Sent by: Emma Tonks/MOH

31/08/2016 04:41 p.m.

To: "Victoria Roberts" <s 9(2)(a)>,
cc:
bcc:

Subject: NHEW Report

Hi Victoria

I have had feedback from Rod, John Crawshaw's team and Derek, the consensus is that the Ministry is happy that the report is shared with the Mental Health Commissioner.

I hope you found your cards etc, looking forward to seeing you tomorrow

Kind regards

Emma Tonks
Senior Contracts Manager
Mental Health and Addiction Services
Mental Health Service Improvement
Service Commissioning
Ministry of Health
DDI: 04 816 4460

http://www.moh.govt.nz/
mailto:Emma_Tonks@moh.govt.nz

Sent by: Rod Bartling/MOH

01/09/2016 08:24 a.m.

To: Emma Tonks/MOH@MOH,
cc: Catherine Coates/MOH@MOH, Derek Thompson/MOH@MOH,
bcc:

Subject: Re: Nga Hau e Wha Report

yes please

Rod Bartling
Group Manager
Mental Health Service Improvement
Service Commissioning
Ministry of Health
DDI: 04 816 4392
Mobile: s 9(2)(a)
Fax: 04 496 2559

http://www.health.govt.nz
mailto:Rod_Bartling@moh.govt.nz

Emma Tonks Hi I have read the report in full and alt... 31/08/2016 10:01:05 a.m.

From: Emma Tonks/MOH
To: Rod Bartling/MOH@MOH, Derek Thompson/MOH@MOH, Catherine Coates/MOH@MOH,
Date: 31/08/2016 10:01 a.m.
Subject: Nga Hau e Wha Report

Hi

I have read the report in full and although the language used is emotive and makes assumptions about service delivery based on the feedback from a few clients, the risk to the Ministry is low/medium if we release it the Commissioner for Mental Health. (that's my opinion as a contract manager anyway) We do need to be prepared to answer any questions that may arise from though.

If you are all happy I will let Victoria know that the report may be released.

Cheers

Emma Tonks
Senior Contracts Manager
Mental Health and Addiction Services
Mental Health Service Improvement
Service Commissioning
Ministry of Health
DDI: 04 816 4460

http://www.moh.govt.nz/
mailto:Emma_Tonks@moh.govt.nz

Sent by:
Akatu.Marters[redacted].

04/05/2016 08:31 a.m.

To: 'Victoria Roberts' [redacted],
cc: 'Julie Whitla' <[redacted], 'Guy Baker' [redacted], 'Tui Taurua' [redacted], "'Grant Cooper'" <[redacted], 'Julie Mhaps' <[redacted],
bcc:

Subject: RE: Finances and May meeting

Morena koutou

I have updated the spreadsheet to incorporate the taxi invoice that has been received which won't show up until April finances have come through. Please refer below, this brings funds available at **$1587.20.**

Healthshare Ltd
Attn: Accounts Payable
PO Box 19064
Hamilton

CONSOLIDATED TAX INVOICE AND FINANCIAL STATEMEN

Voucher Number	Merchant Tax Code	Trans Date	Trans Time	Trip From	Trip To	Narrative
Voucher						
7895799	61517264	25/02/2016	16:00	Aitken St	171 Queens Drive	Taxi
7895800	10343941	25/02/2016	06:50	Hoon Hay Rd	Airport Christchurch	Nhew
7895801	77155368	26/02/2016	18:52	Chch Airport	Christchurch 319 Hoon Hay	Nhew
7895804	61517264	24/02/2016	00:00	Wgtn Airport	Ibis Hotel	Taxi
7895805	61517264	26/02/2016	03:00	Freyberg Building	James Cook Hotel	Taxi
7895810	78719370	24/02/2016	00:00	Wellington Airport	Ministry Of Health	Taxi
7895811	61517264	26/02/2016	17:00	Freyberg House	Wgtn Airport	Taxi
7895812	61517264	26/02/2016	20:00	Ibis Hotel Wgtn	Ministry Of Health	Taxi
7895815	78719370	26/02/2016	13:45	Ministry Of Health Wgtn	Wellington Airport	Nga Han E Wha
7895798	61517264	25/02/2016	08:15	Queens Drive	Aitken St Moh	Taxi

Card Total (Excl Administration Fees)
Administration Fees
Card Total

Cost Centre 7634 **Total (Excl Administration Fees)**
Administration Fees

Cost Centre 7634 **Total**

Kind regards

Akatu Marsters | Senior Administrator | Midland MH&A - HealthShare Ltd | c/- Lakes DHB, Bridgman Wing North – Level 1, Private Bag 3023, Rotorua Mail Centre, Rotorua 3046 | P +64 s 9(2)(a) | F +64 7 349 7983 | M: +64 s 9(2)(a) |E akatu.marsters s 9(2)(a) | W www.midlandmentalhealthnetwork.co.nz

HealthShare He Rourou Takitahi
Midland district health boards' shared services agency

Midland District Health Boards
MENTAL HEALTH & ADDICTION REGIONAL NETWORK
Service Development • Workforce Development • Partnerships & Relationships

Living well with supportive systems

Bay of Plenty • Lakes • Tairawhiti • Taranaki • Waikato

From: Akatu Marsters
Sent: Tuesday, 3 May 2016 11:29 a.m.
To: 'Victoria Roberts'
Cc: Julie Whitla; Guy Baker; Tui Taurua; Grant Cooper; Julie Mhaps; Kieran Moorhead; emma_x@xx; Eseta Nonu-Reid
Subject: RE: Finances and May meeting

Kia ora koutou

I hope you are doing well.

Attached is the financials as of March 2016, I have also attached the invoice for Alpha Recruitment which won't show up until the April financials are out but I have shown this on the attached spreadsheet to give you balance to date. The balance available to date in the budget is **$1964.37**.

Have a blessed week.

Kind regards

Akatu Marsters | Senior Administrator | Midland MH&A - HealthShare Ltd | c/- Lakes DHB, Bridgman Wing North – Level 1, Private Bag 3023, Rotorua Mail Centre, Rotorua 3046 | P +64 s 9(2)(a) | F +64 7 349 7983 | M: +64 s 9(2)(a) |E akatu. s 9(2)(a) | W www.midlandmentalhealthnetwork.co.nz

From: Victoria Roberts [mailto:v s 9(2)(a)]
Sent: Tuesday, 19 April 2016 11:22 a.m.
To: Akatu Marsters
Cc: Julie Whitla; Guy Baker; Tui Taurua; Grant Cooper; Julie Mhaps; Kieran Moorhead; emma_tonks@moh.govt.nz
Subject: RE: Finances and May meeting

Morena Akatu

Thanks heaps for this information.

Nga mihi

Victoria
On 19/04/2016 11:17 am, "Akatu Marsters" <Akatu. s 9(2)(a) wrote:

Kia ora koutou

Hope you are all well.

As per the attached for your information. Please note; The highlighted yellow are amounts as per the invoices submitted however awaiting the March transactional report from our accounts to give you an accurate figure. **Note**: not all travel expenses for February meetings are on this spreadsheet hence awaiting report from accountant, therefore without deducting the travel cost as yet the balance to date is **$5424.67**.

I will endeavour to have the financial report to you pending when the accountant forwards information to me.

Have a great week.

Kind regards

Akatu Marsters | Senior Administrator | Midland MH&A - HealthShare Ltd | c/- Lakes DHB, Bridgman Wing North – Level 1, Private Bag 3023, Rotorua Mail Centre, Rotorua 3046 | P s [redacted] | F +64 7 349 7983 | M: +64 s 9(2)(a) |E akatu.[redacted] s 9(2)(a) W www.midlandmentalhealthnetwork.co.nz

From: Victoria Roberts [mailto[redacted] s 9(2)(a)]
Sent: Monday, 18 April 2016 3:38 p.m.
To: Akatu Marsters
Cc: emma_tonks@moh.govt.nz; Julie Mhaps; Julie Whitla; Kieran Moorhead; Grant Cooper; Tui Taurua; Guy Baker; Victoria Roberts
Subject: Finances and May meeting

Tena koe Akatu

Greetings and warm wishes for your good health.

Right now we at Nga Hau e Wha are wondering the current state of finances are after the end of the February/March period. Since then have the finances been able to be finalised and if so are you able to give us a working total as to just what we have to budget with for the May meeting?

At this point we normally would have in train preparations for guests and speakers for the May meeting and it would be good to

see just what we are able to do for this upcoming meeting.

Thank you very much for your assistance with this matter

Nga mihi

Victoria

Victoria Roberts
Cha
Kia ora Akatu
irperson
Nga Hau E Wha
www.nhew.org.nz
s 9(2)(a)
s 9(2)(a)
A national voice for people with lived experience of mental distress and addictions

Nga Hau E Wha
"Champion many voices"

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NHEW Actuals July - June 2016.xls

Funding -$ 34,000.00

Actual Expenses Paid

	July	August	September	October	November	December
Travel	$ 1,585.32	$ 157.43	$ 4,494.08	-$ 302.60	$ 2,678.08	-$ 441.74
Taxi	$ 496.04	$ 346.16	$ 337.04	$ 610.56	$ 76.64	
Venue	$ 682.20	$ 659.80			$ 367.40	
Catering		$ 344.80			$ 275.60	
Minute Taker	$ 765.00		$ 731.25		$ 652.50	
Conferences	$ 429.13		-$ 1,239.14			
Website			$ 500.00			
M Fees & Reimburse			$ 1,115.00		$ 802.00	$ 419.20
Internal Cost		$ 1,700.00			$ 1,700.00	
Overspend		$ 410.00			$ 410.00	
Total Expenses	$ 3,957.69	$ 3,618.19	$ 5,938.23	$ 307.96	$ 6,962.22	-$ 22.54

$ 20,761.75 6months Expenses

	January	February	March	April	May	June
Travel	$ 358.09	$ 543.83	$ 3,606.80			
Taxi	$ 423.76			$ 377.17		
Venue						
Catering			$ 261.40			
Minute Taker				$ 780.00		
Conferences						
Website						
M Fees & Reimburse			$ 1,080.00			
Internal Cost		$ 1,700.00			$ 1,700.00	
Overspend		$ 410.00			$ 410.00	
Total Expenses	$ 781.85	$ 2,653.83	$ 4,948.20	$ 1,157.17	$ 2,110.00	$ -

$ 11,651.05 Expenses to date

$ 32,412.80	Total Expenses to date
-$ 1,587.20	Balance to date

Nga Hau E Wha - July Expenses

JUL-15	7634-Business Support	3545-ADMIN. CLERICAL & SECRETARIAL STAFF	28-May-2015	NHEW - Minute Taker for May Meeting		765.00	00038567	ALPHA PERSONNEL TEMPORARY ANGELS
JUL-15	7634-Business Support	5230-TAXIS	30-Jun-2015	Taxicharge NZ Ltd - 30 June Invoice 4335252715 - RC7634		496.04	4335252715	TAXICHARGE NZ LTD
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ TAURUA TUI MS	Ticket Issue Service Fee	7.00		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ COOPER GRANT MR	Ticket Issue Service Fee	7.00		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ ROBERTS VICTORIA MS	Ticket Issue Service Fee	7.00		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ TAURUA TUI MS	Ticket Issue Service Fee	10.00		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ WHITLA JULIE MS	Ticket Issue Service Fee	10.00		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ WHITLA/JULIE MS	Domestic Air Travel 150902CHCNSN	228.68		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ COOPER/GRANT MR	Domestic Air Travel 150717WLGDUD	233.91		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ ROBERTS/VICTORIA MS	Domestic Air Travel 151115WLGHLZ	302.60		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ TAURUA/TUI MS	Domestic Air Travel 150621KKEAKL	337.39		
JUL-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jul-2015	Air NZ TAURUA/TUI MS	Domestic Air Travel 151115KKEAKL	441.74		
JUL-15	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	24-May-2015	21 & 22 May NHEW Venue Costs		682.20	B005157	WISE MANAGEMENT SERVICES LTD
JUL-15	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	18-Jun-2015	J Whitla - Cutting Edge 2015		429.13	1016928	CUTTING EDGE CONFERENCE

July Total Expenses 3957.69

Nga Hau E Wha - August Expenses

AUG-15	7634-Business Support	5230-TAXIS	31-Jul-2015	Taxicharge NZ Ltd - July 2015 - Inv 4335253115 RC7634	346.16	4335253115	TAXICHARGE NZ LTD
AUG-15	7634-Business Support	5260-STAFF ACCOMMODATION & MEALS	31-Aug-2015	Westpac Pcard 5550 MR R CRAMOND CQ HOTELS WGTN ACCOMMODATION FOR JULIE WHITLA 20/08/2015	157.43		
AUG-15	7634-Business Support	5675-RECEPTION AND CATERING	20-Aug-2015	NHEW: 20 Aug Morning Tea	39.60	00069351	BLUE CARROT CATERING
AUG-15	7634-Business Support	5675-RECEPTION AND CATERING	20-Aug-2015	NHEW: 20 Aug Lunch & Afternoon Tea	145.60	00069352	BLUE CARROT CATERING
AUG-15	7634-Business Support	5675-RECEPTION AND CATERING	21-Aug-2015	NHEW: 21 Aug - Morning Tea	39.60	00069353	BLUE CARROT CATERING
AUG-15	7634-Business Support	5675-RECEPTION AND CATERING	21-Aug-2015	NHEW: 21 Aug Lunch	120.00	00069354	BLUE CARROT CATERING
AUG-15	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	21-Aug-2015	NHEW: 20 & 21 Aug Venue & Printing	659.80	B005823	WISE MANAGEMENT SERVICES LTD

Total Expenses	**1508.19**
Internal & Overspend	**2110**
August Total Expenses	**3618.19**

Nga Hau E Wha - September Expenses

SEP-15	3545-ADMIN. CLERICAL & SECRETARIAL STAFF	25-Aug-2015	NHEW: Minute Taker for August meeting	731.25	00039986	ALPHA PERSONNEL TEMPORARY ANGELS	
SEP-15	5230-TAXIS	31-Aug-2015	Taxicharge NZ - August 2015 - Inv 4335253615 - RC7634	337.04	4335253615	TAXICHARGE NZ LTD	
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ TAURUA TUI MS Ticket Issue Service Fee	7.00			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ FERGUSSON CHLOE MS Ticket Issue Service Fee	7.00			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ WHITLA JULIE MS Ticket Issue Service Fee	7.00			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ COOPER GRANT MR Ticket Issue Service Fee	7.00			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ KNEEBONE JULIE MS Ticket Issue Service Fee	7.00			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ MOORHEAD KIERAN MR Ticket Issue Service Fee	7.00			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ WHITLA/JULIE MS Domestic Air Travel 150820CHCWLG	406.95			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ COOPER/GRANT MR Domestic Air Travel 150820DUDWLG	419.99			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ MOORHEAD/KIERAN MR Domestic Air Travel 150820AKLWLG	424.34			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ FERGUSSON/CHLOE MS Domestic Air Travel 150820ROTWLG	443.47			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ KNEEBONE/JULIE MS Domestic Air Travel 150820HLZWLG	502.60			
SEP-15	5250-STAFF TRAVEL - DOMESTIC	30-Sep-2015	Air NZ TAURUA/TUI MS Domestic Air Travel 150820KKEAKL	567.81			
SEP-15	5260-STAFF ACCOMMODATION & MEALS	30-Sep-2015	HSL Westpac Pcard # 5550 MR R CRAMOND CHELSEA PARK MOTOR L ACCOMMODATION FOR JULIE WHITLA 04/09/2015	493.04			
SEP-15	5260-STAFF ACCOMMODATION & MEALS	14-Jul-2015	Accommodation for Grant Cooper	506.95	12201M	BAY PLAZA HOTEL	
SEP-15	5260-STAFF ACCOMMODATION & MEALS	20-Aug-2015	Accommodation for Keryn Moorehead	126.08	23008M	CQ HOTELS	
SEP-15	5260-STAFF ACCOMMODATION & MEALS	20-Aug-2015	Accommodation for Julie Kneebone	134.78	23007M	CQ HOTELS	
SEP-15	5260-STAFF ACCOMMODATION & MEALS	20-Aug-2015	Accommodation for Tui Taurua	140.86	23009M	CQ HOTELS	
SEP-15	5260-STAFF ACCOMMODATION & MEALS	20-Aug-2015	Accommodation for Grant Cooper	140.86	23006M	CQ HOTELS	
SEP-15	5260-STAFF ACCOMMODATION & MEALS	20-Aug-2015	Accommodation for Chole Fergusson	144.35	23005M	CQ HOTELS	
SEP-15	5835-COMMUNITY CONSULTATION COSTS	01-Sep-2015	Distribution for miscellaneous receipt HDL1109-11.	-569.57			
SEP-15	5835-COMMUNITY CONSULTATION COSTS	01-Sep-2015	Distribution for miscellaneous receipt HDL1609-18.	-669.57			
SEP-15	5835-COMMUNITY CONSULTATION COSTS	30-Jun-2015	NHEW: Website Design Service	500.00	300615	WILD JAK	
SEP-15	5835-COMMUNITY CONSULTATION COSTS	26-Aug-2015	NHEW: T Taurua - August Meeting Fees	360.00	XV	TUI TAURUA	
SEP-15	5835-COMMUNITY CONSULTATION COSTS	31-Aug-2015	NHEW: Aug Mtg Meeting Fees	360.00	20	WHITLA JULIE	
SEP-15	5835-COMMUNITY CONSULTATION COSTS	01-Sep-2015	NHEW - Meetings Fees V Roberts & Reimbursement	395.00	15	ROBERTS VICTORIA	

September Total Expenses **5938.23**

Nga Hau E Wha - October Expenses

OCT-15	7634-Business Support	5230-TAXIS	30-Sep-2015	Taxicharge NZ - September 2015 - Inv 4335254015 - RC7634	610.56	4335254015	TAXICHARGE NZ LTD	
OCT-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Oct-2015	Air NZ ROBERTS/VICTORIA MS Domestic Air Travel - Refund 151115WLGHLZ	-302.60			

October Total Expenses **307.96**

Nga Hau E Wha - November Expenses

NOV-15	7634-Busines	3545-ADMIN. CLERICAL & SECRETARIAL STAFF	10-Nov-2015	NHEW - Minute Taker for November Meetings	652.50	00041113	ALPHA PERSONNEL TEMPORARY ANGELS
NOV-15	7634-Busines	5230-TAXIS	30-Oct-2015	Taxicharge NZ for October 2015 - Inv 4335254415 - RC7634	76.64	4335254415	TAXICHARGE NZ LTD
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ WHITLA JULIE MS Ticket Issue Service Fee	7.00		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ TAURUA TUI MS Ticket Issue Service Fee	7.00		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ MOORHEAD KIERAN MR Ticket Issue Service Fee	7.00		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ FERGUSSON CHLOE MS Ticket Issue Service Fee	7.00		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ COOPER GRANT MR Ticket Issue Service Fee	7.00		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ TAURUA TUI MS Miscellaneous Services SERV FEE	8.70		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ MOORHEAD/KIERAN MR Domestic Air Travel 151105AKLWLG	406.95		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ WHITLA/JULIE MS Domestic Air Travel 151104CHCWLG	459.12		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ COOPER/GRANT MR Domestic Air Travel 151105DUDWLG	467.82		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ TAURUA/TUI MS Domestic Air Travel 151105KKEAKL	510.42		
NOV-15	7634-Busines	5250-STAFF TRAVEL - DOMESTIC	30-Nov-2015	Air NZ FERGUSSON/CHLOE MS Domestic Air Travel 151105GISWLG	619.99		
NOV-15	7634-Busines	5260-STAFF ACCOMMODATION & MEALS	05-Nov-2015	Accommodation for Tui Taurua	170.08	17443M	BRENTWOOD HOTEL
NOV-15	7634-Busines	5675-RECEPTION AND CATERING	05-Nov-2015	NHEW - 05 November Catering	105.20	00071087	BLUE CARROT CATERING
NOV-15	7634-Busines	5675-RECEPTION AND CATERING	06-Nov-2015	NHEW - 06 November Catering	170.40	00071088	BLUE CARROT CATERING
NOV-15	7634-Busines	5835-COMMUNITY CONSULTATION COSTS	05-Nov-2015	NHEW Nov Meeting Fees	360.00	XVI	TUI TAURUA
NOV-15	7634-Busines	5835-COMMUNITY CONSULTATION COSTS	06-Nov-2015	05 & 06 November NHEW Meeting	367.40	B006250	WISE MANAGEMENT SERVICES LTD
NOV-15	7634-Busines	5835-COMMUNITY CONSULTATION COSTS	12-Nov-2015	NHEW 05 & 06 Nov Reimbursements	82.00	25	ROBERTS VICTORIA
NOV-15	7634-Busines	5835-COMMUNITY CONSULTATION COSTS	12-Nov-2015	NHEW 05 & 06 Nov Meeting Fees	360.00	25	ROBERTS VICTORIA

Total Expenses 4852.22

Internal & Overspend 2110

November Total Expenses 6962.22

Nga Hau E Wha - December Expenses

DEC-15	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Dec-2015	Air NZ TAURUA/TUI MS Domestic Air Travel - Refund 151115KKEAKL	-441.74			
DEC-15	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	29-Nov-2015	NHEW - 05 & 06 Taxi Reimbursements	59.20	21	WHITLA JULIE	
DEC-15	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	29-Nov-2015	NHEW - 05 & 06 Nov Meetings	360.00	21	WHITLA JULIE	

Total December Expenses **-22.54**

Nga Hau E Wha - January Expenses

JAN-16	7634-Business Support	5230-TAXIS	31-Dec-2015	Taxicharge NZ for December 2015 - Inv 4335255315	423.76
JAN-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jan-2016	Air NZ COOPER GRANT MR Miscellaneous Services	7.00
JAN-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jan-2016	Air NZ MOORHEAD KIERAN MR Miscellaneous Services	7.00
JAN-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jan-2016	Air NZ COOPER GRANT MR Hotel Accommodation 1N 05 11 WLG COMFORT HOTE	169.22
JAN-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Jan-2016	Air NZ MOORHEAD KIERAN MR Hotel Accommodation 1N 05 11 WLG COMFORT HOTE	174.87

Total January Expenses **781.85**

Nga Hau E Wha - February Expenses

FEB-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	29-Feb-2016	Air NZ FERGUSSON CHLOE MS Miscellaneous Services	7.00
FEB-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	29-Feb-2016	Air NZ WHITLA JULIE MS Miscellaneous Services	7.00
FEB-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	29-Feb-2016	Air NZ FERGUSSON CHLOE MS Hotel Accommodation 1N 05 11 WLG COMFORT HOTE	175.74
FEB-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	29-Feb-2016	Air NZ WHITLA JULIE MS Hotel Accommodation 2N 04 11 WLG COMFORT HOTE	354.09

Total Expenses	**543.83**
Internal & Overspend	**2110**
February Total Expenses	**2653.83**

Nga Hau E Wha - March Expenses

MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ TAURUA TUI MS Ticket Issue Service Fee	7.00	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ WHITLA JULIE MS Ticket Issue Service Fee	7.00	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ COOPER GRANT MR Ticket Issue Service Fee	7.00	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ BAKER GUY MR Ticket Issue Service Fee	7.00	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ WHITLA/JULIE MS Domestic Air Travel 160225WLGNZ	34.78	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ TAURUA/TUI MS Domestic Air Travel 160224AKLNZ	360.87	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ COOPER/GRANT MR Domestic Air Travel 160225WLGNZ	493.90	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ WHITLA/JULIE MS Domestic Air Travel 160225WLGNZ	537.38	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	31-Mar-2016	Air NZ BAKER/GUY MR Domestic Air Travel 160225WLGNZ	595.64	
MAR-16	7634-Business Support	5250-STAFF TRAVEL - DOMESTIC	29-Feb-2016	NHEW: 25 & 26 Reimburse travel fee	10.50	ROBERTS VICTORIA
MAR-16	7634-Business Support	5260-STAFF ACCOMMODATION & MEALS	31-Mar-2016	HSL Pcard # 5550 MR R CRAMOND HOTEL IBIS ACCOMMODATION FOR GRANT COOPER 25/02/2016	303.38	
MAR-16	7634-Business Support	5260-STAFF ACCOMMODATION & MEALS	31-Mar-2016	HSL Pcard # 5550 MR R CRAMOND HOTEL IBIS ACCOMMODATION FOR TUI TAURUA 25/02/2016	619.18	
MAR-16	7634-Business Support	5260-STAFF ACCOMMODATION & MEALS	31-Mar-2016	HSL Pcard # 5550 MR R CRAMOND HOTEL IBIS ACCOMMODATION FOR GUY BAKER 25/02/2016	310.03	
MAR-16	7634-Business Support	5260-STAFF ACCOMMODATION & MEALS	31-Mar-2016	HSL Pcard # 5550 MR R CRAMOND HOTEL IBIS ACCOMMODATION FOR JULIE WHITLA 25/02/2016	313.14	
MAR-16	7634-Business Support	5675-RECEPTION AND CATERING	25-Feb-2016	NHEW: 25 February Catering	138.20	BLUE CARROT CATERING
MAR-16	7634-Business Support	5675-RECEPTION AND CATERING	26-Feb-2016	NHEW: 26 February Catering	123.20	BLUE CARROT CATERING
MAR-16	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	04-Feb-2016	NHEW: 25 & 26 February Meeting Fees	360.00	WHITLA JULIE
MAR-16	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	29-Feb-2016	NHEW: 25 & 26 Feb Meeting Fees	360.00	ROBERTS VICTORIA
MAR-16	7634-Business Support	5835-COMMUNITY CONSULTATION COSTS	29-Feb-2016	NHEW: 25 & 26 February Meeting Fees	360.00	TUI TAURUA

Total March Expenses **4948.20**

Sent by:
victoria s 9(2)(a)

26/08/2016 03:20 p.m.

To: emma_tonks <Emma_Tonks@moh.govt.nz>,
cc:
bcc:

Subject: Re: Nga Hau e Wha

Hello again Emma

I am attaching the June report. I wonder who Akatu sends it too at the Ministry - I always assumed it was the person in your position.

2pm on Tuesday is great for me. I'll just come up to the reception desk on level 2 at the Terrace?

Nga mihi

Victoria

Victoria Roberts I Chair I Nga Hau e Wha

www.nhew.org.nz I s 9(2)(a)

The national voice of people with lived experience of mental distress and addictions

On 26 August 2016 at 15:13, <Emma_Tonks@moh.govt.nz> wrote:

> Hi Victoria
>
> I have been checking through my records and I don't have a copy of the July 2016 report. Could you send it through just so Derek and I can check the contents before we agree to release it to the Mental Health Commissioner
>
> How does Tuesday afternoon at 2pm suit you to meet up?
>
> Kind regards
>
> Emma Tonks
> Senior Contracts Manager
> Mental Health and Addiction Services
> Mental Health Service Improvement
> Service Commissioning
> Ministry of Health
> DDI: 04 816 4460

http://www.moh.govt.nz/
mailto:Emma_Tonks@moh.govt.nz

From: Victoria Roberts <s 9(2)(a)>
To: emma_tonks <emma_tonks@moh.govt.nz>,
Date: 26/08/2016 12:06 p.m.
Subject: Nga Hau e Wha

Morena Emma

I hope you are enjoying the occasional burst of spring!

Many thanks for all your work to get the new contract holder signed up and ready to go. So far the interactions between our two groups has been brilliant.

I would like to take you up on your offer to meet to talk about the details of the contract. I have time next week on Tuesday, parts of Thursday and Friday afternoon. Does any of that work for you?

I have recently had a conversation with Kevin Allan, the new Mental Health Commissioner. He has asked me to find out whether or not he could have a copy of the Nga Hau e Wha report to the Ministry of Health? The most recent one was July 2016. Are you able to ascertain if that is possible? I know that we cant make the report public ourselves as the Ministry owns it.

Look forward to hearing back from you.

Nga mihi nui

Victoria

Victoria Roberts I Chair I Nga Hau e Wha

www.nhew.org.nz I s 9(2)(a)

The national voice of people with lived experience of mental distress and addictions

Nga Hau E Wha

"Champion many voices"

2016 June_ MOH Report Final_ Akatu docx.docx

Nga Hau E Wha
"Champion many voices"

20 June 2016

Agreement 570458 / 344777/00 – Nga Hau e Wha Report to Ministry of Health

2.2 Meetings Held During Reporting Period

25/26 February 2016			
Present	Victoria Roberts (Central) (Chair)	Julie Whitla (Vice Chair) (Southern)	2016_Feb_MRN_NHEW_Minutes.doc
		Guy Baker (Midland)	
	Tui Taurua (Northern)	Kieran Moorhead (Northern)By phone	
	Vacancy (Central)	Grant Cooper (Southern)	
27 May 2016 Teleconference			
Present	Victoria Roberts (Central) (Chair)	Julie Whitla (Southern) (Vice Chair)	2016-05-27_NHEW_Minutes.doc
	Guy Baker (Midland)	Grant Cooper (Southern)	
	Kieran Moorhead(Northern)	Tui Taurua (Northern)	
	Vacancy (Central) (Midland)		

Meetings yet to be held for 2016 will be the 21 & 22 August and 5 & 6 November.

Meeting Attendees

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

- Dr John Crawshaw - Director of Mental Health – Ministry of Health
- Emma Tonks Fund Administrator – Ministry of Health
- Grant O'Brien Health and Disability Commission
- Jak Wild – Website developer

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

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

- Dr John Crawshaw - Director of Mental Health - Ministry of Health
- Caro Swanson - Te Pou
- Grant O'Brien - Health and Disability Commission
- Kevin Allan Mental Health Commissioner
- Emma Tonks -Ministry of Health

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

Membership Updates

January 2016 – June 2016

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

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

1.7 Nga Hau e Wha Strategic Plan 2013 -2016—Victoria Roberts

The Ngā Hau e Whā Strategic Plan document has been updated with appropriate language as per the strategic plan goals. A Strategic Planning meeting was planned for November 2015. This was to update the Strategic Plan as per the schedule. Because of uncertainty regarding the funding for NHEW this was delayed and the Strategic Plan has been rolled over to late 2016.

