HEALTH AND WELLBEING

COLLABORATIVE DESIGN MENTAL HEALTH AND ADDICTIONS SERVICE DELIVERY

healthy families
Whanganui Rangitikei Ruapehu
He oranga whānau

TE ORANGANUI

TABLE OF CONTENTS

CONTEXT

This document is intended to identify what needs to change to deliver a regional Mental Health and Addiction services system that is readily available, equitable and responsive to people's needs and preferences by capturing the voice of whānau, communities and professionals.

We know that in order to be more effective and accelerate success we will need to transform and change our approach to the delivery of Mental Health and Addiction services across the rohe (region), through shared understanding and ownership of the highest priority changes needed for rapid action across the life continuum.

The insights and priorities that have emerged from our community engagements have informed the priorities for implementation.

BACKGROUND

Healthy Families NZ is a large-scale initiative that brings community and community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play by taking a systems approach for prevention. Healthy Families NZ has an explicit focus on equity, improving health for Māori and reducing inequities for groups at increased risk or preventable chronic disease.

In 2021 Te Whatu Ora Whanganui commissioned Healthy Families Whanganui, Ruapehu, Rangitīkei to facilitate the redesign of community Mental Health and Addiction service delivery for the Whanganui rohe.

The overarching objectives for the Collaborative Design initiative is to:

- Transform existing mental health and addiction services to be a connected ecosystem which meets the needs of our community, supports, protects and improves collective wellbeing, and is shaped by the communities experience of what works.
- Build capability and capacity for better and faster change across the whole mental health and addiction service delivery system in the Whanganui rohe.

The key outcomes we want to achieve are:

- A set of priorities identified by the ecosystem of services and whānau
- Identification of the implementation enablers and impact logic

The approach has a direct line of sight to He Ara Oranga and Kia Kaha Long Term Pathways: The Mental Wellbeing Framework Vision, Pae Ora – healthy futures: an equitable and thriving Aotearoa in which mental health is promoted and protected. The redesign signals a change is required in Mental Health and Addictions service delivery, as despite best intentions and investment we are not seeing the results that we want or need to ensure all communities are thriving.

ACKNOWLEDGEMENT

We are grateful to Frank Bristol, Joseph Macrae and Vinnie Jordan from Balance Aotearoa, John McGuckin whānau member, Wheturangi Walsh-Tapiata and Geoff Hipango from Te Oranganui, Sharon Crombie from Te Oranganui and Te Whatu Ora Whanganui, Alex Loggie, Dr Bridget Fry and Barbara Charuk from Te Whatu Ora Whanganui, Lachie Smith one of our General Practitioners from Aramoho Health, John Pahina from Massey Psychology, and Sam O'Sullivan one of our Community Psychologists for your guidance and contribution to this kaupapa as critical friends over the last 12 months.

We are thankful to whānau and the Mental Health and Addictions sector for leaning into this kaupapa and sharing with us your stories and hope for change. Your voices reflect the community's eagerness to be a part of this transformational change.

