Community and Public Health Advisory Committee and Disability Support Advisory Committee Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	29 April 2021	**Time:**	9am

Commissioners:	Emeritus Professor M Wilson, Deputy Commissioner (Chair) Ms T P Thompson-Evans (Deputy Chair) Dame K Poutasi, Commissioner Mr C Paraone, Deputy Commissioner Mr A Connolly, Clinical Advisor to the Commissioner Ms R Karalus Dr P Malpass Mr J McIntosh Mr F Mhlanga Ms G Pomeroy Ms J Small Mr D Slone Mr G Tupuhi
In Attendance:	Mr K Whelan, Crown Monitor Dr K Snee, Chief Executive Other Executives as necessary

Next Meeting Date:	24 June 2021	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680
	www.waikatodhb.health.nz	

Our Vision: **Healthy People. Excellent Care**

Our Values:

People at heart – **Te iwi Ngakaunui**
Give and earn respect – **Whakamana**
Listen to me talk to me – **Whakarongo**
Fair play – **Mauri Pai**
Growing the good – **Whakapakari**
Stronger together – **Kotahitanga**

Item

2. APOLOGIES

3. INTERESTS
3.1 Schedule of Interests
3.2 Conflicts Related to Items on the Agenda

4. MINUTES AND MATTERS ARISING
4.1 Minutes 24 February 2021
4.2 Matters Arising from the Minutes

5. COMMITTEE MEMBERS UPDATES
5.1 The Chair will invite members to provide updates as they relate to Waikato DHB
5.2 Discussion led by the Waikato DHB Commissioner – Transformation of the Health and Disability System

6. PRESENTATIONS TO BE PROVIDED AT THE MEETING
6.1 COVID-19 Vaccination Update (to be provided at the meeting)

7. INFORMATION
7.1 Whānau Hauā Disabled Peoples Health and Wellbeing Profile 2021
7.2 Disability Profile and Response Plan
7.3 Mental Health System Review
7.4 Community Health Forum Feedback

8. GENERAL BUSINESS

NEXT MEETING: 24 June 2021

Apologies

Schedule of Interests

SCHEDULE OF INTERESTS FOR COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETINGS TO APRIL 2021

Dame Karen Poutasi

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Commissioner, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Network for Learning	Non-Pecuniary	None	
Daughter, Consultant Hardy Group	Non-Pecuniary	None	
Son, Health Manager, Worksafe	Non-Pecuniary	None	
Co-Chair, Kāpiti Community Health Network Establishment Governance Group	Non-Pecuniary	None	
Chair, Wellington Uni-Professional Board	Non-Pecuniary	None	
Chair, COVID-19 Vaccine and Immunisation Governance Group	Non-Pecuniary	None	
Chair, Taumata Arowai	Non-Pecuniary	None	

Mr Andrew Connolly

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Clinical Advisor to the Commissioner, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Acting Chief Medical Officer, Ministry of Health (secondment to 31 December 2021, part-time)	Non-Pecuniary	None	
Board member, Health Quality and Safety Commission (position non-active whilst Acting Chief Medical Officer, Ministry of Health)	Non-Pecuniary	None	
Employee, Counties Manukau DHB	Non-Pecuniary	None	
Clinical Advisor to Chair, Southern DHB	Non-Pecuniary	None	
Member, MoH Planned Care Advisory Group	Non-Pecuniary	None	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Note 3: Roles within the Waikato DHB are recorded but are by definition not conflicts and for practical purposes, non-pecuniary.

Mr Chad Paraone

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Deputy Commissioner, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Independent Chair, Bay of Plenty Alliance Leadership Team	Non-Pecuniary	None	
Independent Chair, Integrated Community Pharmacy Services Agreement National Review (stepped down from role from December 2020 to March 2021)	Non-Pecuniary	None	
Strategic Advisor (Maori) to CEO, Accident Compensation Corporation	Non-Pecuniary	None	
Maori Health Director, Precision Driven Health (stepped down from role from October 2020 to March 2021)	Non-Pecuniary	None	
Committee of Management Member and Chair, Parengarenga A Incorporation	Non-Pecuniary	None	
Director/Shareholder, Finora Management Services Ltd	Non-Pecuniary	None	
Member, Transition Unit (Health & Disability System Reform), Department of Prime Minster and Cabinet)	Non-Pecuniary	None	

Emeritus Professor Margaret Wilson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Deputy Commissioner, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Waikato Health Trust	Non-Pecuniary	None	
Co-Chair, Waikato Plan Leadership Group	Non-Pecuniary	None	

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Ms Te Pora Thompson-Evans

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Attendee, Commissioner meetings, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Iwi Maaori Council, Waikato DHB	Non-Pecuniary	None	
Member, Te Manawa Taki Governance Group	Non-Pecuniary	None	
Iwi Maaori Council Representative for Waikato-Tainui, Waikato DHB	Non-Pecuniary	None	
Iwi: Ngāti Hauā	Non-Pecuniary	None	
Maangai Maaori:			
○ **Community Committee**	Non-Pecuniary	None	
○ **Economic Development Committee**	Non-Pecuniary	None	
Director/Shareholder, Haua Innovation Group Holdings Limited	Non-Pecuniary	None	
Director, Whai Manawa Limited	Non-Pecuniary	None	
Director/Shareholder, 7 Eight 12 Limited	Non-Pecuniary	None	

Dr Paul Malpass

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Consumer Council, Waikato DHB	Non-Pecuniary	None	
Fellow, Australasian College of Surgeons	Non-Pecuniary	None	
Fellow, New Zealand College of Public Health Medicine	Non-Pecuniary	None	
Daughter registered nurse employed by Taupo Medical Centre	Non-Pecuniary	None	
Daughter employed by Access Community Health	Non-Pecuniary	None	
Eldest son employed by Presbyterian Support, Northern	Non-Pecuniary	None	

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Mr John McIntosh

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Community Liaison, LIFE Unlimited Charitable Trust (a national health and disability provider; contracts to Ministry of Health; currently no Waikato DHB contracts)	Non-Pecuniary	None	
Coordinator, SPAN Trust (a mechanism for distribution to specialised funding from Ministry of Health in Waikato_	Non-Pecuniary	None	
Trustee, Waikato Health and Disability Expo Trust	Non-Pecuniary	None	

Ms Rachel Karalus

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Aere Tai Pacific Midland Collective	Non-Pecuniary	None	
Member, Waikato Plan Regional Housing Initiative	Non-Pecuniary	None	
Chief Executive Officer, K'aute Pasifika Trust	Non-Pecuniary	None	

Ms Gerri Pomeroy

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Co-Chair, Consumer Council, Waikato DHB	Non-Pecuniary	None	
Trustee, My Life My Voice	Non-Pecuniary	None	
Waikato Branch President, National Executive Committee Member and National President, Disabled Person's Assembly	Non-Pecuniary	None	
Member, Enabling Good Lives Waikato Leadership Group, Ministry of Social Development	Non-Pecuniary	None	
Member, Machinery of Government Review Working Group, Ministry of Social Development	Non-Pecuniary	None	
Co-Chair, Disability Support Service System Transformation Governance Group, Ministry of Health	Non-Pecuniary	None	
Member, Enabling Good Lives National Leadership Group, Ministry of Health	Non-Pecuniary	None	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

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[a]Mr Fungai Mhlanga

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Department of Internal Affairs (DIA) - Office of Ethnic Communities	Non-Pecuniary	None	
Trustee, Indigo Festival Trust	Non-Pecuniary	None	
Member, Waikato Sunrise rotary Club	Non-Pecuniary	None	
Trustee, Grandview Community Garden	Non-Pecuniary	None	
Volunteer, Waikato Disaster Welfare Support Team(DWST) - NZ Red Cross	Non-Pecuniary	None	
Volunteer, Ethnic Football Festival	Non-Pecuniary	None	

Mr David Slone

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Director and Shareholder, The Optimistic Cynic Ltd	Non-Pecuniary	None	
Trustee, NZ Williams Syndrome Association	Non-Pecuniary	None	
Trustee, Impact Hub Waikato Trust	Non-Pecuniary	None	
Employee, CSC Buying Group Ltd	Non-Pecuniary	None	
Advisor, Christian Supply Chain Charitable Trust	Non-Pecuniary	None	

Ms Judy Small

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Consumer Council, Waikato DHB	Non-Pecuniary	None	
Director, Royal NZ Foundation for the Blind	Non-Pecuniary	None	

[a] *The following statement has been requested for inclusion - All the comments and contributions I make in the Committee meetings are purely done in my personal capacity as a member of the migrant and refugee community in Waikato. They are not in any way representative of the views or position of my current employer (Office of Ethnic communities/Department of Internal Affairs).*

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

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Mr Glen Tupuhi

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Board member, Hauraki PHO	Non-Pecuniary	None	
Board member , Te Korowai Hauora o Hauraki	Non-Pecuniary	None	
Chair Nga Muka Development Trust, a representation of Waikato Tainui North Waikato marae cluster	Non-Pecuniary	None	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

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Conflicts Related to Items on the Agenda

Previous Minutes

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Community and Public Health Advisory Committee (Including the Disability Support Advisory Committee Meeting) held on 24 February 2021 commencing at 9am

Present:
Professor M Wilson (Chair)
Mr A Connolly
Dame K Poutasi
Mr D Slone
Mr F Mhlanga
Mr C Paraone
Ms R Karalus
Dr P Malpass
Ms G Pomeroy
Ms T Thompson-Evans
Mr G Tupuhi (from 9.54am)

In Attendance:
Dr K Snee, Chief Executive
Mr N Hablous, Company Secretary
Mr G Hopgood, Chief Medical Officer
Ms C Tahu, Chief Advisor Allied Health
Ms S Hayward, Chief Nursing & Midwifery Officer
Mr R Nia Nia – Executive Director – Māori, Equity & Health Improvement
Ms C Lowry, Executive Director – Hospitals & Community Services
Mr B Clayton-Smith, Director – Public Health
Mr R Webb, Acting General Manager – Strategy & Funding
Mr M ter Beek, Acting Executive Director – Strategy, Investment & Transformation
Ms M Munro, Programme Lead – Vaccination Rollout
Mr N Wilson, Director Communications

Apologies:
Mr J McIntosh
Ms J Small
Mr G Tupuhi for lateness

ITEM 2: APOLOGIES

Resolved

THAT the apologies from Mr J McIntosh, Ms J Small and Mr G Tupuhi are accepted.

ITEM 3: INTERESTS

3.1 Register of Interests

Amendments to the register were provided by Mr A Connolly and the register will be updated.

Mr P Malpass advised that his son works for Northern Presbyterian Support and he will provide details for the register.

3.2 Conflicts relating to items on the Agenda
No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

4.1 Waikato DHB Community and Public Health and Advisory Committee: 18 November 2020

Resolved
THAT
The minutes of the Waikato DHB Community and Public Health Advisory Committee held on 18 November 2020 are confirmed as a true and correct record.

Moved: Mr C Paraone
Seconded: Dr P Malpass

4.2 Matters Arising
Nil

ITEM 5: MEMBERS UPDATES

Due to time constraints with the agenda items today, there was limited time available for member updates.

It was agreed that the MoH Reporting Results could be shared with the Consumer Council in order for them to understand the drivers.

ITEM 6: PRESENTATIONS

6.1 COVID Vaccination Programme
Mr ter Beek and Ms Munro presented the COVID Vaccination Programme overview and status update for Waikato DHB.

Ms Munro is taking the programme lead for the vaccination rollout.

Directions were received from MoH late last year, along with expectations, roles and timeframes. Vaccination in the Waikato is starting this Friday 26 February with the managed isolation facility at Distinction Hotel. Vaccinators have been trained and done initial vaccinations amongst themselves, as there is a different way of handling this vaccine compared to normal. Tier 3 for the general population will be rolled out from 1 July onwards, but this date could be brought forward.

Two sites in Hamilton have been identified – one at the hospital and another has been set up as the community vaccination centre. The exact address for this centre is not being advertised due to site sensitivities, but will be shared with the public when appointments are confirmed. There is security staff onsite at the centre now and throughout the rollout process.

Planning and scheduling of appointments for the vaccination is important due to the short shelf life of the vaccine. For this reason, no walk ins will be taken. However, there will be a buffer built into the schedule for tier 1 people who bring their household contacts with them.

Work is underway to provide an outreach service, where staff will go into hotels, other settings, local community halls, marae, etc. Administration is a concern at the moment, as there is a very heavy admin process involved. iPM is being used as the booking system and CIR being used to record the vaccination details. Informed consent will be required in writing and scanned into CIR.

Learnings from the flu vaccination in 2020 are being leveraged. Engagement is underway with iwi for population rollout. Equity-based data and reporting will be available.

Barriers to attending appointments for the vaccination will be queried at the time of booking appointments. Consideration is being given to how to overcome these barriers, along with how to engage rural communities and those outside Hamilton.

The flu vaccination will be available from 14 April and there need to be two weeks between any other vaccinations, eg flu, MMR, etc.

The Committee was asked for feedback on rural/disabled community equitable access, vaccine hesitancy, shifting health outcomes more broadly, and assessing other health needs during the half hour post vaccine wait.

Ms Pomeroy queried whether there was an opportunity at national level to collect disability data and link to NHI. In response to engaging with disabled people it was recommended to not only approach service providers, as there are many people that live independently and access support when needed. There are seven disabled people organisations with wide networks worthwhile contacting and national organisations for advertising what is happening in the Waikato. Buses are free in Hamilton for disabled people and their carers who cannot travel independently.

Mr Slone recommended that appointment times may need to be longer for some disabled.

Dr Malpass advised that the Consumer Council is keen to work with the DHB on co design for the rural population. Iwi cross DHB boundaries and there is thinking required around that.

It was recommended that the DHB plans with Iwi and their resources to clearly identify the target population, eg tribal register. Multiple resources are available across the community.

Ms Karalus advised that there were many lessons learned during lockdown that should be leveraged. The approach presented today did not reflect the reliance on community providers. Consideration needs to be given to non resident vaccinations, their access and costs associated for those that experience side effects. It was queried whether the vaccination was safe for pregnant women, however no clear guidance has been provided on this.

Mr G Tupuhi advised that he watched a programme where there was a panel of Māori experts discussing the vaccination. He agreed to circulate the link to the Committee.

Committee members are welcome to contact Mr ter Beek with ideas on key contacts in the wider community.

ITEM 7: INFORMATION

7.1 Quarter 1 MoH Reporting Results 2020-2021
Report noted.

Mr ter Beek agreed to raise the inclusion of disability in NHI with MoH.

Resolved
THAT
The report is received.

7.2 IMT Response – Hamilton COVID Event, Waitangi Weekend
Report noted. There have been three recent events involving the Waikato.

Mr Clayton-Smith is undertaking the incident controller role on behalf of the DHB. He advised that there has been a reliance on past knowledge and relationships, but this is not an enduring solution. There is work underway in the background to tidy up procedures as new knowledge and insights emerge.

Good response in Otorohanga and have seen increased testing rates.

Ms Thompson-Evans provided a mihi to Mr Clayton-Smith for the work around Otorohanga. It was reassuring to hear from him and the team being brought together.

Resolved
THAT
The report is received.

ITEM 8: GENERAL BUSINESS

Nil

ITEM 9: DATE OF NEXT MEETING

9.1 28 April 2021

Chairperson: Professor Margaret Wilson

Date: 24 February 2021

Meeting Closed: 10.21am

Matters Arising from Minutes

Committee Members Updates

Committee Members Updates as the relate to Waikato DHB

Discussion led by the Waikato DHB Commissioner

Transformation of the Health and Disability System

Presentations

Information

REPORT TO COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE
29 APRIL 2021

AGENDA ITEM 7.1

WHĀNAU HAUĀ DISABLED PEOPLES HEALTH AND WELLBEING PROFILE

Purpose
The purpose of this report is to present the completed Whānau Hauā Disabled Peoples Health and Wellbeing Profile.

Recommendations
It is recommended that the Committee:

1) Note the content of this report; and
2) Approve the profile in order to proceed to publish and launch in partnership with the Consumer Council.

DYFED THOMAS
MANAGER PUBLIC HEALTH ADVISORY AND DEVELOPMENT TEAM

on behalf of

RIKI NIA NIA
EXECUTIVE DIRECTOR – MĀORI EQUITY AND HEALTH IMPROVEMENT

Background

The development of this profile originated through engagement between the Consumer Council and the Public Health Unit. The profile was initially completed in December 2019 but was not published due to work on the DHB's Equity Report and the potential for this profile to form part of that report. In addition, the Disability Responsive Plan was not in place as a response to the issues highlighted in the profile.

Discussion

The profile has now been updated as considerable time had elapsed since its original creation. It is now ready to be published and launched. The profile will be published in this format, as well as accessible formats of Etext (including word, html and plain text files) and audio. The executive summary will also be available in NZSL.

Equity
Mana Whakahaere (Article 1)
Māori staff from Strategy and Funding were part of the co-design process to determine the shape and content of the profile.

Mana Motuhake (Article 2)
The profile was co-designed with a rōpū of people with lived experience of disability. Three from seven of this rōpū were Māori.

Mana Tāngata (Article 3)
Data in this profile, where available, is presented by ethnicity, including Māori, Pacific Peoples and non-Māori non-Pacific.

Mana Māori (Declaration/Article 4)
Through the development of the report our endeavour was to co-design the report with whānau with lived experience and to whakamana their kōrero.

Efficiency
The profile is a starting point and provides an overview of the health and wellbeing status of people with disabilities of all ages, using infographics and personal stories for ease of accessibility and understanding.

Quality and Risk
This profile has an extensive data content and there is no central one source for data on disabled peoples; this profile attempts to resolve that for the Waikato.

Strategy
Whānau Hauā Disabled Peoples Health and Wellbeing Profile has been co-designed as a tool for driving conversations toward equitable outcomes for disabled peoples in the Waikato. The profile aligns with Te Korowai Waiora in relation to supporting community aspirations to address the determinants of health (Goal 3) and access barriers for people with disabilities are eliminated (Action 4.3 under Goal 4).

Future Reporting
N/A

Appendices

Whānau Hauā Disabled Peoples Health and Wellbeing Profile 2021

Whānau Hauā Disabled Peoples Health and Wellbeing Profile

Waikato DHB

2021

Public Health
Waikato District Health Board

Ngā whakamihi
Acknowledgements

He tohu aroha ki a Renae Trow. Me mihi ka tika ki a ia
This profile is dedicated to the life lived and memory of Renae Trow

Public Health would like to extend thanks to all who contributed to the development of this Whānau Hauā Disabled Peoples Health and Wellbeing Profile. This profile was developed through a co-design process with members of the community. Special thanks go to Paul Burroughs, Judy Small, Hiria Anderson, Gerri Pomeroy (Waikato DHB Consumer Council Co-Chair), Isaac Rakena, Joy Ho, Louise Were (Waikato DHB Consumer Council Co-Chair) and Kate Cosgriff who were part of the co-design rōpū. We also thank Disability Support Link for their support in developing this profile. Thank you for your views and support in researching key health data, information and document design and review. The time and effort you gave to the Whānau Hauā Disabled Peoples Health and Wellbeing Profile is acknowledged and much appreciated. Similarly we thank those who gave their time and shared their story for this profile. Furthermore, we appreciate the work of Dr. Elaine Bliss in facilitating the co-design rōpū and developing the stories with our contributors.

We also acknowledge the following organisations for providing data: ACC, Disability Support Link, Enabling Good Lives, Ministry of Education, Ministry of Housing and Urban Development, Ministry of Justice, Ministry of Social Development and Hauraki PHO.

This document is fully accessible with audio and Etext versions available under the Health Profile section at www.waikatodhb.health.nz/about-us/key-publications-and-policies/**. The He Whakarāpototanga / Executive Summary is also available in NZSL.**

Ngā rārangi kōrero
Contents

He Whakarāpopototanga
Executive Summary

Whānau Hauā Disabled Peoples Health and Wellbeing Profile has been co-designed as a tool for driving conversations toward equitable outcomes for disabled peoples in the Waikato. The profile is a starting point and provides an overview of the health and wellbeing status of people with disabilities of all ages, using infographics and personal stories for ease of accessibility and understanding. Overall, Whānau Hauā Disabled Peoples Health and Wellbeing Profile aims to present health and social determinants of health holistically, where health is the driver and wellbeing is the outcome, for disabled peoples in the Waikato. Disability is something that happens when people with impairments face barriers in society; it is society that disables people, not their impairments, this is the thing all disabled people have in common.

Disabled peoples should have equity, regardless of ethnicity, gender, age or type of disability. Equity is important because a higher proportion of the Māori and Pacific disabled population are in the younger age groups compared to the European age distribution. Equity also is important because, on average, disabled people earn 41% less than non-disabled people. And, equity is important because up to a third of all unlawful discrimination complaints are on the grounds of disability.

The Profile also acknowledges inequity in accessibility to the types and quality of data available for planning and providing services for disabled peoples' health and wellbeing. For example, there is a particular lack of data on disabled peoples under the age of 65 years and no central source for such data. Key figures on the disabled peoples of the Waikato follow in the remainder of this executive summary.

Disability is not rare,
118,900
people estimated to have an impairment in the Waikato (2021).

Estimated number of people with an impairment by ethnicity (2021).
(Respondents could choose more than one ethnicity)

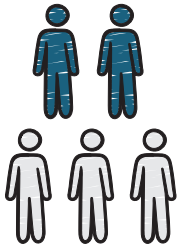
31,600 Māori

5,900 Pacific people

14,200 Asian

87,700 European/ Other

Mobility impairments
are the most common.



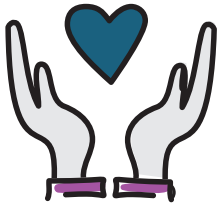
2 in 5 (42%) of disabled people are employed
compared to 4 in 5 for non-disabled people.

On average disabled people earn 41% less
than non-disabled people.

1 in 3 (33%) of disabled Māori find their house damp
compared to 1 in 7 (14%) of disabled European/Other.

Unlawful discrimination
on the grounds of disability is the highest in number along with race grounds.

17%
of disabled people with a physical impairment
have a need for modifications
to their home to improve accessibility.



11%
of the estimated population with an impairment in the Waikato
receive support from Disability Support Link.

Whakataki
Introduction

Whānau Hauā Disabled Peoples Health and Wellbeing Profile has been co-designed as a tool for driving conversations toward equitable outcomes for disabled peoples in the Waikato. The profile is a starting point and provides an overview of the health and wellbeing status of people with disabilities of all ages, using infographics and personal stories for ease of accessibility and understanding. Overall, Whānau Hauā Disabled Peoples Health and Wellbeing Profile aims to present health and social determinants of health holistically, where health is the driver and wellbeing is the outcome, for disabled peoples in the Waikato. A consultative rōpū working group that includes disabled health consumers and service users was established early in the development of the profile to ensure a closer alignment of service delivery with what will work best for service users.

The radical improvement of health and wellbeing outcomes for people living with disabilities is a key strategic intention of the Public Health Unit and the wider Waikato District Health Board. Whānau Hauā Disabled Peoples Health and Wellbeing Profile for the Waikato is a key initial step toward understanding the needs and aspirations of our region's disability communities.

"Disability is sometimes separate from health, sometimes disability is caused by health, sometimes health impacts on disability, and sometimes disability impacts on health." - Judy Small, co-design rōpū member and Waikato DHB Consumer Council member

Disability has traditionally been thought of as a personal problem for individuals to overcome. More recently, however, a social model of disability has become established, based upon principles of empowerment and reciprocity. Disability, therefore, is seen not as a medical problem, but a human rights issue. Unlike dominant medical models, a social model of disability promotes the view that disability is located within societal processes (Ellis, 2008).

Whānau Hauā Disabled Peoples Health and Wellbeing Profile demonstrates the disparities and inequities in access to health and wellbeing and their wider determinants in society for disabled peoples. It is intended for use as

a planning and engagement tool by the Public Health Unit, the Waikato District Health Board, disabled people organisations, iwi, family networks, disability service providers, and other stakeholders throughout the region.

Equity in access

Equity for disabled peoples is about removing unjust barriers. Disabled peoples should have equity, regardless of ethnicity, gender, age or type of disability. Equity is also important because a higher proportion of the Māori and Pacific disabled population are in the younger age groups compared to the European age distribution. Equity is important because, on average, disabled people earn 41% less than non-disabled people. And, equity is important because up to a third of all unlawful discrimination complaints are on the grounds of disability.

The COVID-19 pandemic has further exposed and exacerbated these existing inequities. A report by the Chief Ombudsman highlighted seven areas for urgent action including real involvement in the decision-making process in times of humanitarian emergencies as well as being involved practically on the frontline. Other areas included access to essential goods, services and spaces, access to information and communications, education, work and employment and health as well as access to justice (Independent Monitoring Mechanism, 2021).

Equity is also important because Māori and Pacific students are over-represented in learning support statistics. Barriers to inclusive education in New Zealand are evident and there is a lack of understanding of what inclusion really is (as distinct from integration or mainstreaming). The current system is financially deficient and lacks an appreciation of the benefits of a system that welcomes diversity and difference (IHC, 2019). Every day, barriers to inclusive education in New Zealand are evident – lack of understanding of what inclusion really is (as distinct from integration or mainstreaming), lack of appreciation of the benefits of a system that welcomes diversity and difference and, of course, a lack of resources.

Accessibility[1] is a key focus of Whānau Hauā Disabled Peoples Health and Wellbeing Profile and one of the eight outcome areas identified in the New Zealand Disability Strategy. Whānau Hauā Disabled Peoples Health and

[1] The United Nations Convention on the Rights of People with Disabilities states that improving accessibility options will support more disabled people to participate in the economy and in their communities thus improving their lives and reducing total reliance on government assistance (Joint submission Parliamentary Inquiry into Mobility CCS Disability Action, 2015).

Wellbeing Profile presents accessibility holistically, emphasising equity, rather than equality, in order to achieve inclusiveness for disabled peoples in their access to health and wellbeing.

Equity and access are important principles of social justice. Equity is achieved when obstacles to health are removed and everyone has a reasonable opportunity to be as healthy as possible (Braveman, Arkin, Orleans, Proctor & Plough, 2017). An equity approach to access for disabled peoples recognises that some people are more disadvantaged than others in accessing services and facilities for health and wellbeing.

"It's important to remember that disabled people's lives are very different from people without impairments, we have real expertise in the way our bodies function. It's important for health services to recognize this and work in partnership with us so we can work together to maintain our best health and well-being." - Gerri Pomeroy, co-design rōpū member and Waikato DHB Consumer Council Co-Chair

Equity is giving everyone what they need to be successful; equality is treating everyone the same. Equity in access to health and wellbeing for disabled peoples in the Waikato acknowledges that 'one size does not fit all'. Whānau Hauā Disabled Peoples Health and Wellbeing Profile advocates for this lack of equity in access to health and wellbeing by disabled peoples to be addressed.

Whānau Hauā Disabled Peoples Health and Wellbeing Profile also acknowledges inequity in accessibility to the types and quality of data available for planning and providing services for disabled people's health and wellbeing. For example, there is a particular lack of data on disabled peoples under the age of 65 years and no central source for such data. This is particularly acute at the regional level (e.g. Waikato).

"Children with disability are doubly vulnerable to income inadequacy: both as children, and as people with disability. According to the 2013 New Zealand Disability Survey, parents of children with disability are 1.5 times more likely to report not having enough income than all parents (of both disabled and non-disabled children). There are various direct and indirect costs associated with raising a disabled child, including medical and therapy bills, and difficulty engaging in paid work".

(Child Poverty Action Group Inc., 2020)

The population of the Waikato is also aging and this will increase the number of people with impairments. The over 65 age group is projected to make up nearly a quarter (24%) of Waikato's population from late 2038, compared with 16% in 2018 (Statistics New Zealand, 2018). The effects of an aging population will be particularly high on provincial and rural areas presenting a growing demand for affordable and accessible services (e.g. housing and transport) which central and local government will need to deliver upon (Bascand, 2012). The New Zealand Disability Strategy requires the government to ensure disabled people have access to safe, warm and affordable housing. The 2013 Disability Survey revealed that 107,440 people with a physical impairment in New Zealand had an unmet need for a house modification (Statistics New Zealand 2014). A lack of accessible housing, and appropriate housing modifications, are key factors holding back disabled people from being involved in and contributing to society.

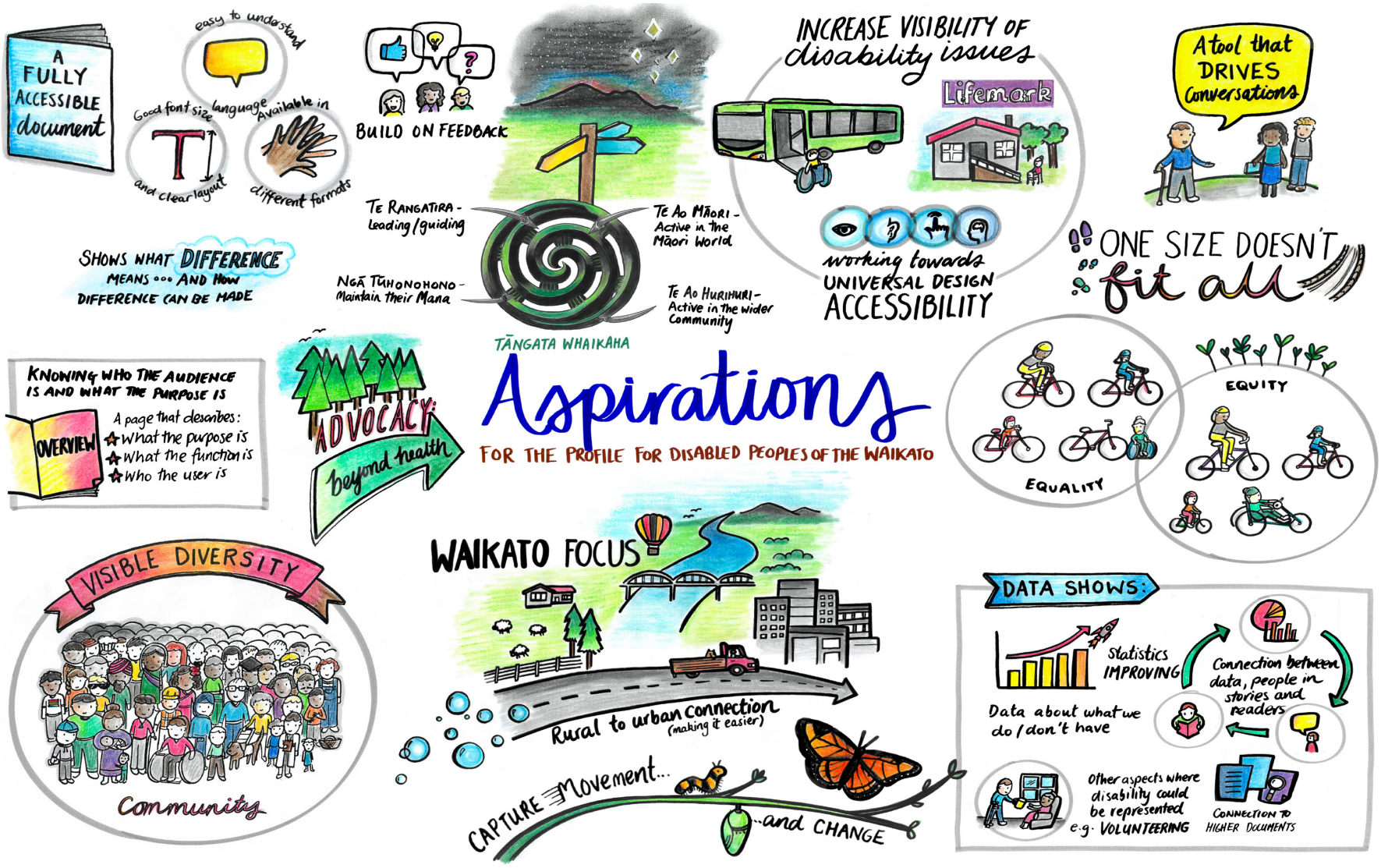
Disabled peoples face additional vulnerabilities when it comes to power and control over their own lives. When negotiating the health system disabled peoples can be denied their autonomy and ability to make decisions independently if they lack supportive family/whānau or are in a financially and/or emotionally controlling relationship. All too often, medical practitioners avoid direct communication with the disabled patient and only interact with parents or spouses/partners. Major decisions, such as enduring powers of attorney, are often made, that can have devastating short and long-term consequences for disabled people.

"Ki te kotahi te kākaho ka whati, ki te kāpuia, e kore e whati." If there is but one toetoe stem it will break, but if they are together in a bundle they will never break." – Ike Rakena, co-design rōpū member

The following strategies provide further context on the access perspective taken in the profile. Recognising that Māori are more likely to be disabled than the general population, and the importance of Te Ao Māori (the Māori world), *Whāia Te Ao Mārama* provides a culturally anchored approach to supporting Māori with disabilities (Whānau Hauā) and their whānau (Ministry of Health, 2018). *Faiva Ora* addresses the under-representation of disabled Pacific people in disability support services and access impediments such as limited choice of culturally responsive disability services and negative traditional Pacific views of disability (Ministry of Health, 2017). *The New Zealand Disability Strategy* includes an accessibility outcome to ensure that disabled people are consulted and actively involved in decision-making about all areas of their lives. *The Waikato DHB Strategic Imperative on Disability* is committed to removing barriers for people experiencing disabilities as outlined in the 2016 DHB Health Strategy, *Healthy People Excellent Care* (Waikato DHB, 2016). *A Disability Responsive Plan* has been developed by the Waikato DHB to address the barriers and inequities facing Whānau Hauā who use DHB services.

Aspirations

Whānau Hauā Disabled Peoples Health and Wellbeing Profile for the Waikato aims to demonstrate inequities within a strengths-based, enabling approach to health and wellbeing for disabled peoples. The aim of the 'Aspirations' graphic overleaf is to reflect a holistic, future-focused worldview for disabled peoples in the Waikato. The graphic was co-created with the co-design rōpū for inclusion in this profile, to initiate conversations, and as a guide for this and future profiles.


A FULLY ACCESSIBLE document
easy to understand
Good font size
language
Available in
and clear layout
different formats
BUILD ON FEEDBACK
INCREASE VISIBILITY OF disability issues
Lifemark
A tool that DRIVES Conversations
SHOWS WHAT DIFFERENCE MEANS ... AND HOW DIFFERENCE CAN BE MADE
TE RANGATIRA - Leading/guiding
TE AO MĀORI - Active in the Māori World
NGĀ TŪHONOHONO - Maintain their Mana
TE AO HURIHURI - Active in the wider Community
working towards UNIVERSAL DESIGN ACCESSIBILITY
ONE SIZE DOESN'T fit all
KNOWING WHO THE AUDIENCE IS AND WHAT THE PURPOSE IS
OVERVIEW
A page that describes:
What the purpose is
What the function is
Who the user is
ADVOCACY beyond health
TĀNGATA WHAIKĀHA
Aspirations
FOR THE PROFILE FOR DISABLED PEOPLES OF THE WAIKATO
EQUITY
EQUALITY
VISIBLE DIVERSITY
Community
WAIKATO FOCUS
Rural to urban connection (making it easier)
CAPTURE Movement... ...and CHANGE
DATA SHOWS:
Statistics IMPROVING
Connection between data, people in stories and readers
Data about what we do/don't have
Other aspects where disability could be represented e.g. VOLUNTEERING
CONNECTION TO HIGHER DOCUMENTS

Te takoto o ngā whakaritenga
Layout of the profile

Whānau Hauā Disabled Peoples Health and Wellbeing Profile for the Waikato is organised around the eight outcome areas of the New Zealand Disability Strategy (Office for Disability Issues, 2019). Access and inclusion for disabled people in decision-making and development of all eight outcome areas is essential to the success of the New Zealand Disability Strategy, its vision of New Zealand being a non-disabling society and to achieving a barrier free New Zealand.

Outcome 1 - Education
We get an excellent education and achieve our potential throughout our lives.

Outcome 2 - Employment and economic security
We have security in our economic situation and can achieve our potential.

Outcome 3- Health and wellbeing
We have the highest attainable standards of health and wellbeing.

Outcome 4 - Rights protection and justice
Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system.

Outcome 5 - Accessibility
We access all places, services and information with ease and dignity.

Outcome 6 - Attitudes
We are treated with dignity and respect.

Outcome 7 - Choice and control
We have choice and control over our lives.

Outcome 8 - Leadership
We have great opportunities to demonstrate our leadership.

Ētehi kupu āpiti hei pānui i ngā whakaritenga
Notes in reading the profile

Where possible, local or regional data sources are used to inform the statistics provided in this profile. National data and information is provided when local or regional data is not available and this is identified throughout the profile. Detailed information about data sources, tables, and references are provided at the end of the document. Estimates may not add up to or exceed the total in some cases, which can be due to the error in estimation of sub-groups. For some ethnicity based data, respondents can choose more than one ethnicity. Therefore the sum of each ethnicity can exceed the total number of people.

Due to small numbers there are limitations to the impairment classification used. There is also a lack of clarity in the scope of classifications, for example, is autism within the intellectual, learning or psychological classification? Also classification varies depending on the purpose of the data collection by an organisation. For some topic areas there are additional data in the tables section that is not displayed in infographic format.

Definitions of disability

"The term 'disability' has been contentious among some Māori as it is a word that can be traced back to European colonial understandings of 'abnormality', terminology that was mobilised to justify the subordination of indigenous peoples. Colonisation led to a loss of Māori understandings of disability; advocates in the Māori disability sector are seeking to reclaim what it is to be Māori and disabled, under the rubric "whānau hauā", "a uniquely Indigenous Māori perspective on disability that is holistic and based on spiritual, collective and relational values."
(Hickey & Wilson, 2017)

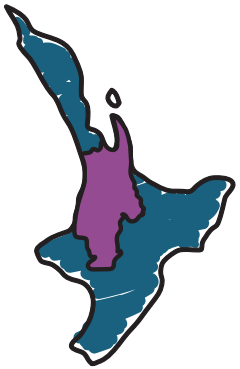
The way we look at disability in New Zealand has changed. Since the first New Zealand Disability Strategy was developed in 2001 there has been real progress in the lives of many disabled people and their families and whānau. Disability is something that happens when people with impairments face barriers in society; it is society that disables people, not their impairments, this is the thing all disabled people have in common (Office for Disability Issues 2019). Because disability is about the way other people treat disabled peoples, it is a dynamic concept that will continue to evolve as our society changes over time and for this reason this profile does not choose a definition.

However, depending on the source, there are many different definitions outlined by different governmental and non-governmental organisations in relation to data and its recording. For example, data in the "Ko wai te hunga hauā i Waikato? / Who are the disabled peoples of the Waikato?" section, disability was defined as: 'an impairment which has a long-term limiting effect on a person's ability to carry out day-to-day activities. Long-term means six months or longer and limiting effect means a restriction or lack of ability to perform (Statistics New Zealand, 2014). This data comes from the 2013 Disability Survey and used the Washington Group Short Set of Questions on Disability.

Ko wai te hunga hauā i Waikato?

Who are the disabled peoples of the Waikato?

Ko wai te hunga hauā i Waikato? | Who are the disabled peoples of the Waikato?



Disability is not rare,

118,900

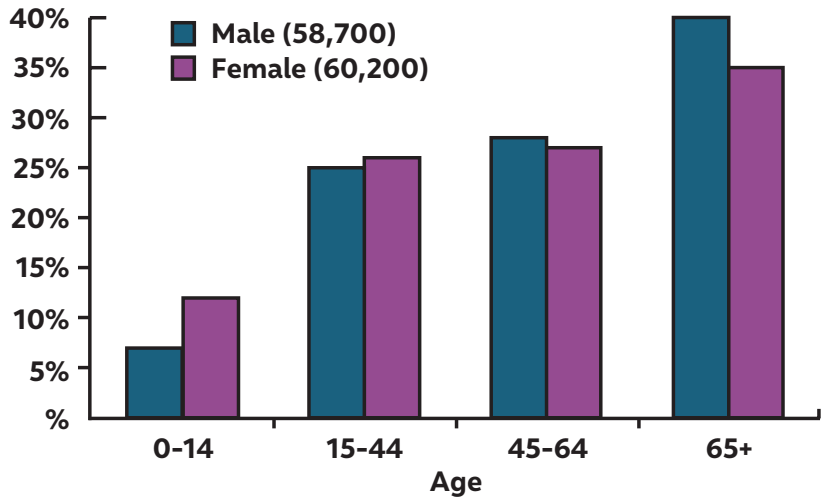
people estimated to have an impairment in the Waikato (2021).

Estimated number of people with an impairment by ethnicity (2021)

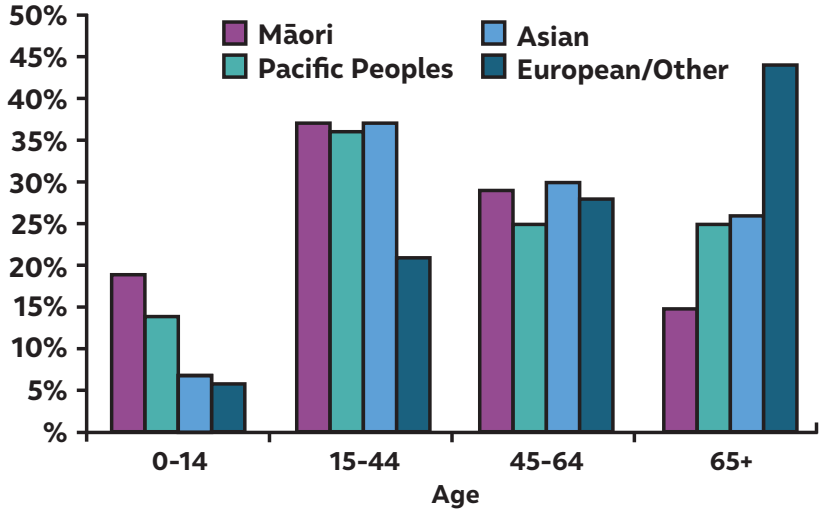
(More than one ethnicity could be chosen).

31,600	5,900	14,200	87,700
Māori	Pacific people	Asian	European/Other

Percentage of people with impairments by age group and gender



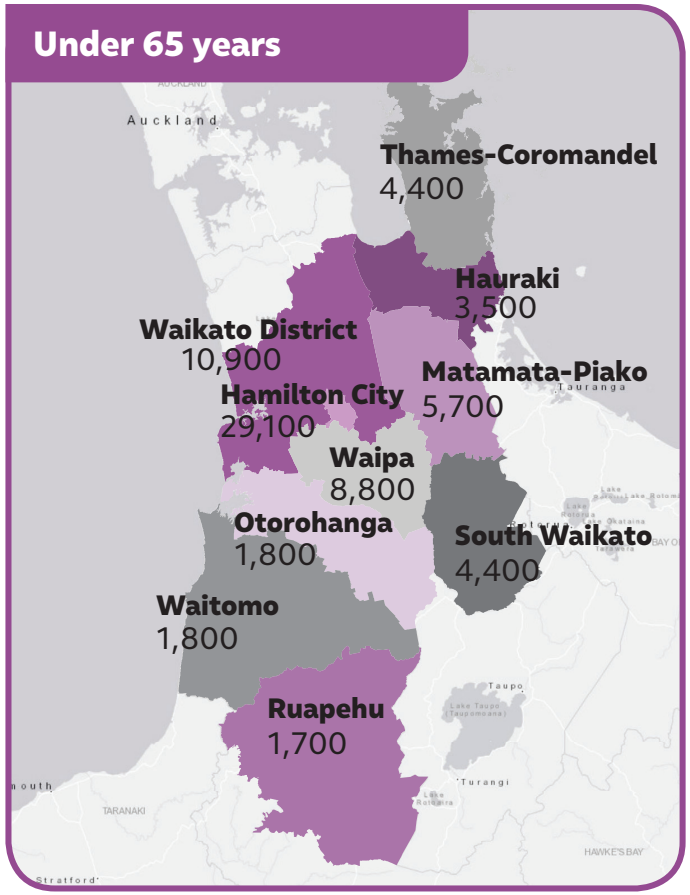
People with impairments presented by age and ethnicity

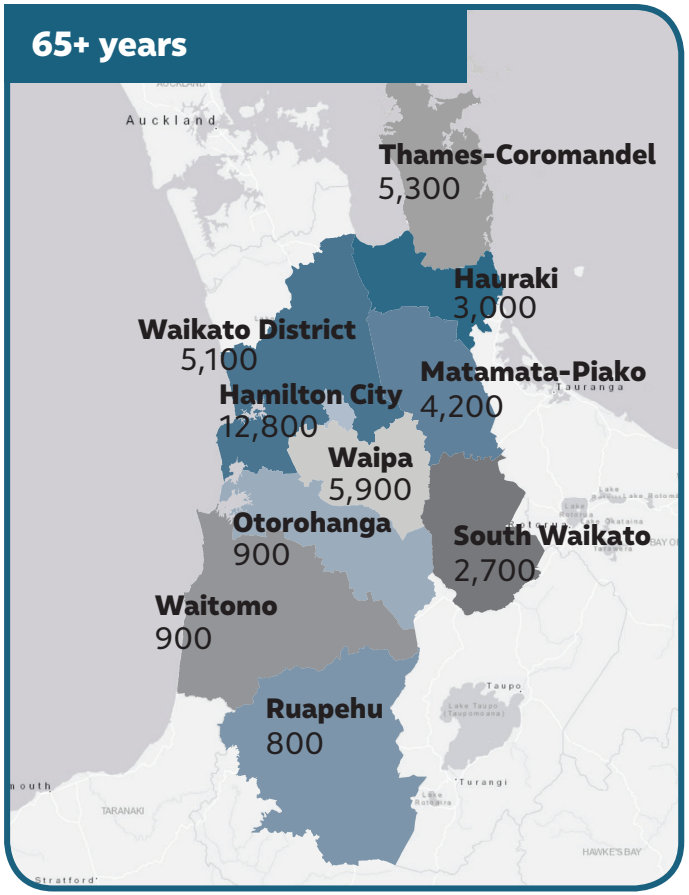


A higher proportion of the Māori and Pacific disabled population are in the younger age groups compared to the European age distribution.

Ko wai te hunga hauā i Waikato? | Who are the disabled peoples of the Waikato?

Estimated number of people with an impairment by Territorial Authority across the Waikato DHB area*





* Parts of Ruapehu and Waikato District not within Waikato DHB area are omitted.

Ko wai te hunga hauā i Waikato? | Who are the disabled peoples of the Waikato?

