steering Group mechanism and broader consultation as agreed.
- Workstream members to map the client journey in, through and out of services and describe opportunities, barriers and potential developments (refer Supplementary information for a detailed summary in Appendix Three.

Emerging themes from the client pathway responses have been noted at the end of this section, and have been reflected in the preliminary recommendations.

governance stock take and regional networks

Throughout the workshops and consultation, it became apparent that the range and mix of Governance structures and sector forums, both nationally, regionally and locally meant that there is no one clear reporting structure or centralised decision making function across services, which often makes communicating clearly, planning collaboratively and working effectively in partnership a challenge.

A list of Health Sector Clinical & Managerial Governance Boards and Subcommittees pertinent to MHA services in TDHB is listed below. Refer to Appendix Four for a more detailed overview.

Taranaki Local

ORGANISATION	BOARD
Taranaki DHB	<ul style="list-style-type: none"> Taranaki DHB Clinical Board
Taranaki DHB Mental Health and Addictions – Clinical Governance Board	<ul style="list-style-type: none"> MH Acute Services Adult Mental Health MHSOP Mental Health CAMHS South Taranaki MH AoD Services
Taranaki DHB & NGO Sector	<ul style="list-style-type: none"> Child Adolescent and Maternal MH & Addictions Clinical Governance Board
Linkage Trust	<ul style="list-style-type: none"> Primary & Secondary MH (Adult) – Quality Management Group and Management Team
New Progress to Health	<ul style="list-style-type: none"> Secondary MH (Adult) Board of Trustees and Senior Management team
Midlands Regional Health Network	<ul style="list-style-type: none"> Taranaki Primary Connections
Te Whare Puawai	<ul style="list-style-type: none"> Primary/Secondary MH Management Team and Quality Health & Safety Forum.
Tui Ora	<ul style="list-style-type: none"> Primary & Secondary MH Adult and Primary CAMHS.
Pathways	<ul style="list-style-type: none"> Primary/Secondary MH National Leadership Team
Te Ihi Rangi Trust	<ul style="list-style-type: none"> Kaupapa Maori Residential (BOT)

Midland Regional Networks

Taranaki providers participate in, and are members of a number of Midland Regional networks, including:

BOARD
Midland Chief Executives
Midland General Managers (Planning & Funding)
Midland Maori Health General Managers
Midland Regional Addictions Forum
Nga Purei Whakataa Ruamano (Maori MH&A Network)
He Tipuna Nga Kakano
Midland Regional Clinical Leadership Forum
Midland MHA Portfolio Managers Forum
Midland Generating Action for Family Whanau Forum
Midland MHA Workforce Development Advisory Group

It is recommended we continue to review the role, functions and membership of these groups, to ensure collaboration and a partnership approach to service development, delivery and review, whilst aiming to reduce duplication and maximise efficient use of time.

emerging themes

Emerging themes from the workstream activity, workshops and project reviews have informed the preliminary set of recommendations. These are described below:

- Develop the capacity and capability across the sector. There is the opportunity to reduce duplication and improve integration across providers within the sector
- Proactively work to develop an infrastructure that is able to work in a partnership environment which is clinically and culturally safe and utilises best practice models
- Develop formal agreements that define partnership relationships with clear lines of shared accountability, responsibility and clinical governance - where the duty of care is clearly defined and delineated
- Combined clinical/cultural work streams that engage clinicians to develop a model of care and client pathways that are continuously improving, are clinically safe, address and manage quality and risk, culturally safe, equitable, consistent and aligned to best practice, including clinical governance structures across the Provider Arm, NGO and Primary Health sectors
- Commitment to an agreed client pathway across the continuum of care that ensures timely referral processes is well coordinated and offers a seamless delivery of service
- Shared duty of care across the continuum
- Development of holistic models of care balancing clinical and cultural paradigms, that will consider national and regional approaches to effective service delivery including the Co-existing disorders problems implementation

service red flag areas

A number of key red flag areas were consistently raised throughout the project which have been picked up in the action plan in Section Four: Next Steps – Implementation Action Plan. These include:

- Residential Care Facilities – shifting to contemporary models of care, review of the mix and models required.
- Respite – Carer and crisis, lack of appropriate levels of service that impact on service users', tangata whaiora presenting to inpatient ward, crisis team response.
- Longer term residential service users', tangata whaiora, gaps in provision of services for 'like in age in interest' clients, dual diagnosis e.g. mental health and physical disabilities issues. Service users', tangata whaiora often staying longer than necessary in residential and inpatient beds due to lack of facilities, and the complexities with funding streams between Accessibility

and Mental Health Services. Physical disabilities is not within the scope of training (or contracts) for MH Staff. Additional support requires approval from Accessibility.

- Provider Arm Community based Mental Health and Addictions Services – explore collocation of service provision within the community / primary care.
- Discharge Planning and the Needs Assessment and Coordination Services, – access management, standardising processes and documentation.

service user, tangata whaiora and families and whanau

As part of the Taranaki DHB Consumer and Family advisors roles, they regularly conduct surveys on their access to and experiences of the services. The following key areas were identified as areas for improvement.

- Families and whanau want to be more involved with and included in treatment and discharge planning and education, particularly when service users, tangata whaiora are living with family or whanau.
- Increasing follow-up response to service users, tangata whaiora who do not attend appointments or are non compliant with medication.
- Access to early intervention with early warning signs to mitigate potential crisis situations.
- Service users', tangata whaiora choice of clinician when compatibility is an issue – ensuring good therapeutic relationships and recovery remains on track; and on the contrary some service users', tangata whaiora experience high turn over of clinician's.
- Increased information on their illness (diagnosis and symptoms), medications (purpose, side effects, and other options), and supports available in the community.
- Flexibility with appointments – establishment of after hour's clinics.
- Improving the process for developing relapse prevention plans, ensuring an inclusive process with service users, tangata whaiora and their families and whanau.
- Reducing appointment waiting times for AoD appointments to ensure opportunity is not lost.
- Inconsistencies with treatment when presenting at Emergency Department.
- Coexisting Problems and issues with treating both AoD and MH issues should be addressed simultaneously.

Section Three: Preliminary Recommendations

As a result of this project a number of high level recommendations have emerged that, once implemented, will result in changes to various aspects of the delivery of Mental Health and Addictions services in Taranaki including:

overarching recommendation

Development of an Action Plan that demonstrates best practice clinical and cultural models of care which will be implemented in the next phase of the project. This will include improved referral pathways and protocols and reducing the barriers to access to services and service gaps for when transitioning in and out of the services and across providers, ensuring people with the highest needs receive required services.

recommendation one

- 1.0** Develop a **formal agreement on how providers work together to support consistent practice** in the care of service users', tangata whaiora and their families and whanau through their journey across the continuum of care specifically in the areas of:
- 1.1 Shared duty of care ⁶.
 - 1.2 Minimum standards for service delivery are agreed across the sector, including
 - Shared documentation
 - Outcomes reporting
 - Relapse prevention planning
 - Advanced directives
 - 1.3 Agreed caseload levels and consistent policies, procedures and practice, regardless of where services are delivered geographically.

recommendation two

- 2.0** **Increased accountability** from Mental Health and Addiction providers across the sector in **planning and delivering** services for service users', tangata whaiora.
- 2.1 Agree and confirm the role of NASC in access management, prioritisation, discharge planning and review processes.
 - 2.2 Improved understanding of (and preparation for) the cohort of service users', tangata whaiora who present with multiple needs, such as the ageing population, longer term clients requiring residential care, complex health needs (including Huntington's, physical, sensory and intellectual disabilities).
 - 2.3 Gaining consistency in service delivery models (e.g. Day programmes, mix of residential beds, AOD residential services, Crisis respite) and an improved understanding of how services are being delivered, ensuring value for money and contemporary practice is followed.
 - 2.4 Improved outreach services to the community and NGO providers, and a greater understanding of the best mix and match of service across the district, including an emphasis on co-location options.

⁶ Health and social care professions have in common the concept of a 'duty of care' toward their users. This means that the wellbeing of the service user should be central to their work. All treatment given must have a therapeutic benefit to the user or must be essential for saving life.(www.mind.org.uk)

recommendation three

- 3.0** Ensure a **stronger focus on clinical leadership at the governance level** and an acknowledgement of the value of leadership in supporting and creating a sustainable sector that is inclusive of Provider Arm and NGOs, evidenced by:
- Formalised clinical oversight arrangements are in place and regularly evaluated
 - Providers having allocated psychiatrists
 - The establishment of a cross sector Mental Health and Addictions Clinical Governance Forum
- 3.1 Describe current regional and local networks and demonstrate how clinical governance is reflected in these forums as part of a completed stock take of existing networks
- Consumer Advisory Group (CAG)
 - Taranaki DHB Local Advisory Group (TLAG)
 - Maori Advisory Group (MAG)
 - Family/ Whanau Advisory Group
 - Workforce Advisory Group

recommendation four

- 4.0** Workforce Development needs and opportunities are reflected in all project activity and service reviews/developments across the sector.
- 4.1 Monitor progress against the Midland Regional and Taranaki Local WFD plans once these have been signed off on a quarterly basis via reports to TLAG.
- 4.2 Maximise access to national & regional WDF and training opportunities by ensuring information is shared so the sector is aware of what is available.

Based on these recommendations, an Implementation Action plan has been developed to as part of this Background and Context document, which will be used as a guide for further enhancing and developing services in the sector. It is also intended that the above recommendations will assist us in streamlining services, integrating these where possible, and also focus on reducing duplication, increasing efficiencies, and ultimately lead to improved health outcomes for service users', tangata whaiora and their families and whanau.

Section Four: Next Steps – Implementation Action Plan

overview

The resulting key prioritised areas for action will be focused initially on the red flag areas. Throughout the Project, the sector were highlighting the need for a cross sector Adult Mental Health and Addictions Clinical Governance Board. Currently the Provider Arm MH&A services are seeking to review the newly established MH&A clinical governance structure, Tui Ora Ltd continues to evolve as a Provider Arm of Kaupapa Maori services, and the remaining NGO providers are keen to participate in any revised Governance structures to enable inclusivity in decision making.

Implementation of the Action Plan will be under the guidance the Cross Sector Mental Health and Addictions Clinical Governance Board, with sub working groups established for the key prioritised pieces of work. The working groups will include a mix of professions with leadership skills to drive tangible outcomes. These pieces of work will continue to be lead by Planning and Funding, with reporting through to General Manager, Planning, Funding and Population Health. These action areas will be supported by 3 working parties be set up in July 2011 to cover off the three most critical change management service areas. Including:

1. Residential and other accommodation services
2. Ageing Clients / Physical & Intellectual disabilities / Longer Term Care
3. Respite service requirements

These working groups will be supported by a small working party that will focus on the standardisation of policies procedures and documentation and improving discharge planning and relapse prevention planning.

A fourth area outlined in the action plan is looking at possible collocation models of care for Mental Health and Addictions Community based services.

Over and above the key actions prioritised there are a number of pieces of work that will need to be conducted, including gaining a better understanding of the issues with a service user, tangata whaiora continuum across other sector agencies, with consideration to cross sector agency working groups to close any gaps. There are also a growing number of areas where literature and evidence support focus of service options into the future, these include, employment as the recognition through international evidence that supports the integration of employment consultants and peer support workers within clinical mental health teams.

Further work will also need to be undertaken once the Mental Health Commission complete their remodelling of Blueprint. This will given District Health Boards an up to date position on the mix of services that bit fit within the current MH&A environment.

Four Key Actions have been proposed, linked to the recommendations highlighted in Section Three above. For each of these actions,

- Specific activities have been described
- Key Performance Indicators proposed
- Responsibility for leadership allocated
- And the timeframe for completion along with required resources has been considered.

implementation structure

Sponsor

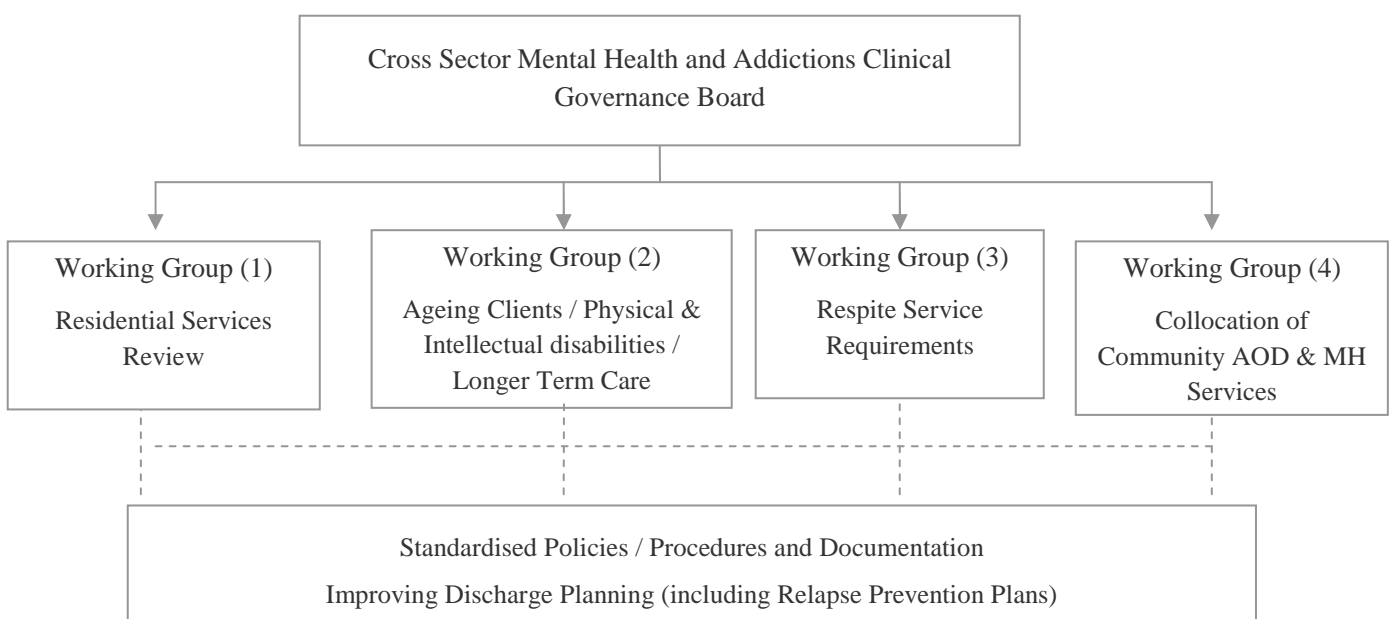
The implementation of the work programme will continue to be sponsored by Sandra Boardman, General Manager, Planning, Funding and Population Health, and facilitation lead by the Portfolio Manager, Child & Youth and Mental Health and Addictions.

Governance Structure and Reporting

It is proposed oversight of implementation of the Action Plan will be by an NGO Provider and Provider Arm Clinical Governance Board. A draft Terms of Reference are included in Appendix Five. The Clinical Governance Board will provide advice and recommendations to the sub working parties to roll out the changes necessary across the prioritised areas. Areas of workforce development will be undertaken with the Midland Regional Coordinator and the national workforce development agencies.

The following proposed structure for implementation of the work plan.

Figure 3: Proposed Working Party Structure



resources required

Stakeholders

- Taranaki DHB Portfolio Manager, Child & Youth and Mental Health and Addictions
- Clinical Director, Mental Health and Addictions
- Clinical Service Managers
- Business Manager, Mental Health and Addictions
- Taranaki DHB and NGO Sector Mental Health and Addictions Services , mix of professions across both NGO and Provider Arm
- National Workforce Development Agencies
- Analytical support
- Primary Care
- Consumer and Family Advisors

Budget

There are no identified costs associated with the Action Plan. Current resources will be used across the sector. While the review of Residential Care, Crisis and Longer Term Client Services are likely to show some issues with funding allocation it has been clearly articulated throughout the project that no additional funding will be available.

Interdependencies and other considerations

- Taranaki DHB Acute Services Review and Implementation
- Ministry of Health Co-existing Addiction and Mental Health Problems Project (CEP)
- Te Kawau Maro RFP – Whanau Ora Model of Care – Kaupapa Maori Services
- Shifting to the new Mental Health and Addictions Services Framework
- Mental Health Commission Review of Blueprint
- Ministry of Health Mental Health and Addictions Service Development Plan
- Health Workforce New Zealand MH&A Service Workforce Plan
- Midland Regional Clinical Governance Project
- Mildands AoD Qualifications Framework Project

Action One: establishment of a cross sector taranaki mental health and addictions clinical governance structure

The purpose of this project to develop and articulate a shared understanding of existing Clinical Governance structures at a sector level with a focus on

- Consumer Value
- Clinical Performance and Evaluation
- Clinical Risk
- Professional Development and Management.