People

No.	Objective	Indicator
1.	*Increase and strengthen local, regional and national relationships*	**Ngā Hau e Whā** is working collaboratively with individuals who are receiving services and other groups locally, regionally and nationally ▪ **Ngā Hau e Whā** continues to work collaboratively with many individuals, groups and organisations. ▪ The National DHB Family and Whānau Advisors Mental Health and Addictions were invited to and attended the November 2015 meeting of **Ngā Hau e Whā** in order to have some face-face time together. This is the second year they have met with us. The two groups will be working together to ensure a family and whānau perspective is included in **Ngā Hau e Whā** work. They have contributed there up to date statements to this report ▪ **Ngā Hau e Whā** continues to share with the network any useful information in regard to issues that affect people with lived experience and the group is pleased to be of assistance to our peers and colleagues. Our distribution list continues to function well. ▪ Requests continue to come in from organisations who would like to have time at Ngā Hau e Whā meetings. ▪ The email network continues to grow and **Ngā Hau e Whā** is always looking to increase the contacts which include individuals using services, as well as advisory groups, peer groups, and service providers with a specific focus on peer led services. People have been approaching Ngā Hau e Whā to be included in this network.
2.	*Be a recognised and respected conduit for the people's voice*	There is an increase in the level and quality of feedback on issues for people receiving mental health services. ▪ Current members have large networks that contribute to the information that is reported to the Ministry. The quantity and quality of feedback continues to improve. ▪ Individuals and groups with lived experience approach **Ngā Hau e Whā** with items that they would like the Ministry to know about. Ngā Hau e Whā continually works on increasing its profile. ▪ Commissioning Framework for MH & Addictions. **Ngā Hau e Whā** represented on the steering group by the Chair ▪ NZ Health Strategy was commented on by individuals from **Ngā Hau e Whā** ▪ Mental Health and Addiction Workforce Action Plan was to be reviewed and feedback was provided by 20 January 2016 ▪ National Organisations request attendance at **Ngā Hau e Whā** meetings, to use

No.	Objective	Indicator
		the **Ngā Hau e Whā** network and to provide consultancy. ▪ Three members of **Ngā Hau e Whā** were part of the Draft Suicide Mortality Review (SuMRC) Feasibility Study Report which has been reported back this year by the Health Quality Safety Commission.
3.	*Champion the use of appropriate language in all major documents.*	Newly written documents contain appropriate language. ▪ Ngā Hau e Whā endeavours to use appropriate language in all minutes, letters, reports and other documents it produces. The wording in the Ngā Hau e Whā Strategic Plan and Terms of Reference has been revised so the term 'consumer' and other labelling language aren't used and all language is appropriate. ▪ The contract document between MOH, Health Share and Ngā Hau e Whā is still to be reviewed to ensure appropriate language. ▪ Ngā Hau e Whā continues to advocate for appropriate use of language in any feedback on documentation that it provides.
4.	*Initiate projects and promote leadership forums.*	There is an increase in leadership and initiatives. ▪ Ngā Hau e Whā led the recruitment for the New Zealand Police National Mental Health Project. We continue to follow and receive reports ▪ Ngā Hau e Whā was asked to provide representation on the Commissioning Framework project - MoH ▪ Ngā Hau e Whā has begun to participate in the Populations Outcome Framework which is work that complements the MoH Commissioning Framework.

Performance

No.	Objective	Indicator
1.	*Fulfill contractual obligations to the Ministry of Health and be in a strong position to negotiate for the future.*	The Ministry of Health demonstrates that it values **Ngā Hau e Whā,** and funding is increased. ▪ **Ngā Hau e Whā** continues to build its capabilities to ensure that the Ministry of Health has access to a strong lived experience perspective, whether that comes from within the group or is sourced from the network. ▪ The Ministry of Health has requested service user input from **Ngā Hau e Whā** members during this reporting period.
2.	*Connect with the grass-roots and collate issues and common themes.*	**Ngā Hau e Whā** has increased the mechanisms for providing and receiving information. ▪ Due to Ngā Hau e Whā, now nearly having full membership an increase in information is expected.
3.	*Be a useful and valued commentator on mental health and addiction service issues.*	Reports and submissions are timely and well-received. ▪ Informed and comprehensive reports by members in regard to their region are received quarterly. ▪ Ministry of Health reports are delivered on time. ▪ **Ngā Hau e Whā** provides feedback to a number of organisations.
4.	*Have strong and effective representation in NHEW from the four regions.*	**Ngā Hau e Whā** is well-known in each of the four regions and representatives are well-supported. ▪ One vacancy remains at present.in Midland ▪ Midland Region is supported by He Tipuana Nga Kakano (Midland Region Consumer Network). ▪ Northern Region is supported by Changing Minds. ▪ Southern is supported by Incite and Awareness. ▪ Central is supported by Kites Trust and the Oasis Network ▪ Positive feedback from members of the network has been received.
5.	*Improve*	**Ngā Hau e Whā** produces a regular bulletin, has a website and Facebook page.

No.	Objective	Indicator
	communication processes.	▪ A new website has gone live. www.nhew.org.nz – see later in this report ▪ The new website is being further developed to improve our online presence. ▪ It will include various ways for people to make comment and to connect with their local representatives and networks ▪ The email network is continually expanding and the website will help drive this expansion further. ▪ A Facebook page will be continued to be worked on though at present the capacity and capability for this is limited. ▪ Business cards have been developed and are being used by members

Strategies

No.	Objective	Indicator
1.	*Become familiar with service user demographics in our regions and identify where we need to increase our visibility.*	**Ngā Hau e Whā** has undertaken some market research and applied the findings. ▪ Still to complete
2.	*Maintain the budget and administrative support to ensure our business processes are efficient.*	Business processes are working well. A financial report is provided regularly. ▪ Health Share forward an updated expenditure report for each **Ngā Hau e Whā** meeting. ▪ All administrative tasks including organisation of travel, accommodation, venue, refreshments, are provided. ▪ **Ngā Hau e Whā** would like to acknowledge Akatu Marsters at HealthShare for her admin support.
3.	*Review our strategic plan and objectives regularly.*	Strategic objectives are addressed and plans in place for the next strategic plan (2015-2017) ▪ The Strategic Plan for 2015 -2017 will be revised in 2016.

1.7 Terms of Reference

The **Ngā Hau e Whā** Terms of Reference was updated with some changes in wording in 2014. These were forwarded to the Ministry for approval. These are not due for another revision according to our contract until late 2016.

Service Specification Deliverables

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

National issues:

At the January 2016 meeting we challenged ourselves to come up with the most challenging problems facing people who are using services in 2016. What follows is the result of that conversation.

1. Mental health staff attitudes/values - Grant Cooper - Southland

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

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

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

2. Peer services/ Peer workforce/Advocacy/Peer Leadership – Grant Cooper - Southland

The peer workforce in general is still poorly funded in New Zealand. The peer workforce is still only 2% of the mental health workforce (source: Adult Mental Health and Addiction Workforce 2014 Survey of Vote Health funded services).

Report for 'He Tipuana Nga Kakano' - Caro Swanson - Consumer Lead for Te Pou:

In the last ten years developing the peer workforce, leadership, input and participation and peer support in mental health and addiction services has been part of every sector development plan but conversely there has not been a national programme of work that has as its aim the development and strengthening of peer leadership and workforce.

This workforce has as a primary requirement- personal lived experience of recovery. There is no way of teaching this experience. The development work here is both around ensuring people working or leading in this workforce have frameworks and policy that supports them while recognising the hard won value of living recovery, but also that the sector is well resourced in every way to work alongside or be led by peers.

Peer Competencies work

Promotion of the Planners and funders guide - a purposeful drive to ensure planners and funders has copies of the guide and an understanding of the peer workforce and its value. This will be done through mail out of the guide and presentations at planner and funder workplaces and meetings both in a planned way and opportunistically as they arise.

Promotion of the Managers and Leaders guide- again a purposeful drive to ensure Managers and Leaders have copies of the guide and an understanding of the peer workforce and its role, work and value. This will be done through mail out of the guide and presentations opportunistically as they arise.

Peer values workbook is well under development and should be available late June. After feedback around the need for Māori world views and values I talked to Keri Opai who is our Paearahi. He then went on to develop whakatauki for each peer value. In my opinion these add so much.

Here is what he came up with for each value from the competencies;

- *Mutuality* - the authentic two-way relationships between people through 'the kinship of common experience'.

"He kīwai ki a au, he kīwai ki a koe engari kotahi tonu te kete" (Though I hold one handle and you hold the other there is but one basket we share.)

- *Experiential knowledge* - the learning, knowledge and wisdom that comes from personal lived experience of mental distress or addiction and recovery.

"Kāore i tua atu i te wheako kia puta ai te māramatanga" (Nothing beats experience in gaining wisdom.)

- *Self-determination* - the right for people to make free choices about their life and to be free from coercion on the basis of their mental distress or addiction.

"I runga o Kāpiti kāore he wehi o te weka" (On Kāpiti island sanctuary the weka bird has no fear – it has its own autonomy)

- *Participation* - the right for people to participate and lead in mental health and/or addiction services including in the development or running of services as well as in their own treatment and recovery.

"Tōia te waka o te hauora! Mā wai e tō?" (Drag the canoe of health in to shore! Who will assist?)

- *Equity* - the right of people who experience mental distress and/or addiction to have fair and equal opportunities to other citizens and to be free of discrimination.

"Me mutu te whakawā haere" (What possible benefit is there in judging others?)

- *Recovery and hope* - the belief that there is always hope and that resiliency and meaningful recovery is possible for everyone.

"Whāia te iti kahurangi, ki te tūohu, me maunga teitei" (Pursue that which you treasure and if you should falter, let it be to the loftiest of mountains)

Peer workforce forum

Te Pou is looking at holding a national peer workforce forum in July or September in Wellington. Its purpose would be to;

- Resource, develop and facilitate annual peer workforce forums. Purpose is to provide time and space for peer leaders to explore next steps in developing our workforce
- Create a Te Pou Peer Workforce Development Work Plan for the coming three years from the outcomes of the 2016 peer forum

Potential suggestions for the first one are;

- Explore creating a NZ peer workforce network, building on what is already working in various places
- Hear about what others are doing
- Workshop on what our workforce needs to continue developing and growing

Evaluation and development

- Use a pilot project to evaluate the efficacy of peer support programmes and models (NOTE this is not to test the efficacy of peer support workers but of a peer support programme or model. I don't think psychiatrists or nurses as a vocation have ever had to have any evidence of efficacy)

Real skills

- Ensure Peer workforce perspectives and options are included in the *LGR* framework and enablers refresh
- Promote use of online peer competencies assessment tool and evaluate (to be available June)

More info to follow as these progresses

Seclusion and restraint reduction

- Continue to ensure this project suite is co-lead and has consumer leadership, input and perspectives into this work

Handover MH Nursing Journal

- Co-edited by me to provide consumer leadership, input, and perspectives into this work

Values and attitudes

- Provide consumer leadership, input, expertise and perspectives into this work

DPO development engagement (disabled people and mental health consumers)

Where possible engage with and align activities with DPOs

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3. Suicide – Victoria Roberts - Wellington

Suicide continues to be an on-going issue in New Zealand. The Office of Director of Mental Health Annual Report 2014 states that "Approximately 40 percent of those who died by suicide or undetermined intent (among those aged 10 – 64) were mental health services users." Further to that a large proportion had been in contact with a medical professional in the weeks preceding the suicide.

Three members of Ngā Hau e Whā were part of the Draft Suicide Mortality Review (SuMRC) Feasibility Study Report in 2015 overseen by the Health Quality Safety Commission. The Commission was contracted to trial a suicide mortality

review mechanism as part of the Suicide Prevention Action Plan 2013-2016. The trial was investigating whether a suicide mortality review mechanism had potential to provide additional information on suicide trends and potential points on intervention over and above what is already known.

The study that Ngā Hau e Whā members were asked to feedback on focused on 3 discrete groups: Rangatahi Māori, aged 15-24 at the time of their death; men aged 25 - 65 at the time of their death; and mental health service users who had face to face contact with mental health services in the year prior to their death. The study covered 1800 people who died between 1 January 2007 and 31 December 2011.

The study confirmed the value of independent mortality review committees in providing useful information to inform suicide prevention programmes. This is because they have the legislative ability to gain and match data across agencies.

This information will be really useful in informing suicide prevention programmes and for researchers seeking to understand.

The Suicide Mortality Review Committee Report and a summary version has been published on the Commission's website on 31 May 2016
http://www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/2471/

Suicide prevention training – Kieran Moorhouse - Auckland

Changing Minds Auckland: Manu is raising suicide prevention awareness through training in the community. There are initiatives from the MoH for suicide prevention in the rural community; we are funded for 5 workshops. We are raising awareness in schools. The National strategy needs to be signed off by the end of this year and our plan will be reviewed next year. We need to make sure we are linking in with services to ensure the same messages are being given at schools. Megan is currently looking at a pathway into ED for risk assessment. We want to develop where we can and match up to those plans.

4. Treatments available to Mental Health Service Users – Victoria Roberts

The mental health service landscape can be depressing from the perspective of a person using services because of the vanilla menu of options offered. And delving deeper one becomes even more disheartened when one becomes aware of the priorities that a DHB sets for itself. Realizing that the vast percentage of $$$ are not spent on patient care but are spent on the periphery - spent on management and all its vast array of structures from HOD's to legal department staff; to financial department staff; to HR departments; to media staff; to asset management staff; to ??? ; then down to administration; to reception; to phones; to secretaries; to security; to drivers; then down further to the medics – the doctors, the nurses, the support workers, the cleaners; then to patient supplies – then eventually to patients, the service users.

It's not surprising then that when service users, experiencing distress for any number of reasons, and some for the first time find the pickings on offer unhealthy, distasteful, leftovers, scraps when they enter psychiatric services. Many are the leftovers from services that were fashionable many years ago (seclusion, ECT, locked wards, staff with clipboards, and draconian beliefs). Looking closer at the mainstream of services we can see that most will employ any staff they can. There are always staff shortages we are told. This may be because many 'enlightened' staff themselves find such coercive and abusive environments untenable to work in. We have been told this as well.

Often doctors who come on short term contracts from overseas are unfamiliar with our indigenous culture - percentage wise our largest group of people who access our services. Not only have the people who are new to services unaccustomed to all the terrifying cacophony of locked wards, solitary confinement, rough treatment, perceived abandonment by family/whānau been terrorized by an unexpected and unwelcome admission -

then someone who doesn't speak English as a first language comes to diagnose and "treat" them!! Even if they do speak English well the encounter can never go well in such circumstances.

Entering services the innocent abroad might well expect to find a kindly psychiatrist who will spend time talking about the range of problems and issues that have beset them and that have brought them to this stage of their life. Most likely the psychiatrist will be overworked with a vast caseload of worried and unwell patients whom he will never have time to get to know even remotely and who he will rely on the others in his team to fill in the details. His job will be to observe his specimen for long enough to confirm his predictive diagnosis and prescribe. A kindly pat on the head maybe, then poof he has gone.

If you were expecting a counsellor, a psychologist, a social worker, an occupational therapist, it is unlikely you will see one. They are just as busy, as scarce as hens' teeth and as likely to be as available as the illusory psychiatrist.

Service user solutions for treatment

It's not surprising then that the service user movement in its disillusionment at what is currently on offer within the mainstream has taken to looking away from it and towards other solutions:

- Peer Support:

There has been a big movement internationally towards Peer Support as a serious contender for assisting people experiencing mental distress Studies in the Aotearoa NZ context should be funded to confirm their relevance. (See also other pages in this report 5; 19; 23)

- Trauma Informed Care:

Trauma Informed Care (TIC) is a model of practice that begins from the premise that existing systems of care do not routinely inquire into histories of adverse early experiences. Concern has been expressed to **Ngā Hau e Whā** that there is not enough trauma informed care in Aotearoa NZ. We believe all mental health professionals practicing in Aotearoa NZ should understand the high incidence, severity, and long lasting effects of such forms of adversity across all aspects of health care – physical, mental, substance abuse, individual / family / whānau. This should comprehensively cover inquiry into all aspects of service users' early, and on-going, experiences of adversity, conflicted attachments, and neglect, abuse, and trauma.

The effects of current high rates of child abuse and neglect in Aotearoa NZ gives rise to the concern for the need for screening in the adult population for historical issues especially as these can be a prerequisite for many a substantially elevated risks of suicide. Given the suicide statistics in Aotearoa NZ this seems a rational appeal.

Currently we do not in this country have any accepted Practice Guidelines for the treatment of PTSD and Complex Trauma. Therefore this week we saw a military veteran suffering complex PTSD from his time in Afghanistan crowdfunding to go to Australia for treatment.

TIC is a model that sees the presenting problem in whole of life context, asking "what has happened to you?" rather than "what is wrong with you?" That way the medical model is replaced by a psychosocial approach to assessment, intervention, care, and on-going, recovery support.

- Dialectical Behavioural Therapy

This is another very valuable treatment that has come onto the scene in Aotearoa NZ with increasing advantages to the people using services who have been able to access it. To those who have experienced DBT it resembles a match-up between Zen Buddhism and Cognitive Behavioural Therapy – as was probably intended by Marsha Linehan who first began it as a therapy. There are many references to the therapy online on the Internet so this will not go into it in detail.

The concerns for Ngā Hau e Whā is that this, widely accepted and exceptionally supportive therapeutic tool is not available widely enough and too enough people using services. In the Wellington region, where this writer resides but it is available to people accessing AOD services. This seems to be another example of DHB not deciding/ justifying offering treatments and/or therapies that would greatly assist even people who could very often benefit from them.

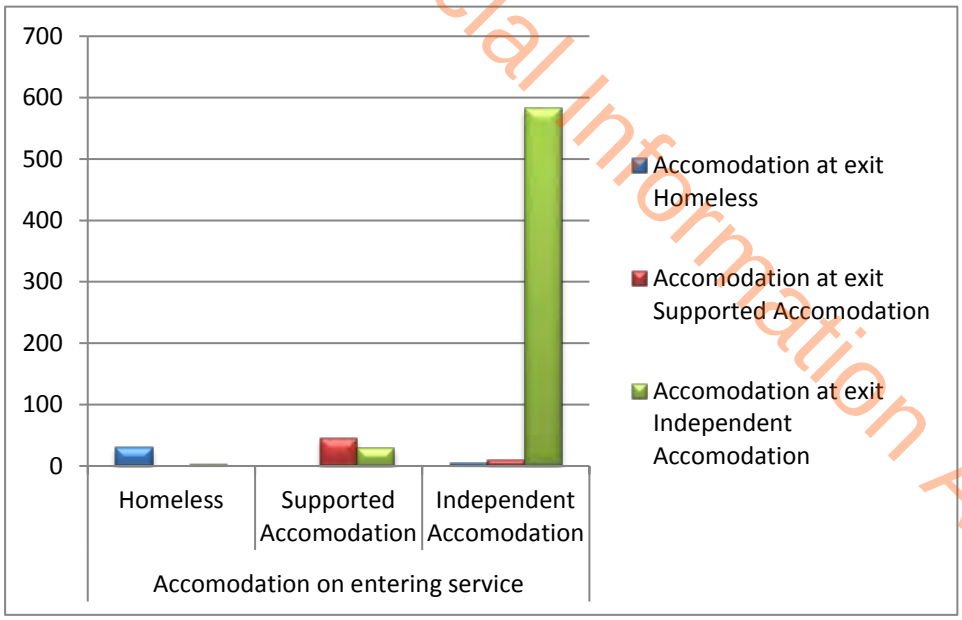
This is cuts to mental health services by stealth – that is by not increasing budget spend even though population increases continue are not okay. Not replacing staff when people leave is also not all right. We know this happens. We make a strong plea to the Ministry to take note of this for the sake of upcoming and current service users.

5. Housing – Grant Cooper - Southland

Suitable housing is a significant issue for people with experience of mental distress. A lot of resources are put into acute mental health services. It is widely acknowledged that more resources are required for people when in recovery and before unwellness becomes acute. The lack of housing is an issue with a number of people homeless. A higher standard (warrant of fitness) for all rental housing is also required. Support for people to gain housing is also lacking. People with experience of distress often feel powerless to advocate for themselves as they feel ground down by the processes to gain support which adds to their mental distress.

Housing graphs for Auckland – Kieran Moorhead

Table 1: Waitematā DHB Q1, Q2 and Q3 15/16 Changes in Housing (N=710)



WDHB and ADHB Employment and Housing Figures for people using secondary mental health and addictions services:

6. Employment Kieran Moorhead

Table 2: Waitematā DHB Q1, Q2 and Q3 15/16 Changes in Employment (N=710)

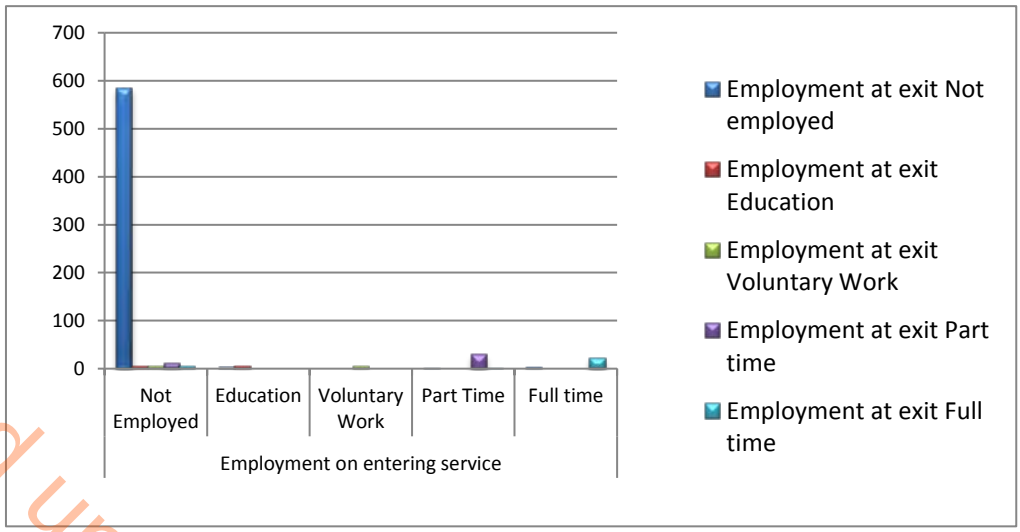


Table 3: Waitematā & Auckland DHBs Q1, Q2 and Q3 15/16 Changes in Employment (N=1098)

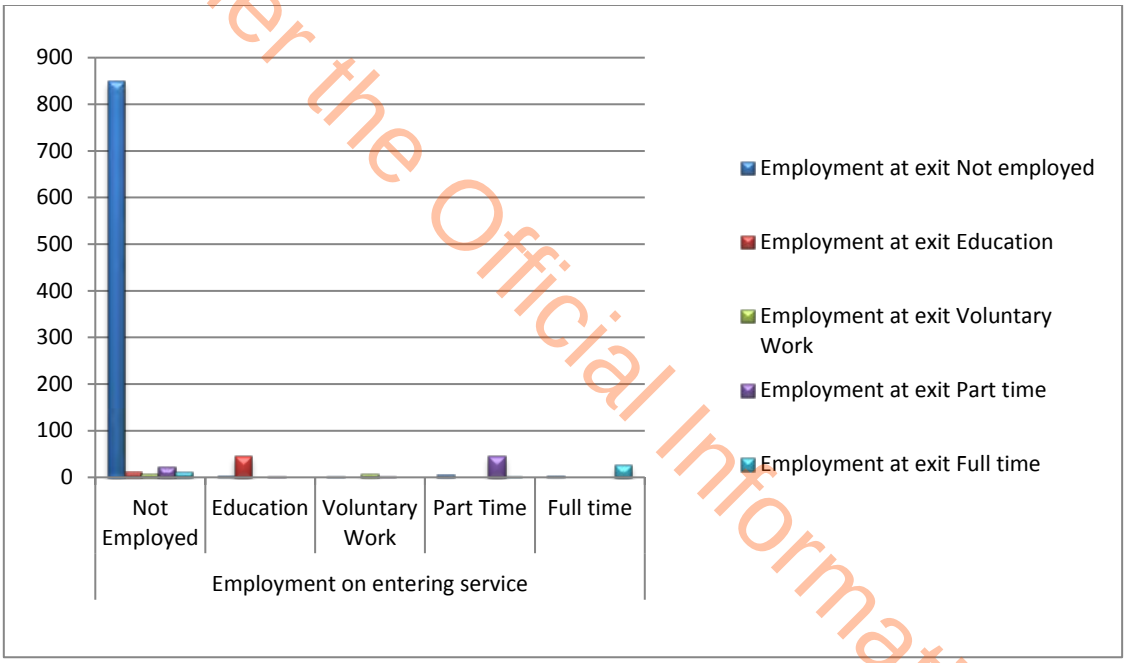
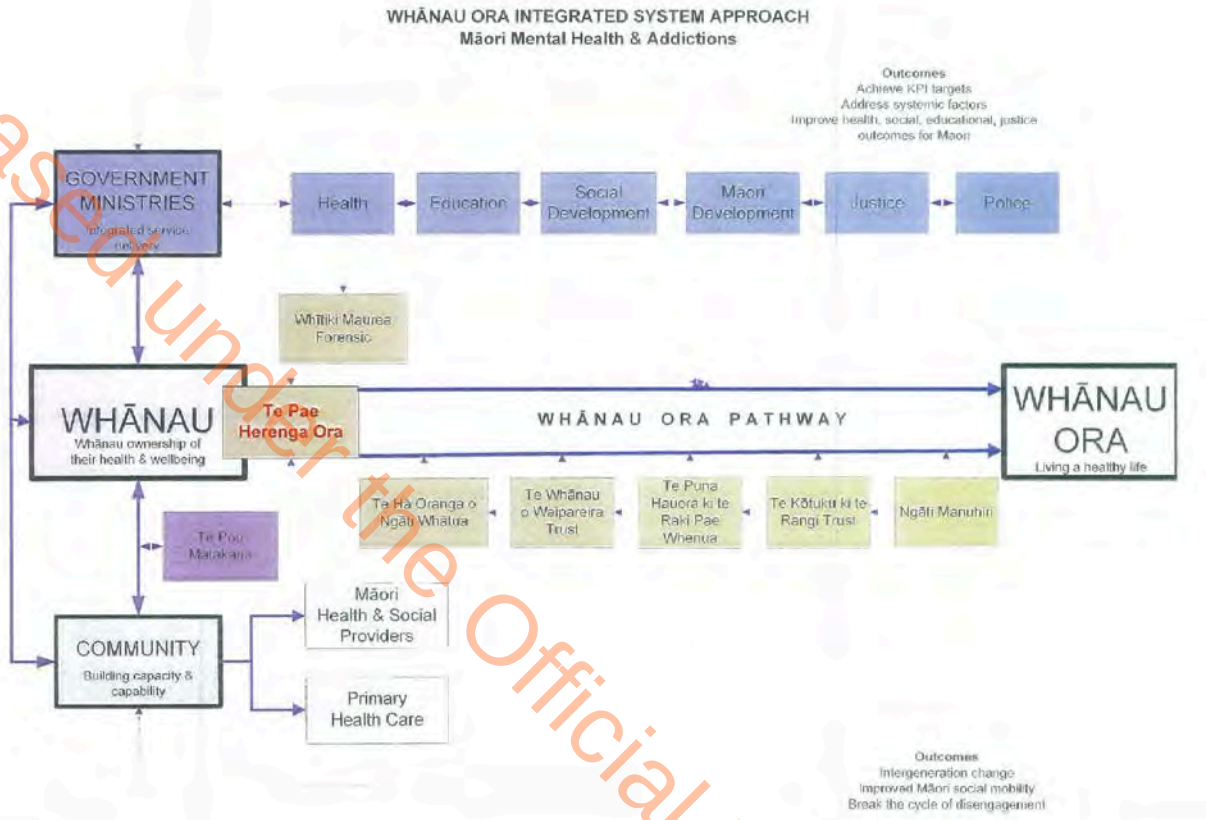


Table 4: Waitematā DHB Q1, Q2 and Q3 15/16 Changes in Housing (N=710)

7. Māori Equity - Whānau Ora and Mental Health and Addictions A strategic view Kieran Moorhead Auckland

Māori Equity - Whānau Ora and Mental Health and Addictions:

8. **Internet Access as a Disability / Health Issue** - Victoria Roberts - Central Region



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

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

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

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

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

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

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

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

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

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

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

Article 9 Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public,

both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

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

2. States Parties shall also take appropriate measures:

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

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

9. Solitary Confinement (Seclusion)

- Following the lead of other Service User groups, Ngā Hau e Whā refers to seclusion as solitary confinement, considering it to be a practice that is not therapeutic for people accessing mental health services.

- There are updates on the progress in the regions to eliminate solitary confinement elsewhere in the report. A special mention for Tairawhiti District Health Board. Ngā Hau e Whā would like applaud the decision that Tairawhiti District Health Board has taken to set an end date (February 2020) for the elimination of the use of seclusion, and urge other District Health Boards to follow suit.

- Although the recent stats for solitary confinement have been slightly increasing in recent months in Tairawhiti, the District Health Board has instigated an "End of Seclusion" working committee to develop strategies on what mechanisms will affect the change towards elimination, with it envisaged that the new service will be operational by August 2019 allowing a 6-month period for any fine tuning prior to the end of the use of solitary confinement. As per the Ministry of Health seclusion standard, peer debriefs for those currently being placed in solitary confinement have been reported as working well in several regions, notably Tairawhiti and Christchurch , and this will contribute to District Health Boards leading the way to end the practice.