Impairment type by gender (all ages)*

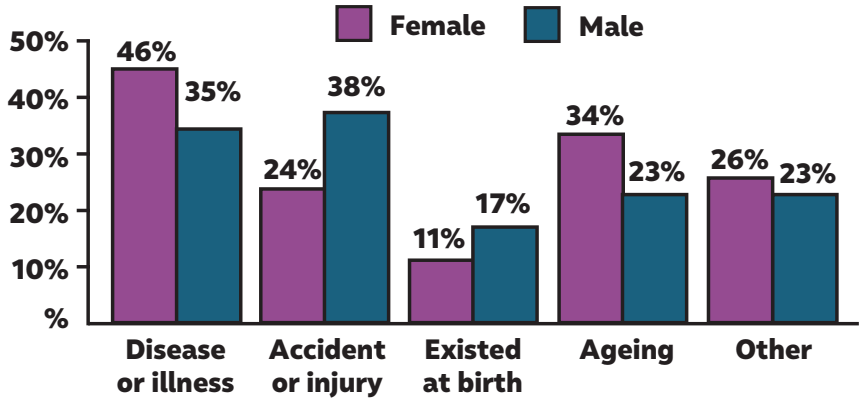
Female			Male		
					
7% Hearing	**4%** Sight	**15%** Mobility	**10%** Hearing	**3%** Sight	**11%** Mobility
					
8% Agility	**1%** Intellectual	**5%** Psychiatric/ psychological	**6%** Agility	**3%** Intellectual	**5%** Psychiatric/ psychological
					
2% Speaking	**4%** Learning	**4%** Remembering	**4%** Speaking	**6%** Learning	**4%** Remembering

* As a proportion of general population. Data and classification identified through the Washington Group Short Set of Questions on Disability. Data for under 65 years and 65+ years are available in the Tables section.

(National data)

Ko wai te hunga hauā i Waikato? | Who are the disabled peoples of the Waikato?

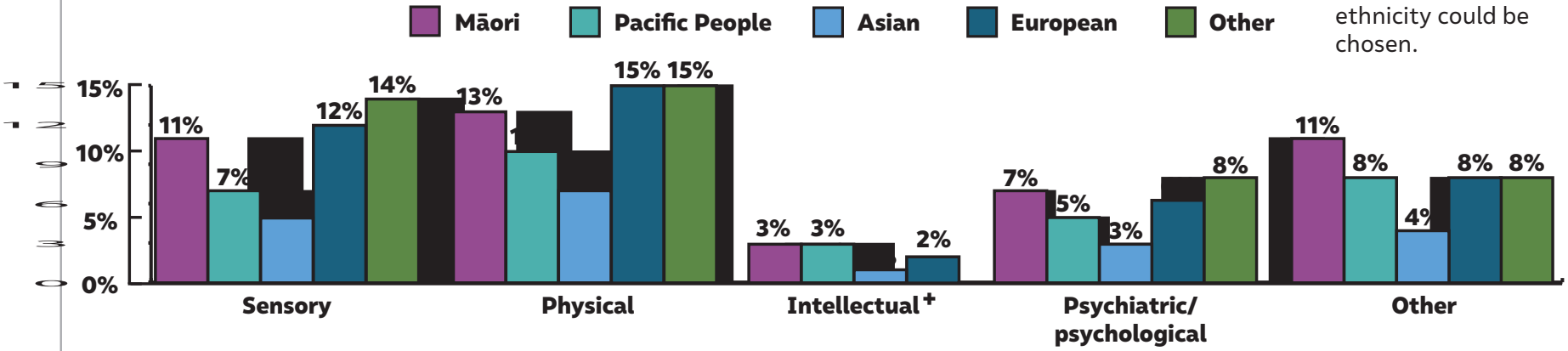
Cause of impairment for people



3% of the adult (15+ years) population use a visible mobility aid*.

* Mobility aids include back or leg brace, splint or support, walking frame, walking stick, crutches,mobility scooter, manual wheelchair and motorised wheelchair.

Impairment type by ethnicity (all ages)*



* More than one ethnicity could be chosen.

+ The data was reported using this term, however this is not the preferred term of many people with learning disabilities.

(National data)

16

Mātauranga

Education

Renae Trow

Renae recently completed a SPACE (Self Paced Applied Computer Education) course through WINTEC. With the assistance of a volunteer at Interactionz Renae gained knowledge and skills in keyboarding, Microsoft Word, Excel, Publisher, Powerpoint and emailing. Renae was very proud of herself and all the hard work and study that she had put in every week to complete her course. She also acknowledged the important role of her volunteer in supporting her to achieve her educational goals by explaining content when she did not understand.

> It was awesome. I learned how to use a computer, websites, and how to type on a keyboard and use a mouse. I had never used a computer before. I use a computer at Interactionz now with my volunteer. She helps me use the computer and puts her hand where I should click. We play games that help me achieve my maths and literacy goals.

Following this Renae helped her peers to use technology like ipads and laptops, teaching them what she had learnt through her course. She also worked with photos on the computer that she had taken with her phone or a digital camera. She enjoyed bringing photos home that she had printed off and used them to make books at home with pictures of her goals. It gave her good visual aids to use when she was talking with her whānau. She would tell whānau what she wanted to do in the future, and they supported her.

People with disabilities get stuck into groups of certain areas in town where its only specifically for disability. WINTEC is an everyday place for everybody. A variety of people go to WINTEC, not just people with disabilities. It has been a really positive, inclusive place, where Renae got to meet different kinds of people.

Mātauranga | Education: Support available for students at school

934 ONGOING RESOURCE SUPPORT

934 (9% of ORS students nationally) **students receive support from the ongoing resourcing scheme (ORS) (2019).**

1,403 (9% of OLS students nationally) **students receive support from other learning support (OLS) services*.**

176 ASSISTIVE TECHNOLOGY

176 (9% of all students that are approved for assistive technology nationally) **students have been approved for assistive technology.**

* Inlcudes High Health, Behaviour, Communication, Physical Disability, Deaf and Hard of Hearing Moderate Needs services.

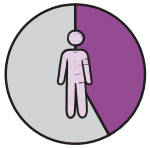
Other Learning Support (2019):

71% **are male (991)**

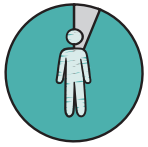
29% **are female (412)**

Children and young people receiving individualised Ministry of Education services represent only a small proportion of those with additional needs. The majority receive support directly within their school or early learning service, or from a Ministry contracted provider.

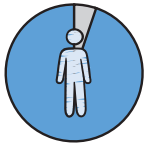
Percentage by ethnicity of children receiving OLS support in the Waikato (2019)*.



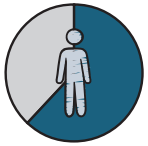
42% **Māori**



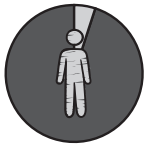
7% **Pacific Peoples**



6% **Asian**



62% **European**



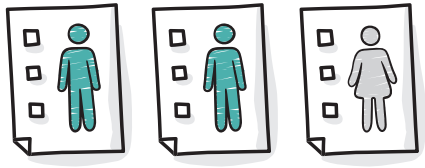
3% **Other**

* More than one ethnicity could be chosen.

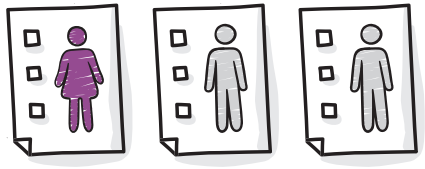
Assistive technology data is available in the Tables section

Mātauranga | Education: Support available for students at school

Ongoing Resourcing Scheme (2019):

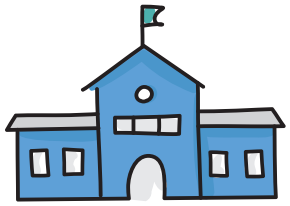


Two-thirds are male (628)



One-third are female (306)

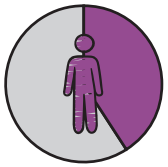
Students receiving support from the ORS (2019):



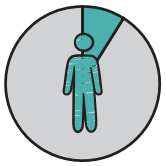
43%
attend special schools

57%
attend other schools

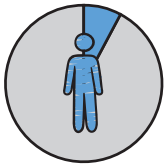
Percentage by ethnicity of children receiving ORS support in the Waikato (2019)*



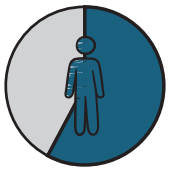
41%
Māori



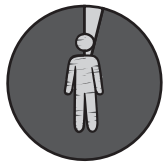
9%
Pacific Peoples



8%
Asian



58%
European

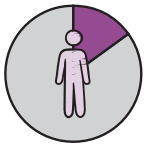


3%
Other

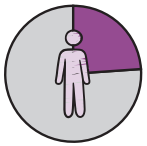
* More than one ethnicity could be chosen and percentages are similar between special and other school type.

Mātauranga | Education: Educational attainment for school leavers

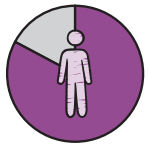
NCEA level 1 or above (2019)*



15% Waikato Ongoing Resource Scheme (ORS) pupils



24% National ORS pupils



88% All Waikato pupils

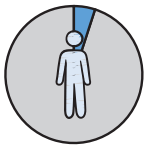
NCEA level 2 or above

7% Waikato ORS pupils

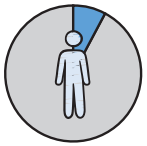
16% National ORS pupils

78% All Waikato pupils

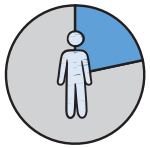
NCEA level 3 or above



5% Waikato ORS pupils



9% National ORS pupils



46% All Waikato pupils

* Educational attainment data available for ORS pupils only.

Highest qualification attained (2013)	15-44 years	45-64 years	65 years or above
Bachelor's Degree or higher	**14%** (28% non disabled)	**13%** (23% non disabled)	**8%** (13% non disabled)
No qualification	**24%** (12% non disabled)	**31%** (15% non disabled)	**42%** (34% non disabled)

Te whai mahi me te tiaki pūtea

Employment and economic security

Catherine Bang

Aphasia is a loss or disruption of language. Catherine had a legal background prior to her stroke, a profession that requires the reading of and engagement with lengthy, complex documents.

> I [now] have difficulty speaking, reading and writing. I have trouble understanding people who talk too fast. I can't read long documents, I have trouble processing the words. If someone interrupts me while I am trying to speak, then I lose my train of thought or the thought leaves my head. I felt that when I went home from the hospital people controlled everything I did. But I didn't need it. I just needed time to get the point across, without interruption. Everyone's in too much of a hurry nowadays they don't give people like me time to get the words out of my mouth in time.

Aphasia is not a loss of intelligence.

> People need to slow down because I am not thick, no way, I just can't get words out of my mouth properly. I have to explain, 'I've had a stroke and I have difficulty communicating with you.' If I don't say something, they start talking really loudly because [they think] I'm clearly deaf, or they think I am thick!

Glen Terry

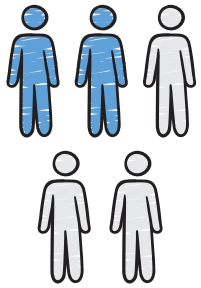
Glen engages in volunteer work which provides him with valuable learning experiences and allows him to achieve goals toward getting a job that he wants.

> One of my volunteering jobs is packing vegetables from the community gardens at the Hamilton East Community Centre. People who can't go grocery shopping buy the boxes. We don't pick the vegetables, we just work with whatever vegetables are there. I chose this programme because it really helped my volunteering experience toward getting a job.

For many years Glen has been doing volunteer gardening on Te Aroha Street as part of a gully restoration.

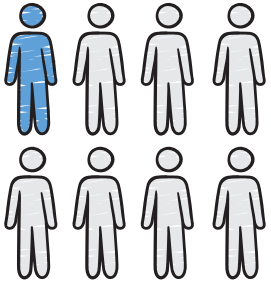
> Volunteering allows me to get to learn experience and achieve goals towards getting a job that I actually want. We plant plants, trees, clean up rubbish, different things every week. It started when I was looking for a job. I had to go to the Hamilton City Council to have a proper interview for the gully restoration volunteer position. I had to learn new skills, like how to carry tools properly. I've also met some good friends there.

Te whai mahi me te tiaki pūtea | Employment and economic security: Labour Force 15-64 years (2020)



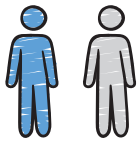
2 in 5 (42%)
of disabled people are employed.
4 in 5 (81%) of non-disabled people are employed.

(National data)



1 in 12 (8%)
of disabled people are unemployed.
1 in 25 (4%) of non-disabled people are unemployed.

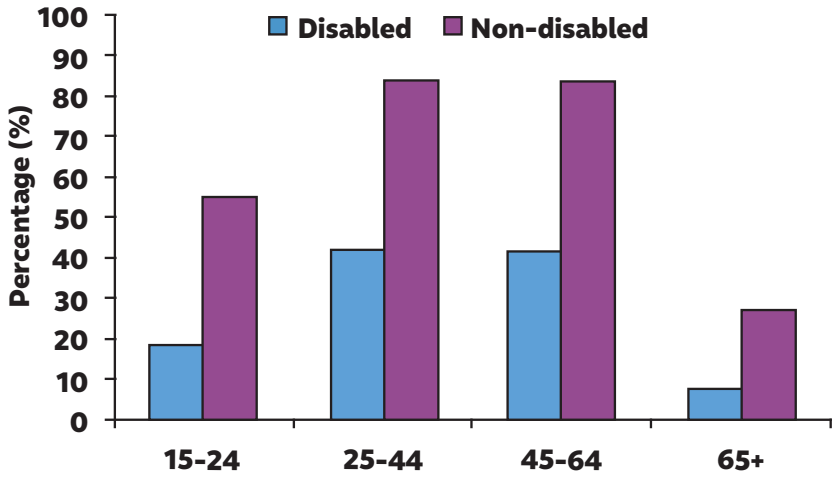
(National data)



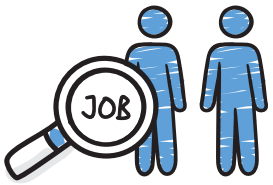
Over half (58%)
of disabled people are not in the labour force.
1 in 6 (19%) of non-disabled people are not in the labour force. (Does not include unemployed).

(National data)

Employment rate by age (June 2020).



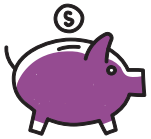
(National data)



A disabled person is
2 times less likely to be employed
than a non-disabled person.

(National data)

Te whai mahi me te tiaki pūtea | Employment and economic security: Sources of income 15-64 years (2020)

Disabled		Non-disabled	
	**11%** **Self employment** (National data)		**15%** **Self employment** (National data)
	**28%** **Wage and salary** (National data)		**64%** **Wage and salary** (National data)
	**49%** **Government transfer*** (National data)		**14%** **Government transfer** (National data)

*Government transfers are income benefits, working for families tax credits, paid parental leave, student allowances, New Zealand (National) Super annuation, and veteran's and war pensions.

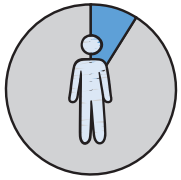
Average weekly income

15-64 years (2020)	Disabled	Non-disabled	65 years and over (2020)	Disabled	Non-disabled
	**$596**	**$941**		**$460**	**$614**

On average disabled people earn 41% less than non-disabled people

Te whai mahi me te tiaki pūtea | Employment and economic security: Jobseeker Support 18-64 years

Jobseeker support is a weekly payment that helps people until they find work. The data presented are for people that have a health condition or disability which affects their ability to work. This means that they have had to reduce their hours or stop work for a while.

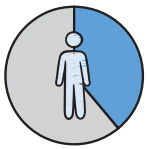


5%
of the estimated disabled population receive support (2020).

6,119 people receiving support in 2020.

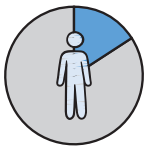
52% male

48% female

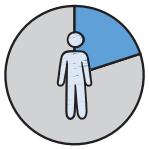


39%
50-64 years

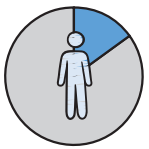
11%
45-49 years



16%
35-44 years



20%
25-34 years



15%
18-24 years

Ethnicity of disabled people receiving Jobseeker Support

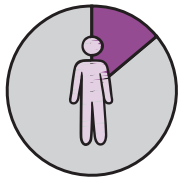
37% are Māori

2% are Pacific Peoples

46% are NZ European

Te whai mahi me te tiaki pūtea | Employment and economic security: Supported Living Payment 18-64 years

Supported living payment (SLP) is a weekly payment to help you if you have, or are caring for someone with, a health condition, injury or disability. Other government support data is available in the Tables section, such as Special Needs Grant.



6%
of the estimated disabled population receive SLP under health conditions and disabilities (2020).

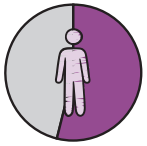
7,043

7,043 people were receiving support in 2020.

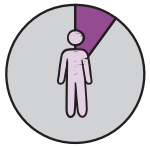
1,031 are receiving support as a carer.

48% female

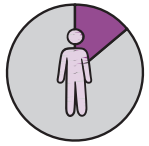
52% male



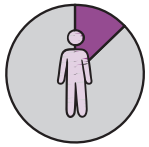
53%
50-64 years



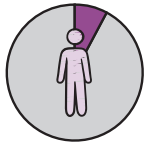
10%
45-49 years



14%
35-44 years



13%
25-34 years



8%
18-24 years

Ethnicity of disabled people receiving Supported Living Payment

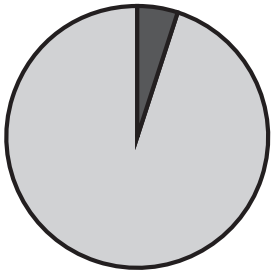
31% are Māori

1% are Pacific Peoples

50% are NZ European

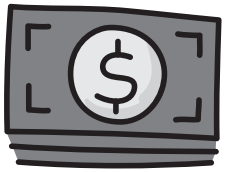
Te whai mahi me te tiaki pūtea | Employment and economic security: Disability Allowance 18-64 years

Disability allowance is a weekly payment for people who have regular, ongoing costs because of a disability, such as visits to the doctor or hospital, medicines, extra clothing or travel. Data presented here are for people who receive Jobseeker support (Health conditions and Disabilities) or the Supported Living Payment and the Disability Allowance.



5%
of the estimated disabled population receive the
disability allowance (2020).

6,164 people were receiving a disability allowance in 2020.



30%
of people receiving Jobseeker Support (Health conditions and Disabilities) receive the
disability allowance.

70%
of people receiving the Supported Living Payment receive the
disability allowance.

Disability allowance is means tested on the household rather than on the individual who has the impairment.

Hauora

Health and Wellbeing

Renae Trow

31 October 1984 – 23 October 2020
(transcribed interview with mum, Renalda and Bernie, Interactionz Community Mentor)

The beauty of 2020 was that Renae grew, in so many areas, from her previous year [at WINTEC]. Her skills increased. Her korero. Her wairua. And then Bernie [Community Mentor, Interactionz] contacted me and we talked about Renae going up a level to see if she could cope with the Foundations Course. We had a look at all the information and decided it would be good. I thought Renae would do really well. She had a lovely volunteer, Catherine, that would come and support her, all the time - her #1 supporter.

However, Covid hit, and that changed a lot. It was okay at first. I think we coped okay. We got in touch with WINTEC and got Renae's mahi and do on-line. That was a bit of a struggle for me, to awhi her, to do the mahi, it really was. We struggled. I struggled to help her with her mahi on-line. It was not easy for her in the course, it really wasn't, but she loved the technology, and she was very good at it. Routine was so important for her - with the bus, and what time to get up, all those things. I thought it would be okay, that I'd be a good teacher. Renae and I had to work out a new timetable to try and keep us in a routine. Everyone - whanau, friends - came to the table to help Renae succeed.

Covid changed a lot, not just for Renae, but for a lot of our people with special needs. Even after moving out of lockdown and into the lower alert levels, I felt that Renae was still scared to go out, afraid that the virus could affect her. When she knew that she couldn't go see her friends, or she had to wear a mask, it actually frightened her. I didn't realise how much it affected her. She'd get out to sit in the sunshine, or to

read a book, but she wasn't really active. Trying to do activities was hard for her. She enjoyed it if other people were around, but I think she missed having contact with others. Everything got cut off. She missed her friends. She couldn't go to see them, and they couldn't come to see her.

Although Renae's course changed after lockdown and, although she couldn't continue, she kept up her learning with Catherine. They continued to connect and help each other. Catherine needed to move out of her home but she didn't know how to cook, but cooking was a great strength of Renae's. Renae also wanted to eat healthier so she taught Catherine how to cook and be more confident in the kitchen. Together, they created and nurtured a brilliant friendship, in the hardest of times.

We [at Interactionz] were really grateful for the opportunity to say goodbye to Renae. She was still laughing and giggling in the ICU. The nurse let all of us in, despite the rules, and Renae was responsive to us. It was good learning for other people with disabilities. A lot of families and residential services hesitated [to let Renae's friends visit her in hospital] so we had to prepare. But death is a constant thing in our lives. And they were grateful. Renae's friends said they would regret if they didn't go be with her. They got to see her in ICU, and we actually had to be 'real'. I think we try hard to protect people with disabilities, but this is a real thing. We gave Renae's friends the choice, and we supported them in that experience. We were all laughing and giggling with Renae. It was real life stuff.

In the end, her beautiful heart couldn't cope.

Renae touched everybody. She humbled us all.

Frances Foote and Catherine Bang

Catherine and Frances met through Stroke Club Hamilton. Frances' stroke affected a different part of her brain than Catherine's and she can no longer see properly. Half the world does not exist for Frances, she cannot drive, and maths, and words, although not to the same extent, can be a problem for her. At first [Frances] wasn't interested [in attending Stroke Club].

> I went from working in a busy office and interacting continuously. I had been at home for long enough and bored out of my tree and just really missing human company during the day. Eventually it had kind of dawned on me that my father-in-law, who is 40 years older than me and has had previous strokes, and I could go together. I wasn't up to doing it on my own and thought at least one of us would have a nice day! This was a watershed moment for me. It was a huge room of people. There was about 60 people there and a lot of them were elderly, but there were a few younger people and that was the first time that I didn't feel like quite such a freak. A few months later Catherine came along.

Catherine and Frances have developed a close and supportive friendship. They spend a day together each week and it has helped both of them. "Catherine and I joke that, between the two of us, we make one whole person."

> Lots of friends fade out. Some people don't adjust well to the changes in people after stroke and that can be hard to deal with. Some people can cope with changes like that, some people can't.

Their respective experience with stroke, and everyday experience with the health system, has highlighted for Catherine and Frances the importance of strong and trusting relationships.

Connor Bell

When I came to my home [through Oranga Tamariki] I was autistic, had ADHD, severe asthma, so all I basically did was just run around, being a pain. I had no emotions. I couldn't smile, I couldn't laugh, I couldn't cry. I had fixations and was frightened of things. I used to play alone and not like hugs.

But my family saw something in me that no one else could. You know how kids say, "when I grow up I want to be a fireman, or something like that"? For me, I wanted to grow up to be a 'normal' person.

When I was five I went to Crawshaw School and was placed in a Special Needs Unit for two years. I got smarter and was at the top of the class. They moved me into a mainstream classroom and put me with a teacher aid. I had ORRS funding for about 20 hours a week. Being in a 'normal' classroom was hard because that classroom sees you as the guy that used to go to the Special Needs class. I just wanted them to see me as a normal person. I used to think it was just funny, but as I got older I realised that it wasn't funny, and that it could hurt me, and I just got really annoyed.

From Crawshaw I went to Peachgrove Intermediate. I didn't want to stay at Crawshaw anymore. I wanted to go to Hamilton Boys' High and I needed to prepare for that in a different school. I needed to be in a bigger school, with more students, to be ready for Boys' High. That worked out well. I ended up being around the middle level classes. If I would have stayed at Crawshaw until Boys' High I may have been in the lower level classes. Tamar and Sam, my sister and brother, went to Peachgrove, so I wanted to go there. I didn't feel different. I just felt like everybody else there.

My brother went to Boys' High so that's where I wanted to go. That's the only high school I wanted to go to. I struggled at first but over the years I got more confident. High school was a whole other level. There was homework every day. I had to go to a lot of different classrooms every day. There were different subjects.

I had a teacher aid at Peachgrove, just to make sure I stayed on task. Once at Boys' High I had no extra help at all, or Special Consideration for exams. I had some catching up to do, having been in a Special Needs school, but I did it. I now have Level 1 and 2 NCEA and enough credits for Level 3. My favourite subjects are IT, music, electronics, physics and maths. In December I am going to Wellington to collect a Oranga Tamariki scholarship to help me attend tertiary school next year.

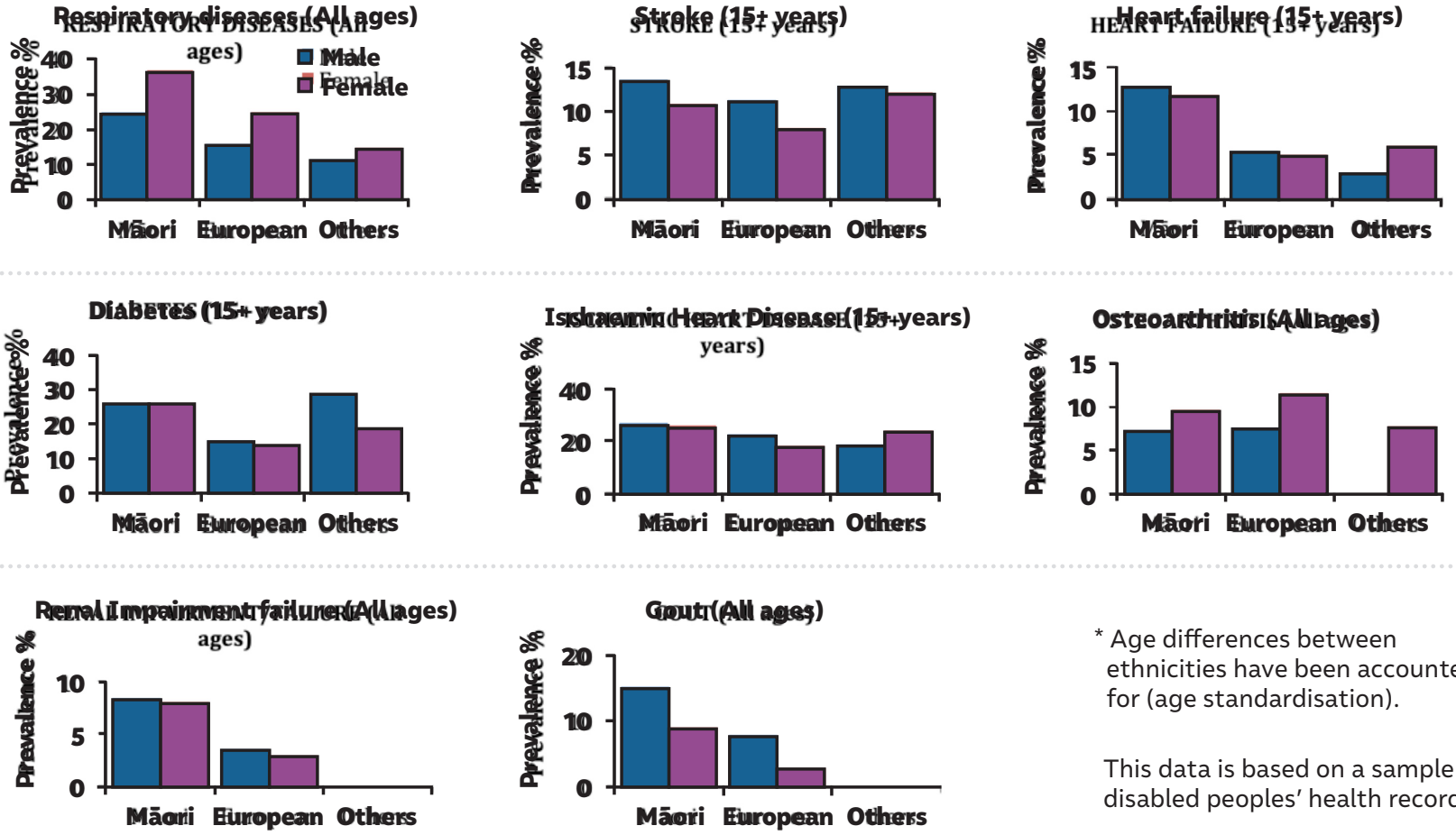
I have overcome a lot since I came into my home at three years old. My parents have really helped me, and my brother and sister have been a real inspiration. When I was younger I wanted to be normal, like them. I have felt part of this family since the first day I walked in. And there is church. I feel safe there and everyone is just really nice. I play music in a worship band and I am a church helper. I have good friends.

After receiving the Prime Minister awards I was offered a job at Team Cabling. I have been there since January the 15th and love working there. Although 2020 was a little unusual, it ended up being a great year for me. I have completed my first year as an apprentice and am looking forward to 2021.

All things are possible if you do not give up.

Hauora | Health and wellbeing: Recorded disease prevalence

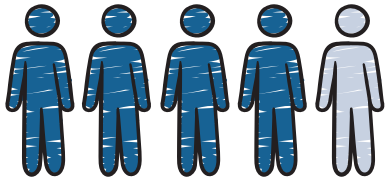
Recorded disease prevalence in primary health care from a sample of Disability Support Link clients (2018).



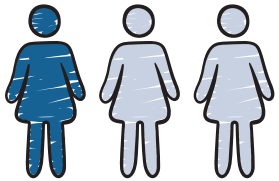
* Age differences between ethnicities have been accounted for (age standardisation).

This data is based on a sample of disabled peoples' health records

Hauora | Health and wellbeing: Recorded primary health care quality measures and hospital ED attendances



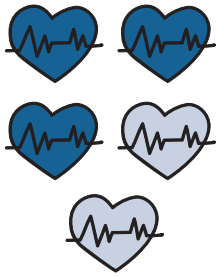
4 in 5 (80%)
current smokers given smoking brief advice in the last 15 months
(similar to Waikato average).



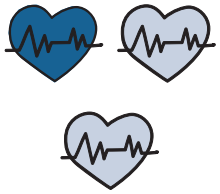
1 in 3 (34%)
females (25-29 years) have had a cervical screen in last 3 years
(compared to 3 in 4 (77%) for the Waikato average).

This data is based on a sample of disabled peoples health records

2 in 3 (68%)
received a diabetes annual review in last 12 months
(similar to the Waikato average).

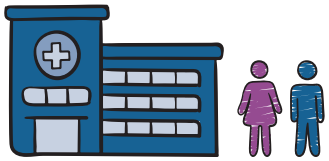


3 in 5 (56%)
of males aged 45+ years without known risks had a cardiovascular risk assessment (CVRA) done in last 5 years.



1 in 3 (36%)
of females aged 55+ years without known risks had CVRA done in last 5 years.

On average over 5 years (2014-18) for every <u>ten</u> Disability Support Link clients there were:*



Male	ED Attendances
Māori	48
Pacific Peoples	25
Asian	27
Other	35

Female	ED Attendances
Māori	55
Pacific Peoples	30
Asian	56
Other	40

* Age differences between ethnicities have been accounted for (age standardisation). ED = Emergency Department.

Ngā tika taumaru me te ture

Rights protection and justice

Isaac Rakena

The early years following my accident were about me and trying to get myself right physically, mentally and spiritually; whakatika te taha tinana, te taha hinengaro me te taha wairua. It was now time to concentrate on strengthening myself as a family man, te taha whaanau, and asserting my rights for self-determination.

Over the years my care support hours were being taken from me because I had a wife, two young children (an 8-year-old and 5-year-old respectively) and our eldest daughter living next door who had just given birth to a daughter. According to ACC, I had a family who could share the responsibility of looking after me. I knew that what was happening wasn't right so I sought a ACC review for 24/7 support care. My request for internal review was declined, which led me to seek an independent review. When my request for independent review was approved, I sought the support of an advocate.

After a thorough review of my file my advocate found multiple discrepancies. ACC had failed to provide a proper care assessment, unfairly decreased my hours of support care, failed to inform me of my entitlements, and was ordered to back-pay all the hours of support I had been denied. A mediator determined that ACC showed intentional negligence in trying to decrease my hours of support and ruled in my favour to receive 24/7 support care.

Now that I had 24/7 full-time support care hours, I found a caregiving agency that could provide me with caregivers other than my whaanau. Deb was able to get a part-time job which gave her a sense of freedom and a break from her caregiving and stay-at-home mum duties.

Renae Trow

Renae was on a benefit, and her mum works full time. Their budget was limited at times. For Renae to get a computer they needed to put money away and save before she could have got one. Finance can be hard. If she wanted to carry on learning and maintaining her education she only had limited ongoing support from a service. There needs to be more services available and service providers need more funding. There are a lot of rangatahi like Renae who need that support. They can't get a job, they struggle. Renae had had about three jobs. The last one a few years ago was at a care centre but because she was last on, she had to be first off. From then on it had been a real struggle to find just a part-time job that would suit Renae's needs. There are some good employers but then there are some who just don't want to take the time to teach.

People's awareness needs to be heightened. People just judge persons with disabilities. They don't take the time to get to know them. Having an awareness of disability, that, 'we are just like everybody else'. [People with disabilities] should have the same chances, the same choices in life. There needs to be more awareness in the health system of what is going on for people with disabilities.

Ngā tika taumaru me te ture | Rights protection and justice: Discrimination

37% (highest) of applications for free legal representation (2019/20)
in Human Rights Review Tribunal made on Disability grounds.

17% of all unlawful discrimination complainants.

249

UNLAWFUL DISCRIMINATION COMPLAINANTS

249 unlawful discrimination complainants (under Human Rights Act)
were on the grounds of disability across New Zealand (2019/20).

UNLAWFUL DISCRIMINATION

Unlawful discrimination on the grounds of disability is the highest in number (along with race grounds).

Te whai wāhitanga

Accessibility

Kylee Black

It would be good to have better access to the hospital.

I can't push the lift buttons, I can't open the door from the carparks to get into the hospital. There are no buttons on the outside, no buttons on the inside. It's just a manual open door and so how do I do that from a wheelchair. A number of the lift buttons are quite high up and I can't lift my hands up that high.

Parking is also an issue. As a disabled person, I might be at the hospital three times a week or more. It would be good if there was a card for frequent users that is connected to appointments to be used for the duration of your time at the hospital. Disabled people don't have a lot of money and parking is horrendously expensive. We spend a lot of time there compared to the general public.

It would be cool to have patient education days for doctors and nurses where patients come in the hospital and share their diagnosis history or some things about their condition and how it affects them. I've started an organisation called Spirit Sparkplugs which is to 'spark the spirit'. We're working with three wards at Waikato Hospital now to bring colour and vibrancy to their interiors.

The other thing I'd like to see more of is something like Friends of the Hospital. How cool would it be to have friends of a ward who commit to go

and visit people on the ward once or twice a week and just say hi to people and encourage them because there are a lot of people who don't have visitors. It would be great to have younger people who were encouraged to become Friends of the Hospital and go around and say hi to people, whether it's once month or once a week.

I think that making sure that people know about health advocates is important so that when you need help to resolve a situation you know where to go and who to talk to – because they're amazing! It would be good if a booklet could be made up that listed resources and supports that are available, like the health shuttle, or the parking cards, how people get support, where to find easy read documents, or an App that had all this information. Kind of like, 'when I come to hospital, what I can expect?'.

Isaac Rakena

Over the years I learned to tackle the issues of disability as a husband and parent and have become an active member of my community. In 2010 I became a Maaori representative of the CCS National Board. I have had the privilege of providing input into the strategic direction and transformation of the organisation. CCS Disability Action and ACC have supported me by funding my support care, organising my rental equipment (hoist and commode), and paying for travel, accommodation and meal costs for me and my support person.

I am now at the stage of my life where I have returned to the Waikato region to live out the rest of my days. Although not returning to Ngaruawahia, finding a home in nearby Huntly has been a good compromise. Despite some initial problems with ACC in organising my temporary and permanent housing needs, my ACC Case Manager and Occupational Therapist have been very supportive around the cultural issues that are important to me. My caregiving agency also understands my personal values within their Te Whare Tapawha Maaori well-being model and know me as a strong-minded tangata hauaa Maaori who values my culture and heritage.

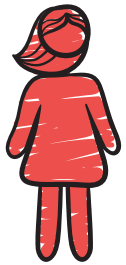
My support workers are part of my whaanau. They support me in living a quality of life and should be afforded reciprocity.

Now that I am settled and my basic needs have been met, I have been able to focus on building my life-coaching and consultancy business. Through the support of ACC and Healthcare Rehabilitation Ltd, I know that I'll be able to achieve my goal and share my knowledge and experience of the many taonga we value as Maaori.

Te whai wāhitanga | Accessibility: Housing

284 (6% of all HNZ) Housing New Zealand properties in the Waikato region with modifications for people with impairments.
(Excludes Rotorua district).

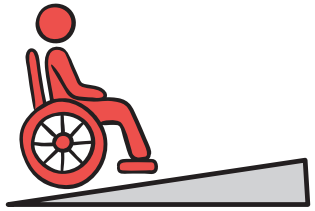
Disabled people are more likely than non-disabled people to live in rental accommodation.



Disabled peoples are more likely to live in a one-person household compared to non-disabled peoples.

29% of disabled people reported having difficulty keeping their home warm,
compared with 16% of non-disabled people.

35% of disabled people with a physical impairment used building modifications to improve accessibility to, or within, their home.



17% of disabled people with a physical impairment have an unmet need for modifications to their home to improve accessibility.

Te whai wāhitanga | Accessibility: Housing quality

Disabled peoples, particularly children, are more likely than non-disabled people to live in a house where it is
too small
for the number of people.

1 in 3 (33%) of disabled Māori find their house damp.

1 in 4 (23%) of disabled Pacific Peoples find their house damp.

1 in 5 (21%) of disabled Asian Peoples find their house damp.

1 in 7 (14%) of disabled European/Other peoples find their house damp.

One third of Māori (36%), Pacific (37%) and Asian (33%) disabled groups are living in a house they find
difficult to keep warm
compared to 22% of disabled European/Other peoples.

Ngā waiaro

Attitudes

Sarah Burrell

It's very important for a Deaf person to choose their own voice. It's part of our rights, our human rights, but the DHB sets up a lot of barriers to us being able to choose the interpreters we want. Many Deaf people don't even realise that they can speak up, they can say that they want a different interpreter. If they're not comfortable with the interpreter offered by the DHB they can ask for another interpreter. Sometimes they'll ask, and the hospital will say 'no', and so they'll say 'ok'. But I'm saying, you don't have to accept it. Don't give up! Just explain to the hospital why you would like to have a particular interpreter. The hospital should be, like, 'fair enough, I get where you're coming from, that's how it should be'. I inform the Deaf community that they don't need to be aggressive, or fight in an aggressive way, just be firm, have a positive attitude, and hopefully the DHB will respond in the same way. It's just helping to settle the frustrations. I won't give up until the DHB decides that we should be able to access interpreters from any agency.

Renae Trow

Renae used public transport to access her classes at WINTEC which had given her independence and a sense of pride. She knew all the bus drivers and felt safe and supported by people at the depot.

It had also helped her to develop daily routines to support her success. Renee knew what time she had to be up, dressed and organised.

> I set my alarm to wake myself up at 7:00am, have a shower, get ready, get changed, make my lunch, then I'm out the door at 8:00am. I meet my friend at the transport centre. I finish at 12:00pm and get the bus back home. Sometimes I go to the library or stay in town to have lunch with friends.

Renae's mum feels that more people like Renae need to know what WINTEC can do. It needs to be put out there. The small steps that Renae had taken to help her education were brilliant, she says.

> The difference at home was so noticeable. Renae was really eager, really keen to talk, talked a lot about what she did, what she was achieving. We believed that one day she would have got that good job, she would have been employed, she would have had her own flat. She would have been an independent young lady who would have supported the community. She would have given back.

Tegan Morris

I'm 32, nearly 33. I've lived in Hamilton for nearly 15 years. I moved here to attend university. I've had a lot to do with the Waikato DHB both up to that point and throughout the years that I've been in Hamilton because I grew up in the northern King Country.

One of my physicians asked me to come in as a case study for medical examinations when I was younger. It was fun for me because I liked to test their abilities, and it was also a good opportunity for me to see what their patient focus was, whether they would address me, or address my mum, or whether they would talk past me, in their 'ticking the boxes' kind of approach. So, throughout my life I generally have felt quite empowered, in terms of owning my own health journey. There are situations I've been in where I have had serious illnesses but I've always been able to be the one who has spoken up, and I've been supported by my family to do so. I've been able to have ownership of my own story and have not been shy about speaking to clinicians.

I think everyone has the capacity to feel empowered, which varies somewhat depending on their disability, and how their lived experience has empowered or disempowered them. I'm advantaged because I am of European descent, I'm from a middle-class family, and I have had the advantage of coming from a family who have empowered me to become confident to speak for myself. From a young age I can remember, if I had an appointment to see a doctor, and they asked my mum about my health history, what operations I had had, or what therapy did I do, mum would say "Ask Tegan". So, I learned from a young, pre-teen age to assert myself and I remember feeling

empowered in my relationships. I think there are a lot of families that, from a well-being perspective, don't give their kids an opportunity to do that. Because I have been able to communicate for myself, the clinicians give me more respect and talk to me like an adult, rather than like a child who doesn't have the power and authority to speak for myself.

Te kōwhiri me te mana whakahaere

Choice and control

Catherine Bang and Frances Foote

Due to her aphasia, Catherine was unable to communicate effectively while in hospital, but she could still see, hear and understand. She felt frustrated and angry, however, when this was not respected by the health professionals caring for her.

Fellow aphasia patients told Catherine that their doctors rarely talked directly with them, but rather interacted only with their parents or spouses/partners. These are important considerations when major decisions, such as powers of attorney, are being made, and can have devastating and lasting effects on patients' lives.

> You have to be really, really, careful about who you choose, how well you know people, to make decisions on your behalf. The social workers, they talked to parents/spouses/partners, in a different room. I think more people need to know what aphasia is. Some doctors and nurses and OTs at the hospital don't know what it is! It feels like not many people know exactly what to do and what help is required so they just assume that everybody else will be fine and there is nothing there, there is nothing to check that people who are going to be making decisions and helping run someone's life are actually any good at it and are going to do it in a caring and inclusive way.
>
> Frances: I tend to tell people I've had a head injury rather than I've had a stroke because I find there's less judgement. "you're too young to have a stroke". And the number of people that will follow that with a question, "Did you have high blood pressure"? Why do we have to blame the victim? It happens to two year olds! No one checked their blood pressure! The FAST thing, I passed all that and the ambulance didn't think I was sick enough to go to hospital, so it's not broad enough. There are so many variances.

Kylee Black

> Right from 8 or 9 years old I was told, 'Your body's not like other people's bodies. You can't do things other people can do. Your body doesn't behave the way other people's bodies behave, and I never understood why.'

Before being diagnosed at age 22 with Ehlers-Danlos Syndrome Kylee had been through 10 years of often being dismissed, misunderstood, or labelled clumsy and had often been relegated to the 'too hard basket'. She was told by a specialist that it was utterly impossible to have so many different things wrong in so many different body systems.

Ehlers-Danlos Syndrome is a multifactorial connective tissue disease that affects every part of the body. It is a complex condition that requires complex care.

> I've recently come out of Waikato Hospital. My surgeon came in one day and asked, "So who is the person overseeing your care? Who is the one who is in the hospital pulling it all together? Who's pulling it together? Who's making sure that everyone's on the same page? I said 'me'."

> I would rather not have to find my own way through the hospital and to my own specialists. We've got some amazing specialists at Waikato Hospital with connective tissue disease understanding. I've had amazing experiences working directly with my nurse specialists who are often the drivers more so than the doctors at times. They have made things so easy and so streamlined and actually hold so much power in themselves.

> Health advocates are very important too to make connections so it's not all on me as the patient, or my GP, because my GP can't have those internal conversations with the hospital either. The most important thing is to have early conversations about quality of life care rather than waiting until you are in palliative care. This

must be supported by a complex care team. We need a hub, or identifiable group of connected specialists and teams within Waikato Hospital in order to pull the right people together.

Having a diagnosis has changed everything for Kylee. She was no longer a set of medical conditions that didn't make sense. All of a sudden, her condition made sense. The diagnosis provided validation for Kylee and enabled her to receive the care she needed.

> For people with disabilities and complex health conditions there needs to be an early focus on quality of life. Disability affects the whole person, physically and psychologically. We need to look at the whole person, and the whole picture.
>
> There is psychology support if you have cancer. There is psychology support for pain management. There is psychology support for older person's rehabilitation, and that's great, but what happens if you're a young person with a complex health condition who is struggling with being told you are going to face deterioration after deterioration after deterioration and are constantly going to face losses? I was told, 'Well we can try older person's rehab and see if they can take you but it depends on, first, how many older persons they've got because that's their priority.' I've had seven surgeries in the last year. I've got a multifactorial, multisystemic condition, that affects every single part of my body. And you're telling me there is no access to psychological support for me?

Despite continuing challenges, Kylee believes that things have gotten better in terms of disabled people knowing their rights as patients.

> I now understand that it is my right, it is my body, it is my choice. Today I have nothing but incredible respect from all my teams. I say to everyone that comes into my room that I've got a life to live and I'll do whatever I have to do here to continue living my best life out there. Your job is to help me, and I'll partner with you in that because I have a life to live, that I want to live, that's out there.

Sarah Burrell

I moved to NZ 13 years ago. The New Zealand health system is really good, for the general public. For the Deaf community, however, there are so many barriers. We can't just turn up and meet the doctor and discuss things. We have to first of all book an interpreter. It takes time to find the right interpreter for the specific job. So, we don't have the freedom to just turn up. That causes a lot of frustration because sometimes you want a specific interpreter but they can't come so you've got to get someone else, who may not be quite right for the job. There is lots of sorting and thinking to do before we even go to our appointment.

About 4 years ago I went to a specialist appointment with a physio, a referral from the DHB, after I gave birth to my daughter. It was a terrible experience. They booked an interpreter for me with the DHB. I told them the specific person I wanted. I didn't want anyone else. I just felt comfortable with this one interpreter, the interpreter knew my history, all my background information, so the appointment would go smoothly. They booked someone completely different, a different interpreter, a younger interpreter.

When I arrived for my appointment I saw a different interpreter. I approached the reception and I said, 'I'm pretty sure that I've asked for these specific people to be booked, one or the other.' And they said, 'Well we booked an interpreter.' I asked, 'Do you realise that this is a personal experience. I've got my legs apart in some situations. It's who I want to feel comfortable with. This person hasn't been a mother, hasn't been to other appointments with me. You can't just book anybody.'

I told the interpreter, 'Look. I'm really sorry, this is not personal, but you need to leave. I would prefer somebody else.' The interpreter was a bit

shocked. I said, 'I'm really sorry, this is not about you, personally, but this appointment is personal to me and I feel it's not appropriate to have you here. You will be paid and I'll ensure that that happens but I would like to go ahead with someone else.'

As it happened, I decided not to have an interpreter there at all. I decided to just go ahead with the appointment by myself. I felt that it was really important for me to feel comfortable. I was frustrated, of course, but that's what I have to deal with all the time. It's an occurrence that happens often. I feel like sometimes we're either drowning or, most of the time I just have to try to swim as best I can.

It's my choice. I can't choose the doctor, but I can choose my interpreter. I do have that right. We should all have the right to be able to do that. I felt that that right was taken away from me.