Links to Recommendations	Action	KPI	Responsibility	Completion Time frame	Resources Required
1.0 2.0 2.3 3.0 3.1	<ul style="list-style-type: none"> • Ensure all stakeholders have a shared understanding of what clinical governance means in the context of Taranaki MHA services • Conduct a review of all formal documentation that supports current Clinical Governance activity across the sector • Develop a Terms of Reference for the reorientation and/or establishment of an across all sector Clinical Governance Forum 	<ul style="list-style-type: none"> • Review is completed • Terms of Reference developed and signed of by GM Planning & Funding 	Portfolio Manager, TLAG and MHA Clinical Board	July 2012	Key personnel and time

Action Two: review services and mix

Three priority areas have been identified as service types by which the range, mix, geographical spread and service models are reviewed. They are:

- Residential Rehabilitation Services (Stage One)
- Respite /Carer and Crisis (Stage One)
- Longer Term residential care / physical and intellectual disabilities / like in age in interest / DSS & MH / Ageing population needs (Stage One)
- Community Mental Health, Alcohol and Other Drug services and Co-Existing Problems collocation options (Stage Two)
- Improving the interface and delivery of other support services, e.g Day Activity Programmes, and Providers with small numbers of resources (Stage Two)

Additionally, Inter District Flows (IDFs) will be reviewed as part of the continuum of Taranaki Mental Health and Addiction services.

Links to Recommendations	Activity	KPI	Responsibility	Completion Time frame	Resources Required
1.0 1.1 1.2 1.3 2.1 2.2 2.3 2.4	<ul style="list-style-type: none"> • Small Technical Working Group established • Complete mapping exercise of services across the 4 agreed areas • Describe the services provided including philosophy and any provider specific terms and conditions • Benchmark against other DHBS, known evidence, practice and funding models • Recommendations for service reconfiguration and options are developed if indicated (including opportunities for the development of consistent policies, practices and procedures) 	Review of Service Mix is completed	Lead – Portfolio Manager	Phased approach Completion Stage One December 2011	Analyst Support Time and Personnel

Action Three: consistency of policies, protocols and procedures

Develop a discussion document and recommendations identifying what Policies, Protocols and Procedures could be reviewed and adapted for consistent practice across the sector. This work will be prioritised to tie in with the service reviews in Action Two.

- Phase One: Standardised documentation - (policies/procedures/protocols)
- Phase Two: Shared electronic notes /one client record

Links to Recommendations	Activity	KPI	Responsibility	Completion Time frame	Resources Required
1.0 1.2 1.3 2.1 2.3 3.0	<ul style="list-style-type: none"> • Small Technical working group established • Directory of Policies, Protocols and Procedures compiled • Prioritise into a list of what aspects could be reviewed to enable consistent practice across the sector and link this to service reviews • Describe process for sector buy-in and involvement • Work plan agreed with Project Leads identified • Development and implementation of consistent policies procedures and protocols 	Directory complied List prioritised Work plan agreed Work plan implemented	Portfolio Manager, TLAG and MHA Clinical Governance Board	Phase One: December 2012	Dedicated Project Time Admin support Stakeholder input

Action four: improve discharge planning processes across the continuum of mental health and addiction services

This includes consideration to of NASC access management, and links into the work for service mix and models as outlined in Action Two. It also will have a focus on the development and improvement of relapse prevention planning to be more inclusive of service users', tangata whaiora and their families and whanau.

Links to Recommendations	Action	KPI	Responsibility	Completion Time frame	Resources Required
1.0 1.3 2.0 2.1 2.2 3.0	<ul style="list-style-type: none"> • Small Technical working group established • Discharge planning processes across all services are described, particularly with reference to NASC services and inpatient services • Client pathway mapped (Value mapping exercises for agreed client pathways) • Improving relapse prevention plans. • Clear protocols developed and implemented • Evaluation and monitoring of amended protocols 	<p>Discharge planning protocols are reviewed and recommendations for improvement agreed</p> <p>Evaluation of monitoring of implementation of amended protocols</p>	Portfolio Manager, TLAG and MHA Clinical Governance Board	July 2014	Key personnel and time

Action Four: establishment of a cross sector taranaki mental health and addictions clinical governance structure

The purpose of this project to develop and articulate a shared understanding of existing Clinical Governance structures at a sector level with a focus on

- Consumer Value
- Clinical Performance and Evaluation
- Clinical Risk
- Professional Development and Management.

Links to Recommendations	Action	KPI	Responsibility	Completion Time frame	Resources Required
1.0 2.0 2.3 3.0 3.1	<ul style="list-style-type: none"> • Ensure all stakeholders have a shared understanding of what clinical governance means in the context of Taranaki MHA services • Conduct a review of all formal documentation that supports current Clinical Governance activity across the sector • Develop a Terms of Reference for the reorientation and/or establishment of an across all sector Clinical Governance Forum 	<ul style="list-style-type: none"> • Review is completed • Terms of Reference developed and signed of by GM Planning & Funding 	Portfolio Manager, TLAG and MHA Clinical Board	July 2012	Key personnel and time

Section Five: Alignment to National/Regional/Local Strategies and Projects

national context

The National mental health and addictions strategy was launched by the Government in 1994 with the publication of *Looking Forward: Strategic Directions for the Mental Health Services*⁷ and developed further in the National Mental Health Plan, *Moving Forward: The national mental Health Plan for More and Better Services*⁸. Shortly after, the Mental Health Commission published the *Blueprint for Mental Health Services in New Zealand: How things need to be (1998)* which became an important document in establishing service levels that guide the development of specialist mental health services.

In response to a number of strategies and plans develop for (and by) the mental health and addictions sector, the Mental Health Commission produced their publication *Te Hononga 2015: Connecting for Greater Well-being* – the purpose of which they describe as presenting a unifying picture of the sector in 2015 from the perspective of the Mental Health Commission and which complements, supports and builds on both Ministry of Health documents *Te Tahuhu* and *Te Kokiri* (MHC, 2007:1).

treaty of waitangi

The principles of the Treaty of Waitangi provide the foundation for future mental health service development, planning, implementation, delivery and monitoring as outlined below:

- Partnership – working together with iwi, hapu, whanau and Maori communities to develop strategies for improving the mental health status of Maori.
- Participating – involving Maori at all levels of the sector in planning, development and delivery of mental health services that are put in place to improve the health status of Maori.
- Protection – ensuring Maori wellbeing is protected and improved as well as safeguarding Maori cultural concepts values and practices.

te tahuhu –improving mental health

The Second National Mental Health Plan takes a more comprehensive approach to improving mental health and addiction services. The strategy builds on the first national plan and takes a stronger emphasis by the inclusion of the health promotion and primary health care. The ten challenges outlined in *Te Tahuhu* are:

Challenge	Description
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⁷ Looking Forward: Strategic Directions for the Mental Health Services. Ministry of Health. 1994.

⁸ Moving Forward: The National Mental Health and Addictions Plan for More and Better Services. Ministry of Health. 1997.

Challenge	Description
Promotion and prevention	Promote mental health and wellbeing and prevent mental illness and addiction
Building mental health services	Build and broaden the range and choice of services and supports, which are funded for people who are severely affected by mental illness
Responsiveness	Build responsive services for people who are severely affected by mental illness and/or addiction
Workforce and culture for recovery	Build a mental health and addiction workforce – and foster a culture amongst providers – that supports recovery, is person centred, culturally capable, and delivers an ongoing commitment to assure and improve the quality of services for people
Maori mental health	Continue to broaden the range, quality and choice of mental health and addictions services for Maori
Primary health care	Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of the people with mental illness and addiction
Addiction	Improve the availability of and access to quality addiction services, and strengthen the alignment between addiction services and services for people with mental illness
Funding mechanisms for recovery	Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration
Transparency and trust	Strengthen trust in services and accountability and information systems
Working together	Strengthen cross-agency working together

current policy settings & government priorities

Whilst the array of legislation, government policy, priorities and national directions are complex, there are a number of key themes:

- Services that are recovery and wellness focussed
- Increasing promotion and prevention relating to mental illness and addictions
- Addressing gaps in service – in particular for
 - Maori
 - People (especially young people) with substance use problems, including reducing the harm from alcohol and improving the availability and accessibility of alcohol and other drug treatment services
 - Children (including addressing conduct and behavioural problems in childhood)
- Building the capacity and capability of primary care to respond to the needs of people with mental illness and substance use problems
- Strengthening linkages between primary care and specialist services and moving some services from specialist to primary care settings where appropriate

- Better management of co-existing mental health and substance use problems - all mental health and addiction agencies will become “co-existing problems capable.”
- Earlier access to services
- Meeting the needs of people in the criminal justice and youth justice system
- Workforce development
- Interagency linkages with a particular focus on services for children with conduct disorders.

The Government’s expectations and priorities for mental health and addiction services for the immediate future have been articulated recently in the “Mental Health and Addiction Action Plan 2010”⁹. The prioritised actions respond to the Government’s immediate and emerging priorities and involve:

Priority	Actions
Moving health resources to increase access to mental health and addiction services and improve health outcomes	<ul style="list-style-type: none"> • New ways of delivering well-connected and co-coordinated services involving primary care, district health boards and non-government organisations • More use of Relapse Prevention Plans and Knowing the People Planning or similar planning tools for people requiring long-term assistance.
Lifting system performance to enhance our communities’ mental health and wellbeing	<ul style="list-style-type: none"> • Enhancing eating disorder services • Establishing regional advisory services for dementia behavioural support • Using national key performance indicators to measure how we’re doing and where improvements need to be made, particularly for Maori and other vulnerable populations • Ensuring that services meet future needs through a new nationwide Mental Health and Addiction Service Development Plan • Collecting better information about publicly-funded mental health and addiction services
Tackling alcohol and other drug-related harm	<ul style="list-style-type: none"> • Improving access to methamphetamine-related services • Developing a modern legislative framework • Providing additional alcohol and drug treatment programmes for young offenders.
Integrating efforts across government for better mental health outcomes	<ul style="list-style-type: none"> • Mental health and addiction services that help to divert children and young people away from negative pathways and increase their life chances.

midland regional guiding principles

The Midland Region Mental Health and Addictions Strategic Plan 2009 – 2015 describes the Midland regional strategic priorities as they relate to the ten challenges that make up Te Tahuhu.

⁹ <http://www.moh.govt.nz/moh.nsf/indexmh/mental-health-and-addiction-action-plan-2010>

The following principles guide the planning and provision of mental health and addictions services in the Midland Region.

- **Service users and family whanau** are central to the mental health and addictions system and will be active partners in their recovery planning
- **Service users and family whanau** are central to the mental health and addictions system and will be active partners in system planning, development, and service delivery
- **Recovery** - “Recovery happens when we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there”¹⁰.

Certain concepts or factors are common to recovery, including hope, medication/treatment, empowerment, support, education/ knowledge, self-help, spirituality, and employment/ meaningful activity. The strengths based approach [will be utilised to] enable consumers to approach their journey towards recovery using their personal strengths, supported by the strengths others can contribute to that journey

- **Whanau Ora and Responsiveness to Maori** - Cultural identity and belonging are necessary for service user wellbeing and recovery. Whanau ora acknowledges the collective familial supports that assist in the wellness journey
- Whanau Ora exemplifies a system responsive to Maori, with respect for Maori concepts, and inclusive of Maori service users and their whanau to achieve optimal health outcomes
- **People in service users’ support networks** - family, whanau, friends, and community - are essential to recovery. The inclusion of support networks in regional service planning, development and service delivery, helps ensure positive outcomes for service users, and recognises that support persons needs may also need to be met by the system
- **Services are responsive** to the specific cultural and individual needs and preferences of service users, with particular attention to Maori
- **High quality services** are outcome-focused, underpinned by continuous improvement and are based on evidence and best practice
- **Well-connected health and social services** (housing, social services, employment, education, justice, corrections, and destigmatisation) promote social inclusion and support service users to achieve optimal mental health and addictions outcomes
- **Partnerships** are vital within the MH&A system, and between it and related systems, to benefit service users.

¹⁰ Source: Our Lives in 2014, a recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors.

midland needs assessment service coordination (NASC) project

This report is the result of a project that was commissioned in December 2010, to gather information about the current models of Needs Assessment and Service Coordination (NASC) being delivered for people that experience mental health and addiction problems; in the Midland region and in other DHBs in New Zealand.

Data collected from a Midland region stock take, and from interviews with key informants from NASC services in other regions was analysed. It was found that there was significant variation in the way NASC services were delivered nationwide including workforce invested, service model implemented and scope of services access managed.

Staff also faced challenges in NASC service delivery. Those challenges were explored and opportunities to collaboratively tackle the challenges were proposed. This included achieving some consistency in service, through implementing standards, guidelines, service specifications and workforce competencies.

The report reflects an aggregated Midland perspective, and the following generic recommendations were made:

Generic Themes	Description
Service Model	<ul style="list-style-type: none"> DHBs understand and confirm the NASC model that they have chosen (combined or separate needs assessment and service coordination functions). This service model is strengthened to enhance service user responsiveness and improve the matching of needs and aspirations to services. DHBs examine the range of community based services available to service users region wide and confirm what may be accessed nationally, regionally, sub regionally and locally for their service users. This information is retained and updated regularly.
Scope	<ul style="list-style-type: none"> DHBs extend NASC responsibilities to incorporate access management to Community Support work and packages of care. This is a growing component of the service continuum.
Funding	<ul style="list-style-type: none"> DHBs recognise the value of NASC in the prioritisation of limited resource and therefore invest in NASC workforce to meet service requirements. NASC budget holding for aspects of service such as packages of care is further explored for implementation.
Systems and Processes	<ul style="list-style-type: none"> DHBs work collaboratively to achieve consistency in systems and processes within the region including adopting standards, guidelines, service specifications, data collection and assessment tools. Review processes are in place to ensure service users' needs (that may fluctuate over time) are addressed and resources fully utilised.
Workforce	<ul style="list-style-type: none"> DHBs confirm the preferred skill mix of their NASC teams and seek to develop NASC expertise using recruitment strategies, training programmes, a competency framework, and establishing a regular networking forum.

midland needs assessment project

This project was commissioned by the Midland Regional Network and completed in December 2010. The report provides up to date information on the needs, unmet needs and current service delivery in the Midland

region. Together with a description of the demographic profile of the region and current national policy setting and priorities, the information is designed to provide a basis for prioritising needs and planning services.

The data analysis in the report used information from the national PRIMHD repository, this meant there were limitations due to approximately 60% of NGO providers across New Zealand were still non compliant. Taranaki however was fully compliant. Comparisons against national and regional data means Taranaki could be overstated and caveats carefully considered. The report does however provide a baseline for future comparisons and the region has recommended the tables be refreshed when the compliance rate increases.

Four approaches are used in the report to identify needs and priorities:

- A population approach which uses prevalence, demographic and utilisation information to identify the mental health and addiction needs and unmet needs of particular population groups (by ethnicity, age, severity and disorder)
- A service benchmarking approach which compares the level of service provided in the region with national average levels, PBF levels and Blueprint targets in an attempt to ascertain whether the region and each DHB in the region have the optimal level and mix of services and whether there are gaps in various service categories
- A comprehensive summary of the views of Midland region stakeholders as represented by the various Midland regional advisory groups
- A summary of the demographic profile of the region and the current policy settings and government priorities to provide the context within which prioritization decisions need to be made.

The draft report has been presented to Midland Advisory Networks, and feedback has been incorporated into the final document, which has now been signed off by the Midland region's CEO's.

taranaki dhb acute services review

This review was sponsored by Joy Farley and Dr Samir Heble in September 2010, with the aim of undertaking an overall review of the current model of Acute MH & A services within Taranaki.

A series of meetings and forums were undertaken with key stakeholders, in both primary and secondary health care sectors, along with clinical specialty groups. All were invited to provide additional written submissions and a number were received. Clinical statistics were obtained and reviewed to inform the draft recommendations.

The feedback was collated, research and literature reviewed, and based on this feedback and research, alternative pathways/models have been proposed for considerations by the project sponsors.

Over 115 recommendations were proposed under thirteen main headings of:

- General recommendations for staff
- Service wide recommendations

- Single point of entry/access for all referrals to Taranaki Mental Health and Addiction services
- Psychiatrists
- Psychology
- Community Mental Health & Addiction teams
- Te Puna Wairua
- NGOs
- Professional Development needs
- MHA Court days
- Mental Health Administration
- Child & Adolescent Mental health services
- MH SMART/PRIMHD Coordinator

It is recognised that further work is now required to form these recommendations into an implementation plan that will streamline the service users', tangata whaiora journey through acute mental health and services. Currently there are additional "Value Mapping" workshops being undertaken to more fully inform the barriers and constraints when accessing services, as well as the opportunity to streamline processes.

mental health pathway for mild to moderate mental health services

This workgroup was commissioned by the Planning and Funding Clinical Project Group in Sept 2010 to provide the Planning and Funding Clinical Project Group with clear recommendations for improving access to non-pharmaceutical treatment for mild to moderate mental health issues.