- Solitary confinement has featured heavily in print media and on social networks over the month of June. Two cases in particular drew national attention after high profile reporting on concerns around the practice. A series of articles in the Herald on Sunday and on National Radio focussed on the case of a Service User at the Central Regional Forensic Mental Health Services in Porirua resulting in national debate and questions in parliament. Whilst at the same time the Dominion Post ran an investigative article over several pages on the 2015 suicide of a Service User in Wellington Hospital's Te Whare O Matairangi inpatient unit with the article noting the impact that prolonged and repeated use of solitary confinement had had on the Service User and his family.

- Here is an embedded document with a selection of electronic links to items that appeared online as a result of the media focus on solitary confinement over the last month, including video and radio interviews, newspaper articles and blogs, followed by a selection of comment that featured on the support page of the Service User residing in the Porirua facility:

June 2016 media on solitary confinement

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

1. Innovation – in Primary Mental Health Care -_Kieran Moorhead – Auckland

Preliminary (Quantitative) Findings of the WDHB Mental Health Services Pilot within Health New Lynn:

Purpose

- To improve access to advice to GPs and their patients
- To enhance the primary care response to those with MH &A problems
- To help build GP confidence and capacity to identify and manage common conditions
- Blueprint II MHC 2012 and Rising to the Challenge MoH 2012

Intent

- To better utilise and deploy specialist expertise to enable early intervention; a more capable and confident primary mental health response and anticipating secondary gains for community mental health services with better targeted referrals and reduced referral volumes.

Outcomes

- The mental health occupational therapist ran (x2) 10 week mood and anxiety groups last year.
- 8 people under Health New Lynn were referred. One person left the group after 2 sessions as they had gained employment. The occupational therapist conducted symptom measures pre and post (DASS21 and Kessler 10) - findings are yet to be calculated.
- As the awareness of the group increases the numbers of people being referred this year has also increased
- The mental health occupational therapist also conducted (x2) 3 week sensory modulation workshops. 2 people under Health New Lynn were referred by the mental health primary care liaison nurse.

Opportunities for improvements

- A consistent system for data collection for all clinicians working out of Health New Lynn. To enhance the capacity for audit & review
- Electronic storage of patient notes direct into GP electronic health records
- Expand SMO consultation capacity (peer review, case supervision, e referral)
- Enhance health navigation and advice. Telephone advice line. PCL support and direction.
- Establish feedback mechanisms of the pilot; regularly reporting back to governance; project summaries & links with related projects
- Recognising the power of relationships (between people) to enhance collaboration and service user outcomes
- Explore future opportunities for integration of effort across primary and secondary care e.g. involvement of peer support workers, family support
- Development of an (electronic) GP referral pathway in the community or through referrals management but bypassing HCC (nimble, safe).

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2. Equally Well - Kieran Moorhead – Auckland

Equally Well - Physical health + mental health

- At last week's Waitemata DHB (May) meeting it was agreed to modify the PHO enrolment measure to capture when a service user last saw their GP. In a recent conversation re the Tamaki work quarterly visits to GPs seemed to be a reasonable goal.
- Physical health should definitely be part of the SNAP, and the SNAP review is a good opportunity to check when the person last saw their GP. It is also a great opportunity to discuss how the person can be supported to see their GP, be supported to raise the issues that are important to them and get a full physical health check.

- If the SNAP review is when housing and employment status are updated it would seem sensible to do the same for GP visits.
- What we are trying to get a picture of is whether people are seeing their GP (as the next step forward from are people enrolled with a PHO). As discussed at the WSN we hear anecdotally that the people using our services are not seeing their GPs regularly (or at all), and when seeing their GP the 10-15 minute appointment is focused on mental health issues (as you have highlighted).
- While we can start to look at whether the people accessing our services are seeing their GPs, for the provider arm or NGOs to report on what occurred in the GP appointment would be extremely challenging. However, through day to day support and the SNAP process provider arm and NGO staff are excellently placed to support people in accessing their GP and making the most of the appointment.

- Lee suggested a stock-take of where we are all at to try and ensure there is no duplication and to identify any gaps. Naomi advised there was an NGO review at the end of last year which would have some of that information. Lee will look into this as it would be a good starting point. People's physical health is important and we need to raise the profile of equally well. Ruth advised we will include this topic in our follow-up on the plan with the community in November. It would be good to try and get PHOs here also.

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3. Collaboration between Consumer Network and Researchers – Julie Whitla Christchurch

This research grew from many complaints from people in Awareness Consumer Network and contacts in the network and has developed into a research project.

The bulk of the work Mental Health and Addictions Advocates are now doing is supporting parents and their children with CYFS and family court issues.

Child custody when Parents have Mental Illnesses and/or Addictions

What are our research questions?

This project is designed to answer two research questions.

1. How are decisions regarding day to day care, guardianship and family reunification made in Aotearoa New Zealand, when a parent is living with a serious mental illness and/or an addiction?
2. What are optimal outcomes, and how can these outcomes be achieved? (This question also involves looking broadly at supports that might be offered to families living with mental illnesses and/or addictions.)

What will we aim to do?

This project is designed in three phases.

1. In the first phase of the project, we:
   - Conducted scoping interviews with professionals who could provide an overview of the care and protection process. We completed ten interviews.

- We conducted a scoping interview with a parent who had been through the child protection system.

2. In the second phase of the project, we are expanding the study; we will interview a wide variety of stakeholders to this issue:
   - Including professionals working in care and protection; professionals working in the family courts; professionals working in support capacities; professionals working in mental health; professionals working in Māori health, and so forth.
   - We will interview parents; whānau members; foster carers; and young people who have been through the care and protection system. These interviews will elicit personal stories, focused on the decision making and support processes. Our ethical protocols ensure that research participants will be carefully supported throughout this process.

3. In the third phase of the project, again assuming we can find funding, we will design an educational intervention – such as a workshop for social workers or an educational resource for parents and their whānau – based on our findings. We will implement and have evaluated our educational intervention. We will also disseminate our findings through academic, policy and community channels.

How are we being funded?

The first phase of the project was funded by the Schizophrenia Fellowship Research Awards. The second phase is being funded by the Oakley Mental Health Research Foundation. For the third phase of the research, we will seek funding from The Law Society, The Mental Health Foundation and so forth.

Ethical and community approval:

We have consulted widely on this project amongst community organisations, as noted above in our resulting partners, and amongst service providers such as Te Korowai Atawhai, the Māori mental health services in Canterbury; Canterbury Mother and Pipi support; and the Champion Centre for disabled young people. We have found broad support for the project. We have received ethical approval from the University of Canterbury Human Ethics Committee: REF 2015/80.

Who are we?

This project is being undertaken by a community-based working group under the leadership of principal investigator, Dr. Anne Scott of the University of Canterbury.

- Dr. Anne Scott is a Sociologist of Health and Medicine at the University of Canterbury, with a focus on mental health and wellbeing. She has prior publications in the areas of peer support in mental health; the mental health consumer's movement; genetic testing; bio banking; approaches to hepatitis C treatment; and community informatics. She is finishing a co-written text: '*Social, Political and Cultural Dimensions of Health*, to be published by Springer in 2016.

Other members of the working group include:

- Ms. Kelly Pope: Coordinator of Awareness: Canterbury Action on Mental Health and Addictions, (which is centrally involved in this project) and consumer advisor at the Werry Centre.
- Ms Adele Parkinson: Social worker, formerly working at the Caroline Reid Family Support Service, Stepping Stone Trust, and currently a PhD candidate at the University of Otago
- Dr. Don Quick: Recently retired psychiatrist, currently studying the anthropology of belonging and connection at University of Canterbury.
- Ms. Sarah Wylie: Independent social researcher and member of the research committee of The Collaborative for Research and Training in Youth Health and Development.

- Ms. Nicola Dorward: Ngati Kahungungu ki Wairarapa. Social worker with experience of kaupapa Māori orientated research, and experience of paid and voluntary work at Te Whare Roimata.
- Ms Jo Stewart: Qualified social worker and counsellor; member of the research committee of The Collaborative for Research and Training in Youth Health and Development.

The working group is being actively supported by *The University of Canterbury*; by Awareness*: Canterbury Action on Mental Health and Addictions*. It is also supported by *MHAPS – Mental Health Advocacy and Peer Support;* and by the *Collaborative for Research and Training in Youth Health and Development*.

We are seeking interview participants:

At this stage, we would like to interview about 15 parents who live with a mental illness and/or an addiction and who have experienced the child care and protection process. We would like half of these interviews to be with people who identify as Māori, and we would like to also include interviews with some young parents. Interviews with participants who identify as Māori will be undertaken with a Māori researcher.

It is important that the participants in this research are properly supported, and have enough information to make an informed decision about whether they wish to participate. Please see the attached information sheet and consent form for participants. We are happy to meet with participants, along with a support person, to discuss the research beforehand if this is desired.

We would appreciate it if we could interview parents from your agency in a room at your agency, or nearby, so that they can have access to a trusted person with whom to debrief and find support afterwards. If this is not possible, we will make a similar set of arrangements at MHAPS – Mental Health Advocacy and Peer Support.

We are seeking two to three participants from your organisation. If there are clients of your organisation that would like to participate, please contact Kelly Pope, Anne Scott or the researcher who made contact with your agency.

Contact details:

Anne Scott: s 9(2)(a)

Kelly Pope: s 9(2)(a)

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4. Crisis Peer Service Project Christchurch - Julie Whitla Christchurch

20th April 2016

Update from Sue Rickets CEO MHAPS (Mental Health Peer Advocacy and Peer Support Service)

Sue Rickets wrote up the background to the project and presented this to the MHAPS board.

An increasing number of people are presenting to MHAPS in crisis or intense distress. Four main areas of distress are: severe mental illness distress, psychosocial distress, distress threatening alcohol and drug use recovery and people discharged from hospital following admission or self-harm issues. The MHAPS board discussed whether MHAPS would take on a project like this. There was discussion around:

Is this core business for MHAPS? Answer: not currently, but it needs to be.

Is there a need for this service? Yes, definitely

What is the situation currently? There needs to be discussion and statistics provided from mental health services, police, etc.

Suggested other agencies to work with:

Crisis Resolution services which has reinforced the need for a service like this. The access criteria for Specialist Mental Health Service support are really tight, very psychiatrically focussed and even then hard to access.

Odyssey AOD drop in service has been established and could be a service to work with.

Stepping Stones Sue Rickets has spoken with Mike Douglas from Stepping Stones who is supportive of contributing some crisis respite beds for the service. These could be staffed by peers, and would overcome the issues previously discussed: what would the service do if it was closing time and there were still people in need at the service? Would Mike Douglas like to join the working group? He is very busy but would be interested in being involved when we begin to arrange more practical details.

Suicide Prevention Coordinator Canterbury DHB (CDHB David Cairns is interested in being involved. Sue Rickets will invite him to the next meeting. His Suicide Prevention work currently focusses around following up people following a suicide attempt - postvention.

Researching where things are currently:

There was a suggestion that we utilise the UC intern programme, and get a student to do a project talking to GPs in Christchurch to find out who/what they are seeing. Steven Hardman oversees this programme at UC. Sue Rickets has been in touch with Steven in the past to arrange an intern and is happy to make contact to arrange intern/s for this project. Anne is happy to provide academic supervision to the student. We could start this as early as next semester.

Youth:

Will the 'crisis drop in' also be available to youth? If so, our scoping could include talking to schools and teachers to find out what they are seeing and/or experiencing with youth in distress. This could create a lot of scoping work – we could possibly get two interns, or if schools are not prepared we could talk to 298 Youth Health Centre.

John will find out about the current emergency support available to young people and whether that differs from adult crisis support. If we had a youth support, it would be good to have two different premises. We will plan to include youth, and will talk about this in more detail as ideas develop.

Māori service provider input:

Sue Rickets mentioned the importance of including a Māori service provider in the planning of this project early on. Sue is thinking of talking to Karaitiana from Purapura Whetu, or Dallas from He Waka Tapu to see if they would like to be involved. The group feels that it's crucial to collaborate because of the experience of distress and high suicide rates for Māori. Sue will contact Karaitiana to be involved.

Alcohol and Drug Recovery Support:

With Marc's involvement we can keep a focus on the way that the service can support people in recovery. Marc mentioned that the mental health system does deal with a lot of complex issues that the AOD sector is currently not able to deal with, e.g. medical detox.

Health and Safety:

When we come to put in a proposal, the issue we will be questioned around the most will be around how we manage health and safety, and situations where people are together with different behaviours, issues and needs.

Concept plan and business plan:

A smaller group will work together to develop a concept plan which can be taken to Toni to begin a discussion around the need for a service. Sue and Anne are happy to work on writing this.

To do this we need:

1) More data and research around the current situation
2) A firmer plan of what the service were designing would look like

We will talk to:

- SPOE – John will continue to follow up with stats
- 298 – Anne will contact Sue Bagshaw from 298
- Police – Ali and Julie Whitla will talk to the Police, Julie has a contact with the Māori liaison officer
- BIC coordinator – Sue will talk to the BIC coordinator
- AOD central – Marc Beecroft and Julie will talk to Steve
- Jeremy Baker – Sue will contact Jeremy Baker
- David Cairns – Sue will contact David, and Ali will also attend meeting if possible

Gathering data:

It would be good to know:

- The number of people who contact SPOE, the number of people who get referred onwards into SMHS, the number of people who don't meet access criteria and are referred back to community
- Ask for information from the past year to capture the seasonal nature of crisis support calls.
- Number of mental health crisis that Police field calls around, number of calls police attend to
- What does exist for youth in crisis currently?

To access this data, we can talk to police, specialist mental health service (SMHS) or as a last case scenario putting in an Official Information Act request.

Who are we planning to provide service to?

If we are looking for funding through Specialist Mental Health Services, we are looking at the top 3% of people. If we are keen to see the top 20% of people this might be harder to have funded through specialist mental health. We may be able to get funding through mental health though if the project is pitched as an early intervention to stop people getting to being in the 3% - this has been the case when crisis cafes have been set up overseas.

Blueprint argues for a life course approach that looks preventatively. That said the funding model currently used around the country still breaks people up into the 3%. There was discussion about how these focusses fit with a peer conceptualisation of crisis. Is there data on how many people experience crisis? If so, we could use this to determine the percentage of people the service will work with. Sue has some data around this from a publication by Te Rau Matatini – this will be good to cite in our concept plan even if the data is 10 years old, as it does focus on how many people experience suicidality etc.

Partnerships:

A suggestion for how to pitch this project is as a partnership project between Partnership Health PHO and Specialist Mental Health Services. If we can meet with both Toni Gutschlag (General Manager Mental Health Services CDHB) and the leader of the PHO, that would be ideal. This kind of project may fit well with primary care focus, as the sector has just released 'Closing the Loop' which is about mental health support in the primary setting. Jeremy Baker has been involved in this and will be a good person to involve. There was a suggestion to involve Canterbury PHO as well as Partnership

Health, as Canterbury PHO covers the university health centre and 298 youth health so may have more knowledge about young peoples' needs.

Research:

Ali and Anne can work together to access literature on the journal databases.

Brainstorming:

We looked at some of the key areas for discussion pulled out of the conversation at the last meeting. There were also some points raised around other areas of consideration. These are detailed below.

Purpose/Mission:

- Relieving distress
- Restorative approach to health and wellbeing
- Support to take the first steps for resolving crisis
- Key linkage between specialist and primary supports
- Safe space, that is emotionally supportive to allow people to move beyond/let go of fear
- Support to develop distress tolerance skills
- Help address immediate crisis, but also provide options for continued learning and recovery
- Support and enable connections
- Helpers principle – by helping others, you're helping yourself (a focus on volunteers)
- Normalising distress, not pathologising crisis

What happens in this space? The person's journey through the service:

- People can come in with support people, but it's crucial that they are support people
- Two-people staff the foyer area; one person keeping an eye on the door welcoming people; another peer who can meet and have initial discussions with people coming in
- Initial conversation with the person about where they are at, why they are here? What are the triggers? Background? What are they concerned about? What is the current crisis?
- Options-focussed discussion – one option could be continuing support if the service's support fits what's relevant to/needed by the person at the time
- There will be a focus on continuity and relationship
- People continuing with support through the service can choose
    - Continuing to talk with the peer support worker in a quiet room inside, this could include distress tolerance skills discussion, useful books, dvds
    - Hanging out in a group room which has games, tables, hot drinks, other peers and volunteers to chat to, books,
    - Utilising books, dvds in a quiet room for distraction
- People will be followed up by the person who supported them with a txt or call to check in
- Following crisis people can be supported to link in with Purapura Whetu, MHAPS, and/or other peer/cultural support services
- Education opportunities will be available during the day, on site for people who have used the crisis service on: self-advocacy, writing advance directives,
    - People who have accessed the support can move on to providing support in a volunteer capacity, people can train in peer zone and become involved in providing hospitality, support, company and conversation at the crisis café space as "peer volunteers"

Health and Safety:

- Panic buttons under tables to get support from others if needed
- One-way traffic through the building

Capacity:

- Need to think about absolute numbers of people allowed in building

Ideal venue:

- A house, with reasonable sized rooms but separate rooms, so that you can either support people together in the sitting room, or individually in other rooms.

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5. Action Research Peer Advocacy – Victoria Roberts - Wellington

In Confidence – Not for Public Disclosure -A report for Nga Hau E Wha from Kites Trust in confidence.

June 2016

Introduction

In 2015 Capital and Coast DHB (CCDHB) held a meeting with four community providers[1] in their district to develop a piece of work aimed at developing a best practice Peer Advocacy Service delivery model initially for Kāpiti, Porirua and Wellington. Contracts for service were developed for each provider from 1 July 2015 to 30 June 2016.[2] The contract specifications included a requirement to identify what best practice peer advocacy is with consideration to the needs of people with experience of mental health and addiction an issue of all ages and cultures. Kites was contracted to lead the team, undertake joint research and development as well as meeting all CCDHBs reporting requirements.

This report describes some of the work carried out and interim considerations.

Definition

After time spent researching, this is the definition that we felt best describes peer advocacy.

> *Peer advocacy is taking up an issue with a person and assisting them to uphold their rights and achieve the best possible outcome. Peer advocacy takes place when the individual providing the help has been, or is going through a similar experience. The underlying principle is that peer advocacy is not about creating dependence but is a partnership where the person is an active participant. The overall aim is for the peer advocate is to make themselves redundant by assisting the partner to self-advocate in the future.*

Work

Various methods were and still are undertaken to scope and develop the work. These include: research, consultation, marketing and communication, information gathering and presentations. The team has continued to meet fortnightly and has developed a strong and collaborative way of working.

An initial job was to promote the peer advocacy service. As part of that a 0800 number was set up which links people to "The Call Centre", a 24/7 service. The staff at the Call Centre refers callers to the peer advocates. It has been found that many people self-refer to the services.

Each provider employs a single peer advocate and between the 3 of them they cover the district from Kāpiti to Wellington. Initially there was a steady increase of people seeking advocacy and as time passed and information about

[1] Kites Trust, Newtown Union Health Service, Te Ara Korowai and Vincents Art Workshop.

[2] At the time of writing this report negotiations were underway with CCDHB and the providers to extend the contracts to 31 December 2016.

the service became more widely known their workloads increased. Currently they are almost to capacity which raises the question about how many peer advocates there have to be in the Wellington area to cover the demand.

Approximately 40% of the peer advocacy work is directly about CCDHB mental health and addiction services. Peer advocates work in Te Whare O Matairangi; attend Community Mental Health Teams, GPs, government agencies and some community providers. Currently Porirua Hospital campus is not included in this work.

Each peer advocacy provider reports to PRIMHD and to Kites monthly on activities and issues. Kites then incorporates these reports in the monthly report to the funder.

Some Interim Considerations

It seems that the peer advocacy work will be extended to 31 December 2016. This will provide more opportunities for research and learning about provision of best practice peer advocacy. Therefore the following points indicate some of what has been learnt to date and should not be taken as final results.

- Any organisation providing peer advocacy needs to be as independent as possible from other organisations and preferably would not provide peer advocacy along with other contracts for mental health and addiction services.
- Organisational best practice starts with having sound policies and guidelines that provide direction and support to staff and members of the organisation.
- Peer organisations and advocates must develop sound working relationships with community groups and mental health and addiction service providers.
- A best practice peer advocacy service provides adequate training for peer advocates and facilitates opportunities for ongoing training and professional development during their employment.
- Key skills required to be a peer advocate are; an ability to listen to and understand what people are saying; negotiation and compromising. Attributes include; being honest, non-judgmental, patient, non-discriminatory and non-patronising.
- Best practice means peer advocates work towards being redundant so the person can self-advocate if and when required.
- Peer advocates and their organisations have a responsibility to locate and provide peer advocacy services that are convenient, accessible, timely and culturally appropriate to the people who use them.
- Organisations need to adopt processes for evaluating their performance and peer advocates' work to ensure they are working towards best practice service provision.

All of us working to provide best practice peer advocacy are pleased to have an extension to the CCDHB contracts and feel that more time should mean more accuracy in our findings.

We look forward to being able to offer more information and recommendations to CCDHB as they embark on acquiring a best practice peer advocacy service in 2017.

Suzy Stevens

On behalf of Kites Trust

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6. Feedback about Māori Services - Tui Taurua - Northland

National Māori Roopu

Haurahi te Kete Pounamu – The Pathway of the Pounamu

A new solely Māori initiative has been slowly taking shape and is focusing solely on the needs of tangata whaiora nationally:

- Underpinned by Te Rau Matatini support – to seek other sponsors as well as time goes on
- Still in the process of building the kaupapa so the base Māori will be strong (e.g. Tangata whenua; Te Reo etc.)
- Will be national body for all Māori peer support groups – still building
- Setting up model of Māori peer support
- Gathering Māori stories
- Currently meetings around the regions at Marae so each region will be strong. Eventually they can stand alone with trained tangata whaiora. Each region will have their own kaumatua/kuia.
- Connected with Nga Puhi Kaumatua at the moment
- Learning modes between peers to develop base Māori to be strong
- All tikanga based
- Want to see quality assurance with regards to the putea

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

Rising to the Challenge - Kieran Moorhead - Auckland

Rising to the Challenge

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

What are we aiming for in2016/17? (Our measures)

Key measures

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

Other measures

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

How will we achieve this?

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

Actively using our current resources more effectively

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

develop, agree and implement a transition plan. June 2017

Integration between primary and specialist services

- Plan and implement integration of General Practice and NGO support services based on the model(s) developed within the Tamaki Mental Health and Well-being Initiative, prioritising Whānau House and Totara Health, by June 2017
- Further develop primary mental health integration with Totara Healthbased on the evaluation (evaluation due March 2016) by June 2017
- Improve the interface between the Community Alcohol and Drug Service and primary care – ongoing
- Design access for primary care clinicians to advice, information and screening from provider arm clinicians by June 2017

Resilience and recovery

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

Delivering increased access

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

Impact of NHEW

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

- **Ngā Hau e Whā** work supports the Ministry of Health (MOH) to respond to the issues people receiving mental health and addiction services face in a timely manner. This information is directly from people using services and includes NGO's and their clients and so cannot be sourced from the reporting District Health Boards. Because it is sourced from people with lived experience it is invaluable.
- MOH is able to use the information provided by **Ngā Hau e Whā** to inform policy, procedure and new developments. **Ngā Hau e Whā** gives the ministry an insight into what matters to the people who are affected by the decisions made at ministry level.

- **Ngā Hau e Whā** reports are distributed throughout the ministry and sent to the Director of Mental Health's office.
- The integrity of **Ngā Hau e Whā**'s work means that the group is a ready resource for gaining the viewpoint of people with lived experience for example: the external reference group for 'Rising to the Challenge' and for ministry interview panels. Also quarterly reports keep the ministry in touch with what is happening in service user's daily lives.
- The MOH sees worth in the work that **Ngā Hau e Whā** is doing. Especially the networking of groups such as **Ngā Hau e Whā** with SF, Platform and other service user interest groups.
- Many opinions and standpoints, give the Ministry a more rounded picture of what is happening for people with lived experience in the sector.

E-Network

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

Website

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

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

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

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

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

Further work is being undertaken so that the website will manage the entire Ngā Hau e Whā networking capability, such as the distribution list, feedback and comment, and promotion of our stakeholders and network communications, and most importantly a blog and links to Facebook and Twitter.

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

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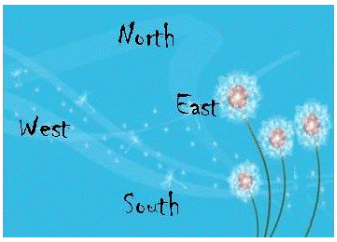
Jak Wild Website Design.

Bulletin

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

Regional Reports



Nga Hau E Wha

"Champion many voices"

Representative Names: Victoria Roberts

Region: Central

Meeting dates: February 21/22 Meeting & May 27 2016 Teleconference

1. Issues or challenges in the sector as identified by people using services

Oasis Forum - Hutt Valley

Oasis is a peer run network that operates the Hutt Valley. It offers peer support, peer advocacy, peer education, a drop-in, and self-help assistance. They help people with things from problems with addictions, to WINZ, to housing to loneliness. Find them here: oasisnetwork.wordpress.com. Here's what their people told us:

- Isolation – this affects both the elderly and youth. It has become worse since the entire drop in places were closed.
- Access to services. The process is difficult and hard to get through.
- CYFS There has been an escalation in the number of people needing advocacy
- Reception at hospital. The people on reception are atrocious and hard to deal with. They need good customer service training.
- WINZ There are 5 guards at the Lower Hutt office – that is overkill. People are often treated badly and then get blamed for bad behaviour when it is the fault of the case worker. One person said that a security guard was laughing at them all the time while they were waiting because they had gone in late in the day. Many report that it is irksome trying to deal with them and most would prefer not to.
  Everyone believes benefits need to be increased and the tax free threshold for earnings should be increased.
- Lots of members are still saying they get treated a lot better when they take an advocate with them
- ADS – Pathways have the contract. Need them to come and tell us what they will be doing with the service now.
- CATT – Don't respond quickly and leave people vulnerable. Lack of responsiveness, - onus on services to deal with the issue. For known consumers there is a lacklustre attitude about assistance.
- MH Act – Lack of info for people put under the Act, lack of interaction with psychiatrist. Consumers need legal advice, time-delay between when people are admitted to TWA and the time when they actually get some access to rights advocacy
- Police – A situation was described where a person was on the bus and carrying a pocket knife in a bag; he tipped bag over and knife fell out and someone rang the police. Stopped the bus, it was alright (police behaviour was okay).
- Reception at hospital: The people on reception are atrocious and hard to deal with. They need good customer service training.
- Some staff in services act under the assumption that people don't know their rights so service users are being abused.

- What is the Mental Health Act? It's for doctors to treat you, put you in hospital, forced treatment, dictating where you live.
- At what point are you entitled to a lawyer? Once you go into the mental health service you have a meeting with a psychiatrist to determine medication. You should have a lawyer straight away.
- Usually an act or situation which results in a consumer being put under the Mental Health Act.
- Ask them to tell you your rights immediately and ask for an advocate.
- You're in a vulnerable position when you're at the point of psychosis and there's a fear that your rights may be violated.

Health issues

- Referrals to CBT counselling are too hard to get – we need more psychologists and talk therapy
- We need more medication reviews – especially when starting a new medication
- Psychiatrists are too medication based
- We need more education around medications – we could invite a pharmacist to talk to us
- We need to keep separate the mental health issues from the physical health issues
- There is a need for an A&D support group to be set up by HVDHB
- "My nurse doesn't listen to me"
- We need to learn about our rights when receiving a mental health service
- Tools for independence need to be provided
- There are very low employment opportunities in our region for people trying to access part time work
    - There needs to be some investment for work for consumers.
    - We want to be treated fairly by prospective employers

Wellington Issues

Homelessness

1. Housing in Wellington is dire for many people, with many of the beggars on the streets having dual diagnoses of mental health and addiction problems. Often they are not able to secure stable or constant accommodation, usually due to bad debt, AOD issues, and they tend to congregate because they as they have nowhere else to go. We need more appropriate supported accommodation, single men's accommodation and AOD support service with accommodation.

2. People are often released from prison to homelessness in our area. We have two prisons releasing prisoners into this area – Rimutaka and Arohata Women's Prison. The $360 Steps to Freedom grant that they receive when they leave prison does not cover the rent and bond in advance that they need to secure accommodation even if they could find a landlord willing to rent a property to them straight out of prison.

3. Many of the "homeless" currently squat with others and have shelter. There are currently housing NZ homes that are empty in the town and people assume they are ear-marked to be sold. Crisis accommodation is always full when people seek help. Wellington City Council discussions have included the idea of banning beggars which thankfully was not agreed upon.

4. Newspaper reports have suggested that some people have 'migrated' to Wellington because of the supposed generosity of Wellingtonians towards beggars. It does seem in recent weeks and months that the numbers of people begging have increased on the streets and some seem prepared to attempt to negotiate with potential donors. For example when offered food two declined and suggested money would be preferable. Just because this was the experience of this writer a couple of times does not obviate the clear presence of many very desperate on the streets of Wellington who are very vulnerable. How many have mental health and addiction problems has not been calculated but if you take the time to talk to some of them it becomes clear that begging is a fraught option and an end of the line choice.

5. It is also a very unsafe option for some who are begging. The Wellington CBD has been drawn into 'territories' and some beggars have staked claims to certain spots that they defend with violence. It seems, anecdotally that this

could also extend to some suburbs as well. Loud arguments are frightening for passersby and Police are involved. Because of this women are at greater risk than men when begging on the streets.

6. Access to prescription medication is difficult for some people because of the cost. The end result is they don't take medication and can end up in crisis.