Te kōwhiri me te mana whakahaere | Choice and control: Enabling Good Lives

Enabling Good Lives (EGL) is a partnership between the disability community and Government. EGL Waikato seeks to build local leadership, momentum and capacity and also demonstrate changes to the way disabled people and whānau get disability support to enable self-determination, choice and control.

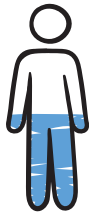
EGL **426** participants in EGL Waikato

252 **Male** 252 (59%)

174 **Female** 174 (41%)*

* 2% of data had an unspecified gender

EGL participants by age



39% aged 0-14 years

26% aged 15-24 years

26% aged 25-39 years

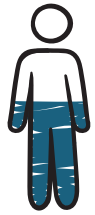
9% aged 40 years and over

EGL participation by ethnicity

35% are Māori

5% are Pacific Peoples

8% are Asian

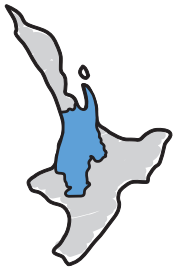


50% are European

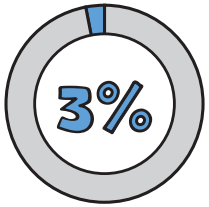
Te kōwhiri me te mana whakahaere | Choice and control: Disability Support Link clients

Disability Support Link is a needs assessment and coordination (NASC) service for people with disabilities such as intellectual, physical, age related or psychiatric for any age. Short term illnesses or ACC related conditions are excluded. DSL's clients get to make independent choices on the services they receive and who delivers them. Individualised Funding, Choices in Community Living and Supported Independent Living are all options available to clients. A Service Co-ordinator will arrange for support services to be provided such as personal care, household assistance, carer support, medication oversight, day programmes, shopping assistance or residential care and support.

12,613
disabled people are supported by Disability Support Link (DSL) in the Waikato (October 2020).

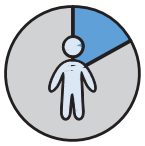
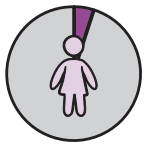
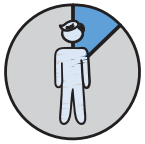
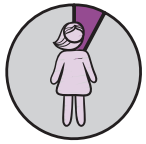
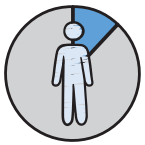
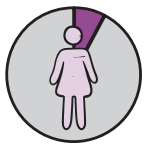


11%
of the estimated population with an impairment in the Waikato are DSL clients.

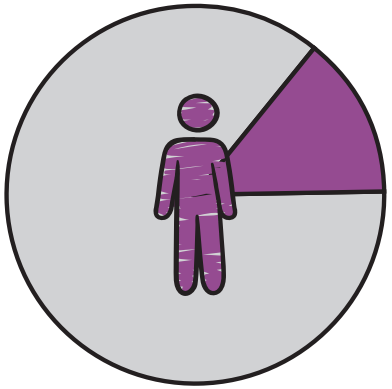


3%
of the total population of the Waikato.

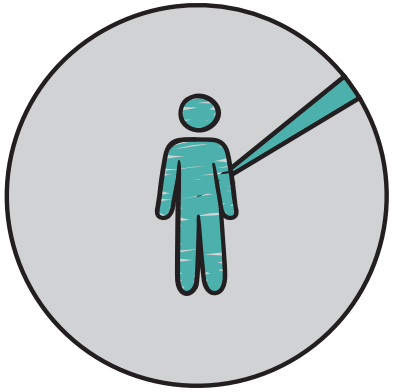
Number and percentage across age groups within gender (2020):

Male		Female	
	**1,020 (19%)** 0-14 years		**363 (5%)** 0-14 years
	**772 (15%)** 15-44 years		**543 (7%)** 15-44 years
	**560 (11%)** 45-64 years		**612 (8%)** 45-64 years
	**2,934 (56%)** 65+ years		**5,809 (79%)** 65+ years

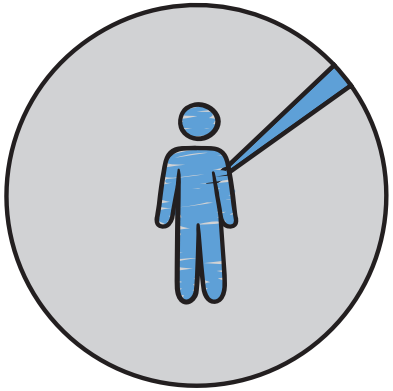
Te kōwhiri me te mana whakahaere | Choice and control: Disability Support Link clients by ethnic group



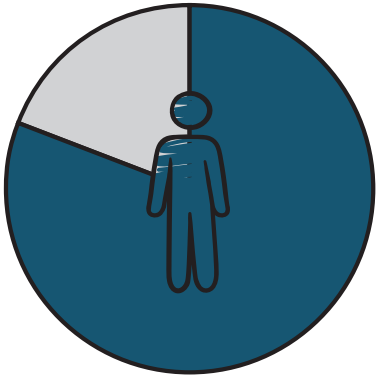
15% Māori (1,856)



2% Pacific Peoples (216)



3% Asian (352)

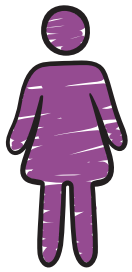


80% European (10,055)

Te kōwhiri me te mana whakahaere | Choice and control: Te Kapore Āwhina Hunga Whara/Accident Compensation Corporation (ACC) clients

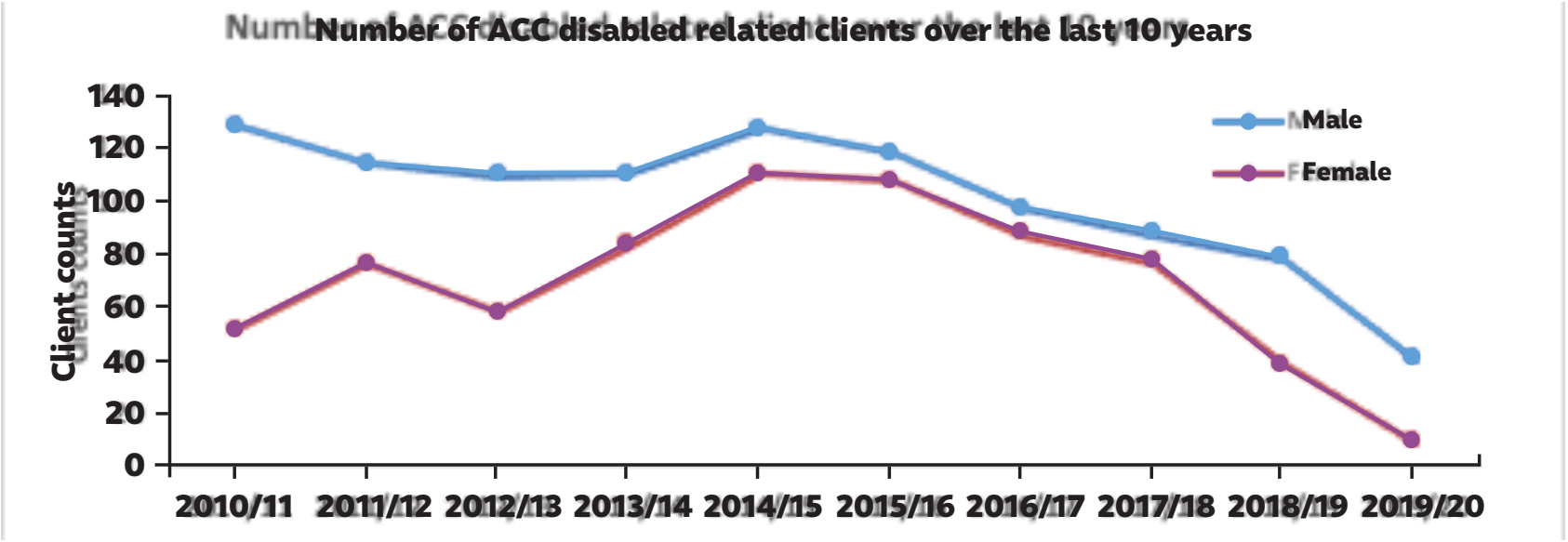
49 disability related ACC clients* in 2019/20

40 (82%) male



9 (18%) female

* Clients who have long term incapacity / disabilities as a result of an accident they have suffered, for which a claim was lodged with ACC.



Ārahitanga

Leadership

Isaac Rakena

During the four years I was involved in wheelchair rugby, I got to travel across the country and even took a team to a wheelchair rugby tournament in Montréal, Canada in 1998, which was a personal highlight. I gained administration skills which came in good stead when I organised the NZ National Wheelchair Rugby Championships in 2000, which was another personal highlight. I learned a lot about my new life in a wheelchair and how to look after my body when I was playing wheelchair rugby. Deb and I made a lot of friends within our new community, who were a great source of tips and information; a few of whom are still close friends some 20 years later. Although I tried to seek ACC approval to fund my rugby wheelchair, I was declined under some sort of funding criteria, instead of considering how it could have benefitted in my rehabilitation. Therefore, I had to make do with other people's rugby wheelchairs which were either too big or too small, because I couldn't afford one.

Tegan Morris

I was 21 when I was asked to come onto the Board of Interactionz. I enjoy public speaking, I've gone to conferences, I've been to forums and done various types of advocacy, and I do regular voluntary education work with AUT students. I've written publications for disability organisations, I've written a novel, I have a YouTube channel, I have Instagram. I have a life coaching business that fits with my interest in trying to help others.

I think one of the challenges in my leadership experience, and not just my own, but in general for people with disabilities, is being given the same voice as others, and not just, "hey we've given you a space" but actually tuning everybody in to the same time and the space for that person to be valued. And, having people actually adjust their ears and their eyes and their hearts to be open to want people with difference, whether it comes from a person with a disability, or someone who comes from a different culture, or sexual orientation. If all people who are trying to lead together, trying to make change, who are part of that shared experience, are not there whole heartedly, then all they're going to be doing is having their ears going, but there will be no buy in, which means that nothing will change. If there is a way to activate people to feel secure, even if there is conflict and unease, there is space for disabled people to grow.

I have felt successful in my leadership when people are able to put aside strongly held beliefs or bias to think, "Yea, ok, well, this is another perspective, or another way of looking at something that might look to some people one way, but actually there are other perspectives that we can build on to move forward together". It's not just one person on a stage, or on a soapbox. All voices need to be heard.

Glen Terry

Glen is recognised for his leadership abilities. He is a member of the Leadership Group at Enabling Good Lives and a Consumer Advisor on the Health and Disability Commission.

> I was nominated by People First to be on the Health and Disability Commission Advisory Group. I was interviewed for the position and I got in and have served two terms already. I am sent and review all the papers and travel to Wellington for meetings several times a year. We talk about patient complaints and policy, and how the medical profession can support people like me, people living with a disability, who are going into hospitals, or going to the doctor, so that doctors learn to explain medical issues in easy to understand ways.

The people that support Glen in his work with the Disability Commission Advisory greatly appreciate the valuable contribution that Glen makes. He brings the conversation to the issues facing disabled people and makes it real. His voice is an important voice to the Disability Commission Advisory Group.

Ngā tūtohi me ngā kohinga āwhina

Tables and references

Ko wai te hunga hauā i Waikato? | Who are the disabled peoples of the Waikato?

Number of people with an impairment in the Waikato by ethnicity (2021)

Age (years)	Waikato estimate (2021)[1]				New Zealand (2021)[2]			
	Māori	Pacific Peoples	Asian	European/Other[3]	Māori	Pacific Peoples	Asian	European/Other[3]
Under 15	7,000 (19%)	1,300 (14%)	900 (7%)	4,700 (6%)	38,300 (15%)	12,200 (9%)	6,600 (4%)	73,100 (11%)
15-44	17,500 (37%)	3,500 (36%)	9,100 (37%)	26,500 (21%)	78,100 (23%)	31,600 (17%)	41,100 (10%)	205,300 (16%)
45-64	6,000 (29%)	800 (25%)	3,100 (30%)	25,400 (28%)	64,200 (43%)	17,500 (26%)	35,300 (20%)	260,400 (28%)
65 or older	1,100 (15%)	300 (25%)	1,100 (26%)	31,100 (44%)	35,500 (63%)	17,900 (74%)	37,900 (50%)	398,700 (58%)

Numbers denote population counts and were rounded to the nearest 100. Numbers in parentheses are proportions of the total disabled population, in each ethnic group, by age. Percentages were calculated on unrounded numbers. [1]Estimated from 2021 population (medium) projection. Ethnicities were grouped by total response method i.e., where a person reported more than one ethnic group, they were counted in each applicable group. Projections for the 'European/Other' group include people who belong to the 'European' or 'Other (including New Zealander)' ethnic groups defined in Level One of the ethnicity classsifiation. If a person belongs to both 'European' and 'Other' ethnic groups, they have only been counted once. Almost all people in the 'Other' ethnic group belong to the 'New Zealander' subgroup. Source: Statistics New Zealand. (2018). *Subnational ethnic population projections, by age and sex, 2013(base)-2038 update* . Disability rates from Disability Survey 2013 were then applied onto the estimated count of the Waikato population to derive the estimated disabled population count. Source: Statistics New Zealand. (2014). *Disability Survey: 2013* . [2]Data from Disability Survey 2013. Ethnic grouping was by total response (rather than prioritised approach). [3]Includes Middle Eastern/Latin American African and Other. Relative sampling error is 30% or more, and less than 50%. Source: Statistics New Zealand. (2014). *Disability Survey: 2013* .

Population of disabled peoples of the Waikato by gender (2021)

Age (years)	Waikato estimate (2021)[1]						New Zealand (2021)[2]					
	Number[1]			Percentage[2]			Number[1]			Percentage[2]		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Under 15	3,300	5,900	9,200	7%	12%	9%	37,228	63,889	101,117	8%	13%	11%
15-44	22,700	23,800	46,500	25%	26%	25%	159,240	162,744	321,984	16%	16%	16%
45-64	17,100	15,500	32,600	28%	27%	28%	178,178	164,878	343,056	28%	28%	28%
65 or older	17,100	13,500	30,600	40%	35%	38%	261,570	220,864	482,434	60%	58%	59%
Population	60,200	58,700	118,900	100%	100%	100%	-	-	-	-	-	-

Numbers denote population counts and were rounded to the nearest 100. Percentages are proportions of the total disabled population for each gender, by age. Percentages were calculated on unrounded numbers. [1]Estimated from 2018 population (medium) projection. Ethnicities were grouped by total response method. Source: Statistics New Zealand. (2018). *Subnational ethnic population projections, by age and sex, 2013(base)-2038 update* . Disability rates from Disability Survey 2013 were then applied onto the estimated count of the Waikato population to derive the estimated disabled population count. Source: Statistics New Zealand. (2014). *Disability Survey: 2013* . [2]Data from Disability Survey 2013. Count data was weighted using population projection for 2021. Due to rounding, numbers may not sum to stated totals. Percentage is calculated as proportion of the total population, in each age and sex group, that was disabled. Source: Statistics New Zealand. (2014). *Disability Survey: 2013* .

Ko wai te hunga hauā i Waikato? | Who are the disabled peoples of the Waikato?

Number[1,2] of people with an impairment across the Waikato DHB area (2021)*

Territorial authority	Under 65 years	65 years or above
Waikato DHB[3]	75,400	43,300
Hamilton City	29,100	12,800
Waikato	10,900	5,100
Waipa	8,800	5,900
Matamata-Piako	5,700	4,200
Thames-Coromandel	4,400	5,300
South Waikato	4,400	2,700
Hauraki	3,500	3,000
Otorohanga	1,800	900
Waitomo	1,800	900
Ruapehu	1,700	800

Numbers denote population counts and were rounded to the nearest 100. *Parts of Ruapehu and Waikato District not within Waikato DHB area are omitted. [1]Estimated from 2018 population projection. Ethnicities were grouped by total response method. Source: Statistics New Zealand. *Subnational ethnic population projection, by age and sex, 2013(base)-2038 update* . [2]Disability rates from Disability survey 2013 were then applied onto the count of estimated Waikato population. 3. There is 5,000 population estimate undercount when estimating by territorial authority when added up and compared to the Waikato level population estimate. Source: Statistics New Zealand (2014). *Disability Survey: 2013* .

Impairment rate by gender (all ages)[1]

Impairment type[2]	Female	Male
Mobility	15%	11%
Agility	8%	6%
Hearing	7%	10%
Psychiatric/psychological	5%	5%
Sight	4%	3%
Learning	4%	6%
Remembering[3]	4%	4%
Speaking	2%	4%
Intellectual	1%	3%

[1]As proportion of general population; [2] individual may appear in more than one impairment type; [3]Only asked of adults aged 15 years or above. Source: Statistics New Zealand. (2014). *Disability Survey: 2013.*

Ko wai te hunga hauā i Waikato? I Who are the disabled peoples of the Waikato?

Cause of impairment (all ages)[1]

Cause of Impairment[2]	Total population		Māori	
	Female	Male	Female	Male
Disease or illness	46%	35%	44%	36%
Accident or injury	24%	38%	23%	33%
Existed at birth	11%	17%	20%	27%
Ageing[3]	34%	23%	27%	11%
Other	26%	23%	29%	27%

[1]An individual may appear in more than one cause of impairment group. [2]As percentage of disabled total, or Māori, population, in each gender group, who had the specified cause of impairment. [3]Only asked of adults aged 15 years or above. Percentages may not sum to the stated totals because: a) individuals were counted in each applicable higher level impairment type and ethnic group, and b) percentages are rounded. Source: Statistics New Zealand. (2014). *Disability Survey: 2013.*

Impairment rate by ethnicity (all ages)[1]

Impairment type[2]	Māori	Pacific Peoples	Asian	European	Other[3]	Total population
Sensory[4]	11%	7%	5%	12%	14%	11%
Physical[5]	13%	10%	7%	15%	15%	14%
Intellectual	3%	*3%	*1%	2%	S	2%
Psychiatric/psychological	7%	5%	3%	6%	*8%	5%
Other[6]	11%	8%	4%	8%	*8%	8%
Total	**26%**	**19%**	**13%**	**25%**	**28%**	**24%**

[1]As proportion of general population. Ethnicities were grouped by total response method i.e., where a person reported more than one ethnic group, they were counted in each applicable group. [2]An individual may appear in more than one impairment type. [3]Includes Middle Easter/Latin American/African and Other ethnicities. [4]Includes hearing and vision impairments. [5]Includes mobility and agility impairments. [6]Includes impaired speaking, learning, and developmental delay for children aged 0-14 years, and impaired speaking, learning, and remembering for adults aged 15 years or above. *Relative sampling error is 30% or more, and less than 50%; S: Suppressed. Source: Statistics New Zealand. (2014). *Disability Survey: 2013.*

Mātauranga | Education

Number of students receiving learning support or services, by school year level (as at 1 July 2019)

	ORS			OLS			AT		
Gender	Waikato	%[1]	%[2]	Waikato	%[1]	%[2]	Waikato	%[1]	%[2]
Female	306	9%	0.8%	412	10%	1.1%	61	9%	0.2%
Male	628	9%	1.7%	991	9%	2.6%	115	8%	0.3%
Total	934	9%	1.3%	1,403	9%	1.9%	176	9%	0.2%

ORS: Ongoing Resource Scheme; OLS: Other Learning Support; AT: Assistive Technology.
[1]As proportion of national numbers for the corresponding support type, for each gender.
[2]As proportion of Waikato's student number, for each gender. Source: Ministry of Education, 2020.

Number of students receiving learning support or services in the Waikato region, by school year level (as at 1 July 2019)

School Yr	ORS		OLS*		AT		ORS school type			
Level	Waikato	%[1]	Waikato	%[1]	Waikato	%[1]	Special	%[2]	Other	%[2]
Yr 1-8	563	9%	1,312	9%	138	8%	233	12%	330	9%
Yr 9-13	371	9%	91	8%	38	9%	170	10%	201	8%
All Levels	934	9%	1,403	9%	176	9%	403	11%	531	8%

ORS: Ongoing Resource Scheme; OLS: Other Learning Support; AT: Assistive Technology. [1]As proportion of national numbers, in each level, for each support type. [2]As proportion of national numbers, in each level, for each school type. Data breakdown by school type is unavailable for OLS and AT due to small numbers. *Please note that children and young people receiving individualised Ministry services represent only a small proportion of those with additional needs. The majority receive support directly within their school or early learning service, or from a Ministry contracted provider. Source: Ministry of Education, 2020.

Mātauranga | Education

Number of students receiving learning support or services, by ethnicity (as at 1 July 2019)

Ethnicity[1]	ORS			OLS			AT[3]		
	Waikato	%[2,4]	%[3,4]	Waikato	%[2,4]	%[3,4]	Waikato	%[2,4]	%[3,4]
Māori	379	41%	29%	586	42%	35%	54	31%	27%
Pacific Peoples	81	9%	14%	92	7%	13%	9	5%	11%
Asian	79	8%	12%	83	6%	8%	10	6%	7%
European	546	58%	57%	875	62%	59%	127	72%	67%
Other	29	3%	4%	39	3%	3%	2	2%	4%
Total[4]	**934**	-	-	**1,403**	-	-	**176**	-	-

[1]More than one ethnicity could be chosen. [2]As proportion of students receiving each support type, by ethnicity, in Waikato. [3]National rates of students receiving each support type, by ethnicity. [4]Students who identified with more than one ethnicity were counted in each ethnic group, but only once in 'Total' ethnic group. Thus, proportions by ethnicity do not sum up to 100%. Source: Ministry of Education, 2020.

Students receiving ORS support, by student age and school type (as at 1 July 2019)[1]

Age (years)	Waikato		National	
	Special schools	Other schools	Special schools	Other schools
0-5	32(47%)	36(53%)	198(36%)	358(64%)
6	23(33%)	47(67%)	282(36%)	507(64%)
7	44(48%)	47(52%)	243(32%)	517(68%)
8	25(45%)	30(55%)	229(32%)	480(68%)
9	28(35%)	52(65%)	220(30%)	503(70%)
10	31(42%)	42(58%)	243(31%)	537(69%)
11	32(43%)	42(57%)	232(33%)	477(67%)
12	18(35%)	34(65%)	220(32%)	475(68%)
13	25(40%)	37(60%)	217(31%)	481(69%)
14	24(37%)	41(63%)	230(35%)	424(65%)
15	20(45%)	24(55%)	222(35%)	405(65%)
16	31(51%)	30(49%)	220(38%)	366(62%)
17 or above	70(50%)	69(50%)	772(45%)	956(55%)
All ages	**403(43%)**	**531(57%)**	**3,528(35%)**	**6,486(65%)**

[1]Numbers indicate student counts; Numbers in parentheses indicate proportion of student in each age band, by school type. Source: Ministry of Education, 2020.

Mātauranga | Education

NCEA level attained by ORS school leavers in the Waikato (as at 1 July 2017)

NCEA Level Attained[1]	Region	Per 100 ORS school leavers	Per 100 General school leavers
1 or above	Waikato	15	88
	National	24	90
2 or above	Waikato	7	78
	National	16	81
3 or above	Waikato	5	46
	National	9	54

[1]Includes University Entrance Qualification. Note that the proportions for Waikato ORS school leavers are based on small numbers and should be interpreted with caution. Source: Education Counts, Ministry of Education, 2019.

Highest educational qualification attained for the national working age population, by age and disability status

	15-44 years		45-64 years		65 years or above	
Highest Qualification attained	**Disabled**	**Non-disabled**	**Disabled**	**Non-disabled**	**Disabled**	**Non-disabled**
No qualification	24%	12%	31%	15%	42%	34%
School qualification at Level 1-4[1]	41%	41%	30%	33%	27%	31%
Post-school qualification at Level 1-6[2]	21%	20%	25%	29%	22%	23%
Bachelor's degree or higher	14%	28%	13%	23%	8%	13%
Total[3]	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Percentages are calculated as proportion of the total working age population in each age group and by disability status. Working age population is defined as the usually resident, non-institutionalised, civilian population of New Zealand aged 15 years and over on census night. [1]Include Level 1–4 certificates gained at school and overseas school qualifications. [2] Include Level 1–4 certificates, and Level 5–6 diplomas completed post school. [3]Total number of people who answered the survey question with a useable response. Source: Statistics New Zealand. (2014). *Disability and the labour market: Findings from the 2013 Disability Survey.*

Te whai mahi me te tiaki pūtea | Employment and economic security

National employment rate for 15-64 year-olds (2020)

Labour status	Disabled	Non-disabled
In labour force	42%	81%
• Employed	38%	78%
• Unemployed	8%	4%
Not in labour force	58%	19%
Working age population	100%	100%

Source: Statistics New Zealand (2020). *Labour market statistics (disability): June 2020 quarter* . Table 2.

National employment rate (2020), by age

Age group (year)	Employment rate[1]	
	Disabled	Non-disabled
15–24	18.7%	55.1%
25–44	42.2%	83.9%
45–64	41.8%	83.6%
65+	8.0%	27.3%

[1]As proportion of labour force. Source: Statistics New Zealand (2020). *Labour market statistics (disability): June 2020 quarter* . Table 5.

National average weekly income, in each age group and population, by income source (2020)

	Income source:	Self-employment			Wage and Salary			Government Transfer[1]			Total		
Age group (years)	Population group	Average weekly income[2]	Number[3]	%[4]	Average weekly income[2]	Number[3]	%[4]	Average weekly income[2]	Number[3]	%[4]	Average weekly income[2]	Number[3]	%[4]
15-64	Disabled	$956	11,500	11%	$1,057	30,000	28%	$342	53,500	49%	$596	108,400	100%
	Non-disabled	$1,042	468,000	15%	$1,218	2,005,600	64%	$293	434,600	14%	$941	3,115,000	100%
65 or above	Disabled	$724	4,200	4%	$830	4,800	4%	$418	114,400	96%	$460	119,000	100%
	Non-disabled	$879	73,000	12%	$1,033	98,900	16%	$391	595,200	94%	$614	633,600	100%
All ages	Disabled	$894	15,600	7%	$1,025	34,700	15%	$393	167,900	74%	$525	227,400	100%
	Non-disabled	$1,020	541,000	14%	$1,210	2,104,500	56%	$349	1,029,900	27%	$886	3,748,600	100%

[1]Government transfers are income from benefits, working for families tax credits, paid parental leave, student allowances, New Zealand (National) Superannuation, and veteran's and war pensions. [2]Calculated as the total weekly income from that source divided by the number of people who receive income from this source. [3]The number of people receiving income from a particular source. [4]As proportion of the total population, in each age and disability status group. The total population is the total number of people in 'all sources collected' group. Source: Statistics New Zealand (2020). *Incomes. Income by disability status, age groups and income source. Household Labour Force Survey: June 2020 quarter* .

Te whai mahi me te tiaki pūtea | Employment and economic security

People receiving government transfer (18-64 year-olds), by transfer type and region (September 2020)

Support	Support subtype	Waikato Number	Waikato %[1]	Waikato %[2]	National Number	National %[1]
Jobseeker	Health Condition or Disability	6,119	30%	5%	71,280	35%
	Work Ready	14,471	70%		132,836	65%
	Total	**20,590**	**100%**		**204,116**	**100%**
Supported Living	Health Condition or Disability	7,043	87%	6%	85,075	90%
	Caring (carer support)	1,031	13%		9,071	10%
	Total	**8,074**	**100%**		**94,146**	**100%**

[1]As proportion of people receiving Jobseeker, or Supported Living Payment, benefit type. Data is for year ending 30 September 2020. Source: Te Hiranga Tangata - Work and income, 2020. As proportion of the estimated disabled population in the Waikato. The estimate was based on 2018 population projection, and then disability rates from Disability Survey 2013 were applied onto the count of estimated Waikato population. Source: Statistics New Zealand. (2018). *National ethnic population projections, by age and sex, 2013(base)-2038 update* . Statistics New Zealand. (2014). *Disability Survey: 2013* . Data received through OIA via email from Ministry of Social Development Insights and Strategy Group.

People receiving selected supplementary assistance in the Waikato (18-64 year-olds), by transfer subtype (September 2020)

Support subtype:	JS HC&D Number	JS HC&D %[1]	SLP HC&D Number	SLP HC&D %[1]	JS & SLP HC&D Total	JS & SLP HC&D %[2]
Accommodation Supplement	4,602	75%	3,789	53%	8,391	7%
Disability Allowance	1,966	32%	4,198	59%	6,164	5%
Temporary Additional Support	1,829	30%	1,246	17%	3,075	3%
Total	**6,119**	**100%**	**7,161**	**100%**		

[1]As proportion of people receiving Jobseeker, or Supported Living Payment, benefit type. [2]As proportion of the estimated disabled population in the Waikato (118,900). Data is for year ending 30 September 2020. JS HC&D: Jobseeker Support under Health Condition or Disability. SLP HC&D: Supported Living Payment under Health Condition or Disability. Source: Te Hiranga - Work and income, 2020. Data received through OIA via email from Ministry of Social Development Insights and Strategy Group.

Selected hardship assistance that were approved (16 year-olds or older) in the Waikato, by transfer subtype (2019/20)[1]

Support subtype:	JS HC&D Number[2]	JS HC&D %[3]	SLP HC&D Number[2]	SLP HC&D %[3]
Special Needs Grant	7,098	116%	5,365	76%
• Emergency Housing Grant	1,909	27%	1,346	19%
Advance Payment of a Benefit	7,377	121%	6,390	91%

[1]For year ending 30 September 2020. JS HC&D: Jobseeker Support under Health Condition or Disability. SLP HC&D: Supported Living Payment under Health Condition or Disability. [2]Counts of grants approved for clients. [3]Special Needs Grant as a proportion of Jobseekers or Supported Living Payment. Emergency Housing Grant as a proportion of Special Needs Grant, for each benefit subtype. A client may receive more than one grant so, the proportion may sum up to be more than 100%. Source: Te Hiranga Tangata - work and income, 2020. Data received through OIA via email from Ministry of Social Development Insights and Strategy Group.

Te whai mahi me te tiaki pūtea | Employment and economic security

People receiving Supported Living Payment under Health Condition or Disability in the Waikato (September 2020), by age, gender, ethnicity or incapacity group

Gender	Number	%
Female	2,948	48%
Male	3,171	52%
Total	**6,119**	**100%**

Age (years)	Number	%
18-24	907	15%
25-34	1,211	20%
35-44	960	16%
45-49	665	11%
50-64	2,376	39%
Total	**6,119**	**100%**

Ethnicity	Number	%
Māori	2,262	37%
Pacific Peoples	114	2%
European	2,799	46%
Other	761	12%
Unspecified	183	3%
Total	**6,119**	**100%**

Incapacity group	Waikato Number	%
Psychological or psychiatric conditions	3,159	52%
Musculoskeletal system disorder	851	14%
Accident	370	6%
Cardiovascular disorders	277	5%
Metabolic & endocrine disorders	222	4%
Other disorders & conditions	1,240	20%
Total	**6,119**	**100%**

People receiving Supported Living Payment under Health Condition or Disability in the Waikato (September 2020), by age, gender, ethnicity or incapacity group

Gender	Number	%
Female	3,369	48%
Male	3,674	52%
Total	**7,043**	**100%**

Age (years)	Number	%
18-24	576	8%
25-34	962	13%
35-44	987	14%
45-49	741	10%
50-64	3,777	53%
Total	**7,161**	**100%**

Ethnicity	Number	%
Māori	2,202	31%
Pacific Peoples	87	1%
European	3,516	50%
Other	926	13%
Unspecified	312	4%
Total	**7,043**	**100%**

Incapacity group	Waikato Number	%
Psychological or psychiatric conditions	2,505	36%
Intellectual disability	814	12%
Musculo-skeletal sys. Disorder	678	10%
Nervous system disorders	574	8%
Congenital conditions	476	7%
Other disorders & conditions	1,996	28%
Total	**7,043**	**100%**

Source: Te Hiranga - Work and income, 2020. Data received through OIA via email from Ministry of Social Development Insights and Strategy Group.

Te whai mahi me te tiaki pūtea | Employment and economic security

People receiving selected supplementary assistance in the Waikato (September 2020), by age

Age Group (years)	Accommodation Supplement				Disability Allowance				Temporary Additional Support			
	JS HC&D		SLP HC&D		JS HC&D		SLP HC&D		JS HC&D		SLP HC&D	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
18-24	734	16%	296	8%	196	10%	211	5%	215	12%	27	2%
25-34	983	21%	543	14%	294	15%	457	11%	327	18%	113	9%
35-44	774	17%	563	15%	272	14%	547	13%	321	18%	146	12%
45-49	491	11%	428	11%	228	12%	467	11%	218	12%	163	13%
50-64	1,620	35%	1,959	52%	976	50%	2,516	60%	748	41%	797	64%
Total	**4,602**	**100%**	**3,789**	**100%**	**1,966**	**100%**	**4,198**	**100%**	**1,829**	**100%**	**1,246**	**100%**

People receiving selected supplementary assistance in the Waikato (September 2020), by gender

Gender	Accommodation Supplement				Disability Allowance				Temporary Additional Support			
	JS HC&D		SLP HC&D		JS HC&D		SLP HC&D		JS HC&D		SLP HC&D	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Female	2,197	48%	1,827	48%	1,126	57%	2,293	55%	976	53%	727	58%
Male	2,405	52%	1,962	52%	840	43%	1,905	45%	853	47%	519	42%
Total	**4,602**	**100%**	**3,789**	**100%**	**1,966**	**100%**	**4,198**	**100%**	**1,829**	**100%**	**1,246**	**100%**

People receiving selected supplementary assistance in the Waikato (September 2020), by ethnicity

Ethnicity	Accommodation Supplement				Disability Allowance				Temporary Additional Support			
	JS HC&D		SLP HC&D		JS HC&D		SLP HC&D		JS HC&D		SLP HC&D	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Māori	1,650	36%	1,116	29%	654	33%	1,288	31%	642	35%	363	29%
Pacific Peoples	91	2%	50	1%	24	1%	52	1%	40	2%	14	1%
European	2,162	47%	1,994	53%	950	48%	2,177	52%	884	48%	695	56%
Other	560	12%	479	13%	288	15%	550	13%	231	13%	145	12%
Unspecified	139	3%	150	4%	50	3%	131	3%	32	2%	29	2%
Total	**4,602**	**100%**	**3,789**	**100%**	**1,966**	**100%**	**4,198**	**100%**	**1,829**	**100%**	**1,246**	**100%**

JS HC&D: Jobseeker Support under Health Condition or Disability. SLP HC&D: Supported Living Payment under Health Condition or Disability. Source: Te Hiranga Tangata - Work and income, 2020. Data received through OIA via email from Ministry of Social Development Insights and Strategy Group.

Hauora | Health and Wellbeing

Disease prevalence in primary health care from a sample of Disability Support Link clients (2018/19)

Disease	Ethnicity	Number[1]			Prevalence[2]		
		Male	Female	Total	Male	Female	Total
Respiratory diseases[3] (All ages)	Māori	139	219	358	25%	37%	32%
	European	289	591	880	16%	25%	21%
	Others	18	31	49	11%	15%	13%
	Total	**446**	**841**	**1,287**	**18%**	**27%**	**23%**
Stroke[4] (15 years or older)	Māori	51	74	125	13%	11%	12%
	European	309	421	730	11%	8%	9%
	Others	19	27	46	13%	12%	13%
	Total	**379**	**522**	**901**	**12%**	**9%**	**10%**
Heart failure[4] (15 years or older)	Māori	57	81	138	13%	12%	12%
	European	196	307	503	5%	5%	5%
	Others	8	13	21	3%	6%	5%
	Total	**261**	**401**	**662**	**7%**	**7%**	**7%**
Diabetes[4] (15 years or older)	Māori	108	153	261	26%	26%	26%
	European	324	455	779	15%	14%	14%
	Others	30	39	69	29%	19%	23%
	Total	**462**	**647**	**1,109**	**19%**	**18%**	**18%**
Ischaemic heart disease[4] (15 years or older)	Māori	116	180	296	27%	26%	26%
	European	678	1,014	1,692	22%	18%	20%
	Others	34	54	88	19%	24%	22%
	Total	**828**	**1,248**	**2,076**	**24%**	**21%**	**22%**
Osteoarthritis[3] (All ages)	Māori	36	82	118	7%	10%	9%
	European	206	500	706	8%	12%	10%
	Others	S	22	29	S	8%	6%
	Total	**249**	**604**	**853**	**7%**	**10%**	**9%**
Renal impairment/ failure[3] (All ages)	Māori	35	65	100	8%	8%	8%
	European	120	183	303	4%	3%	3%
	Others	S	S	9	S	S	2%
	Total	**159**	**253**	**412**	**5%**	**4%**	**4%**
Gout[3] (All ages)	Māori	63	67	130	15%	9%	12%
	European	181	136	317	8%	3%	5%
	Others	S	S	16	S	S	3%
	Total	**252**	**211**	**463**	**10%**	**4%**	**6%**

[1]Source: Hauraki PHO, 2019. Data are for all ages unless otherwise stated. [2]Age-standardised rates. The standard population used for age standardisation was the estimated number of disabled people in Waikato which was derived from the sum of territorial authority level estimates using data from Household Disability Survey 2013 and 2013 Census. Source: Statistics New Zealand. (2017). *Disability estimates for small areas: 2013.* [3]For period ending 31 December 2018. [4]For period ending 31 March 2019. 'S' denotes suppressed data due to small numbers.

Hauora | Health and Wellbeing

Current smokers aged 15 years or above[1], by ethnicity (as at 31 March 2019)

Ethnicity	Smokers	Total	%
Māori	133	830	16%
European	256	3,927	7%
Others	14	243	6%

[1]For period ending 31 March 2019. Source: Hauraki PHO, 2019.

Primary health care quality measures (as at 31 March 2019)

	Female		Male	
National Health Screen	Number[1]	%[2]	Number[1]	%[2]
Smoking Brief Advice[3]	185 (225)	82%	138 (178)	78%
Cervical Screening[4]	220 (641)	34%	-	-
Diabetes Annual Review[5]	402 (604)	67%	287 (418)	69%
Cardiovascular Risk Assessment[6]	258 (715)	36%	202 (361)	56%

[1]These are a sample of Disability Support Link clients (aged 15 years or above) who enrolled with Hauraki PHO, for period ending 31 March 2019. Number indicates count of eligible clients who received a health screen. Number in parentheses indicates total count of eligible clients, by health screen. [2]As proportion of total eligible clients, by gender, for each health screen. [3]Current smokers who received brief advice in the last 15 months. [4]Females aged 25-69 years who were screened in the last 3 years. Waikato's screening rate is 77% (Waikato District Health Board Coverage Report - period ending 31 March 2019). [5]People diagnosed with diabetes who enrolled with the PHO within the last 12 months, and had a Diabetes Annual Review conducted. [6]Eligible females (aged 55 years or above) or males (aged 45 years or above) without known risk factors who were screened in the last 3 years. Source: Hauraki PHO, 2019.

Hauora | Health and Wellbeing

Emergency department attendances between 2014 and 2018, by ethnicity[1]

	Female		Male		Total	
Ethnicity	Number of attendances	Attendances per 10 persons[2]	Number of attendances	Attendances per 10 persons[2]	Number of attendances	Attendances per 10 persons[2]
Maori	3,999	55	3,425	48	7,424	50
Pacific Peoples	233	30	188	25	421	27
Asian	398	56	376	27	774	29
Other	19,574	40	13,774	35	33,348	37
Total	**24,204**	**43**	**17,763**	**37**	**41,967**	**40**

[1]Data is of the average number of emergency department attendances made by clients of Disability Support Link, Waikato, over the last 5 years (1 January 2014 to 31 December 2018). [2]Age-standardised rates (across all ages). Source: Waikato Hospital register CostPro, 2019.

Emergency department admissions between 2014 and 2018, by ethnicity[1]

	Female		Male		Total	
Ethnicity	Number of admissions	Admissions per 10 persons[2]	Number of admissions	Admissions per 10 persons[2]	Number of admissions	Admissions per 10 persons[2]
Maori	1,668	21	1,340	20	3,008	20
Pacific Peoples	80	11	77	12	157	11
Asian	181	21	178	15	359	14
Other	9,605	16	6,407	14	16,012	15
Total	**11,534**	**17**	**8,002**	**15**	**19,536**	**16**

[1]Data is of the average number of emergency department admissions made by clients of Disability Support Link, Waikato, over the last 5 years (1 January 2014 to 31 December 2018). [2]Age-standardised rates (across all ages). Source: Waikato Hospital register CostPro, 2019.

Ngā tika taumaru me te ture | Rights protection and justice

Five most cited grounds of alleged unlawful discrimination along with total number of alleged discrimination (2017-18 to 2019-20)

	2017-18		2018-19		2019-20	
Ground[2]	**Number**	**%[1]**	**Number**	**%[1]**	**Number**	**%[1]**
Race-related	426	31%	369	29%	383	27%
Disability	**425**	**31%**	**411**	**32%**	**249**	**17%**
Sex	244	18%	183	14%	110	8%
Age	150	11%	135	11%	93	6%
Sexual harassment	123	9%	106	8%	69	5%
Total alleged unlawful discrimination	**1,381**		**1,282**		**1,445**	-

[1]As proportion of the total enquiries and complaints (which includes unlawful discrimination) received for the year ending 30 June 2020. [2]Relates to unlawful discrimination under Part 1A or Part 2 of the Human Rights Act 1993. Source: Te Kāhui Tika Tangata - Human Rights Commision. (2020). *Annual Report - Pūrongo ā Tau 2019/20 NZ Human Rights.*

Applications for free legal representation in the Human Rights Review Tribunal (2019-20)

Ground	**Number**	**%[1]**
Disability	**24**	**37%**
Race	**8**	12%
Sexual harassment	**6**	11%
Age	**5**	8%
Ethnic / National origin	**5**	8%
Sex	**5**	8%
Racial harassment	**2**	3%
Religious belief	**2**	3%
Sexual orientation	**2**	3%
Employment status	**1**	1%
Family Status	**1**	1%
Political opinion	**1**	1%
Victimisation	**1**	1%
Total	**65**	-

[1]As proportion of all applications for the year ending 30 June 2020. Source: Te Kāhui Tika Tangata - Human Rights Commision. (2020). *Annual Report - P ūrongo ā Tau 2019/20 NZ Human Rights.*

Te whai wāhitanga | Accessibility

Use and unmet need of housing modifications[1], by impairment and modification type (2013)[2]

Impairment type	Modification type	Use	Need
Physical limitations	Entrance	17%	8%
	Kitchen	3%	2%
	Bathroom	25%	10%
	Moving about	3%	3%
	Other modifications	3%	4%
	Total any modification[3]	35%	17%
Vision limitations	Entrance	13%	8%
	Kitchen	2%[4]	S
	Bathroom	19%	9%
	Moving about	3%[4]	3%
	Other modifications	3%	4%[3]
	Total any modification[3]	26%	16%

[1]It is estimated that about 284 Housing NZ (HNZ) properties in the Waikato region (excluding Rotorua District) have modifications for people with impairments. The total number of properties in the Waikato region (excluding Rotorua District) owned and leased by HNZ was 4,496, as of 30 Jun 2018. This means that only about 6% of HNZ properties have modifications for people with impairments. Source: The Waikato Plan. (2018). *The Waikato Plan - Regional Housing Initiative 2018 Housing Stocktake. Nifa Limited.* [2]As proportion, in each impairment type, based on national data. Source: Statistics New Zealand. (2016). *Disability and housing conditions: 2013.* [3]People were able to select more than one modification, therefore percentages add to more than the total. [4]Relative sampling error between 30% and 40%. S: suppressed.

Access to good housing conditions

Accessibility indicator	Household measure[1]	Disabled	Non-disabled	Total
Household tenure	Owner occupied	48%	53%	52%
	Rented	**38%**	**30%**	**32%**
	In a family trust	13%	17%	16%
Household composition for adults (15 years and over)	One-family household			
	• Couple only	**33%**	**23%**	**26%**
	• Couple with other people or child(ren) and others	30%	49%	43%
	• One parent with child(ren)	8%	7%	7%
	• One parent with child(ren) and others	3%	2%	2%
	Two-family household	5%	6%	6%
	Three- or more-family household	1%	1%	1%
	Other multi-person household	5%	5%	5%
	One-person household	**17%**	**7%**	**10%**
Household crowding measure	**Need more bedrooms**	**19%**	**14%**	**14%**
	Enough bedrooms	32%	30%	30%
	Spare bedrooms	50%	56%	55%
House problems	**Difficulty keeping house warm**	**29%**	**16%**	**19%**
	• Māori[2]	36%	21%	26%
	• Pacific Peoples[2]	37%	28%	30%
	• Asian[2]	33%	12%	15%
	• European/Other[2]	22%	15%	17%
	Experiences damp	**23%**	**12%**	**14%**
	• Māori[2]	33%	19%	23%
	• Pacific Peoples[2]	23%	22%	23%
	• Asian[2]	21%	9%	10%
	• European/Other[2]	14%	11%	12%

[1]Age-adjusted household measures. As proportion based on national data. Source: Statistics New Zealand. (2016). *Disability and housing conditions: 2013.* [2]Source: McIntosh, J., and Leah, A. (2017). *Mapping housing for the disabled in New Zealand. New Zealand Medical Journal, 69-78.*

Te kōwhiri me te mana whakahaere | Choice and control

Participants of Enabling Good Lives, by demographics gender, age, ethnicity and location (as at 14 October 2020)

Source: Cosgriff, K. (2020). Correspondence with Director, Enabling Good Lives Waikato, Kate Cosgriff dated 14 October 2020.

Gender	Number	%
Male	252	59%
Female	174	41%
Total	**426**	**100%**

Age (years)	Number	%
0-14	165	39%
15-24	110	26%
25-39	111	26%
40-64	36	8%
65 or above*	4	1%
Total	**426**	**100%**

*Aggregated due to small numbers.

Ethnicity	Number	%
Māori	148	35%
Pacific Peoples	23	5%
Asian	33	8%
European	215	50%
Others	7	2%
Total	**426**	**100%**

Location	Number	%
Hamilton	234	55%
Te Awamutu	30	7%
Cambridge	21	5%
Huntly	17	4%
Ngaruawahia	15	4%
Raglan	13	3%
Taumarunui	13	3%
Paeroa	8	2%
Kihikihi	6	1%
Te Kauwhata	5	1%
Tokoroa	5	1%
Whangamata	5	1%
Other*	54	13%
Total	**426**	**100%**

*Includes Gordonton, Taupiri, Te Aroha Thames, Te Kuiti, Putaruru, Waitoa, and others. Aggregated due to small numbers

Te kōwhiri me te mana whakahaere | Choice and control

Disability Support Link clients: an overview (2020)

12,613 total disabled people supported by Disability Support Link, Waikato[1]
• 11% of the total population of the Waikato[2]
• 3% of the estimated population with an impairment in Waikato[3]

[1]Source: Disability Support Link, Waikato (as at 19 October 2020). [2]Estimated from 2020 population estimates. Source: Statistics New Zealand (2020). *Subnational population estimates (RC, constituency), by age and sex, at 30 June 2018-20 (2020 boundaries).* [3]Disability rates from Disability Survey 2013 were applied to the count of estimated Waikato population. Source: Statistics New Zealand. (2014). *Disability Survey, 2013.*

Disability Support Link clients by gender and age (2020)[1]

Age group	Number			Proportion(Age group)[2]			Proportion(Gender)[3]		
(year)	Female	Male	Total	Female	Male	Total	Female	Male	Total
0-14	363	1,020	1,383	5%	19%	11%	26%	74%	**100%**
15-24	234	398	632	3%	8%	5%	37%	63%	**100%**
25-44	309	374	683	4%	7%	5%	45%	55%	**100%**
45-64	612	560	1,172	8%	11%	9%	52%	48%	**100%**
65 years or above	5,809	2,934	8,743	79%	56%	69%	66%	34%	**100%**
Total	**7,327**	**5,286**	**12,613**	100%	100%	100%	-	-	

[1]Source: Disability Support Link, Waikato - as at 19 October 2020. [2]As proportion of total clients in each gender, by age group. [3]As proportion of total clients in each age group, by gender.