In Sept – Nov 2010, the workgroup engaged in a range of activities and discussions, including:

- Description of the current state of mental health pathways for mild to moderate patients, including benefits of current system, barriers and issues and counseling services available through existing programs such as Taranaki Primary Connections
- Identification of funders of services, access criteria, services provided and outcomes desired
- Description of ideal state characteristics for a mental health pathway for patients with mild to moderate mental health issues
- Quantification of volume of services provided by Work and Income, ACC, and Primary Care
- Review of evidence regarding intersection of employment and mental health
- Creation of recommendations to meet ideal state characteristics and proposal of new pathway

Several recommendations were proposed as per below, as part of the Midlands Regional Health Network development, their Service Level Alliance Team's ongoing service development (SLAT's) the recommendations are being considered.

Recommendations

- Create a Single Point of Entry and Coordination Process to which GPs and individuals could refer (could be a person or a clear role for an office). The creation of this Single Point of Entry would ideally

be within an existing agency/entity and would be coordinated with existing workstreams/initiatives such as those being put forth by the Midlands Health Network

- Coordinate planning and funding of mental health services by bringing together agencies involved in this workgroup plus additional service-providing agencies
- Provide a reminder of the Adult Depression Module that is already available through MedTech systems.

Section Six: Taranaki DHB – Demographic Characteristics and Prevalence Data

In order to understand the future needs of the population, we have reviewed current ethnicity and age profiles, contrasted by the national and Midland positions respectively. In addition this section describes Taranaki DHB's prevalence and access rates to Mental Health and Addiction Services.

In 2010/2011 the Midland Region undertook a needs assessment for Mental Health and Addictions Services. The resulting report described the local and regional populations covered by the 5 DHBs and the differences between district, regional and national populations. For access and prevalence data the project used Te Rau Hinengaro: The New Zealand Mental Health Survey 2006 and data extracted from national PRIMHD database. At the time data was extracted, Taranaki DHBs MH&A sector compliance was significantly higher than the rest of the Midland and National compliance. While the report provided a baseline template for refreshing information, it is felt until compliance has increased comparison data used in this report is limited to Te Rau Hinengaro prevalence against Taranaki DHB's access to service rates.

When comparing national prevalence rates with Taranaki DHB access rates for those presenting across Mental Health and Addictions services with severe disorders it shows the number of individuals receiving services is significantly lower than the prevalence. For ages 0 – 64¹¹ years and estimated 2010 clients would not be receiving services based on the prevalence. In comparison however, Taranaki DHBs spending against Blueprint funding and against the Population Based Funding Formula shows Taranaki is overspend in Mental Health and Addictions Services. In summary, while TRH estimates the need across the population show under delivery against need, the ring fenced funding has been exceeded by the District Health Board.

When comparing the volumes each Midland Region DHB purchases against services, the mix of services are varied. Taranaki methadone places exceed benchmark by 28.3 for example, whereas Adult Community Support FTEs shows 9.9 below benchmark.

population data

- Taranaki's population at 2010 was reported to be 109,530 people in total
- The Asian population of 2.6% is well below the national average
- The Maori population of 16.8% is lower than the Midland average of 24.8%, but slightly above the national average of 15.1%
- At 1.0%, the Pacific population is significantly lower than the national average of 6.4%
- "Other" ethnicities make up almost 80% of the Taranaki population which is significantly higher than the national average of 67.5%.

Figure 4: Ethnicity Breakdown

¹¹ For age 65+ TRH did not use rest home and dementia data, which significantly understated the need for this age group.

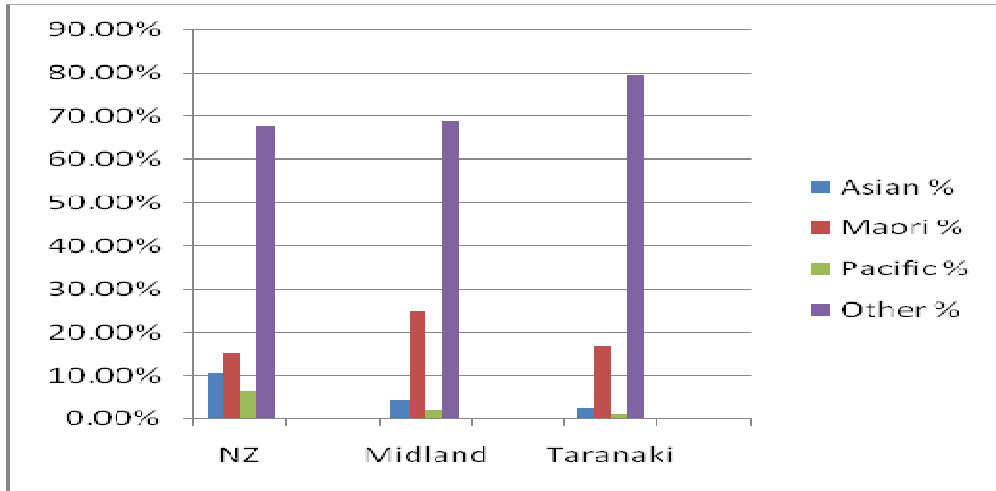


Table 1: Ethnicity breakdown

	Asian		Maori		Pacific		Other		Total Pop
	Pop	%	Pop	%	Pop	%	Pop	%	
NZ	463,095	10.5%	664,230	15.1%	279,365	6.4%	2,966,840	67.8%	4,373,530
Midland	36,420	4.4%	206,860	24.8%	16,385	2.0%	575,730	68.9%	835,395
Taranaki	2,860	2.6%	18,450	16.8%	1,090	1.0%	87,130	79.5%	109,530

Taranaki Population Breakdown by Age

- As at 2010, just over a third of the population is 24 years or younger
- Approximately a quarter of the population are in the 24 – 44 age group
- People in the 45-65 age group make up the largest population group at 26.3%, slightly less than the Midland average of 25.4%
- 15.7% of the population are in the 65+ age group, slightly more than the Midland average of 14.5%

Figure 5: Population by age

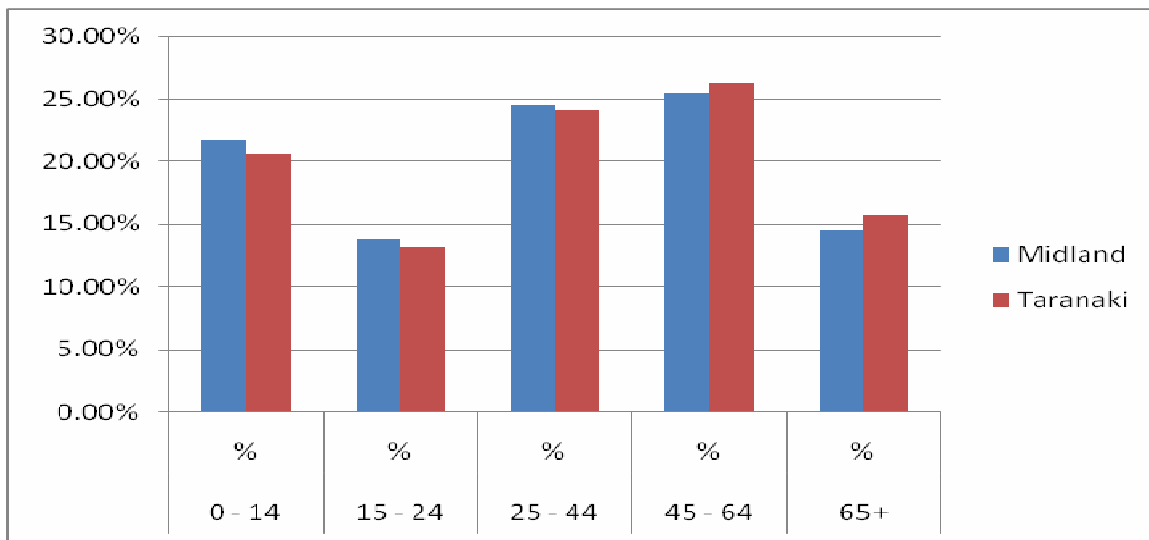


Table 2: Population by age

	0 - 14		15 - 24		24 - 44		45 - 64		65+	
	Pop	%	Pop	%	Pop	%	Pop	%	Pop	%

Midland	182,010	21.8%	115,130	13.8%	204,655	24.5%	212,515	25.4%	121,085	14.5%
Taranaki	22,720	20.7%	14,305	13.1%	26,425	24.1%	28,865	26.3%	17,215	15.7%

Population Projections

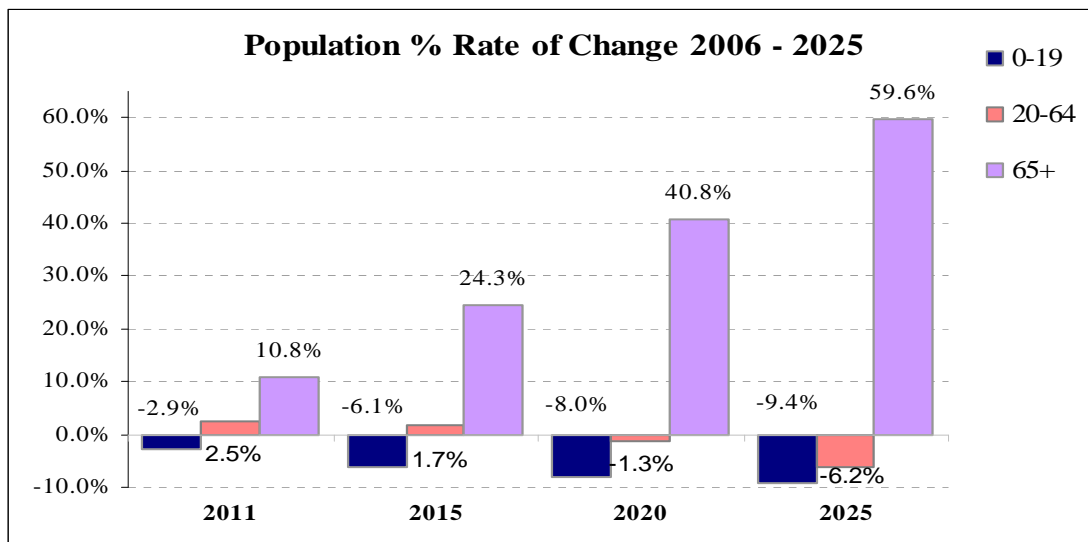
- The New Zealand population is projected to increase by 14.1% between 2010- 2026, with a 9.21% increase expected for the total Midland population
- This trend is not reflected within the Taranaki population which is only predicted to increase by 0.4% over the 15 year period. This is a marginal increase of less than 500 people.

Table 3: Population Projections

	2010	2016	2021	2026	% increase in population 2010 –2026
NZ	4,373,530	4,630,495	4,817,555	4,991,595	14.1%
Midland	835,395	870,435	893,020	912,350	9.21%
Taranaki	109,530	110,545	110,525	109,975	0.4%

- While Taranaki’s overall population rate of change is minimal, the 65+ population will increase by 59.6% between 2006 and 2025, which equates to 9,500 people.
- Within the marginal increase, the projected changes are significantly different across ethnic groups. Maori % rate of population increase is 23.7% (+4380) between 2010 -2026 and Asian/Pacific is 56.3% increase (+2225).
- Within the 65+ age group, rates of increase for Maori 65+ are projected at 103%, Pacific/Asian are 245% and other 44%.

Figure 6: Percentage Rate of Population Change



prevalence and access data

Based on the data from Te Rau Hinengaro, for all mental health and substance disorders the 12 month prevalence rate is 4.7% for a serious disorder, 9.4% for a moderate disorder and 6.6% for a mild disorder. Prevalence is highest for Maori (8.7% have a serious disorder) and Pacific people (6% have a serious

disorder) and for younger people, people with less education, people with less income and people who live in more deprived areas. In comparison 3.5% of the population experienced a substance use disorder within a 12 month period with 75% of disorders beginning before age 24.

Around 20% of children and youth are estimated to have a mental disorder or problem, and the estimated 12 month rate of disorder with significant clinical impairment for children and youth is around 12-15%. Of those that are youth offending, between 40 – 60% have a mental health and/or AoD disorder, with 20% of those offenders having disorders so severe that their ability to function is significantly impaired.

Calculating the Expected Number of the population with any Disorder – Severe Mental Health and Substance Use for Taranaki

The table below shows Te Rau Hinengaro (TRH) prevalence rates and Taranaki DHB expected volumes and actual volumes (PRIMHD). Te Rau Hinengaro prevalence rates are significantly underestimated as Rest Home and Dementia was not included in the report. The expected number of the population with MH&A needs across all age groups is 4,003 compared to 2,674 unique individuals who access services. *PRIMHD data period 1 April 2009 – 31 March 2010.*

Table 4: Access & Prevalence by Age

Age Group	National Prevalence	Demographic information - number of people TDHB	Expected Number with MH & AoD Needs	Number of Unique Individuals Accessing MH & AoD services	Variance	Age Group	Access Rates
0-15	No Info.	24,370	No info TRH	334		0-19	3.60
6-15	7.2 Estimate	14,622	1,053	No info			
16-24	7.2	12,655	911	512	399	20 - 64	3.88
25-44	5.8	26,425	1,533	1,099	434		
45-64	3.8	28,865	1,097	639	458		
65 +	1.1	17,215	189	424	-235	65+	3.32
All ages over 15	4.7	85,160	4,003	2674	1329	All Ages	3.60

Access rates for ethnic groups are also understated compared to the prevalence rates in TRH. While its encouraging to note Maori are access to services is higher than other, access is less as a proportion of prevalence than Other ethnicities. While the table below also includes National and Regional access rate, both sets of data have a significant number of providers that were not submitting data to PRIMHD during the reporting period. With the Taranaki compliance rate being so much higher, it would expected that our rate would be higher than both comparison groups.

Table 5: Access and Prevalence by Ethnicity

		Te Rau Hinengaro 12 month prevalence	NZ access rate (%)	Midland access rate (%)	Taranaki access Rate %
ages	All Maori	8.7	3.85	3.48	4.68
	Pacific	6.0	2.35	1.83	2.66

Other	4.1	2.57	2.79	3.39
All	4.7	2.75	2.95	3.60

Calculating the Expected Number of the population with any Disorder – Mild to Moderate Mental Health and Substance Use for Taranaki.

The funding and service options within Taranaki for the treatment of mild to moderate mental health and alcohol and drug issues are significantly varied. There are multiple funders and Planning and Funding Clinical Project Group in Sept 2010 noted over 50 service providers in the region. For this reason, the actual numbers of the population accessing these services is unobtainable.

Table 6: Prevalence Mild to Moderate

Age Group	National Prevalence	Demographic information - number of people TDHB	Expected Number with MH & AoD Needs
0-15	No info TRH	24,370	No info TRH
6-15	No info TRH	14,622	No info TRH
16-24	21.4	12,655	2,708
25-44	19.3	26,425	5,100
45-64	13.6	28,865	3,926
65 +	6.0	17,215	1,732
All ages over 15	Mild – 8.2	85,160	5,621
All ages over 15	Moderate – 12.6	24,370	8,005

The Midland Regional Needs Assessment Report 2011 highlights only 36.5% of people with a moderate disorder make a mental health visit to any healthcare provider in a 12 month period and only 18.5% of those with a mild disorder. The number visiting general medication sector (doctors, nurses and other healthcare professionals, but mainly GP's) is 38.9% of people with a moderate disorder, and 15% of people with a mild disorder.

Based on this the estimated unmet need for people over 15 years with mild disorders are:

1. Expected number of people in Taranaki with mild disorder 5,621
2. % people with mild disorder accessing services 18.5%
3. Estimated number of people with mild disorder accessing services 1,040
4. Estimated unmet need for people with mild disorder 4,581

Based on this the estimated unmet need for people over 15 years with moderate disorders is:

1. Expected number of people in Taranaki with moderate disorder 8,005
2. % people with moderate disorder accessing services 36.5%
3. Estimated number of people with moderate disorder accessing services 2,922
4. Estimated unmet need for people with moderate disorder 5,083

Midland Region Mental Health and Addictions Needs Assessment Report - Gaps by Population Groups

The report highlights a number of gaps by population across the region, which included:

- Gaps for children and young people with severe substance use disorders (particularly high for young Maori and Pacific people)
- Gaps for school age children with severe mental health disorders
- % gaps are greatest for Pacific people with significant gaps also for Maori
- High level of unmet need for primary mental health services for people with mild and moderate disorders.