Housing New Zealand – Hutt Valley

- Housing New Zealand has become very difficult to do business with since it joined forces with the Ministry of Social Development. They are consistently unfriendly to service users. They are often not there when they say they will be.
- Under policy they have a mandate to be a social housing provider however they consistently operate more as a rental agency. Service users report difficulties pursuing complaints, being fobbed off and dealing with discriminatory attitudes regarding their mental health issues.
- Of concern is that housing inspections are not being done at the beginning of the tenancy and throughout the duration and service users are being blamed for damage or maintenance issues that aren't their responsibility.
- There are difficulties getting maintenance issues rectified. Tenants are being blamed for issues that are actually general maintenance, they are automatically getting charged for things like broken windows without any investigation about who's responsible.

Other tenancies

- Property managers play favourites.
- Rental costs and issues with ghettoization of city suburbs is resulting in service users moving out of the city.
- People with criminal history and or mental illness find it very hard to get decent accommodation. Often pay high rent for places that are in bad condition

Tenancy rights

- Tenancy group needed to support tenants in these kinds of situations (Hutt Valley based)

2. Best Practice according to people in your region

1. A good psychiatrist stands out
2. "My GP listens to my problems well"
3. "I would like patients to evaluate their doctors" (Real Time Feedback)
4. Someone suggested that they install Real Time Feedback into WINZ offices.
5. We would like to learn about alternative health options
6. We would like to see a paid consumer monitoring panel for processing complaints about mental health services
7. If you leave the ward you should not be charged for offences you are charged with. It is the doctors' fault you weren't cared for properly in the first place. Also if you break anything or assault someone in the ward you can be charged and trespassed.
8. There needs to be some research in NZ to see if there is any connection between schizophrenia and metals in a person's head (such as fillings etc.)
9. We need table tennis available – its good exercise
10. Track down Kites publication Alternative Therapies
11. Human Rights training available. To plan for next 2 months

Capital and Coast DHB

A review of the MHAID[3] Consumer Workforce was nearing completion in March. Report on next steps expected in early March

[3] Mental Health Addictions Intellectual Disability

The MHAID Consumer Leadership Group (CLG)[4] - is now up and running.
This group is tasked with monitoring the effectiveness of the partnerships, at all working levels, between consumers and the agencies developing, implementing or affected by the Strategic Framework. Waiatamai Tamehana chairs the CLG, assisted by Deputy Chair, Sarah Porter.

Amigos Social Club

Welcome to the June edition of the Amigos Newsletter 2016

Amigos is a group of adults who have experienced mental distress and are interested in connecting with other adults who have had similar experiences for: friendship, to help in their recovery and as a stepping stone to integration with the community.

Amigos is Spanish for friends and we are always looking for more Amigos. So try one of the following groups to see what you would like to do or feel free to try all of them and see what works for you. Either way we look forward to seeing you soon.

Amigos Coffee Club

This group meets weekly on a Tuesday afternoon in Newtown. It gives you a chance to catch up with old friends and an opportunity to make new friends. Here's what one participate has had to say about the group: "I go to the Amigos coffee group to make social contact as I tend to suffer with social anxiety and it helps. I also feel some empathy with the people there as they too have been through the mental health system. I guess it's my way of offering a little support too."

Times: Tuesday 1.30pm-2.30pm. Location: Baobab Café/Newtown shops/ 152 Riddiford Street (opposite Wilson Street)

Amigos Creative Writing Group

This group meets weekly on Thursday evenings in the central city. A typical writing group sessions consists of members bring starters (something for group members to write about) and the group spends 10 mins writing about the starter. Then, if they want to, people share what they have written. All levels of ability are catered for so come and give it a go. It's fun.

Here's what one participant has to say about their experience: "Writing with others makes me feel a part of a community like-minded people and I am always encouraged to write the most creatively that I can. I am often surprised by what I come up with in such a short time."

Times: Meets Thursday from 5.30-6.30pm.
Location: Clark's Café
Wellington Central LibraryVictoria Street

Amigos Book Club

This group meets the first Monday of the month. A typical meeting involves members discussing books and articles that they have read and think others might be interested in. One participant describes their experience like this "the discussion is often lively and you never know where the discussions end up."

Time: First Monday of the month from 1.30-2.30pm.
Location: Penthouse Café
Ohiro Road
Brooklyn

[4] Consumer Leadership Group

Amigos go on an outing to Makara Beach

"Six of us met at Ace House at 11am, and with Nick driving, we headed for Makara via Aro Valley and Karori. We had coffee at Makara. They kindly allowed us to eat our packed lunches in the cafe with our coffees as it was windy on the beach. It was followed by cake as it was Natalia's birthday. Chocolate cake yum! They wouldn't let me sing her Happy Birthday.

After lunch we went for a work around to Opau Bay. The more intrepid among us climb the hill to get the view while the others sat and chat and enjoyed the sea air. We walk back to Makara.

We decided to drive back via Takarau Gorge Road and Stopped in Ohariu Valley for a coffee at Horse stables. Celia had a Pink Princess to drink! By all accounts everyone had a great time and would like to do it again."

Amigos Art & Craft Group

The Arts and Crafts group is another great place to try a hobby out or perhaps find a new one. One participant describes our Arts and Crafts group as a "great place to work on your project or just come for some company, either way you are welcome." Tea, coffee and materials are provided.

Times: Every fourth Saturday from 2pm-5.30pm.
Location: Ace House
111 Brougham Street
Mount Victoria.

If you are unable to get there, we will organise a lift there and back. Phone and give at least three or four days advance notice.

Amigos Drama Group

This year the Amigos team dug deep out of its idea bag and decided to run a drama group and this is how it went:

"Drama Group (Joy of Improv) Group Leader, Ali Little was enthusiastic and energetic in her presentation of a most enjoyable eight weeks of fun and group learning through sharing her skills in Theatre Improv. Everyone who participated gained confidence and self-esteem with regard to their creativity and expression in interacting with others through inventing group stories, acting out games, creating group songs, fun with large puppets, and all sorts of interaction based on imagination and fun. We were all good friends by the end of the course, and we all want more, please!"

*The drama group is currently taking a break.

Amigos Sports Group

Another idea from our Amigos team was to run a sports group and so we did. Here are what one of the participants had to say:

"I attended the Amigos sports group over a period of several months in late 2015. I thoroughly enjoyed attended these sessions. They were fun, and there were a variety of activities to participate in. I got to meet a lot of new peers. This has built my confidence in building new relationships and interacting in the community. I found Fiona to be extremely organised and communicated well with all. She organised a good structure for the full two hours, and she always had plenty of equipment for us to use. She encouraged us all to participate. I found Fiona to be a brilliant leader. I would like to see the sports group continue as it is a great way to meet other peers and help in their recovery."

Here what our first sports group leader Fiona had to say about her experience:

"I was the group leader for the Amigos sports group in November and December 2015. Four sessions were held, at the Newtown Hall on the corner of Daniell and Constable Streets. We played a range of sports like soccer, hockey, volleyball, and dodgeball, using equipment hired from Wellington City Council. We also played less active games like

"zip zap pop", the chocolate game, the bamboo stick game, and gumboot and jandal throwing. The chocolate game was a particular favourite!

Group members were able to give suggestions for activities, and were able to participate as much or as little as they liked. Turnout was good, with at least five members at each group and up to 15 at times. We welcomed peers from the community and from Te Whare O Matairangi, along with members of the occupational therapy team. Amigos members enjoyed the group; with some saying it was the highlight of their day and many saying they would return if the sports group was run again in 2016."

*The Amigos sports group ran for a less frequent time during 2016 and was also enjoyed despite the challenges involved. This group is currently taking a break for a while.

Have you got any questions?

Feel free to contact us by phone:

Monday to Friday 9am-5pm only on s 9(2)(a) Or by email on: s 9(2)(a)

Find us online here:

http://amigosnz.wix.com/amigospeersupportwnz

Amigos is run entirely by volunteers and are supported by these wonderful organizations: Kites Trust, The Christine Taylor Foundation for Mental Health and Wellington After-Care Assn Inc.

3. New Initiatives /Developments in your region

Action Research Peer Advocacy

In Confidence – Not for Public Disclosure -A report for Nga Hau E Wha from Kites Trust in confidence.

June 2016

Introduction

In 2015 Capital and Coast DHB (CCDHB) held a meeting with four community providers[5] in their district to develop a piece of work aimed at developing a best practice Peer Advocacy Service delivery model initially for Kāpiti, Porirua and Wellington. Contracts for service were developed for each provider from 1 July 2015 to 30 June 2016.[6] The contract specifications included a requirement to identify what best practice peer advocacy is with consideration to the needs of people with experience of mental health and addiction an issue of all ages and cultures. Kites was contracted to lead the team, undertake joint research and development as well as meeting all CCDHBs reporting requirements.

This report describes some of the work carried out and interim considerations.

Definition

After time spent researching, this is the definition that we felt best describes peer advocacy.

> *Peer advocacy is taking up an issue with a person and assisting them to uphold their rights and achieve the best possible outcome. Peer advocacy takes place when the individual providing the help has been, or is going through a similar experience. The underlying principle is that peer advocacy is not about*

[5] Kites Trust, Newtown Union Health Service, Te Ara Korowai and Vincents Art Workshop.

[6] At the time of writing this report negotiations were underway with CCDHB and the providers to extend the contracts to 31 December 2016.

creating dependence but is a partnership where the person is an active participant. The overall aim is for the peer advocate is to make themselves redundant by assisting the partner to self-advocate in the future.

Work

Various methods were and still are undertaken to scope and develop the work. These include: research, consultation, marketing and communication, information gathering and presentations. The team has continued to meet fortnightly and has developed a strong and collaborative way of working.

An initial job was to promote the peer advocacy service. As part of that a 0800 number was set up which links people to "The Call Centre", a 24/7 service. The staff at the Call Centre refers callers to the peer advocates. It has been found that many people self-refer to the services.

Each provider employs a single peer advocate and between the 3 of them they cover the district from Kāpiti to Wellington. Initially there was a steady increase of people seeking advocacy and as time passed and information about the service became more widely known their workloads increased. Currently they are almost to capacity which raises the question about how many peer advocates there have to be in the Wellington area to cover the demand.

Approximately 40% of the peer advocacy work is directly about CCDHB mental health and addiction services. Peer advocates work in Te Whare O Matairangi; attend Community Mental Health Teams, GPs, government agencies and some community providers. Currently Porirua Hospital campus is not included in this work.

Each peer advocacy provider reports to PRIMHD and to Kites monthly on activities and issues. Kites then incorporates these reports in the monthly report to the funder.

Some Interim Considerations

It seems that the peer advocacy work will be extended to 31 December 2016. This will provide more opportunities for research and learning about provision of best practice peer advocacy. Therefore the following points indicate some of what has been learnt to date and should not be taken as final results.

- Any organisation providing peer advocacy needs to be as independent as possible from other organisations and preferably would not provide peer advocacy along with other contracts for mental health and addiction services.
- Organisational best practice starts with having sound policies and guidelines that provide direction and support to staff and members of the organisation.
- Peer organisations and advocates must develop sound working relationships with community groups and mental health and addiction service providers.
- A best practice peer advocacy service provides adequate training for peer advocates and facilitates opportunities for ongoing training and professional development during their employment.
- Key skills required to be a peer advocate are; an ability to listen to and understand what people are saying; negotiation and compromising. Attributes include; being honest, non-judgmental, patient, non-discriminatory and non-patronising.
- Best practice means peer advocates work towards being redundant so the person can self-advocate if and when required.
- Peer advocates and their organisations have a responsibility to locate and provide peer advocacy services that are convenient, accessible, timely and culturally appropriate to the people who use them.
- Organisations need to adopt processes for evaluating their performance and peer advocates' work to ensure they are working towards best practice service provision.

All of us working to provide best practice peer advocacy are pleased to have an extension to the CCDHB contracts and feel that more time should mean more accuracy in our findings.

We look forward to being able to offer more information and recommendations to CCDHB as they embark on acquiring a best practice peer advocacy service in 2017.

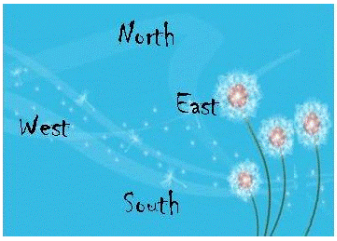
Suzy Stevens

On behalf of Kites Trust

Capital and Coast DHB

The MHA Integrated Leadership Group, Chaired by Dr. Alison Masters, recently had its first meeting.
Drawn from the wider health, social services and community sector, it includes the Chair of the Consumer Leadership Group (CLG). The group was appointed following an Expression of Interest (EOI) process late last year to provide oversight of the strategic direction of the sub-regional Mental Health and Addictions system, and to guide and actively support joined-up *whole of system* transformational change as signaled by the Strategic Framework.

Service Improvement and Development Unit (SIDU) have been running a series of Stakeholder Forums gathering grassroots Community opinion to inform the development of the MH & A Strategic framework. There are two final forums this month:
Two of these were held in the community at Te Piki, Ratonga Rua-O-Porirua Campus, Upper Main Drive, Porirua; SPCA, The Ward conference room, 140 Alexandra Road, Newtown



Nga Hau E Wha

"Champion many voices"

Representative Names: Grant Cooper

Region: Southern

Meeting dates: February 21/22 Meeting & May 27 2016 Teleconference

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

Terry Lynch – Southland

Terry is concerned that there is still lack of peer support and advocacy in Southland.
Terry identified issue of getting consumers to meet together in numbers to promote peer support and have their say. "Consumers appear to be apathetic about their cause. If people were paid for their insight it would make a difference to people attending and contributing to consumer meetings. Mental health services appear to be happy with how things are going regarding consumer input which is not very much. The exception is the consumer advisors who do some good work."

Carron Cossens - Waitaki

We are concerned about the lack of support available once people finish formal counselling. Many return to feeling isolated and confused having lost this important relationship and sounding board.
We continue to be concerned about the difficulty accessing low level/entry level support. We believe the Brief Intervention model needs to be extended in our community to prevent situations escalating into more intensive and expensive support being needed.

Grant Cooper – Otago Mental Health Support Trust

Collaborative Notewriting is still only scarcely used in mental health services. Although mental health services are starting to promote collaborative note-writing to its staff, there is still limited uptake by staff. Collaborative note-writing is simply where people who access services have input into what is written in their own file notes. Involving people in their own notes promotes transparency and can aid communication between people giving and receiving support.

Some people are concerned about accessing emergency psychiatric services. In particular they find that responses over the phone can be inconsistent where they find some staff respond better to their needs than others. One way of promoting consistency of response especially over the phone is to record phone calls to psychiatric emergency services. This is apparently been done in a least one other psychiatric emergency service in New Zealand with apparently no issues. Recording of phone calls would promote consistent responses and could be helpful for training purposes for staff. It is also a useful way to check back on conversations over the phone in respect to complaints which can verify what was said by everyone concerned.
People I have talked to who have accessed emergency psychiatric services are supportive of their phone calls being recorded.

2. Best Practice according people in your region.

Carron Cossens - Waitaki

Peer Support would be provided in the Waitaki Region as a form of best practice

3. New initiatives / developments in your region

Carron Cossens – Waitaki

1. Free Suicide Bereavement Counselling for a limited period: thanks to issues being raised during the Raising Hope meetings Stuart Grey from MSD (Ministry of Social Development) has allocated funds for targeted sessions of counselling for community members affected by loss of a loved one through completed suicide. Jodi Ryan from Family Works is maintaining the overview, supported by a team of Waitakians who guide the referral process

2. WOLFPACK- Alone no more: See attached excerpt from the ODT (Otago Daily Times). This is a Male only support that has a public face on Facebook and a closed group for more personal discussion. Meetings (Howlings) are monthly and include social activity. The excerpt is below: from February 17th edition of Otago Daily Times and can be viewed at http://www.odt.co.nz/regions/north-otago/372162/wolves-offer-pack-support

A group of young Oamaru men are tackling the vital but difficult conversation of men's mental health and the stigma surrounding it. Rebecca Ryan finds out what is involved.

An all-male network in Oamaru has been set up as an alternative way to reach out to men who are not reaching out themselves.

The "Oamaru Wolfpack" was launched last year, led by Oamaru man Sean McGeown, as a support group for men dealing with mental illness.

For a long time, Mr McGeown had discussed a need for a men's specific mental health support network in North Otago.

"Really, it started because of the suicide statistics getting higher and higher in Oamaru. No-one else was doing anything ... we needed to do something [and] I didn't have anything to lose by giving it a shot."

He spread the word among friends and started a public Facebook page - Oamaru Wolfpack, alone no more - with an extension of a private group where men could engage in discussions and support others.

The group had its first monthly gathering - a "howling" - last month.

The meetings were social gatherings, where people could feel comfortable, Mr McGeown said.

The first was a games day at Ardgowan Hall.

This month, it would be a firewood-chopping afternoon, with a barbecue and a group talk.

"We're not sitting there talking about mental health issues all the time, but if it comes up, it comes up.

"Not everyone in the group suffers from depression, anxiety or anger issues; some guys just want to be there to show there is care out there."

The group was a support group and, by no means, a "fix-all".

"We are young men ... trying to reach out to men who are similar to us. We have our experiences and we can share them with others."

For a long time, Mr McGeown used alcohol as a solution to his problems.

He said he knew no other way.

"The best thing I ever did was give up alcohol. Hopefully, we can show other men that there is another way."

Mr Morris said they hoped that by being gender-specific, men would feel more comfortable to open up.

Representative	Guy Baker
Region:	Midland (Tairawhiti)
Meeting Date:	February 21/22 Meeting & May 27 2016 Teleconference

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

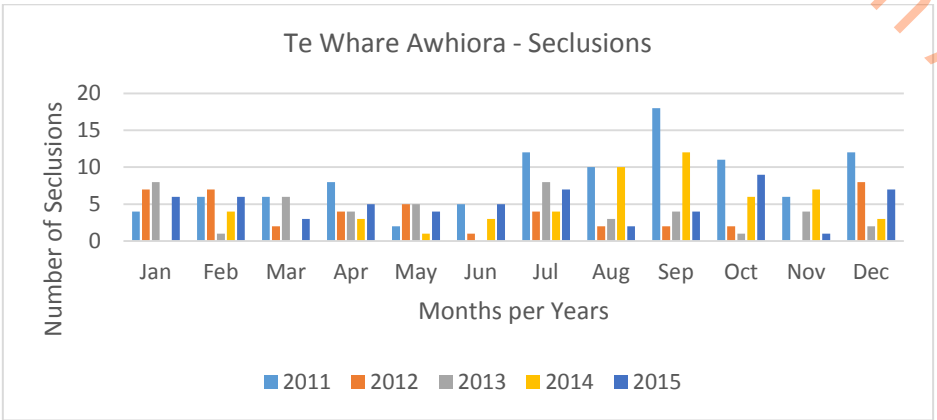
TAIRAWHITI – Guy Baker

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

- (December hui): Still a lot of discrimination being experienced by those under the Mental Health Act
- (December Hui): Whaiora finding it difficult to gain employment once it is known that they are journeying with a mental illness. Consequently, a Support Employment Co-ordinator spoke to the group on how she can assist whaiora into employment with preparation of CV's, job applications and the whole employment process. She also could provide on-going support once employment was gained as well as educating employers on the experiences whaiora faced with their illness.
- (February Hui): Need to find some amicable solution for whaiora who are having difficulty getting to day activity programs (having to catch 2 buses) that are now on the other side of town. Emerge Aotearoa say that they want whaiora to own some independence and so it is up to them to get to the programs.
- (February Hui): Changes need to be made to staff at Ward 11 especially if they think they are going to end seclusion. Their attitudes "suck" and "rather than talk to me they talk down to me which makes me angry".
- (February Hui): Concerns that WINZ staff are another lot of people with attitudes. They think they are in a position of power and don't understand how hard it is for us.

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

- The use of Solitary Confinement in 2015 (59) is still high compared with earlier rates in 2012 (44), 2013 (46) and 2014 (53) and appears to be on the rise. This is concerning especially when agreement has been reached to end seclusion on 1 February 2020.



- Investigations for 2 x SAC1 incidents carried out under the London protocol reveal some gaps and recommendations have been made to address these

- Suicide rates could be climbing again (anecdotally – not confirmed by coroner statistics yet).
- Housing respite service being placed under increasing pressure as there are not enough beds to cope
- Although there have been improvements in medication deliveries there are still instances where deliveries are being made late or in some instances not at all. Communication between pharmacy to clinician and then to community support worker (CSW) is found to be wanting. CSW's, who have the more regular contact with whaiora in the community, find that at times medication hasn't been taken for 3 days raising the risk of unwellness. This feedback is in light of a national initiative for increased integrated services into the community by pharmacies and the need to have supporting structures firmly embedded in these initiatives.

TARANAKI UPDATE- Nic Magrath

The Taranaki Consumer Advisory Groups still struggle to encourage people to attend. The South group were due to meet in February to commence the year but the North group meeting has been delayed due to sickness. There is however some encouraging signs as several people have indicated during interviews for the OST survey that they would be willing to participate in the Consumer Group.'

EASTERN BAY OF PLENTY – Arana Pearson

Opotiki (along with Kawerau) remain the place of highest deprivation on the MSD measures and more so than the Far North. Reporting of incidences of domestic violence to CYFS are in the highest in the country. Alcohol abuse is a major co-factor to domestic violence crime. Drug cultivating (marijuana) is widely practiced and there remains an active supply of synthetic marijuana here. Our closest AOD residential rehab is in Lakes DHB at Te Utuhina Manaaki Trust as the local AOD residential rehab was closed down some few years ago. Methamphetamine is readily available here. Opotiki is the highest earner in pokie machines per capita in New Zealand.

People with diagnosis of mental illness face limited access to health services in general.

LAKES – Susan Freeman

- Lack of communication from Community Mental Health
- Timely response to complaints
- Consumers not knowing if they are under the Mental Health Act
- Privacy Act being used as a barrier to obtaining information on behalf of consumers
- Accommodation affected due to people's re-establishment grants being used on dental, food and clothing

WAIKATO – Julie Kneebone & Brendon Dolman

A common theme coming from the service users on the wards is that they want to stick with the same keyworker to build relationships. There appears to be some inconsistency and service users are feeling like they are repeating their story too many times.

2. Best Practice according to people in your region

TAIRAWHITI – Guy Baker

- After an initial 90day induction period, the new values and vision of Hauora Tairawhiti (DHB) are now firmly entrenched and though it is being widely accepted there is still a small minority resisting change. Regardless, changes in culture are beginning to be incorporated into everyday practise.
- Feedback Informed Treatment continues to provide feedback on patient's experiences of the level of care being provided by Hauora Tairawhiti. This is being accepted as a valuable tool to affect some changes.
- An "End of Seclusion" working committee has been established to develop strategies on what mechanisms will affect this change, how the facility will look and planning from now till February 2020. It is envisaged that the new service will be operational by August 2019 allowing a 6-month period for any fine tuning prior to seclusion closure.

- Peer debriefs for those currently being placed in seclusion are being undertaken that will contribute to the initiative to end seclusion.
- Consumer Engagement Strategy is working well providing for increased consumer engagement at all levels of the organisation. The group responsible for analysing responses meet monthly.

TARANAKI – Nic Magrath

- Te Puna Waiora nurses have begun working under a core team model with primary nurses allocated to a person. The outcome should provide improved communication.
- A change in the Psychiatrists working model of care means that a service user's psychiatrist will remain the same whether they are an inpatient or outpatient. This has resulted in feedback from service users over a number of years.

EASTERN BAY OF PLENTY – Arana Pearson

- Consumer lead feedback has only begun which will seek to give a snapshot of service user feedback and comment about how services have impacted on their lives. These will provide input for outcomes of the integrated contracts initiative.

LAKES – Susan Freeman

- Rotorua Consumer Group meeting fortnightly with increasing numbers

WAIKATO – Julie Kneebone & Brendon Dolman

- 3 months into operating a new consumer partnership model with Progress to Health and MH&AS reveals positive delivery on a suite of services purchased.
- The seclusion minimisation group is gaining momentum. All post seclusion interviews are being completed or at least are being offered.
- Staff are being involved in workshops to hear first-hand about the impact seclusion has on individuals, whānau and also the experiences from staff.
- Real Time Feedback continues. Results are mainly positive. Plans and strategies are being done to set up an overall quality framework to address, implement and make changes that have come forth from the feedback received.

2. New initiatives / developments in your region.

TAIRAWHITI – Guy Baker

- With no service available in Gisborne a new Youth Respite Service is in the infant stages of development. It is receiving very positive feedback. An "outside the square" approach in collaboration with local artists will transform ideas from a stakeholder Hui, to be held in March 2016, on what this service may look like into pieces of art which will be displayed within the new facility.
- Dr. Di Rangihuna, Psychiatrist for Child & Adolescent Mental Health services (CAMHS) continues to promote her Mahi-A-Atua program alongside tohunga and Whānau Ora Pakeke, Mark Kopua, who have successfully introduced this into a local school to deal with cutting issues. This program is receiving both national and international acclaim.
- Arrangement's for a LEAN ON ME – Gisborne concert being held on 26 March 2016 to promote awareness of suicide prevention and intervention are well on the way which follows the similar and successful concert that was held in Ruatoria (East Coast) on 5 December 2015. It is envisaged that a further concert will be held in Wairoa.

TARANAKI – Nic Magrath

- Draft Recovery Action Plan/ Health Passport have been completed with work continuing on a draft booklet. It is envisaged that an on-line version will also be developed. A translation to Māori is also being adopted with work to undertake a plan pilot roll out in the future for a 3-6 month period from which a review will be done.
- Positive responses have been received from a telemedicine initiative to which a questionnaire is to be developed which will allow the South Taranaki MH Service to begin talking to people.
- Acute Service, Night Triage, Crisis, Acute Home Based Treatment and Acute Intervention Service Clinical Specialists Teams have reconfigured into a single Acute Brief Intervention Service. The service is yet to acquire a name.
- Real Time Feedback is nearing a trial phase before it goes live

EASTERN BAY OF PLENTY – Arana Pearson

- Discussions are underway for integrated contracts which are expected to begin from 1 July 2016.

LAKES – Susan Freeman

- Names are being collected to start a Taupo Consumer Group.

WAIKATO – Julie Kneebone & Brendon Dolman

- In the process of revamping and rebranding service user/whānau information packs to make information more relevant and user friendly. These will include service user information about integrated care pathways. All other information displays and pamphlets will also be overhauled.

3. Addictions.

TAIRAWHITI – Guy Baker

- Corrective actions from the Opioid Substitute Treatment Program Audit have been put in place and consistent feedback from program users indicates these are having effect.

TARANAKI – Nic Magrath

- Surveys of people receiving the Opiate Substitution Treatment Service have been completed with a 32% response rate. The outcomes were extremely positive. The service is due for audit in February 2016.

4. Family and Whānau

TAIRAWHITI – Guy Baker

- Arrangements for a whānau day LEAN ON ME – Gisborne concert being held on 26 March 2016 to promote awareness of suicide prevention and intervention are well under way which follows the similar and successful concert that was held in Ruatoria (East Coast) on 5 December 2015. It is envisaged that a further concert will be held in Wairoa later in the year.
- Principal Family Court Judge Laurence J Ryan sought a formal opinion from the Crown Law office in response to our request to have mental health hearings conducted on a marae. The opinion upholds the Judges earlier decision that under the provisions of the Mental Health Act that such hearings cannot be held on a marae.

Despite this, and with local support from kaumatua/kuia, the District Health Board further opinion on what options are available is being investigated.

Nga Hau E Wha

"Champion many voices"

Representative Names:	Julie Whitla
Region:	Southern (Christchurch)
Meeting Dates:	February 21/22 & May 27 2016 Teleconference

1. Issues or Challenges according to people in your region

The Canterbury District Health Board said demand for specialist mental health services had risen dramatically since the quakes, with about 500 more adults and close to an extra 100 children being seen a month. It said it was coping, and there had been a stabilisation of adult mental health demand - but that had not yet happened for children and youth

Specialist Mental Health Services

Inpatient occupancy in January 2016 was 80%. CDHB specialist mental health services believe that the reduction over time is related to the model of care foe adult services and the successful implementation of crisis resolution.
In January 2016 there were 187 crises new case starts. Crisis new starts require an assessment within a day of referral. Crisis resolution is also experiencing a number of initial assessments and follows ups in peoples on home. In January 25 initial assessments were in the persons' home.
The steady increase of demand for specialist mental health services in Canterbury continues to cause concern.

ISSUES: Some people have raised concerns at the January Consumer meeting of Awareness that Crisis resolution is using a standard script on the telephone when you phone Crisis resolution. Some felt patronised by the advice of a hot chocolate, a bath or go for a walk.

Seclusion

Acute Inpatient Unit, Te Awa Kura, had two consumers who experienced seclusion during January 2016 for a total of 9.7 hours. There is a strong commitment dedication and leadership by the nursing staff.

Accommodation

18 people in inpatients wards needed accommodation during the first week of February.

Making formal complaints:

It was mentioned that the feedback we have had previously from the DHB was that it is helpful where people are willing to make a complaint or highlight a specific incident with specific staff for services to follow up on. There was discussion around the issues with making complaints including that letters sent in response from the DHB seem very generic. One person mentioned that the complaints process has been one of the most frustrating processes to be involved in as a consumer, and others agreed. It was suggested that Awareness could hold another complaints forum to address these issues.

Hepatitis C A man was on the West Coast was told by the Hepatitis Foundation he had both Hep B and Hep C, when they gave him a fibro scan. Follow up research into previous results and then a current HCV test indicated he had neither.

2. Best Practice according to people in your region

Submission on Substance Addiction (Compulsory Assessment and Treatment) Bill

We welcome the opportunity to comment on the Substance Addiction (Compulsory Assessment and Treatment) Bill (the Bill). We are pleased that the Ministry of Health is approaching substance dependence as a health issue requiring treatment rather than an issue that can be resolved through the criminal justice system and that the proposed legislation seeks to improve the health of those individuals experiencing severe substance dependency. In principle we are in support of the changes being proposed. The Alcoholism and Drug Addiction Act 1966 is no longer fit for purpose. However we have concerns about some aspects of the Bill.