Te kōwhiri me te mana whakahaere | Choice and control

Disability Support Link clients by ethnicity and age (2020)[1]

Age group (year)	Number						Proportion (Age group)[2]					Proportion (Ethnicity)[3]					
	Māori	Pacific Peoples	Asian	European	Other[4]	Total	Māori	Pacific Peoples	Asian	European	Other[4]	Māori	Pacific Peoples	Asian	European	Other[4]	Total
0-14	432	39	107	788	17	**1,383**	23%	18%	30%	8%	13%	31%	3%	8%	57%	1%	**100%**
15-44	357	34	50	854	20	**1,315**	19%	16%	14%	8%	15%	27%	3%	4%	65%	2%	**100%**
45-64	319	27	25	756	45	**1,172**	17%	13%	7%	8%	34%	27%	2%	2%	65%	4%	**100%**
65 years or above	748	116	170	7,657	52	**8,743**	40%	54%	48%	76%	39%	9%	1%	2%	88%	1%	**100%**
Total	**1,856**	**216**	**352**	**10,055**	**134**	**12,613**	**100%**	**100%**	**100%**	**100%**	**100%**	**15%**	**2%**	**3%**	**80%**	**1%**	**100%**

[1]Disability Support Link, Waikato - as at 19 October 2020. [2]As proportion of total clients in each ethnic group, by age. [3]As proportion of total clients in each age group (or all ages), by ethnicity. [4]Includes Middle Eastern/Latin American/African and Other.

Disability Support Link clients by age and primary impairment type (2020)[1]

Primary impairment type	0-14 years		15-44 years		45-64 years		65 years or above	
	Number	%[2]	Number	%[2]	Number	%[2]	Number	%[2]
Physical	15	1%	34	3%	168	14%	4,082	34%
Dementia	<5		<5		45	4%	1,175	10%
Medical	88	6%	54	4%	240	20%	902	10%
Frailty	<5		<5		<5		1,039	8%
Cognitive	<5		<5		13	1%	622	5%
Neurological	65	5%	100	8%	180	15%	468	6%
Age-related	<5		<5		<5		118	1%
Sensory	10	1%	19	1%	23	2%	128	1%
Other	<5		<5		<5		58	1%
Psychiatric	142	10%	31	2%	12	1%	18	2%
Intellectual[3]	1,061	77%	1,073	82%	484	41%	133	22%
Total	**1,383**	**100%**	**1,315**	**100%**	**1,172**	**100%**	**8,743**	**100%**

[1]Disability Support Link, Waikato - as at 19 October 2020. Data is of DSL clients who received DHB-funded assistance. '<5' denotes small client numbers (fewer than 5). Number of clients aged under 65 years are generally small, by primary impairment type, so these results should be interpreted with caution. [2]As proportion of total clients in each age group, by primary impairment type. so these results should be interpreted with caution. [3]Aspergers, autism spectrum disorder (ASD), attention deficit disorder (ADD), attention deficit/hyperactivity disorder (ADHD), speech delay, and developmental delay are all categorised as intellectural disability (ID).

Te kōwhiri me te mana whakahaere | Choice and control

Clients of Te Kapore Āwhina Hunga Whara / Accident Compensation Corporation by demographics gender, ethnicity and weekly compensation terms (2019/20)[1]

Demographic		2014/15[2]		2019/20[3]	
		Number	%	Number	%
Gender	Male	127	54%	40	82%
	Female	110	46%	9	18%
	Total	**237**	**100%**	**49**	**100%**
Ethnicity	Maori	54	23%	13	27%
	non-Maori	183	77%	36	73%
	Total	**237**	**100%**	**49**	**100%**
Weekly compensation	Long Term	67	28%	6	12%
	Short Term	32	14%	17	35%
	Undefined	138	58%	26	53%
	Total	**237**	**100%**	**49**	**100%**

[1]Source: Te Kapore Āwhina Hunga Whara / Accident Compensation Corporation, 2020. Data is of clients who have incapacity as a result of an accident they have suffered, for which a claim was lodged with ACC. long term claims are for clients who are in receipt of Weekly Compensation entitlements for 365 days or more (note this does not include clients considered to be Serious Injury claims). Claims that receive less than 365 days of Weekly Compensation entitlement would be short term claims. [2]For period 1 July 2014 - 30 June 2015. [3]For period 1 July 2019 - 30 June 2020.

Number of disability-related Te Kapore Āwhina Hunga Whara / Accident Compensation Corporation clients over the last 10 years[1], by gender

	Year:	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Number	**Male**	128	114	109	110	127	118	97	87	78	40
	Female	51	76	58	83	110	107	87	77	38	9
	Total	**179**	**190**	**167**	**193**	**237**	**225**	**184**	**164**	**116**	**49**
Proportion	**Male**	72%	60%	65%	57%	54%	52%	53%	53%	67%	82%
	Female	28%	40%	35%	43%	46%	48%	47%	47%	33%	18%
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

[1]Source: Te kapore Āwhina Hunga Whara / Accident Compensation Corporation, 2020 - for the period 1 July 2010 - 30 June 2020.

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REPORT TO COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE
29 APRIL 2021

AGENDA ITEM 7.2

WAIKATO DHB DISABILITY RESPONSIVENESS PLAN 2021-2023

Purpose
The purpose of Waikato DHB Disability Responsiveness Plan 2021-2023 is to improve the responsiveness of health services, address barriers and inequities experienced by Whānau Hauā (people with disability) and outcomes.

Recommendations
It is recommended that the Committee:

1) Receive the Waikato DHB Disability Responsiveness Plan 2021-2023; and
2) Approve the Waikato DHB Disability Responsiveness Plan 2021-2023, developed to address barriers and inequities experienced by Whānau Hauā.

LISA GESTRO
EXECUTIVE DIRECTOR – STRATEGY, INVESTMENT & TRANSFORMATION

Background

The Waikato DHB Whānau Hauā (disabled people) Health and Wellbeing Profile 2021 provided an overview of the health and wellbeing status of people with disability residing in the Waikato District Health Board (DHB) district. According to this report, disability is relatively common and it is estimated to have 118,900 people living with an impairment in the Waikato district. Whānau Hauā, in health services, understood as those people who live with physical, mental, learning, or sensory impairments.

Whānau Hauā are active members of society, communities and whanau. Disability happens when people with an impairment face barriers in society, including poor access to health and social services.

Therefore, this plan aims to improve the responsiveness of health services to address barriers and inequities that Whānau Hauā experience when using the services at Waikato (DHB).

Discussion

To develop the Disability Responsiveness Plan, an extensive community consultation was carried out over a period of 10 months. Specific workshops and focus groups (Hui) were held with rangatahi, older people, Maori and Pacific groups across six localities of the DHB.

Ike Rakena, who facilitated the engagement and consultation Hui during 2019, set the themes that guide the goals of this plan. Following are the four themes:

1. **Theme: Tāne te wānanga (The collaborator)** - *Listen to and value the voice and experience of Whānau Hauā*
2. **Theme: Tāne-toko-i-te-Rangi (Pillar of the sky) -** *Provide information and health services that Whānau Hauā can understand and access*
3. **Theme: Tāne Matua (The present) -** *Support Whānau Hauā to achieve their health and wellbeing*
4. **Theme: Tāne te Waiora (The life giver) -** *Partner with Whanau Hauā to improve the design, quality, accountability, and delivery of services.*

Each of the themes' is also supported with specific actions and activities. Both, the Whānau Hauā and other stakeholders consulted also advised that the plan focus on some specific prioritised and targeted actions and activities to address commonly experienced barriers that are most likely to have a positive impact on the outcomes of Whānau Hauā.

This plan has already been reviewed by the Executive Leadership Team of Waikato DHB that required engagement with ELT members before submission to CPHAC. This has occurred. Overall, the successful implementation of this plan is likely to ensure that Whānau Hauā have appropriate and timely access to services at Waikato DHB that are respectful and mana enhancing.

Equity

The Disability Responsiveness Plan aims to address equity as demonstrated by ngā pou mana below:

Mana Whakahaere (Article 1)
Māori leadership is evident at throughout the planning, design, engagement and completion of the plan.

Mana Motuhake (Article 2)
Plan was co-developed with Māori Whānau Hauā and includes solutions that uplift Māori.

Mana Tāngata (Article 3)
Equity for Māori is priority. Equity focused monitoring and evaluation is to be prioritised.

Mana Māori (Declaration/Article 4)
Partnership and co-design are guided by tikanga and the plan actively champions matauranga Māori models and frameworks.

Efficiency

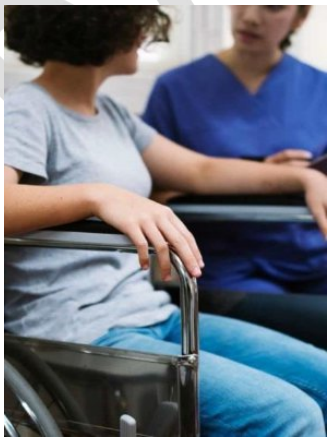
This framework aims to make efficient use of resources across our health system by ensuring people are able to access the right information and resources as required.

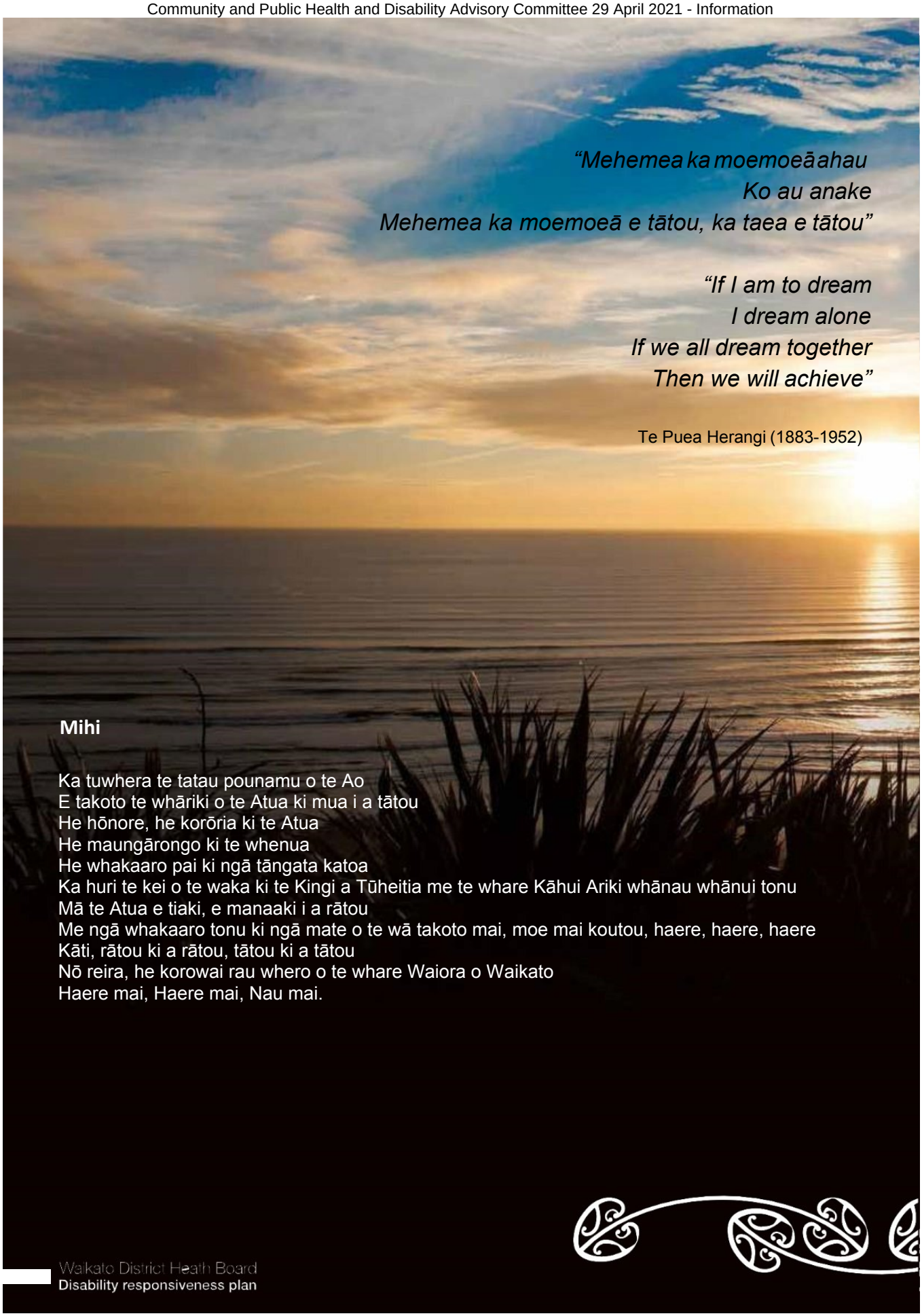
April 2021

Waikato District Heath Board

Disability Responsiveness Plan 2021-2023

With Guidance by Whānau Hauā/Disabled Peoples





"Mehemea ka moemoeā ahau
Ko au anake
Mehemea ka moemoeā e tātou, ka taea e tātou"

"If I am to dream
I dream alone
If we all dream together
Then we will achieve"

Te Puea Herangi (1883-1952)

Mihi

Ka tuwhera te tatau pounamu o te Ao
E takoto te whāriki o te Atua ki mua i a tātou
He hōnore, he korōria ki te Atua
He maungārongo ki te whenua
He whakaaro pai ki ngā tāngata katoa
Ka huri te kei o te waka ki te Kingi a Tūheitia me te whare Kāhui Ariki whānau whānui tonu
Mā te Atua e tiaki, e manaaki i a rātou
Me ngā whakaaro tonu ki ngā mate o te wā takoto mai, moe mai koutou, haere, haere, haere
Kāti, rātou ki a rātou, tātou ki a tātou
Nō reira, he korowai rau whero o te whare Waiora o Waikato
Haere mai, Haere mai, Nau mai.

The vision for this plan

Health Services are provided in accessible and equitable ways to meet the diversity of Whānau Hauā (disabled people and their families).

This Disability Responsiveness Plan has been developed from the voices of local Whānau Hauā and stakeholders to assist Waikato DHB to improve health and wellbeing outcomes for our Whānau Hauā / Disabled people and their whanau. The plan offers a set of themes, goals and actions that aim to improve the responsiveness of services and therefore address barriers and inequities Whānau Hauā experience when using health services at the Waikato District Health Board (DHB)[1].

Whānau Hauā, in health services, understood as those people who live with physical, mental, learning, or sensory impairments. Our society and health system however has not been designed for people living with impairments. Disability is something that happens when people with impairments face barriers in society; it is society that disables people, rather than their impairments and all disabled people have it in common.

The Waikato DHB Whānau Haua Disabled Peoples Health and Wellbeing Profile 2021, provides an overview of the health and wellbeing status of disabled people residing in the Waikato DHB district. It has been developed as a tool for driving conversations toward equitable health outcomes for whānau hauā / disabled people. Equity for disabled peoples is about removing unjust barriers and this plan aims to make measurable and sustainable improvements in some key areas that local whānau hauā /disabled people and their whānau voiced as important.

For positive change as health services we need to:

- *Listen to and value the voice and experience of Whānau Hauā*
- *Providing information and health services that Whānau Hauā can understand, access and aligned to their needs*
- *Support Whānau Hauā to achieve their health and wellbeing*
- *Work with Whānau Hauā to improve the design, quality, accountability and delivery of services*

[1] Waikato District Health Board Consumer Council Terms Of Reference, 2018

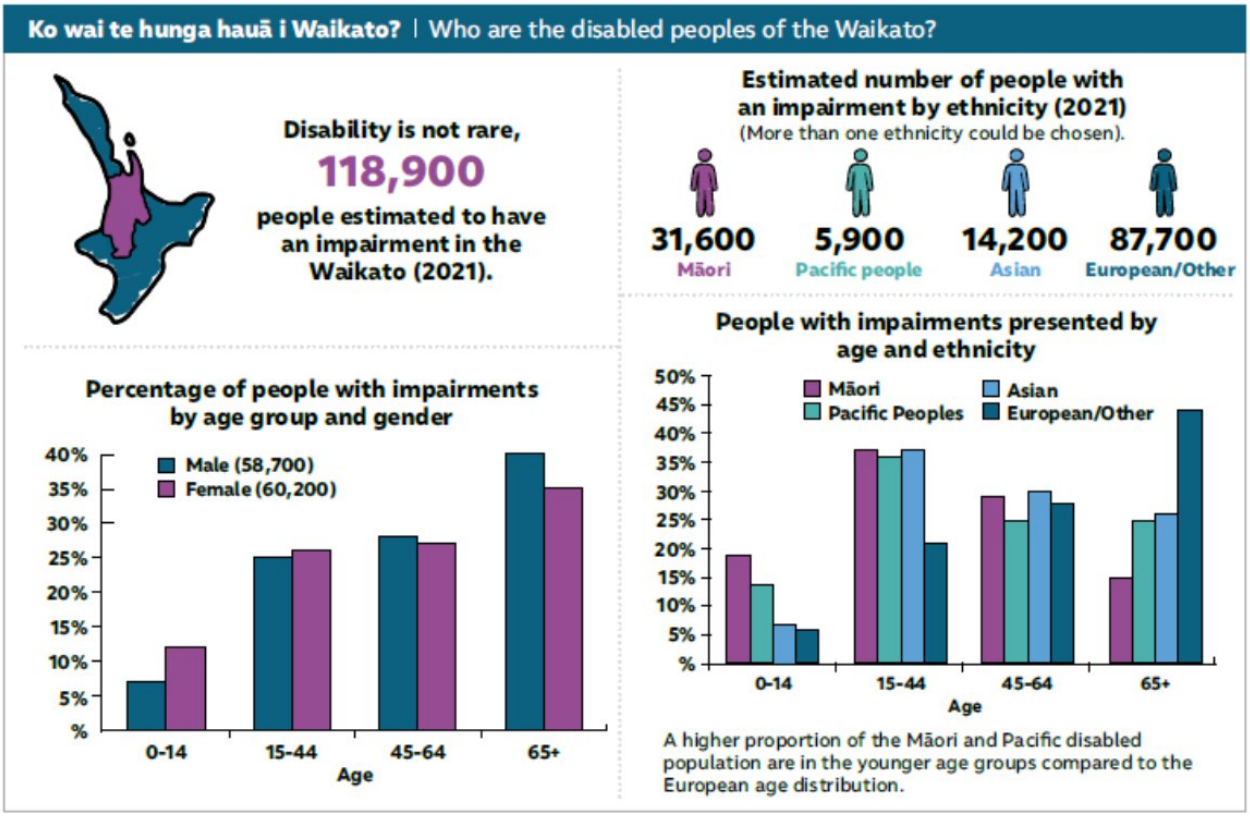
Whānau Hauā

There are several terms, such as Tāngata Whaikaha, Hunga Hauā, Tāngata Hauā, Whānau Hauā used to describe disabled people. The term Whānau Hauā and its description was gifted by Donny Rangihau (Tuhoe) to Te Rōpū Waiora, a Māori disability agency based in South Auckland[2] and has been in use in the Waikato since 2006.

Following consultation with Te Rōpū Tiaki Hunga Hauā (Māori Disability Forum) and seeking advice from Waikato Tainui and mana whenua (iwi within our District Health Board area) we use the term **whānau hauā** as a more appropriate reference for disabled people and their whānau throughout this plan**.**

Disability is not rare, almost one hundred and nineteen thousand people are estimated to have an impairment in the Waikato (2021). Whānau Hauā are active members of society, communities, whanau, and in promoting health and wellbeing.

Whanau Hauā in the Waikato DHB district



[2] MAI Journal 2017: Volume 6 Issue 1 – www.journal.mai.ac.nz/content/whānau-hauā-reframing-disability-indigenous-perspective

Equity

Equity for Whānau Hauā has a focus on achieving inclusiveness in their access to health and wellbeing. It is about removing unjust barriers including those of ethnicity, gender, age or type of impairment.

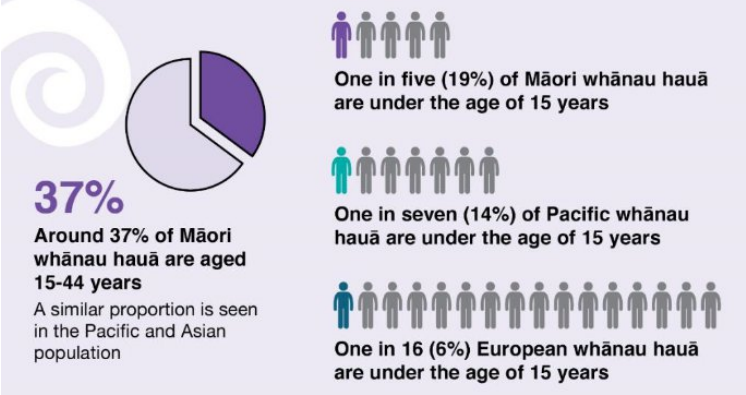
An equity approach for health services is particularly important for at least following 3 reasons:

a) Maori and Pacific peoples are over-represented in disables persons population;

b) on average, disabled people earn 41% less than non-disabled people; and,

c) 33% of all unlawful discrimination complaints are on the grounds of disability.

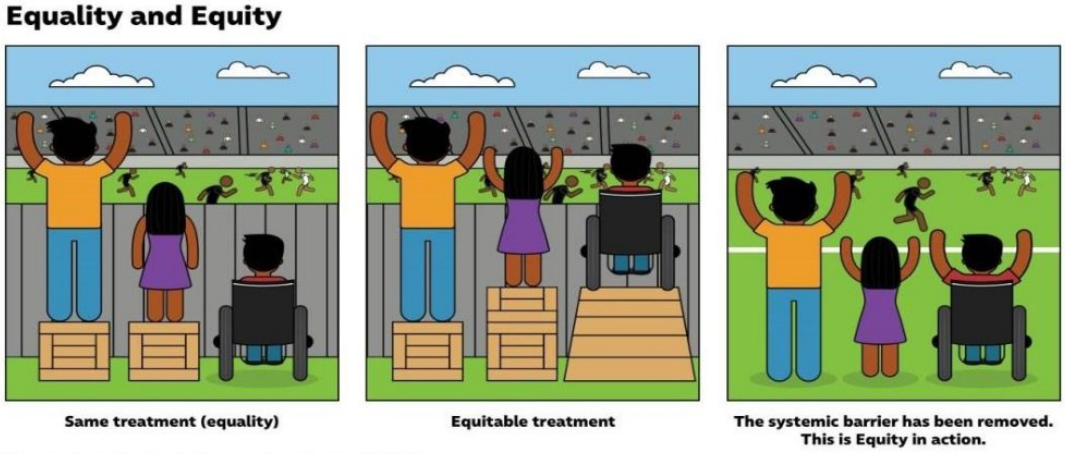
Due to the higher proportions of young Whānau Hauā among Māori and Pacific communities, they experience the impact of unjust barriers over a longer period of time and the related inequities (Graphic of age adjusted rates – National Tāngata Whaikaha).



Equity and equality are two terms that are used in an effort to ensure that people receive fair and just treatment. However, they do not mean the same thing as is illustrated below.

Equality is treating everyone the same. Equality aims to promote fairness, but it can only work if everyone starts from the same place and needs the same help. In most societies people are not equal; some are more privileged in the system than others. People living with impairments, particularly Māori and Pacific peoples, are seldom privileged by the system.

Equity is an approach where people are given what they need to be successful. 'Equity in action' goes a step further to ensure that both treatment and systems barriers are removed; there are no fences and walls to prevent full engagement.



Whānau Hauā and health services

Whānau Hauā, in health services, are understood as those who have physical, mental, learning, sensory or other impairments. Disability occurs when people experiencebarriers that prevent them from being able to fully and effectively participate on an equal basis as others. There are many who have lifelong impairments as well as a growing number who acquire a disability later in life, often as a result of long-term health conditions. Disability is something that happens when people with impairments face barriers in society; it is society that disables people, not their impairments, this is the thing that all disabled people have in common.

It is well documented that Whānau Hauā experience poor health outcomes when compared to the general population. Research has identified the multiple barriers faced by Whānau Hauā of all ages and disability categories when accessing primary and secondary care[3].

- When compared with non-Māori and non-Pacific peoples, on average Māori and Pacific peoples have poorer health and greater unmet needs which have unfavourable impacts on the health and wellbeing of Whānau Hauā from these population groups
- Whānau Hauā with intellectual impairment often have a lower life expectancy, an increased risk of a range of chronic health conditions, and higher hospitalisation rates
- Whānau Hauā with physical impairment are more likely to have chronic health conditions and secondary health conditions

- Whānau Hauā provide valued voices and actively contribute to our governance and quality improvement processes including our Consumer Council. There are both capacity and capability from Whānau Hauā to be active in the implementation of this plan.

[3] Ministry of Health indicators of people with intellectual disabilities, 2011. Te Pou o te Whakaaro Nui, Improving access to primary care for disabled people, 2013

Developing the Whānau Hauā Action Plan

Whānau Hauā and key stakeholders were involved in the development of this plan. They engaged in discussions to identify issues important to them and selecting priorities for action.

Acknowledgement and thanks go to Whānau Hauā who shared their experiences and learning in the development of this plan.

Thanks also to Waikato DHB Consumer Council, Waikato DHB Disability Rōpū, Te Rōpū Tiaki Hunga Hauā (Māori Disability Forum), Waikato Tainui, Enabling Good Lives and other disability providers who have provided valuable insight.

Over 150 people have given generously of their time to shape the goals and actions in this plan through, for example, community focus groups, hui and individual feedback.

The principles of Te Tiriti o Waitangi of active protection, partnership, equity and options have guided how this plan has been developed. These principles will also guide the implementation and monitoring of this plan.

Whānau Hauā asked for the plan to focus on actions which will have a positive impact. These actions are to be aligned with existing documents, including:

- "Healthy people. Excellent care", Waikato DHB Strategy 2016
- Waikato Health System Plan, Te Korowai Waiora 2019
- The Waikato DHB Strategic Priority, Remove barriers for people experiencing disabilities
- Whāia Te Ao Mārama
- New Zealand Disability Plan
- New Zealand Disability Strategy
- Health and Disability Commissioner Code of Rights
- United Nations Convention on the Rights of Persons with Disabilities

The Whānau Hauā Action Plan has been developed to sit within the broader context of Te Korowai Waiora (Waikato DHB Health System Plan). This plan describes the determinants of health and wellbeing which apply to all people, including those with impairments.

The Whānau Hauā Action Plan recognises that certain groups, including Whānau Hauā, do not achieve health equity due to factors such as discrimination, social and economic factors and barriers to access health care.

To ensure implementation of actions listed in this plan, it is recommended to incorporate these into Waikato DHB's District Annual Plan, including other action focused plans.

The Whānau Hauā Responsiveness Plan

This plan identifies goals and activities that will ensure Whānau Hauā have access to appropriate and timely services at Waikato DHB which are respectful and mana enhancing.

The plan provides a clear direction for those working alongside Whānau Hauā to address inequities and ensure better health outcomes. It identifies a number of key areas for improvement across a defined range of dimensions, and it sets some clear performance measures for the DHB.

Themes and goals for Whānau Hauā Responsiveness Plan

The themes which guide the goals for this plan were set by Ike Rakena, who guided the engagement approach including the facilitation of a number of hui during 2019. These themes align with the key areas identified in national strategic disability documents and reflect the Waikato DHB values.

The themes flow from creation narratives, ngā korero i tuku iho.
Ranginui, Papatūānuki and their tamariki, particularly Tāne, inform the themes, goals and actions for this plan.

Tāne is known by many names that reflect his strategising skills. The strategies he used to separate his parents so that he and his siblings were able to grow and fulfil their dreams shape the themes that guide this plan. These are:

- Tāne te wānanga – the receptor/receiver
- Tāne te waiora – the life giver
- Tāne matua – the parent
- Tāne Toko-i-te-Rangi – Tāne pillar of the sky.

1. Theme: Tāne te wānanga (the receptor/receiver/dutiful)

Listen to and value the voice and experience of Whānau Hauā

This will mean Whānau Hauā

- **feel welcomed, respected, valued and treated with empathy and care**
- **receive services tailored to meet their needs**
- **are recognised and respected as experts in health and wellbeing**
- **are active partners in their health and wellbeing journey with health services**
- **can safely provide feedback that leads to improvements**

Action 1.1 Whānau Hauā voice are included in the design, implementation, monitoring and review of services

Activities

a) Establish mechanism to include Whānau Hauā perspective or voice in relevant service design, development and delivery.

Action 1.2 All Waikato DHB staff work respectfully with, and for, Whānau Hauā

Activities

a) Provide training that empowers and supports staff to better understand, engage and work respectfully with Whānau Hauā.

b) Support staff to respectfully assist Whānau Hauā to improve their health and wellbeing.

Action 1.3. Welcome feedback from Whānau Hauā and act on this to improve responsiveness and service delivery

Activities

a) Establish feedback mechanisms that are known, easy to use, culturally appropriate, and accessible to Whānau Hauā, for example, to identify improvement priorities.

b) Encourage participation and engagement of Whānau Hauā to co-design, co-develop and further improve the existing services.

2. Theme: Tāne-toko-i-te-Rangi (Tāne pillar of the sky)

Provide information and health services that Whānau Hauā can understand and access

This will mean Whānau Hauā

- **are better informed about their health and wellbeing**
- **are better informed about health and wellbeing related issues that may impact them, their whānau, and communities**
- **make informed decisions with health services**
- **are able to easily access information and services without discrimination or barriers**

Action 2.1 The Waikato DHB will provide information that is relevant, understandable and accessible for Whānau Hauā

Activities

a) That systems are in place to include the expertise of Whānau Hauā in the development and review of DHB plans, information resources, and communication (including virtual health technology).

b) That all Waikato DHB plans are accessible in formats for different disability groups' i.e. easy to read in word or video formats.

Action 2.2 Whānau Hauā will be included as active partners in decisions about their care and treatment

Activities

a) Staff are supported to work inclusively with Whānau Hauā throughout their care and treatment.

b) Whānau Hauā care and treatment options are discussed with them and their decisions considered and respected.

Action 2.3 Waikato DHB to implement activities listed to reduce barriers and discrimination experienced by Whānau Hauā when accessing care and treatment

Activities

a) Ensure **mental health service improvements** address the specific access barriers raised by Whānau Hauā for rural crisis respite[4], autism and foetal alcohol syndrome.

b) Provide Whānau Hauā with **holistic care** (physical and social needs) at every point of engagement with health services.

c) Put a booking system in place to allow **wheelchairs** to be easily accessible for hospital appointments in a timely manner.

d) Identify and remove **financial barriers** preventing Whānau Hauā from accessing care.

e) Review **timeframes** for and **limits** on **medication and other supplies** on a case by case basis so that Whānau Hauā can access additional medication and supplies when needed.

f) Seek input from disability access experts and designers when designing all new building projects or alterations to existing **buildings** to ensure that **physical spaces** are universally accessible and easy to navigate with appropriate support, equipment and/or technology available.

g) Improve information about **transport options, including accessibility provisions** to all Waikato DHB campuses.

[4] Around 60% of the 394,000 people that live in the Waikato DHB area live rurally, making it difficult to give everyone consistent and appropriate healthcare. (2016)

3. Theme: Tāne Matua (the parent)

Support Whānau Hauā to achieve their health and wellbeing

This will mean Whānau Hauā

- **receive services free from discrimination**
- **know how to get support and assistance to resolve issues**
- **are safe and in control of decisions about their care**
- **receive timely and appropriate care in all stages and at transition points**
- **social needs are considered alongside their health and disability needs**

Action 3.1 Increase staff knowledge and practice to understand the rights of Whānau Hauā when delivering services

Activities

a) Ensure staff demonstrate the awareness of equity and discrimination issues

b) Promote the Health and Disability Code of Rights throughout all hospital and community services

c) Provide information about the free and independent Health and Disability Advocacy Service, and the Health and Disability Code of Rights.

d) Make available online resources accessible in formats, including Māori and Pacific languages, relating to the rights of Whānau Hauā when using health services.

Action 3.2 Staff will engage in practices that enable Whānau Hauā to be safe and in control of decisions about their health and care

Activities

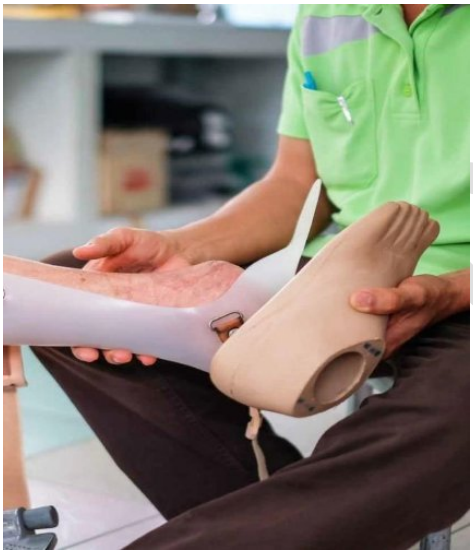
a) Staff to work with Whānau Hauā to co-design, co-develop, co-ordinate and provide comprehensive complex care services.

b) Establish resources and roles, including accessible and trained kaitiaki and/or hospital volunteers, and appropriate interpreter services to improve health and wellbeing outcomes for Whānau Hauā.

c) Staff to ensure and support Whānau Hauā in the decision making process including taking account of their will and preferences as outlined in the Health and Disability Code of Rights.

d) Staff will take into account the social context and wider needs of Whānau Hauā when providing a service.

Action 3.3 Provide a timely and seamless process for Whānau Hauā to transition from one service to another when accessing multiple health services



Activities

a) Staff to communicate effectively with Whānau Hauā, especially related to treatment options and transition discharge planning, so positive outcomes are increased.

b) Review and improve the process for transitioning from child disability/health services to adult services.

c) Co-ordinate and integrate DHB Clinic appointments and surgical bookings to eliminate the need for multiple visits.

4. Theme: Tāne te Waiora (the life giver)

Partner with Whanau Hauā to improve the design, quality, accountability, and delivery of services.

This will mean Whānau Hauā

- **experience staff who are both well informed and demonstrate a positive attitude about disability**
- **experience improvements in care that are linked directly to their feedback**
- **experience positive outcomes from all service delivery**

Action 4.1 Support staff to be more responsive to the needs of Whānau Hauā

Activities

a) Disability rights and responsiveness training is included in learning and development programmes for all staff using facilitators who have a lived experience of disability. For example: “Let’s get real: Disability Workforce Development framework” has a competency focus.

b) Co-design and deliver with Whānau Hauā Te Ao Māori cultural and disability responsiveness training to staff that aligns to Te Tiriti o Waitangi.

c) Support and encourage staff to further develop their knowledge and competencies related to the cultural needs and disability perspectives of Māori and Pacific peoples, including other ethnic groups in the Waikato community.

d) Build workforce capacity and capability to lead change by valuing Whānau Hauā staff as a key resource and identifying opportunities to build a network and grow knowledge and expertise.

Action 4.2 Whānau Hauā monitor and influence the quality of care and services

Activities

a) Appoint Whānau Hauā representatives on the Waikato DHB Consumer Council to provide leadership and oversight to systems' performance and improvement for Whānau Hauā

b) Whānau Hauā perspective is included on all new and reviewed Waikato DHB plans and policies

c) Ensure Whānau Hauā are involved in service review and quality improvement initiatives, particularly in mental health and all other services

d) Include, this plan in the overall Waikato DHB's quality improvement framework

Action 4.3 The Waikato DHB will collect relevant data to improve its quality of service to Whanau Haua

Activities

a) Provide information technology led systems, structures and solutions that support the appropriate collection of data and analysis to guide decision making and practices, including support for Whānau Hauā health and wellbeing, particularly for Maori and Pacific people respecting data sovereignty rights.

b) Ensure developed systems are easily able to provide relevant information across DHB services and localities.

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REPORT TO COMMUNITY AND PUBLIC HEALTH AND DISABLITY SUPPORT ADVISORY COMMITTEE
29 APRIL 2021

AGENDA ITEM 7.3

WAIKATO MENTAL HEALTH AND ADDICTIONS SYSTEM REVIEW

Purpose
The purpose of this report is to submit the final draft of the Waikato Mental Health and Addictions Systems Review to CPHAC/DSAC.

Recommendations
It is recommended that the Committee:

1) Receives the Waikato Mental Health and Addictions System Review;
2) Notes that the Executive Leadership Team has considered the recommendations within the Review; and
3) Notes that an implementation plan will be submitted to the April Commissioner meeting.

RIKI NIA NIA
EXECUTIVE DIRECTOR – MĀORI, EQUITY AND HEALTH IMPROVEMENT

APPENDICES

Appendix 1: Waikato Mental Health and Addictions System Review 2020

Background

The Waikato Mental Health and Addiction System Review 2020 was commissioned to report on the performance of the current Mental Health and Addiction System ("MH&AS") within the Waikato District Health Board ("Waikato DHB"). It is integral to the success of the MH&AS that the population of the Waikato DHB rohe (area) can have confidence in their MH&AS when accessing services in the community and as an inpatient. It is noted that many of the issues and challenges identified in this Waikato DHB review are also experienced by other District Health Boards across Aotearoa.

The review was undertaken by an expert review panel led by Dr. David Chaplow (Chair). Members included:

- Charles Joe, JP
- Gail Goodfellow
- Joanna Price
- Sherida Davy
- Sheryl Matenga
- Wi Keelan
- Dr Maria Baker.

Professor Ron Paterson provided expert advice. Carolyne Grainger was Executive Coordinator for the review, and Nicola Birch assisted in writing the report. Riki Nia Nia has been the DHB's Executive lead for the review.

A clear Terms of Reference has guided the scope and focus of the review team (attached).

A holistic approach to the review has meant wide engagement with over 180 persons and groups were interviewed as part of the review process, across both the provider arm and the associate community providers. This approach has allowed identification and acknowledgement of the many successes within the realm of MH&AS. However, it has revealed gaps within the MH&AS, some requiring immediate action.

These matters are outlined in the attached report.

Next Steps

The Waikato Mental Health and Addictions System Review has been made available to DHB staff and publicly.

An implementation plan which outlines the priorities and timetable for addressing the recommendations from the review has been developed and will be considered at the April 2021 Commissioner meeting.

Waikato Mental Health and Addictions Systems Review

Tēnā koutou katoa,
Me mihi ki ngā mate o te wā. Rātou ki a rātou. E te Kingi me te Makau Ariki, koutou te Whare o te Kahui Ariki. Pai maririe ki a rātou
Mihi hoki ki ngā puipuiaki o te Waikato. Mihi whakaute ki a koutou, ki a rātou katoa.

Mental Health and Addiction Services (MH&AS) in the Waikato provide care to approximately 5000 people each week. It is a core service which contributes significantly to the wellbeing of our community and supporting people across all stages of life to achieve their full health potential.

Waikato DHB has recorded a sharp increase in demand for MH&AS in recent years, particularly for whaiora with high and complex needs and methamphetamine use. Although this is by no means unique to the Waikato, the effects have been particularly pronounced as the region has experienced unprecedented population growth.

In response to this growing need, hospital services have expanded over a number of years, as has the community-based provider network and the level of dedicated MH&AS funding (up 45% since 2011/12).

Although there has been considerable effort to meet growing demand, as service expansion and additions have occurred over a number of years, the result has been a system and structure which was not designed 'as one' with the level of interconnectedness and service options which best reflect the needs of our Waikato community today.

We are fortunate to have an outstanding group of people in our MH&AS team, and a highly skilled and dedicated group of partners in our community providers. The DHB has commissioned this independent report to inform our pathway forward.

What is recommended is a pathway of connected services along which there are multiple opportunities for whaiora to receive care and support at an earlier stage to enhance wellbeing and prevent the need for acute admission.

There have been previous reviews of MH&AS which have tended to focus on a specific service area. The intent of this review is different. We have asked an independent team with considerable expertise and experience to consider the full range of services and practices, from primary care in the community through to our acute services, strategy and funding, and governance – a true 'system' review.

It is intended that this review will help to shape our MH&AS system in a way which better supports our staff and enhances the quality, equity and access to care for all whaiora.

On behalf Waikato DHB I wish to thank Dr David Chaplow and the Review Group for their work and recommendations. We are also grateful to all those who have contributed to this review by sharing their time and knowledge.

Acknowledging the importance of the review, the commissioners have requested that a report be provided in April which includes priorities and a timetable for addressing the Review Group's recommendations.

Nō reira, tēnā koutou katoa

Dame Karen Poutasi
Commissioner
Waikato DHB

WAIKATO MENTAL HEALTH AND ADDICTIONS SYSTEMS REVIEW

2020

"IF THINGS STAY THE SAME, WE ALL BECOME PART OF THE PROBLEM

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WAIKATO MENTAL HEALTH AND ADDICTIONS SYSTEMS REVIEW

"IF THINGS STAY THE SAME, WE ALL BECOME PART OF THE PROBLEM"

Foreword

The Waikato Mental Health and Addiction System Review 2020 was commissioned to report on the performance of the current Mental Health and Addiction system ("MH&AS") within the Waikato District Health Board ("Waikato DHB"). It is integral to the success of the MH&AS that the population of the WDHB rohe (area) can have confidence in their MH&AS when accessing services in the community and as an inpatient. It is noted that many of the issues and challenges identified in this Waikato DHB review are also experienced by other District Health Boards across Aotearoa.

This review is not merely a platform to report on deficiencies of a system, it is an opportunity. It is an opportunity to build on all that has gone before and take a look back to map out the future. It is an opportunity to take stock of progress and state what needs to happen to achieve the key priorities identified in Me Kōrero Tātou and in the DHB's strategic plans and priorities. It is an opportunity to ensure the health and safety of tāngata whaiora ("whaiora").[1]

We thank the DHB for the privilege of serving on this review. We acknowledge the many whaiora, whānau, kaimahi, individuals and organisations associated with the MH&AS across the Waikato rohe who generously shared their experiences and suggestions to enhance and improve services. They have made significant contributions to our findings and recommendations.

Review team members

1. Dr. David Chaplow – Chair
2. Charles Joe, JP
3. Gail Goodfellow
4. Joanna Price
5. Sherida Davy
6. Sheryl Matenga
7. Wi Keelan
8. Dr Maria Baker

Professor Ron Paterson provided expert advice. Carolyne Grainger was Executive Coordinator for the review, and Nicola Birch assisted in writing the report.

The review team reported to Waikato DHB's executive team via Riki Nia Nia, Executive Director Māori, Equity and Health Improvement.

[1] People with experience of mental illness, who are seeking wellness or recovery of self.

Review Process

The review team members met on a weekly basis, 2-3 days per week, from the end of September 2020 through to mid-December 2020. During this time, the team met with key services and individuals throughout the MH&AS and met as a panel to discuss findings.

On the commencement of the review, key individuals, groups, and resources were identified and subsequently engaged in interviews. During the initial interviews, based on the information gathered, the list of those that needed to be interview evolved. Over 180 persons and groups were interviewed as part of the review process, across both the provider arm and the associate community providers. A full list of those interviewed is appended to this report.[2]

A draft indicative report was presented to the Executive Leadership Team (ELT) on 23 December 2020

Approach

At the review team's powhiri, the expectation was set that the team needed to be candid about their findings and that these findings were to reflect reality. This has been a key driver in our approach to this review. Our aim has been to ensure a safe, efficient, effective and accessible environment for whaiora. With that in mind, we considered it our responsibility to present the MH&AS with transformational recommendations to ensure Waikato's mental health and addiction services (MH&AS) were fit for purpose.

To investigate the current way of "doing things" was to confront systems, practices and processes within the MH&AS domain. It is important to note that MH&A does not operate in isolation. It operates in a system. It was essential therefore to review other areas that directly affect MH&AS, such as Strategy and Funding, how MH&AS connects with other medical services and other community mental health providers (such as primary services).

Essentially, this holistic approach to the review has meant the net was cast widely in who was included when undertaking interviews. This approach has allowed identification and acknowledgement of the many successes within the realm of MH&AS. However, it has revealed gaps within the MH&AS, some requiring immediate action.

Engagement of tāngata whaiora (whaiora) and whānau was central to the approach taken in carrying out the review and writing of this report. This report seeks to express the views of whaiora, whānau and the lived experience workforce who helped the reviewers to understand the issues and what is needed within the Waikato DHB mental health and addiction system.

Terms of Reference

The Terms of Reference ("TOR") were fashioned by the DHB Executive Leadership Team (ELT) and after several iterations were approved.

TOR 1-4 refer to interrelated system issues: processes of Strategy and Funding; 'system delivery' both in the provider arm and across the community; clinical and cultural governance; and application of Māori methodology and practices. These four TOR are part of a continuum

[2] Appendix 2 – List of interviewees

to ensure adequate and appropriate needs are met for whaiora. If there is a failure in the continuum, the needs of whaiora are not met.

Statements 5 and 6 in the TOR concern the important procedural elements key to effective and respectful practice as they relate to leave protocols and procedures for whaiora, and communication with whaiora, family and whānau.

There is overlap between some of the TOR statements and their findings. However, for the sake of clarity and comprehensiveness, the discussion, findings and recommendations for each TOR are set out separately.

Background

The Waikato District Health Board region covers a land mass of more than 21,000km and services an estimated 425,836 people in the region. Waikato has a higher proportion of Māori than the national average with 23% of the population identifying as Māori, and a lower proportion of Pacific people with 3% identifying as Pacific peoples. Of the Mental Health population, Māori are significantly over-represented, making up approximately 40% of the whaiora that access the system.

Over the last decade, there has been a series of reviews, reports and inquiries that have examined the Mental Health system, at both a National and a District Health Board level. These reports provided essential background material to the findings and recommendations of this report.

He Ara Oranga (2018) is the report of the Government Inquiry into Mental Health and Addiction. From this inquiry emerged consensus that for many parts of New Zealand society, there was a readiness for the need for change and a new direction. “An emphasis on wellbeing and community, with more treatment options, close to home, whānau and community based responses and cross government action”. He Ara Oranga proposed major changes to current policies and laws, and made 40 recommendations, 38 of which the Government accepted.
The Health and Disability System Review (2020) was charged with “recommending system level changes that would be sustainable, lead to better more equitable outcomes for all New Zealanders and shift the balance from treatment towards health and wellbeing”. The review report, Pūrongo Whakamutunga, identified four key themes:

- Ensuring whaiora, whānau and communities are at the heart of the system
- Culture change and more focused leadership
- Developing more effective Te Tiriti based partnerships with health and disability and creating a system that works more effectively for Māori
- Ensuring the system is integrated and deliberately plans ahead with a longer-term focus.