Section Seven: Local Service Mapping Exercise – High level overview of services

locally delivered services

For the 2010-2011 financial year Taranaki DHB funded approximately \$31.80m of Mental Health and Addiction services. Around 72% of this funding is via Provider Arm and Specialist services (including Inter District Flows), and 28% is for the delivery services across the NGO and Primary Health sectors. For the 2011-2012 year, the NGO Mental Health and Addictions Providers have a contribution to cost pressures (CCP) applied of 3.45%. A breakdown of the 2010/11 funding mix is provided below.

Table 7: Funding Analysis

Sector	Funding	% of Total	Comment
Provider Arm	\$ 21.24 (m)	66.8 %	Total Specialist Provider Arm and NGO funding is \$29.64 (m). Provider Arm = 71.7% of total.
NGO's	\$ 8.40 (m)	26.4%	NGO = 28.3% of total
Inter District Flows	\$ 1.65 (m)	5.2%	
Primary MH	\$.56 (m)	1.6%	
MSD	\$.44 (m)		

Funding Analysis by Purchase Type

When comparing the types of services that are purchased within the \$29.65 Taranaki DHB expenditure, \$9.36 (m) or 31.6% funds Accommodation Services, across both Provider Arm and NGO community residential facilities, (includes Odyssey House and STEP Programme). The % of total funding for Senior Medical and Nursing/Allied Health is 51.1%, \$ 15.14 (m) with 82.1% in Provider Arm and 17.9% in NGO sector. Non clinical staff including peer support and cultural roles equates to \$4.2 (m) or 14.3%, with splits of 87.8% or \$3.7 (m) for NGO sector and 12.2% or \$.52 (m) for Provider Arm. The following table provides further breakdown of funding allocation by purchase method for Specialist Provider Arm and NGO services.

Table 8: Funding Analysis by Purchase Type

Purchase Type	NGO \$'s (m)	Provider Arm \$'s (m)	Total \$'s (m)
Bed days*	\$ 1.89 (20.2%)**	\$ 7.47 (79.8%)	\$ 9.36 (31.6%***)
Senior Medical	\$ -	\$ 2.46 (100%)	\$ 2.46 (8.3%)
Nurse & Allied	\$ 2.71 (21.4%)	\$ 9.96 (79.6%)	\$12.68 (42.8%)
Non Clinical	\$ 3.13 (87.5%)	\$ 0.45 (12.5%)	\$ 3.58 (12.1%)
Cultural Staff	\$ 0.37 (100.0 %)	\$ -	\$ 0.37 (1.2%)
Consumer Advocacy	\$ 0.23 (75.9%)	\$ 0.07 (24.1%)	\$ 0.30 (1.0%)
Places	\$ -	\$ 0.42 (100%)	\$ 0.42 (1.4%)
POC	\$ 0.02 (21.8%)	\$ 0.06 (78.2%)	\$ 0.08 (0.3%)
Respite - Adult	\$ -	\$ 0.13 (100.0%)	\$ 0.13 (0.5%)
Respite - C&Y	\$ -	\$ 0.08 (100.0%)	\$ 0.08 (0.3%)
Workforce	\$ -	\$ 0.19 (100.0%)	\$ 0.19 (0.6%)
Grand Total	\$8.35	\$21.30	\$ 29.65

*In 2011/2012 \$1.07 (m) of residential services are purchased by Clinical and Non Clinical FTEs, rather than bed days.

**Percentage calculation represents % of the total for the purchase type.

***Percentage calculation represents % of purchase type to the total funding.

The numbers of FTEs for services purchased on this basis are as follows, note this excludes other purchasing methods e.g. bed days, packages of care, places and programmes.

Table 9: FTE's by Service

Service	FTE Type	NGO (FTE's)	Provider Arm (FTE's)	Total
Alcohol and Drug Services	Non Clinical	2.0		2.0
	Nurse & Allied	4.0	10.8	14.8
	Senior Medical		1.1	1.1
Sub Total AoD		6.0	11.9	17.9
Child and Youth Services	Nurse & Allied	5.0	16.6	21.6
	Senior Medical		2.0	2.0
Sub Total C&Y		5.0	18.6	24.6
Maternal	Nurse & Allied	1.0	1.5	2.5
Mental Health Services	Non Clinical	48.5	4.9	53.4
	Nurse & Allied	12.0	48.8	60.8
	Senior Medical		5.1	5.1
Sub Total Mental Health		60.5	58.7	119.2
Mental Health & Addictions Services	Consumer Advocacy	3.0	2.0	5.0
	Cultural Staff	4.0		4.0
	Non Clinical	2.0		2.0
Sub Total MH&A		9.0	2.0	11.0
Co-existing Problems Disorders	Nurse & Allied	3.0	2.0	5.0
Mental Health and C&Y	Nurse & Allied		0.4	0.4
Mental Health Services for Older People	Non Clinical	2.3		2.3
	Nurse & Allied	0.5	7.8	8.3
	Senior Medical		1.0	1.0
Sub Total MHSOP		2.8	8.8	11.6
Grand Total		87.3	103.9	191.2

Funding Analysis by Purchase Method and Purchase Unit Code (PUC)

In 2011-2012 the Mental Health and Addictions sector are shifting to the delivery of the services through the new purchasing framework. The following analysis has been compiled on the new purchase units and is shown by, Service Type, NGO/Provider Arm splits, Purchase Methods and by Purchase Unit coding.

The Mental Health Services proportion of funding across both NGO and Provider Arm is larger than any other service area with 66.1% (NGO = 70.0% and Provider Arm = 64.4%). Child and Youth and Alcohol and Drugs are next with 10.3% and 9.6%. The following table shows the groups

The following purchase unit code analysis is on the basis of the new mental health and addictions purchasing framework, but uses 2010-2011 funding allocation. This means some purchase units funded on bed days in table 8. above are allocated on the basis of FTE's.

Alcohol and Drug Services

Table 10: AoD Funded Services

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHD76	Intensive and other drug services with accommodation	Beds	\$32,431		\$32,431
MHD53	Alcohol and Drug Community Support with Accommodation	Beds		\$444,226	\$444,226
MHD72C	Early intervention and other drug service – Nursing and allied health staff	Nurse & Allied	\$98,909		\$98,909
MHD74C	Community based alcohol and other drug specialist services – Nursing and allied staff	Nurse & Allied	\$282,134	\$1,128,100	\$1,410,234
MHD73D	Community Support Services Mental Health and Addiction - Non-clinical staff	Non Clinical	\$153,643		\$153,643
MHD69D	Alcohol and other Drugs Service - Opioid Substitution Treatment – Primary Care Support Places – Non clinical	Places		\$124,021	\$124,021
MHD70	Alcohol & Other Drugs Service – Opioid Substitution Treatment – Specialist Service	Places		\$297,434	\$297,434
MHD74A	Community based alcohol and other drug specialist services – Senior medical staff	Senior Medical		\$296,154	\$296,154
Grand Total			\$567,117	\$2,289,935	\$2,857,052

Child and Youth Services

Table 11: Child & Youth Funded Services

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHDI48C	Child, adolescent & youth alcohol & drug community services - Nurses & allied health	Nurse & Allied	\$94,045		\$94,045
MHI44C	ICAY community mental health services - Nurses & allied health	Nurse & Allied	\$396,600	\$1,879,527	\$2,276,127
MHI44A	Infant, child, adolescent & youth community mental health services - Senior medical staff	Senior Medical		\$538,461	\$538,461
MHI40	Infant, child, adolescent and youth acute package of care	POC		\$12,328	\$12,328
MHI56	Infant, child, adolescent, and youth package of care	POC		\$50,831	\$50,831
MHI42	Infant, child, adolescent and youth crisis respite	Respite - C&Y		\$31,955	\$31,955
MHI52	Infant, child, adolescent and youth planned respite	Respite - C&Y		\$43,724	\$43,724
Grand Total			\$490,645	\$2,556,826	\$3,047,471

Mental Health Services

Table 12: Mental Health Funded Services

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHA01	Adult Acute Inpatient Beds	Beds		\$4,959,635	\$4,959,635
MHAK25	Housing and recovery services day time/responsive night support - Kaupapa Māori	Beds	\$409,260		\$409,260

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHA25	Housing and Recovery Services Day Time/ Responsive Night Support	Beds	\$187,263		\$187,263
MHAK24	Housing and Recovery Services Day Time/ Awake Night Support - Kaupapa Maori	Beds	\$188,869		\$188,869
MHA24C	Housing and Recovery Services Day Time/ Awake Night Support Nursing/Allied	Nurse & Allied	\$106,003		\$106,003
MHA24D	Housing and Recovery Services Day Time/ Awake Night Support Non Clinical	Non Clinical	\$964,109		\$964,109
MHA02	Intensive Care Inpatient Beds 4 beds	Beds		\$1,173,417	\$1,173,417
MHA09A	Community clinical mental health service - Senior medical staff	Senior Medical		\$1,184,615	\$1,184,615
MHA11A	Mobile intensive treatment service - Senior medical staff	Senior Medical		\$175,000	\$175,000
MHA09C	Community Mental Health Service - Nurses and allied health staff	Nurse & Allied	\$212,007	\$4,713,536	\$4,925,542
MHA10C	Early Intervention for People First Time Psychosis - Adult (over 18 years) - Nursing /allied health	Nurse & Allied	\$209,588		\$209,588
MHA18C	Needs Assessment and Service Coordination - Kaupapa Maori - Nursing and/or allied health staff	Nurse & Allied	\$212,007		\$212,007
MHA11C	Mobile intensive treatment service - Nursing/ allied health staff	Nurse & Allied	\$106,003	\$806,158	\$912,162
MHK59C	Kaupapa Maori Community Based Clinical Support Services - Nursing/ allied health staff	Nurse & Allied	\$208,160		\$208,160
MHA09D	Community Mental Health Service - Non clinical staff	Non Clinical	\$76,821		\$76,821
MHA11D	Mobile intensive treatment service - Nursing/ allied health staff	Non Clinical		\$218,731	\$218,731
MHA20C	Adult Community Support Services - Non Clinical	Non Clinical	\$424,013		\$424,013
MHA20D	Adult Community Support Services - Non- clinical staff	Non Clinical	\$1,127,431		\$1,127,431
MHA21D	Activity Based Recovery Support Services - Non clinical staff	Non Clinical	\$398,936	\$154,079	\$553,016
MHA22D	Vocational Support Services - Non clinical staff	Non Clinical	\$890,117		\$890,117
MHA26D	Supportive Landlord - Non Clinical	Non Clinical	\$153,643		\$153,643
MHFF	Mental Health - flexi fund	POC	\$17,586		\$17,586
MHA03	Adult Crisis Respite	Respite - Adult		\$117,833	\$117,833
MHA17	Adult Planned Respite	Respite - Adult		\$17,154	\$17,154
MHWF	Mental Health - workforce	Workforce		\$185,593	\$185,593
Grand Total			\$5,891,816	\$13,705,750	\$19,597,567

Services that deliver across, Mental Health, AoD, Child and Youth and Co-existing Disorders

Table 13: Funding Across Services

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHCS67D	Family and whanau advisory service – non-clinical staff	Non Clinical		\$73,127	\$73,127
MHW68D	Family & Whanau Support, Education, Information and Advocacy Service	Non Clinical	\$153,643		\$153,643
MHCS34F	Consumer Advocacy Service	Peer Support	\$230,464	\$73,127	\$303,592
MHK61E	Kaumatua Roles - Cultural staff	Cultural Staff	\$367,598		\$367,598
MHAD14C	Co-existing disorders (mental health & addiction) - Nursing /allied health staff	Nurse & Allied	\$310,053	\$226,449	\$536,501
MHE29C	Clinical outpatient services for eating disorders - Nursing and/or allied health staff	Nurse & Allied		\$44,760	\$44,760
Grand Total			\$1,061,759	\$417,463	\$1,479,221

Maternal Mental Health and Addictions Services

Table 14: Maternal MH & A Funded Services

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHM90C	Perinatal Mental Health Specialist Community Service Nurses & allied health	Nurse & Allied	\$111,063	\$189,408	\$300,471
Grand Total			\$111,063	\$189,408	\$300,471

Mental Health Services for Older Persons

Table 15: Mental Health for Older Persons Funded Services

PUC	PUC Description	PU Method	NGO	Provider Arm	Total \$\$'s
MHO98	Mental Health of Older People – Acute Inpatient Service	Beds		\$895,111	\$895,111
MHO99C	Mental Health of Older People - Specialist Community Service – Nurses & allied health	Nurse & Allied	\$49,169	\$974,786	\$1,023,955
MHO99D	Mental Health of Older People – Specialist Community Service – Non-clinical staff	Non Clinical	\$176,689		\$176,689
MHO99A	Mental Health of Older People – Specialist Community Service – Senior medical staff	Senior Medical		\$269,231	\$269,231
Grand Total			\$225,858.	\$2,139,128.	\$2,364,987

Benchmarking Gaps

The Midland Region Mental Health and Addictions Needs Assessment Report May 2011, identified the Midland region as having a different mix of services compared with the national average, with less reliance on inpatient beds and more service provided through community FTE's. Services where the Midland regional appeared low compared to the national benchmarks included:

- Adult, child and youth and alcohol and drug beds.
- Child and youth day programmes.
- Specialist community FTE's and beds (services for complex and low prevalence disorders, such as eating disorders and severe personality disorders).

- Methadone places.

The Midland region is however above the national benchmark for AoD community FTEs. In comparison, the table below shows how many more or fewer beds or FTE's Taranaki would need for the age specific population if Taranaki was providing the services at the national benchmark. Taranaki shows a different trend to the analysis provided above.

Table 16: Service Benchmarking

Service	Age specific population	Midland	Taranaki	Taranaki
		How many more or fewer beds or FTEs would be needed for the age specific population if Midland was providing services at the national average	How many more or fewer beds or FTEs would be needed for the age specific population if Taranaki was providing services at the national average	How much more or less would be spent on the age specific population if Taranaki was providing services at the national average \$m
Adult community clinical FTEs	20-65	0.0	-8.2	\$ -1.2 (m)
Adult inpatient beds	20-65	28.3	-0.6	\$ -1.3 (m)
Adult community support FTEs	20-65	-16.5	8.9	\$ 0.4 (m)
Adult residential beds	20-65	4.7	3.4	\$ 0.4 (m)
AOD community FTES	All	-47.7	-1.0	\$ -0.3 (m)
AOD beds	All	31.3	-7.3	\$ -0.1 (m)
Methadone places	All	87.9	-30.4	\$ -0.1 (m)
Child and youth community FTES	0-19	-5.4	-1.3	\$ -0.3 (m)
Child and youth day programme	0-19	4.9	1.5	\$ 0.1 (m)
Child and youth beds (inpatient and community)	0-19	8.1	1.5	\$ 0.3 (m)
Forensic beds	20-65	-4.3	-0.9	\$ -0.1 (m)
Forensic community FTEs	20-65	-4.4	-0.1	\$ 0.0 (m)
Older people's community FTEs	65+	9.5	0.8	\$ -0.3 (m)
Older people's beds	65+	6.3	0.3	\$ 0.2 (m)
Older people's day programme	65+	-6.1	0.6	\$ 0.0 (m)
Specialist community FTEs	All	4.6	2.6	\$ 0.1 (m)
Specialist Beds	All	5.7	0.8	\$ 0.1 (m)
Non Blueprint	All	0.0	0.0	\$ -1.0 (m)

inter-district flows and other out of region services

The process and funding for calculating inter-district flows is complex, and often the basis for adjustments for the next financial years in on the basis of actual utilisation for two years prior.

The largest service area for funding for out of region services is for Forensics, Prison and Court Liaison type roles. For the 2011-2012 financial year, this equates to \$604,944 (13% of the total regional pool). Adult Alcohol and Drug Services is next highest with \$251,586, this includes Nova Trust, Bridge Programme, Springhill and Te Uuhina Manaakintanga. Other services funded out of region include Eating Disorders, Child and Youth via Starship, Acute Adult/Sub Acute services through Henry Bennett Centre in Waikato.

Waikato is also the lead DHB for the Day Activity/Vocational Programmes delivered locally by Progress to Health. These volumes are captured in the local services above. Taranaki DHB and MOH also jointly fund a package of care for a Huntington's client in the Waikato. Because of the complexity in the mapping of year trends for IDF's, further work is required and is identified in the Action Plan.

As a result of an MoH led RFP process for Methamphetamine services, Salvation Army has established a service in Taranaki. The longer term continuation of this services is dependent on MoH commitment post the two year funding commitment. As of January 2011 Taranaki DHB exited our proportion of the Waikato based Salvation Army IDF service funding with the intention of including a small proportion into local services. The education component for Eating Disorders was unbundled back to District Health Boards to manage for regional training held at each DHB.

The table below provides a 2011-2012 snapshot of the IDF and other out of region funding currently allocated for service provision.