The Convention for the Rights of People with Disabilities, Article 33 was ratified by the NZ Government in 2008. Compulsory treatment is an infringement of these rights. New Zealand's mental health legislation is now in conflict with the philosophical approach required by Government; and in breach of our international treaty obligations. At the same time, compulsion under mental health legislation in New Zealand appears to be increasing,

SUBMISSION

We support the intent of the Bill that the objective of compulsory treatment is: 'a) to facilitate the stabilisation of the patient through medical treatment, including medically managed withdrawal; and (b) if possible, to restore the patient's capacity to make informed decisions about their own treatment and to give the patient an opportunity to engage in voluntary treatment' (Clause 35). We recognise that this outcome will not be possible for all people with enduring substance dependency coupled with a co-morbid presentations but it is an aspirational goal.

We note that many people presenting to our services with severe substance dependency have significant co-morbidities including acquired brain injury, cognitive impairment, and liver disease. The Bill however does not appear to consider the medical management of these patients.

The feedback below addresses clauses and sub-sections within the Bill.

Part One

Clause 10 – Compulsory treatment as a last resort

- This section sets out that compulsory treatment is necessary only if voluntary treatment is unlikely to be effective. It is unclear whether someone must have previously had or should have had an opportunity to engage in treatment voluntarily.

Part Two

Clause 16 – Medical examination for application

- There is no requirement for the person to be detained pending the medical assessment. There is no provision to 'force' them to go to the doctor hence there is no requirement to discuss the person's rights.
- Assessment of the person's addiction and/or capacity requires particular skills so the selection of suitably qualified authorised officers will be important.

Clause 19 - Specialist assessment

- It is at this point that the person starts to lose their freedom to choose where they are at any time indicating the start, to a degree, of a detainment process. Although not specified in the Bill we would see this as the appropriate time for the person to have the opportunity to the support of a consumer advocate/ peer support worker who can help the person and their family whānau navigate their way through the system and who can 'translate' the entire process in lay terms. This is also the appropriate time for the person to have access to legal representation or advice.

Clause 20 – Children or young people

- Specialist assessments must be conducted by an approved child and adolescent psychiatrist or psychologist. It is likely that these practitioners will not be available in some services and that child and youth psychiatrists etc. will need training in addiction and capacity assessments in order to provide this part of the process.

Clause 22 – Specialist assessment requirements

- The processes described in ss4 should be the same as for all persons seeking alcohol and drug treatment. Suggest changing the wording of ss4a to "disclosed all the information generally provided to all persons seeking alcohol and drug treatment in order that the person can make an informed decision about the treatment".
- This section has provisions that include 'reasonable' opportunities for the person to discuss treatment with other parties but there is no guidance as to what is 'reasonable'.
- This section makes reference to the right of the person to seek independent advice from another approved specialist but does not give a specific timeframe for this to occur. Also unclear are the implications that seeking another opinion have for continuation of the process at this point. For example, is the process to be 'suspended' pending the outcome of this opinion? What is a reasonable timeframe for this opinion to be made available? If however the process is not to be suspended at this point, then this needs to be clearly stated.

Clause 25– Approved specialist to notify Area Director

- 25(1) (b) states that the patient is to be detained in an appropriate facility until admitted to a treatment centre. This raises several issues:
    - It is unclear what this interim facility should be. At present this is likely to be general adult psychiatry units or detox units. We do not believe it is appropriate that people are detained in general adult psychiatry units as the current clinical programme and patient mix would not meet the needs of patients under compulsory care for severe alcohol or other drug dependence. It is our understanding that occupancy levels of existing detox units are such that it would not be possible to admit this new group of patients.
    - While admission to a detox facility might be more appropriate in terms of patient mix there is an expectation in the Bill that this facility will be able to restrict people from leaving. (This also applies to the treatment centre.) Locked units are not common to addictions services. People admitted to Auckland's medical detox facility are there voluntarily so the facility is not designed to detain people. The requirements of this legislation therefore run counter to the philosophy and practices and physical design of the current detox and other treatment services.
- Supporting and treating these clients differs substantially to the current service delivery model of general adult psychiatry units, detox units and residential addiction treatment services. We believe services need to be reconfigured appropriately to meet the needs of the Bill and more importantly this client group. We believe specific facilities are required; they need to be purpose built and staffed appropriately and provide interventions in a clearly structured therapeutic environment.
    - Stand-alone facilities could commence treatment immediately once the compulsory treatment certificate and authority to detain has been provided. This would be preferable to admitting someone to an interim 'detention' place then transferring them to a treatment facility and is likely to be less stressful for the person and their support people.
    - Although there is literature from therapeutic communities that suggests it is possible to integrate "voluntary" and "compulsory" treatment within one clearly defined approach it may blur the distinction between 'an appropriate facility' and 'a treatment facility'. There are potential challenges with a combined model not least of all the frustration felt and expressed by voluntary patients about having

no choice about being with people compelled to be there, many of whom are unlike the voluntary clients, resistant to change.

Clause 38 – Requirement to stay in treatment centre

- This section makes it clear that the person must stay at the treatment centre (except as agreed in accord with s39); treatment centres need to be designed to support this and staff trained to enable the safe detention of these persons.

Clause 42 – Condition of patient to be kept under review

- It is not clear what 'regular' means in this context. We believe there is a need to define a 'regular' review schedule within the legislation.

Clause 44 – Plan for future treatment and care

- 44(1) states that the responsible clinician must develop a plan for the person's 'release from compulsory status. We believe the treatment plan developed at the commencement of the compulsory process ought to be oriented toward enabling the person to be released from compulsion.
- It may be that the intention of this section (s44) is to prepare a plan for the period when the person is no longer subject to compulsion. If this is so then the language of 44(1) ought to be reworded to clarify this distinction with the focus on what happens after the period of compulsion rather than to enable release from compulsion.

Clause 58– Right to company

- Whilst this section intends to make it clear that a patient cannot be isolated from other people the term 'others' may be ambiguous and could be interpreted as staff/carers in the treatment facility. We suggest using the wording of Health and Disability Service Standard 1.12 that people are 'able to maintain links with their family/ whānau and their community'.

Mad Poetry:

The Mad Poetry project which we ran last year went fantastically and we are very keen to keep events happening this year. Kelly read the highlights from the evaluation report for the project which we recently sent off to our funders for the 2015 events – Think Differently. Almost everyone who attended the writers workshops wanted to come along to future events, most people experienced increased awareness of their strengths and talents and confidence sharing their writing, and almost everyone reported finding the writers workshops and poetry nights a supportive space. The open mic nights were seen as a good event to challenge stigma and discrimination around mental illness. Some comments that people made about the events over the year were:

- "I liked the light-hearted tone. While touching on difficult subjects it was made easy to address and think about without being upsetting or triggering"
- "Being able to share without the fear of judgement"
- "Relaxed attitude and space. Very welcoming and accepting"
- "Being with others and hearing their stories. Others enjoying what I have written"
- "Working together – really unusual for me due to social phobia"
- "This is the first thing I've actually been able to attend because of my mental health, I had a good experience and nothing but positive feedback"

- "Before this class I had no idea what grounded me, now I know, and I'm so proud of the beautiful artwork representing this – thanks!"

- "Awesome experience, vulnerable but safe, lovely environment"

- "These workshops are one of the best things about living in Christchurch for me at the moment. Thanks heaps!"

A copy of the full evaluation report is available to anyone interested, contact Kelly or Beth at MHAPS.

We have our first Open Mic night arranged for this year which will be held on Friday 19th February from 7pm at Beat Street Café – all are welcome so come along and bring friends and family. This is the only event planned so far for this year, as since our funding finished up at the end of 2015; we have to fundraise at the moment to keep the events going. Kelly showed the group our Pledgeme fundraising page where people can go online to donate. So far we have raised $465 which is an exciting start and we have one month to go to reach our goal of $2,500. The way that Pledgeme works is: people can pledge an amount they would like to give, but this only is transferred across when the fundraising goal is reached. This can help people feel confident they are only supporting a project that will actually happen, but it also means that if Awareness doesn't reach our goal we won't receive any of the funding pledged.

Making a donation is really easy – just find the page called "Mad Poets Society" and make a pledge. There are prizes for people who make a donation based on the donation they make – these include badges for a $10 donation, and books, t-shirts, and other gifts for larger donations. For people who would like to support without going online, we are also selling Mad Poets Society t-shirts for $30, as well as badges and books of mad poets writing which we are publishing.

We are still producing our book of Mad Poetry and welcome any writing people would like to submit for publication. This can include poetry, short stories, songs and anything else people would like to submit. George would like to submit some poetry for the booklet. Eve would also like to submit some poetry but has to decide what poems to send in.

Suggested made that we could apply for the Creative Communities funding. The project group who have been overseeing the future of mad poetry plans have decided to apply for this, but to hold writers workshops rather than the open mic nights because this seems more appropriate project for the fund.

Discretionary funding grant through Christchurch City Council is another possibility if we are applying for funding. COGS were also suggested as a fundraising idea.

3. New initiatives / developments in your region.

A new AOD Education Group which targets Tangata Pasifika Communities for both genders started beginning of June on Saturdays from 9.30 to 12.30. The age is 18 plus and is a small group of up to 15 people.

"Incite and Excite" Art Exhibition: The Arts Council and CORS/CADS Specialist Mental Health Services are hosting three art workshops and an Art exhibition in October. The winner of the exhibition will have their art displayed at Christchurch Opioid Recovery Service and Community Alcohol Drug Service at Hillmorton Hospital.

A new Peer Support Youth Service started in May at MHAPS, Mental Health Advocacy and Peer Support.

Child Custody Research Project

The Child Custody project is a group that came out of an Awareness discussion at a LEADR research group meeting. The issue came up of how parents who have mental illness or addictions often experience issues keeping custody of

their children. A group of several Awareness members formed around this issue and the group grew to include other researchers and members of the Collaborative Research Committee.

We've divided the research into three phases: The first phase was a scoping phase to find out what's going on. Ali did a search of court transcripts where a court ruled on custody where a parent had mental illness or addiction and we're doing a discourse analysis of these court rulings to look for stigma and discrimination. We have now received some funding from the Oakley Foundation which will allow us to undertake 50-60 interviews for the second phase of the project. These interviews will include talking to mental health professionals, care and protection staff, legal professionals, and parents with experience of the system and mental illness/addiction, young people whose parents have been in that situation, and wider family and whānau members.

The third phase of the research will be developing some kind of resource or intervention based on the findings of the phase two interviews, which will help staff working in services better support parents with mental illness or addiction. We don't know exactly what this will look like yet, and it will depend on funding, but it's an important part of the project – making a difference to address the issues revealed in the research.

At the moment we're trying to work out what to do with all the data that we've got and what to ask in the second phase of the interviews.

Darryn asked about representation of Māori in the interviews. Anne shared that the group's aim is to have fifty percent of the parents, young people and wider whānau interviews be with Māori.

Michelle fed back that the project is a great idea. "It's really important that the next generation have some kind of a cushion"

Peer support café Discussion: February 2016

In Aldershot in England, a peer support café has been set up which is open in the evenings when other support services are closed and is a place where people can go if they are having a crisis. The cafe sounds like it is making a huge difference to people struggling with mental health issues in the Aldershot community, and there has been a 33% decrease in people using the emergency department for mental distress during the café's opening hours. Julie and Ali, talked about what the café in England is doing, and asked the Awareness group if it sounded like something that would be valued in Christchurch and whether it would be something to try and make happen.

Someone mentioned that Dawn Hastings wanted to set up something similar a few years ago but it didn't gain a lot of traction and funding was a barrier. It might be worth talking to Dawn and doing a collaborative push to the DHB about establishing something like this.

Julie has checked out the funding for the Aldershot service and this comes from the mental health commissioning framework in England. The initial funding was for only a small amount about $150,000, but this was enough to get it happening. Someone mentioned that that kind of funding would be sufficient if people staffing the café were volunteers.

We discussed having a space for the café. The group room/Latnam space at MHAPS was suggested but it would be impractical due to other bookings in the evenings, and people thought it could be good to have its own space. Could it be run out of a space like Presbyterian Support – somewhere that has an established venue? Someone mentioned that it would be important to have the project run by a peer support service, rather than being run by an organisation like Presbyterian Support and people discussed a collaborative approach where a service with a space that's unused at night could provide the venue, a peer support service could provide the programme.

We could collaborate in with CPIT and SIT who, in the future, will be looking into providing a Peer Support course. These students will be needing placement hours. There are a lot of voluntary groups, people, organisations and schemes that we could tap into as well including supported employment services, project 300 which aims to place 300 people in work, and the wage subsidy offered by the government to employers who hire people with mental illness experience.

Conversation turned to some of the challenges with operating a crisis café in the evenings including safety for staff and managing any incidents. It's a new idea and all these discussions would need to be had when the idea gained traction and before the café was established.

We talked about who a crisis café could serve and what the kind of support there might look like. It would be good to see this space also open to people who have experience of addiction who wanted somewhere to go physically go to help

stay on track with their recovery. It shouldn't be diagnosis specific; it should be for people who are struggling, including the people who might be turned away by psych emergency. It would be less of a drop in centre, more of a quiet space for people to come and be heard. It would be a space open to young people as well as adults, basically accessible to anyone who needs support at that moment. Beth mentioned that SYNAPS could provide a good input to making the space and the social media communication of what is happening. Alice is keen to be involved in the project to bring a youth focus.

Someone mentioned that to get something off the ground like this it's all about marketing, the simplest marketing slogan will get across what the project is about. A brainstorming session around a slogan could be a good first step. Someone else mentioned that the most important people in thinking about developing this are consumers and that it has to be driven by what the consumer community needs and wants, not through marketing. There was general agreement that putting thought into communicating the idea to potential funders, and once established getting the word out to the community would be useful.

Ali talked about her experience with getting new funding for organisations which she has had success with in the past. Ali's suggestion is to run the project as a pilot project for the first year, staffing at this stage could be volunteers if there is insufficient funding. Having a good evaluation process would allow the group to then take the project to the CDHB and show its value and ask for funding to continue the work started.

It was mentioned that COGS is a funder that specifically funds pilot projects – we could put an application in to COGS to help with the first year of the project. Anne mentioned that we shouldn't discard the idea of putting a proposal to the CDHB as they may want to fund it from the beginning.

We discussed forming a project group of interested members to do more research about this kind of support option, talk with Dawn about her experiences around trying to establish this in the past, and come up with a way to market or communicate the idea should the project seek funding. People interested in joining a project group to find more information around this are: Julie, Ali, Anne, John, Darryn and Alice. Bob would be interested in attending the meetings that focus on the vision, mission and communication of this. Julie will talk to Dawn about being involved. Kelly will send out a When is Good to the project group to make a meeting time.

Other issues related to Christchurch

AWARENESS Canterbury Action on Mental Health and Addictions

Minutes of the Awareness Monthly Meeting Monday 14th March 2016,

Financial Report:

Carol gave a finances update. The balance of our everyday account $3050.72, when the Mad Poetry funds go into the account this will bring the balance to $4250.00.

There was discussion about the need for transparency in the process of raising funds for projects such as the pledge me campaign. Issues were raised about the lack of clarity regarding the exec's decision to "top up" the fundraiser to reach the funding goal, and particularly that the project could now be completed with less funding than initially set as the goal, so could be seen to be overstating the funding needs to complete the project. It was decided that more robust discussion around the details of fundraising efforts could be had at the membership level in the future to ensure that any issues are identified, talked through and a good solution reached early in the process.

Writers Workshops

A group met several times to develop a funding application for the Creative Communities fund and submitted this couple of weeks ago. Because of the funds description of how much they will usually contribute to projects was $2000, the group decided to structure the writers' workshops in their applications differently from last year's workshops where more funding was available. The proposal is to run bi-monthly writers workshops from May to November, and on in-between months to support attendees to meet for discussion, sharing and editing their poems. We should hear back with regards to our application in the coming weeks.

Exec numbers

The exec numbers have fallen, and we have two continuously active exec members and two members who attend when they are able to. Past attempts to ask people to join the exec have not resulted in any more members joining. There were some suggestions from the membership around addressing this:

- It was suggested that we move the ACM forward for the election of a new exec in May rather than June
- We can put a call out by email to all Awareness members with the need to find new people to come on to the exec
- We could review the criteria for exec membership and restructure the exec so that there are some members who attend meetings in person, and an additional layer to the exec of members who can contribute to decisions by email
- Changing the meeting times for the exec to evenings could make them more accessible to busy people in Awareness
- It was suggested that, while the exec numbers a low, more decisions or discussions could be sent out to the submissions approval group.
- Nic indicated that she is interested in being on the exec but can only commit in the second half of the year when her study is less demanding.

Family Organisations such as Familiar Trust and Supporting Families will get some extra positions.

Presentation

Kelly and Nic gave their presentation on the Child Custody research project, which was presented last year at the Service User Academia Symposium. This is available to anyone interested in seeing the slides.

Minutes of the Awareness Monthly Meeting Monday 11th April 2016

Presentation, Specialist Mental Health Services Crisis Resolution

Debbie Selwood and Joan Taylor attended the meeting to give an update around Crisis Resolution

We want it to be a good support for people; that people find helpful.

The research was interviewing people who had just recently used Crisis Resolution, as well as family members where they also attended, and Primary Care.

We have done a second, more informal survey of staff, mostly to look at processes as well. There is a focus on how the service needs to be developed in the service.

Moving from a separate Psychiatric Emergency service, to having the function of a psychiatric emergency service embedded in the sector base team. An aim of this was to have improved integration of services, prevent people being held by Psychiatric Emergency service for, at times, months, so that they could get proper case management sooner, avoiding unnecessary assessments, and having more flexibility so that people could be seen in their homes etc.

The plan initially was to look at some of the quantitative data, e.g. numbers – how many people were seen etc., as well as doing some interviews. Due to changes however, the research was wholly qualitative – interview rather than numbers based.

The survey was over 4-6 week period with people who had contact with Crisis Resolution. The aim was to look at global satisfaction; the survey also looked at different aspects of the service, compare service satisfaction across different demographic groups, areas for improvement.

In total 75 people, 22 Family members, and 16 primary care providers were interviewed. There was an even gender split, and a range of ethnicities.

Results: 80% of consumers were satisfied on all measures, except in the area of being seen in a place of their choice.

Budget Cuts

There was discussion about the funding cuts that were proposed recently. Since this announcement, the Ministry of Health has announced several million dollars additional funding to support mental health in Canterbury, sparked by Cantabrians renewed issues following the February 14 quake.

The plan that was submitted to the Ministry of Health for spending the new funds focussed on:

- Increased child, youth family support, expands into rural areas.
- Work with children and families – the largest growing need and hopefully making a difference now will pre-empt mental health issues later in life.
- More extended GP consults in primary care
- Invest more in Alright campaign http://allright.org.nz/
- SBMHT's (school based mental health teams) to be expanded in capacity to include interventions with younger children and families
- BIC roles to be extended and not limited to a short number of sessions to support youth and children and families. Comcare will have an extra housing support role
- Services require reporting to the MOH
- Youth peer support role

Funding is to have a youth and family focus, and not to service the deficit. The package will not be accepted if it is trimmed. People commented general support for the plan and were pleased to see the funding being used in diverse, community ways, not just to increase specialist mental health services. There were concerns about the time limited nature of the funding, and what will happen to support in Canterbury once the funding is spent, as there is no plan currently for ongoing increase to mental health funding in Canterbury.

Exec numbers

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Discussion around legal roles

Nigel has found that a number of legal roles and responsibilities exclude people who have a mental illness or have formerly been under the mental health act. These include being on a school board or being executor to a will. There was some discussion based on others experience as to whether this was the case, or is always the case.

We decided to contact Penny at Community Law Canterbury to find out what the situation is. Kelly will follow up before the next meeting so we can discuss further if needed.

Natural health products submission

We have missed the deadline to make a submission to the first phase of consultation around the Natural Health and Supplementary Products Bill; however there will be another opportunity to have a say later in the year. The bill is of potential interest to Awareness members, as it will restrict access to, and research around the use of supplements to

help manage mental health issues. Canterbury researcher Julia Rucklidge has had some good outcomes with her research into this and is a strong advocate against the legislation.

Minutes of the Awareness 2016 ACM Monday the 9th May 2016

MHAPS Community Wellbeing Centre

1. MHAPS Strategic Plan:

Andrew attended from the MHAPS board to discuss with Awareness network members about the MHAPS strategic plan. Andrew has been consulting with other groups of staff and stakeholders at MHAPS about the strategic plan and is seeking a consumer perspective.

One of the strategic goals from a couple of years ago was to develop a focus on supporting youth, and following this the board developed a plan, approached funders, and now have two staff employed in youth peer support roles.

What do members of Awareness want to see from MHAPS in the future? What has been coming up at recent meetings for discussion or prioritisation?

- Support for Māori is a priority for Awareness members currently. Māori services in Christchurch have been facing challenges so there could be a gap for MHAPS to move into and develop more support for this population group who are overrepresented in statistics. Peer support for Māori youth would be particularly of value.
- The DHB is does not recognise some kinds of distress as "mental illness" and people with issues such as self-harm, self-sabotage. Can MHAPS be doing something to support this group of people? Andrew mentioned that MHAPS can write a letter to the CDHB outlining the concerns with lack of support.
- Does MHAPS have a communications strategy for highlighting issues with the public? This can sometimes push the public conversation in useful directions.
- Peer crisis support is a priority for Awareness currently. A Crisis Café project group has been meeting to look into the feasibility of developing a peer crisis centre for Canterbury and Sue has taken this idea to the MHAPS board already
- People asked about expansion of the youth peer support programme. Whether there will be the development of a support group or youth drop in space like Latnam for youth. Carl mentioned that the team would like to develop a youth support group, but currently
- Members voiced the frustration of ringing up services for support and being told that they are outside the box they are funded for. The need to ensure services are available for people in
- Is there any need to look at the advocacy service here in terms of "are they over-stretched?" There is a need for this service to be responsive.
- There were general issues expressed around the need for timely services both within and outside of MHAPS and a focus on delivering services in a responsive way was felt to be a significant priority.

Thanks to Andrew for coming along to consult with the network. It was mentioned that regular contact with the MHAPS board could be valuable for Awareness, but also for the board to keep a sense of how things are going.

2. Outgoing Chairs report:

Wendy delivered her Chairs Report for the 2015-2016 year.

I would first like to thank Carol, without you, we would have not had an executive, thanks also to Harris, David and Bernie for your help during the year.

I would like to thank Kelly, Beth, Sue and MHAPS for their hard work and support. Without them we wouldn't run so smoothly Thanks to the DHB for funding us.

I would like to thank all the participants of the different project groups and participants that help

With the writing submissions, without you we wouldn't have a vibrant, effective network that we are.

Thanks also go out to Debbie Selwood for letting us know what is happening within the SMHS and their manager, Toni Gutschlag for welcoming us, to hear our list of questions. In particular, the excellent seclusion statistics, over the last 2 years.

We have had a busy year as usual:

- Child custody project
- Mad poetry Group writers workshops and presentations
- Technology training/polytechnic placement
- Submission to the commissioning framework
- Technology Forum
- Journal club
- Peer Crisis Service Project
- Presentations at various conferences
- Law forum
- Submission for peer support workers
- Forums included
- WINZ; 72 people (a record)
- Budgeting forum
- Various fund raising submissions which we have been successful
- Sending members to various trainings
- Quiet minds radio interviews
- We have various members on committee's at both regional and at a national level.

As you can see it has been a fruitful and busy year. A big thank you goes out to all the members that have made all of this possible. I now like to invite the members to consider being on the executive this year to support us in this valuable work.

3. Election of Chair

Bernie and Wendy both put themselves forward for chair.

There was discussion about the two nominees. The possibility of electing both Wendy and Bernie as co-chairs was discussed. The co-chair structure was discussed with some support, and some reservations. One person with committee experience mentioned that in previous groups they have been involved in it has been really valuable to have co-chairs to share the work and support each other; another mentioned that it is also valuable to have one person with the accountability. Wendy and Bernie were both voted in as Co- Chairs.

Forums:

People were very keen to see WINZ covered this year and there are still a lot of issues and uncertainties people are experiencing with the welfare system. Speakers should include Work and Income for most of the time e.g. the first hour, talking about the system, answering questions, and several organisations that can support people when they have difficulties understanding or accessing their entitlements.

Draft speakers line up:

- Work and Income on the system, how it works and entitlements

- Community Law on helping with reviews

- Beneficiaries Association, on what they can do

- MHAPS, on what the advocates can do

It was suggested that this forum could be the first for the year and take place in April.

Nga Hau E Wha

"Champion many voices"

Representative Names:	Kieran Moorhead
Region:	Northern (Auckland)
Meeting Date:	February 21/22 & May 27 2016 Teleconference

1. Issues or Challenges in the sector as identified by people in your Region

MHS Older Adult

The sensory modulation work is continuing. They are currently putting frameworks together. A bed increase on ward 12 / KMU is on the agenda for a new build in 2025. There will be two separate wings, one for dementia and one for psychiatric care. We still struggle to attract staff to MHSOA, so FTE can be difficult. We are tracking our vacancy and sickness rates. At the moment we are working on a pamphlet to provide to inpatients and families. They're on the ward for 30 days so it is good to have something available to explain to them why.

Suicide prevention training

Manu is raising suicide prevention awareness through training in the community. There are initiatives from the MoH for suicide prevention in the rural community; we are funded for 5 workshops. We are raising awareness in schools. The National strategy needs to be signed off by the end of this year and our plan will be reviewed next year. We need to make sure we are linking in with services to ensure the same messages are being given at schools. Megan is currently looking at a pathway into ED for risk assessment. We want to develop where we can and match up to those plans.

Equally Well - Physical health + mental health

At last week's Waitemata DHB (May) meeting it was agreed to modify the PHO enrolment measure to capture when a service user last saw their GP. In a recent conversation re the Tamaki work quarterly visits to GPs seemed to be a reasonable goal.

Physical health should definitely be part of the SNAP, and the SNAP review is a good opportunity to check when the person last saw their GP. It is also a great opportunity to discuss how the person can be supported to see their GP, be supported to raise the issues that are important to them and get a full physical health check.

If the SNAP review is when housing and employment status are updated it would seem sensible to do the same for GP visits.

What we are trying to get a picture of is whether people are seeing their GP (as the next step forward from are people enrolled with a PHO). As discussed at the WSN we hear anecdotally that the people using our services are not seeing their GPs regularly (or at all), and when seeing their GP the 10-15 minute appointment is focused on mental health issues (as you have highlighted).

While we can start to look at whether the people accessing our services are seeing their GPs, for the provider arm or NGOs to report on what occurred in the GP appointment would be extremely challenging. However, through day to day support and the SNAP process provider arm and NGO staff are excellently placed to support people in accessing their GP and making the most of the appointment.

Lee suggested a stock-take of where we are all at to try and ensure there is no duplication and to identify any gaps. Naomi advised there was an NGO review at the end of last year which would have some of that information. Lee will look into this as it would be a good starting point. People's physical health is important and we need to raise the profile of equally well. Ruth advised we will include this topic in our follow-up on the plan with the community in November. It would be good to try and get PHOs here also.