Preliminary Comments

Mental Health and Wellbeing

Mental Health is often defined as the absence of illness. Mental Health Services are set up to assess and treat illness in whaiora, the majority who then progress to wellness.

Wellbeing is a distinct concept. It often concerns cultural and spiritual alignment enshrined in the meaning of existence (the components of existing or being human).

Clearly, mental health and wellbeing are intricately linked. Clinicians need to consider wellbeing issues and do this by understanding the whaiora narrative, known as 'formulation'. However, many people who are not unwell also have wellbeing issues: issues of loss; concerns with self-identity; displacement; cultural dissonance; worth and belonging. As well as personal and whānau supports, a range of community agencies and institutions (clubs, churches, welfare, counselling organisations), may assist in meeting the wellbeing needs of an individual and/or whānau. Hence, mental health services often fail unless connected to other agency providers. 'Interagency' cooperation is important to any health system dealing holistically with a person or whānau.

It is in this context that 'Whānau Ora' was developed as a navigation philosophy to assist individuals and whānau access disparate agencies and, in doing so, reduce inequities.

Inequality and inequity

Inequality and inequity are terms that are closely related. They have different meanings and implications. Inequality refers to groups not being treated equally. Inequity refers to the unfairness that may lead to poorer outcomes for some groups. Essentially inequities for individuals involve gaps, often driven by social determinants such as education, housing, employment/income and deprivation that result in a lack of access to necessities that are technically available to everyone.

Inequity occurs in a complex web of circumstance; if a person doesn't have the appropriate education that leads to gainful employment this directly affects access to housing, employment and income. This leads to inability to access services that a person has a right to access. However, if petrol is unaffordable, or indeed a car, a person is negatively impacted if to access something requires travel. Hence, services that are equally available for a given community cannot be accessed by those suffering inequities. One of the major obstacles to accessing adequate mental health and wellbeing are existing inequities. A Māori outcome indicator is given[3].

[3] Equity outcome for Māori means "restoration of mauri, maintenance of mana, reciprocation of manaakitanga, establishment of mana motuhake"

The 'system'

Epidemiological studies in NZ indicate that approximately 50% of people will suffer from a mental disorder in their lifetime; 20% over the previous 12-months. Ethnic disparities are noted as well as comorbid illnesses in 40% of cases. Other studies demonstrate that about 7% of sufferers initially access their primary providers and about 4% access secondary MH&A services because of the need for specialist care.

Strategy and Funding is a division of the DHB. Money is allocated by the government on an annual basis. The DHB has two 'arms': 'Strategy and Funding', and 'Provision of Specialist Services'. Funding for MH&A services occur across both the provider arm and across the community. Current funding split for mental health and addiction services between provider arm and community is in favour of the provider arm (56:44%) noting an increase in investment in the system of almost 45% over the past decade, exceeding 'ring-fenced' expectations for 2020/21.[4]

Primary mental health Services include GP practices, Primary Health Organisations (PHOs) including Māori-led PHOs and other agencies that deliver primary care. These are funded differently from secondary and tertiary services; by 'capitation' (the government paying an amount for every whaiora registered) and by fee for service, in addition. Primary services are often 'first contact' services though those with inequity issues experience barriers to care due to cultural attitudes, cost and comorbidities.

Secondary mental health includes the provider arm of the DHB who are funded for age-related mental health[5] and related services as well as community-based services, mainly NGOs[6] (set up as non-profit charitable services to support whaiora).

Addiction Services were historically separate services from MH services but were brought within the ambit of MH in the 1990's (hence the current 'MH&A services') due to the comorbidities that often exist in respective whaiora and due to management efficiencies and in an endeavour to 'professionalise' the addiction services. The importance of these services highlights the challenges that encompass the amount of alcohol consumed by our society and the rampant illicit drug use, currently prevalent, and, in rangatahi, the devastating adverse effect on the maturing brain, on behaviour and on relationships. Different types of addiction services are provided in both the provider arm and in the community.

Te Tiriti o Waitangi and Mana Motuhake

In 1840 an accord signed between Māori and the Crown came to certain agreements. These are often simplistically summed up as 'the three P's' (Partnership, Participation and Protection). This understanding is outdated and the Ministry of Health's new Treaty

[4] Report to Finance Risk and Audit Committee 18 Nov 2020.
[5] General adult, inpatient and community; consultation-liaison, eating disorders, dual diagnosis, Intellectual disability, infant, child and adolescent, forensic services and mental health services for older persons.
[6] NGOs referred to by the Review Team as 'Associate Community Providers'.

Framework[7] sets the government direction to improve health outcome and inequity for Māori over the next 5-years. The more important agreement (Article II) was to have Māori aegis over Māori 'taonga', the ability to manage their own affairs, often referred to as 'Mana Motuhake'.

[7] Whakamaua: Māori Health Action plan 2020-2025.

Themes

A number of key themes emerged in our discussions and are reflected in our findings and recommendations.

Theme 1 – Structure:
The Waikato DHB structure must embrace Te Tiriti o Waitangi
Te Tiriti o Waitangi provides the framework for how the Board and iwi Māori may meet their obligations for Māori self-determination (mana motuhake) in the design, delivery and monitoring of health and disability services. The vision of iwi Māori is that Te Tiriti o Waitangi will be embedded and enacted in all systems of Waikato DHB. The DHB has committed, through the creation and publication of Te Pae Tawhiti 2018-2030 (The Framework for Change) to the principles of Partnership, Participation and Protection which should underpin engagement with Māori to develop Māori responsiveness. These principles need updating to reflect current understanding of these obligations. To embrace a Te Tiriti o Waitangi framework will ensure that Waikato DHB is working in a safe, culturally competent and equitable health and disability service environment.

As part of the review, the review team considered the Waikato DHB organisational leadership structure. The most senior Māori position in Waikato DHB is the Executive Director: Māori, Equity and Improvement of Health. This position is a direct report to the Chief Executive. The Executive Director: Māori, Equity and Improvement of Health leads the Public Health Unit , Pacific Health Unit (a new unit) and Te Puna Oranga.

Te Puna Oranga is the Waikato DHB's Māori Health Services, and provides a service that reaches across all levels within the Waikato DHB and into the Waikato communities. It is a kaupapa Māori led service that provides strategic, as well as Mātauranga Māori, services. Included in the services provided are the Kaitakawaenga (Māori cultural workers), who provide a Māori specific service of cultural care and guidance to whaiora in the mental health system.

Other groups are part of the structure, some at a governance level and some at an advisory level. Of interest to the review panel was the Iwi Māori Council (IMC), the Oversight Group and Mental Health and Addictions Service (provider arm) Clinical Governance Forum.
The review team understood that the IMC is involved in some Waikato DHB operational meetings; they are present or represented at meetings held by Te Puna Oranga, the provider arm Clinical Governance Forum and the Oversight Group.

The Oversight Group, created to provide (community) sector governance, leadership and direction, and to oversee Waikato DHB Mental Health Sector investment, is not functioning according to its initial vision. This was reflected in written and oral reports to the review panel, which variously described the Oversight Group as *'Fragmented; lacking collaboration between the Waikato DHB and NGOs; highly political; and struggling to convene the NGO providers'*. This group needs to be disbanded or be reconstituted and work differently; it needs to provide, and work within, a clinical structure in which community providers can meet according to their respective common interests (i.e. child and adolescent, addiction, Pacific,

kaupapa Māori services). As a general conclusion, the review panel noted that there is a lack of trust within the group.

The provider arm Mental Health Clinical Governance Forum operates effectively over the 'provider arm' Mental Health Services at a high level, monitoring the consistently high and rising demand for mental health and addictions services within the Waikato region. Proposals have been developed to mitigate the significant risks identified. This has led to additional funding being allocated. It is recognised that further work and funding will be required to fully mitigate risks.

Theme 2 – Māori and Mental Health

Equity outcome for Māori means "restoration of mauri, maintenance of mana, reciprocation of manaakitanga, establishment of mana motuhake"

As identified above, the structure of Waikato DHB needs to be wrapped in a Te Tiriti o Waitangi framework; so too must the MH&AS be grounded in the same framework as expressed in Whakamaua: Māori Health Acton Plan 2020-2025. To ensure an effective and successful model of care for Māori, Mental Health need to focus on: Te Tiriti o Waitangi; Equity; kaitakawaenga; Me Kōrero Tātou; and Mātauranga Māori.

Māori, although 23% of the overall Waikato rohe population, are only 9% of the Waikato DHB MHAS staff population. This needs to increase over time to ensure there are staff who can be the champions of 'tikanga' and 'Mātauranga Māori '. There is also the issue of equity. Persistent inequity of health outcomes experienced by Māori whaiora and their whānau are a concern. This inequity is symbolised in the over representation of Māori being coercively managed via Section 29,[8] by being subject to disproportionate seclusion events and by the unenviable high death rate by suicide. Furthermore, Māori are more likely to be admitted in the weekend when there is no kaitakawaenga service available.

Throughout the review, the kaitakawaenga team received uniform acceptance and praise for the service they provide. However, with only 7 Full Time Equivalents (FTE) available, all of whom sit in the provider arm, the kaitakawaenga has insufficient FTE to resource the current demand. To give full effect to the cultural importance of the kaitakawaenga, their reach needs to extend past the provider arm and should not be limited to "office hours". The cultural guidance provided by kaitakawaenga is essential to whaiora and whānau well-being and directly aligns with the aspirations outlined in Me Kōrero Tātou.

Me Korero Tātou represents the community Māori voice and clearly defines iwi aspirations for Māori. The iwi voice is to move deliberatively to 'Mana Motuhake'; the enablement of Māori to be Māori and exercise authority over their own lives (inclusive health services) according to their needs, values and traditions. The review team was informed that disappointment was expressed by iwi that no immediate feedback to them occurred as to what action would follow by Waikato DHB following Me Kōrero Tātou's release.

Mātauranga Māori, the knowledge of Māori, needs to be recognised and applied within the Mental Health system. There is immense value in Mātauranga Māori approaches and Te Ao

[8] Mental Health (Compulsory Assessment and Treatment) Act 1992.

Māori traditional healing practice, including the use of 'Rongoa' as effective interventions for Māori whaiora and their whānau. There is strong evidence that effective Mātauranga Māori cultural intervention programmes can reduce inequity and increase health outcomes for Māori in the MH&AS. The 'medical model' approach to medicine can easily dismiss the cultural importance to well-being. To successfully implement Mātauranga Māori approaches there needs to be recognition and education of different cultural approaches. These approaches must also recognise the importance of staff working collaboratively with tangata whaiora and their whānau in their own treatment. MH&AS must ensure that whaiora and whānau are active partners not only in their own treatment but also within service and organisational processes i.e. the whaiora leave process.

Theme 3 – Action through planning
"Many services; one system"

Of concern was the repeated comment throughout the review process that there are simply *"no plans"* (to action the vision set out in the various documents).

The review team were not clear whether this was entirely accurate. The S&F team, previously titled the 'Planning and Funding' team, is impacted by the fact that there appears to be no focused planning when looking at how to allocate funds. Strategy and planning is everyone's business. Funding and contracting is a specialist area. Despite the creation of a number of strategic and visionary documents, including: Creating our Futures; Iwi Māori Health Strategy; Ki Taumata o Pae Ora; Waikato Health System Plan Te Korowai Waiora; Mental Health and Addictions Te Pae Tawhiti; and Me Kōrero Tātou – Let's Talk, clinicians are keen to see operational planning. A clinical service's plan for mental Health will be completed in advance of the Final Business Case in the current financial year. Strategizing and planning should be a conjoint effort between S&F and senior clinical personnel. These documents have identified a number of at-risk areas that require attention, and highlighted specific issues for Māori that need addressing, all of which can only be addressed if specifically, and adequately funded. The omission of planning in this area has meant that funding is not being allocated to what should be priority areas. Without the appropriate planning to create conjoint, time-framed implemented action plans for the visions and strategies outlined in the aforementioned documents, the vision lies dormant and remains merely a "dream". This challenge is at the door of all DHBs

Demand for services within the Waikato DHB has increased dramatically over recent years. The review team heard that mental health services should be sited within communities, or close to them. Acknowledgement of this statement is a start; planning for this issue has begun.

The lack of focussed planning also highlights the limited connection between and across all mental health services, including between the provider arm and associate community providers (NGOs), and between the respective associate community providers. The rationale of this 'dated' contracting lies in history when a competitive business model was promoted in order to encourage efficiencies. Instead, we find a provider arm, 'capability rich' but 'capacity poor' and a community sector struggling to access capability when required and having unused capacity because of inflexibility in interpreting contracts. The provider arm and

associate community providers (NGOs) require (re)-planning and purchasing as unified and connected services.

Theme 4 – Funding and Relationships

"Investment in successfully proven initiatives is required to expand access and choice for whaiora and whānau"

Over time demand has outstripped supply in MH&AS. This has had a negative impact on MH&AS relationship managers who, in interviews, stated they feel frustrated. This impact has partially contributed to the turnover of staff who have held the relationship manager position (four relationship managers in three years).The situation has also resulted in frustration for the NGO/ACP's and provider arm management who felt powerless to seek solutions when demand for service was overwhelming them.

As indicated above, a competitive model of health care was brought in during the 1990's which resulted in tension between providers and a lack of partnership between them. Although there has been a movement away from this type of model of health, consequences of this model design are still influencing the sector today. The competitive approach of funding splits providers from a "joined up" partnership approach across all services as one system. The system needs to move to a 'many providers, one service' system approach; however, this approach can only be achieved through meaningful, trusting relationships. Years of poor management and governance has seen the introduction of Commissioners to the WDHB with a new approach.

With 44% of mental health users identifying as Māori, the current model of funding struggles with Māori inequity. The investment focus must be on moving whaiora from illness to wellness and ultimately to 'wellbeing'. The change in approach, which needs to result in a strong shift away from the competitive model of care, must be supported by a sound MH&AS Strategy and Funding (S&F). It will require S&F to undertake appropriate planning, implementation of service development, and investment logic mapping. The development and use of a funding framework with a clear plan of actions, along with reconfiguration of services that meets current and future needs of the populations of Waikato as a whole, is also required. Strategy requires 'partnership'.

The Commissioning Framework for Mental Health and Addiction Services (2016) is a government created and endorsed outcome focused approach for funding that provides national guidance to enable the measurement of outcomes that make a real difference for people.[9] Strategy and Funding could benefit greatly by implementing the commissioning framework. This framework can support and provide the structure for WDHB to support a new way of working.

Inequities in pricing existed between WDHB provider arm services and NGO/ACPs and between NGO/ACPs. This had led to mistrust and unhelpful competition between providers. There needs to be accountability and transparency across the sector particularly in terms of pricing public funding. Agreements, between two parties (MOH and providers) were

[9] https://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide .

effectively not a partnership as ACPs did not believe they had the necessary input into the agreements e.g., service delivery mission, vision, philosophy, model of care and flexibility clauses were not included in the "provider specific terms and conditions" section of the agreements.

Theme 5 – Management frameworks and Governance
"Governance: accounting for cultural, fiscal and clinical issues"

Governance, concerning cultural, fiscal and clinical issues begins with a genuine, power-sharing partnership. Partnership within the Waikato DHB requires Waikato DHB, Māori and 'mainstream services' to work collaboratively in the governance, design, delivery and monitoring of services. Māori must co-design the health system with Waikato DHB to ensure the best outcomes for Māori. It is essential that Māori have a say in how Waikato DHB, and essentially the Government, can exercise effective and appropriate stewardship over the health and disability system for all. To achieve this, stronger and more visible Māori leadership is required. Genuine iwi Māori partnership for developing Mātauranga Māori and Te Ao Māori approaches need to be embedded in Waikato DHB. Change is needed to minimise the impact, towards both staff and patients, of conscious and unconscious bias towards Māori.

Governance around funding decisions has been problematic. At the time of the review the Commissioners provided governance oversight for WDHB. Delegations of Authority across the provider arm services were strictly managed as a result of the significant WDHB deficit. Historically, funding decisions have been made via S&F with input from the CE and SFO at funding meetings. Presently, the funding decisions are made by the following roles who make up the Executive Leadership Team (ELT): CE; Chief Medical Officer; Chief Nursing and Midwifery Advisor; Chief Advisor Allied Health; Executive Director Māori, Equity and Health Improvement; Executive Director Strategy and Funding; Executive Director Organisational Support; Executive Director Digital Enabling; Executive Director Hospital and Community Services, Executive Director Finance, Procurement and Supply Chain.

The review team noted that while the provider arm is clinically 'capability rich' and 'capacity poor', the associate community providers (NGOs) tended to have clinical capability commensurate with their contracts. Recently, the acute units had in excess of seventeen (17) over their contracted beds, yet the community had a similar number of vacancies that could not be filled because of alleged contractual specification. (There is also a view that NGO providers could have been more flexible)

In regard to governance, the provider arm MHAS has a well-honed governance structure. The community providers each have governance (as demanded of Charitable Trusts) but are relatively isolated with little communication between related services and difficulty accessing capability when needed.

Theme 6 – Unique challenges to the service
"We are at breaking point."

It is near impossible to review mental health in isolation; every part of the system is interrelated and either positively or negatively impacts the other parts. This creates unique and specific challenges to the services. Challenges faced include, but are not limited to:

capacity issues in acute services; whaiora presenting with complex needs; addiction services; and ICAMHS (infant, child and adolescent mental health services). Issues affecting these services will be expanded on in the report below.

During this review, it was reported on several occasions that the onsite acute adult inpatient facility was not just at capacity, but had exceeded capacity, with more acute patients than beds available. Added to this has been increase in demand for services. There is a general lack of community triage and short-term treatments available in the primary sector and in the secondary community sector, thereby pushing whaiora into the acute system.

Service design is also an issue due to separate 'strategy, planning and funding' for hospital services as distinct from community services. The two areas must be considered as two aspects of the single, continuous service.

The number of whaiora ,with high and complex needs, living in the inpatient wards has grown over time. Since deinstitutionalization in the 1990's, the Midland Region has discussed the need for a regional 'high and complex' service yet nothing concrete has eventuated. Numerous reviews and papers have been written and discussions have occurred at executive levels. Each DHB region in Midland is also trying to grapple with the challenges faced in managing acute inpatient beds when whaiora are effectively living in the wards.

The Waikato DHB MH&A services are experiencing high numbers of: complex presentations (including dual diagnosis, head injury, homelessness, addictions, antisocial personalities and mental illness). These presentations have a negative impact on the availability of acute beds and staffing. At the time of the review, thirty (30) whaiora presenting with high and complex needs were effectively living in the acute and forensic wards and were unable to be placed. The 'opportunity cost' of this situation is vast.

Addiction services across Waikato DHB, in the provider arm and across the community, lack both a framework and collective governance across providers. The consequence of this is that services are not integrated and necessities such as detoxification are deemed wholly inadequate.

Having a significant impact on the system are whaiora under the influence of methamphetamine. Anecdotally, they are the mental health patients most likely to be placed in seclusion, albeit usually with shorter admissions. It raises the issue of where whaiora can be safely managed while under the influence of methamphetamine in a clinically safe environment. These admissions place added pressure on staff due to the potential aggression and higher assault risk. This also results in additional staff needed for the care and management of these whaiora.

Lastly, it is imperative that a discussion occurs regarding infant, child and adolescent mental health (ICAMHS), as this area has been in crisis alert since 2015, despite reviews occurring in 2017 and 2019 the focus tends to be on the service, yet it is essential that the focus shifts to the child. The service, with waiting lists for psychological services as high as 12 months, is unacceptable. In spite of over 60% of the 2019 recommendation having been completed, the services continue to struggle.

Discussion of Terms of Reference

Terms of Reference (i): ***Review the configuration of Mental Health and Addictions Services (MH&AS), what is purchased and whether that meets the District population needs, especially its Māori population***

The Waikato District Health Board (Waikato DHB) Strategy, Planning and Funding procure parallel mainstream and Māori Kaupapa (Hauora Waikato) hospital and community clinical Mental Health and Addiction Services (MH&AS) for the region. Associate providers (NGOs) – mainstream and kaupapa – provide a suite of mainly support services along with clinical services e.g. Adult Addiction and other Substances (AOS) Services.

The configuration of services purchased requires change to ensure the services can meet the burgeoning demand on MH&AS and AOS services currently and into the future. The population of the Waikato is 425,806 (Waikato DHB Annual Report 2020) and increasing. However, a change in the configuration of services needs to be planned and informed by the Māori Equity Report (not available to the reviewers at the time of the review); be based on the Waikato DHB strategic documents, research evidence and best practice; and be future proofed for the coming years. A case in point is Mental Health Services for Older Persons (MHSOP) with an ever increasing older population with the number of New Zealanders diagnosed with dementia being expected to triple in the coming years. Yet investment in MHSOP has remained relatively static for the past ten years. The whaiora group with 'high and complex' needs is increasing the demand for long-term clinical rehabilitation and care and as a result this cohort are effectively "living" in the inpatient units.

AOS funding has not kept pace with the increasing negative impacts of alcohol, methamphetamine and synthetic cannabis misuse. INTACT Youth/Rangatahi AOD Services development delivered across the region has been successfully planned, funded and implemented well. This approach could be replicated for Adult AOD Services to improve access to service.

A significant percentage of people presenting acutely to MH&AS do not have a major mental illness but they do have wellbeing and social issues that require addressing. To meet this need the Waikato DHB MH&AS clinical services have been funded 1FTE as well as Whanau Pai 42 new staff (Primary Health Care), both via the Ministry of Health. This is a limited resource given the increase in demand for services and the numbers of people presenting with wellbeing issues.

Strategy and Funding (S&F) is made up of a range of divisions including the Finance and Enterprise Portfolio Office (EPO) in charge of investments; Analysts who review data; Senior Funding Managers including the Director of Māori Health and Equity; Māori Service Development Manager and Relationship Managers who have the direct relationship with the Associate Providers (NGOs). The separate sections of S&F

personnel makes it difficult for providers to negotiate with S&F, particularly when issues arise

Procurement and agreement management is an area of frustration particularly for Associate Providers (NGOs) with a practice of "rolling contracts over" for many years, instead of ensuring review of agreements every three years with new base agreements and variations being utilised for increases in funding during that period. This approach would provide time for planning and investment in the future services for both parties.

Strategy and Funding

Strategy and Funding are responsible for the distribution of New Zealand Vote Health funds including the allocation of funding for MH&AS and AOS.

The S&F roles are complex and poorly understood by providers of services. Staff in S&F are required to have a broad range of knowledge, requiring an understanding of the following, however not limited to:

- population health assessment frameworks
- needs analysis
- research evidence (qualitative and quantitative)
- strategy, planning, accountability and legal frameworks
- current legislation
- agreement management
- commissioning frameworks
- procurement practise
- service specifications tiers
- auditing requirements and processes
- funding and payment processes, including budget management across the sector
- change management along with risk management processes
- reporting
- actual service delivery expectations, models of service delivery and expectations of the populations served.

Staff include:

- Three analysts with high level analytical expertise who utilised structure to manage data effectively utilising algorithmic procedures to reach output information and inform development. *Process funding mapping was underway using equity algorithms with an equity focus for allocation to ICAMHS, AOD, MHSOP, Adult OST services. Algorithms provided automatic decision-making processes used by computer programmes to identify patterns in data. These algorithms can be used to help government better understand New Zealand and New Zealanders. This knowledge means government can make good decisions and deliver services that are more effective and efficient.* Quarterly Performance Monitoring Reporting (PMRs) undertaken by ACP's and sent to MOH sector services were loaded onto the MOH Health Information Network (HIN) platform that analysts were able

to access to inform planning. PRIMHD reporting was also utilised by analysts as part of monitoring qualitative and quantitative data.

- The MH&AS Senior Funding and Relationship Manager, an experienced (11 Years) DHB MH&AS Accountant, planner and funder who had oversight of the PVS: part of the way in which District Health Boards inform the Ministry of Health about their expenditure and activity plans to meet local demand for services and government priorities for the provision of health care services for provider arm clinical services. In December 2020 the staff member was seconded into the role of Director of Funder and Provider Relationships (Interim). A Māori Health, Mental Health & Addictions Funding Relationship Manager had oversight and a commissioning role (the process of procuring health through population needs assessment, planning of services to meet those needs and securing services on a limited budget, then monitoring the services procured) for the ACP's. The staff member was relatively new to health and had worked in their current role for two months at the time of the review. Both staff identified as accountants.

- The Director of Māori Health and Equity (DMH&E) had more than 20 years working in WDHB MH&AS planning and funding roles. The DMH&E was providing orientation and mentoring to the new Funding Relationship Manager through introductions to the ACPs in the community during the review.

- An experienced Māori Service Development Manager (SDM) MH&AS S&F had been in their role for more than a year working on MH&AS initiatives. The SDM who had credibility in the sector had worked in clinical and senior management roles. One of the developments that the SDM had been involved was Awhi Mai – Awhi Atu (Our Model of Wellbeing – Our Solution) a mental health community based acute alternative to admission service.

Despite the vast knowledge required to work in S&F, there is a general lack of any national strategy and funding training that supports the development of S&F staff. Senior staff expressed an interest in teaching new staff however they are restricted by the pressures of their roles and are limited in the support that they can offer. The consequence of limited training means that staff come under unnecessary pressures.

Enterprise Portfolio Office

The Finance and Enterprise Portfolio Office (EPO) also has a part to play in the allocating of funds. Their role is to monitor, report on and prioritise all investments. Types of investments include "Change the Business" Investments, and "Run the Business" Investments with budgets over $500k. All other "Run the Business" investments, with budgets under $500k, fall within the respective Executive Director's DFA (Delegations of Financial Authority) to track and deliver the investment. The EPO offers a prioritisation process for any investment in new services. Other aspects of the EPO role included operating expenses (OPEX) and management of capital expense (CAPEX). Cost benefit analysis was embedded into the work activity. A guideline for health benefits drivers was also utilised by the EPO. Delegations and process for investment prioritisation usually sit hand in hand.

However, the EPO activities are either not known or poorly understood across the MH&AS and AOS sectors

Accountability and Governance: Who approves funding?
S&F are often seen as the only decision makers for funding. At the time of the review the Commissioners provided governance oversight for WDHB. Delegations of Authority across the provider arm services were strictly managed as a result of the significant WDHB deficit and to bring spending under control. Historically, funding decisions would be made via S&F with input from the CE and SFO at funding meetings. Presently, the funding decisions are made by the following roles who make up Executive Leadership Team (ELT): CE; Chief Medical Officer; Chief Nursing and Midwifery; Chief Advisor Allied Health; Executive Director Māori, Equity and Health Improvement; Executive Director Strategy and Funding; Executive Director Organisational Support; Executive Director Hospital and Community Services; Executive Director Digital Enabling; Executive Director Finance, Procurement and Supply Chain. funding decisions.

Ministry of Health
There was a limited understanding across the sector of the Ministry of Health (MOH) responsibility for funding, monitoring, sector compliance along with accountability expectations and reporting responsibilities that S&F are required to meet and report through to the MOH.

MOH accountability documents that planning and funding teams are expected to work within include:

- Crown Funding Agreement (CFA) https://nsfl.health.govt.nz/accountability/crown-funding-agreement
- Annual Plan and Statement of Intent (SOI) Guidelines
- Operational Policy Framework (OPF) https://nsfl.health.govt.nz/accountability/operational-policy-framework-0
- Service Coverage Schedule (SCS)
- DHB Reporting Requirements
- Health Needs Assessment (HNA) plus a range of other requirements such as e.g.:
    - Financial Standards and guidelines https://nsfl.health.govt.nz/accountability/financial-standards-and-guidelines
    - Annual planning package requirements https://nsfl.health.govt.nz/dhb-planning-package and Equity Action Plans
    - Legislative timeframes and statement of performance https://nsfl.health.govt.nz/dhb-planning-package/legislative-timeframes-submission-201920-dhb-statements-performance

NB: The above is not an exhaustive list of MOH requirements of DHBs.
Although those working in the MH&AOS service sector do not need an intimate knowledge of the MOH accountability and related planning, legislation and financial requirements of S&F, it is important for them to understand that public funding accountabilities are paramount given the Health Vote spend in the Waikato.

Current Commissioning Framework

A competitive model of purchasing health care was brought in during the 1990's and resulted in tension between providers and a lack of partnership between them. Although there has been a movement away from this type of model of purchasing, consequences of this model design are still influencing the MH&A sector today. It should be noted however that the current situation has been as much due to poor system management and poor governance. The competitive approach of funding splits providers. There needs to be a "joined up" partnership approach across all services as one system. The system needs to move to a many owners one service system approach. This approach can only be achieved through meaningful, trusting relationships.

Despite the creation of a number of strategic and visionary documents, including: Creating our Futures; Iwi Māori Health Strategy; Ki Taumata o Pae Ora; Waikato Health System Plan Te Korowai Waiora; Mental Health and Addictions Te Pae Tawhiti; and Me Kōrero Tātou – Let's Talk, the decision to action the findings and objectives of these documents through operational planning has been slow. Instead, there is the impression from the sector that funding is ad hoc and not based on evidence.

A change in approach needs to result in a strong shift away from the competitive model of care and must be supported by a sound MH&AS Strategy, Planning and Funding (S&F). It will require S&F to undertake service development through investment logic mapping and produce action plans that are achievable. The development and use of a funding framework with a clear plan of actions, along with reconfiguration of services that meets current and future needs of the populations of Waikato as a whole, is required. Furthermore, a Te Ao Māori methodology to commissioning, as outlined in "Me Kōrero Tātou – Let's Talk" undertaken with the Waikato Tainui community including iwi Māori and Mātauranga models and approaches, is required.

		2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
		$ 132,730,164	**$ 139,038,845**	**$ 146,479,763**	**$ 153,444,382**	**$ 169,673,474**
DHB Provider Arm	All MH & A Inpatient & Community Services	$ 84,480,839	$ 87,547,580	$ 89,606,422	$ 91,623,378	$ 95,762,441
NGO Services	All MH & A Inpatient, Residential & Community Services	$ 45,921,174	$ 48,474,586	$ 53,463,616	$ 58,263,505	$ 64,814,826
PHOs	Three PHOs	$ 2,328,151	$ 3,016,678	$ 3,409,725	$ 3,557,498	$ 3,827,031
NGO Providers	Whanau Pai					$ 4,583,455
NGO Providers	Pasifika Support,	$ -	$ -	$ -	$ -	$ 685,720

	Psychology Services					
		$ 132,730,164	**$ 139,038,845**	**$ 146,479,763**	**$ 153,444,382**	**$ 169,673,474**
			$ 6,308,681	*$ 7,440,918*	*$ 6,964,618*	*$ 16,229,092*
		2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**

It is understood that the investment process is a result of planning and funding decisions. This has been hampered by the deficit, necessary oversight by the Commissioner and turn over by the relationship managers.

Investment challenges have also resulted in frustration for the ACPs/NGOs and provider arm management who felt powerless to seek solutions when demand for service was overwhelming them. It has also driven ACPs/NGOs to seek funding (some successfully) from other ministries instead of health e.g. MSD funding. Several providers reported to the reviewers that they were moving away from delivering MH&AS as commissioning and procurement processes were more robust with other ministries including a longer term (three years) funded agreements enabling them to enact service planning more robustly.

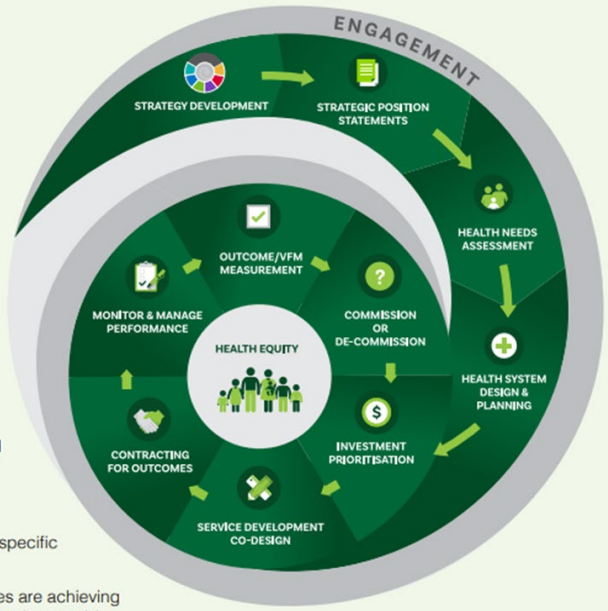
The Commissioning Framework for Mental Health and Addiction Services (2016) set out below is a government created and endorsed outcome focused approach for funding that provides national guidance to enable the measurement of outcomes that make a real difference for people.[10] Strategy and Funding could benefit greatly by implementing the commissioning framework. It should be noted that S&F team have already introduced the 'Commissioning Koru' (see diagram below). This framework can support and provide the structure for WDHB to support a new way of working. For some parts of the sector this change is already occurring, and this framework will support this evolution. For others, this framework will be a revolutionary new way of working, freeing up areas that have previously been more prescriptive and tightening up on results. It will require clear articulation, partnership (co-design), and agreement on the outcomes and results we expect to see and how these will be measured.

[10] https://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide .

The Waikato DHB commissioning approach includes the following key activities:

- Developing Waikato DHB's strategic direction and aligning strategic imperatives across different service areas.
- Understanding the health and social needs of specific populations and communities.
- Developing services that respond to the needs. This involves engagement with the community, service users and the wider health sector to agree the desired outcomes and define how services will be delivered.
- Identifying and contracting providers for services and specific outcomes.
- Monitoring how well services are achieving the desired outcomes, managing provider performance and engaging with communities and the sector on improvements.
- Directing resources to services where communities will benefit and value is optimised.

Figure 2: **Waikato DHB commissioning approach**



MOH: Commissioning Framework for Mental Health and Addiction Services (2016)

Note: KPIs = key performance indicators

Agreements between two parties (MOH and Providers) were effectively not a partnership as NGO/ACPs did not believe they had the necessary input into the agreements e.g. service

delivery mission, vision, philosophy, model of care and flexibility clauses were not included in the "*provider specifics terms and conditions*" section of the agreements.

NB: The Awhi Mai – Awhi Atu Alternative Acute Bed development agreement utilised the provider specific terms and conditions of the funded agreement to include model of care and relevant expectations of service. This work was led by the Service Development Manager S&F and could be replicated in all funded agreements.

Inequities in pricing existed between WDHB provider arm services, ACPs and between ACPs. This has led to mistrust and unhelpful competition between providers. There needs to be accountability and transparency across the service sector particularly in terms of pricing.

'Wash Up'[11] was considered by the ACPs sector as another pressure particularly when funding was Full Time Equivalent (FTE) based. Recruitment to invest in the right person for the right job often took longer than the three months allowed and incurred costs. While it is sensible to ensure funding is utilised appropriately for services, some leeway allowing for recruitment should be considered. This would alleviate the pressure and allow providers to recruit the right staff and not be forced into recruiting quickly and inappropriately creating performance issues and impacting on care delivery.

Probity: RFP (Request for Proposal) management and decision-making, NGO/ACPs reported, was poorly managed and providers queried that due process was being followed. NGO/ACPs understood that sensitive information must be secure. However, NGO/ACPs submitting RFP's reported that feedback from S&F was spasmodic or absent. They did not have confidence that the process was fair and equitable.

Associate Providers (NGOs) expressed frustration due to agreement management practises of the funder. "Rolling" a contract over on an annual basis as is the current practice, is frustrating and often results in time lags before variations are completed, delaying payment to providers delivering services. This impacts budget management which includes payroll of employed staff delivering services. Whereas agreements for a three year term, including all service lines (PUCs) that meets all the requirements of current legislation, makes agreement management easier for both parties. Variations should only be required in the three year period for increases in the CPI (Consumer Price Increase).

What is purchased/investment?
Overview on Mental Health and Addiction Services funding for 2020/21 November 2020 (provided by Strategy & Funding)

Mental Health (MH) funding is ring fenced and reported on. Waikato DHB's MH ring-fence is set at $158.8 million for 2020/21. The Annual Plan submitted for 2020/21 is forecasting expenditure of $161.1m, which exceeds the ring-fence expectation of $158.8m, by over $2m. The 20/21 planned S&F MH&AS expenditure detailed below:

Service	***Annual $ 20/21***
DHB Provider arm	*$94,112,579*

[11] 'Wash up' is roughly equated to the end of year balancing of the books

NGOs	*$63,654,822*
Primary Mental Health	*$3,977,028*
20/21 Planned Expenditure	***$161,744,429***
MH ring-fence expectation	***$158,800,000***

A further $3.4 million in MH&AS investment was planned for 20/21. Demographic funding aims to address volume increase associated with population growth. The demographic funding was not specified by MoH, but is deemed to be the difference between funding received for cost pressure increases and the total percentage funding increase received

In addition to the expenditure noted above, the new national investment in Primary Mental Health Services has seen the commencement of 'Access and Choice' services in Waikato DHB, with $4.7 million now contracted with four Māori providers (via Whānau Pai) to deliver a new approach to community and primary care. This funding was not included in the ring-fence expectation.

Investment in Mental Health and Addiction had grown from $111.6 million in 2011/12 to $161.7 million in 20/21; a 44.9% increase. This compared favourably to population growth of 18.7% and general (CPI) inflation of 17.6% over the same period.

Investments over Recent Years

FY commenced	***Service***	***FTE***	***Beds***	***Programme***
2015/16	*YouthINtact – Youth AOD – expansion of existing services/ new model of care*	*8.65*		
2016/17	*Additional adult crisis respite bed nights*		*Approx. 1.7*	
2016/17	*Integrated Primary Care packages for People with Long Term Mental Illness*			*1*
2017/18	*Further investment in Youth Forensic Services*	*3.4*		
2017/18	*Psychiatrist advisory role in Primary Mental Health*	*1.2*		
2017/18	*Community Placement of several high/complex needs individuals*		*10*	
2018/19	*Additional minimum secure (Forensic) inpatient beds*		*8*	
2019/20	*Awhi Mai acute alternative inpatient facility*		*10*	
2019/20	*Clinical Support for Awhi Mai – DHB Provider arm*	*4*		
2019/20	*Ahikaroa – Community Support including Housing Co-ordination*	*20*		
2019/20	*Additional clinical FTE – DHB Provider arm*	*6*		

2019/20	*Additional whānau support role in Thames Coromandel*	*1*		
2019/20	*Regional pricing alignment for AOD residential services*		*25*	
2020/21	*Support for additional acute inpatient beds (Henry Bennett Centre)*		*7*	

Pay Equity, https://www.health.govt.nz/new-zealand-health-system/pay-equity-settlements/care-and-support-workers-pay-equity-settlement/summary-pay-equity-settlement while funded, had resulted in the WDHB S&F not being able to support Consumer Price Index (CPI) increases in agreements for ACPs while legislative changes had increased costs e.g. Worksafe Act 2015; Vulnerable Children Act 2014.

Contrary to sector opinion, S&F have actively been focused on reducing demand on acute inpatient beds. However, S&F agreed that the development of services over the past decade could be viewed as "tinkering around the edges". Many of the ACPs voiced their concern at lack of planning and implementation of aspirational documents – *"what is the plan and what actions are being taken".*

Reporting

A key aspect of accountability is transparency of actions which can be achieved through robust, independent reporting.

There is a belief that the burden of reporting is extensive. Further, NGO/ACPs believed that quarterly Performance Monitoring Reports (PMRs) were not valued by S&F as there was often no feedback or follow-up. A number of providers completed extensive narratives that were time consuming yet they believed no one bothered to read them. Further, the secondary services were providing comprehensive monthly reporting (sighted by the reviewer) through to the WDHB Chief Operating Officer (COO), whose focus was on clear accountability.

Multiple audits for multiple agreements (each agreement must be audited). Large providers experienced 'audit fatigue' as they may have numerous agreements based on the wide range of service provision. One funded agreement for a term of three to five years that includes all funded services lines (PUC) in the base (00) agreement, would reduce the number audits required, be cost effective, less disruptive to the providers and reduce time spent and required by S&F and the provider on audit corrective action plans.

NB: Health Share Ltd does audit collaboratively with the Ministry of Social Development (MSD) audit and compliance team where providers are funded through MSD and Health and where possible attempt to audit a number of agreements held by a provider to reduce audit fatigue.

Associate providers/NGOs reported quarterly via Ministry of Health (MOH) Performance Monitoring Reports (PMR) process. The Programme for Information Mental Health Data (PRIMHD) along with Alcohol and Drug Outcome Measure (ADOM) reporting is extracted electronically and stored on the MOH Health Information Network (HIN) enabling S&F to

monitor the services funded. ACPs/NGOs on the other hand, while they understood that secondary services were required to complete Health of the Nation Outcome Scale (HONOS) and Health of the Nation Outcome Scale Child & Adolescent (HONOSCA) reporting via PRIMHD, were not aware of the separate WDHB accountability reporting frameworks. ACPs/NGOs also believed that the provider arm did not have the same scrutiny or requirements of service delivery as secondary services were funded through a Service Level Agreement (SLA) via a Price Volume Schedule (PVS) and were guaranteed future funding. ACPs/NGOs suggested that the funder and provider arm should be further separated as they were too "close", yet the funder and provider definitely displayed real tensions, although each sector indicated they wanted to work collaboratively with each other.

Misunderstandings between ACPs /NGOs and DHB services related to auditing. All APC/NGOs were routinely audited (three year programme carried out by Healthshare Ltd https://healthshare.health.nz/) against the funded agreements, whereas the clinical services were not audited routinely against the services delivered. Further, if issues arose S&F could request an Issued Based Audit (IBA) be carried out. MH&AS inpatient units were required to be certificated via HealthCERT to provide safe and reasonable levels of service for whaiora. The HealthCERT audit was carried out by a Designated Audit Agency. However, ACPs/NGOs whose facilities contained more than five beds were also required to undertake HealthCERT audits. Inpatient units were also subject to the Crimes and Torture Act - Unannounced monitoring of places of detention[12]. Mental health inpatient units were additionally subject to unannounced visits by District Inspectors who provided representation for patients subject to the Mental Health (CAT) Act 1992 or the Intellectual Disability Compulsory Care and Rehabilitation Act 2003 (IDCCR Act.

Does what is funded meet the need of the district population?

As outlined above, reporting is inconsistent across the sector therefore it is difficult to ascertain whether what is being purchased meets the needs of the district population. The MH&AOS and Hauora Waikato (Kaupapa Service) provide parallel clinical services (not all district health boards fund parallel Māori and mainstream clinical services) and there are a range of associate community providers who hold Kaupapa funded agreements too.

Generally, the funding allocation does not appear to reflect the current population of the district. Population increases across the region have been unprecedented (populations moving from Auckland; Migrants and New Zealanders returning from overseas particularly since the Covid19 outbreak, many of who have high health and MH&AS needs).

There are persistent equity gaps within mental health system between Māori and non-Māori. Significant equity issues have occurred, (access to GP primary care and medical services, high use of seclusion, limited housing stock, discrimination, limited income) for Māori and those people experiencing a serious mental health and addiction illness.

NB: *People with severe mental disorders on average tend to die earlier than the general population. This is referred to as 'premature mortality'. There is a 10-25 year life expectancy*

[12] Crimes of Torture Act 1989 inspections by the Ombudsman - OPCAT

reduction in patients with severe mental disorders: World Health Organisation. Life expectancy at birth, by gender, Māori and non-Māori, 1951–2013 [1] in 2013, life expectancy at birth was 73.0 years for Māori males and 77.1 years for Māori females; it was 80.3 years for non-Māori males and 83.9 years for non-Māori females. Statistics NZ Aug 2, 2018.

Te Pae Tawhiti sets out the direction for MH&A services over the next few years. There will need to be considerable investment in Te Pae Tawhiti to ensure the district has an appropriate system of care that minimises the need for additional inpatient beds above the sixty-five (65) specified in the indicative business case. A roadmap for investment is currently under development and should be presented to FRAC (Finance, Risk and Audit Committee) in early 2021.

The issue of well-being, in contrast to major mental illness/disorder, is problematic. There are limited services in place to address well-being issues. Up to eighty percent of presentations to the crisis team are for well-being issues. The community have expectations that MH&AOS services will address these issues, many of which relate to social issues such as homelessness.

Funding is currently not meeting the high and complex needs of whaiora. There has been an increase in the number of high and complex whaiora living in the inpatient wards. This number appears to have been steadily increasing since the 1990's, which saw the deinstitutionalization of the mental health system. Although a positive step for many, it has left high and complex whaiora in limbo without any regional solutions.

WDHB MH&AS staff reported that associate community providers (NGOs) would not accept whaiora into their services based on their funding agreements. Clinical staff were not privy to the agreements in terms of what service line (Purchase Unit Code) was funded, resulting in thirty (30) (high and complex) whaiora being unable to be placed into the community residential services. As a result, access to acute inpatient care for people with severe mental health and addiction issues has been impacted negatively.

Adult Addiction and other Substances (AOS) Services were not "joined" up across the sector although there was more and more pressure from Corrections, Probation and the Courts for AOS services. For rangatahi/youth, the Youth Intact AOS Services model of service had been refreshing and successful as a joined up model with consistent marketing, leadership (including rangatahi advice) and approaches to care delivery. Rangatahi and whānau spoke highly of the services they received and appreciated the ease of access and expertise of the staff delivering the services. This approach led by S&F could be replicated in Adult AOS services. A range of residential AOS services are funded out of the Midland Region. Consideration needs to be given to moving them back to the Midland/Waikato Region particularly with the proposals set out in Pūrongo Whakamutunga – The Health and Disability System Review 2020 report.

Methamphetamine-dependent whaiora presenting to acute mental health services with a high risk of acute physical (violence) and mental health harms (psychosis) were stretching human resources and roster management of staff. Adding to the stress of this situation is the genuine fear by staff, of being assaulted by whaiora in a drug-induced state. The incident summary for the period August 2020 identified 77 incidents of violence and aggression on

staff; the number one ranking for a twelve month period. NB: There is no national methamphetamine plan in place for MH&AS managing excited delirium often seen in this cohort.

Whaiora, whānau/family found access to services confusing and difficult to navigate. ACPs/NGOs provided harrowing examples of whaiora and whānau being unable to access services when the need was acute. This was exacerbated when people lived rurally. ACPs/NGOs had the same difficulties when trying to access provider arm services.

There is a long wait list time for ICAMHS of 12-months (in order to access psychological services). The ICAMHS clusters particularly in rural South Waikato were unwieldy and were not functioning as planned. This had resulted in one provider mitigating the significant risks they carried by terminating their agreement for services with S&F, in a rural locality. In part this was as a result of the high demand for ICAMHS services and the pressures placed on clinicians in the provider arm services and ACPs/NGOs managing the challenging behaviours resulting in crisis, on a day to day basis with limited clinical input.