Table 17: Service Benchmarking

Service Provider	Service Type	PU Code	Service Description1	Vol type	11/12 DOD \$ share Taranaki
Auckland DHB	Eating Disorders	MHWD01	Eating disorders (education)	Education	\$ -
Midland Region	Eating Disorders	MHWD01	Midland Regional Mental health (Blueprint)	Blueprint	\$ 91,436
			Eating Disorder Total		\$ 91,436
Hauora Waikato	Forensics/Court Liaison	MHCS12	Court Liaison	1	\$ 60,987
Hauora Waikato	Forensics/Court Liaison	MHCS12	Court Liaison	FTEs	\$ 30,493
Hauora Waikato	Forensics/Court Liaison	MHCS11 B	Community Forensic (Senior Medical)	Senior Medical FTE	\$ 9,551
Waikato DHB	Forensics/Court Liaison	MHF80A	Community Forensic Service	FTE	\$ 21,350
Waikato DHB	Forensics/Court Liaison	MHF80C	Community Forensic Service	FTE	\$ 80,945

Service Provider	Service Type	PU Code	Service Description1	Vol type	11/12 DOD \$ share Taranaki
Waikato DHB	Forensics/Court Liaison	MHF84A	Prison Mental Health	FTE	\$ 95,577
Waikato DHB	Forensics/Court Liaison	MHF84C	Prison Mental Health	FTE	\$ 237,253
Waikato DHB	Forensics/Court Liaison	MHF85A	Court Liaison	FTE	\$ 38,231
Waikato DHB	Forensics/Court Liaison	MHF85C	Court Liaison	FTE	\$ 91,544
Forensics/Court Liaison Totals					\$ 604,944
Henry Bennett Centre	Sub Acute/Extended Care	MHA07	Sub-acute/Extended Care inpatient beds	Bed Days	\$ 4,879
Henry Bennett Centre	Acute Adult	MHA01	Adult acute Inpatient beds	Bed Days	\$ 9,224
Whakatane*	Acute Adult	MHIS01	Acute MH Available Beds	Bed Days	\$ 27,650
Acute Adult/Sub Acute Adult Totals					\$ 41,752
New Progress Enterprises**	Vocational and Activity Programmes	MHA22D	Vocational-based rehabilitation	Non Clinical FTE	\$ 183,825
New Progress Enterprises	Vocational and Activity Programmes	MHA21D	Activity-based Rehab	Non Clinical FTE	\$ 175,635
Activity/Vocational Services					\$ 359,460
Nova Trust	Alcohol and Drug Rehab	MHCR07	A&D - Residential Treatment	Bed Days/POC	\$ 21,675
Salvation Army / Bridge	Alcohol and Drug Rehab	MHD76	Intensive AOD Service - Bridge	Bed Days	\$ 44,676
Springhill	Alcohol and Drug Rehab	MHCR07	Residential Treatment - Alcohol and Drug Service	Bed Days	\$ 17,093
Te Utuhina Manaakitanga Trust	Alcohol and Drug Rehab	MHCS01c	Regional Kaupapa Maori AOD - non-clin FTE	Non Clinical FTE	\$ 78,605
Te Utuhina Manaakitanga Trust	Alcohol and Drug Rehab	MHCS01a	Regional Kaupapa Maori AOD - FTE	Non Clinical FTE	\$ 38,862
Te Utuhina Manaakitanga Trust	Alcohol and Drug Rehab	MHCR07	Regional Kaupapa Maori AOD - bed-days	Bed Days	\$ 50,674
Alcohol and Drug Rehab Totals					\$ 251,586
Starship	Child & Youth Services	MHCS08 A	C&Y community service	FTE	\$ 25,033
Starship	Child & Youth Services	MHIS09	C&Y inpatient beds - Intensive Care	Bed Days	\$ 14,767
Starship	Child & Youth Services	MHIS07	C&Y inpatient beds	Bed Days	\$ 24,627
Te Waireka	Child & Youth (AoD)		C&Y AoD Services	Bed Days	\$ 15,808
Child & Youth Services Total					\$ 80,235
Laura Ferguson	Huntingtons	DSS1030	Huntingtons Client	Bed Days	\$ 123,188

* The IDF line for Whakatane is being reviewed. The service is not a known service used by Taranaki DHB AoD services.

** Progress to Health Services contract held by Waikato DHB as the lead. FTE information also included in the analysis for local services.

Further work on inter-district flows has been identified in the Action Plan.

Taranaki DHB Specific Gaps

The following gaps have been identified.

- Spectrum of Respite services including Crisis and Family respite (adult & youth)
- Housing and accommodations, particularly for 18 – 25 year olds and for people with co-existing mental health and AOD disorders
- Packages of care, funding and flexibility
- People with co-morbid disorders (e.g. severe physical and mental health needs such as Huntington's disease)
- Mental health and ageing issues
- Desire for families and whanau to be more involved with treatment.
- Early intervention and relapse planning
- Day programmes and therapy options
- Mentoring programmes and staff support
- Sharing of information (electronic notes)
- Collaborations between justice and health
- Better liaisons with intersectoral agencies
- Ensuring all services are recovery and client focused

References & Key Documents

Blueprint for Mental Health Services in New Zealand – How things need to be. Mental Health Commission (1998)

Kingi ,T., 2005. *Maori Mental Health: Past Trends, Current Issues, and Maori Responsiveness*. Wellington: Massey University.

MacEwan, I., 2007. *Mental Health and Alcohol and Drug Co-existing Disorders: An Integrated Experience for Whaiora*. Wellington: Matua Raki.

National Service Specifications (Ministry of Health)

Oakley Browne, MA ., Wells, JE & Scott., KM (eds), 2006, *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

Robson, B., Harris, R., (eds), 2007. *Hauora: Maori Standards of Health Iv: A study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare.

Service Delivery for People with Co-existing Mental Health and Addiction Problems – Integrated Solutions. Ministry of Health (2010)

National Documents

- MOH: Te Tahuhu, Improving Mental Health 2005-2015, The Second NZ Mental Health and Addiction Plan, 2005
- Mental Health Commission: Te Hongongo 2008

Regional Documents

- Midland Region Maori Health Plan 2008 – 2011
- Midland Region Mental Health and Addictions Draft Strategic Plan 2009 – 2015
- Midland Region Mental Health Draft Workforce Development Plan 2008 – 2011
- Midland Regional Needs Assessment – Draft 2011
- Midland Regional Review of NASC services – Draft 2011

Local Documents

- Taranaki DHB District Annual Plans 2010 / 2010
- Taranaki DHB Māori Health Plan 2006 - 2007
- Te Puawaitanga Ki Taranaki – Maori Mental Health Action Plan 2005 – 2015
- Taranaki Acute Mental Health Services Review - 2010
- Mental Health Pathway for Mild to Moderate Mental Health Services - 2010

Appendix One: Project Stakeholders and Participants

<p>Steering Group</p>	<p>Sue Philipson – (AoD) Kathleen Mary – (MH&A) Tyron Pini Denise Aylward Norah Puketapu-Collins Suzy Paratene Hinemoerangi Ngatai Tangirua Andrew Brock Jenny Rae Anne Ridgway Dr Samir Heble Matua Ray</p>
<p>Client Pathway workstream (including family/whanau)</p>	<p>Nic Magrath (CAG) Shane Smith (Pathways) Tony Hansen (Workwise) Don Paratene (CAG) Chris Sorensen (MH&A) Anne Ridgway (MH&A) Hayley Scott Gary Walls-Renwick Terry Huntley (Family/Whanau) Pene Te Puni Patrick Morris Norah Puketapu-Collins Lauren Cameron</p>
<p>Service Continuum workstream (Service mix/models of care)</p>	<p>Nic Magrath (CAG) Denise Aylward (Pathways) Suzy Paratene (Te Whare Puawai) Pene Te Puni Anne Ridgway (MH&A) Vicki Magill Gary Walls-Renwick Graham Donlon Frances Kahui Gordon Hudson Rhiannon (Bindy) Huntley</p>

Appendix Two: Service Continuum Workstream Supplementary Information

terms of reference

TARANAKI ADULT MENTAL HEALTH AND ADDICTIONS CONTINUUM PROJECT

SERVICE CONTINUUM Work Stream

Terms of Reference

Title of Policy Manual:	Taranaki Adult Mental Health and Addictions Continuum Project – Service Continuum Work Stream
Date Issued:	January 2011
Review By Date:	N/A
Responsibility:	Portfolio Manager
Authorised By:	Project Sponsor(s)
Version:	V2
Page:	1 of 8

Vision / Ko te Moemoea

Ehara taku toa i te toa takitahi, He toa takatini ke'

My strength does not lie in working alone. Rather my strength lies in working with others.

Mission Statement / Ko Te Mana Whakaritea

Kia mahi tahi ai, tatou ki te hapai ake te whanau ora o nga tamariki, rangatahi, whanau.

Working together to strengthen the health and well being of people and their families and whanau.

Purpose

The purpose of Taranaki Adult Mental Health and Addictions Continuum Project, Service Continuum workstream is to describe service types, models and mix/range of services to ensure that a comprehensive and full range of appropriate, contemporary, evidence based, high quality, targeted and effective services are available as part of a seamless set of options for people with mental health and addiction problems. The deliverables from this workstream will be a set of recommendations to the Steering Group describing an agreed Service Continuum that will be included in a final report to the General Manager, Planning, Funding and Population Health. A draft Implementation Plan will also be included.

Objectives and Role

The Taranaki Adult Mental Health and Addictions Service Continuum workstream will:

1. Provide a transparent and cooperative mechanism for meeting the objectives of the overall project
2. Discuss and understand the range of services (both contracted and delivered via other agencies) across the continuum and consider additional types of contemporary, evidenced based and contemporary practice options that may be applicable to Taranaki DHB
3. Map existing models of service against the National Service Framework (NSF), and based on known data, evidence and benchmarks, identify service gaps and potential areas for development
4. Propose, advise and recommend the development of an implementation plan aimed at a seamless service delivery across the Adult Mental Health and Addictions continuum within an agreed model of care that ensures
 - o A holistic approach to care, demonstrating cohesive and seamless pathways across various levels and providers of care
 - o A range of services are delivered that achieve the best possible health and well-being outcomes
 - o Provision of care where and when it is needed, avoiding unnecessary admission to services
 - o Sustainability within the current fiscal environment

The Service Continuum workstream will also:

1. be conducted in an evidence based manner and engage members meaningfully
2. build on work that develops from the Client Pathways workstream and other activities /initiatives aligned to the project, and engage with those leading such work
3. focus on longer term outcomes that reduce barriers to access and effectively partner with service users', tangata whaiora and their families and whanau to achieve sustainable mental health outcomes for them
4. feedback to the appropriate project and relevant sector groups developments from the work stream and any concerns raised from the participants and offer solutions to those concerns.

Key Activities

1. To discuss and scope the impact of service delivery for areas of the service that may be affected during the implementation
2. Process map what service types, models & mix/range of services that are currently in practice across the continuum
3. Review of relevant local, regional, national, and where applicable, international literature, reports and reviews that guide contemporary practice
4. Workshop opportunities for innovation and creativity
5. Evidence base and outcomes reviewed
6. Stakeholder interviews and focus groups that may inform the following dimensions
7. Process map of the Service Continuum in a new model of care that draws together the services from across primary, secondary and social care and the interaction with tertiary where appropriate, ensuring a safe and seamless transition of clients between providers of care

Workshop Existing Models of Practice	Mapping	Implementation plan
<ul style="list-style-type: none"> • Contracted and non contracted services • Needs of the TDHB population 	<ul style="list-style-type: none"> • Existing models against NSF • Gap analysis • Future population needs 	<ul style="list-style-type: none"> • Recommendations • Transition approach • Potential risks & mitigation • Evaluation

8. Inform the draft Implementation Plan of the required changes to the service that best meet the needs of the service users', tangata whaiora and their families and whanau, and relevant organisations that fits within the overall objectives of the project

9. Provide a cohesive overview to the emerging work from other projects/initiatives to ensure that access to appropriate services within the sector is maximised and streamlined
10. Proactively monitor and manage the risks across the Service Continuum workstream and raise any significant risks to the Steering Group.

Assumptions

The following assumptions are considered as part of the overall project:

- This project will ultimately result in improved services and therefore outcomes for service users', tangata whaiora and their families and whanau
- Providers will proactively engage, and have the capacity and willingness to participate in the project
- Any recommendations from the project will be cost neutral and financially viable
- Duty of care will be well defined and in line with Ministry of Health expectations of primary, secondary, tertiary and NGO services.

Accountability

- Project Sponsor – Sandra Boardman, General Manager, Planning, Funding and Population Health
- Secretarial support to be provided by the TDHB
- To service users', tangata whaiora and their families and whanau
- To iwi.

Membership

The Group members for this workstream will be appointed for their particular expertise, range of perspectives and credibility in representing stakeholders. Refer to Appendix Two for detailed membership and representations.

All members (or their agreed delegate) will attend at least 85% of planned meetings. If a member is unable to attend or send a delegate, they will forward written comments and reports in advance of the meeting. Should a member need to send a delegated representative, it is the member's responsibility to ensure the representative is appropriately briefed in advance of the meeting.

Co-opting Power

The Service Continuum workstream will only be able to co-opt additional members with approval from the Project Steering Group.

Decision making process

Where a decision needs to be made by the Service Continuum workstream, all efforts will be made to reach a consensus. When this is not achieved, and the decision is considered material to the project, the issue will be elevated to the Project Steering Group.

Meeting Frequency

Meetings will be routinely held monthly, but may be more frequent in the initial stages of the project or as significant issue arise. This is a working group and therefore participants may be expected to do work

outside of the scheduled meeting. The meetings will be no longer than two hours. Group member's time is precious, so to ensure meetings are focused and productive, it is expected that:

- The meeting is held primarily for decision making. The agenda and all papers will be prepared and sent to the Group at least five working days before the meeting to allow sufficient time for each member to read the papers and seek advice from their own networks
- Members may at times be required to read papers and send their recommendations in before a meeting so the Chair can determine the issue and time needed to address this in the meeting
- Sub-working parties may be formed when pieces of work are identified that requires their expertise. They will report back to the group with any recommendations for approval
- When the Portfolio Manager may require operational or planning advice from a specific member with expertise in that area, they may meet separately.

Declaration of Interest

The membership of the Service Continuum workstream is necessarily broad, involving a variety of stakeholders. Each member of the group is present for their knowledge of the mental health and addictions sector, and/or Maori health imperatives. Members have been nominated by their colleagues and do not represent individual organisations. However, where a potential conflict exists within an agenda item, this is to be declared, including the exact nature of the potential conflict. The Service Continuum workstream will determine the appropriate response.

Confidentiality

All information obtained by the Service Continuum workstream, its members or representatives in the course of performance of the services for which it has been established, must be treated as confidential and must not be divulged to any persons, media representatives, firms or corporations other than as approved by the Chair of the workstream in writing. The requirement for confidentiality does not apply to any information that has become part of the public domain.

When representing the Service Continuum workstream, members shall take care to reflect the views of the Group accurately. Members shall respect decisions made in due process, even if they do not agree with the decision.

Reporting Relationship

To the Project Steering Group, who then report to the Project Sponsor, Sandra Boardman, General Manager, Planning, Funding and Population Health.

Minute Circulation

- TDHB General Manager, Planning, Funding and Population Health
- Adult Mental Health and Addictions Continuum Steering Group
- Workstream participants.

Changes to these Terms of Reference

Any revisions to these Terms of Reference require agreement and acceptance by the Service Continuum workstream and must be made through a formal change control process.

case scenario template

As part of the project a Case Study template was developed to provide information on individual stories for clients, tangata whaiora for both successful outcomes and for scenarios that had a negative impact on outcomes. Due to the confidentiality around the details outlined to individuals these case studies are unable to be published as received, but instead key points from the sections, ‘What Helped’ and ‘Things that we would do differently’ were extrapolated from each study.

The template includes the following guideline for completion and 10 case studies were received.

1. Background

Give a brief background to the case (client needs and situation, history, goals etc).

2. Problem Being Addressed

Describe the problem being addressed – what are the key issues

3. The Approach Taken

Describe the approach taken.

4. Problems Experienced and Impact

- Summarise any problems experienced, e.g. financial implications of not meeting the needs of clients – e.g. (client on ward for extended period).
- Impact on resources where the client journey has not been seamless or within an adequate period of time.