WDHB and ADHB Employment and Housing Figures for people using secondary mental health and addictions services:

Table 1: Waitematā DHB Q1, Q2 and Q3 15/16 Changes in Employment (N=710)

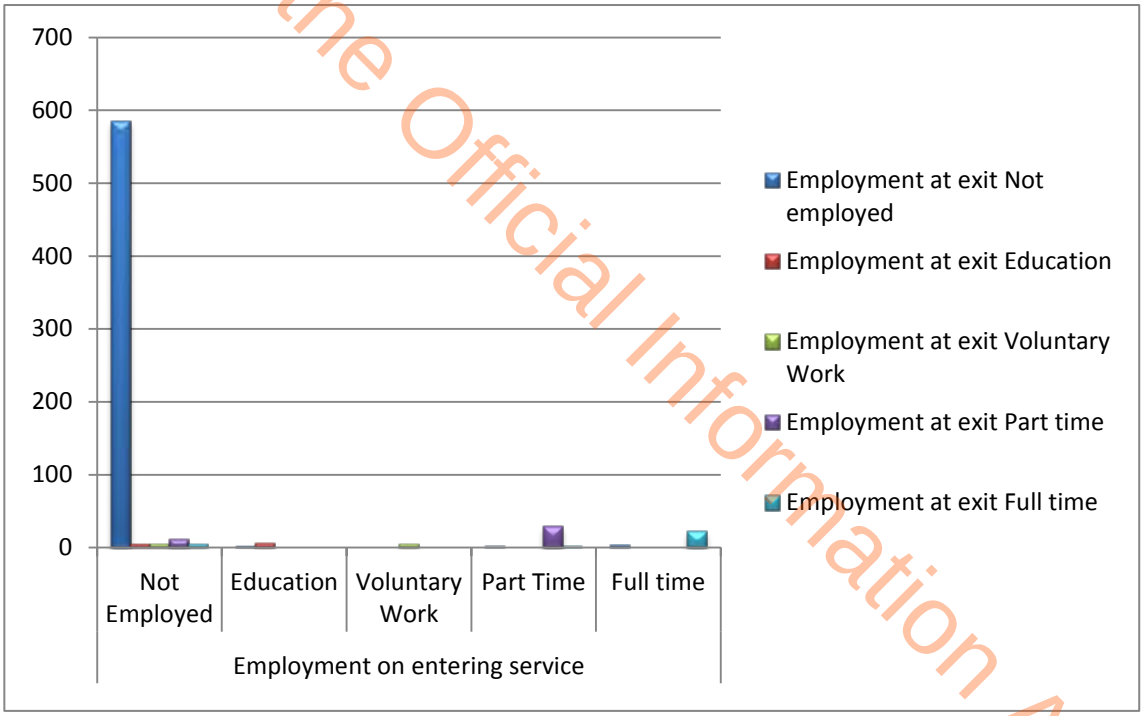
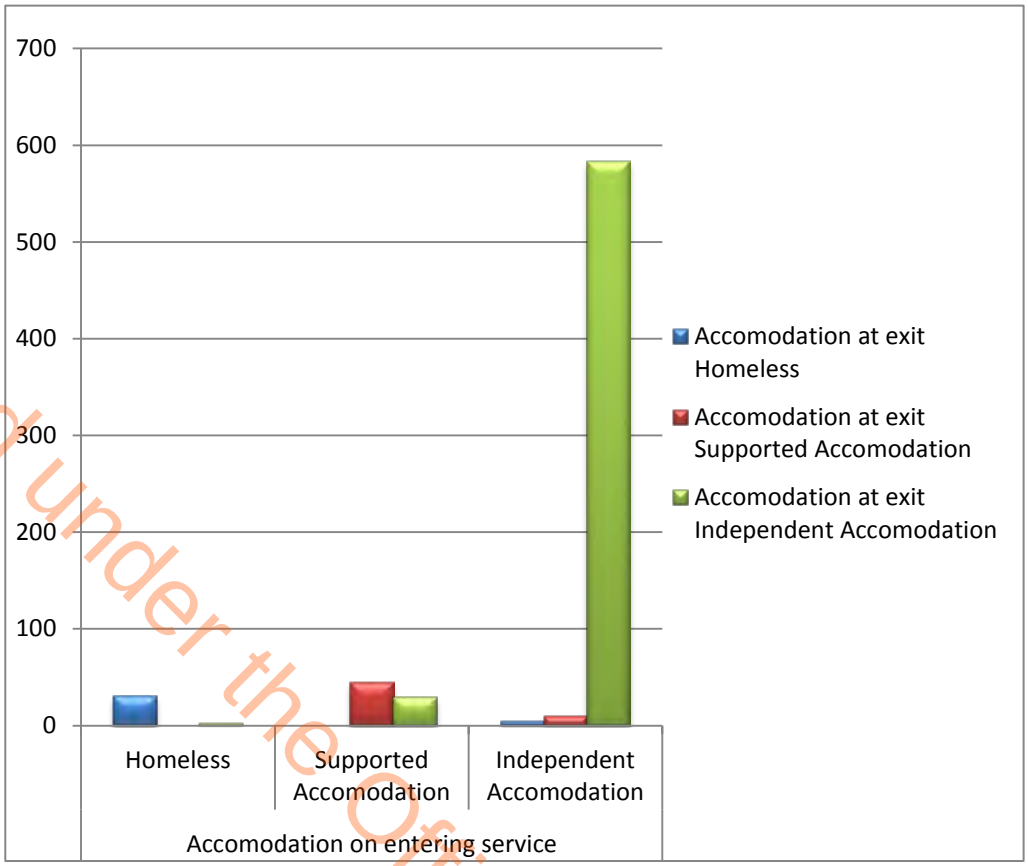


Table 2: Waitematā DHB Q1, Q2 and Q3 15/16 Changes in Housing (N=710)



2. Best Practice according to people in your region

Rising to the Challenge

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

What are we aiming for in2016/17? (Our measures)

Key measures

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

Other measures

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

How will we achieve this?

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

Actively using our current resources more effectively

- Continue roll-out of a new model of community acute response in Rodney and West Auckland, following the successful North Shore pilot, by June 2017
- Participate in regional plan activity – High and Complex needs, Eating Disorders, Substance Addiction (Compulsory Assessment and Treatment) Bill, Māori workforce development plan, framework for suicide prevention training, review of child and youth services, offender health, and forensics (youth and adult) - ongoing

Rising to the Challenge

- Mental Health and Addictions NGO sustainability - with the Mental Health and Addictions sector, implement the agreed work plan and complete 2016/17 objectives by June 2017
- Utilising a co-design process, develop a Shifting Services plan across DHB Provider Arm and NGO services to deliver the right care, in the right place, at the right time, by the right people. Plan to be completed by June 2017
- Continue to work collaboratively with Police to identify and implement initiatives that will improve the experience of people with mental distress who come to Police attention. Ongoing.
- Actively participate in the development of the Commissioning Framework and develop an implementation plan once the final Framework is published by June 2017.
- Maintain regular meetings and communication with key stakeholders from the Ranui Social Sector Trial to develop, agree and implement a transition plan. June 2017

Integration between primary and specialist services

- Plan and implement integration of General Practice and NGO support services based on the model(s) developed within the Tamaki Mental Health and Well-being Initiative, prioritising Whānau House and Totara Health, by June 2017
- Further develop primary mental health integration with Totara Health based on the evaluation (evaluation due March 2016) by June 2017
- Improve the interface between the Community Alcohol and Drug Service and primary care – ongoing
- Design access for primary care clinicians to advice, information and screening from provider arm clinicians by June 2017

Resilience and recovery

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

Delivering increased access

- Implement the 2016/17 actions of the Waitemata Stakeholder Network Service development Plan (2015-2020). Actions to be completed by June 2017 include increasing access to Child and Youth services in Rodney, delivering the first Incredible Years course in Chinese and Korean languages, and utilising service user feedback in Older

Rising to the Challenge
Adult service planning and evaluation • Continue development of shared care between secondary and primary services for aging population between Services for Older Adults and primary care. Ongoing. • Increase access to alcohol and drug services through improved relationships with education, justice, health and child protection services by June 2017

3. New initiatives / developments in your region.

Innovation – in Primary Mental Health Care

Preliminary (Quantitative) Findings of the WDHB Mental Health Services Pilot within Health New Lynn:

Purpose

- To improve access to advice to GPs and their patients
- To enhance the primary care response to those with MH &A problems
- To help build GP confidence and capacity to identify and manage common conditions
- Blueprint II MHC 2012 and Rising to the Challenge MoH 2012

Intent

- To better utilise and deploy specialist expertise to enable early intervention; a more capable and confident primary mental health response and anticipating secondary gains for community mental health services with better targeted referrals and reduced referral volumes.

Outcomes

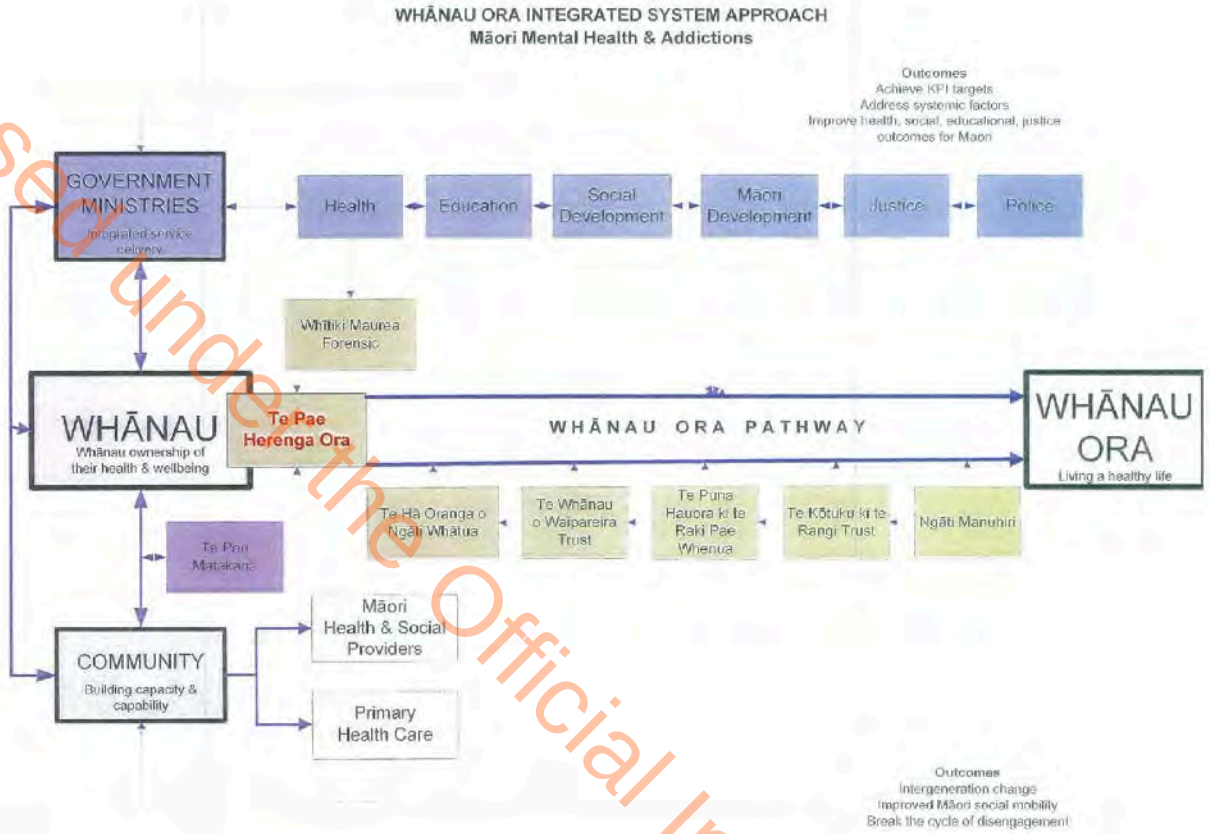
- The mental health occupational therapist ran (x2) 10 week mood and anxiety groups last year.
- 8 people under Health New Lynn were referred. One person left the group after 2 sessions as they had gained employment. The occupational therapist conducted symptom measures pre and post (DASS21 and Kessler 10) - findings are yet to be calculated.
- As the awareness of the group increases the numbers of people being referred this year has also increased
- The mental health occupational therapist also conducted (x2) 3 week sensory modulation workshops. 2 people under Health New Lynn were referred by the mental health primary care liaison nurse.

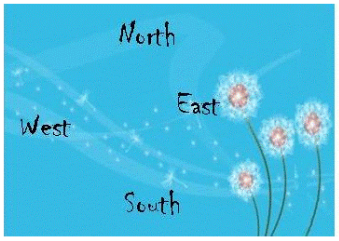
Opportunities for improvements

- A consistent system for data collection for all clinicians working out of Health New Lynn. To enhance the capacity for audit & review
- Electronic storage of patient notes direct into GP electronic health records
- Expand SMO consultation capacity (peer review, case supervision, e referral)
- Enhance health navigation and advice. Telephone advice line. PCL support and direction.
- Establish feedback mechanisms of the pilot; regularly reporting back to governance; project summaries & links with related projects
- Recognising the power of relationships (between people) to enhance collaboration and service user outcomes

- Explore future opportunities for integration of effort across primary and secondary care e.g. involvement of peer support workers, family support
- Development of an (electronic) GP referral pathway in the community or through referrals management but bypassing HCC (nimble, safe).

Māori Equity - Whānau Ora and Mental Health and Addictions:





Nga Hau E Wha

"Champion many voices"

Representative Names: Tui Taurua

Region: Northland

Meeting dates: February 21/22 Meeting & May 27 2016 Teleconference

1.Issues or Challenges in the sector as identified by people in your Region

1) Main issues
   a. Attitudes' of staff
      i. Absolutely no faith in MH services so focusing on peer services
      ii. Want to work different
      iii. Nothing has changed/ people want changes

   b. Peer support
      i. That is the way that MH Services should be going

   c. Major issues told to rep
      i. They report not being listened to by service providers
      ii. They use the services because they have to not because they want to
      iii. Not recovery based, do shopping, running home etc.

   d. WINZ/Housing NZ if you don't know what they want from you then you don't succeed
      i. The questions HNZ ask are huge – you firstly have to have a 15 minute telephone interview – then if you get through that a 2 hour interview follows. Have to do interviews over phone making it hard for advocates to assist. Very difficult process for people who are unwell.
      ii. You have to be in dire straits to have support needs met (close to suicidal)
      iii. A lot of homeless. Increased tangata whaiora begging, picking up cigarettes, asking for money

   e. Report of areas having very high unemployment – even worse for tangata whaiora
      i. E.g. 1 in10 of one housing complex have jobs

2. Best Practice according people in your region.

New Whangarei Employment Service (via Tui)

PATHS training

To get people back to work.

Going through Māori communities

Program to be done in stages:

- Mentoring and coaching people
- Wellness first
- Staying well
- Training: MH / Addiction certificate
- Peer support group to come.

Mental Health Court hearings on the marae:

Māori in Northland have been talking about the common sense approach to having mental health court hearing on the marae. While this is already done for the Department of Justice there are some issues that are unique for mental health service users. All the basics need to be done correctly.

When we talk about our own Māori mental health court hearings on Marae:

- We need time to ensure our tikanga is correct
- Our Kaumatua need to see what's going on around the country
- Need to recognize our elders own unmet historic MH issues
- Recognize this as another step in our de-colonization process.

Convention Coalition Monitoring Group in Northland

Northland Convention Coalition Monitoring Group/ Monitoring Convention 33 of the UN Convention of the Rights of People with Disabilities

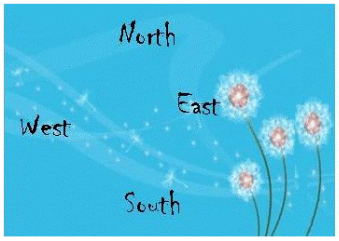
- Good project overall
- Valuable learning and knowledge base for the interviewers.
- Lots of learning for monitors, especially pan disability
- Noticed a big difference between Pakeha and Māori equity e.g.: home ownership
- The methodology of the research wasn't a good fit for Māori
- The end of the project didn't finish well for researchers
- Would have liked better final evaluation

3. New initiatives / developments

National Māori Roopu

Haurahi te Kete Pounamu – The Pathway of the Pounamu

- Te Rau Matatini support – to seek other sponsors as well
- Still in the process of building the kaupapa so the base Māori will be strong (e.g. Tangata whenua; Te Reo etc.)
- Will be national body for all Māori peer support groups – still building
- Setting up model of Māori peer support
- Gathering Māori stories
- Currently meetings around the regions at Marae so each region will be strong. Eventually they can stand alone with trained tangata whaiora. Each region will have their own kaumatua/kuia.
- Connected with Nga Puhi Kaumatua at the moment
- Learning modes between peers to develop base Māori to be strong
- All tikanga based
- Want to see quality assurance with regards to the putea



Nga Hau E Wha

"Champion many voices"

Representative Names: Jak Wild

Region: Central

1. Best Practice according to people in your region

The previous representative's distribution lists are being reviewed and re-drafted so as to include additional known sector networks and contact persons in the region. Communications will be sent out introducing the sector to the new Central Region Ngā Hau e Whā representative, offering an opportunity for face-to-face meetings over the next 3 months.

2. New Initiatives / developments in your region

HUTT VALLEY – Wellington Rights Advocacy Project

A series of education workshops have been provided by WRAP for Service Users from the Oasis Network. 3 workshops have been provided to date, the first two being introductory sessions on Human Rights legislation, monitoring and advocacy, and the first of five workshops has looked at solitary confinement (AKA seclusion)looking at how Service Users can develop a strategy similar to Tairawhiti to work towards the elimination of the solitary confinement in the local inpatient unit.

Other Reports

Family, Whānau Feedback for Nga Hau E Wha report - New actions implemented Dec – May 2016 (Collated by Leigh Murray, Co-chair DFWA)

This report contains a national update from the DHB Family Whānau Advisor group followed by feedback from Family Whānau North in the Northern Region. At this stage we are not able to gather feedback from the other 3 regions in Aotearoa relating to progress from a family, whānau perspective in these projects/topics due to insufficient capacity. Regional family, whānau networks in mental health and addictions that are led by DHB Family Whānau Advisors are not resourced to function at this stage.

DHB Family Whānau Advisors

Promoting **the Family, Whānau and Aiga Perspective and collaborating** with you to develop mental health and addiction services that promote wellbeing for us all. http://www.matuaraki.org.nz/workforce-groups/dhb-family-whānau-advisors/148

DFWA brought a family, whānau perspective to the development of the MoH Mental Health and Wellbeing Outcomes Framework via Co-Chair Leigh Murray's attendance at the 3 MoH sponsored workshops in Wellington.

DFWA put in a submission to the Substance Addictions (Compulsory Assessment & Treatment) Bill collated by Sue Philipson, the Taranaki DHB Addictions Family Advisor. A key theme in the feedback was that family, whānau will require written resources to inform and support them as a key stakeholder in this process. It is hoped that family advisors will be able to contribute to the development of this information.

Sue Cotton, the Family Advisor from Counties Manukau Health contributed an excellent article called 'Co-Design: beyond consultation, a family perspective' to the Family Column in the April 2016 edition of Handover. This is the 12th article written by the Family Whānau Advisor group. Recent Handover articles written for the workforce can be obtained on our webpage at Matua Raki website.

Family Whānau North – The Mental Health & Addictions Sector Voice for family, whānau in the Northern Region

Family Whānau North

	Initiative/Project	Locality	Progress/Actions
1	Suicide Prevention (Information for **whānau)**		• MHF Suicide prevention resource continues to be distributed across DHB services.
2	Suicide Prevention (Education for **whānau)**	WDHB ADHB/WDHB CM Health	• SafeTALK evening for 35 whānau members in Helensville marae 10/5 funded via ADHB/WDHB Suicide Prevention plan • 3 x 12 week Family Connections courses provided to whānau supporting someone with BPD or severe emotional dysregulation in Henderson(NGO)Greenlane(DHB) & Morningside (DHB) April-June 2016 • SafeTALK evening for 35 Pasifika Aiga & fanau in Glen Innes 17/5 funded via ADHB/WDHB Suicide prevention plan • SafeTALK evening for 35 family whānau in Grafton 1/6 funded via ADHB/WDHB Suicide prevention plan & organised by ADHB Family Whānau Perspectives group • 9 x MH First Aid weekend workshops delivered in the community, including workshops delivered in Asian & Pacific languages. Dec to May 2016 • 1 x 12 week Family Connections course provided to whānau

			supporting someone with BPD or severe emotional dysregulation, delivered by DHB Provider Arm. March - May 2016.
3	Suicide Postvention	WDHB/ADHB CM Health	• April – June 2016 'Waves Bereaved by Suicide' group delivered to whānau in Equip office. • Development underway for introduction of a policy and supporting resource kit for 'Supporting Family Whānau Bereaved by an Unexpected Death'.
4	Implementing Supporting Parents/ Healthy Children (COPMIA) guidelines	WDHB ADHB CM Health Regional NGO	• Supporting Parents Healthy Children (SPHC) steering group continuing to work on implementing guidelines. • After conversation with WDHB funder and planner, Connect Supporting Recovery will be running groups for Parents and Children in line with SPHC guidelines. • WDHB provides funding for parents to seek education from Triple P parenting programme providers. • Training provided to MH & AOD services developing skills of staff to talk with clients about their parenting & what, if any, support they want or need and the development of care plans for children if they are hospitalised. • SPHC steering group continuing to work on implementing guidelines. Connect continuing to deliver groups for parents & children. • Odyssey House delivering community programmes to children/teens and parents during school Holidays. • Continuation of DHB MH staff receiving training in responding to Family Violence and Child Protection concerns. • CM contracts providers of Triple P parenting programme to provide support to parents. • Ngaire Candido leading national project for Emerge Aotearoa that will cover ▪ SPHC ▪ Vulnerable Children's Act ▪ Family engagement
5	**Family, whānau** involvement in service improvement	Regional -FWN CM Health ADHB	• March 2016 - FWN subcommittee formed to organise 23rd Aug THEMHS pre-conference family, whānau forum in Auckland called 'Building Authentic Relationships'. • Marama Real Time Feedback for Service Users and their Family Whānau was extended to Tiaho Mai Inpatient Unit, as the third service to introduce this feedback mechanism. • Final Family Whānau Reference Group for the detailed design phase of the planning for the new Acute Inpatient Unit. • Focus groups & telephone interviews with 17 whānau members as part of ADHB Early Intervention service improvement/review process • Several whānau members giving feedback as part of Te Whetu Tawera Co-Design project
6	Top 2 concerns for **whānau**	Regional -FWN	(1) Anecdotal concerns from family, **whānau** indicate inconsistent responses in accessing MH crisis services for

			their whānau across region. Potential solution – Real Time feedback electronic survey of service user and whānau experience when discharged from crisis service. (2) SPHC - DHB staff not consistently referring parents who experience mental illness and their children to NGO contracted SPHC services & programmes. (At 23/5 FWN mtg we identified this concern from our conversation about SPHC work across DHBs/NGOs). Potential solution – Change documentation i.e. regional assessment form to include a question on parenting. DHB adult MH staff receives training & resource to work with parents, their children and wider whānau. Systems & processes to be developed in DHB. Propose that a regional mtg be organised later in year to share ideas & best practice.

Financial Report 15/16 Year - $34,000.00

Expenditure Item	Amount
July 2015	$ 3,957.69
August 2015	$ 3,208.19
September 2015	$ 5,938.23
October 2015	$ 307.96
November 2015	$ 6,552.22
December 2015	-$ 22.54
January 2016	$ 781.85
February 2016	$ 2,243.83
March 2016	$ 4,948.20
April 2016	$ 1,172.17
May 2016	$ 1,728.18
Overspend 14/15year	$ 1,639.00
Total expenses	$32,454.98
Underspend	-$ 1,545.02

	July	August	September	October	November	December
Travel	$ 1,585.32	$ 157.43	$ 4,494.08	-$ 302.60	$ 2,678.08	-$ 441.74
Taxi	$ 496.04	$ 346.16	$ 337.04	$ 610.56	$ 76.64	
Venue	$ 682.20	$ 659.80			$ 367.40	
Catering		$ 344.80			$ 275.60	
Minute Taker	$ 765.00		$ 731.25		$ 652.50	
Conferences	$ 429.13		-$ 1,239.14			
Website			$ 500.00			
M Fees & Reimburse			$ 1,115.00		$ 802.00	$ 419.20
Internal Cost		$ 1,700.00			$ 1,700.00	
Overspend		$ 410.00			$ 410.00	
Total Expenses	**$ 3,957.69**	**$ 3,618.19**	**$ 5,938.23**	**$ 307.96**	**$ 6,962.22**	**-$ 22.54**

	January	February	March	April	May	June
Travel	$ 358.09	$ 543.83	$ 3,606.80	$ 15.00		
Taxi	$ 423.76			$ 377.17	$ 28.18	
Catering			$ 261.40			
Minute Taker				$ 780.00		
M Fees & Reimburse			$ 1,080.00			
Internal Cost		$ 1,700.00			$ 1,700.00	
Overspend		$ 410.00			$ 410.00	
Total Expenses	**$ 781.85**	**$ 2,653.83**	**$ 4,948.20**	**$ 1,172.17**	**$ 2,138.18**	**$ -**

Sent by: victoria s 9(2)(a)

22/09/2016 05:43 p.m.

To: emma_tonks <emma_tonks@moh.govt.nz>,
cc:
bcc:

Subject: Nga Hau e Wha

Kia ora Emma

Thank you so much for coming along to our last meeting. It was really great to have you there. Are you able to pencil us in for sometime on the 3/4 of November. I am thinking that if you are able you might be able to join us for some part of the Strategic Planning day we are organizing for Friday 4th November? As you will see from the attached letter we have some planning and decisions to make before then.

I have attached to this message a leeter (as promised!!) and also 2 other attachments that are relevant to the questions in the letter.

Hope that's not too convoluted.

Nga mihi

Victoria

Victoria Roberts I Chair I Nga Hau e Wha

www.nhew.org.nz I s 9(2)(a)

The national voice of people with lived experience of mental distress and addictions

DPO Attributes - as at 13 May 2014.doc DPO Self Assessment Form.doc Emma Tonks September 2016.doc

Disabled People's Organisation (DPO) Role and Attributes

(Version 8, 13 May 2014)

Background

The United Nations Convention on the Rights of Persons with Disabilities (Convention) describes key roles for Disabled People's Organisations (DPOs). Articles 4.3 and 33 oblige states to closely consult with and actively involve people with disabilities through their representative organisations and to fully participate in the process of promoting, protecting and monitoring the Convention.

In any country that has ratified it, the Convention creates a form of partnership between that country's government and people with disabilities. A partnership that upholds the mantra "Nothing about Us without Us" by ensuring people with disabilities will be closely involved in decisions that affect us and impact on our lives. Article 4.3 of the Convention recognises the role of organisations that represent people with disabilities as having the authority to dialogue with the Government on behalf of people with disabilities on the issues that concern us.

Defining "What is a Disabled People's Organisation"

The term Disabled People's Organisation (or DPO) has developed to encompass a variety of organisations made up of, or primarily governed by, people with disabilities. There are some DPOs that have both a representation and a service delivery function. As there is no universally accepted definition of what a

disabled people's organisation is, there are a variety of organisations that might consider they are a DPO.

The Convention does not define organisations that represent us. It does accord special recognition however, to organisations that do represent us by creating an obligation on governments to engage with us through our representative organisations on issues that impact on our lives.

DPOs are working collectively and we have developed a proposal on how we can engage with government. We have outlined our vision, mission, values, and principles for implementation. We are committed to working with Government, non-governmental organisations and other partners within the disability sector to make the right real for people with disabilities in Aotearoa New Zealand.

We value our allies who walk alongside us and stand up for the principles that engagement with DPOs, based on real information and evidence drawn from our lived experience, will bring real economic benefit in society and the economy, including the elimination of poverty in our people.

Description of Te Tiriti o Waitangi

Te Tiriti o Waitangi (The Treaty of Waitangi) signed on 6 February 1840 is the founding document of Aotearoa, New Zealand and is not only a blue print for how Māori and Pākehā can live together, but it contains a set of rights guaranteed to Māori with regard to self determination and sovereignty and also with regard to equality in society (Article Three).
Given the different ways in which Te Tiriti has been read, interpreted and understood by Māori and Pākehā, the government and courts developed a set of Treaty of Waitangi

principles. These principles have become the primary way in which the government and its agencies understand and express commitment to the Treaty of Waitangi. The four primary principles include: (1) protection and the Crown's duty to protect Māori lands, waters, possessions and self determination; (2) partnership and the idea that the Treaty established a partnership between Māori and the Crown and the duty of the Crown to act in good faith; (3) participation in which Māori are guaranteed all the rights and privileges of citizenship; and (4) consultation in which the Crown has a duty to consult with Māori.

The 'principles approach' to the Te Titiri o Waitangi has arisen out of western legal deliberation. Notwithstanding this criticism, Māori continue to use the articles of Te Tiriti o Waitangi, as well as the principles, to advance their claims for redress, equality and self-determination. *(Higgins, Phillips, Cowan, Wakefield and Tikao 2010 - Growing up kāpo Māori: Whānau, identity, cultural well-being and health / E tipu kāpo Māori nei: Whānaungatanga, Māramatanga, Māoritanga, Hauoratanga, 2010).*

DPO Attributes

New Zealand DPOs have produced a set of attributes to help define what a DPO is, in Aotearoa New Zealand. These attributes are:

	DPO Attributes	Yes/No
1.	The organisation has a legal existence i.e. must demonstrate it exists as a group of individuals with certain rules that bind them to a common purpose or goal (refer appendix for additional information).	
2.	The organisation has a national structure and focus. If the organisation has a regional focus, it demonstrates that there is no national organisation	

	that speaks on behalf of its members.	
3.	The organisation upholds and promotes the philosophy that people with disabilities have the right to participate collectively in decisions that impact on our lives (Nothing about Us without Us).	
4.	The organisation's primary goal, objectives and operations reflect and support the primary purpose of the Convention (refer appendix for additional information).	
5.	The organisation functions effectively and demonstrates it is putting into practice its constitutional requirements (refer appendix for additional information).	
6.	The organisation may focus on a single disability or it may be a multi-disability organisation. It is open to all disabled people who meet its membership criteria.	
7.	The organisation must be governed by a significant majority of disabled people who reflect its community of interest and meet its membership criteria.	
8.	Only disabled people who meet the organisation's membership criteria may elect and vote for its governing body.	
9.	A significant majority of the organisation's members are disabled and reflect its community of interest.	
10.	The organisation demonstrates that it has a mandate or authority to speak on behalf of its members and this remains paramount over any other obligations including direct service provision (refer to appendix for additional information).	
11.	The organisation responds to and is driven by the collective voice of its disabled members who reflect its community of interest (refer to appendix for additional information).	

12.	The organisation demonstrates that it has strong links to its members throughout the country, or throughout the region for a regional organisation (refer to appendix for additional information).	
13.	The organisation has a variety of ways to ensure its members are informed of key decisions at both a local and national level (refer to appendix for additional information).	

Conclusion

Each member organisation should meet the requirements set out in the schedule of attributes. Essential to being a DPO is that the organisation is the authoritative voice of the disabled community or community of interest the organisation constitutionally represents. A number of factors can be taken into account such as the number of members the organisation has compared with the size of its community of interest, any characteristics of its community of interest that would impact on the number of members or their ability to organise, how well spread the organisation is geographically through the country or region, etc.

It is anticipated the DPO Network will make every effort to ensure it has member organisations that cover the full spectrum of the disabled community. The DPO Network will try to avoid any situation developing in which it appears that a particular group becomes over-represented due to too many separate and disparate organisations each claiming to speak on behalf of that group.

Appendix

More information about DPO attributes

Attribute 1: Although the organisation does not need to have any particular legal structure such as an incorporated society, it must show that it exists as a group of individuals with certain rules that connect them as members of the group working to a common purpose or goal. Without a legal structure, it cannot be an organisation in the true sense of the word.

Attribute 4: Goals and objectives need to follow the stated purpose of the UN Convention on the Rights of Persons with Disabilities "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity" (UNCRPD Article 1).