Consult Liaison Services funded through the PVS 2.5FTE was inadequate for the population. Consult Liaison is part of a suite of services required for Registrars in training to undertake and is effectively the "shop window" of mental health and addiction and other substances services across all hospital services.

Paediatrics/ICAMHS were unable to access psychology services for traumatised children. Further, the paediatric services had noted an emerging increase in the number of children presenting to services who met the criteria of Fetal Alcohol Spectrum Disorder (FASD).

Psychologists identified that they worked well with mild to moderate mental illness yet the majority were working with whaiora with severe and enduring mental illness. Psychology assessment and psychometric testing was not available per se across the sector. Provider arm psychologists identified access to therapeutic interview rooms was a resource issue impacting the number of people seen. A mixed model of utilising private and employed psychologists would better meet the needs of whaiora and ensure timely access to talking therapies.

Rehabilitation services had lost allocated FTE as the provider arm had reallocated funding within the Price Volume Schedule (PVS) yet this is an important service particularly when supporting the recovery of high and complex cohort of whaiora. Reallocation of FTE within the PVS was achievable when open and transparent conversations occurred between both S&F and provider arm staff.

Health of the Older People: The Mental Health Services for Older Persons (MHSOP) inpatient facility was overstretched and pathways of access limited. Concern was expressed to the reviewers regarding the increasing health needs of older people particularly the increase in the rates of dementia. The rest home sector utilise a business model to fund their services. Provision of dementia care is publicly funded. However, many of the major players in the sector were not interested in the provision of dementia care as it was not viewed as 'profitable'. Concern was expressed at the recent indication by a major rest home provider

that they would exit dementia beds in the Waikato region. S&F were aware and were at the time of writing seeking solutions for MHSOP.

There appears to be minimal investment in technology. There are many advantages to utilising the technical solutions available to the mental health system. Practical rehabilitation services can be strengthened through the use of mental health technologies that can be used by clinicians and support staff as an adjunct to mainstream clinical practices. Technologies such as email, virtual reality, computer programs, blogs, social networks, the telephone, video conferencing, computer games, a variety of applications (i.e. for the management of anxiety, phobias), instant messaging, podcasts and virtual appointments for people in rural communities, could improve mental health and addiction health outcomes for all. They are also likely to be more cost effective. There are number of technology platforms already available. ACPs are successfully utilising technology platforms more effectively while the provider arm services are limited due to in-house Information Services barriers.

Advantages of using technology include:

- Treatment anytime anywhere
- Anonymity assured
- Lower Cost (some apps are free or cost less than traditional processes)
- Treatment via technology for remote areas (Facetime; Skype, Zoom)
- 24 hour service for intervention support
- Ability to collect information quickly.

During the Covid-19 lockdown staff had the ability to work remotely including engaging with whaiora in the community via phone. It was noted that during the period community staff made more contact (telephone) with whaiora and demand on inpatient services decreased.

Technology, in the form of social media, can also have positive outcomes. Social media was utilised by many of the ACP's, very successfully, as a means of contact (messaging) and providing stories of hope. The WDHB has a Facebook account, however, its Facebook page did not feature any MH&AS stories.

There are persistent equity gaps within Mental Health system between Māori and non-Māori. Significant equity issues have occurred (access to GP primary care and medical services, high use of seclusion, limited housing stock, discrimination; limited income) for Māori and those people experiencing a serious mental health and addiction illness.

Recommendations

1. Operational planning needs completion and planned actions need to be implemented. It is important for whaiora, whānau, mainstream and iwi to have time-framed, incremental pathways to realise the issues expressed as important to them in documents such as 'Me Kōrero Tātou'.
2. S&F consider utilising the expertise clinicians to explore ways or working and supporting the transition of high and complex whaiora out of the inpatient services into a community service "home for life".

3. Whaiora transition plans be developed with both provider arm and ACPs/NGOs, agreed and implemented incrementally (over many months) to allow whaiora to adapt to their new environment successfully. This will require a package of care funding envelope.
4. Clinicians support ACP/NGO staff to implement behavioural management plans for whaiora, provide oversight, mentoring and supervision to enable staff expertise working with this cohort to grow and develop positively.
5. Waikato DHB consider funding a provider with expertise in delivering high and complex services.
6. That regular, open and transparent, quarterly meetings occur between the Provider arm manager and S&F for the purpose of reporting against the PVS. The process would also be an opportunity for the provider arm management to highlight key achievements e.g. therapeutic "leave" management recently instigated in the inpatient services (reduction in absence without leave / AWOL) and the numerous quality initiatives of merit that were being achieved.
7. Any reconfiguration of FTE be agreed with S&F with a relevant rationale to share and mitigate risk.
8. New service development must include S&F and not be undertaken in a "vacuum".
9. The DHB involve clinicians to a greater degree in service planning
10. Strategy and Funding assist provider arm clinical leadership by supporting co-location opportunities with MH&AS NGO/ACPs (supportive letter to all providers identifying what the clinical leadership were attempting to achieve), particularly in the smaller urban areas and rural communities for closer to home responsive services.
11. ACPs be provided with a template to input their mission, vision and model of care for service delivery along with service expectations and relevant monitoring in the Provider Specifics Terms of Conditions section of the funded agreement and this be included in the new agreements.
12. Utilise the use of flexibility clauses to support whaiora costs e.g. clothing to attend an interview for a job; respite placement. A schedule of the rationale and flexibility spend would need to be sent to S&F by ACPs as agreed, for monitoring within a flexibility (variable) funding envelope for each provider.
13. Review all pricing across the MH&AS sector and agree pricing standards (price by unit) e.g. clinical FTE rates; non -clinical rates; bed rates etc.
14. Agreed pricing rates are transparently shared by S&F with providers to minimise competition and enable trust to grow in the sector.
15. All MH&AS provider service specification by FTE, Bed Day, Programmes are listed on a template and all providers have access to the information. This approach allows staff to identify who provides what service across the system.
16. Longer term funded agreements be renewed every three years to ease payment processes and improve budget efficiencies. This will also reduce demand on staff at the WDHB and MOH managing ad-hoc payments and follow up payments on behalf of providers.
17. Move to PRIMHD reporting for all providers across the sector moving away from Performance Monitoring Reports.
18. Consider a similar accountability reporting framework that is aligned to monthly provider arm reporting to identify value for money and emerging risk analysis. NB: S&F relationship managers would need to actively engage with ACPs regularly for the purpose of communicating any emerging risks to ensure risk is shared and managed.

19. Reconsider Wash Up management as an exception not a rule. However Relationship Managers will need to have regular (four times a years) face to face meetings with NGO/ACPs staff to ensure transparent open communication is ongoing to mitigate relevant risks and implement wash up as required.
20. Audit schedules are provided annually and communicated to all providers. This will reduce the miscommunication across the sector regarding audit activity. One agreement includes all service lines funded to ensure one routine contract audit occurs every three years.
21. Issues Based Audits (IBA) are utilised more often by S&F.
22. S&F seek solutions of support for providers who face challenges e.g. utilising other provider support of staff.
23. Consider including the mandatory Governance Social Sector Accreditation Standard (SSAS) in routine audits and IBAs as a more comprehensive criterion for audit.
24. That feedback is provided to all providers at the conclusion of an RFP process to clarify learnings.
25. EPO activities are profiled and relevant outcome updates are posted on the WDHB Facebook page and communicated by the Relationship Manager to the MH&AS sector
26. RFP processes and outcomes are managed on such a way to ensure transparency
27. Specify provider MH&AS models of care and whaiora outcomes on WDHB Facebook pages on a monthly basis where health outcomes/gains have been identified (provider arm and ACPs).
28. Profile all evaluation of service activity on Facebook as well, to enable providers to learn from each other to facilitate replication of cost-effective treatments and wellbeing outcomes.
29. Each month profile a service (provider arm and ACP) the team, what they do and how they work. With consent, ask whaiora who are willing to share their stories of hope on Facebook/social media.
30. As a publicly funded sector, set up a portal for all MH&AS providers or alternatively utilise the WDHB Facebook page to include all related planning, funding and service development being undertaken.
31. Provide a schedule of services by PUC and provider to all funded services including provider arm staff via email or hardcopy and update this annually.

Terms of Reference (ii) ***Review the approach to ensure that services are safe, effective, integrated in a seamless manner across the continuum of care and are adequately resourced, cognisant of both Māori and non-Māori communities and ongoing and persistent inequities that exist for Māori***

The following description of the mental health and addictions system (MH&AS) and accompanying recommendations illustrates that many current services are struggling with capacity issues, lack of specific planning, no common governance over community services, and low morale among staff. As a consequence, some services are not safe or effective and few services are integrated. Serious inequities persist for Māori.

The disconnection between the provider arm and the community (NGO) services is historic and is a major factor of inefficiency. The remedy is for both Strategy and Funding (S&F) with senior MH&AS clinicians and management to strategize and plan for respective services that will enable contracting for connected services.

Connected service contracting across the provider arm /community divide will go a long way to sort the capacity issues that bedevil the acute unit. This will necessitate further community contracting for sub-acute care with clinical capability.

Mention is made of areas needing immediate attention. These include the provision of service for whaiora with 'high and complex' needs and the rationalisation of Infant, Child, and Adolescent Mental Health Services (ICAMHS).

Inequity for Māori is illustrated in the statistic of 23% of Māori in the district with up to 40% of Māori entering MH&AS at any one time. Te Puna Oranga is a key service for Waikato DHB with kaitakawaenga funded by MH&ASs. All those interviewed extolled the value of these workers. However, with a total of 700-800 FTEs in the MH&AS and only 7-FTE kaitakawaenga, the disparity is obvious and needs immediate attention. (More will be said in TOR (iv)).

As noted in the pre-amble there is a conflation between mental illness and crisis of wellbeing. There is a need to re-apportion team members approximate to the need. What is often needed in a well-being crises are counsellors, navigators and kaitakawaenga working alongside clinicians.

Safe,[13] effective,[14] integrated[15] and adequately resourced services are the 'gold standard' that all service management strive for. Waikato MH&AS leaders are no different. The review team found capable and competent management at many levels; people who have withstood challenging circumstances and withering criticism.

[13] Safe practice includes safety for whaiora, staff and community; it includes all the dimensions of life (bio/psycho/social/cultural and spiritual).
[14] 'Successful in producing a desired or intended result'.
[15] 'Different aspects of the whole, linked or coordinated'.

Adult mental health and addiction services (provider arm) include general adult inpatient and community services, specialty adult services (consultation-liaison, eating disorder, dual diagnosis/ID services, infant, child and adolescent services, forensic Services and mental health Services for older persons). In addition, MH&AS are provided in the community by primary health and by some Non-Government Organisations (NGOs)/Associate Community Partners (ACPs). Secondary service provision also occurs via a mix of urban community teams and rural services based in the Thames, Te Awamutu, Te Kuiti Tokoroa and Taumaranui areas. These services are, in some cases, being re-developed according to a negotiated strategy with the target populations.[16]

Understanding the Whaiora journey

The beginning of the journey for whaiora, into the Mental Health system, can be via many 'doors'. Access to the 'provider arm' secondary (or specialist services) is often via a primary service; some contacts are direct (from the community) via crisis services or via the Emergency Department. Other sources are via police, courts, prison services. The common methodology that follows an admission entails assessment and triage, noting that a high percentage of referrals to 'crisis' services relate more appropriately to 'wellbeing' issues and services. However, interagency availability and cooperation are associated challenges yet to be fully resolved.

Throughput of whaiora varies, and of a given population cohort, only a minority of whaiora (up to 10%) access specialist in-patient services. To maintain flow, input must be managed carefully, throughput must be efficient, output must be managed with the whaiora and their whānau with available community options, and outcomes must be robust enough to minimise relapse in whaiora. Throughput also involves the work of the whaiora journey. This work ranges from assessment and treatment, depending on the assessed cause. Output encompassed in the whaiora journey involves moving through the services according to need, both in the provider arm and in the community. Whaiora with 'high and complex' needs will be discussed separately.

A significant percentage of whaiora relapse within a specified period (often within 28 days). This signals a challenge in how adequately whaiora are managed while exiting the inpatient service. Those requiring supported care are referred to the NGO/ACP sector, notional extensions of the respective secondary services. The connections between the provider arm and the NGO/ACP community sector need improvement. The need at times is for rapid clinical advice and/or re-assessment. Whaiora under the aegis of the MH Act will continue to have a 'Responsible Clinician[17]' and be seen at regular intervals, via a case manager. However, the majority, not under the Act, should also be able to have easy access to specialist assistance when needed.

Outcomes for whaiora are often mixed. The experience of the unpleasantness of having a mental illness is often conflated with the experience of being in an inpatient unit. Outcomes are measured differently by whaiora, by their whānau and by clinicians. Seclusion is rarely pleasant for whaiora and never therapeutic. It is utilised when risk demands a 'duty of care'

[16] Refer 'Me Kōrero Tātou' and 'Closer to Home' strategy.
[17] Responsible Clinician as defined by the Mental Health (CAT) Act 1992 Section 2.

response. In spite of huge and sustained effort, mixed results regarding lessening the incidence of seclusion have resulted.

Issues present in the system can negatively affect the journey for individual whaiora and contribute to the mixed outcomes. There is a current crisis in capacity of the acute inpatient units illustrated by the systemic nature of flow. The heavy load carried by community clinicians is reflected in the barriers to care preventing whaiora returning to primary providers. These barriers entail the so called 'high and complex' factors seen in many whaiora. As a generality, biomedical treatments predominate in inpatient settings and as whaiora attain wellness, these in-patient settings become increasingly inappropriate. The current MH&AS system lacks the ability to easily decant to subacute community provision; recovering whaiora transferred to a suitable community setting whereby they can access more appropriate treatments. A glaring issue is the 'stasis' in the inpatient units whereby a dozen or so whaiora (with 'high and complex' needs) have been present for lengthy periods, with no ability to move to a contained, supported and supportive setting.

Important to note are recent inpatient trends evident in the mental health service. There has been an increase in: whaiora presenting with comorbid disorders for inpatient care, often complicated by methamphetamine use/abuse; social dislocation (homelessness, poverty, dislocation, relapsing mental disorder); young people presenting with self-harm.

An additional element, albeit indirect, that contributes to the disrupted whaiora journey is the critical function of Strategy and Funding (S&F) where historically, the provider arm and the community have been funded independently.

Waikato DHB has been involved in a number of reviews over the past five years and it is acknowledged that these reviews have produced important findings that have helped shape the current system. They have brought about the beginnings of change through projects and initiatives that have positively influenced the mental health and addictions system. The review found innovation and determination to improve the whaiora journey and experience. However, there have been aspects of safety that have needed improvement (see TOR (v)); the lack of comprehensive planning following envisioning strategies has made some contracts ineffective, and, with few exceptions, services are not integrated. It should be noted that work to sort this is in train.

Safety at an individual level immediately depends upon robust assessment and having the resource options to manage the findings effectively for the whaiora and family. Contextually, capacity is an important factor that allows flexibility of service that in turn contributes to safe practice. Current adult inpatient services are running well above 100% capacity. The ICAMHS waiting lists (of many months) are unacceptable and waiting times to access psychology is now above 12-months. These facts indicate that some services are not safe and are not effective.

The problems that exist demand change. The amelioration of these challenges will entail:

- Viewing the sector, functionally, as one entity, albeit with many providers,

- A new model of care with a management structure across both 'arms' with shared resource (TOR 1 and 3)
- A focus on both whaiora wellness and wellbeing
- An assertive response to capacity challenges
- Both 'arms' (provider and community) being able to share risk.

Further, initiatives to address the recommendations of this review should work within the expected principles outlined below:

- That Treaty articles with translational application operate through all strata of the DHB
- That visible leadership of the DHB are reflecting the principles of safe practice, integrity, trust, integrated systems, and acknowledging primacy of Whaiora and their whānau
- That system culture reflects 'many providers; one system'
- That strategic philosophy must translate to strategic operation that translates to dynamic, specific, time-framed, operational, conjoint planning
- That health and wellbeing are intertwined, and must be reflected in transcultural and interagency approaches and cooperation
- That MH&A issues for an individual whaiora are not uniform and 'treating the cause' must follow an evaluation process and availability of remedial treatments, be they biological, psychological, sociological, cultural or existential, in nature. All are equally important to wellness and wellbeing.

Strategy and Funding

The response to whaiora-need begins with the strategy and planning of services. The review team was told that the planning of the new sixty-five (65)-bed build (replacing HRBC units) was largely determined by the fiscal ceiling, not on the assessed need. This is disputable. It was in this context that 'Awhi Mai; Awhi Atu' was established, a valuable but insufficient asset.

A common refrain from many contributors was "there is no 'plan'", referring to discrete planning of all the respective services that constitute MH&AS, over the next period. Planning is not just the preserve of S&F. It involves all interested parties. 'Te Pae Tawhiti', 'Creating our Futures', 'Me Kōrero Tātou' all provide a solid start with consultation and an enunciated vision for desired outcomes. These documents have been augmented with a variety of 'equity' documents. The vision that these plans espouse, however, needs translation, specific planning and integration with the existing operational services, both within the provider arm and within the community. In short, many of these excellent visions lack accompanying specific, time-framed plans, framed in conjunction with targeted populations. This is in hand. Note: A draft Commissioning plan is nearing completion[18]

Further, the review found that there is no 'Framework' of organisational management for MH&AS across the entire system, also reflected in incomplete/inconsistent governance methodology. Governance will be addressed in TOR (iii). It has been clear to the review team that excellent MHAS governance exists in the provider arm. What governance exists over community services is not clear (beside the accountability to the Charities Commission). Each

[18] Personal Communication, Dir. S&F.

service unit (whether in the provider arm or the community) requires an accountability structure encompassing fiscal, clinical and cultural issues.

A common governance structure over common subspecialties would provide some unity. Another factor that accords with a 'one service' approach may be to place an operational management structure across all Waikato DHB MH&AS provision in order to close the divide between the 'arms' and also to enable meaningful support to those who need it. This may possibly occur at the Community MHS level with management accounting to the MH&AS management.

The review team identified that the synergy between S&F and the 'provider arm' MH&AS leadership is minimal. Discussion with the S&F Director[19] agreed that 'churn', work demand, capacity and capability issues were a hindrance to close working synergies with target populations, including with the provider arm.

It was also noted that synergy between the provider arm leadership and the 'community' MH&AS (NGO/ACP's) is lacking. S&F contracts with individual NGOs to supply needed services. These service contracts are generally not widely known by other NGO providers or by the provider arm. There is concern regarding contract monitoring in that it is not uniform, and many contracts are merely rolled over. There were also issues regarding notified problems. It was stated that in the past there has not been any follow-up to notified problems. However, these should always be followed by issue-based audits.

There was an expressed desire for closer working agreements between the provider arm and the NGO sector by a uniting structure across all MH&AS provision that would be to everyone's benefit. Interest was also expressed, for practical reasons, to reorganise Hamilton's community mental health teams from a single site (London Street) and explore a different service model, perhaps encompassing attachment of clinicians and clinical support to the respective hubs with regional visits as necessary.

The review team noted that two 0.6FTE positions have been created to liaise between secondary MH&AS and Primary services. This is an excellent model, though frustrations expressed by those involved speak of fragmentation, 'cherry-picking', and 'lack of ownership' of challenging cases. Integrated care is hampered generally by fiscal issues, multi-morbidity in many whaiora, doctor attitudes (in some instances) and the 'business model' (see below for a full discussion).

Recommendations

32. Operational/commissioning planning needs completion. This will be important for Whaiora and Iwi to have a time framed, incremental pathway to realise the issues expressed important to them in documents such as 'Me Kōrero Tātou'.
33. To explore common criteria of service governance across the entire MHAS spectrum
34. To explore a framework of 'management' over the entire spectrum of services

[19] Interview 4/11/20.

35. S&F and the MH&AS explore ways whereby S&F can retain independence while funding for service integration. Likewise, S&F portfolio managers to avail themselves of the opportunity to be part of sector governance.
36. MH&AS leadership explore ways with the community service providers to mutually support services and whaiora when needed
37. Concerted effort to build on the two PT liaison specialists with GPs with improved integration and perhaps mentoring with common governance explored for those dealing with whaiora.

Capacity

This review was partially triggered by unacceptable (over)capacity issues in the acute adult inpatient units (Henry Rongomau Bennett Centre). Such a small service carrying the risk for an entire service is untenable and a recipe for 'burnout', high staff turnover and, eventually, risk for the DHB.

The inpatient unit is under the impression of 'doing more and more with less and less'. Waikato MH&AS are funded for around 3.5% access rates to secondary services. Actual rates are 4.6% for adults and 4.1% for Child and Youth.[20] Adult crisis contacts have increased exponentially, and adult inpatient service occupancy has reached the highest recorded (since 2013). *"Unrealistic expectations from the general population regarding access to and response from the DHB sits behind expressed frustration".*[21]

There is a lack of flexibility and capacity in the acute units. This is well enunciated by the Director and Manager MHAS in their submission.[22] Until 'Awhi mai; Awhi atu' community beds came on stream there were few options to safely transfer whaiora who experience subacute symptoms.

Intensifying the issue of capacity is the stasis in throughput due to whaiora with high & complex needs, who appear to have no clear placement options. Currently there are up to thirty plus (30) 'high and complex' whaiora (both in the acute adult and forensic wards) unable to move from the units due to safety concerns. This is a growing cohort in every DHB in New Zealand. The keys to stability and safe management of those with 'high and complex' presentations involve:

- Stable residence
- A drug free environment
- Sustained treatment of mental illness
- Intensive support

There is a general belief that the new build will alleviate capacity problems within the current service. The review team is clear that unless 'sub-acute' services are provided in the community (with associated clinical capability) and unless whaiora with 'high and complex'

[20] Creating our Futures, Waikato Picture.
[21] Personal Communication, Dir. MHAS.
[22] 13 October 2020.

needs have a clinical pathway out of the acute adult and forensic units, the effectiveness of the new build will be severely compromised. This will be address in the 'Clinical Services Plan'.

Concern was expressed around the lack of shared risk by whole of MH&AS system, with risk always defaulting to the inpatient unit. An aspect of 'many providers; one service' could, with a district management framework with common governance, encompass the shared concerns for all whaiora, early recognition of risk and a shared planning approach.

There is also a lack of treatment options in the system. The cry of many whaiora, is to have available 'talking' therapies. There will always be a place for one-to-one psychotherapy. Because of its nature (specialised, lengthy, limited) consideration needs to be given how this precious resource be apportioned. Why this therapeutic modality should be regarded as the preserve of one discipline (psychology) is unclear given the training of all clinical disciplines and other cultural modalities (in therapeutic endeavours).

Recommendations

38. With urgency, subacute beds to be contracted in the community, connected (by planning, contracting and by governance) to the inpatient and forensic units
39. Capacity must be created by creating flexibility in the acute adult inpatient services. This may occur in two ways:
    i. Ability to decant to supported community services with clinical capability
    ii. Dealing with the 'high and complex' whaiora.
40. Creation of a small specialist unit dealing with the 'high and complex' whaiora. This would necessitate the involvement of specialist care experienced in dealing with risk, rehabilitation and interagency involvement.
41. Immediate enlargement of the 'active transition team' dedicated to this small but significant group of whaiora with 'high and complex' needs
42. Early interagency involvement in the assessment and triage of whaiora in crisis; a 'Whānau Ora' type navigation model (noting that the majority of whaiora who present in crisis with social needs need assistance other than inpatient admission)
43. There needs to be an insistence on 'diagnostic formulation' and one transferable 'management plan' [23]
44. Careful discharge planning, involving the triangulation of whaiora, whānau and clinician, needs to occur with commensurate managed follow-up.

[23] Noting that it may be referred to as a 'recovery' or 'wellness' plan.

Resources

Respective (provider arm) Clinical Disciplines

All disciplines were able to present in person, as groups with written submissions. They came across as dedicated and concerned to improve the lot of whaiora. Some of the submissions were extensive and cannot be captured in their entirety here. Many of their concerns overlap with the respective service descriptions. Summaries and excerpts are given:

SMOs[24]

Positive aspects of services encompassed ability to attract trainees to the DHB and 'surviving' the media 'onslaught'. They mentioned high retention rates and confidence in their immediate team leaders. However, the following concerns were expressed:

- staff (and bed) shortages in critical areas (CL, MHSOP)
- little growth of services in spite of population increases (e.g., in the burgeoning drug crisis)
- poor staff resources after hours
- inadequate facilities
- lack of respite beds and lack of support for staff managing crises
- frequent restructures
- leadership model with 'ivory tower' approach with little contact with clinicians at the 'coal-face'
- delays in replacing staff
- lack of clear models for services (e.g., Eating DO services)
- Concerns re community mental health services
- Distrust and lack of confidence in the 'funder'

Encouragingly, innovative suggestions were put forward, these include:

- Greater connection with S&F to understanding 'how things work'
- Involve and communicate
- Distributive leadership
- Dedicated local res-rehab facilities
- Address prevention strategies (e.g., in schools)
- Decentralise CMH teams
- Explore the 'outsourcing' of psychology services
- Closer ties and communication with GPs

Nurses

The review panel met with groups of nurses within leadership positions. This was inclusive of the inpatient charge nurse managers, the community charge nurse managers, the operations managers, clinical nurse specialists and the clinical nurse director across the provider arm.

[24] This was a sampling only and unclear how representative of the entire cohort

There was a plea for more nursing resource, and specific nursing speciality resource across services especially in the community. This sits alongside a sense of being 'overwhelmed' in the provider arm services by the inability to discharge whaiora with "high and complex" needs. Impacting on this is the lack of suitable community residential care.

It was identified by several nurse leaders that residential providers can struggle with the complexity of the presentations and have limited training/ knowledge in the management of acute situations within the NGO milieu, thus resulting in whaiora being (re)admitted to acute care. Furthermore, as discussed by community mental health nurses, the housing crisis impacts on outcomes for people accessing care, whereby whaiora have limited or minimal support from families. It was noted this cohort can be transient, or challenging to follow-up, can become unwell after a period treatment and go through the process of (re)admission to HRBC (or other DHBs). In addition the nursing teams reported that overall access to the Primary Health Organisations (PHO), the increasing physical health concerns and nursing time, of an aging population also impacted on the 'overwhelmed system'.

Mental health nursing is in a 'hard to recruit to' position nationally and it is noted that the recruitment and retention of registered nurses in the NGO sector proves to be more difficult. Comments were made that some registered nurses employed in mental health and/ or addictions NGO providers (at times) come with limited mental health and addictions experience. It should be noted that NGO nurses are invited to the education workshops facilitated by the Waikato DHB.

There was a desire among nurses for developing a values-based service ensuring the right person, at the right time, with the right service, which would improve outcomes of whaiora. One example of a suggested initiative was the 'short term pathway', i.e., whaiora discharged and followed up for a limited period of six to twelve weeks. It is currently in its infancy regarding the outcomes, but this would meet the ideal in terms of decreased reliance on provider arm services, and increased independence for whaiora and whānau.

MH&AS, in principle, commenced a Dedicated Education Unit (DEU), however due to changes in CNM's it is not functioning as it should. The philosophy is to distribute DEU staff across the inpatient services; however, this is dependent on the educational provider having the academic liaison and MH&AS accepting an increase in students. Initially the DEU, when trialled, was successful; the students became part of the team, in action learning. MH&AS had aligned a Māori nurse educator to support the preceptors. It was a partnership between Te Whare Awanuiarangi, Wintec, professional development unit and provider arm MH&AS.
Regarding the New Entry to Speciality Practice (NESP) nurses within the provider arm, the impression is that they are well supported during their first year of registered work and within their postgraduate studies.

The Māori nursing workforce FTE within the provider arm has been on a slight decline over the past 5 years. There is a sincere determination to increase the numbers of Māori nurses with strategic planning, to retain the nurses who identify as Māori within the provider arm and to identify Māori nurses early in order to support into leadership positions. There is a hope that the work around attracting and recruiting tāngata Māori to mental health nursing will start to show a positive effect on increasing the Māori FTE. The number of Internationally Qualified Nurses (IQN) is 20-30%.

Some nurses raised a few concerns; in 2007 the Māori Director of Nursing was removed and this role has not been replaced. They acknowledged the importance of Māori in significant influential and leadership positions.

In 2018 three Clinical Nurse Specialist (CNS) positions were disestablished to increase the number of Associate Clinical Nurse Managers (ACNM) about which several nurses raised their concerns. However, the adjustment to these roles related to supporting the need for extended nursing leadership outside of business hours. The establishment of the ACNM positions support nurses to work at the top of their scope to ensure that tāngata whaiora, whānau and staff experience positive outcomes of acute inpatient care. It seems to be a difficult balance of keeping within budget, and meeting the needs of provider arm s services. It is important to keep in mind the outcomes and what is beneficial for whaiora.

Nurses working in MH&AS are in position to further develop their skills, both in talk therapy (which is supported by Te Pou) and in postgraduate nursing studies, which can also lead nursing to speciality pathways. It seems that the MH&AS have a culture of supporting nurses to develop their potential.

Psychologists

A meeting was held with six of the psychology leaders.[25] Three well-written and comprehensive submissions were received;[26] some of the points are noted below.

It should be acknowledged that psychology as a discipline is a highly valued resource to any multi-disciplinary team. Training is extensive; in measurement (behaviour, brain and mind, adaptation), assessment (all modalities), in psychotherapy (group, individual) and work-place management. Concerns noted are as follows:

- The modality in many of the provider-arm units is predominantly 'bio-medical' (viz., a focus on medication vs trauma)
- Concerns expressed that there is no 'protection' for psychology FTEs
- There is a long wait for some therapies (e.g., DBT, 18-months)
- Logistic frustrations
    - Management is slow, detached and complex (7-layers of approval to recruit)

[25] 25 November 2020.

[26] Dr Gerard Pauley, Leena Brindley-Richards, Kirstin Thomson, Renate Bellve-Wack, Jon Ballantyne, Lily de Bruin. All submissions available on request with requisite permissions.

- Often no access to interview rooms (CMHS)
- A lack of productivity (e.g., Patient DNAs)
- No representation at the 'top table' and a need to be involved in 'governance'
- Opportunity cost in transporting whaiora out of district
- Wasted effort (previous work being discarded for something new).

Several clinical issues were expressed during the meeting, including:

- Increasing whaiora complexity
- Stress and burnout
- Major concern around ICAMHS
- Need for early intervention
- Replacement of four recently retired psychologists
- 'Boundary' protection of other allied services meaning greater workload for ICAMHS
- Struggling rural centres
- Service work overwhelmed by crisis
- Major need for cultural input (e.g., kaitakawaenga)
- Specific issues in specific services (e.g., preponderance of Māori in forensic MH, longer stay allowing for allied health modalities of intervention.

Suggestions were made; many are implicit in the concerns. For example:

- Being valued, involved, responded to.
- The creation of a stand-alone service that deals with complex personality DO e.g., 'borderline', with associated residential services
- The possibility of 'eating DO' beds within the Midland region.

Recommendations

45. Convene a meeting with the psychology leaders in order to discuss, clarify and remedy these concerns.

Social Workers[27]

The review team were informed that there were sixty-seven (67) Social Worker FTEs across the various Waikato Mental Health services, spread over provider and community arm services. Their professional lead had been recently disestablished in favour of one 'Director of Allied Health'. They alleged there had been little discussion or communication of this move. Other comments were received:

- Homelessness, a major issue
- 'Navigation is the way of the future'
- Need to address trauma
- A promising start to the 'Huntly initiative'

[27] Jinny Grey, Karen Rowan, Lyn Eade.

- Large caseloads

Occupational Therapists[28]

It was not made clear during the review process the exact number of Occupational Therapist FTEs in MH&AS. However, concern was raised about the lack of leadership in the discipline, noting that many FTE had recently been lost.
Their suggestions:

- Restore leadership
- Fill FTE positions
- Ensure CME and competency matters are adhered to
- Provide supervision to trainees.

[28] Linda Hardman, Maree Sievwright, Goodhelp Nyashanu.

Area Specific Issues in Mental Health and Addictions Services

Community Mental Health Services

Because of the media attention on the acute adult services over the past five years, the community service has lacked the attention that its importance merits. It was described as a 'broken system' by many of the clinicians interviewed. A claim was made that over the past ten-year period demand had increased by 70% without commensurate increase in funding (45%). The review team was unable to substantiate this claim. The result currently is services under pressure with low morale due to a perceived lack of response.

Recent strategies ('Creating Our futures', 'Closer to Home') have inspired a renewed vision; to decentralise from London Street and create a series of integrated 'health and clinical' hubs that will function more effectively and safely. Initial work has begun in Waharoa, Cambridge, and Huntly but planning is at an early stage.

Recommendations

46. That decentralisation is supported with a move to 'health and clinical' hubs at designated centres.
47. That with the change in configuration and modelling, NGO access to clinician assistance is facilitated

Mental Health Services of Older Persons (MHSOP)

The MHSOP is a service was developed to provide mental health care for the older person populace of 65yrs and over. Nine percent of the total population of Waikato DHB are 65yrs+. MHSOP comprises both 'inpatient' and 'community' arms, that are integrated (meaning the same service is across both 'inpatient' and 'community' arms). It stands as a model for other services in these respects as this integration makes for efficiency, good communication, a single point of accountability and of governance.

This service includes a fifteen (15)-bed inpatient unit; a facility that covers the entire Waikato DHB region. On Review of the data provided relating to capacity, OPR1 sits at 100%-103%. Due to this level of capacity, OPR1 holds a waitlist for admission, which results at times in a reliance on adult services for help with very acutely unwell people. With limited capacity it is noted that the patient configuration can make for a difficult 'mix' and to make the situation work there is a need to 'manage smarter'. Complicating unit capacity is the issue of three (of the fifteen) having nowhere to be discharged to; essentially being 'stuck'. Further, three of the inpatients are younger than 65yrs.

It is recognised that the projected population growth will be a challenge. The older person populace (65yrs+) under the Waikato DHB as of 2019 represents 68,075 of the overall population. Māori total 6,114 (of the older person population). It is projected by 2025 to have a total older persons population of 83,544, and a total of 8,559 older

people that identify as Māori. The population growth as of 2033 is predicted to be 104,008 and for Māori 11,951.

In addition to the falls risk, OPR1 is one of the higher risk areas for assault (either co-patient or staff). It was stated in review interviews that there is no current permanent access to psychogeriatric beds for people with advanced dementia, and/ or behavioural concerns. It was noted by the MHSOP leads that the demand for services is increasing. Additionally, there are currently two older persons who are difficult to place and one 'high and complex need' older person. At the time of meeting with the teams, there were three people under MHSOP services under the age of 65yrs. It is noted and cited that a business case for a MHSOP acute response team has been submitted, with a desired outcome to reduce, or prevent the need for MHSOP inpatient admissions by providing a more targeted response. The team function with an integrated model of care between inpatient and community services for tangata whaiora having the consistency in psychiatrist input. The team report working in a whānau centred way, encouraging whaiora connectedness to whānau.

Concerns were raised about nursing staff in the inpatient milieu. It was stated that the Registered Nurse FTE was frequently down and that recruitment into OPR1 roles is difficult. Enrolled nurses are heavily utilised in OPR1.

The low number of Māori accessing MHSOP care, was verified anecdotally and also presented on data. As an equity emphasis, the MHSOP team will see people that identity as Māori younger than 65yrs, this being on a case by case basis. The rationale being that Māori can present with earlier onset concerns and the team could provide and offer earlier interventions.
The MHSOP specialty supports the Tairawhiti district with their older person cohort who utilise ECT services from that region. This places additional pressure on the families travelling from out of area to support their whānau.

Recognising the growing population, the MHSOP team reports previously petitioning for twenty-five (25) beds to improve service capacity to meet this growth with a plan to have ten (10) functional beds and fifteen (15) organic beds. Their rationale for the split is that it is a difficult combination to manage the two different presentations.

'Rosendale' (a residential provider under BUPA) are closing some of their beds. Strategy and funding are aware of this and are working through a solution with other possibilities. Strategy and funding anticipate arrangement and formal communication early 2021.

The community mental health for the older person is described as a "robust team" that helps slow the process down into the inpatient setting. There is a multi-disciplinary team mix of specialties in the community consisting of social work, nursing, occupational therapy, psychology and psychiatry. kaitakawaenga were reported to be of 'huge benefit', but have been 'pulled' from the MHSOP service. Within the community setting under the provider arm is the 'memory service', and an older persons services in Thames

within the Manaaki centre. The wait list to obtain an MRI Scan is now of the order of eight months.

Comment: The service is well set up with competent leadership. It does lack capacity for such a large and growing regional population.

Recommendations:

48. Seriously reconsider capacity building (beds) in the light of the increasing population
49. Provide kaitakawaenga cover to the service.

ICAMHS

Three clusters were formed many years ago. They amalgamated ICAMHS with a number of NGOs and allied agencies relating to childcare. There is no shared governance, and the 'provider arm' is the backup to all problems, after hours. All participants appear unhappy with the arrangements and a review was requested in 2015 (commissioned in 2018) after a rating of 'extreme risk' was recorded on the DHB risk register.[29] ICAMHS continues to be the number one risk for the MHAS of the DHB.[30] The 'unhappiness' appears to relate to the lack of shared risk and the lack of efficiency, meaning that many practitioners are often tied up in meetings in regard to a whaiora they don't know and will not be expected to follow up.

There are two rural areas; The Thames cluster and South Waikato cluster (based in Te Kuiti, Tokoroa, Te Awamutu and Taumaranui) and a Central cluster with two providers (ICAMHS and Hauora Waikato) providing services. The central service provides all assessment and triage in the Hamilton area and requires re-modelling to cope with the number of crisis referrals as well as routinely dealing with managed referrals and therapeutic input.

One interview[31] referred to*" 'golden days' of ICAMHS with marked deterioration in the past two years due to leadership issues, 'toxic' work environment, 'churn' and the stress and disruption of the COVID-19 'lockdowns."*

In addition, problems enunciated included: escalating demand, limited or unavailable advice in times of crisis, unacceptable waiting times, high numbers of suicidal whaiora, limited funding, increasing complaints.

Currently all referrals occur via Hauora Waikato (in partnership with the provider arm operating a 'one service/two provider' model). There is a team of six (6) FTEs (multidisciplinary) with a need to develop a new and more efficient model of care,

[29] Report to Executive Leadership Team/'Investment requirement for Infant Child and Adolescent MH Services Undated
[30] MHAS Review Submission Dr Rees Tapsell.
[31] Interview with A/CD.

dealing with the tension that occurs between consultation with acute presentations and ongoing assessment and triage.

Waiting lists to see a psychologist are unacceptably high (<12-months) and attempts are being made to explore the utility of group therapy of an educative model prior to referral for one-to-one approach. The importance of psychology is emphasised and accepted.

The consensus appears to be that the regular work of ICAMHS is suffering due to the volume of crisis referrals. Many of these are 'kids out of control' presenting with 'gross deregulation'.

Recommendations

50. Accelerate the implementation of the proposals enunciated in the 2018 report, which was to reconfigure the ICAMHS services to deal with crisis work more effectively.
51. Rather than only refer to psychology services, initially utilise other therapeutic modalities in the first instance (e.g., training parents, use other trained disciplines, ration the psychology sessions and review)
52. Utilise the 'Psychology Centre' (by contracting from the DHB).
53. In the Central cluster, remodel 'assessment and triage' as distinct from dealing with 'crisis' (I.e., develop two teams with different functions).
54. Provide a 'dedicated crisis clinical pathway' including a Waikato DHB or Midlands Regional solution.

Pacific Populations[32]

K'aute Pasifica is an NGO that offers a range of services designed for the Pasifika communities. In many ways it can be considered a functional 'Health, wellbeing and clinical' service providing for physical and mental health, navigation services, employment and housing, school health, immunisation and a raft of social services (crisis counselling, gambling and 'whānau resilience'). They also have established links with other Pasifika NGO/ACP's in Tauranga and Tokoroa.

Approximately thirty-six (36) FTE are seconded to various sub services. The services are built around a general practice and pharmacy. The service knows all the Pasifika families in district and is able to follow the health and welfare of the 127 children they serve. If one area is stressed, the service is able to apportion FTEs temporarily from other areas of service.

In regard to ICAMHS, K'aute Pasifica is in the central cluster. However, because of the high entry criteria to access services and because of the lengthy waiting list, they rarely, if ever, make referrals of children. Their philosophy is to deal with crises and need as they arise.

[32] Services provided under the NGO/ACP 'K'aute Pasifica

When asked about their need and access to secondary MH&A service they responded that, on occasion they do need specialist advice, which is hard to access. They also said that they are unable to access patient files and notes. They requested a 'residential contract' in order to respite parents from problem children.

Recommendations

55. Pasifica need to be connected with other community services and be able to access secondary mental health advice more easily.

Regional Approaches

Developing regional 'hubs' ('Closer to Home' project) is an important vision.
The regional hubs were based on iwi:

i. Tuwharetoa
ii. Maniapoto
iii. Raukawa
iv. Hauraki
v. Waikato ki Tainui and Ngati Haua.

The Review encompassed many of these groups. (One, when the technology failed, was followed by a regional visit by some members of the review team).

The Review Team was in committed support of the concept of 'Mana Motuhake' (self-determination) and, indeed, a couple of groups are well on the way with well-developed plans and nascent services.

The review Team was equally clear that incremental development following a conjointly developed, time-framed planning was necessary to forestall failure by inadequate support and perhaps a different funding model, based not on inputs but on outputs of a developing system. This would mean accreting the part FTEs and spot funding into a coherent whole.
More discussion will occur in TOR (iv).

Recommendations

56. That specific time-framed plans be developed with enunciated goals, respective responsibilities and accountabilities and support with each of the hub developments.

Addiction Services

The organisational chart of Waikato DHB and associated services shows that addiction services have a little under 10% of the total MH&AS budget (@ $10.3m/PA); $3m in the 'Provider arm' and $5.2m in the community, which is provided by a mix of beds and FTEs.

While individual addiction services seem to be running efficiently, they are largely unconnected from each other and between the community and the hospital. There is also little in the way of a connected governance framework. According to the Director of Clinical Services MH&AS, there is increasing demand and an 'epidemic' of methamphetamine use and abuse. There are also '*problems related to poor planning and piecemeal contracting for AOD services...with some aspects of the service continuum simply not funded or provided here.'*[33]

[33] Dr R Tapsell.

Services encompass: 'managed withdrawal' ('detox services'), 'methadone management', residential services and community case management.

Detoxification Services: These are 'wholly inadequate' with two notional beds available (but not dedicated). This means that the beds are rarely available, meaning those requiring 'detox' are diverted to medical beds in the general hospital.

In regard to general AOD services, the Clinical Director[34] suggested that the current services provide *'the bones of a very good service'*. However, problems arise as community services do not have multidisciplinary teams and therefore, *'any complex case is referred to CADS'*.

While there are good relations across AOD community services, there is *'no robust model of care across the continuum...'* The standard of care across all services is 'uneven' and there are major issues in rural communities (of access to services).

'Youth Intact' services for Child and Youth is a model that should be emulated.

The 'Drug Court': this will focus on community addiction presentations and be functioning by mid-2021. There will be an anticipated need for addiction expertise and 'kaupapa Māori' advice. Apart from that few details are presently known.

Recommendations

57. There needs to be a clinical, governance framework across all related community AOD services
58. Contracts need to operate across the system and be flexible
59. There needs to be more clarity what contracts are held by respective providers in the community
60. Peer support and kaitakawaenga are vital in AOD services and should be contracted
61. 'Navigation FTEs' would be helpful to those who have co-morbid social presentations
62. Support the establishment of the Drug Court and monitor and evaluate its impact
63. As 60-80% of referrals are from Courts and Corrections, greater cooperation and clarity is needed in regard to coordination, and shared responsibility.

[34] Dr A Darby.

Māori MH&AS clinical services

Each of the following service providers was interviewed:

- Te Runanga o Kirikiriroa
- Raukawa Charitable Trust
- Ngati Maniapoto
- Hauraki
- Waikato Tainui
- Hauora Waikato
- Awhi Mai (Te Awhi Whānau Charitable Trust)

All were impressive in their dedication and commitment to providing the best MH&AS care to their respective whaiora (and their whānau). Each gave a breakdown of service coverage; how many FTEs were employed and how they relate to each other. Some of the comments are recorded here:

- 'No confidence in the current system'
- Current services under-funded
- Procurement processes flawed
- Insufficient dedicated resource to 'Māori kaupapa'
- An authentic Treaty of Waitangi relationship lacking with huge potential for change
- Contracts generally do not cater for inclusion of whānau
- Māori programmes are often not funded
- Clinicians are often not equipped to be therapeutic (for Māori)
- Funding methodology needs changing from FTEs and 'beds' to 'packages of care'
- 'Systemic, sustainable and service-design issues' (e.g., No CPI increases)
- 'Kaupapa services not valued'
- Procurement issues: 'no pattern to service development; fragmentation, service gaps, RFP delays'
- Major rural challenges with ICAMHS (see below)
- Desire for 'connected services', transparent, accountable leadership

Recommendations

64. Convene a hui between providers, IMC and S&F to clarify and address the above concerns.

Important interfaces[35]

Dr Mills emphasised the importance of Psychiatry Consultation Liaison Services (CL) to general medical (and surgical) patients. Topics ranged over the following illustrating the importance of this service:

Acute presentations to ED: Many people present acutely to ED with overdose. This requires 24-48 hrs of assessment and treatment prior to 'clearance'. All need to be seen by the CL team regarding the presence of illness and aftercare follow-up. The issue here is 'responsiveness'[36].

Eating Disorder services: these services were described as 'dysfunctional' as, in spite of there being a Community Eating DO Service, it will only see persons domiciled in the community and not those presenting acutely. In these circumstances CL becomes the 'provider'. Whaiora hospitalised with eating DO issues occupy 380-600 bed-day stays per annum[37]

Pain clinic: There are two aspects of this service: post-operative pain and chronic pain. This latter service is staffed by part-time anaesthetist and psychiatrist. Resource is lacking[38].

Gender Dysphoria: this is serviced by sexual health and endocrinology. From a handful of cases per year this service has burgeoned in the last year with young people presenting for assessment and advice.

Mother and baby service: CL staff make the assessments and triage. Ongoing assessment and treatment are the preserve of the perinatal Team.

Detoxification: most cases are outliers from the Adult General Psychiatry Service where two beds are notionally for 'withdrawal'. Because of pressure these are rarely utilised[39].

[35] Dr Graham Mills, Medical Director Waikato Hospital.

[36] Note: *Clarification noted that one FTE is supplied by MH&AS to service 'well-being' concerns.*

[37] *In clarification, CL services will initially assess admissions, especially those not known to the community service. Patients admitted under the Act will be managed by the CL team while they are being re-fed. Others will be seen and managed by the dedicated FTE for Eating DO.).*

[38] Note: CL has no involvement here.

[39] Consideration is being given to contracting an NGO for this work.)

Primary Mental Health Services[40]

Studies show that mental health constitutes a good percentage of General Practitioners' practice (40-60%). While about 20% of the population will suffer from a mental health issue in a given year, only about 7% will attend their GP for their problem. Many of the mild to moderate mental health complaints are conflated with 'wellbeing' concerns. Many general practitioners see that primary mental health services could drive mental health improvement for the community.