5. Things We Would Do Differently/What helped

- Summarise things you would do differently today, based on the experienced you have gained.
- Include summary anything that helped you get the best result for the client

summary of case studies: things to do differently/what would have helped

Organisation	Comments
<p>Case Study (1&2)</p> <p>Healthcare NZ</p>	<p>Wherever possible one psychiatrist, one Key Worker, one provider. This would help avoid duplication, transfers from one silo to the next and reduce intrusion and intervention into clients life .Perhaps even change focus from medical and hospital to more client and community focus.</p> <p>Community Support worker to start work with client as early as possible. For eg support worker to meet and support while client still an in-patient and also while client at TWW and even if client was transitioned to residential care as well. This could mean, perhaps in some cases, the AHBT may not be required and resources would be saved. Previously this would have been defined as double dipping with respect to funding. By the time the client is actually in the community they have a familiar face and relationships that will help in the community phase of their journey- the most important phase and where we want the client</p>

Organisation	Comments
	<p>to endure and sustain.</p> <p>Things We Would Do Differently Not a lot Ensure earlier access for higher level, specialist psychological or A&D counselling if required.</p> <p>What helped most Experienced Capable staff 1:1 Relationship established with client Collaborative Team Meetings to share responsibility and involve client Strengths Focus Flexibility within POC to use funding as required.</p>
<p>Case Study (3&4) Te Ihi Rangi Trust</p>	<p>More education and training for staff.</p>
<p>Case Study (5) Tu Tama Wahine o Taranaki (NASC)</p>	<p>What helped Involvement of Whanau Clinical Teams and NGO Providers complemented each other during this process. Regular weekly reviews. TW input into their recovery and rehabilitation Plan. Coordination of the services provided as it allowed for a rapid response for issues that arose. Allowed the team to look at the bigger picture in regards to this TW. Having Maori Support Workers/ Mentor enabled TW to engage willingly and to feel that his cultural needs were being acknowledged. Funding and planning agency were flexible and open to changes in TW circumstances during TW transition from Residential services to independent living TOR with each provider established to ensure clarity for everyone's role.</p> <p>Things We Would Do Differently We would recommend that collaboration between providers in terms of funding be streamlined in the form of short term reviewable transition packages that allows discharge planning to be swift and not impede TW recovery pathway. For example this particular TW spent more than 2 years at huge expense of money resources etc because the funding required for his discharge on the path to recovery could only be accessed as a last resort after every other option had been tried despite obvious lack of success.</p>
<p>Case Study (6&7) Te Whare Puawai</p>	<ul style="list-style-type: none"> • Need to address the lack of long term care options (particularly for Maori) in the mental health care continuum • The issues of lack of independent support and pressure from family resulted in x2 clients not being offered kaupapa Maori support. With the Non Maori client being allocated the bed when he did not wish for this kind of support and is often resistant to residency contract requirements and principles of rehabilitation • An IPC would have been more appropriate for this client
<p>Case Study (8) Pathways</p>	<ul style="list-style-type: none"> • What helped - involvement of the police and their willingness to assist when the behaviours placed the person and others at risk • The change of clinical director and his involvement has ensured that the young man is now appropriately receiving services trained in working specifically with intellectual disabilities. • Clearer understanding to the reason for referral with some agreed time frames for

Organisation	Comments
	<p>exit.</p> <ul style="list-style-type: none"> • Not to be pressured into providing support until all parties have agreed on a plan, i.e. the inclusion of psychology input from the start.
<p>Case Study (9)</p> <p>Pathways</p>	<p>What helped</p> <ul style="list-style-type: none"> • The collaboration between Pathways and the psychiatrist, also the involvement of Keys living choices at an early stage to support the person's goal and make it a reality. • Family \ Whanau involvement, ensuring they were informed and part of the plan to support the person into independent living. • The involvement of the Pathways Healthy Lifestyle coach whom has helped the person to establish themselves in activities in the community. • It is important to always listen to the goals and dreams of the people we support. Sometimes the goals may not seem realistic to us but it's not until that person starts to work on their goal that it becomes a reality for them and they begin to improve. • I don't believe there is anything we could have differently. The outcome was a positive, successful one and this person remains very happy living independently in the community
<p>Case Study (10)</p> <p>Te Whare Whakaahuru</p>	<p>Things We Would Do Differently</p> <ul style="list-style-type: none"> • Policy for transitioning client back to community is usually driven by TWW however in this scenario the clinical team was driving discharge with long periods of inactivity. • If clinical team drive discharge, meeting should be held with all parties at TPW prior to clients being admitted to TWW with clear plan for the client in regards to LoS, outcomes and rehabilitation goals. • Plan to explain who is responsible for each part of the plan when moving clients on from TWW. • Copies of plans to all agencies involved, client, service coordinator clinical team RC and TWW. If a staff member leaves a service then replacement staff are able to follow a plan and work accordingly. • Clarity of the role of TWW as a rehabilitation unit and not an accommodation provider.

Appendix Three: Client Pathway Supplementary Information

terms of reference

TARANAKI ADULT MENTAL HEALTH AND ADDICTIONS CONTINUUM PROJECT

Client Pathway Work Stream

Terms of Reference

Title of Policy Manual:	Taranaki Adult Mental Health and Addictions Continuum Project – Client Pathway Work Stream
Date Issued:	January 2011
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Vision / Ko te Moemoea

Ehara taku toa i te toa takitahi, He toa takatini ke'
My strength does not lie in working alone. Rather my strength lies in working with others.

Mission Statement / Ko Te Mana Whakaritea

Kia mahi tahi ai, tatou ki te hapai ake te whanau ora o nga tamariki, rangatahi, whanau.
Working together to strengthen the health and well being of people and their families and whanau.

Purpose

The purpose of Taranaki Adult Mental Health and Addictions Continuum Project, Client Pathway workstream is to describe responsive and effective recovery focused **pathways in, through and out of services** for service users', tangata whaiora and their families and whanau. The deliverables from this workstream will be a set of recommendations to the Steering group describing an agreed Client Pathway that will be included in a final report to the General Manager, Planning, Funding and Population Health. A draft Implementation Plan will also be included.

Objectives and Role

The Taranaki Adult Mental Health and Addictions Client Pathway workstream will:

1. Provide a transparent and cooperative mechanism for meeting the objectives of the overall project
2. Provide direction, advice, leadership and support to the Project Consultant and Project Lead to ensure that the development of an agreed Client Pathway, aimed at seamless service delivery across the Adult Mental Health and Addictions Continuum. This will ensure:
 - a holistic approach to care, demonstrating cohesive and seamless pathways in, through and out of services across various levels and providers of care
 - delivery of high quality care that is preventative, flexible and responsive to service users', tangata whaiora and their families and whanau needs
 - achievement of the best possible health and well-being outcomes
 - enablement of longer, healthier and active lives
 - maximum social participation and social inclusion

- empowerment of service users', tangata whaiora to be in control of their care by offering a choice of services
- promotion and protection of the health and wellbeing of the population
- reductions in inequalities in health
- improved experiences for service users', tangata whaiora and their families and whanau
- provision of care where and when it is needed, avoiding unnecessary admission to services
- efficient utilisation of all resources involved in the delivery of services.

The Client Pathways workstream will also:

1. Be conducted in an evidence based manner
2. Engage members meaningfully
3. Build on work that develops from the Service Continuum work stream and other activities /initiatives aligned to the project, and engage with those leading such work
4. Focus on longer term outcomes that reduce barriers to access and effectively partner with service users', tangata whaiora and their families and whanau to achieve sustainable mental health outcomes for them
5. Feedback to the appropriate project and relevant sector groups developments from the work stream and any concerns raised from the participants and offer solutions to those concerns.

Key Activities

1. To discuss and scope the impact of service delivery for areas of the service that may be affected during the implementation
2. A literature review of a sample of Client Pathways within other services that aligns with best practice
3. Ensure services align within the National Specifications Framework, and any pathway has clear lines of accountability and responsibility, including duty of care
4. To provide a cohesive overview to the emerging work from other projects/initiatives to ensure that access to appropriate services within the sector is maximised and streamlined
5. Process map of the Client pathway in a new model of care that draws together the services from across primary, secondary and social care and the interaction with tertiary where appropriate, ensuring a safe and seamless transition of service users', tangata whaiora between providers of care
6. Inform the draft Implementation Plan of the required changes to the service that best meet the needs of the service users', tangata whaiora and their families and whanau, and relevant organisations that fits within the overall objectives of the Project
7. Proactively monitor and manage the risks across the Client Pathway work stream and raise any significant risks to the Steering Group.

Assumptions

The following assumptions are considered as part of the overall project:

- This project will ultimately result in improved services and therefore outcomes for service users', tangata whaiora and their families and whanau
- Providers will proactively engage, and have the capacity and willingness to participate in the project
- Any recommendations from the project will be cost neutral and financially viable
- Duty of care will be well defined and in line with Ministry of Health expectations of primary, secondary, tertiary and NGO services.

Accountability

- Project Sponsor – Sandra Boardman, General Manager, Planning, Funding and Population Health
- Secretarial support to be provided by the TDHB
- To service users', tangata whaiora and their families and whanau

- To iwi.

Membership

The Group members for this workstream will be appointed for their particular expertise, range of perspectives and credibility in representing stakeholders. Refer to Appendix Two for detailed membership and representations.

All members (or their agreed delegate) will attend at least 85% of planned meetings. If a member is unable to attend or send a delegate, they will forward written comments and reports in advance of the meeting. Should a member need to send a delegated representative, it is the member's responsibility to ensure the representative is appropriately briefed in advance of the meeting.

Co-opting Power

The Client Pathways workstream will only be able to co-opt additional members with approval from the Steering Group.

Decision making process

Where a recommendations need to be made by the Client Pathways workstream, all efforts will be made to reach a consensus. When this is not achieved, and the recommendations are considered material to the project, the issue will be elevated to the Project Steering Group.

Meeting Frequency

Meetings will be routinely held monthly, but may be more frequent in the initial stages of the project or as significant issue arise. This is a working group and therefore participants may be expected to do work outside of the scheduled meeting. The meetings will be no longer than two hours. Group member's time is precious, so to ensure meetings are focused and productive, it is expected that:

- The meeting is held primarily for developing recommendations. The agenda and all papers will be prepared and sent to the Group at least five working days before the meeting to allow sufficient time for each member to read the papers and seek advice from their own networks
- Members may at times be required to read papers and send their recommendations in before a meeting so the Chair can determine the issue and time needed to address this in the meeting
- Sub-working parties may be formed when pieces of work are identified that requires their expertise. They will report back to the group with any recommendations for approval
- When the Portfolio Manager may require operational or planning advice from a specific member with expertise in that area, they may meet separately.

Declaration of Interest

The membership of the Client Pathways workstream is necessarily broad, involving a variety of stakeholders. Each member of the group is present for their knowledge of the mental health and addictions sector, and/or Maori health imperatives. Members have been nominated by their colleagues and do not represent individual organisations. However, where a potential conflict exists within an agenda item, this is to be declared, including the exact nature of the potential conflict. The Client Pathway workstream will determine the appropriate response.

Confidentiality

All information obtained by the Client Pathway workstream, its members or representatives in the course of performance of the services for which it has been established, must be treated as confidential and must not be divulged to any persons, media representatives, firms or corporations other than as approved by the Chair of the workstream in writing. The requirement for confidentiality does not apply to any information that has become part of the public domain.

When representing the Client Pathways workstream, members shall take care to reflect the views of the Group accurately. Members shall respect decisions made in due process, even if they do not agree with the decision.

Reporting Relationship

To the Project Steering Group, who then report to the Project Sponsor, Sandra Boardman, General Manager, Planning, Funding and Population Health.

Minute Circulation

TDHB General Manager, Planning, Funding and Population Health

- Adult Mental Health and Addictions Continuum Steering Group
- Workstream participants.

Changes to these Terms of Reference

Any revisions to these Terms of Reference require agreement and acceptance by the Client Pathways workstream and must be made through a formal change control process.

Continuum Project

Adult Mental Health and Addiction Services

components of the client pathway in, through and out of your services

THEMES - Feedback, Opportunities, Potential Development – this a high level summary of the 38 Client Pathways that were submitted by Providers, the service user, tangata whaiora service pathway mapping is included in a separate document.

	Barriers	Opportunities	Potential Developments
Referrals to and from	<ul style="list-style-type: none"> • Lack of resources, impacts on caseload and ability to pick up new referrals. • Timing for supported accommodation. • (PHO) Being able to pre-empt someone leaving work for MH issues. • (PHO) Communication with WINZ • (PHO) Limitations with funding and vouchers available. • Geographical distance in South causes delays for NASC services. No OT to do functional assessment. • NASC find inconsistencies with referrals, non compliance from clients. • Accessibility not picking up clients who don't fit under MH when they clearly 	<ul style="list-style-type: none"> • Greater flexibility with POC, to support wider range tangata whaiora in community. • (PHO) Better integration of WINZ programmes involving PATHS MH coordinators. • (PHO) Education to GPs on appropriate referral agency. • OT support for South. • NASC to be fully informed and complete extensive assessment with positive outcome for client, family/whanau. • More work focused on and complete in 1° sector. • (South) – TRP holds monthly/bimonthly 	<ul style="list-style-type: none"> • BSMC Primary MH Project • Making sure polices, procedures and referral forms are current. • Presence of Employment services within CMH weekly.

	Barriers	Opportunities	Potential Developments
	<p>have intellectual disability.</p> <ul style="list-style-type: none"> • GPs cost of visit. • Patea client’s difficulty in accessing services in Hawera. • Differing levels of entry in some services 3% verses 5%. • (South) ED and Inpatient Clinicians not aware to entry criteria into CMH. • (South) not enough information provided to make judgment on appropriateness. • Not all GPs on GP Liaison Programme. • GPs unable to prescribe Clozapine despite clients being stable. • Only one supported accommodation facility in South, clients may have to move away from supports. • Residential – unsuitable referrals for admission e.g. Disabilities. • ?who offers the choice of service? • Employment Service physically located apart from CMH teams • Knowing TKoTRP’s entry, criteria and newly scoped service provision. • Lack of accurate information to make initial contact via letter, or phone. <p>Brief referral details</p>	<p>clinics in Patea.</p> <ul style="list-style-type: none"> • (South) Reinstate discharge planning meetings inclusive of family if applicable. • Maternal MH utilising other Support Service Agencies. • GP education, clear DHB criteria, Develop set format, Educations sessions. • All GPs to be part of the GP Liaison programme. • More explanation of what services are available for Maori. • Benefits of Kaupapa Maori service and involvement of whanau. • Early Intervention in the time before diagnosis – community awareness. • Continued EI Support of primary sector/GPs. • No door is the wrong door • Same point of entry. 	

	Barriers	Opportunities	Potential Developments
Assessment	<ul style="list-style-type: none"> • Access to specialised assessment once clients exited from 2° • (PHO) GPs often note physical ailments and not include MH aspects. • (NASC) lack of data available, out of date CMP can result in inappropriate supports being requested. • (South) Crisis appointments only available in the North. • Crisis team covering all Taranaki – potential for time delays. • Consent – at times person referred not aware of referral. • Irregular assessment by NASC and CMP by CMHN. • Duplication of Assessment. • Workwise Criteria: client wants paid employment and has a mental illness. Is employment discussed by CMH during assessment or treatment options? • Processing, timing and coordination issues if others need to be involved. 	<ul style="list-style-type: none"> • More effective communication and liaison with community based support services. • All staff have up to date Clinical Management Plan, Risk Assessment and Ward staff educated in doing CMP. • NASC better resourced. • (South) Allocation of crisis appointment slots in South. • Establish South Crisis service. • Ensure GPs discuss Consent (clients not always aware of referral). • GP to offer mainstream or Maori options for services. • Allow the community sector to do their assessments/CMP. • If employment options not included as treatment option, should be included. 	<ul style="list-style-type: none"> • Longer stays supported accommodation • Establishing and maintaining link between 2° and 1° post client discharge. • NASC independent from Provider Arm • Change in contracting to allow for community sector to do own assessments and CMP. • Extend current home based activity assessment.
Risk	<ul style="list-style-type: none"> • Timing in accessing and establishing connections from supporting services. • Early identification and intervention for clients living independently. • Risk Assessment as par of admission 	<ul style="list-style-type: none"> • Community agencies. • Accurate assessments to ensure appropriate interventions. • Forming effective relationships with supporting services – ongoing 	<ul style="list-style-type: none"> • Adequate FTE employed to allow for 2 RN's per day to cover 12 hour shift. Increased capacity within community based home support agencies (medication oversight).