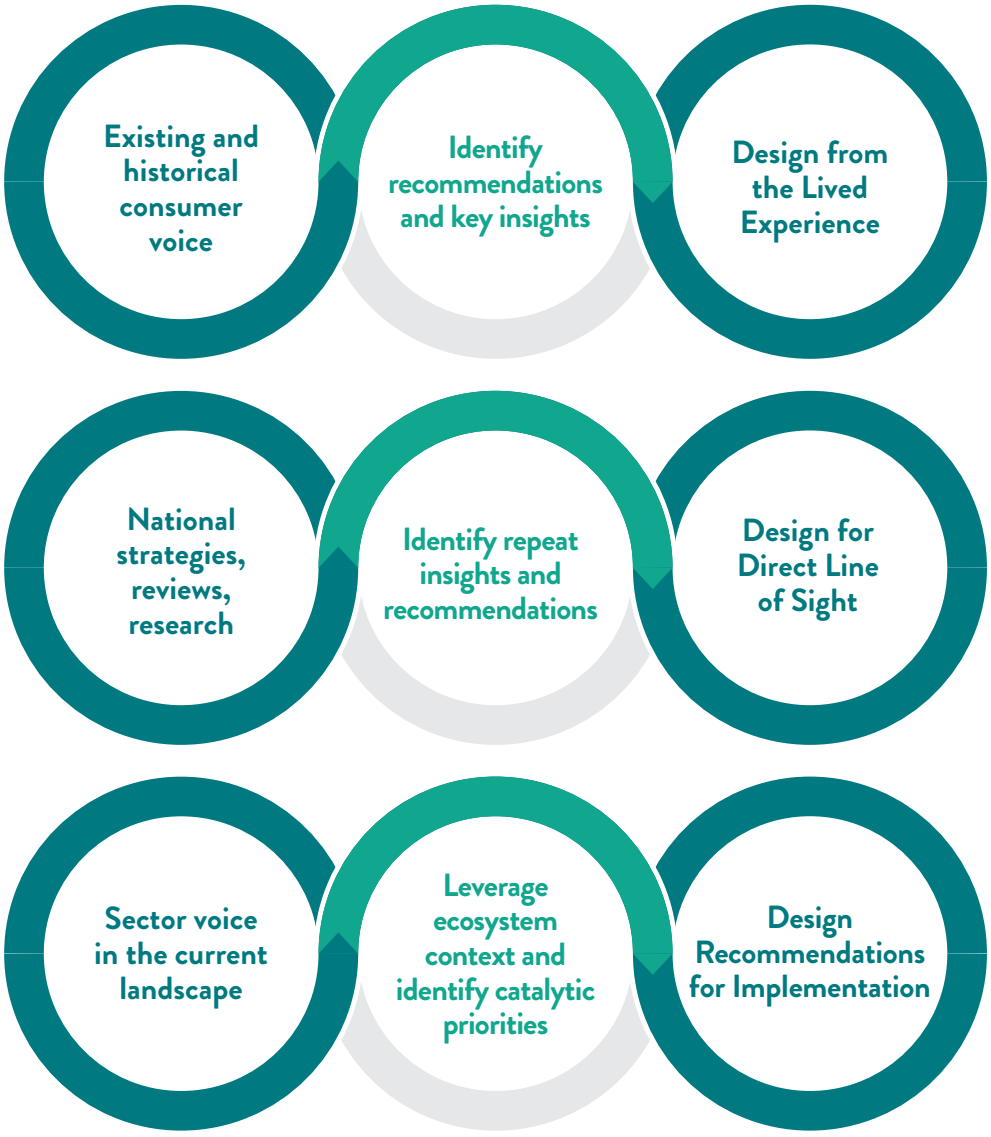
PURPOSE

The Collaborative Design of Mental Health & Addictions approach sits as an initiative and priority within the Growing Collective Wellbeing Regional Suicide Prevention Strategy. Whānau identified the challenge to finding the right type of support at the right time was difficult and daunting. Whānau talked about experiencing discrimination and judgement through their interactions with different services. Community and practitioners wanted to see a collaborative re-design of services to make finding support a mana-enhancing experience.

We know that our strengths begin with whānau and communities; to provide clear direction for our partnership relationships with Iwi and the community NGO sector; to reprioritise and activate valuable resources; extend reach and to communities in need. Several Phase One initiatives of the Growing Collective Wellbeing Traction Plan have generated momentum and demonstrated how we grow system and community capability and transform current capacity to impact change. Cross agency, cross sectoral and whole of systems approach requires ownership and contribution from the community, this heightens the need and commitment towards agreed ways of working cohesively together.

METHODOLOGY

In the beginning of our engagement with whānau and services we identified themes that were repeating, and had been for over a decade. We therefore decided to pivot the approach and to include all previous insights, research and strategy recommendations that kept repeating over the decade but had never been fully addressed.



The Wellbeing Spectrum and Continuum of Support frameworks from the Growing Collective Wellbeing Regional Suicide Prevention Strategy have been used to assist us to think about how the collaborative design explores and informs the priority actions and conditions for change, as requested by the community. It has been imperative that we include the actionable intelligence that has already formed from previous and relevant local initiatives.