There are several concerning issues that demand the attention of a high-level commission:

- The business model is antithetical to an understanding and resolution of the whaiora presentation
- Access and financial issues mitigate against equity for some, especially Māori
- With the usual short consultation times (typically 15-minutes), the predominant modality is bio-medical. Those requiring counselling are referred on. Counselling services for whaiora are valued by GPs. However, due to budgetary concerns and overwhelming demand, counselling sessions are commonly limited to three to six sessions, sufficient only for mild to moderate cases.
- 'Cherry-picking' of who to see means that many of the whaiora with 'high and complex' needs are referred on to secondary services, who often reject the referrals as 'not meeting the criteria.'

Some practical suggestions are made by primary clinicians:

- Primary MH to be funded differently from the current 'capitation plus fee for service'. There would need to be ease of access and greater subsidy in lieu of the greater time required to listen, assess and treat whaiora.
- There needs to be more support from secondary MH services. The current primary/secondary liaison psychiatrist is the starting point to communicate between the services, provide advice, provide mentoring and advocacy in an important area of service growth.
- One of the pressing needs is to have direct communication with an MHS consultant at the very time of need (when the patient is in front of the GP when issues need clarification or instruction). In some places e.g., Lakes DHB, the 'red phone' hot line exists. This is a dedicated line, manned 24/7 (or in office hours) by consultants on a roster.
- Greater integration would be helpful, viewing the general practitioner as a key member of the multi-disciplinary team. An aspect of this is 'information sharing'. Many general practitioners do not know or are not aware of the many service provision changes in their area and need advice as to where to refer a whaiora with

[40] Thanks to Dr A Darby, Dr Mark Taylor, Drs Maree McCracken, Sheryl-Anne Wilson and Bernadette Doube.

'high and complex' needs. Transparent contract specifications need to be shared knowledge among a group of providers, particularly the rural providers.

- Practical improvements to the primary/secondary MH service interface will include
    - A greater number of 'liaison' specialists attached to GP clusters
    - Provision of a dedicated and 'manned' telephone consultation service
    - Consideration of increasing the 'free' counselling session.

Terms of Reference (iii) ***Review the clinical governance structure across all MH&A services within District***

'Governance is all those processes that underpin governing. It defines the interactions and decision making processes that are directed toward addressing an agreed collective challenge.... Regardless of the definitions, all organisations have rules, policies, procedures and agreed behaviours that drive the organisation towards achieving its goals and moving it from its present position to a position closer to that expressed in its vision statement...Effective governance requires an understanding of authority and its delegation, responsibility, accountability, a sense of stewardship, effective leadership and an agreed mission to move the organisation to that of the boards vision. Activity and outcome must be measured (and measurable), standards set and maintained and opportunities for improvement sought...'[41]

Cognisant of the above statement, all services, provider arm and/or community, should be able to account in a transparent manner for moneys received by contract for services rendered.
The review team found that governance in the community based services was not uniform and did not function to connect like-service provision. An interesting feature of interviews was that nearly all services expressed a desire for a more uniform governance structures.
The Oversight Group was initially convened to support S&F in a quasi-governance role, albeit without success. This is discussed in this chapter and also in TOR (iv).

The review team interviewed approximately 180 individuals, many set in the contexts of teams and services, both in the 'provider arm' and in the Community (as NGOs/Associate Community Providers). All interviewed were asked about clinical governance and clinical governing structures.

Clinical governance can be defined as a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, creating an environment in which excellence in clinical care will flourish.[42] Clinical governance groups were examined as part of this review.

The findings were unequivocal; Clinical Governance of MHAS in the Provider arm is well organised and works well. It accounts for clinical, fiscal and cultural concerns. It is stratified in that each service management accounts eventually to senior MH&AS leaders who hold clinical governance meetings every month. There is also excellent data collection and the review team were regaled with how governance data could note and manage trends and respond accordingly. This is important in understanding work output linked to whaiora outcomes, namely 'productivity.'

[41] Taken from 'Quality Assurance Framework (Clinical)' Waikato DHB, draft document.
[42] http://www.hqsc.govt.nz/assets/Capability-Leadership/PR/HQS-ClinicalGovernance.pdf .

Governance appeared to stop at the border between the provider arm and community. We (the review team) surmised that this concerned 'ownership', NGOs maintaining their respective stewardship themselves. We understood that each NGO needed to provide 'governance' as a necessary function to maintain charitable status. However, it was a common finding that community services voiced their support for some common governance across the community, linked with the provider arm . The review team agreed that NGO services receiving government money needed to demonstrate accountability for that funding, delivered and audited by contract. Contract monitoring and auditing is a S&F function and occurs at a 'high level' and seldom gets down to day-to-day clinical issues and has no linking mechanism with like providers or indeed with the Provider arm . The Review Team is aware of the impost on NGOs with further governance compliance via regular reporting but feel that governance regarding common challenges (capacity, flow, risk, assistance) will appreciably help in the current challenges bedevilling the MH&A services.

At a practical level, the review team thought that bringing like services together in a governance framework would assist in feedback (on contracting and clinical need) but also in linking groups working in a similar field of service provision for mutual understanding and support. Governance thus could bring together services such as adult MH, Addictions, ICAMHS, MHSOP and so on with Governance shared between provider arm and community nominees.

Recommendations

65. That a framework of governance be instituted across the provider arm /community divide to all contracted services, according to their respective speciality.

The 'Oversight Group'

According to the chair of that group,[43] the group was convened in late 2018 (by S&F) to *provide sector governance, leadership, and direction to oversee DHB MH Sector investment toward a vision of improved health and service delivery* for Waikato to 2030. The 'Te Pai Tawhiti' and MH&AS 'Model of Care' documents in concert with 'Creating our Futures' were pieces of work intended to be the blueprint for the Oversight Group. The Iwi Māori Council nominated persons. Others were nominated by Hauora Waikato, Tainui, Kokiri Trust. Senior clinicians (provider arm) and senior members of S&F (as co-chair) were appointed. It was envisaged that 50% of the group would be Māori and that all sectors of health would be represented. This group met regularly but tended to 'fall apart' during the COVID-19 period when the group went into abeyance. Aside from that, the group had problems of focus and was fragmented and directionless. It was clear that any remit the Group had was either misunderstood or lost in the size and composition of the group. Needless to say, the Oversight Group was not able to succeed in its vision to provide limited governance to the sector.

The review team met with the Oversight Group for 90-minutes or so. The review team also met on two further occasions at the invitation of both the chair of the IMC and of the Review Team in order to understand its intended function. It appeared to have a

[43] Tio Sewell, letter to the Review Team, 18 November 2020.

commentary role on development and act in some manner as a governance body. The IMC was insistent that the formation of the 'Oversight Group' was a partial answer to IMC being marginalised from sincere consultation (giving the example of being excluded from the new build). The importance of Wai2575 was raised with its emphasis on 'partnership' and its interpretation.

The review team heard that the Oversight Group is not functioning according to its initial vision. This was reflected in written and oral reports to the review panel, which variously described the Oversight Group as *'fragmented; lacking collaboration between the Waikato DHB and NGOs; highly political; and struggling to convene the NGO providers'*. It appears that the Oversight Group was conceived and birthed by S&F with lofty goals but has lacked the necessary leadership, structure and support in order to achieve its goals.

The review team noted the Oversight Group Terms of reference, which are highly aspirational; if the group is to continue, will need serious consideration regarding what can realistically be achieved by such a group, its composition, its size, and how it is supported and resourced.

Recommendations

66. That the S&F together with IMC and provider arm leadership consider the continued viability of the 'Oversight Group', its function, size and composition and support.

Some focus was placed on the optics of Māori governance (structures and leadership) within the DHB. With 23% of the population, Māori, and 40% of the MHAS cohort, Māori, providing Māori with clear a message that the organisational structure of the DHB is capable of understanding Māori and their needs, is important. Some of this is discussed in TOR (iv).

Terms of Reference (iv) ***Review the application of Mātauranga Māori and Te Ao Māori practices and approaches across the MH&A services***[44]

Equity outcome for Māori means "restoration of mauri, maintenance of mana, reciprocation of manaakitanga, establishment of mana motuhake"

Three factors emphasise the importance of health to Māori: they are Treaty of Waitangi partners; they present to services disproportionately to their numbers in the District; they present with serious equity issues that have a discriminatory impact on their health and wellbeing.

Important cultural services for Māori in MH&AS are provided by Kaitakawaenga, stationed and nurtured within Te Puna Oranga of the DHB. Te Puna Oranga is the Māori Service provider within the DHB to all services. Kaitakawaenga are the 'champions' of 'tikanga Māori' for the Waikato. Another task of Te Puna Oranga is that of Mātauranga Māori.

Equity concerns are prominent in Māori health and relate to 'whole of life issues'. Their entry to MH&AS is invariably another contribution to inequity symbolised by increased use of the Mental Health Act (s 29) and by seclusion incidents, both markers of what has gone before. These 'whole of life' issues also underscore the need for greater use of kaitakawaenga (from their current seven (7) FTEs), and the use of other non-clinical navigators.

Te Tiriti o Waitangi provides the framework for how the Board and iwi Māori meet their obligations for Māori self-determination (Mana Motuhake) in the design, delivery and monitoring of health and disability services. This is related to the application of Mātauranga Māori with the DHB. The vision of iwi Māori is that Te Tiriti o Waitangi will be embedded and enacted in all systems of Waikato DHB, including the framework of the DHB itself. The DHB has committed, through the creation and publication of Te Pae Tawhiti 2018-2030 (The Framework for Change), to the principles of Partnership, Participation and Protection which should underpin engagement with Māori to develop Māori responsiveness. These principles need to be updated to reflect current understanding of these obligations. To embrace a Te Tiriti o Waitangi framework will ensure that Waikato DHB is working in a safe, culturally competent and equitable health and disability service environment.

As identified above, the structure of Waikato DHB needs to be wrapped in a Te Tiriti o Waitangi framework; so too must the MH&AS be grounded in the same framework as expressed in Whakamaua: The Māori Health Action Plan 2020 – 2025. To ensure an effective and successful model of care for Māori, Mental Health need to focus on: Te Tiriti o Waitangi; Equity; Kaitakawaenga; Me Kōrero Tātou; and Mātauranga Māori .

[44] NB Appendix 3 Independent report by Wi Keelan.

Te Puna Oranga is the Waikato DHB's Māori Health Services, and provides a service that reaches across all levels within the Waikato DHB and into the Waikato communities. It is a kaupapa Māori led service that provides strategic, as well as Mātauranga Māori, services. Included in the services provided are the kaitakawaenga (Māori cultural workers), who provide a Māori specific service of cultural care and guidance to whaiora in the Mental Health system.

Kaitakawaenga have acceptability across all domains of the MH&AS providers, both in the provider and community arms. They have two functions: to be the champions of tikanga Māori as determined by the mana whenua of the Waikato; second, to be involved in Mātauranga Māori (in brief, cultural education). Being the champions of tikanga requires expertise. Many Kaitakawaenga will be attached to clinical teams. As with all disciplines they will account to Te Puna Oranga in respect of taha Māori and to the multi-disciplinary teams for their respective clinical involvement. Mātauranga Māori is undefined. It may pertain to whakapapa, local history, narrative therapy (e.g. Mahi Atua), or skills such as kapahaka, mirimiri, or mahi maara (gardening skills). The outsourcing of these contracts may be a possibility.

Other groups are part of the structure, some at a governance level and some at an advisory level. Of interest to the review panel was the Iwi Māori Council (IMC), the Oversight Group and MHAS Clinical Governance Forum.

The review team understood that the IMC is involved in some Waikato DHB operational meetings; they are present or represented at meetings held by Te Puna Oranga, the Provider arm Clinical Governance Forum and the Oversight Group.

As noted under TOR (iii), the role and continued viability of the Oversight Group, created to provide (community) sector governance, leadership and direction, and to oversee Waikato DHB Mental Health Sector investment, needs to be reconsidered (see recommendation 64 above).

Māori, although 23% of the overall Waikato rohe population, represent about 40% of those accessing MH&AS. Māori staff are only approximately 11% of the Waikato DHB population. This needs to increase over time to ensure there are staff who can also be the champions of 'tikanga' and 'Mātauranga Māori '. There is also the issue of equity. Persistent inequity of health outcomes experienced by Māori whaiora and their whānau are a concern. This inequity is symbolised in the over representation of Māori being coercively managed via section 29 community treatment orders,[45] by being subject to disproportionate seclusion events and by the unenviable high death rate by suicide. Furthermore, Māori are more likely to be admitted in the weekend when there is no kaitakawaenga service available.

Throughout the review, the kaitakawaenga team received uniform acceptance and praise for the service they provide. However, with only 7 FTE available, all of whom sit in the provider arm, the kaitakawaenga has insufficient FTE to resource the current

[45] Mental Health (Compulsory Assessment and Treatment) Act 1992.

demand. To give full effect to the cultural importance of the kaitakawaenga, their reach needs to extend past the provider arm and should not be limited to "office hours". The cultural guidance provided by kaitakawaenga is essential to tangata whaiora and whānau well-being and directly aligns with the aspirations outlined in Me Kōrero Tātou.

Me Kōrero Tātou represents the community Māori voice and clearly defines Iwi aspirations for Māori. The iwi voice is to move deliberatively to 'Mana Motuhake'; the enablement of Māori to be Māori and exercise authority over their own lives (inclusive health services) according to their needs, values and traditions. The review team was informed that disappointment has been expressed by iwi that no immediate follow-up response/action by Waikato DHB followed Me Kōrero Tatou's release.

Mātauranga Māori, the knowledge of Māori, needs to be recognised and applied within the Mental Health system. There is immense value in Mātauranga Māori approaches and Te Ao Māori traditional healing practice, including the use of 'Rongoa' as effective interventions for Māori whaiora and their whānau. There is strong evidence that effective Mātauranga Māori cultural intervention programmes can reduce inequity and increase health outcomes for Māori in the MH&AS. The 'medical model' approach to medicine can easily dismiss the cultural importance to well-being. To successfully implement Mātauranga Māori approaches there needs to be recognition and education of different cultural approaches. These approaches must also recognise the importance of staff working collaboratively with tangata whaiora and their whānau in their own treatment. MH&AS must ensure that whaiora and whānau are active partners not only in their own treatment but also within service and organisational processes i.e. the whaiora leave process.

Recommendations

67. Establish a co-designed Te Ao Māori Advisory Committee (TAMAC) to strategize, plan, receive and provide monthly reports on the achievements, outcomes of Māori Health gains against a Māori Health Strategy Work Plan.
68. Te Puna Oranga to hold an internal review of its capability and capacity to fulfil its obligations to incorporate Te Ao Māori worldviews into the wide range of DHB clinical and business activities.
69. Reconsider the necessity and function of the 'Oversight Group'; possibly into a newly constituted 'DHB and Associate Service Providers (NGO) Forum' for the clinical-management partnership of the whole MH&AS sector system.
70. Implement Me Kōrero Tātou with specific, conjoint, time-framed planning with respective iwi with the aim leading to Mana Motuhake
71. Ensure training and ongoing education programmes are provided to frontline staff and MHA service operational managers on the Mātauranga Māori Framework and the new Treaty of Waitangi framework and principles as well as good clinical practice
72. That an evaluation is carried out of the MH&A services requirements of the Kaitakawaenga, to determine the level of resource required to provide an effective and culturally competent Mātauranga Māori service to whaiora and whānau of the district, both 'provider' arm and community services

73. Encourage the implementation of a Māori Health Outcomes Framework (such as Hua Oranga) in the MHA service to enable improved measurement of how Māori whaiora and whānau experience the service from their own cultural perspective
74. Co-design across the mental health and addiction sector of implementation plans, with whaiora and whānau at the very outset.

Terms of Reference (v) ***Review leave protocols and procedures within the Waikato DHB Provider arm***

It is acknowledged that there are a number of leave protocols and procedures in place in the inpatient services, which were updated in 2020. In addition there is a formal auditing structure in place, auditing against leave guidelines and documentation of leave. It is also acknowledged that the nature of leave has had a change in philosophy, where leave is now part of the therapeutic process and discharge.

The review of the leave protocols and procedures involved three of the panel members (psychiatrist, RN/auditor/management and clinical nurse director/DAMHS[46]) engaging with the operations manager and psychiatrist working in the adult acute services and with the social worker in this area. Further to this, each panel member was involved in a number of interviews, although not directly related to this ToR, which has fed into the overall understanding of the system.

From 2015 – 2019 there were several serious incidents at the inpatient facility, each relating to the leave procedures and protocol. Some incidents sadly resulted in tragedy. Each of these incidents was reported as per the national incident management policy attracting Severity Assessment Codes (SAC[47]) level 1 or 2. It is also noted that WDHB MH&AS have been exposed to negative media attention related to these SAC events.

These events instigated a review of the leave process at that time and AWOL procedures that were in place. Both the past and newly implemented processes of leave and AWOL procedure were investigated as part of these terms of reference.

Leave and AWOL procedures

The COVID-19 lockdown allowed for a period where the operations and quality team within acute and forensic inpatient services, an in-house team, could review the leave and AWOL procedures. The leave and AWOL[48] procedures related to Adult Acute Services only, and prior to the in-house review, it was conveyed that the leave procedures were subject to interpretation.

Previous practice (which is no longer acceptable) permitted whaiora to periods of escorted leave to 'smoke, or access the dairy'. This had resulted in several SAC incidents, reporting at varying severity levels, of whaiora 'running away', or legally deemed AWOL.

To be considered AWOL, versus self-discharge, the whaiora had been admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), noting that a large percentage of whaiora are admitted in this manner. A consequence of

[46] Director of Area Mental Health Services, as defined by the Mental Health (CAT) Act 1992
[47] Severity Assessment Codes are used to categorise incidents reported under the national incident management process for health
[48] Absent without leave.

AWOL often resulted in a substantial amount of work and pressure for staff. The AWOL procedure requires the completion of necessary legal paperwork, as well as notification to the Police, and to the whaiora's whānau. The aforementioned escorted leave practice placed constant pressure on staff to be vigilant on escorted leave due to risk of AWOL. Within the acute adult inpatient environment whaiora placed frequent demands on staff to escort for short 'smoke' leave periods.

It has recently been acknowledged that the practice of leave being taken for smoking and dairy visits was considered non-therapeutic and has since ceased. The revision and improvements for the management of leave and AWOL, principally, is a modification in leave philosophy. Leave is currently recognised for purposes of therapeutic benefits and outcomes, generally with whaiora close to discharge and as part of an assessment of readiness for the preparation of discharge.

The leave is a collaborative approach with whaiora, the service and whānau. It was discussed by the operations team and as part of these terms of reference; the importance of whānau engagement and that whānau are actively engaged in the whaiora's discharge planning. Additionally, it provides an opportunity to discuss with the whānau their sentiments on whaiora taking a period of leave and the involvement in the decision making process. Moreover, this meets the section 7A legal requirements for the service to consult with whānau of whaiora subject to the MHA.

The service has recognised the importance of philosophical principles when addressing leave for a whaiora and is guided by the following:

- Leave is always an aspect of therapy
- Leave is not for smoking or vaping
- Admission to a ward is always for good reason
- Leave is an aspect of discharge planning
- Leave should always be goal-oriented and related to self-accountability.

Of note, the changes of procedures went through a consultation process which was inclusive of cultural and whānau advisors. It is noted that the operations manager (for adult acute services) is already working to make adjustments towards a cultural shift for the new build.

An updated AWOL policy and procedure had been implemented utilising a risk matrix by category. The procedure is clearly set out as a flow chart for staff to follow. An addendum to the AWOL policy included: Risk Management Missing Person AWOL policy and Procedure. A Missing Patient Incidents Report 1 January 2020 to 28 September 2020 was sighted and provided the opportunity for staff to learn from.

As a quality improvement initiative to help mitigate AWOL events, the Senior Medical Officer together with nursing staff, reviews and undertakes a mental health assessment of whaiora, identifies any risks, and goals for leave. This is reviewed in conjunction with daily documented clinical assessment, and is completed prior to whaiora taking leave.

Leave is now a 'risk formulation' and considered process and a planned clinical intervention used to facilitate safe transition into the community. This process is documented on the electronic 'inpatient leave management plan' form. What is missing is the shared understanding and shared decision making with whānau to co-sign a form following discussion for leave (refer to recommendations, below).

Despite initial concerns, specifically from the nursing staff who alerted the unions to shift to a 'blanket' no smoking philosophy, the new protocol has had positive outcomes. There were concerns raised regarding the patient's rights versus a smoke free environment and a fear that a no-smoking policy would distress whaiora. However it has been reported, and noted by the operations and quality and patient care team, that there is a reduction in hostility, aggression and seclusion events. Furthermore, applying this 'across the board' no smoking/ vaping philosophy, has aided in decreasing pressure for staff due to a reduction in whaiora requesting leave. This has meant decreased numbers of whaiora taking non-therapeutic leave, resulting in a reduction of AWOL events.

There are several components that impact on whaiora wellbeing and containment within the ward milieu. As part of engaging whaiora for improved outcomes and to minimise whaiora requesting leave for smoking periods, the team are developing a therapeutic programme within the acute adult ward milieu. This programme will facilitate talk therapy skills and approaches, a range of activities and open-air environmental engagements, led by occupational therapy and psychology. Alongside this programme, and already in practice, is smoking cessation education and Nicotine Replacement (NRT) options for whaiora that smoke. This includes gum, spray and patches. This is fundamentally carried out by the inpatient unit staff.

Documentation

To minimise variability in the general practice of nursing documentation, documenting against an approved framework provides a consistent approach of assessment and is helpful in identifying clinical risk from day to day. This helps to provide further information for the formulation, and decision for whaiora to take leave. The nursing team document, in the whaiora clinical file, using the Subjective, Objective, Assessment Plan (SOAP) framework. On-going audit highlights an improving compliancy with almost 100% routine practice week by week. The reviewers sighted audit which demonstrates near 100% consistency in clinical risk being documented over the past few months.

To aid in the identification of whaiora and aggression, the Dynamic Appraisal of Situational Aggression (DASA) tool is applied across wards 34, 35 and 36. Alongside the DASA, a quality improvement initiative is noted regarding a clear escalation process across the adult inpatient units. Education is provided related to different degrees of risk and scenarios, for registered nurses to have an increased understanding of when and how to escalate concerns.

Other factors impacting on the environment and staff time critical issues

It is acknowledged that overcrowding and acuity issues can take staff time that impacts on the therapeutic milieu, this in turn impacting on tāngata whaiora, potentially impacting on the risk of AWOL. The review team acknowledges the other factors in the wider picture.

The MH&A services are experiencing high numbers of: complex presentations (dual diagnosis, head injury and mental illness); co-existing disorders (substance misuse and mental illness); anti-social personality traits. These presentations are having a negative impact on the availability of acute beds. At the time of the review, thirty (30) people presenting with high and complex needs were effectively living in the acute wards and were unable to be placed, or find placement, due to their complex needs.

Also, having an impact on the system are whaiora under the influence of methamphetamine. Anecdotally, they are the highest users of seclusion events, however usually with shorter admissions. It raises the issue of where whaiora can be safely managed while under the influence of methamphetamine in a clinically safe environment. These admissions place added pressure on staff due to the potential aggression and higher assault risk. This also results in additional staff being needed for the care and management of these whaiora.

The review team acknowledge there can never be a 'fool proof' procedure or policy in place for zero SAC events. In addition, the review team acknowledges that the unexpected death of a person that occurs during a hospital inpatient admission is a tragic event that causes immense distress to families, carers, and staff. There is currently training on the Ko Awatea learn platform for staff;[49] this needs to be well socialised.

This is especially so where the person has died by suicide. Recognising that these events can impact on health professionals, it is vital that they have a clear understanding of the incident review process.

Recommendations

75. Establish and develop a form for whānau to co-sign to hold a level of accountability in regards to whaiora leave
76. Make a therapeutic programme for tangata whaiora (currently in the development stages) a priority
77. Ensure the community and crisis teams advise tangata whaiora of the smoke free and leave procedures. Smoking cessation can start in the community
78. Ensure a clear algorithm is set and socialised to all staff regarding the process of the incident review. Recognising that Serious and Sentinel events impact on health professionals, an on-line tool has been developed to support health practitioners through those difficult times. This is accessible via Ko Awatea LEARN platform.

[49] Ko Awatea LEARN is a health sector focused eLearning and education community with a wide range of programmes, courses, and community forums.

Reference Material

- Leave-Adult Mental health inpatient Wards Doc 2184 v06, 21 May 2020
    - Monitoring record
    - Leave management guide
- Leave-Puawai Inpatient wards, Doc 6266 v01, 21 May 2020
    - Approved leave form
    - Patient profile form + photograph
    - Approved leaves special and non-special patients
- Informal tangata Whaiora-Client information
- AWOL Procedure, Doc 3555 v06, date 12 Dec 2019
    - Flow charts
    - Risk Management-Missing Persons AWOL
- Missing Patient Incidents reported in DATIX for MH&A services 1/01/20-28/09/20
- 2015 Section 99 review (Dr John Crawshaw; Ministry of Health)
- Leave management plan

Terms of Reference (vi) ***Review communication protocols and procedures in respect of 'tangata whaiora', family and whānau on admission, during assessment and treatment, at discharge and in any adverse incident within the Waikato DHB Provider arm .***

It is acknowledged that there are a number of communication protocols and policies that guide engagement between tangata whaiora, whanau and staff. These provide high level guiding principles. However, there was little evidence that these principles had been adapted into ward procedures. Further, although audit mechanisms have been built into MH&A services protocols and policies, it is not clear whether these audit tools had been utilised effectively. This review relied on anecdotal evidence to establish whether the communication protocols and procedures where being implemented and, if so, whether they were successful.

Whaiora, whānau and staff services and the mental health & addiction sector recognise that currently the best possible care and support for whaiora, whanau and family is not yet provided.

The documents to support effective communication and engagement with whaiora and whānau are in place. However, according to the people and services who contributed feedback, there are still major gaps between the vision and the reality.

Background

Whaiora and whānau, being active partners in people's journey with mental health and/or addictions, are widely acknowledged as essential to providing person-centred care in MHA&A services. Whānau inclusion in educational and therapeutic interventions can improve outcomes for whaiora, with aspects of medication compliance and throughout the duration of inpatient stays (Wonders, Honey & Hancock, 2019). Working alongside whaiora and their whānau towards recovery requires shared decision-making, collaborative communication and information sharing (Fukui, Mathias & Salyers, 2015). To ensure the quality of shared decision-making, there needs to be needs to be equitable attention paid not only to scientific evidence but also consumer preferences and values (Fukui, Mathias & Salyers, 2015).

What are the communication protocols and procedures for 'whaiora', family and whānau on admission, assessment and treatment and discharge?

Whaiora engagement is linked to providing people-centred care (Waikato DHB, 2015). Waikato DHB Mental Health and Addiction Services (MH&AS) recognises this with specific protocols for Tāngata Whaiora and Whānau participation. Underpinning the protocols and guidelines around communication with whaiora and whānau in the Waikato DHB is the strategic focus in particular of:

- Oranga
- Manaaki and

- Whanaketanga (Waikato DHB, 2016).

Oranga concerns a focus on health equity for high needs populations, whaiora and particularly Māori whaiora, who do not have equitable health outcomes when compared to the general population.
Manaaki, is about people-centred services and ensuring that care provided across all health services are respectful to individuals and whānau needs and values.

Whanaketanga is about productive partnerships in health, Waikato DHB incorporating Te Tiriti o Waitangi in everything they do, and authentic collaboration with all services and communities. Having this strategic document supports the need to ensure that whaiora and whānau are active partners in care.

In Waikato DHB, a framework for providing people-centred care has been established through a number of reports developed by, and for, Waikato DHB. These include *Me Kōrero Tātou: Let's Talk* and *Te Pae Tawhiti*. They are helpful in that they express the general principles that should be adhered to when engaging whaiora, and family and whānau during admission, assessment and treatment, and discharge, however there are specific policies developed to guide staff. These policies, developed by Waikato DHB, include:

- *Whānau Participation. Doc ID: 0896.06*;
- *Service user/Tangata Whaiora Participation. Doc ID: 1855.06;*
- *Family/Whānau Inclusive Practice. Doc ID: 5795.01;*
- *Use of seclusion in Mental Health and Addiction Inpatient Services. Doc ID: 1860;*
- *Visiting Adult Inpatient Mental Health wards. Doc ID 6267;*
- *Mental Health & Addictions Services, Integrated Care Pathway. Doc ID: 1703.*

These protocols outline the need for employees to "work inclusively" with whaiora and their whānau, ensuring that whaiora and whānau are active partners not only in their own treatment but also within service and organisational processes (Doc IDs: 0896, 1855, and 1703, 2019).

Waikato DHB MH&AS has a guideline for whānau inclusive practice which outlines how staff can ensure that whānau are included throughout their loved one's recovery journey (Doc ID: 5795, 2017). The policies also acknowledge that when working with whānau, through the incorporation of the Te Whare Tapa Wha framework enunciated by Dr Mason Durie, it is important to acknowledge the potential impact of mental illness on whānau (Doc ID: 5795, 2017).

Specific guidelines have been developed regarding the communication required throughout the seclusion process for both whaiora and whānau. It is stated that every effort should be made to provide the whaiora with information on what to expect within the seclusion room and how their basic needs can be met (Doc ID: 1860). Further, the decision to use seclusion must be discussed with the whaiora whānau as soon as practicable.

Contact with whānau/family can have significant positive impact on a whaiora's recovery. Therefore it is important to a service user's recovery that they continue to maintain contact with family / whānau and significant others (visitors) as their main support systems throughout their care, including during admission to an acute inpatient unit, and that users have reasonable access to a family / whānau / carer and visitors whilst in the inpatient unit (Doc ID: 6267).

As well as setting a clear expectation for staff regarding their behaviour towards tangata whaiora, it is stated that all staff working in the MH&AS are responsible for ensuring their practice is up to date with appropriate learning about working in partnership with service users / tangata whaiora; this includes, but is not limited to, attendance at regular education forums.(1855)

Waikato also has a DHB wide framework for consumer engagement which provides further backing to the MH&AS protocols. The framework was intended to ensure that consumer engagement was embedded in practice in way that was more systematic and effective, with the goal of improving consumer experience (Waikato DHB, 2015).

Working? Why/why not?

The documents are in place to support effective communication and engagement with whaiora and whānau. However, according to the people and services who contributed feedback, there are still major gaps between the vision and the reality.

Whaiora and whānau often feel unheard and excluded from decisions about their care and the treatment plan. There were 49 complaints made to MH&AS from October 2019 to September 2020; of those, 63% were related to communication in some way. Lack of clear and courteous communication were the most common reasons for the complaints, indicating a lack shared decision-making and working in active partnership with whaiora and whānau.

While the value of whaiora and whānau engagement and participation is recognised in protocols and strategic documents, staff and services need to be supported with working in active partnership. There have been mixed reviews through Real Time Feedback survey, which provides an overview of whaiora and whānau feedback for MHAS, as to whether this is occurring. Some respondents felt that people in adult inpatient services communicated with each other; (from October 2019 to September 2020) the average score out of five was 3.4 for whaiora and 4.3 for whānau. Twenty-seven people chose to comment; 41% of those comments were positive about MH&AS and 33% offered suggestions for improvement.

The differences in experience suggest that the protocols are not always being adhered to. It is not enough to have something written down without having adequate resourcing, education, training, peer and cultural workforce and self-care for all parties to back up what is written.

It has been widely accepted that advocacy and peer roles are recognised as being key to supporting whaiora and their whānau in the recovery journey (Stomski et.al., 2018). Despite this, consumer and whānau support/advocacy roles and services often continue to be excluded from the decision-making process and the value of these roles are not fully recognised. For the funding for adult mental health and addiction services within the provider arm there are 202.2 FTE, with 2 FTE (1%) of that directed to consumer and whānau leadership roles. In the funding for NGO adult mental health and addiction services there are 234.2 FTE with 13.6 FTE (6%) specifically directed to consumer services.

Consumer services

Within Waikato DHB rohe there are a few well established and experienced consumer services which provide support and advocacy for whaiora. Many of these services embrace the principles that Waikato DHB and its Mental Health service have expressed throughout their communication documentation, however are yet to be implemented. It is the application of these principles that is at the centre of peer-led services success; success that Waikato DHB could learn from.

Centre 401 located in the centre of Kirikiriroa/Hamilton, is a completely tangata whaiora owned and operated service. The ethos of Centre 401 is self-determination, self-help and recovery promotion; the staff at Centre 401 apply wisdom from their own learned experience to walk alongside whaiora in their recovery journey. Centre 401 have established 'He Roopu Manaakitanga', with the approval and support of the local iwi, Ngāti Māhanga. They recognise they are not a kaupapa service but do have responsibility to Te Tiriti o Waitangi and support their people in their push for 'mana motuhake' (self-determination).

'Stepping Out Hauraki' is another peer led service located in Thames that works across the Hauraki area. 'Stepping Out Hauraki's' aim is to support people to maintain mental wellbeing through peer support, resources, advocacy, referrals and education.

'Progress to Health' is based in Kirikiriroa and provides community-based support for people with long-term mental health conditions. There is a team dedicated to consumer resource and information services and 44% of staff identify as having lived experience of mental health and/or addictions.

'Te Runanga o Kirikiriroa Charitable Trust', a peer support services for adults, is an urban authority, acknowledges mana whenua and tangata whenua of the Kirikiriroa city area.

'Ngā Ringa Awhina o Hauora Trust', a kaupapa Māori organisation specialising in needs assessment and service coordination at a secondary mental health services level, resides in greater Hamilton area, and has 1.3 FTE specifically funded for consumer roles. There are 13.6 FTE funded by Strategy and Funding for consumer/peer support roles in community services.

Recommendations: solutions suggested by those with lived experience

79. Compassionate care starts at the start of the whaiora and whānau journey with mental health and addiction services. The way people are greeted and treated matters. All staff in the sector (including administration roles) must have education and training on effective communication skills, trauma informed care, and the recovery approach.
80. The Mental Health and Addiction sector needs to have, as a genuine foundation, the premise that tangata whaiora and whānau deserve to be active partners in care. Information and decisions should all be shared, and people should be supported to understand the information and decisions need to be made.
81. Effective communication is essential to the journey of tangata whaiora and whānau with mental health and addiction services, so the responsibilities outlined in protocols and strategic documents need to be aligned with accountability.
82. Align funding streams so that support can be tailored to tangata whaiora and whānau needs. Build connections rather than services working in silos and isolating people.
83. Mana motuhake for tangata whaiora and their whānau requires a multi-level focus on effective communication and active partnership, with:
    i. Appropriate and adequate resourcing of peer and cultural workforce
    ii. Tangata whaiora and whānau active in decision-making process about their care
    iii. Peer and whānau roles and services active in decision-making process about sector
    iv. Genuine co-design across the mental health and addiction sector, with whaiora and whānau at the very first step
    v. Tangata whaiora and whānau roles to coach and support staff on whaiora and whānau perspectives
    vi. Adequate resourcing for staff self-care.

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Lived Experience/Whānau individuals & services represented (ie face to face meeting)

Henry Rongomau Bennett Centre – met with tāngata whaiora

London St Community Mental Health – sat in reception area talked to tāngata whaiora and whānau
Centre 401 – peer led support provider
Evolve Peer Trust – peer led programme funded through MSD
Stepping Out Hauraki – peer led consumer resource & information provider
Progress to Health -consumer resource & information, activity & vocational support provider
MHAS Recovery Advisor Quality and Whānau Community Development Advisor

Appendices

Appendix 1 – Terms of Reference

Waikato Mental Health and Addiction System Review 2020

The Waikato DHB MH&AS has been subject to media scrutiny in recent times and have been under increasing pressure from increasing demand and internal and external pressures. The 2018 Mental Health Inquiry of NZ also found that across the mental health system, the outcomes for Māori are worse than for the overall population. Health system deficiencies for the Māori population were further highlighted in the Stage One Wai 2575 report of findings in 2019.

Recent transformative changes (of MH&AS) locally, include progress on the development of a new model of care for service delivery to support the new acute adult MH facility and placing ownership of the MH&AS provider arm with the Executive Director Hospital and Community Services.

Given the expectations of the Waikato DHB under the NZ PH&D Act (2000), its commitment to 'Te Tiriti o Waitangi' and obligation to all stakeholders within the District, the Chief Executive and Executive of the DHB need to know that the population of Waikato can have confidence that the MH&A services that service our community are safe, effective, integrated in a seamless manner and are adequately resourced.

These services must be aligned to the Waikato DHB Strategic Priorities and Opportunities for improving in planning, structuring and delivering MHAS. This review provides us the opportunity to build on the previous valuable work undertaken in this area.

TERMS OF REFERENCE

MENTAL HEALTH AND ADDICTIONS SYSTEMS REVIEW

Scope:

A review of the current configuration of MH&A services in the Waikato District is required. An independent Review Team has been established to do this.

They will:

i) Review the configuration of MH&A services, what is purchased and whether that meets the District population needs, especially its Māori population;
ii) Review the approach to ensure that services are safe, effective, integrated in a seamless manner across the continuum of care and are adequately resourced, cognisant of both Māori and non-Māori communities and ongoing and persistent inequities that exist for Māori;
iii) Review the clinical governance structure across all MH&A services within District;
iv) Review the application of Mātauranga Māori & Te Ao Māori practices and approaches across the MH&A services;
v) Review leave protocols and procedures within the Waikato DHB Provider arm;
vi) Review communication protocols and procedures in respect of tangata whaiora, family and whānau on admission, during assessment and treatment.

Methodology

i) The review will be conducted in a culturally appropriate manner and in a way that is consistent with the principles of Te Tiriti o Waitangi as outlined in the Ministry of Health's, Māori Health Action Plan entitled, Whakamaua (2020-25).
ii) The review team will account and report to the Waikato DHB, Executive team via an appointed person.
iii) The review team will capture the range of perspectives across the system and consider available documentation necessary to meet the objectives of the review.
iv) In reviewing the system the panel should also consider the insights, intelligence and guidance provided within Te Pae Tawhiti, the Lets Talk Me Kōrero Tātou report and 2019, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction and Tumu Whakarae Mental Health Inquiry Submission, 2018.

Timeframe An independent draft report will be presented to the Chief Executive and Executive of the DHB, and key persons by mid-December, 2020.
Name of Chairperson: Dr David Chaplow **Advisor:** Prof. Ron Paterson
Independent Review Panel Members 1. Dr. David Chaplow – Chair 2. Charles Joe, JP 3. Gail Goodfellow 4. Joanna Price 5. Sherida Davy 6. Sheryl Matenga, Mana Whenua Mana Rangatahi. Mana Whaanau 7. Wi Keelan 8. Dr Maria Baker

Date: 20 November 2020

Appendix 2 List of Interviewees

The Review Team met with:

Waikato DHB Senior Leadership:

Te Pora Thompson-Evans, Chair, Iwi Maori Council
Riki Nia Nia, Executive Director Maori, Equity & Population Health
Tanya Maloney, Executive Director Strategy, Investment & Transformation
Leena Singh, Executive Director Hospital & Community Services
Clinical Leadership
Dr Graham Mills, Clinical Unit Lead, General Medicine
Dr David Graham, Clinical Unit Lead, Waikids/Paediatric Medicine

Suicide Pre/Post-Vention Coordinator

Clare Simcock

Te Puna Oranga

Kaitakawaenga
Janice Eketone, Director

Waikato DHB, Mental Health and Addictions Services:

Vicki Aitken, Services Director Mental Health and Addictions Services
Dr Rees Tapsell, Director of Clinical Services Mental Health and Addictions Services
Sue Critchley, Director
Rachael Aitchison, Director
Kylie Balzer, Operations Manager
Nicki Barlow, Operations Manager
Nicola Livingston, Operations Manager
Grant O'Brien, Project Manager
Carole Kennedy, Nurse Director
Virginia Endres, Team Leader Intelligence
Brendon Dolman, Recovery Advisor
Wheeti Maipi, Community Whanau Advisor

Professional Groups:

Senior Medical Officers
Psychologists,
Social Workers
Occupational Therapists
Community Team Leaders/Charge Nurse Managers
Inpatient Team Leaders/Charge Nurse Managers
Rehabilitation Team

Specialist Services:
Mental Health Services for Older People
Infant Child and Adolescent Mental Health Services
Forensic Mental Health Services
Community Alcohol and Drug Services
Adult Community Mental Health Services
Crisis Assessment and Homebased Treatment Services
Perinatal Mental Health Services
Primary Care Psychiatry

Strategy, Investment & Transformation

Tanya Maloney, Executive Director
Phil Grady, Director
Regan Webb, Director
Rachel Poaneki, Director
Gareth Fanning, Manager
Jolene Profitt, Manager
Alana Ewe-Snow, Manager
Francie Dibley Mason

Enterprise Portfolio Office
Chris Fisher, Director
Michelle Jones, Project Director

Primary Care Liaison Team

Mark Taylor
Bernadette Doube
Maree Munroe
Sheryl-Ann Wilson

Iwi Maori Council

Te Runanga o Kirikiriroa
Raukawa
Ngati Maniapoto
Pare Hauraki
Waikato Tainui

Consumer Organisations
Stepping Out
Evolve
Centre 401
Progress to Health
Individual tangata whaiora discussions.
Te Runanga o Kirikiriroa

Associate Providers
Hauora Waikato
Wise Group
Emerge Aotearoa
Te Kokiri Trust
Te Runanga o Kirikiriroa
Awhi Atua, Awhi Mai
K'aute Pasifica
Care NZ
Community Support House (Manning Street)
Youth Intact

Other Groups/Meetings

Te Roopu Tautoko Ki Waikato
MHAS Joint Leadership Group
Clinical Equity Leaders Group
Ara Poutama – Project Director, Waikeria Mental Health Services
Local Advisory Group (LAG)
Managed Isolation Facilities
Wai2575 Claimants/Maipi whanau
Primary Health Organisations (Pinnacle, Hauraki)

Appendix 3 Recommendations for Te Ao Maori & Maatauranga Maori – Manuka Takatohia: Kawea

Waikato DHB MHAS System Review 2020 - Mana Tangata: Achieving Equity in Health

Recommendations for Te Ao Maori & Maatauranga Maori – Manuka Takatohia: Kawea

Whakautu Roopu Maori

December 12 2020 wikepa keelan

Contents

Purpose

The purpose of this document is to provide recommendations from the Te Ao Maori, and Matauranga Maori perspective as set out in the Terms of Reference (TOR) for this project (Terms of Reference WDHB 2020). Our task as Maori representatives of the review team was set after discussion with our colleagues and the chair. In so doing we agreed to provide an appropriate response to two areas:

- TOR ii: review the strategy to ensure services are safe, effective, integrated in a seamless manner across the "provider arm" and across the "community" and are adequately resourced, cognisant of both Maori and non-Maori communities and ongoing persistent inequities that exist, and

- TOR iv: Review the application of Matauranga Maori and Te Ao Maori practices and approaches across the Mental Health and Addiction services (MH&As).

Introduction

The Waikato Mental Health and Addiction service (MH&As) has been the subject of media frenzy and scrutiny over recent years relative to perceived poor quality of care and treatment dispensed to whaiora and their whanau. Added to this has been increases in demand for services and back pressure emanating from issues involving capacity and flow and community confidence in the system. Further-more the persistent inequity of health outcome experienced by Maori whaiora and their whanau. All these problems have led to the appointment of the review panel which over the next two months have been set the task of fulfilling the Terms of Reference given it by the leadership of the District Health Board (DHB).

Te Tiriti o Waitangi and Equity

The DHB itself in one of its documents, Te Pae Tawhiti The framework for Change (WDHB 2018 - 2030) identifies the principles of Partnership, Participation and Protection will underpin engagement with Maori to develop Maori responsiveness. The writer notes that the DHB version of Te Tiriti o Waitangi is outdated and a recommendation will be made to update to the Ministry of Health's new Treaty Framework as set out in Whakamaua: Maori Health Action Plan 2020 – 2025 (MOH 2020) that sets the Government's directions to improving health outcome and inequity for Maori over the next five years. We have comprehensively outlined the new Treaty Framework below to clearly outline the changes for the purpose of the review. Also contained in the Maori Health Action Plan are the advances by the Waitangi Tribunal in 2019 to the Treaty principles (Wai 2575 2019). All this information is contained in this section of the document.

The vision of iwi Maori is that the Treaty of Waitangi will be embedded and enacted in all systems of the DHB. In so doing it will guide everyone's way to working together in a safe, culturally competent and equitable health and disability service environment. This means stronger partnership and sharing with iwi Maori upholding the Articles of Te Tiriti o Waitangi as identified in the new Treaty Framework of MOH:

- Article one Governance: Mana Whakahaere: How the DHB (government) exercises effective and appropriate stewardship over the health and disability system for all
- Article two: Mana motuhake: enabling Maori to be Maori and exercise authority over their own lives (inclusive health services) according to their needs, values, and traditions
- Article three Mana tangata: Achieving equity in health and disability system outcomes for Maori contributing to Maori wellness
- Article four: Mana Maori: Enabling Maori access (to health services) which are framed by Te Ao Maori, enacted through tikanga and encapsulated with Matauranga Maori (IBID 2020)

The principles of Te Tiriti o Waitangi as articulated by the courts and the Waitangi Tribunal provide a framework for how the Crown through the DHBs meet their obligations under the Treaty in our day to day work. From the Waitangi Tribunal Inquiry into the primary health care system, the 2019 Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry held in Wellington recommended changes to the principles now applicable to the wider Health and Disability system:

- Tino Rangatiratanga (provides for Maori self-determination and Mana Motuhake in design, delivery and monitoring of their H&D services)
- Equity (requires the DHB to commit to achieving equitable health outcomes for Maori)
- Active protection (fully requires the DHB to act to achieve equitable health outcomes for Maori. That it's Treaty partner the Iwi Maori Council are well informed to the extent, the nature and efforts to achieve Maori health equity)

- Options (requires the DHB to properly resource Kaupapa Maori H&D service delivery. Furthermore, the DHB is obliged to ensure that all H&D services are provided in a culturally appropriate way that recognises and supports the expression of hauora Maori models of care)
- Partnership (requires the DHB and Maori to work in partnership in the governance, design, delivery and monitoring of the H&D services. Maori must co-design with the DHB, of the health system for Maori (Wai 2575 2019)

Background

This review is taking place against a background of research that shows Waikato District Health Board (WDHB) has one of the largest proportional Maori populations at 23% (89,861) of the total population and that over the next 15 years the Maori population will rise to 30% (117,210) of the total population. This means that WDHB will need to take a more than piece meal approach to future service development with respect to Maori whaiora and their whanau who are disproportionately high users of the MH&A system. This has been highlighted in the Needs Assessment of Mental Health and Addiction Service Utilisation carried out in 2017 by WDHB which showed significant health inequities for Maori across the MH&A system some related to co-morbid physical conditions which lead to shorter lives. (WDHB 2017)

The quality of MH&A services at WDHB is impaired by pressures on inpatient and community services and other factors. The available occupancy rate data clearly shows occupancy rates beyond their capacity, add to this the apparently limited availability of community services, such as suitable community crisis and community treatment teams and rehabilitation programmes or accommodation to discharge people and you begin to appreciate the size of the problem. There is also the issue of what to do for people whose needs are so complex that none of the range of existing programmes can care for them outside the hospital, mainly young Maori men aged 18 to 35 years. And now, factor in the Maori complexities brought by the lack of culturally competent MH&A services in an area where the Maori population who are high users is of MH&A services is increasing. These are some of the difficulties for this DHB going forward. One thing is certain! The same old will not do! Reliance on clinical services approaches alone will not heal the system for Maori. This view is supported by Whanau ora Commissioning Agencies that the new direction is toward local solutions – that empowering whanau to find solutions for themselves is the right approach (Whanau Ora Commission 2019).