	Barriers	Opportunities	Potential Developments
	<p>process, not part of discharge process.</p> <ul style="list-style-type: none"> • Lack crisis respite • Lack flexible packages of care • (South) Timing re: acceptance of referral MDT's meet 1x week or Patea bi-weekly. Risk continues to sit with GP. • Isolation social and cultural. • Non compliance with treatment. • Behavioural boundaries of clients. • DD resources limited. • With referrals onto community services, ensuring information on clients assessed as having risk to self/others is included. • Many factors impact on a clients ability to obtain and hold on to work. • Not always identified in new referrals. • Non TKoTRP Tangata Whaiora being presented at MDT's. 	<p>assessment, identification and intervention.</p> <ul style="list-style-type: none"> • One shared plan of care. • All clients RA as part of discharge process. • 24 hour service separate from residential (Crisis respite) • Agency collaboration to meet peoples support needs. • (South) Timing for acceptance of referral – team to review urgency. • Ensure adequate resource in services that are offered. • Education and promotion • Cultural guidance. • More effective and efficient services. • Continue to support Primary sector/GPs with sub crisis work. • Linked to TDHB Clinical Governance 	<ul style="list-style-type: none"> • Increased understanding of what services are available and process for accessing them. • One individual plan of care shared from client/whanau/GP/Support services. • Risk Training Team looking at compulsory, voluntary, refreshers auditing of Risk Assessments. 1-1 as needed. • Flexible funding options. • Working on the same policies in relation to medications. • Strengthen framework around risk factors to include cultural constructs that can be applied as practise tools. • Individual POC as opposed to current funding structure.
Treatment	<ul style="list-style-type: none"> • Expectations re: medical model and medication regime from CMHS for HBS, seen as back up or 2° to clinical support. • Variable treatment, lack of consistency with processes for CMP and RA. Not enough supported accommodation to house our ageing population. 	<ul style="list-style-type: none"> • Support for Mild to moderate • Teaching tools for clients to get most out of GP visits. • (PHO) Group therapy • Clear Policies re: pathway through inpatient and rehab. • More supported housing that can incorporate ageing physical needs as 	<ul style="list-style-type: none"> • GPs provided with prioritised list of client needs. • Crisis respite service development with enhanced crisis/AHBT. • Extend activity programmes for older persons. • Peer Support in AoD and CAMHS areas. • Respite for Maternal and CAMHS.

	Barriers	Opportunities	Potential Developments
	<ul style="list-style-type: none"> • Facility for DD, e.g. Huntington’s • Lack of community treatment options • Shared electronic notes. • (South) MDT no onsite (Base) so discharge communication hampered at times. • (South) No AoD clinician attending MDT • Oranga Ngatahi clinical not replaced in south. • Transport to DBT treatment programme in North and issue. • (South) GP to CMH, do not attempt medication review – tend to refer when no necessary. • Late presentation to services. • Lack of education resources re: treatment options. 	<p>well as MH needs for long term.</p> <ul style="list-style-type: none"> • Development of home based treatment and crisis respite options. • Reinstate discharge planning meetings. • (South) Identify AoD clinical to attend MDT. • Establish Acute Home Based Treatment in South. • (South) increase Dr to Dr consultation phone contact • Continued strengths based approach focus to employment – supporting clients to gain confidence and belief in their abilities. • Where illness or medication is impacting on clients ability to find work. Information is shared with clinicians/ key workers via phone, email and in person at monthly MDT meetings etc, to identify potential solutions. • Dedicated employment consultants who can manage capacity directly with assigned CMH team • Facilitating MDT for Kaupapa Maori MH&A. • SLA with TDHB • Shared client file. 	<ul style="list-style-type: none"> • Funding for longer term beds to free up rehab beds.

	Barriers	Opportunities	Potential Developments
Review	<ul style="list-style-type: none"> • Timely access to Drs. • Not always regular. Often client due to be discharged and SNA, FA to assist with referral to supported accommodation not done. • Lack of resource, NASC and flexible POC • Clinical staff changing appointment times. • Reviews need to be timelier. 	<ul style="list-style-type: none"> • Timely manner – regular interview to map progress. • Checklist to be completed prior to each MDT as part of discharge planning. • Develop individual POC that are time limited. • Keeping to appointment times wherever possible. • Increased communication with all stakeholders. 	<ul style="list-style-type: none"> • Develop group assessment forms, supported detox, agonist therapies, and anti-craving therapies. • Collaboration of services. • Strengthen NASC service delivery. • MDT Navigator
Discharge	<ul style="list-style-type: none"> • Clients needing medication supervision held longer than two weeks due to capacity in community based providers. • Placement to suitable supported accommodation – clients moving in timely manner. • Cost of discharging to primary sector. • (South) Limited Support Agencies to refer to. • Costs of GP visits. Depot. • Limitation GP Integration places. • No follow up service available to tangata Whaiora when being discharged from facility. • Clients may disengage when in 	<ul style="list-style-type: none"> • Planning to occur from admission with regular reviews on where client is at and anticipated discharge date, what issues at admission remain? changed? what family/whanau supports are in community. • Wider MDT group. • Allow models of care which mean facility staff to be part of the transition post discharge of clients. 	<ul style="list-style-type: none"> • Increased capacity – re: medication oversight. • Longer stay supported accommodation. • (PHO) Clients need help once finished counselling sessions to find employment. • BSMC • Strengthen Service Delivery.

	Barriers	Opportunities	Potential Developments
	employment or if they become disheartened during their job searching phase.		
Evaluation and Satisfaction	<ul style="list-style-type: none"> • Costly and people report feeling over consulted/surveyed. • Not always completed by service users 	<ul style="list-style-type: none"> • (PHO) better post treatment follow-up will result in more successful uptake and growth of service. • Interagency wide sector review rather than individual organisations. • Service user data base • Community Advisory Committed 	<ul style="list-style-type: none"> • Peer support specialists in the workforce, additional training required.

Appendix Four: Stock take of Clinical/Managerial Governance Boards

Stock take of Health Sector Clinical and Other Advisory Governance Boards

March 2011

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
Taranaki DHB	All	Clinical Board	2009	<p>Ensuring appropriate systems in place for good quality clinical practice that is equitable and mechanisms for ongoing learning and improvement.</p> <ol style="list-style-type: none"> 1. Oversee the process of development, sign off, and review, and implementation of organisation wide clinical policies and guidelines. 2. Oversee function of clinical committees throughout DHB 3. Promote development of primary / secondary interface and cooperation across between the clinical services. Promote collaborative projects 4. Promote improved clinical practice. 5. Clinical advice/opinions EMT, CEO, on prioritisation clinical services and strategic guidance for decisions services/therapies. 	Chief Medical Officer	<ul style="list-style-type: none"> ▪ CMA ▪ DON ▪ Senior Medical ▪ Senior Nursing ▪ Allied Health ▪ Pharmacy ▪ Rad/Lab ▪ Primary Health ▪ Maori Health ▪ Quality Risk ▪ Operational Mgmt 	CEO	Monthly
Taranaki DHB	Mental Health & Addictions		Nov 2010	<p>The Clinical Governance Board (<u>Executive Directorate</u>) is the final decision body and receives advice from the CGB <u>subcommittees</u> and is responsible for informed and consultative implementation of the decisions and advice of the CGB subcommittees</p>	Executive Clinical Director MH & Addiction Services	<ul style="list-style-type: none"> ▪ ECD ▪ ADON ▪ Clinical Services ▪ Manager 		

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				<ol style="list-style-type: none"> To support Mental Health & Addiction Services and its service goals and objectives, whilst providing input into strategic direction and business development. To provide a forum for discussion and decision making regarding Ministerial, local/regional/national and organisational decisions that may affect service delivery/function To make recommendations and/or support decisions to relevant committees. To provide strategic decision making for services and therapies. To receive briefings and information from specific services such as Training, Quality & Risk, Finance, Human Resources, Data Analysis and the CGB subcommittees- MHSOP, Adult-North, Adult-South, Acute Services, AOD, CAMHS and Te Rau Pani. 		<ul style="list-style-type: none"> Allied Health Consumer Advisor Family Whanau Advisor Maori Health Directorate 		
Taranaki DHB	MH Acute Services		Nov 2010	<ol style="list-style-type: none"> To give briefings and information to the Clinical Governance Board Mental Health and Addiction Service, Provider Arm. To Develop/suggest service goals and objectives to the CGB for consideration. To develop and improve the quality of our service (MH Acute Services) and safeguarding high standards of care. To formulate clinical decisions at subcommittee level and present for endorsement to CGB. To encourage all staff members working in the MH Acute Services Team to submit any original novel, new ideas or suggestions for improving delivery of service, to the MH Acute Services CGB sub 	Psychiatrist	<ul style="list-style-type: none"> Clinical Lead Admin Support ACNM – Crisis Team, AHBT TWW and TPW Clinical Nurse Manager Allied Health shared OT/SW Discharge Coordinator Cultural 	Executive Clinical Director	

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				<p>committee for consideration.</p> <p>6. To communicate and liaise back to MH Acute Services Team via the represented disciplines., through meeting minutes and a set agenda or the fortnightly staff meeting.</p>		Advisor		
Taranaki DHB	Adult MH		Nov 2010	<ol style="list-style-type: none"> To give briefings and information to the Clinical Governance Board Mental Health and Addiction Service, Provider Arm. To Develop/suggest service goals and objectives to the CGB for consideration. To develop and improve the quality of our service (MH Adult North) and safeguarding high standards of care. To formulate clinical decisions at subcommittee level and present for endorsement to CGB. To encourage all staff members working in the MH Adult Team to submit any original novel, new ideas or suggestions for improving delivery of service, to the MH Adult CGB sub committee for consideration. To communicate and liaise back to MH Adult Community Staff via the represented disciplines., through meeting minutes and a set agenda or the monthly Business meeting. 	Psychiatrist	<ul style="list-style-type: none"> Clinical Lead Admin Support North Community Team Leaders Delegates from all various disciplines this includes Social Work Occupational Therapy Early Intervention Intake, Maternal Nursing Psychology 	Executive Clinical Director	
Taranaki DHB	MHSOP MH	MH Service for Older People Clinical Governance	Dec 2010	<ol style="list-style-type: none"> Provide briefing, information to MH&A Clinical Governance Board. Develop/suggest service goals and objectives to CGB for consideration. Develop, improve the quality of our service and 	Psychiatrist	<ul style="list-style-type: none"> Clinical Lead Admin Support MSHOP Team Leader Allied – Social 	Executive Clinical Director	Monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
		Board Sub-Committee		<p>safeguard high standards of care</p> <ol style="list-style-type: none"> 4. Formulate clinical decisions at sub-committee level and present for endorsement at CGB 5. Encourage all staff in MHSOP team to submit new ideas etc. for improving service delivery. 6. Communicate and liaise back to MHSOP staff through meeting minutes and a set agenda or the monthly Business meeting. 		<p>Work</p> <ul style="list-style-type: none"> ▪ Rotating Team member on a 2-3 month basis 		
Taranaki DHB	CAMHS	Clinical Governance Board	Jan 2011	TBA	Psychiatrist	<ul style="list-style-type: none"> ▪ Psychiatrist ▪ CAMHS Team Leader ▪ System Coordinator ▪ Social Worker ▪ Nursing ▪ Psychology ▪ South Team 		
Taranaki DHB	South MH	Clinical Governance Board	Feb 2011	<ol style="list-style-type: none"> 1. To give briefings and information to the Clinical Governance Board Mental Health and Addiction Service, Provider Arm. 2. To Develop/suggest service goals and objectives to the CGB for consideration. 3. To develop and improve the quality of our service (MH Adult South) and safeguarding high standards of care. 4. To formulate clinical decisions at subcommittee level and present for endorsement to CGB. 5. To encourage all staff members working in the MH Adult Team to submit any original novel, new ideas or suggestions for improving delivery of service, to the MH Adult CGB sub committee for 	Clinician	<ul style="list-style-type: none"> ▪ Clinical Lead ▪ Admin Support ▪ South Team Leader ▪ All South Team ▪ Clinicians ▪ Clinical Services ▪ Manager as available ▪ Quality Risk Manager as available ▪ Consumer 		Monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				consideration. 6. To communicate and liaise back to MH Adult Community Staff through meeting minutes and a set agenda or the monthly Business meeting.		Advisor as available		
Taranaki DHB	AOD Services	Clinical Governance Board	Dec 2011	<ol style="list-style-type: none"> To support AOD Service and its service goals and objectives, whilst providing input into strategic direction and service development. To provide a forum for discussion and decision making regarding ministerial, local/regional/national and organisational decisions that may affect service delivery/function To provide strategic decision making for services and therapies. 	Clinician	<ul style="list-style-type: none"> Service Clinical Director- Chair Team leader AOD service- Vice Chair AOD Professional Advisor Cultural Representative Consumer Advisor AOD Family Advisor Opiate Substitution Representative Clinical Service Manager as available Quality and Risk Manager as available. 		
Linkage Trust	Primary and Secondary	Quality Management		1. Accountability for quality and safety and risk of the organisation, including the critical and systematic	Clinical Leader	<ul style="list-style-type: none"> Clinical Leader Operations 	Monthly	Monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
	Mental Health – Adult	t Group		<p>evaluation of issues related to the identification, elimination, and control of risk and hazards.</p> <p>2. The Group provides advice, manages change, audits, reports, and researches relevant matters to the Board of Trustees.</p>		<p>Manager</p> <ul style="list-style-type: none"> ▪ Health & safety Representative 		
Linkage Trust	Primary and Secondary Mental Health – Adult	Management Team		<p>1. Provides supervision, oversight, operational and strategic direction and oversight to the organisation.</p> <p>2. Maintains relationships with external organisations</p>	<p>Operations Manager</p> <p>Marketing & Funding</p>	<ul style="list-style-type: none"> ▪ Operations Manager ▪ Manager Marketing & Funding ▪ Contracts Manager ▪ Clinical Leader 		
Progress to Health	Secondary Mental Health – Adult	Board of Trustees	1995	<p>1. Oversee the competent and lawful conduct of the Progress to Health’s affairs;</p> <p>2. Encourage and oversee the work of the Progress to Health in accordance with the objects as set out in the Trust Deed and the policies from time to time set by the Trust in general meeting;</p> <p>3. Set policy and direction for the chief executive in conducting the affairs of Progress to Health; and</p> <p>4. Exercise the powers as specified in the Trust Deed.</p>	Chairperson	<ul style="list-style-type: none"> ▪ Trustees and CEO ex officio 	Annually	Six weekly
Progress to Health	Secondary Mental Health – Adult	Senior management team	2007	<p>1. Provides supervision, oversight, operational and strategic direction and oversight to the organisation.</p>	CE	<ul style="list-style-type: none"> ▪ Service manager ▪ compliance manager ▪ finance manager, 	Monthly	At least bi-monthly
Primary Health	Taranaki Primary		2005	<p>1. The purpose of the Taranaki Primary Mental Health Group is to provide leadership in the development</p>	CEO PHO	3 PHOs	PHO Boards	Bi-monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
Organisations	Connections			and monitoring of the joint PHO primary mental health service.				
Te Whare Puawai	Primary and Secondary MH – Adult	Management Team		<ol style="list-style-type: none"> 1. Supports Manager and Trust Governance 2. Clinical Governance 	Manager	<ul style="list-style-type: none"> ▪ Manager ▪ Clinical Operations Manager ▪ Clinical Coordinator ▪ MA Coordinator ▪ Residential Coordinator 		
Te Whare Puawai	Primary and Secondary MH Adult	Quality Health and Safety Forum		<ol style="list-style-type: none"> 1. Quality Health and Safety Functions 2. Supports Representatives 3. Open Forum for staff/clients/whanau 	Quality Coordinator, Health and Safety Rep	Committee Reps Open forum		
Tui Ora Limited	Primary / Secondary Mental Health (Adult) & Primary CAMHS	Quality & Management Group	2008	<p>Ensuring appropriate systems in place for good quality cultural & clinical practice that is equitable and mechanisms for ongoing learning and improvement.</p> <ol style="list-style-type: none"> 1. Oversee the process of development, sign off, and review, and implementation of organisation wide cultural & clinical policies and guidelines. 2. Promote development of primary / secondary interface and cooperation across between the clinical services. Promote collaborative projects 3. Promote improved clinical practice. 4. Clinical advice/opinions and strategic guidance for decisions services/therapies. 	TDHB Executive Director Mental Health/TOL Mental Health Manger	<ul style="list-style-type: none"> ▪ TDHB Executive Director Mental Health ▪ TDHB Clinical Services Manager: Mental Health & Addictions ▪ TOL Clinical Coordinator ▪ TOL Operations Coordinator ▪ TOL Mental 		Monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
						Health Manager		
Pathways Health	Primary and Secondary Mental Health	National Leadership Team	1990	The National leadership convenes to review and develop the activities of Pathways <ol style="list-style-type: none"> 1. Analysis of quarterly statistics, IAC' and trends 2. Review service trends 3. New developments- national and regional 4. Workforce issues 5. Review organisational plan 	General Manager	<ul style="list-style-type: none"> ▪ CE, General Manager ▪ Psychiatrist ▪ Regional Managers ▪ National workforce Manager ▪ Quality Manager ▪ Well workplace Manger 		Quarterly face to face meetings. Monthly VC's
Te Ihi Rangi Trust	Kaupapa Maori Residential level 3	Board of Trustee's (Charitable Trusts Act 1957)	Established 27/2/1996	1. The purpose of the board is to ensure the Governance and Strategic planning of the business is accountable to the provision of services for residential care. The Board has five advisors including a clinical advisor	Not applicable	Clinical issues of our organisation is presented at MDT by Community mental Health Nurses from DHB and Te Rau Pani	Te Rau pani bi-weekly. TDHB when required	Weekly
Taranaki DHB + NGO Sector	Child, Adolescent and Maternal Mental health and Addictions	Clinical Governance Board	2011	The Child, Adolescent and Maternal Mental Health and Addictions Clinical Governance Board will undertake scrutiny on behalf of the Taranaki DHB and NGO Sector Child, Adolescent and Maternal Mental Health and Addictions Service providers to ensure that organisations provide services which are of acceptable standard of quality. <ol style="list-style-type: none"> 1. Service users, tangata whaiora, and family and whanau values. 2. Clinical Performance and Evaluation 	TBC	<ul style="list-style-type: none"> • Quality and Risk • Clinical Head • Tui Ora Network Clinical • Tui Ora Network Management • Addictions 	Executive Clinical Director / Portfolio Manager Planning & Funding (Interim)	Minimum Monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				<ol style="list-style-type: none"> 3. Clinical and Cultural Risk 4. Whanau Ora 5. Professional Development and Management 		<ul style="list-style-type: none"> • Maori Rep. • Psychiatrist • Management • Paediatrics • Service User • Planning & Funding 		
Provider Arm + NGO Sector	Taranaki Local Advisory Group	Advisory Board to Planning & Funding	2002	<p>TLAG is Taranaki District Health’s advisory forum on Mental health and Addictions. Its purpose is to aid communication and foster collaboration to ensure mental health and addiction service provision continues to progress for the benefit of consumers and whanau in the Taranaki region.</p> <ol style="list-style-type: none"> 1. Establish a baseline record of mental health and addictions services in the region with regular updates on initiatives, trends, themes and risks of each provider. 2. Establish a strong mental health and addictions network for the Taranaki region to maintain and improve current services and their quality. 3. Foster an effective relationship with Taranaki DHB, the Taranaki community and community groups based on community needs and addictions networks representing Taranaki requirements and issues. 4. Maintain oversight of the funding, service developments, service quality and advocacy for this region. 5. Provide advice and expertise of mental health and addictions issues to Taranaki DHB by 	Rotates between NGO and Provider Arm annually	<ul style="list-style-type: none"> • Executive Clinical Director • NGO Service representative • MAG representative • Kaumatua • AoD Clinician • Primary Care – GP • MHSOP Older People Clinician • CAMHS • Family/Whanau representative • Consumer representative x 2 • Employment 	GM Planning & Funding	Monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				supplying minutes and inviting Board members to attend meetings as required.		Services <ul style="list-style-type: none"> Portfolio Manager Mental Health and Addictions 		
Midland Regional DHBs	Midland Regional Consumer Advisory Group	He Tipuana Nga Kakano		<ol style="list-style-type: none"> 1. Represent the views of consumers in the Midland Region to the Midland Planners and Funders and Midland CEO groups 2. To improve mental health and addiction services by identifying current gaps with a view to strategising to meet the needs of consumers in the Midland Region 3. Provide a vehicle for ongoing integration, transparent processes, collaboration and cooperation between consumers, stakeholders, providers, networkers, and funders. 4. To consolidate ideas and passion to proactively minimise inequality and facilitate change 5. Bring and take information back to the local consumers through the Consumer Advisory Groups in each local region to facilitate discussion and enhance regional thinking 6. Take concerns, issues and achievements for consumers to DHB decision makers (DHB Planning & Funding GMs and CEO's) via the Midland Region Director 7. Participate in the development and review of the Midland Region Strategic Plan and ensure consultation is undertaken at a local level 8. Support He Tipuana Nga Kakano representatives 	As elected	Consumers from 5 DHB regions: <ul style="list-style-type: none"> Pacific Island Maori, Child & Youth Older Persons DHB NGO Addictions 	LCAG LAGs Regional MAG Regional CLF Regional PMG Regional Advisory Families Group MoH Nga Hau E Wha MH Commission Advocacy Coalition Midland GM P&F Midland Regional Director	Quarterly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				<p>to attend national forums as agreed at regional forums</p> <p>9. Strive towards autonomy by maintaining connectedness to the Midland region.</p>				
Midland Regional DHBs	Maori MH&A Regional Network	Nga Purei Whakataa Raumano	2002	<ol style="list-style-type: none"> 1. To provide a regional leadership and to advocate for Maori mental health and addictions needs. 2. To provide leadership on Maori mental health and addictions regional workforce priorities. 3. Develop strategy for regional Maori provider development aligned to the national workforce imperatives. 4. To promote the inclusion and implementation of Whanau Ora in Maori mental health and addictions across the region 	As elected	<ul style="list-style-type: none"> • 3 members from each Rohe. • Local MAG reps from each DHB. • Kaumatua/Kuia from Local MAG from each DHB. • MRMH&A Network team. 	<p>Midland CEO's group</p> <p>Midland P&F Maori Health Forums (via Midland Regional Director).</p>	Quarterly
Midland Regional DHBs	MR Clinical Leadership Forum	MR Clinical Leadership Forum		<ol style="list-style-type: none"> 1. To promote the development of regional clinical leadership and accountability 2. provide advice to DHB Funding & Planning on local and regional clinical business and strategic service development issues 3. provide a clinical perspective to regional and local mental health planning 4. To promote shared development across the region, and identify strategies which will promote integration and collaboration across mental health service provider boundaries and other sectors, at a regional and local level. 5. To develop a mentorship infrastructure in Midland to, provide access to group expertise; peer review; 	As elected	<ul style="list-style-type: none"> • Clinical Leaders • Directors • Service/General managers • AoD Clinician • Professor of Psychiatry • Midland Regional • MH&A Director • Portfolio Manager 	Bi-monthly or more frequently if required.	