Attribute 5: An organisation cannot simply exist in a technical sense. It must be able to show that its governing structure is working effectively and that it is working to meet its objectives on behalf of its members.

Attribute 10:

a) The mandate arises directly from the organisation's primary goal, objective(s) or philosophy. It also takes into account aspects such as how the organisations' governors and leaders are elected and how members are involved in making the organisation's fundamental policies and beliefs. This sums up the real meaning of the word "represent" in Article 4.3 of the Convention. It must be clear that the organisation's members have agreed to the organisation speaking on their behalf.

b) The organisation can take part in other activities including direct service provision, but the agreement and obligation to speak on behalf of its members must be the most important activity above any other obligations the organisation may have.

Attribute 11: This might happen in a variety of ways, but ideally the organisation should hold some sort of national meeting, at least every year or every two years at a minimum,. This meeting should be open to members in general and should involve a number of representatives from around the country who can speak on behalf of the members in their regions and effectively participate in the final decision making process. Decisions made at such meetings must be put into practice.

Attribute 12: This could be achieved through a national or regional structure with local branches or chapters. Or through some other more informal structure that involves regular local forums or meetings that are open to people with disabilities at the local level. Or even through a more virtual structure in which members can join in from wherever they live.

Attribute 13:

a) The organisation must be able to show that its members, regardless of where they live, can formally raise and discuss issues through a variety of ways and that their views influence the approaches taken by the organisation's governors.

b) Information sharing can happen in a variety of ways including regular local and national newsletters, access by members to minutes of meetings, ability to observe at meetings etc.

Self Assessment Form - DPO Role and Attributes

Refer to Disabled People's Organisation (DPO) Role and Attributes document
Version 8, 13 May 2014

DPO Name: _____

Date of Assessment: _____

Assessment completed by: _____

DPO Statement: We meet all 13 DPO Attributes, except …

	DPO Attribute	Yes/No	Comment
1.	The organisation has a legal existence i.e. must demonstrate it exists as a group of individuals with certain rules that bind them to a common purpose or goal (refer appendix for additional information).		
2.	The organisation has a national structure and focus. If the organisation has a regional focus, it demonstrates that there is no national organisation that speaks on behalf of its members.		
3.	The organisation upholds and promotes the philosophy that people with disabilities have the right to participate collectively in decisions that impact on our lives (Nothing about Us without Us).		
4.	The organisation's primary goal, objectives and		

	operations reflect and support the primary purpose of the Convention (refer appendix for additional information).		
5.	The organisation functions effectively and demonstrates it is putting into practice its constitutional requirements (refer appendix for additional information).		
6.	The organisation may focus on a single disability or it may be a multi-disability organisation. It is open to all disabled people who meet its membership criteria.		
7.	The organisation must be governed by a significant majority of disabled people who reflect its community of interest and meet its membership criteria.		
8.	Only disabled people who meet the organisation's membership criteria may elect and vote for its governing body.		
9.	A significant majority of the organisation's members are disabled and reflect its community of interest.		
10.	The organisation demonstrates that it has a mandate or authority to speak on behalf of its members and this remains paramount over any other obligations including direct service provision (refer to appendix for additional information).		
11.	The organisation responds to and is driven by the collective voice of its disabled members who reflect		

	its community of interest (refer to appendix for additional information).		
12.	The organisation demonstrates that it has strong links to its members throughout the country, or throughout the region for a regional organisation (refer to appendix for additional information).		
13.	The organisation has a variety of ways to ensure its members are informed of key decisions at both a local and national level (refer to appendix for additional information).		

Additional Comments

Add any additional comments on where your DPO is at against the DPO Attributes.

Nga Hau E Wha

"Championing Many Voices"

September 22nd 2016

Emma Tonks
Senior Contracts Manager
Mental Health and Addiction Services
Mental Health Service Improvement
Service Commissioning
Ministry of Health

Kia ora Emma

I am writing with regard to some questions that arose during our last meeting from which we would appreciate some direction.

1. **Media:**

We have quite an extensive email distribution list and we are often in the position of needing to decide whether or not to post some of the items that are submitted to us. We are not sure how non-political we are supposed to be given that we are funded by the Ministry.

As an example there is currently a campaign called the "Peoples Review of Mental Health Services" by Mike King and others from the Nutters Club. We were asked to publicize this via our distribution list and we had to think hard about how to respond to that request.
Some sort of direction from you would be appreciated.

In our group we regularly scan the media. Would the ministry agree to us including such scans in our reports and would the ministry want to see these as they become available?

2. **DPO status.**

DPO[1] as defined by the UNCRPD[2] -
The Convention Coalition (CC) is the body in NZ established to monitor the UNCRPD. We have been discussing within the group the reasons Nga Hau e Wha were asked to leave the Convention Coalition even though we were one of the original members who

[1] DPO – Disabled Persons Organisation
[2] United Nation Convention on the Rights of People with Disabilities

signed the first documents as a part of the Coalition. There was a cabinet Minute regarding the establishment of the CC naming Nga Hau e Wha as a founding member.

We have concluded that we still fit the criteria for a DPO (see attached) and would like to make progress towards re-establishing ourselves as a functioning and effective commentator within the mental health sector and across government on issues related to our constituency.

So our questions are:

1. Does the ministry want us to progress the work towards full DPO status and reintegration back into the Convention Coalition which would involve establishing a governance group and other legal requirements?
2. Would the ministry allow and support us to secure funding from other sources to enable this to occur (e.g. the National Innovation Fund –funded by the Ministry; Te Pou etc.)?
3. Eventually we could look at setting up governance group to involve certain advisors, a strategic advisor, media advisor etc.

3. Strategic Plan

We are planning to revise our Strategic Plan in November. We held this over from last November when it was due for revision. It is required in our contract. We are planning to contract the person who created our first Strategic Plan to assist us again.

If we are able to move forward with the DPO work we would like this to be included in the new Strategic Plan. This makes the approval of the ministry of key importance.

I will attach some other documents which I hope will help inform you.

I am happy to come and meet with you if that would be useful or a telephone conversation would be welcome as well.

Nga mihi

Victoria

Victoria Roberts l Chair l Nga Hau e Wha

www.nhew.org.nz l s 9(2)(a) s 9(2)(a)

The national voice of people with lived experience of mental distress and addictions

Sent by: reception@mhaps.org.nz

03/10/2016 10:04 a.m.

To: <Emma_Tonks@moh.govt.nz>,
cc:
bcc:

Subject: RE: NHEW Minutes report

Thanks Emma

Please find attached report from NHEW September Meeting

Kind Regards

Shelley Engebretsen

Receptionist/Administrator
MHAPS – Mental Health Advocacy and Peer Support

826 Colombo Street, Christchurch, 8013
P.O. Box 33332, Barrington, Christchurch 8244

03 365 9479
reception@mhaps.org.nz

From: Emma_Tonks@moh.govt.nz [mailto:Emma_Tonks@moh.govt.nz]
Sent: Monday, 3 October 2016 9:11 a.m.
To: MHAPS
Cc: MentalHealth&Addictioncontracts@moh.govt.nz
Subject: Re: NHEW Minutes report

Hi Shelley

It was good to meet you too. Once NHEW are happy with the minutes if you could send them through to me and to a generic mailbox mentalhealth&addictioncontracts@moh.govt.nz that would be great.

Many thanks

Emma Tonks
Senior Contracts Manager
Mental Health and Addiction Services
Mental Health Service Improvement
Service Commissioning
Ministry of Health
DDI: 04 816 4460

http://www.moh.govt.nz/
mailto:Emma_Tonks@moh.govt.nz

From: "MHAPS" <reception@mhaps.org.nz>
To: <Emma_Tonks@moh.govt.nz>,
Date: 30/09/2016 12:37 p.m.
Subject: NHEW Minutes report

Hi Emma

Great to meet you at the September Nga Hau E Wha meeting earlier this month.

I need to know who I send the minutes to please. Is it you or someone else in the ministry?

Thanks

Kind Regards

Shelley Engebretsen

Receptionist/Administrator
MHAPS – Mental Health Advocacy and Peer Support

826 Colombo Street, Christchurch, 8013
P.O. Box 33332, Barrington, Christchurch 8244

03 365 9479
reception@mhaps.org.nz

NHEW Minutes Sept 2016.doc

8:30am G.01 Freyberg Building, Ministry of Health, 20 Aitken Street, Wellington

8 September 2016

Minutes – Prepared by Jay Thompson-Munn

Nga Hau E Wha
"Championing Many Voices"

Day 1

Present: Victoria Roberts (Chair – Cetnral/North) Julie Witla (Deputy Chair – Southern/North) Tui Taurua (Northland), Grant Cooper (Southland/South), Guy Baker (Midlands/East), Kieran Moorhead (Northern/South), Jak Wild (Central-North), Taimi Allan (Changing Minds guest), Sue Ricketts (MHAPS) Shelley Engebretsen (MHAPS), Jay Thompson-Munn (Minute taker)

No.	Topic	Discussion Points	Planned Action	By/Who
1.0	**Whakatau / Welcome**	▪ A Whakatau was held for Sue Ricketts (MHAPS CE) Shelley Engebretsen (MHAPS administrator) Emma Tonks (MoH Contract Administrator),Jak Wild (New member – Central Region) and Taimi Allan (Changing Minds). It was led by Guy Baker (Tairawhiti DHB)	▪	
1.1	**Approval of Minutes**	▪ Minutes previously approved by teleconference	▪	
2.0	**AGENDA ITEMS**			
2.1	**Emma Tonks MoH – Financials – Contract Manager** **Emma_Tonks @moh.govt.nz**	▪ MOH have gone out to the DHB for expressions of interest for new project which needs $5 million funding. This money had to be 'found' within the sector they were not awarded new money. The $90K which we were expecting last year has been absorbed into this budget. ▪ Noted it is in budget as placeholder in out years – MOH 4 year plan to go to treasury shortly. ▪ Ministry wants to get feedback from all groups on how to change the Mental Health Sector across board. ▪ Victoria provided hard copy of John Crawshaw's Power Point presentation from Fit for the Future workshop one. Workshop two is mid September. ▪ Noted that the Ministry has set up email address specifically to send suggestions on what is proven to work/not work, for a new project called "Fit for the Future". fitforthefuture@moh.govt.nz	▪ Obtain & distribute email address for Ministry submissions fitforthefuture@moh.govt.nz	Victoria

No.	Topic	Discussion Points	Planned Action	By/Who
		▪ Peer support isn't literature based enough; there is plenty of research but not all in a central place. Need more consistency, look to join with academics agreeing this is more recent and accurate etc. ▪ MOH is changing their workspaces to 'flexible working' lightweight portable laptops, hot desking. This will be from when they move back into the refurbished Molesworth St offices. ▪ Jak raised a question around Contractors to the Ministry being able to hot desk and work on site too. ▪ Restructure announced today, in place by time of move to new building in October. ▪ Emma noted that the budget has gone from $34k to $48k per year in new contract.	▪ Follow up re. hot desking question ▪ Add Emma's email address to minutes	Emma Victoria
2.2	**Dr John Crawshaw MoH**	▪ *Deferred as Dr Crawshaw is off sick.*	▪ N/A	N/A

No.	Topic	Discussion Points	Planned Action	By/Who
2.3	**Discussion of members regional reports – see members reports attached**	**Julie Whitla & Grant Cooper – Southern report:** ▪ The Pacific Health Trust has closed. Primary Health has started recruitments for GP's, to have a better commitment to patient's Mental Health. Visiting their homes, being able to connect to right services. ▪ Odyssey House started a youth & offenders service, has developed a women's group covering self-esteem, body awareness. ▪ Started central coordination service in CHCH, all clinicians sit at – has peer support person & consumer advisor. Produced some graphs from MAPS showing that there is a big spike in new referrals. ▪ Discussed the increase in suicides across the country, clusters in regions and the type of follow up that's done in communities. ▪ The Wolf Pack – Oamaru, The Wolfpack is a non-profit support group, established and run by volunteers, focusing on local men's mental health issues such as depression, anxiety and anger issues. The group aims to be able to provide a link of sorts to men in the community to access information and support, we also aim to fundraise, and subsidise local counselling for our members if needed. It is now a Charitable Trust ▪ Still concern over the high number of people under the Mental Health Act ▪ Lack of Peer Support still identified as an issue in the rural Otago and Southland areas **Guy – Midlands Report** ▪ Consumer Advisory Groups within region range from very active to groups struggling to get people to meetings. In many cases this is attributed to sparseness of the areas and ability for consumers to attend. ▪ There is a lack of emergency, respite and social housing in the region. ▪ Accessibility to Rehab poses a problem for some areas. DHB budget restraints means that people are being sent to "out of area" rehab facilities on a bus often without whanau or other support and then following treatment return similarly without that support. ▪ Transport is a challenge for consumers to access services, activities and initiatives as often they don't have driver's licenses, vehicles or the availability of public transport. ▪ Real Time Feedback (RTF) is mostly working in the region despite some resistance. ▪ Discrimination is still high in the region with example given by Guy who wrote a Letter to the Editor in response to a local newspaper article that quoted District Councillors prejudicial comments that linked mental health to "beggars" and how they should be dealt with under bylaws. Suicide post-	To send out email with link	

No.	Topic	Discussion Points	Planned Action	By/Who
		vention groups, a collaboration of service providers, have been established to co-ordinate support following an event aimed to reduce the number of services appearing at the home. **Jak Wild – Central region** ▪ Information from last 5 years ombudsman reporting is now publicly available. The Herald website has links, to 67 reports that the most serious highlight concerns. The executive summaries in each report give an overview of concerns. ▪ There is a new Ombudsman Inspector role for a person with lived experience either as a consumer or a family member. This is funded by the UN OHCHR. ▪ Mid-central and Palmerston North elder-care are still using T belt restraints to keep patients in bed. Concerns noted around potential of 'lived experience' could become confused if it extends to include carers. ▪ Lower North Island 3DHB response to damning Ombudsman reports has suggested there is misinformation being released. Terminology is contested by the 3DHB around what defines 'seclusion' with concerns noted by service users supporters that the DHB is getting caught up on semantics. ▪ The recent high court case in Wellington has been atended regulalry by local peers and reported back to reps. The case has focussed attention on arbritary detenion, seclusion and restraint. Lots of focus on standards. Reports from service users note clinicians assume a standard is a goal – rather than the minimum standard. Standards and guidelines are found to have lapsed beyond the 4 yearly review dates. Both the Seclusion and the Restraint Standards haven't been reviewed since 2008. Many other documents are out of date, with suggestions this makes them not legally binding. Eg; The Seclusion guidelines last updated in 1998. Link to Herald article containing Ombudsman's Reporting on Torture in NZ http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11676336 **Kieran – Northern region:** ▪ Counties Manukau DHB has commissioned the Peer Potential Strategic Action Plan (2016-2021). Largest funded peer workforce in NZ 69.0 FTE. Noted that over 130 people participated in Peer Employment Training but only 12% of those people go on to employment as peer support workers. ▪ Discussed Peer Group Project. Gave some feedback on the the MHS Conference. Australia appears to be behind NZ in terms of consumer engagement and is still using the consumer consultation terminology rather than the concept of equitable consumer relationships.		

No.	Topic	Discussion Points	Planned Action	By/Who
		Victoria Roberts - Central region South ▪ A service user went missing; clinical services should be providing support around the user group for grief counselling etc. systemic issue. ▪ Civil Defence lines should be tied into peer support lines and numbers. ▪ Dedicated government funding for peers to apply to, to fund first aid training, governance, civil defence etc. ▪ CATT team in Wellington is restructuring and will be called the Crisis Resolution Services (CRS). ▪ Homeless Women's Shelter just opened in Wellington. ▪ Jak and Victoria have begun meeting with DPA and will continue to meet every month for information sharing, strategic discussions etc. **Tui Taurua – Northland region** ▪ Medication prescribing – only one psychiatrist in the region. ▪ Up to four security guards are at the local WINZ office at any one time. Tangata whaiora feel watched, intimidated and judged. ▪ There is no Maori Consumer Advisor anywhere in the region. ▪ Te Huarahi o Te Pounamu – a newly formed national Maori network. Kia Noho Rangatira Ai Tatou – is a new human rights education program, one for Disabled Support Services and one for Disabled people. It has been provided in Northland as well as eswhere around the country. **Tamie Allan - Auckland:** ▪ Suggested the idea of an access pathway for referral processes, if you need to tell someone where to get help. Roadmap of the services. ▪ Wellington linkage, started by Pathways, developed such maps linked in to Navigator system in Wellington		
2.5	**Collaborative research**	▪ Collaborative research project with psychiatrists, researchers, nurses and people with lived experience across NZ. Research bid is currently in front of the Health Research Council panel. One of the panel members has a strong focus on mental health which is a good sign. The research summary is to implement an online based questionnaire in primary healthcare, to gauge mental health as well as physical health. The tool will be led by nurses and the research will be coordinated across the country. ▪ See more in Regional Reports	▪ Distribute one-pager	Kieran

8:30am G.01 Freyberg Building, Ministry of Health, 20 Aitken Street, Wellington

9 September 2016

Minutes – Prepared by Jay Thompson-Munn

Nga Hau E Wha
"Championing Many Voices"

Day 2

Present: Victoria Roberts (Chair) Julie Witla (Deputy Chair) Tui Taurua, Grant Cooper, Guy Baker, Kieran Moorhead, Jak Wild, Taimi Allan (Changing Minds), Jay Thompson-Munn

No.	Topic	Discussion Points	Planned Action	By/Who
2.0	**AGENDA ITEMS**			
2.1	**Distribution list discussion**	▪ Discussion on the issue of naming people in reports, noting the distribution list is available widely including online ▪ NHEW Contract stipulaltes we need written consent to use people's names in reports. ▪ Recommendation is to have a confidential version of the full report with sections which are either controversial or have personal information to be highlighted for later redaction from public released copy of report so if there's a real concern around a particular person it still gets reported on but not in the public records. ▪ Tamie suggested having a 'media watch' section in our reports. Mental Health Foundation – Stigma Watch covers this. Dovetail into strategic plan. Newsletter. Facebook page. Hamilton – the four oh one. Copy of strategic plan. ▪ Concerns over content being too political? Add disclaimer. The People's Review of Mental Health. Questions on whether People's Review is too political for NHEW to report on?	Questions to ask Emma: Process around confidential information ▪ Questions to ask Emma: Do they want Media Scan? ▪ If agreed set up Google Alerts for Media scanning ▪ Report on the People's Review but add disclaimer ▪	Victoria Victoria Jak
2.2	**Strategic planning –**	▪ Postponed last year because as not enough money in the budget.	▪ Arrange	Victoria

No.	Topic	Discussion Points	Planned Action	By/Who
	confirm for November	▪ Discussion around how the Strategic plan is being updated to take account of changing vision, funding and work plan ▪ New Strategic plan to include work on progressing DPO status to meet DPA criteria of a DPO ▪ Terms of Reference may need to be reviewed to keep in line with Strat Plan ▪ Agreed to proceed with Strat plan at next meeting ▪ Contact contractor to facilitate again.	requirements for our Strategic Plan review ▪ Victoria to organise with contractor	
2.3	**MOH report list for members**	▪ Discussed benefit of having all NHEW's internal documents in one place on website. ▪ To have the documents in dropbox linked to the webpage	▪ Load all documents into dropbox and develop the webpage	Jak
2.4	**Questions for guests**	▪ Discussed	▪ N/A	N/A
2.5	**Grant O'Brien HDC / Kevin Allan MHC**	**Kevin Allan – Mental Health Commissioner (at Health and Disability Commission)** ▪ Robust and fair watchdog service for heath & disability services. Looking at patterns & trends from the varied complaints we receive. Been in role for 9 months. ▪ Actively involved at looking into complaints, rather than monitoring. Deputy Health and Disability commissioner as well as Mental Health Commissioner. Includes Prison Health services. Working on how we get good information on sector performance across board. ▪ Also working on National Mental Health and Wellbeing Outcomes Framework. ▪ Query around second opinion if people are unhappy with their clinician, and workability when they request a review. ▪ Entitled to review. Need to know what happened and why. Important the person knows the reason if it's not possible to change clinicians. Better to get things resolved as early as possible and as closely and directly with the people involved. ▪ Query around advocacy in Auckland – some DHBs have funding for personal advocacy and others don't. Needs to be a facilitated way to progress complaints. ▪ National Advocacy Trust attached to the Health and Disability Commission being available in each region. People are generally really happy with how things are sorted out from there. Generally if system is not working for consumer, it's not working for provider either. ▪ Issue with WINZ with Dr's med cert, MHC don't get involved in that because		

No.	Topic	Discussion Points	Planned Action	By/Who
		it's outside their jurisdiction – but they pass it onto the right department. Refer to WINZ or ACC etc. guide person to that. ▪ Concern raised that the Mental Health Act seems to be used as a proxy for poor relationships. Under the act we tend to have one course of treatment being medication. Importance of increasing wellbeing, not just managing mental health problems. Noted alternative treatments are more cost effective in the long run. ▪ DHBs making impact on reduction of seclusion. Refernce to Rising to the Challenge report. Lots of arguments for restraint & control from different directions for very different reasons. Suggestion media can sometimes generate heat rather than light. ▪ Query around discrimination of people with criminal records trying to get a job, giving chances and providing support to do that. No employment advocates in more rural and marginalised regions. ▪ Concerns noted around HDC advertising for recent positions – eg; requesting consent to contact every single previous employer ▪ Human Rights Commission advertising for Disability Commissioner role but not stating lived experience of a disability as desirable. Reps noted government agencies need to lead by encouraging people with lived experience to take up position and not to discriminate. Suggestion experince shouldn't have to be disclosed unless relevant to the role. Noted experience, needs to be an attribute and valued rather than a barrier. Need for more peer voices – especially at the top. ▪ Example raised about Virgin trains policy of set percentage of ex-prisoners. Question whether MHC could be promoting good employers. Eg Fulton Hogan (check this out). Bridgepoint, catapult etc. need to be more visible in rural areas. ▪ Question raised around the Statistics on HDC complaints and resolutions – to help us be more confident in promoting the reporting process. HDC Annual Reports distriubted which covers the latest statistics **Grant O'Brien – Health and Disability Commission** ▪ Intro: Been in/out of clinical work over years, worked for WHO and NHS. ▪ Issues from NHEW latest report: Housing in Auckland. Accurate data from MSD shows those with mental health diagnosis and homeless, just over 2000 people nationally. ▪ Kieran's work around primary care & access: 94% of the country enrolled with PHOs, enrolment is different to numbers actually using services. Inability to allow people to have early access.	Kevin to follow up	

No.	Topic	Discussion Points	Planned Action	By/Who
		▪ Over use use of the MH Act. Suggerted the MH Act isn't the problem; it's the way it's being used. Rep noted criterias to be sectioned are much less than criterias of being released from sectioning. If providing right level of service it should be easy for those three sectioning criteria to not be met. ▪ Isses around 'co-existing disorders'. 168,000 people seen by services last year. 80% have coexisting condition. We don't have a workforce that is trained to work with people who have coexisting disorders, or to look for them. ▪ Provided additional comments/points to Minutes of last meetings presentation ▪ HDC receives 1800-2000 complaints each year 10% in mental health. ▪ Provided copy of HDC Annual Report 14/15 which shows statistics. 15/16 should be out in a few weeks. ▪ <u>Actions from Feb meeting</u> – the 3 priorities listed should be at the core of any decisions made. (list 3 priorities??) The fourth wave. 250% increase in mental health services used. ▪ Innovation: Internet Access is a priority that could be very important for NHEW to give attention to – blue sky issue. Telehealth services, homecare medical. Recommended to contact Andrew Slater – CE Homecare medical, invite him to a meeting. (Action list??) ▪ Choice and Medication pilot evaluation – continues to run for another 12 months, then look to roll out nationally. choiceandmedications.org.nz ▪ HDC MH&A changes & developments ▪ Grant informed moving on from HDC but remains as a casual advisor. ▪ New role as an advisor to Polytechnic on a new qualification in Mental Health Sector: Bachelor's course 3 majors: mental health, addiction, disabilities - Bachelor of Social Health & Wellbeing NZ Open Polytechnic. Grant to send out promotional material. Hoping to get it accredited to teach next year. Also Programme Lead on change initiative at Waikato DHB.		
2.6	**Caro Swanson Service User Lead –**	*Deferred due to lack of internet connection*	▪	

No.	Topic	Discussion Points	Planned Action	By/Who
	Te Pou (Skype)			
2.7	**DPOs discussion**	▪ We are a DPO, even if we are not a Convention Coalition DPO. Put in strategic plan. List it as "we are a DPO as defined by…" ▪ Could look at setting up governance group to involve certain advisors, a strategic advisor, media advisor etc.	▪ Send out PowerPoint presentation ▪ Look into Slack app	Jak Jak
2.8		▪	▪	
2.9	▪ **Confirmation of Actions List** ▪ **MOH report contributors finalised** ▪ **Mtg dates confirmed**	▪ Taimi mentioned Rob Mokaraka's performance piece "Shot Bro" – there was discussion around organising a group event in Wellington with korero & kai and koha from audience ▪ Noted that Mental Health Awareness week is coming up in October (around World Mental Health Day 10 October, 2016 is 10-16 October) ▪ Access to Peer Support Evidence. To be stored in Drop Box and shared around ▪ Mentioned that Lifeline has lost funding, but Telehealth still have a contract.	▪ Add files to Dropbox and share link	Taimi
3.1	**Meeting Concluded**	▪ Finished at 3pm	▪	
3.2	**Next Meeting**	▪ **November 3 & 4 2016**		

Regional Reports

Nga Hau E Wha
"Champion many voices"

Member: Tui Taurua-Peihopa
Region: Northland
Meeting: 7/8 September 2016

1. Issues/challenges identified by people in your region

Hui to discuss the Mental Health and Addiction Framework

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

Prescribing of medication

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

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

Security at WINZ

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

Maori Consumer advisor

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

Communications

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

2. Best Practice according to people in your region

Intra-muscular prescribing

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

3. New Initiatives /Developments in your region

Te Haurahi te Pounamu – Maori pathways

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

Kia Noho Rangatira Ai Tatou:

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

Representative: **Jak Wild**
Central (North) Region: **MidCentral DHB / Hawkes Bay DHB / Whanganui DHB**
Meeting date: **8/9 September 2016**

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

1. Issues/challenges identified by people in your region

1. Mental health services:
Opposition parties, trade unions and special interest groups have been highlighting many issues of concerns nationally in Mental Health service delivery over the last 6 months. Local Media has culminated reporting on calls for a public inquiry with special mention of waiting lists for youth in the region. Up to June 2016 Whanganui DHB had 35.6% of young people waiting more than three weeks to access mental health services. Hawkes Bay DHB reportedly reduced their waitlists for youth of 3 weeks or more from 32.6% to 13.9%. The national target is 20%.

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

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

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

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

4. Legal Challenge

Local peers have attended the past months high court hearing in Wellington brought by human rights lawyer Dr. Tony Ellis. The case involved three men with intellectual disability and mental health issues (two also have autism). Dr. Ellis said the treatment of all three had caused them to become institutionalized describing their treatment as 'warehousing'.

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

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

Link to Herald article containing Ombudsman's Reporting on Torture in NZ
http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11676336

2. Best Practice according to people in your region

Fielding Integrated Health Centre

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

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

Kites

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

Whirlwind

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

3. New Initiatives /Developments in your region

Kia Noho Rangatira Ai Tatou:

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

Mental health Awareness week:

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

Campaign to review the mental health system:

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

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

Review of the Disability Strategy

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

Peer Tree

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

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

Buddies

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

New Hawkes Bay mental health unit

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

Rural Mental Health

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

4. Addictions

New Wairarapa Gambling service

- The Salvation Army has been contracted to provide a new problem gambling services in the Wairarapa -- including counselling support for those struggling with a gambling addiction, as well as family members, partners and others affected by someone else's gambling.
- Public Health services are also delivered, aiming to reduce the harm that gambling can cause, help agencies to develop policies around gambling and raise awareness of problem gambling in the community.

- Counselling for problem gamblers in Wairarapa was previously offered by Wairarapa Addiction Services and then Care NZ, until the Salvation Army picked up the contract recently. Since then, the service has seen new clients, including family members, who range from professionals to beneficiaries.

5. Whanau/family services

New links with Family Whanau Services

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

6. Maori services

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

Member: Kieran Moorhead
Region: Northern
Meeting date: 8/9 September 2016

1. Issues/challenges identified by people in your region

CHAMP – Counties Manukau Peer Potential Project – Cassandra Laskey

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

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

Counties Manukau (CMDHB) has the largest funded peer workforce in NZ – 69.0 FTE.
CMDHB has three fully peer-led services, the rest of the peer workforce operate in Multi-Disciplinary Teams.

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

Recommendations:

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

Next part of the Peer Potential Project 2016/2017:

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

2. New Initiatives /Developments in your region

Feedback from Waitemata DHB CAMHS:
Respect – **4.5 / 5**
“The majority of you feel that you are respected by people here”

Communication – **4.5 / 5**
“Most of you feel that staff work as a team and support each other to ensure you get the best care”

Support – **4.5 / 5**
“We’re glad most of you feel safe here. If you’ve been here a little while and still feel unsure about stuff, talk to your keyworker or write the consumer advisor a letter”

Appointments – **3.2 / 5**
“This is one we are pretty worried about. We’ve implemented CHOICE teams to get through appointments quicker as our demand increases!”

Plan Reviewed – **4.5 / 5**
“Treatment goals should be reviewed consistently – even if it’s just to say ‘Yep all good’.”

Decision Making **– 5 / 5**
“Clinicians ask you what you want for yourself”
“We’re committed to this, so we are happy to see this result”

Recommend – **4.3 / 5**
“Most of you would recommend us to friends/family”

Family/Whanau – **4.5 / 5**
“The majority feel their family is encouraged and informed”

Culture – **4.5 / 5**
“You feel that we acknowledge your cultural needs”
“Many NZ Europeans did not answer this question – please do!”