There are two developments on the horizon that may alleviate pressure. The first is a new build adult acute inpatient area at Waikato hospital, the second is the establishment of 100 new mental health beds at Waikeria prison (Waikeria Prison Development 2020) . However, people interviewed by the review criticised the lack of connectedness and coherence of these developments, that although they welcome the new investment in MH&A in the region they believe its success will be short-lived because part of the sector really requiring investment, the community, has been largely neglected. Others commented the planned treatment of mental health patients in prison flies in the face of past reviews, the Gallen Inquiry (1983) and the Mason Report (1988). Both strongly opposed building prison hospitals for psychiatric patients. There are no plans to imminently invest in the community mental health services of the DHB. People who work in those services told about resources being taken as were recently kaitakawaenga from ICAMHs, or positions much needed placed on hold by the administration negatively affecting capacity and flow of whaiora through the whole MH&A system.

A new commissioning approach is needed similar to that employed by the Whanau ora Commissioning agencies aimed at community development, strengthening whanau and incorporating Matauranga Maori service approaches. We heard that the conventional funding model used by the DHB in the MH&A area is preventing maximising health outcome for whaiora and their whanau. Furthermore, the model cannot address the impact of social determinants that create pressure within whanau thereby increasing their susceptibility to ill health. The need for a new commissioning approach based on shared outcome has been discussed widely by Maori nationally however main-stream health services, it seems, prefer the status quo. The need for change was made clear to WDHB during Me Korero Tatou consultations.

To give credit where it is due WDHB has over the past two years, embarked on a community development approach involving Iwi Maori (Me Korero Tatou 2018) and those consultations have been the initiative for commissioning - small at this stage, but exciting possibilities and partnerships with Iwi Maori primary health providers. Six small contracts commissioned to provide Matauranga Maori modelled services in their communities, close to their homes thereby enabling them access to a wider range of primary and community cultural interventions to enhance the work of clinicians. Maori believe this holistic approach to be the way forward.

The Report of the Mental Health Inquiry (He Ara Oranga 2018) found a striking degree of consensus on the need for a new direction in mental health and addiction services: one that gave greater emphasis to community development, including a larger focus on prevention and involving people and communities in designing and transforming the system, providing expanded access and increased choice of services, strengthening whanau and community based responses. These are similar to directional changes asked for by Maori of the MH&A service both nationally and locally as reflected in the views

and ideas given by the Waikato community to the DHB during recent consultation to guide new directions and improve their MHSs. These themes included:

- More support, education and involvement of whanau and more rapid response to their needs
- Whanau ora as a model of care for the Mental Health Service
- Access to alternative treatments to medication and alongside medication .e.g. (Rongoa Maori, Talk therapies)
- People who listen, show respect and treat whaiora and whanau with care
- Improved access to crisis care, local solutions for people in crisis while waiting for the community assessment team
- More local solutions including local respite, local points of entry, to services and local follow up
- Better integrated care
- Addressing transport issues in rural communities
- Provide support for rural GPs (Me Korero Tatou DHB Report on Community Consultation including Iwi Maori 2019)

The Journey so Far

The review team has agreed to a Treaty approach to the model we are applying in compiling the recommendations for the review. This has enabled the development of the following recommendations for TOR ii and TOR iv that are contained in a framework and divided into two rows: Whaikupu (Recommendation) and Putanga Matua (Key Finding). The explanation of the recommendation column is self-explanatory as is the Key Finding where we considered the need to reasonably explain the why of what was required for each recommendation. This would be important when the information from this document is transferred to the larger overall review document(s) Maori and non-Maori.

The process undertaken to identify these recommendations follows the casting of the Maori equity lens over the organisational structure beginning at Corporate Governance and Leadership cascading into necessary recommendations for Te Puna Oranga that supplies kaitakawaenga and kaitaiaki cultural workers into parts of the organisation and on into the MH&A provider services and the Planning Funding service, to look at commissioning arrangements for achieving Treaty benefits including equity. In each of these arenas care processes and practice have been examined incorporating the use of the equity lens and relevant recommendations have been made.

Corporate

Whaikupu: Recommendation	Putanga Matua: Key Finding
Governance and Leadership	
1. That overall accountability for implementing the governance and leadership section recommendations will be the Executive Director Maori Health Equity and Public Health.	That Maori leadership and genuine Iwi Maori partnership for developing Matauranga Maori and Te Ao Maori approaches across the DHB is required to reduce inequity and increase Maori health outcome That conscious and unconscious bias and confusion and ambiguity are creating barriers to agreement and implementation of a MH&A wide Matauranga Maori service model

Te Tiriti o Waitangi	

2. That a review and update Te Tiriti o Waitangi (TOW) in the DHB be carried out to reflect the Ministry of Health's new Treaty of Waitangi framework	The DHB requires to upgrade to the new Treaty of Waitangi Framework recently published by the Ministry of Health in Whakamaua, the Maori Health Action Plan 2020-2025 (MOH 2020)

Memorandum of Understanding (MOU) between the Iwi Maori Council and DHB	
3. That the MOU agreed between the DHB and Iwi Maori Council 2017 is reviewed and updated to the new Treaty of Waitangi Framework	The DHB and IMC MOU requires upgrading to reflect the new Treaty of Waitangi Framework, including the Waitangi Tribunal's recent review of the Treaty principles.
4. That the training education programme for governance and leadership groups is informed with respect to the new Treaty of Waitangi framework	Commitment of the DHB is required embedding and enacting the new MOH principles and articles of the Treaty of Waitangi in the new MOU
5. That the DHB commit to the development of visible and genuine partnership arrangements for achieving health equity for Iwi and whanau in the governance programme of the DHB	
6. That the DHB provide secretariat and other resources as necessary to IMC that they may operate effectively and carry out their responsibilities as the Iwi partner to the DHB as set out by Te Tiriti o Waitangi	

Te Puna Oranga Maori Service

Whaikupu: Recommendation	*Putanga Matua: Key Finding*
Te Puna Oranga/Kaitakawaenga	
7. That an evaluation is conducted with respect to the deployment of all kaitiaki and kaitakawaenga staff from Te Puna Oranga into frontline health and disability services of the DHB and determine if the current modus operandi is the most effective and efficient use of this valuable resource	Currently there are seven kaitakawaenga providing cultural services to whaiora and their whanau. They are not able to meet the cultural requirements of all of the M&A service. They are employed Monday – Friday 9 am – 5pm . According to MH&A data the majority of Maori are admitted to the MH&A service after hours and those people cannot access cultural care on entry to the MH&A service Equity gaps exist in the MH&A service relative to the cultural competence of staff. In order to assess what is required to improve health outcome for Maori an evaluation of the resources is needed
8. That an evaluation is carried out of the MH&A services requirements of the Kaitakawaenga and determine the level of resource required to provide an effective and culturally competent Matauranga Maori service to whaiora and whanau of the district	There is a need to quantify the number of Kaitakawaenga required to deliver an effective and competent service for Maori consumers and their whanau across the MH&A service.
Maori Health Outcome Framework	
9. That resource is made available for designing and implementing a Maori Health Outcomes Framework such as Hua Oranga (HO) in the MHA service to enable improved measurement of how Maori whaiora and whanau experience the service from their own cultural perspective	There is no health outcome measurement tool available in the MH&A service to adequately evaluate how Maori whaiora and their whanau experience care from their own cultural perspective. Hua Oranga A Maori measure of mental health outcome – Kingi and Durie Massey University School of Maori Studies – Te Pu Manawa Hauora Palmerston North. The measurement of Matauranga Maori based aspects of the MH&A service for improving equity and Maori health outcome are inaccessible using existing conventional outcome measurement data sources Data collected from the Maori Health Outcome Framework can better inform the development of more effective and equitable MHA service and imp[rove the quality of care for whaiora and their whanau. (file:///:/Users/Kahu/Download/ORA DATA BASE MANUAL 20.03-2014%20(3).pdf.

The Mental Health and Addiction Provider Services

Whaikupu: Recommendation	Putanga Matua: Key Findings
Te Ao Maori approach and Matauranga Maori service model	
10. That a Matauranga Maori service model based on Te Ao Maori healing practices and approaches is agreed and implemented across the MH&A service at WDHB 11 That accountability for implementing the Te Ao Maori approach and Matauranga service model will be the Directors Maori Health and Mental Health and Addiction 12. That whanau participation in the care of their loved one is one of the basic tenets of care and treatment for Maori whaiora in the MH&A service	There is no agreed Matauranga Maori model or agreed Te Ao Maori healing practice and approach consistently employed across the MH&A service Matauranga Maori approaches and Te Ao Maori traditional healing practice, including the use of rongoa as effective interventions for Maori whaiora and their whanau are effective in reducing inequity and improving health outcome (Bpac.org.nz, Practical Solutions for Improving Maori Health, 2008) (Me Korero Tatou DHB Report on Community Consultation including Iwi Maori 2019) Effective Matauranga Maori cultural intervention programmes can reduce inequity and increase health outcome for Maori in the MHA services (Inquiry into Maori health inequities-Whanau ora Commissioning Agency 28 August 2019 https//www.whanauora.nz/)
13. That a training and education programme is provided to frontline staff and MH&A service operational managers on the Matauranga Maori Framework and the new Treaty of Waitangi framework and principles	MH&A workforce requires to improve cultural safety and competency for meeting the needs and aspirations of Maori whaiora and their whanau MH&A service needs to reflect on how being a good Treaty partner impacts on the roles of people who work in MH&A services and improves health outcome for Maori people who use the MH&A services
Clinical Governance	
14. That the governance group is expanded to overview the MH&A system, including primary mental health and NGO services to provide an environment where the system for treatment and care is monitored, safe, effective and delivered by a competent workforce. 15. That as well as clinical skills the governance group will contain the necessary expertise to enable access to Matauranga Maori approaches and	No one group has a joined-up view of capacity and flow throughout MH&A service from community providers to primary providers and secondary providers or the opportunity to identify areas for improvement particularly for Maori who are disproportional users of the system The governance group lacks the focus to bring together future strategies for primary care and inpatient care as requested by Iwi/ Maori of the region where the aim is prevention and education and strengthening whanau to care for their own in primary and community settings closer to their homes Matauranga Maori and community experts interviewed about the governance group were unsure as to their (the governance group's) capacity or capability to design, plan and future proof the MH&A service for Maori

broaden treatment options for Maori whaiora and their whanau.	The governance group does not have a whole of system view with up to date data and knowledge of service capacity and whaiora flow within the system.
Improving Service Transition	
16. That a review of MH&A service transitions be carried out for whaiora and their whanau who along with iwi Maori will be engaged as part of the review	Service transitions are multiple and recognised as a risk to whaiora and their whanau and service providers. A significant number of whaiora are lost to follow up and are a failed transition From 2017/18 DHBs have been monitored and required to report on discharge planning, 95% of people are required to have a discharge plan
17. That a review be conducted on the effectiveness of discharge planning processes for whaiora and whanau and necessary improvements made to keep them safe	International evidence shows when done well discharge planning brings together a persons health and broader social needs and enables those needs to be met (Report Office of Auditor General 2016)
Maximising Physical Health	
18. That key stakeholders including Maori and consumer representatives explore the need for initiating a review to assess the physical condition of whaiora Maori in the MHA service with chronic mental illness	WDHB's MHA Health Needs Assessment MHA Utilisation, 2017 identified significant health inequalities for people with mental illness. Additionally, the document highlighted mental illness and other morbidities disproportionately impacting Maori facing greater socioeconomic deprivation than non-Maori. Many people who suffer with serious mental illness also suffer chronic physical health conditions and many live shorter lives The Office of the Auditor General IBID The impact of mental illness or/ and physical health disproportionally impacts Maori people who face greater socio-economic deprivation
Improving Medication Management	
19. That a review of Maori whaiora prescribed clozapine, that has significant adverse reactions and increased risk of cardiac death, is carried out	That Guidelines concerning practice and administering of Clozapine are available in the policies and procedures manual of the MH&A service Literature concerning increased health risk and adverse reaction when prescribing clozapine are well known (BPac Clozapine: Safe Prescribing 2014),(Clozapine – Safe Prescribing – we are counting on you, Waitemata DHB 2017) Researchers at Otago University tracked ethnic use of Clozapine and found that Increasing numbers of Maori and Pacific people are being prescribed clozapine. They found Maori are more likely to be prescribed clozapine than other people and the rate of prescribing is increasing (Otago University 2018) When a group of MH&A physicians were questioned by members of the review about the use of atypical antipsychotics especially clozapine in relation to the need for regular

	monitoring, they responded…. "We do not think patients here (at the DHB) are being prescribed this medication." They did not sound certain therefore a recommendation has been made to review its use at the DHB in the MH&A service
Minimising Restraint and seclusion	
20. That approaches employed to prevent and reduce seclusion use are reviewed including: the use of equity lens approaches, recovery, trauma informed care, the human rights approach, the public health prevention model and the use of Maori cultural interventions	Maori consumer inequity and experience of seclusion features very strongly in the data from both the HRBC and Puawai. The reasons for high Maori frequency and duration in this service requires in depth exploration and analysis and questions asked as to whether we have tested all approaches and tools available to us to avoid admission to seclusion in the first place.
21. That regular training is provided to all frontline staff with respect to the latest evidence-based approaches for forensic care.	Frontline staff in MH and the forensic service need to be armed with the most up to date forms of evidence-based practice.
22. That the training programme should also include conscious/ structural bias and unconscious/ implicit bias. Lastly, the training to include korero about health equity and Te Tiriti o Waitangi and how these frames impact the roles of health workers and the well-being of Maori	The evidence is clear, to reduce Maori inequity and improve health outcome, cultural interventions are required to enhance clinical practice (A window on the quality of Aotearoa New Zealand's health care 2019. He matapihi ki te kounga o nga manaakitanga a hauora – Health Quality & Safety Commission)
Use of the Mental Health Act on whaiora Maori	
23. Review the use of the Mental Health Act 1992 with respect to Maori consumers receiving treatment at MHA services.	MHA service data shows that Maori are treated at a higher rate than non-Maori either under inpatient or community compulsory treatment orders. There is significant inequity between Maori and non-Maori
24. Staff are trained in the appropriate application of the Act, the use of equity instruments and can identify and deal effectively with issues that emanate from that perspective	Ensure the Act is applied appropriately and in a way that maintains the person's dignity, mana and safety The workforce involved during the application of the Act are appropriately trained and supported acknowledging it can be traumatic for them, and for the person and their whanau

Planning and Funding Service

Whaikupu: Recommendation	*Putanga Matua: Key Finding*
Commit to Te Ao Maori service development and commissioning approaches	
25. That the accountability for planning and implementing these recommendations is shared between the Directors Maori and Planning Funding 26. That the Planning and Funding (PF) service commit to service development that builds on Te Ao Maori approaches for Maori as outlined in the Report Me Korero Tatau – Let's Talk undertaken with the Waikato Tainui community including Iwi Maori	The Planning and Funding service needs to recognise the value of Matauranga Maori approaches and Te Ao Maori traditional healing practice, including the use of rongoa as effective interventions for Maori whaiora and their whanau
Strengthen Te Ao Maori approach and commissioning in the Planning and Funding Workforce	
27. That the PF team is strengthened with a person who has experience and knowledge of commissioning services that incorporate Te Ao Maori and Matauranga models and approaches	The evidence shows effective Matauranga Maori cultural interventions can reduce inequity for Maori in the MHA services
Improve Planning and Funding Clinical Governance	
28. That formal engagement is completed between the MHAS, Planning and Funding Service and clinical governance group for overall MHA system improvement	There is no formal relationship across the MH&A system to enable an over-view of capacity and flow and mitigate potential problems before they occur There does not appear to be a clear understanding or over view of the MH&A system

Resource and evaluate current and developing DHB/ Maori/ Iwi provider initiatives	
29. That resource is provided to evaluate current and developing DHB/ Maori/ Iwi provider partnership initiatives	Consultation with Iwi and Maori communities has resulted in whanau being very clear about the services they want close to home. These services are to be built on the following principles. They will: • Strengthen whanau • Build resilience • Stop Suicide • Access wellness influencers • Recognise Maori Mana Motuhake • Provide crisis resolution and • build a well-being workforce
Invest in successful initiatives that contribute to Maori health equity	
30. That investment be provided to expand access and choice for whaiora and whanau to proven successful initiatives	There are currently six Iwi Maori innovations either completed or in development in partnership with the DHB. Monitoring and rewarding successful innovation between the DHB and Iwi Maori providers and communities are an effective way of healing the Maori population of the Waikato Tainui district Maori are over-represented at 44% of the people who use these services, particularly Alcohol, Drugs and Other Substances (WDHB's MHA Health Needs Assessment MHA Utilisation, 2017) Health equity is a strategic Imperative for the DHB stated in its documents as: "a radical improvement in Maori Health outcomes by eliminating inequity for Maori"

Conclusion

Our brief for this document was to provide recommendations from the Te Ao Maori, and Matauranga Maori perspective for the review. In so doing we agreed to provide an appropriate response to two areas:

- TOR ii: review the strategy to ensure services are safe, effective, integrated in a seamless manner across the "provider arm" and across the "community" and are adequately resourced, cognisant of both Maori and non-Maori communities and ongoing persistent inequities that exist, and

- TOR iv: Review the application of Matauranga Maori and Te Ao Maori practices and approaches across the Mental Health and Addiction services (MH&As).

TOR ii Review of the Strategy

From the TOR we focused particularly on two questions:

- Are services provided in a safe, effective and integrated manner across the "provider arm" and across the "community" and are they adequately resourced cognisant of the Maori community and persistent inequities that exist? And
- How are Matauranga Maori and Te Ao Maori practices applied across the MH&A system?

The information below captures the salient response to our questions which aimed at the provider and funding arm of the DHB which were subjected to health equity tool analysis. The following are

Provider Arm

In response to the first question the review found a number of areas of inequity particularly in the provider and funding arms of the DHB. In the provider arm these occurred in the following:

- The compulsory use of the Mental Health Act where Maori whaiora were two times more likely than Europeans to be placed under both Community Treatment Orders and one point 9 times more likely to be placed under Inpatient Treatment Orders
- The area of Medication Management was also given a recommendation particularly with respect to the prescribing and monitoring of the high risk adverse reactions atypical antipsychotic, clozapine and deaths internationally and nationally associated with this medication
- The area of whaiora Physical Health as identified by the DHB Needs Assessment of Mental Health services conducted during 2017 with respect to the ageing Maori mental health population affected by co-morbidities and shortened lives
- In the area of service transitions where a high number of whaiora Maori are lost to follow up and therefor a failed transition
- The High Needs and Complex group where Maori men aged 18 – 35 years were disproportionately represented. There is no specialist service to meet their needs
- Maori whaiora were disproportionally represented in the forensic and inpatient adult mental health services with limited access to kaitakawaenga cultural services
- Maori whaiora were disproportionally represented in the CAMHs with no identified Maori service to meet their cultural needs. This was similar for Maori whaiora in the ICAMHs.
- There is no agreed Matauranga Maori or Te Ao Maori model and approach across the MH&A service
- The existing Kaitakawaenga practioners number only seven and cannot extend their reach to all services of the MH&A service. Neither can the provide after-hours support, the time when most Maori enter the adult inpatient service
- There is no Maori Health Outcomes Framework to measure their experience of the MH&A service from their own cultural perspective. Existing conventional measurement tools are incapable of capturing culturally practices, rituals and relevant data.

Funding Arm

In the funding arm although recent consultation had occurred (Me Korero Tatou 2018) exploring the opinions and views of the Waikato community, including Maori, of their preference for MH&A services, very little investment or action had been taken with respect to changing commissioning practices aligned to those Maori views and preferences. In the funding arm inequity occurred in the following areas:

- Governance and management across the MH&A system where investment is required to establishing a single point or group to govern and monitor: fiscal, clinical, cultural and flow and capacity issues in real time thereby enabling better overview and use of the system
- The equity lens to be used over the funder commissioning system. Purchasing needs to reflect the realities of Maori health and what is required to shift whaiora and whanau from illness to wellness
- The PF team is strengthened with a person who has experience and knowledge of commissioning services that incorporate Te Ao Maori and Matauranga models and approaches
- Connection between provider, funder and associate providers (NGOs) to be improved and purchased as a single system (many providers; one system)
- That greater investment be provided to expand access and choice for whaiora and whanau to proven successful and culturally competent initiatives in the provider arm and the community including primary mental health

TOR iv Matauranga Maori and Te Ao Maori practice

Question two related to the application of Matauranga Maori and Te Ao Maori practices. The review found that because access to kaitakawaenga cultural services are limited, it follows that the application of Matauranga Maori approaches are inconsistently performed across the MH&A system. Some parts of the service had no access at all thereby providing a poor quality of service to whaiora and their whanau. Furthermore, there is not a system wide and agreed Matauranga Maori service model. Recommendations have been made to improve this situation.

In view of our findings we concluded the MH&A services are not provided in an effective and integrated manner across the provider arm or across the community for Maori whaiora and their whanau. We also agreed that funding is required cognisant of their needs to reduce inequity and improve health outcome.

Our findings were similar for the funding arm of the DHB where small steps in terms of recently commissioned partnerships with Iwi Maori health providers have been made in the right direction, but more investment is needed if positive impact is to be made on the persistent poor quality of MH&A service currently experienced by Maori in the Tainui Waikato area.

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Appendix 4 MH&A Systems Review Recommendations

Terms of Reference (i): Review the configuration of Mental Health and Addictions Services (MH&AS), what is purchased and whether that meets the District population needs, especially its Māori population		
1.	Operational planning needs completion and planned actions need to be implemented. It is important for whaiora, whānau, mainstream and iwi to have time-framed, incremental pathways to realise the issues expressed as important to them in documents such as 'Me Kōrero Tātou'.	
2.	S&F consider utilising the expertise of provider arm clinicians to explore ways or working and supporting the transition of high and complex whaiora out of the inpatient services into a community service "home for life".	
3.	Whaiora transition plans be developed with both Provider Arm and ACP's/NGOs that is agreed and implemented incrementally (over many months) to allow the whaiora to adapt to the new environment successfully. This will require a package of care funding envelope.	
4.	Clinicians support ACP's staff to implement behavioural management plans for whaiora, provide oversight, mentoring and supervision to enable staff expertise working with this cohort to grow and develop positively.	
5.	Strategy and Funding consider funding a provider that has expertise delivering high and complex services.	
6.	That regular, open and transparent, quarterly meetings occur between the Provider Arm manager and S&F for the purpose of reporting against the PVS. The process would also be an opportunity for the provider arm management to highlight key achievements e.g. therapeutic "leave" management recently instigated in the inpatient services (reduction in absence without leave- AWOL) and the numerous quality initiatives of merit that were being achieved.	
7.	Any reconfiguration of FTE be agreed with S&F with a relevant rationale to share and mitigate risk.	

8.	New service development must include S&F and not be undertaken in a "vacuum".	
9.	The DHB involve clinicians to a greater degree in service planning	
10.	Strategy and Funding assist Provider Arm Clinical Leads by supporting co-location opportunities with MH&AS NGO/ACPs (supportive letter to all providers identifying what the Clinical Leads were attempting to achieve) particularly in the smaller urban areas and rural communities for closer to home responsive services.	
11.	ACPs be provided with a template to input their mission, vision and model of care for service delivery along with service expectations and relevant monitoring in the Provider Specifics Terms of Conditions section of the funded agreement and this be included in the new agreements.	
12.	Utilise the use of flexibility clauses to support whaiora costs e.g. clothing to attend an interview for a job; respite placement. A schedule of the rationale and flexibility spend would need to be sent to S&F by ACPs as agreed, for monitoring within a flexibility (variable) funding envelope for each provider.	
13.	Review all pricing across the MH&AS sector and agree pricing standards (price by unit) e.g. clinical FTE rates; non-clinical rates; bed rates etc.	
14.	Agreed pricing rates are transparently shared by S&F with providers to minimise competition and enable trust to grow in the sector	
15.	All MH&AS provider service specification by FTE, Bed Day, Programmes are listed on a template and all providers have access to the information. This approach allows staff to identify who provides what service across the system.	
16.	Longer term funded agreements be renewed every three years to ease payment processes and improve budget efficiencies. This will also reduce demand on staff at the WDHB and MOH managing ad-hoc payments and follow up payments on behalf of providers.	
17.	Move to PRIMHD reporting for all providers across the sector moving away from Performance Monitoring Reports	

18.	Consider a similar accountability reporting framework that is aligned to monthly provider arm reporting to identify value for money and emerging risk analysis.	
19.	Reconsider Wash Up management as an exception not a rule. However Relationship Managers will need to have regular (four times a years) face to face meetings with NGO/ACPs staff to ensure transparent open communication is ongoing to mitigate relevant risks and implement wash up as required.	
20.	Audit schedules are provided annually and communicated to all providers. This will reduce the miscommunication across the sector regarding audit activity.	
21.	Issues Based Audits (IBA) are utilised more often by S&F.	
22.	S&F seek solutions of support for providers who face challenges e.g. utilising other provider support of staff.	
23.	Consider including mandatory the Governance Social Sector Accreditation Standard (SSAS) in routine audits and IBA's as a more comprehensive criterion for audit.	
24.	That feedback is provided to all providers at the conclusion of an RFP process to clarify learnings.	
25.	EPO activities are profiled and relevant outcome updates are posted on the WDHB Facebook page and communicated by the Relationship Manager to the MH&AS sector	
26.	RFP processes and outcomes are managed transparently and lawfully.	
27.	Specify provider MH&AS models of care and whaiora outcomes on WDHB Facebook pages on a monthly basis where health outcomes/gains have been identified (provider arm and ACPs).	
28.	Profile all evaluation of service activity on Facebook too to enable providers to learn from each other to facilitate replication of cost effective treatments and wellbeing outcomes	
29.	Each month profile a service (Provider Arm and ACP) the team, what they do and how they work. With consent, ask whaiora who are willing to share their stories of hope on Facebook/social media.	

30.	As a public funded sector, set up a portal for all MH&AS providers or alternatively utilise the WDHB Facebook page to include all related planning, funding and service development being undertaken.	
31.	Provide a schedule of services by PUC and provider to all funded services including provider arm staff via email or hardcopy and update this annually.	
Terms of Reference (ii) Review the approach to ensure that services are safe, effective, integrated in a seamless manner across the continuum of care and are adequately resourced, cognisant of both Māori and non-Māori communities and ongoing and persistent inequities that exist for Māori		
32.	Operational/commissioning planning needs completion. This will be important for Whaiora and iwi to have a time framed, incremental pathway to realise the issues expressed important to them in documents such as 'Me Kōrero Tātou'.	
33.	To explore common criteria of service governance across the entire MHAS spectrum	
34.	To explore a framework of 'management' over the entire spectrum of services	
35.	S&F and the MH&SA explore ways whereby S&F can retain independence while funding for service integration. Likewise, S&F portfolio managers to avail themselves of the opportunity to be part of sector governance.	
36.	MH&AS leadership explore ways with the community service providers to mutually support services and whaiora when needed	
37.	Concerted effort to build on the two PT liaison specialists with GPs with improved integration and perhaps mentoring with common governance explored for those dealing with whaiora.	
38.	With urgency, subacute beds to be contracted in the community connected (by planning, contracting and by governance) to the inpatient and forensic units)	
39.	Capacity must be created by creating flexibility in the acute adult MH inpatient services. This may occur in two ways	

	i. Ability to decant to a supported community service with clinical capability ii. Dealing with the 'high and complex' whaiora.	
40.	Creation of a small specialist unit dealing with the H&C Whaiora. This would necessitate the involvement of specialist care experienced in dealing with risk, rehabilitation and interagency involvement.	
41.	Immediate enlargement of the 'active transition team' dedicated to this small but significant group of whaiora with 'high and complex' needs	
42.	Early interagency involvement in the assessment and triage of whaiora in crisis; a 'Whānau Ora' type model (noting that the majority of whaiora who present in crisis with social needs need assistance other than inpatient admission)	
43.	There needs to be an insistence on 'diagnostic formulation' and a one transferable 'management plan'. Note aka recovery or wellness plan	
44.	Careful discharge planning, involving the triangulation of Whaiora, Whanau and clinician needs to occur with commensurate managed followup	
45.	Convene a meeting with the psychology leader in order to discuss, clarify and remedy these concerns	
46.	That decentralisation occurs with a move to 'health and clinical' hubs at designated centres.	
47.	That with the change in configuration and modelling, clinician access to NGOs is considered	
48.	Seriously reconsider capacity building (beds) in the light of the increasing population	
49.	Provide kaitakawaenga cover to the MHSOP	
50.	Accelerate the implementation of the proposals enunciated in the 2018 report, which was to reconfigure the ICAMHS services to deal with crisis work more effectively.	

51.	Rather than only refer to psychology services, initially utilise other therapeutic modalities in the first instance (e.g., training parents, use other trained disciplines, ration the psychology sessions and review)	
52.	Utilise the 'Psychology Centre' (by contracting from the DHB).	
53.	In the Central cluster, remodel 'assessment and triage' as distinct from dealing with 'crisis' (I.e., develop two teams with different functions).	
54.	Provide a 'dedicated crisis clinical pathway' including a Waikato DHB or Midlands Regional solution	
55.	Pasifica need to be connected with other community services and be able to access secondary mental health advice more easily.	
56.	That specific time-framed plans be developed with enunciated goals, respective responsibilities and accountabilities and support with each of the hub developments	
57.	There needs to be a clinical, governance framework across all related community AOD services.	
58.	Contracts need to be more systemic and flexible	
59.	There needs to be more clarity what contracts are held by respective providers in the community	
60.	Peer Support and kaitakawaenga are vital in AOD services and should be contracted	
61.	'Navigation FTEs' would be helpful to those who have co-morbid social presentations	
62.	Support the establishment of the Drug Court and monitor and evaluate its impact	
63.	As 60-80% of referrals are from Courts and Corrections, greater cooperation and clarity is needed in regard to coordination, and shared responsibility	
64.	Convene a hui between providers, IMC and S&F to clarify and address the above concerns.	

Terms of Reference (iii) Review the clinical governance structure across all MH&A services within District		
65.	That a framework of governance be instituted across the provider arm/community divide to all contracted services, according to their respective speciality	
66.	That the S&F together with IMC and provider arm leadership consider the continued viability of the 'Oversight Group', its function, size and composition and support.	
Terms of Reference (iv) Review the application of Mātauranga Māori and Te Ao Māori practices and approaches across the MH&A services		
67.	Establish a co-designed Te Ao Māori Advisory Committee (TAMAC) to strategize, plan, receive and provide monthly reports on the achievements, outcomes of Māori Health gains against a Māori Health Strategy Work Plan.	
68.	Te Puna Oranga to hold an internal review of its capability and capacity to fulfil its obligations to incorporate Te Ao Māori worldviews into the wide range of DHB clinical and business activities.	
69.	Reconsider the necessity and function of the 'Oversight Group'; possibly into a newly constituted 'DHB and Associate Service Providers Forum' for the clinical-management partnership of the whole MHAS sector system.	
70.	Implement Me Korero Tatou with specific, conjoint, time-framed planning with respective Iwi with the aim leading to Mana Motuhake;	
71.	To ensure a training and ongoing education programmes are provided to frontline staff and MHA service operational managers on the Matauranga Māori Framework and the new Treaty of Waitangi framework and principles as well as good clinical practice;	
72.	That an evaluation is carried out of the MH&A services requirements of the kaitakawaenga and determine the level of resource required to provide an effective and culturally competent Matauranga Māori service to whaiora and whānau of the district, both 'provider' arm and community services;	

73.	Encourage the implementation of a Māori Health Outcomes Framework (such as Hua Oranga) in the MHA service to enable improved measurement of how Māori whaiora and whānau experience the service from their own cultural perspective;	
74.	Co-design across the mental health and addiction sector of implementation plans, with whaiora and whānau at the very outset.	
Terms of Reference (v) Review leave protocols and procedures within the Waikato DHB Provider arm		
75.	To establish and develop a form for whānau to co-sign to hold a level of accountability in regards to whai ora leave	
76.	Make a therapeutic programme (noted that it is in the development stages) for tangata whaiora a priority	
77.	Ensure the community and crisis teams advise tangata whaiora of the smoke free and leave procedures. Smoking cessation can start in the community	
78.	Ensure a clear algorithm is set and socialised to all staff regarding the process of the incident review. Recognising that Serious and Sentinel events impact on health professionals, an on-line tool has been developed to support health practitioners through those difficult times. This is accessible via Ko Awatea learn platform.	
Terms of Reference (vi) Review communication protocols and procedures in respect of 'tangata whaiora', family and whānau on admission, during assessment and treatment, at discharge and in any adverse incident within the Waikato DHB Provider arm .		
79.	Compassionate care starts at the start of whaiora and whānau journey with mental health and addiction services. The way people are greeted and treated matters. All staff in the sector (including administration roles) must have education and training on effective communication skills, trauma informed care, and the recovery approach.	
80.	Mental health and addiction sector needs to have, as a genuine foundation, the premise that tangata whaiora and whānau deserve to be active partners in care. Information and decisions should all be shared, and people should be supported to understand the information and decisions need to be made.	

81.	Effective communication is essential to tangata whaiora and whānau journey with mental health and addiction services, so the responsibilities outlined in protocols and strategic documents needs to be aligned with accountability.	
82.	Aligned funding streams so that support can be tailored to tangata whaiora and whānau needs. Building connections rather than services working in silos and isolating people.	
83.	Mana motuhake for tangata whaiora and their whānau requires a multi-level focus on effective communication and active partnership.	

REPORT TO COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE
28 APRIL 2021

AGENDA ITEM 7.4

UPDATE ON DHB COMMUNITY HEALTH FORUMS AND ENAGAGMENT

Purpose

The purpose of this report is to update Community and Public Health Advisory Committee members on key feedback from the February-April 2021 Community Health Forums (CHF) (Round 1). It also provides an update on the DHB engagement workshop (March 20201) and associated agreed actions.

Recommendations

It is recommended that the Committee:

1) Note the second round of Community Health Forums was held in February-April 2021 and a number of issues were raised:
    - Consumer advocacy service changes
    - Access to primary and secondary services
    - Mental health and wellbeing - Local community access to crisis and other services;
    - Local community leadership: Hauora/health and wellbeing events
    - COVID vaccination and ongoing COVID impacts; and
    - Wider socio-economic issues facing local communities

2) Note DHB engagement workshop has been held (10 March 2021) and a DHB engagement framework is in development.

LISA GESTRO
EXECUTIVE DIRECTOR – STRATEGY, INVESTMENT AND TRANSFORMATION

REPORT DETAIL

The Community Health Forums (CHF) are an important communication mechanism for the Waikato DHB to engage with its communities. They also provide information for the Community and Public Health Advisory Committee (the Committee) to inform discussion and deliberations.

This report provides an update on key CHF themes (February-April 2021) from local communities health wellbeing experiences, impacts and aspirations.

February-April CHF (Round 1): Locations and key feedback themes

The second round of CHF were facilitated in the following areas (date):

- Te Kauwhata (22 February)
- Taumarunui (23 February)
- Hamilton East (25 February)
- Raahui Pookeka (Huntly) (25 February)
- Tokoroa (2 March)
- Te Kuiti (4 March)
- Morrinsville (8 March)
- Thames (6 April)
- Cambridge (8 April)
- Raglan (13 April)

Much of the engagement feedback received from CHF participants is broad higher level feedback, rather than specific issues to which the DHB can take action on. The latter can sometimes be consumer/whanau feedback on which CHF participants are encouraged by DHB staff at CHF to provide discreet details separately to DHB Quality and Patient Safety for action and response (DHB Quality and Patient Safety staff attend CHF).

Key feedback themes identified by CHF participants across the CHF include:

- <u>Consumer advocacy services changes</u>

  Concerns were raised by participants at four of ten CHF on the DHB decision to not renew the Health Consumer Trust consumer advocacy support service. Many opposed the decision on the basis that there was now no independent advocacy support available in local communities for DHB health consumers. The Health Consumer Trust Chair has identified that he will assist in the hand over to the DHB Quality team who will now be responsible for receiving and responding to all DHB health consumer feedback.

  The DHB noted that it would now take responsibility for this feedback and associated responses and improvements via the DHB Quality and Patient Safety team.

  It was suggested by some participants that the DHB identify and share some examples of changes implemented as a direct result of consumer feedback at future CHF. Further suggestions included that the DHB create a simple flow chart which outlined the feedback process on the DHB webpage so that health consumer understand the process when they provide feedback to the DHB, and when they will be contacted by the DHB on the outcomes when changes are implemented as a result of this feedback. DHB Quality and Safety, and Communications will be approached to action this.

  Actions:
  - DHB to include at each CHF examples of actions taken as a result of feedback from CHF participants.
  - DHB Communications will develop a simple flow chart for the DHB feedback webpage to show key points in the DHB feedback process.

- <u>Access to primary and secondary health services</u>

  Access to primary care services afterhours was noted at several CHF as being a barrier, as was cost for some community members. Wait times at primary care and emergency services was also raised as a concern by participants at some CHF. The DHB noted that

triage occurs between Waikato Hospital and Anglesea Urgent Care Clinic to ensure appropriate levels of care are provided to health consumers.

A lack of local midwifery service providers was raised at the Matamata-Piako CHF (held in Morrinsville). The DHB acknowledged this and noted that there are national and regional issues linked to this that need to be considered and addressed e.g. workforce training and retention. Respite care for whanau/caregivers for health consumers who have experienced a stroke was also raised at this CHF.

Participants at two CHF queried Waikato/Auckland inter-district transport options in regards to accessing health service appointments and increased demand from consumers with no other transport option to travel within local towns or to and from Hamilton.

Action:

- The DHB noted that this has been raised previous at CHF, and that a transport service contract was in development with Māori Wardens to help with the former, and that a transport and access plan is being completed, along with updated brochure outlining available health transport services.

An update on remote access to health services (e.g. telehealth) from the DHB and other health system partners, was requested by participants at three of the ten CHF.

Action:

- The DHB will provide this telehealth update for CHF participants as part of the next CHF round.

- <u>Mental health and wellbeing – Local community access to crisis and other services</u>

  Participants at five of the ten CHF identified concerns regarding limited or no access to mental health services, particularly for those in crisis or with an acute care need. Three examples were identified where a local community NGO felt obliged to drive someone who appear to have an acute mental health illness into Te Rongomau Henry Bennet Centre in Hamilton due to them being unable to access afterhours support from the mental health and addiction service crisis team. The DHB independent review of DHB mental health and addictions was noted at CHF.

  As a further example, participants at the Taumarunui CHF raised access to mental health services and support and suicide as a particular concern for the rural farming community.

  Action:

  - The DHB is working alongside the local branch of the Rural Support Trust to facilitate a Mental Health 101 training for the local rural sector on 3 June in Taumarunui.

  Rural communities at several CHF also identified the need and their support for more of a focus on prevention, early support and maintaining mental wellbeing. This included building upon existing locally developed mental health and wellbeing and/or suicide prevention and postvention support plans. The DHB notes that activity is already underway on this in different local areas across the district.

  Activity underway noted:

  - DHB Mental Health and Addiction Services are now provided locally in Raahui Pookeka/Huntly, Waharoa (partnership with local hapū), Thames (in partnership with Te Korowai Hauora o Hauraki), and in Cambridge via the Cambridge Community House.

- Local community leadership: Hauora/health and wellbeing events

  Participants noted examples of local health and wellbeing/hauora events organised by hapu, sometimes in conjunction with local councils, community health services and/or the DHB. This was a subject of particular interest at the Cambridge CHF where many participants spoke of the event at Maungatautari Pa. Several organisations present at this CHF identified support for, and offered contributions to, a further potential health and wellbeing event for greater Cambridge.

  Action:
  - Participants at the Cambridge CHF agreed to identify organisations (including DHB) interested in participating in and facilitating a joint local community health and wellbeing/hauora event.

  Support was noted for joint health and wellbeing promotion or training sessions by participants at several CHF e.g. Thames and Taumarunui. This included a suggestion from the Hamilton CHF for a women's health local community event/forum.

  Finally, the South Waikato CHF participants identified the importance of seeing themselves and their local community represented in DHB communications - makes the local community feel valued e.g. reference to Raukawa's Mahi Tahi Agreement with the DHB (December 2020 CEO Update newsletter).

  Action:
  - DHB Communications to include reference to locality activity and development e.g. in future CEO Updates.

- COVID vaccinations and ongoing COVID impacts

  Participants at most CHF identified that many in their local community lacked awareness of the COVID vaccine and its benefits with little knowledge of the vaccination programme. Some also noted the importance of connecting with local community leaders in planning for the vaccination rollout as they will also be able to help with communicating key messages for different population groups to ensure awareness and access for all communities.

  Participants at the Morrinsville CHF discussed that evidence is lacking in regards to the COVID vaccine and hapū mama, and DHB staff confirmed that there is no Ministry of Health guidance currently on this.

  Participants observed that there has been an increase in anxiety in the community which they thought could be linked in part to COVID – particularly for very young people and children. Participants suggested that it could in part be as a result of students' school lockdown experiences, or reduced inter-personal communication (as a result of prevalent use of social media and negative messaging). A participant at one CHF noted that the concept of a village raising a child seems missing somehow now.

- Wider socio-economic issues facing local communities

  Broader socio-economic issues such as access to and affordability of housing, income and poverty, and social isolation were also raised at five of the ten CHF. Rising levels of poverty in rural communities including increasing rents are forcing people to live with

extended family or in their cars. More children are now reliant on breakfast clubs and sponsored school lunches.

In terms of income support, it was noted that Te Aroha now has no local Work and Income office and many fund accessing financial support and support services a challenge. Participants again identified at several CHF that some in their local communities were disadvantaged as a result of losing access to key services such as local banks.

Further, discussion at a number of CHF identified that current emergency housing provision is insufficient to meet escalating demand. The DHB noted that it is changing its service approach to intervene earlier, make links to wider social services support for consumers, and be present in local communities (rather than only be being based in Hamilton). Population growth is also putting pressure on available health and social services.

Youth service providers in greater Hamilton and Matamata-Piako identified that they are also seeing the impact on increasing housing poverty, homelessness and a local of social support and alternative education services for rangatahi.

DHB Consumer and Community Engagement workshop

An engagement workshop was facilitated in March by the Quality team with support from Strategy and Funding for Commissioners and the ELT. The purpose was to provide information on engagement activity undertaken by DHB, and the outcomes of recent DHB consumer engagement self-assessment against QSM engagement markers, and to reflect on opportunities for consumer and community engagement improvements.

Key workshop outcomes included agreement:

- To continue with key engagement mechanisms such as CHF and to further develop the approach to better reflect local community needs and existing engagement opportunities.

- To develop a Te Tiriti o Waitangi based engagement framework for DHB as a basis for its engagement with both consumers (to support service improvements by service area) and local communities (to support locality development).

CHF approach developments

The following are examples of actions that will be taken by DHB staff in regards to facilitating future CHF:

- The DHB update focus will be on vaccination programme, and if released by government, information on national health system changes

- Two key options for future community engagement:
    - DHB facilitated community health forums akin to current facilitated forums or

    - DHB participation in existing community meetings such as the Nga Kaumatua o Te Mauri Atawhai hui in Taumarunui.

- Hamilton community engagement improvements:
    - Retain a Hamilton East and Hamilton West focus for CHF for now (look to the south as a future focus as this area grows as a result of new residential development).

Investigate linking into Pukete Community House and Western Community House for a Hamilton East forum regarding opportunities to link into one of their regular local community meetings.

- DHB to trial linking into, and participating in 'Neighbourhood community network meetings' facilitated across Hamilton by Hamilton City Council, rather than facilitating an independent health forum. The DHB will provide a brief up-date on DHB activity, and then invite participants of these neighbourhood meetings to raise matters directly with DHB staff directly after the community meeting.

- DHB to continue to participate in Nga Kaumatua o te Mauri Atawhai hui in Taumarunui, but won't facilitate a dedicated community health forum following this hui. Instead, invite hui participants who have particular feedback matters related to health service access, equity or quality to meet with DHB staff (Greg, Norma and MH&AS staff reps) prior to and during the shared lunch for hui participants which follows the Nga Kaumatua hui.

- Strengthen linkages between the CHF and Consumer Council e.g. encourage Consumer Council members to also consider taking on the role of CHF Chairs for their local areas; and CHF community engagement and localities development.

DHB Engagement Framework

A draft DHB engagement framework is also in development by Strategy and Investment and Quality and Patient Safety which will guide future DHB consumer and community engagement. It will be based upon Pae Ora and Te Korowai Waiora, and provide guidance for the DHB on the purpose of consumer and community engagement, and associated principles and engagement facilitation mechanisms and reporting tools.

To conclude, planning for the upcoming round of CHFs in July/August (round 2) is underway and details will be confirmed once they have been finalised.

Mana Whakahaere (Article 1)
The IMC Chair and Commissioners are invited to participate and provide governance oversight.

Mana Motuhake (Article 2)
Iwi Māori participation is encouraged and Māori community stakeholder involvement in CHF and wider DHB engagement is growing. Māori are encouraged to speak and share their views on the health system and their experience of it and share on behalf of the whānau they represent.

Mana Tāngata (Article 3)
Māori equity gap(s) are identified at CHF and via DHB engagement, and the DHB and participants are challenged to take practical and systematic steps to help address these at local and District levels. This includes inequitable access to health care, culturally appropriate practice, and holistic wellbeing.

Mana Māori (Declaration/Article 4)
Matauranga Māori, knowledge and practices inform CHF and wider DHB engagement planning and facilitation. Key examples of strategies to support this include encouraging the appointment of co-chairs for each Forum, and opening and closing of engagement wānanga with a karakia.

Efficiency

The main efficiency benefits are through having community connection to future service design to ensure they are aligned to local consumer and community need. CHF and wider DHB engagement will also support locality development to be effective and efficient at local and district levels.

Quality and Risk

CHF and DHB engagement often highlight areas of risk and issues of consumer quality of care. They are important feedback mechanisms for the DHB to act on and improve services as a result of some of the issues raised by the community.

Strategy

CHF and DHB engagement are aligned to the DHBs strategic direction and goals within Te Korowai Waiora and will be one of the key mechanisms moving forward to implementation of the strategy.

Future Reporting

There will be regular reporting to the Committee on the key themes from CHF.

General Business

Next Meeting: 24 June 2021