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				<p>share positive outcomes and opportunities</p> <ol style="list-style-type: none"> 6. Participate in LAGs and regional Advisory Groups 7. Develop Regional quality process with regional coordination. 				
Midland Regional DHBs	Families and Whanau Forum	MR Generating Action for Families and Whanau		<p>To provide regional strategic leadership, develop and grow a network of families and whanau who will provide a mandated voice for local Mental Health & Addiction family/whanau from a regional level to a national level:</p> <ol style="list-style-type: none"> 1. Improve services by identifying current gaps 2. Vehicle for integration, transparent processes, collaboration, cooperation between consumers, Family/whanau, stakeholders, providers, networkers and funders 	As elected	<ul style="list-style-type: none"> • Pacific Island • Maori, • Asian • Male • Child & Youth • Older Persons • DHB • NGO • Addictions 	Quarterly	
Midland Regional DHBs	Addictions Forum	Midland Regional Addictions Forum		<ol style="list-style-type: none"> 1. Influencing quality 2. Influencing funding 3. Heard and advice taken on board by DHBs 4. Services to receive advice 5. Feedback given via observations – recommendations – issues raised by DHBs to this group 6. Provide guidance and direction strategically 7. Confidence feedback is provided and implemented – communication 8. Reviewing progress and contributing to the development of the Midlands strategic plan and local DAPS 	As elected	<ul style="list-style-type: none"> • 3 from each DHB 	Quarterly	

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
Midland Regional DHBs	Workforce whole of sector	MR Workforce Advisory Group	2009	<p>The purpose of this advisory group is to provide leadership and direction for regional workforce development, promote relationships and partnerships locally and regionally and provide support and guidance to the regional coordinator role.</p> <ol style="list-style-type: none"> 1. Building strong relationships within and across the mental health and addictions sector 2. Facilitating the uptake of national mental health workforce development opportunities 3. Increasing regional feedback on, and participation in, national, regional and district mental health and addictions workforce development planning 4. Ensuring national centers and programmes are responsive to the needs of the mental health and addictions sector 5. Supporting DHB, Primary, Iwi and NGO mental health and addiction workforce development 	As elected	<p>Midland Regional Reps:</p> <ul style="list-style-type: none"> • MH&A Workforce Coordinator • Purei Whakataa Ruamano • He Tipuana Nga Kakano • Generating Action for Family / Whanau • Addictions Portfolio Manager • Clinical Leadership • CAMHS • National Workforce Centre 	Quarterly	
PHO's	Primary and secondary mental health	ALT	2011	<p>The Service Level Alliance Team (SLAT) will also be responsible for considering possible service delivery alternatives and innovations for people who are at risk, disengaged or who have significant barriers to services. Aspects of these considerations may feed into the protocols and guidelines of the terms of reference for a SLAT as determined by the mandate set by the ALT:</p>	Public Health advisor MHN	<p>TDHB</p> <p>Waikato DHB</p> <p>Tairāwhiti DHB</p> <p>Lakes DHB</p>	ALT	monthly

Org.	Service Area	Board / Forum	Estab.	Purpose	Chair	Representatives	Report	Meeting Freq.
				<p>The delivery of primary health care for people with mental health and/or addiction issues across the Midland Health Network needs to:</p> <ol style="list-style-type: none"> 1. Improve early detection, diagnosis and treatment services 2. Ensure a continuum of care between primary and secondary services 3. Prioritise people who are at risk, disengaged or who have significant barriers to services 		MHN		

Appendix Five: Terms of Reference

Terms of Reference

Title of Policy Manual:	Cross Sector Adult MH & Addictions Clinical Governance Board
Date Issued:	July 2011
Review By Date:	July 2012
Responsibility:	Jenny James
Authorised By:	Sandra Boardman
Version:	V1
Page:	1 of 5

Vision / Ko te Moemoea

Ehara taku toa i te toa takitahi, He toa takatini ke'

My strength does not lie in working alone. Rather my strength lies in working with others

Mission Statement / Ko Te Mana Whakaritea

'Kia mahi tahi ai, tatou kit e hapai ake te whanau ora o nga tamariki, rangitahi, whanau'

Working together to strengthen the health and wellbeing of people and their families and whanau

Introduction

Clinical Governance is a framework through which mental health organisations are accountable for continuously improving the quality of their services and safe guarding high standards of care by creating an environment in which excellence in clinical care will flourish. The four key aspects of Clinical Governance include Service User, family/whanau Value, Clinical Performance and Evaluation, Clinical Risk and Professional Development and Management. The establishment of the Board results from recommendations from the Adult Mental Health and Addictions Continuum Project and provides an integrated approach to Governance across multiple organisations.

Purpose of the Board

The cross sector Mental Health and Addictions Clinical Governance Board will undertake scrutiny on behalf of the Taranaki DHB and NGO Sector Mental Health and Addictions Service providers to ensure that organisations provide services which are of acceptable standard of quality. The Board comprising of a mix of organisations from Mental Health and Addictions Sector will provide support

to each individual organisation existing Clinical Governance Structures. The Board will report have dual reporting to Taranaki DHB Clinical Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager.

Objectives

Service Users, Tangata Whaiora and Family and Whanau Value

- Health services encouraged to involve their communities and stakeholders in maintaining and improving the performance of their services.
- Ensuring effective leadership that ensures involvement by communities and stakeholders are valuable, effective and results in positive health outcomes.
- Ongoing strategies which promote two way communication between service users, tangata Whaiora and families and whanau and health services.
- Service users, tangata whaiora and families and whanau involvement in health service planning and decision making ensuring provision of accessible, equitable and responsive health care meeting national, regional and local priorities.

Clinical Performance and Evaluation

- Progressive introduction, use, monitoring and evaluation of evidence-based clinical standards with the objective being a culture where evaluation of organisational and clinical performance, including clinical audit, is commonplace.
- Clinical Standards incorporate clinical guidelines, pathways and local practice protocols.
- Clinical indicators and key performance indicators will be meaningful and reflect clinical practice with the objective of improving health services.
- Clinical audits will analyse the quality of clinical care outcomes, procedures used for diagnosis and treatment, use of resources and the adequacy of evaluation of clinical outcomes and patient quality of life.

Clinical and Cultural Risk

- Minimising clinical and cultural risk and improving overall clinical and cultural safety by, identification and reduction of potential risks and examination of adverse incidents for causative and contributing factors and trends across the continuum.

Whanau Ora

- Families and whānau are supported to achieve their maximum health and wellbeing

Professional Development and Management

- Ensuring the selection and recruitment of clinical staff, their ongoing professional development, the maintenance of their professional standards and to the relevant professional bodies, and the control and monitoring of new and innovative workforce development and new procedure opportunities.

Duties

To support the Mental Health and Addictions Services delivered through Taranaki DHB and the NGO Sector, the Board will have three key roles:

- The guidance and oversight for the prioritised key pieces of work as result of the Adult Mental Health and Addictions Continuum Project;
- Systems Assurance: ensuring that clinical governance mechanisms are in place and effective throughout the mental health service providers; and
- Health Governance: ensuring that the principles and standards of clinical governance are applied.

To fulfill these roles the Board will:

1. develop a provisional work plan;
2. ensure appropriate structures and systems are in place to support and deliver clinical governance;
3. assure Planning and Funding that these structures are operating effectively;
4. agree and monitor strategies and annual plans for clinical governance, service user input and clinical audit;
5. delegation of review of complaints process, claims, serious adverse incidences and other forms of feedback received from service users, ensuring learning from all clinical risk management activity and making recommendations to relevant Clinical Directors / Lead from organisations represented on the Board. Ensuring processes in place for reporting;
6. make recommendations to Taranaki DHB Clinical Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager, on the development and maintenance of effective knowledge management, supporting individuals as well as organisational development;
7. overseeing arrangements in place throughout the service providers relating to the quality and continuing improvement of its clinical services, and to provide assurances to Taranaki DHB Clinical Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager of the same;

8. advising Taranaki DHB Clinical Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager on all Clinical Governance issues and concerns with service providers;
9. monitoring the implementation of, and delegation of annual review of service providers auditing of systems and clinical governance documentation;
10. ensure appropriate Clinical Director or Leader in each organisation represented on the Board is informed as appropriate of clinical concerns irrespective of their source, and advise on any actions that may be required to safeguard standards of care, safety of services users' tangata whaiora or improve the quality of the service provided;
11. develop and maintain a risk register and advise on quality and risk matters;
12. advise on strategic direction for joint venture keeping in line with Government policies and initiatives;
13. advise Taranaki DHB Clinical Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager be accountable to them for all aspects of the services integrated governance arrangements.

Membership

The Board is responsible for nominations of the Chairpersons and Deputy Chairpersons.

The Sector is responsible for all appointments to the Clinical Governance Board and a range of processes may be used for these appointments.

The Board should include members and advisors that are able to provide a broad range of perspectives, which may include:

Quality and Risk perspective

Clinical Head

NGO Kaupapa Maori Clinical perspective

NGO Mainstream Clinical perspective

NGO Management perspective

Psychiatrist (MH)

Psychologist (MH)

Psychiatrist (Addictions)

Addictions – another clinical representative

Management

Service User perspective

Co-opting Power

The Clinical Board has the power to co-opt additional members as and when issues arise.

Term

Where membership is not by virtue of position, appointments will be for a three year term and except in exceptional circumstances members may serve for a maximum of two consecutive terms. A process will be established whereby no more than half the existing Board is changed at any one time.

Quorum

A quorum shall consist of not less than half of the members and must include Chairperson or Deputy Chairperson

Meeting Frequency

Monthly or frequency as determined by Chairperson to fulfill the Terms of Reference.

Confidentiality

All information obtained by the Board its members or representatives in the course of performance of the services for which it has been established, must be treated as confidential and must not be divulged to any persons, media representatives, firms or corporations other than as approved by Taranaki DHB Executive Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager in writing.

The requirement for confidentiality does not apply to any information that has become part of the public domain.

When representing the Board, members shall take care to reflect the views of the Group accurately. Members shall respect decisions made in due process, even if they do not agree with the decision.

Conduct of Meeting

1. The Clinical Board Chairperson will be nominated by the Board members.
2. The Board will have a deputy chairperson
3. Clinical Governance Board meetings will be open to Clinical Governance Board members and invitees only.
4. A "Register of Interests" will be maintained for all Clinical Board members and reviewed at each meeting.

5. Meeting agenda and papers will be distributed at least one week in advance of meeting to allow members to prepare adequately.
6. Industrial relations or personal issues including personal grievance are not the business of the Clinical Governance Board.
7. The Clinical Board reports to the Taranaki DHB Clinical Director MH&A Services and Planning and Funding MH&A Services Portfolio Manager.
8. Minutes will be distributed to all members of the Clinical Governance Board, Mental Health Services, Taranaki DHB and NGO Providers, and published to the organisation excluding information deemed to be sensitive for privacy or commercial reasons.
9. Meetings shall not be open to the public

The Clinical Governance Board will have administrative support provided Planning and Funding, TDHB.