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

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

Collaborative research:

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

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

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

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

Aim

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

Primary hypothesis

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

Exploratory aims

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

Centres and Participants

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

- All patients presenting to the trial GP practices with a suspected diagnosis of depression over a 12-month recruitment period will be invited to participate in the study.
- Patients who verbally agree to take part will be registered on to the Psynary system by the practice nurse. When patients log on to Psynary for the first time they will be presented with information about OptiMA3-NZ, available in English or Te Reo Māori.
- Patients will then complete the online consent form. Only if they consent to all the items will they be able to proceed with the Psynary baseline assessment (detailed below).
- The initial part of that assessment involves a diagnostic algorithm for ICD-10 mood and anxiety disorders. Only those patients meeting criteria for a moderate or severe depressive episode will be included in the intervention or Treatment As Usual arms of the trial.

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

Interventions

Description of the online support system: Psynary

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

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

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

4. Addictions

Counties Manukau Health - AOD Collaborative:

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

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

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

LookUp Auckland DHB Youth Event – Wellbeing and AOD:

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

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

1. Balance and Connect

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

2. Know Better, Do Better

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

3. Brave Conversations

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

4. Making a Difference

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

TheMHS Conference August 2016

Keynotes:

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

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

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

TheMHS Conference - Coercive Community Treatment:

- Discussion on the readiness to end coercive community treatment practices.
- Clinicians argue that CTOs enable people to reliably access treatment in their community.
- Some questions were raised asking why we can't have reliable and effective services without CTOs.
- In the context of reviewing NZ's mental health legislation, someone who works for the Ministry of Health commented that there is the fear that we are currently living in a more socially conservative time and any changes to our legislation could result in more coercive practices.

Member: **Victoria Roberts**
Region: **Central South**
Meeting date: **8/9 September 2016**

1. Issues/challenges identified by people in your region

1. Mental health services:
Oasis
Te Whare Ahuru HVDHB

- Staff in mental health wards need to be trained to be non-aggressive
- Long term services users do not get a fair go.
- In the inpatient unit there are no discharge plans; informed consent does not happen at all; no wellness plans
- Service users need more advocacies around their rights.
- Most agencies will only pick up new clients if they are suicidal or threatening harm to themselves.
- Person reported that while they were in TWA (Te Whare Ahuru – inpatient ward) they were refused permission to call a lawyer.
- There are no services funded especially for the elderly: this makes it hard for them to get to Oasis; maybe there is a need for an elderly peer support group?

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

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

3. Crisis services
Oasis

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

4. Housing
Oasis

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

5. Civil defence
Oasis

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

6. Service user fund

Oasis

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

Linkage

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

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

PATHS Wellington

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

2. Best Practice according to people in your region

Oasis Network

- A question was asked: When you first make contact with Ambulance, Police or CATT do they routinely ask if you affected by drugs, alcohol or gambling? The group agreed that they did.
- A nurse from Ward 27 (Wellington Hospital) told a person that the first thing she asks for when a new person is admitted is whether or not they have an Advance Directive.
- Warmline is excellent and Samaritans are a good support. A suggestion was made for a list of all available support services.
- Oasis is a great community support. People are not sure why there is no money for food at Oasis because the DHB always has plenty of money for food at their events and meetings.

Vincents Art Workshop

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

Linkage

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

3. New Initiatives /Developments in your region

Oasis

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

CATT

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

Homeless Women's Shelter

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

Mosaic

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

Collaborating with DPA

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

4. Addictions

Oasis

- There is no Peer addiction support or recovery group in the Hutt.
- AOD services in Hutt include: Welltrust, Care NZ

- Problem is knowing what exists, how to access it and being able to afford it (e.g. transport)
- Alcohol is a depressant and the use of illegal drugs is not helpful but the group would like more wellness information and information about harm reduction.
- Also education regarding the interaction between medications and street drugs.
- Before people can get into rehab they have to have been abstinent for 2 weeks. It was stated that if you could be abstinent for two weeks on your own then why would you need rehab? This requirement also makes it impossible for many people to access rehab that otherwise would.
- Detox is mainly done in people's homes or in police cells. Home detox is okay but hospital would be the best.
- The Smoke free work is creating stigma and discrimination for smokers. Mental health services "should not back smoke free. They should back wellness and some people need to smoke to be well."

5. Whanau/family services

DHB Family and Whanau Advisors: Co-Chair Leigh Murray

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

☐ Family Whānau Advisors are looking forward to their annual national meeting Nov 3-4 in Christchurch. This is a great opportunity to feed into & be updated about key projects as well as share best practice ideas 'kanohi te kanohi'. There is a full agenda with all 4 workforce centres, MH Foundation, MoH & HDC Mental Health Commissioner taking up slots. Unfortunately some of our key family advisors won't be there due to travel restrictions currently in place for some DHBs. We are hoping to link them in via video conference.

☐ DFWA recognises there is probably not a widespread understanding/appreciation of the systemic advocacy family whanau advisor role across NZ. This may be a contributing factor to family advisor vacancies that are of several years duration in a few DHBs. We appreciate that this might also be the case for some consumer advisor positions. Currently there are 22 family advisors in post which equates to 17.87 FTEs nationally.

☐ we also note that the importance of family, whānau perspective and participation is increasingly mentioned in MH & addictions though this does not always seem to translate into tangible ways of ensuring that the whanau voice is present or included.

☐ To end on a positive note DHB Family Whānau Advisors contributed significantly to the successful TheMHS pre-conference family & whānau forum held in Auckland on August 23rd with 65 attendees. At the start of the day we demonstrated our commitment to the theme of 'Building Authentic Relationships' with our own whānau by presenting the consumer forum delegates with the gift of a peace lily, a fun fruit face & chocolate with good wishes for an inspirational, fun and learning day.

Atareira Family Whanau Services Wellington

- Atareira provides a multidisciplinary team: whanau/family workers; counselling
- Atareira has a COPMIA worker and support group.
- Atareira was formerly SF in this region.

6. Maori services

Te Paepae Arahi

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

Representative Name: **Guy Baker**
Region: **Midland**
Meeting Date: **8-9 September 2016**

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

TAIRAWHITI – Guy Baker

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

- Still a lot of discrimination being experienced by those under the Mental Health Act. Gisborne District Council Councillors reported in the Gisborne Herald their desire to rid beggars, whom they termed as mental health sufferers, from the streets of Gisborne. This was followed by a covert survey

by Heart of Gisborne (Business Collective) asking retailers if "beggars" were sitting outside their premises or if they were aware that "beggars" were outside other premises, if they supported this and if so why? Some Councillors were of the opinion that they should be prosecuted through the courts.

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

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

TARANAKI UPDATE- Nic Magrath

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

EASTERN BAY OF PLENTY – Arana Pearson

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

LAKES – Susan Freeman

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

2. Best Practice according people in your region.

TAIRAWHITI – Guy Baker

- Feedback Informed Treatment data is providing valuable indicators however progress is developing in this area with the knowledge that wider use and increased data will only enhance current services

- Consumer Engagement Strategy has been completed and wider consultation workshops are to be held this month.
- Peer debriefs for those currently being placed in seclusion continue to support initiatives for ending seclusion.
- Consumer Advisory Group (CAG) continues to be very active despite the wintery months. This monthly meeting of consumers has had a number of different guest speakers including Psychiatric Ward Manager, Health & Disability, Budget Advice and even a previous Consumer who related benefits they have had after successfully completing a smoke cessation programmes following 14 months of continuing to be smoke free etc.
- A submission to the Minister of Justice, Amy Adams, is currently being prepared to advocate for marae based mental health hearings.

TARANAKI – Nic Magrath

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

EASTERN BAY OF PLENTY – Arana Pearson

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

LAKES – Susan Freeman

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

3. New initiatives / developments in your region.

TAIRAWHITI – Guy Baker

- A collaborative Post Vention Suicide Group has been formed bringing together an array of services (Police, Victims Support, Hauora Tairawhiti Mental Health & AOD, NGO Mental Health & AOD providers etc.)
- Developments occurring as Hauora Tairawhiti works towards "ending seclusion". Funding has recently been granted to refurbish a current seclusion room into a low sensitive environment. Training for staff is also being planned.
- Revelations of occurring themes continuing to be identified in SAC1 incidents have prompted further investigations into the effectiveness of initiatives to address the gaps and the recommendations and whether these have actually been fully incorporated.

- Dr. Di Rangihuna (ICAMHS Psychiatrist) and her Whanau Ora Pakeke husband Mark Kopua continue to develop their Mahi-a-Atua programme, that delivers a holistic approach to instill “purakau” (Maori Atua stories) to enhance a consumers well-being, by training of mataora (practitioners) to facilitate workshops on this practice.

TARANAKI – Nic Magrath

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

EASTERN BAY OF PLENTY – Arana Pearson

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

LAKES – Susan Freeman

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

4. Addiction

TAIRAWHITI – Guy Baker

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

TARANAKI – Nic Magrath

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

5. Family and Whānau

TAIRAWHITI – Guy Baker

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

LAKES – Susan Freeman

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

Members: **Julie Witla and Grant Cooper**
Region: **Southern**
Meeting: **7/8 September 2016**

1. Issues/challenges identified by people in your region

From Grant Cooper – manager – Otago Mental Health Support Trust

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

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

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

- We continue to need a peer support worker based in Oamaru/Waitaki

From Sharon Gutsell – Consumer Advisor – PACT Southland

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

No training opportunities in Peer Support.

Housing for people with mental health issues

At the moment there is no single person accommodation available in Christchurch. There are a number of people in the acute wards who could leave if there was a place to go.

Purapura Whetu is now partnering with Comcare for family housing.

Acute Wards

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

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

2. Best Practice according to people in your region

From Sharon Gutsell – Consumer Advisor PACT Southland

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

Acute Wards in Christchurch:

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

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

From Grant Cooper – manager – Otago Mental Health Support Trust

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

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

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

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

From Sharon Gutsell – Consumer Advisor PACT Southland:

- Consumer Advisor has been appointed for Pact Southland, whose responsibilities include individual and systemic advocacy, and peer support.

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

Seclusion – Julie Witla Christchurch

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

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

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

Individualised Funding TRENDS
Discussion about viability of increasing number of IFA requests (from a cost perspective), which must be balanced with right of individuals to live in the community (in so far as possible).
Agreed that Planning and Funding team will draft a discussion/analysis paper covering the issues, options etc and circulate for further consideration.

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

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

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

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

3. New Initiatives /Developments in your region

Psychosocial Committee

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

The committee meets monthly and meetings continue to be well attended

The committee are responsible for the shared programme of action (**SPOA**)
SPOA is comprised approx. 90 services working together to achieve the shared goal of recovery in Canterbury.

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

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

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

A recent evaluation of All Right? found that:

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

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

PRIMARY HEALTH

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

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

Primary Mental Health Discussion Paper

Background

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

Current Primary Mental Health Service

Role	Brief Description	Resource
Brief Intervention Counselling/Co-ordination (BIC)	BIC offer up to 5 counselling sessions for people with mild to moderate mental health and AOD issues referred from their General Practice. In addition to the 3 main PHO providers St John of God Waipuna have 1.75 FTE specifically for youth BIC in Primary Mental Health	**23.16 FTE**
General Practice Liaison	GPL are to provide clinical interventions and supports for those with enduring mental illness but no longer require specialist services or those who have a more serious episode of mental illness but it is deemed appropriate to manage their needs within Primary Care	**5.2 FTE**
Intensive General Practice Liaison (IGPL) *Being recruited at the time of writing this paper*	While these new roles will increase the capacity in PMH of the standard GPL role, it is expected that this role will include a range of different interventions such as group work, family work, support for those post a suicide and strengthen the integration with Specialist services	**8 FTE**
Senior Clinical	Provides clinical supervision to staff and clinical expertise required to deliver services that meet best practise requirements	**2 FTE**
Extended Consultations	Allows for double the time for the General Practitioner to spend with an individual who is presenting with a mental health /AOD issue	**5919 sessions per**

		annum

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

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

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

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

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

Service Performance
Data is taken from the quarterly reporting from the 3 PHOs.
Total referrals for BIC combined for 3 PMH services are on average between 750 and 900 referrals per month.
BIC services worked with 1,000 12-19 year olds in 2014/15 and 7,505 adults aged between 20 and 64 years.
This reduced in 2015/16 to 444 12 – 19 year olds in 2015/16 and 5,509 adults aged between 20 and 64 years.
There is no information provided for the 2,000 per annum plus referrals not seen in BIC services.

Average number of BIC sessions per individual is 3 sessions. This is unchanged despite reports from PMH teams that this has increased with the number of people needing interventions for their complex needs.
There is no discharge information as providers refer back to the General Practice and there is inconsistent reporting on the numbers referred onto Specialist Mental Health.

While no clear conclusions can be drawn, the data in Table 1 and 2 has been obtained by cross checking SMHS and Primary Care reporting for 2015/16.
Table 1:
2015/16
Count of SMHS NHI also seen by Primary Mental Health Teams

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

Table 2:
% of SMHS NHI also seen by Primary Mental Health Teams

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

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

Extended Consults

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

Where some of the opportunities might lie?

- PMH services provide services to those who have mild to moderate mental health conditions. While these people make up the majority of people seen, in reality PMH services work with people who are experiencing psychosocial distress through to those with severe and enduring mental illness. Are we seeing the right people? Are services configured in a way that meets peoples' needs. Are there barriers for people getting the services they need in a primary care setting?
- New ways of working adopted in the NGO sector and SMHS, such as the youth collaborative provided by 3 NGO's for those with mild to moderate mental health conditions and centralised referral points, needs to be considered for their applicability to PMH.

- Could the Service model be adapted so that there was direct flow of information from PMH to NGO and SMHS e.g. does the referral pathway and discharge processes lead to an integrated system. How could IT systems support this?
- Over the last 5 years an increasing number of Mental Health NGO services have accepted referrals from General Practice. The majority of these services are non-clinical and they rely on the General Practice for their clinical support when working with a consumer referred from General Practice. How could PMH increase their involvement with mutual consumers in the NGO sector.
- How can PMH, work together to provide packages of care, group work, etc. in collaboration with and for other parts of the system.
- The additional 8 IGPL FTE from MOH, BIC 3 FTE from Red Cross and MSD and Community Connector are all time limited agreements from between 12 -36 months. Without this resource services across the mental health sector are at capacity. Looking to 3 years ahead, are we making the best use of the resources we have?
- Are there opportunities to move work to other parts of the health and social service system e.g. telephone consults, e-therapies, MSD services. Who decides?
- There is variation across the 3 PMH services, what needs to happen to provide equitable services? Why aren't more Maori accessing BIC services?
- PMH undertake Alcohol Brief Intervention Counselling, are we doing enough in Primary Care for people with alcohol and other drug issues

Consumer Thoughts
Will the Intensive GPS be free?
Will there be adequate choice of Intensive GPS?
Seeing people in their homes is a great idea.

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

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

Satisfaction with Crisis Resolution: Consumer, family and referrer perspectives
Project Information Sheet

Satisfaction with Crisis Resolution: Consumer, family and referrer perspectives

Name and address of service/department/organisation

Name: Clinical Research Unit, Specialist Mental Health Service, Canterbury District Health Board
Address: Terrace House, 4 Oxford Terrace, Christchurch 8011

Contact person

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

Please tick the category you think best fits your project

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

(Please note Assessors make the final decision)

Full list of project investigators

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

ABSTRACT

Overview

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

Aim

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

Goals and objectives
Specifically, the study sought to do the following:

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

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

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

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

INTRODUCTION AND BACKGROUND

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

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

PLANNING

Aims

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

Specifically, the study sought to do the following:

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

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

Links to planning principles and service priorities

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

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

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

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

Team process

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

Collaboration

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

Sensitive issues identified in the planning phase

Privacy issues

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

Vulnerability

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

Avoiding unwanted communication following loss

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

Consultations

Conducting structured interviews

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

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

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

Training

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

Ethical approval

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

IMPLEMENTATION (METHOD)

Participants

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

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

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

Exclusion criteria
Consumers needed to not meet any of the following criteria:

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

Family

'Family' was broadly defined to include any people who had been involved in the consumer's recent care with Crisis Resolution in a non-professional capacity (e.g., partner, friend, Pastor, neighbour who facilitated the consumer's involvement with Crisis Resolution, or supported them while they were under the care of Crisis Resolution).

Referrer

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

Measures

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

RESULTS

Who participated?

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

What did participants say?

Forced choice questions [1]

Would you recommend the Crisis Resolution Service to family and friends if they needed similar care or treatment?
Consumer = 92% satisfied, Family = 86% satisfied, Referrer = 93% satisfied.

How would you rate the care you received from the Crisis Resolution Service?
Consumer = 96% satisfied, Family = 91% satisfied, Referrer = 91% satisfied.

How easy was it for you to access the Crisis Resolution Service (e.g., find out how to contact them, get someone on the phone and make an appointment)?
Consumer = 86% satisfied, Family = 88% satisfied, Referrer = 91% satisfied.

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

Were you given a choice about where you were seen (at least some of the time)?
Consumer = 65% satisfied, Family = 57% satisfied

Were you asked if you wanted family involved in your care? (e.g., maybe to attend appointments with you, or for staff to talk to them)?
Consumer = 84% satisfied, Family = 79% satisfied.

How straightforward was it for you to meet with staff, tell your story and develop a plan?
Consumer = 86% satisfied, Family = 83% satisfied.

Were your needs met by the Crisis Resolution Service (either by them, or did they suggest somebody else who could help)?
Consumer = 81% satisfied, Family = 81% satisfied.

How respected did you feel by staff at the Crisis Resolution Service?
Consumer = 93% satisfied, Family = 91% satisfied.

How would you rate the communication that you received from the Crisis Resolution Service about XX?

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

Referrer = 81% satisfied.

Who was more likely to feel dissatisfied?

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

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

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

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

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

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

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

EMBED, SUSTAIN & FUTURE DIRECTIONS

The findings have been presented in person and in writing to both the front line Crisis Resolution staff and to clinical leadership teams on several occasions. Open discussions have occurred with these groups about what can be learned from the results, and what the implications may be for service

delivery. The present research is also informing a working party looking at improving Crisis Resolution services. A complimentary piece of work has been conducted by Dr Charlie Whan (SMHS) on **staff** perspectives, and is also contributing to the working party. By taking all perspectives into account, meaningful improvement will occur within Crisis Resolution services and changes will be more likely to be consistently implemented and maintained.

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

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

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

I understand that…

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

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

CONCLUSIONS

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

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Minutes attached to Southern Regional Report

Minutes of the Awareness: Monthly Meeting
Monday the 8th August 2016, 12.30pm-2.00pm
SPEAKER Debbie Selwood: SERVICE MANAGER

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

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

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

Mental Health Awareness Week: *Naturally Happy*

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

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

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

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

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

Another example Trans people have experienced is a practitioner needing to lie for them to get access to trans health care such as Hormone Replacement therapy.

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

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

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

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

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

5/ There have been disparities in what members of the network have been offered in terms of support following a contact with Crisis Resolution, for example, one member was contacted every day for a week following being in touch with CR where staff checked how they were doing. Another member was told the only options would be a medication change or inpatient stay and if they didn't want an inpatient stay then their GP could just as easily oversee medication change so further SMHS or CR support would not be needed. Why does this discrepancy occur? Should consumers be given the full range of options for support and be able to choose what feels best for them?

These issues can be taken to Joan Taylor as she is developing clinical pathways right now. It may help people to know that they are short of Doctors right now and there has been a lot of staff change. Thankfully the request for services has levelled off and isn't still increasing. It has stabilised at a very high level though.

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

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

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

Toni's (Gutschlag) Items

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

Sent by: Emma Tonks/MOH

17/10/2016 11:43 a.m.

To: Victoria Roberts [redacted]
cc:
bcc:

Subject: Re: Fwd: Nga Hau e Wha

Hi Victoria

The move hasn't happened yet but is looming on the horizon. I have been away from work for a couple of weeks so apologies for not getting back to you sooner.

I had a catch up with Derek Thompson (my team leader) and we discussed the letter and appropriate response.

Media - In general if Nga Hau e Wha can report facts and refrain from opinion when dealing with the media that would be the safest option. There is a clause in the contract which I have included below which refers. I can understand your dilemma when these requests come in, the Ministry does not want to stop you from being the advocate that consumers can rely on as that is what we value and the initiatives that you support is a decision for you to make.

A16 PUBLIC STATEMENTS AND ADVERTISING
A16.1 Neither of us may during or after this agreement either directly or indirectly criticise the other publicly, without first fully discussing the matters of concern with the other in good faith and in a co-operative and constructive manner. Nothing in this clause prevents either of us from discussing any matters of concern with our respective staff, subcontractors, agents or advisers.

DPO Status - The decision to become a full member of the Convention Coalition is one that Nga Hau e Wha should take. The contract with the Ministry does not stop you from securing funding from other sources (provided they are legal and the organisations are reputable and are supportive of health and wellbeing) the Ministry are happy for NHEW to do so.

I hope this helps you form your decisions

Kind regards

Emma Tonks
Senior Contracts Manager
Mental Health and Addiction Services
Mental Health Service Improvement
Service Commissioning
Ministry of Health
DDI: 04 816 4460

http://www.moh.govt.nz/
mailto:Emma_Tonks@moh.govt.nz

Victoria Roberts Kia ora Emma I am wondering if the... 12/10/2016 03:34:15 p.m.

From: Victoria Roberts <[redacted]
To: emma_tonks <emma_tonks@moh.govt.nz>,
Date: 12/10/2016 03:34 p.m.
Subject: Fwd: Nga Hau e Wha

Kia ora Emma

I am wondering if the big move has taken place yet as I write? If so I hope you are not too discombobulated!!

Have you had a chance yet to read the letter and 2 other attachments (see below)?

If we are able to get the Strategic Planning organised (waiting for some input from you) we would like to invite you to the next meeting - maybe early on the 4th November so you can meet the person we aare contracting to run the day and also have your input as well.

Look forward to hearing from you

Nga mihi

Victoria

From: **Victoria Roberts** <[redacted]
Date: 22 September 2016 at 17:43
Subject: Nga Hau e Wha
To: emma_tonks <emma_tonks@moh.govt.nz>

Kia ora Emma

Thank you so much for coming along to our last meeting. It was really great to have you there.

Are you able to pencil us in for sometime on the 3/4 of November. I am thinking that if you are able you might be able to join us for some part of the Strategic Planning day we are organizing for Friday 4th November? As you will **see from the attached letter** we have some planning and decisions to make before then.

I have attached to this message a letter (as promised!!) and also 2 other attachments that are relevant to the questions in the letter.

Hope that's not too convoluted.

Nga mihi

Victoria

Victoria Roberts I Chair I Nga Hau e Wha

www.nhew.org.nz I [redacted]

The national voice of people with lived experience of mental distress and addictions

[attachment "DPO Attributes - as at 13 May 2014.doc" deleted by Emma Tonks/MOH] [attachment "DPO Self Assessment Form.doc" deleted by Emma Tonks/MOH] [attachment "Emma Tonks September 2016.doc" deleted by Emma Tonks/MOH]

Sent by: s 9(2)(a)

31/10/2016 11:53 p.m.

To: emma_tonks <emma_tonks@moh.govt.nz>,
cc:
bcc:

Subject: Nga Hau e Wha

Kia ora Emma

I hope this finds you not too frazzled after the big shift.

I was only able to sort the final agenda for this weeks meeting on Friday and I apologise for not sending you an invitation to the meeting earlier today. I will attach the agenda as well as the outline for the Strategic Planning we have organised. We have Suzy Stevens to guide us. She was the constructor of the first StratPlan.

If you see a time on the thursday that interests you and you would like to attend at any time during the day you would be made very welcome. And /or can we invite you at 9am on Friday the 4th?

Look forward to seeing you sometime during the meeting.

Nga mihi nui

Victoria

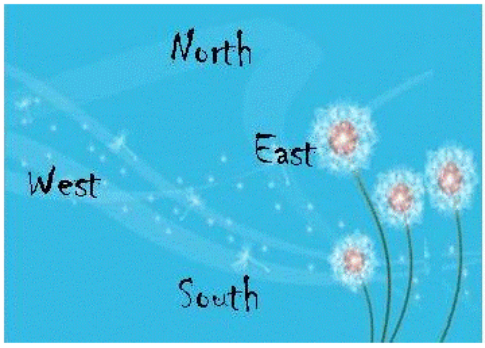
Victoria Roberts I Chair I Nga Hau e Wha

www.nhew.org.nz I s 9(2)(a)

The national voice of people with lived experience of mental distress and addictions

Agenda November 2016 (2).doc Suzy Stevens Information for NHEW October 2016.docx

Nga Hau E Wha Strategic Planning Day Outline November 2016 Final.docx



Nga Hau E Wha

"Champion many voices"

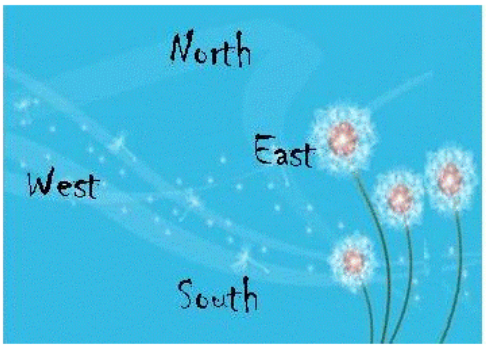
Date: Thursday 3rd November 2016

Venue: GC.3 in GS.2 / VC- Display-Public / Ministry of Health / 133 Molesworth St / Wellington,

Time: 8.30.00am

Kaupapa / Agenda

Time	Description	Responsibility	Document
8.30am	▪ Tea and coffee		
9.00am	▪ Mihi whakatau	*Guy*	
10.00am	▪ Dr. John Crawshaw	*Victoria*	
11.00 am	▪ Morning tea		
11.15 am	▪ Strategic Planning	**Suzy Stevens**	
12.45	**LUNCH**		
1.15pm	▪ Strategic Planning	**Suzy Stevens**	
3.00pm	**A F T E R N O O N T E A**		
3.15pm	▪ Strategic Planning	**Suzy Stevens**	
	▪ Strategic Planning	**Suzy Stevens**	
4.30pm	▪ **Meeting Closed**		



Nga Hau E Wha

"Champion many voices"

Date: Friday 4th November, 2016

Venue: GC.3- in GS.2 / VC- Display-Public / Ministry of Health / 133 Molesworth St / Wellington,

Time: 8.00am

Kaupapa / Agenda

Time	Description	Responsibility	Document
8.00am	Coffee and tea		
8.30am	▪ Mihi whakatau	*Guy*	
9.00am	▪ **To dos in the future - who and how** ▪ Strategic Plan ▪ Process for contracting ▪ Meeting attendance – do we need extra time ▪ MOH report due in December	*Victoria*	
11.00am	Morning Tea		
	▪ Regional Reports	*Victoria*	
1.00pm	**LUNCH**		
1.30pm	▪		
2.30pm	▪ People start to leave.		
3.00pm			
3.15pm	▪		
4.15pm	▪		
4.30pm	▪ **Meeting Closed**		

No.	ACTION POINTS From 3 / 4 September 2016	Who
1	Guy is to follow up with a possible NHEW representative in Midlands	Guy
2	A map showing the different NHEW regions will be put on the NHEW website.	Jak
3		
4		
5		
6		
7		
8		
9		
10		

Tena kotou katoa

I live on the Kāpiti Coast with my partner. We have been here over 8 years now and really love being near the sea and the beach. I have 3 grown up children, 3 grandsons and one granddaughter.

s 9(2)(a)

I have been involved in the national consumer movement in different roles over the years and I am a passionate advocate for the removal of compulsory treatment and detention.

I have worked in the social services and not-for-profit sectors for many years where I have learned considerable skills and experiences which together with my personal life experiences, form the foundation and motivation for the work I do.

My partner and I have a small business called Partnership Works and currently I have a contract with Kites in Wellington to work on action research peer advocacy.

My other work experiences include:

- systemic and individual peer advocacy
- project development management, evaluation, report and resource writing
- strategic and business planning, contracting, budget and staff management policy advice and implementation
- peer supervision
- training, monitoring and auditing
- community development.

I am truly looking forward to working with members of Nga Hau E Wha to bring all the ideas and plans there are into a strategic plan to move forward with.

Nga mihi

Suzy Stevens

Nga Hau E Wha

"Championing Many Voices"

Strategic Planning Day Outline

11.15 am Opening Karakia

Introductions and overview of the session.

Any questions/comments before we start?

11.30am Where is NHEW at currently?

Brainstorm: Where do people think NHEW is at today?

Where we want NHEW to be by 2020+

In Pairs: Discuss becoming a Disabled Persons Organisation.

Feedback: What needs to be included in the Strategic Plan about becoming a DPO?

Exercise: Move into groups of 2 or 3 - Discuss:

- What will be different in 2020?
- What will NHEW be doing?
- What structure/membership will it have?
- What is needed to move from now until then?

Feedback together: Aim to form a consensus.

12.45 LUNCH

1.15pm From the old to the new.

In pairs: Read over the **new** Terms of Reference and Service Specs.

Feedback: Is there anything from them to include or allow for in the new Strategic Plan?

Read: The current NHEW Strategic Plan 2013 – 2015. Decide what to change, keep, add or delete in relation to: **Vision; Our Strategic Goal; Guiding Principles; Purpose**.

Review: Key Result Areas; Critical Issues. Decide what to change, keep, add or delete in relation to:

3.00pm AFTERNOON TEA

3.15pm Actions

Go over decisions/work so far. Be clear about what has been agreed to.

Explain the process from here.

4.30pm WRAP UP

Explain the process from here. Any final questions?

Comments on the day (poroporoaki). Closing karakia.