HEALTHY FAMILIES PRINCIPLES

Collaboration for Collective Impact

Leadership

Line of Sight

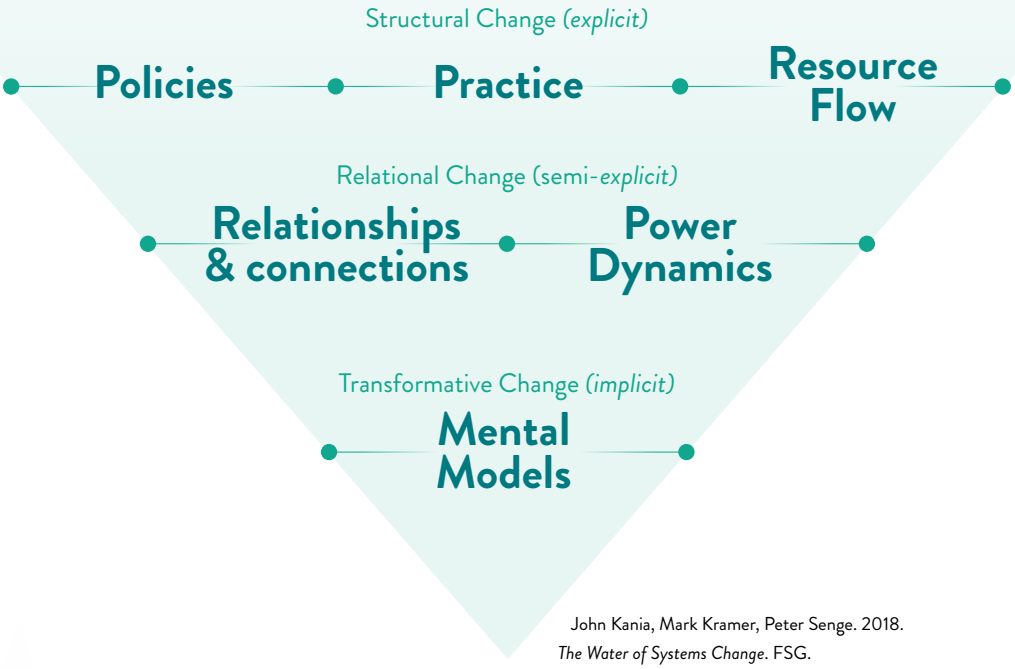
Equity of Outcome

Adaptation

Experimentation

Implementation at Scale

SIX CONDITIONS OF CHANGE



John Kania, Mark Kramer, Peter Senge. 2018. *The Water of Systems Change*. FSG.

There are six interdependent conditions that typically play significant roles in holding social or environmental problems in place. These conditions exist with varying degrees of visibility to players in the system, largely due to how explicit, or tangible, they are made to most people. It is important to note that, while these conditions can be independently defined, measured, and targeted for change, they are also intertwined and interact with each other. The interaction can be mutually reinforcing (e.g., a change in community and legislator mental models may trigger a policy change). The interaction can also be counteracting (e.g., scaling effective practices may be thwarted by poor relationships between players in the system).

The semi explicit and implicit conditions are the most challenging to clarify but can have huge impacts on shifting the system. Changemakers must ensure that they pay sufficient attention to the relationships, power dynamics, and especially the underlying mental models (such as racism and gender biases) embedded in the systems in which they work.

During wananga with whānau and the workforce, we were able to map the conditions for change across the mental health and addictions ecosystem. From this, seventeen conditions for change were identified which then informed the six high priority themes for collaborative innovation and change across the system.

HIGH PRIORITY THEMES AND INSIGHTS

OUR FUTURE REALITY

We can amplify and accelerate our impact through stakeholders and community working together across the wellbeing spectrum and the continuum of support.

Wellbeing Spectrum

Suicidal Behaviour	Suicidal Thoughts	At Risk	Well but Vulnerable	Wellbeing

Access to an interconnecting health system that is easily navigated and enables self-management.	Trusted adults to buffer the impacts of extreme and prolonged states of stress.	Normalising vulnerability as strength.
Intersectorial response protects peoples' wellbeing.		Whānau have capability to respond.
Whānau know where and how to get support.	Individuals and whānau have increased protective factors	
Environments/settings where we live, learn, work, and play reflect and promote health and wellbeing.		
Improving access to a range of supports within community.	System and community can intervene and protect earlier.	Common narrative and wellbeing campaigns.

Intervention & Impact Support	Prevention	Protection	Resilient	Promotion

Support Continuum

1 APPLICATION OF A TE AO MĀORI WORLDVIEW ACROSS THE SYSTEM

The community has identified that Kaupapa Māori approaches, Te Ao Māori world views and Mātauranga Māori practices are a fundamental for providing a culturally responsive and holistic model of care. A Te Ao Māori worldview provides a much deeper and inclusive frame for shifting the system from a clinically-led model to a human and ecocentric continuum of care.

Cultural knowledge and indigenous narratives assist the collective to value the relational constructs needed for deepening connections with whānau, community, between the ecosystem of support services, and in relation to environments, both natural and built. This ecocentric mindset sees everything as connected and inter-related, influencing how we think, act, and behave.

When we observe mental wellbeing or mental distress and addiction from this perspective we shift from a crisis-only response to be inclusive of growing collective wellbeing, whānau-led solutions, community designing prevention, and earlier interventions by services.

A Te Ao Māori worldview understands the total system, not just the parts. It contextualises whakapapa - relationship between all things, providing opportunity for everyone to understand the vast and complex nature of systems and the conditions for change.

COMMUNITY SAYS

"A model of care needs to be implemented that is founded upon respect, time taken to know the individual and understanding their life course (whakapapa) and needs. Mental health needs to be understood and responded to from a Te Ao Māori perspective and within the context of Māori models of health".

“The inclusion of the perspectives of whānau and those with cultural expertise is necessary to ensure sufficient context is provided to contribute to appropriate decision-making”.

“Addressing Māori health without addressing the root causes of poor health outcomes narrows the capacity of the system to respond to Māori illness. It limits the effect the health and disability system can have on improving health equity”.

“As Māori, we want to be able to make decisions relating to our health and wellbeing. And we want the option of having Mātauranga Māori practices including mirimiri, whakawhiti kōrero and rongoā alongside mainstream services”.

“Māori have their own understanding of intergenerational wellbeing that draws on cultural values, beliefs, social norms and indigenous knowledge”.

OBSERVATIONS

Māori and Iwi are valued experts and decision makers that need to be at the forefront of design and whānau determine how and what information is shared, and work in partnership to identify what their needs are.

Communities are seeking wellbeing solutions that connect to their culture, a Māori worldview supporting preventable approaches helping to nurture identity, wellbeing and connectedness.

Cultural approaches to be considered in all decision-making, equitably against psychiatric assessments; including capacity for increased resourcing to ensure cultural interventions are conducted to a high standard and undertaken by culturally competent practitioners.

There is a concern that there is a lack of cultural competence among work environments. Mainstream health services can be alienating and culturally unsafe environments for Māori and their whānau. There is a need for services to uphold obligations to Te Tiriti o Waitangi and ensure equity through "for Māori, with Māori" approaches.

RESEARCH SAYS

Māori health outcomes continue to indicate persistent, systemic problems in the health care sector and for these reasons, Māori are affected by the policies and legislation that underpin this sector, whether they are staff of health organisations or people who need to use health services *(Came, 2012; Durie, 2001; Kingi et el., 2017; Waitangi Tribunal, 2019)*.

Inequality and institutional racism also continue to remain prevalent and are evident within the healthcare, social development and education sectors which continue to be dominated by western and bio-medical discourses rather than a wellbeing continuum *(Baxter, 2008; Durie, 2011; Kingi et el., 2017; Ministry of Health, 2020)*.

Māori models of wellbeing require mental health initiatives to occur in an inclusive and integrated manner as intra-sectoral and inter-sectoral collaboration is essential when embedding and implementing kaupapa models of care across services *(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020; 2021)*.

2 WHANAUNGATANGA

Whanaungatanga is essential to Māori for wellbeing. The Priority intention of whanaungatanga is for services and community to form quality relationships and strengthen connections so a united and more cohesive response to Mental Health & Addictions can be achieved. We need a more joined up ecosystem of leaders and services working in concert with each other and the community. This becomes the starting point for moving the sector and community towards collectively addressing the systemic conditions holding persistent issues in place. Maintaining quality relationships and uniting together with a shared vision and purpose will expand efforts within and outside of the health system to activate solutions across the wellbeing spectrum.

COMMUNITY SAYS

"Whanaungatanga, if you don't or can't make that connection and build that trust, then services will be of no use no matter how good they are. People won't engage when whanaungatanga isn't the foundation of contact".

"People need time to be able to trust the service. The importance of listening and hearing is essential, it's the basis of all communication and connection. Warmth, receptiveness, validation, welcoming tones need to be compassionate".

"The ecosystem is not well connected. We don't have a broad understanding of what each other does, what services are available and who we can contact if we need something specific for whānau that we may not be able to provide. We need to be better integrated and connected".

"I need someone to pick up the phone when I call. Whether it's the hospital, the GP or services in the community it's extremely difficult to get hold of an actual person to talk to. You play phone tag or leave messages and it might be days before you speak to someone. Often by this point the situation has worsened".

"I rang one health service who said they were suicide prevention only and they did not know who could help me. I rang another service who also didn't know who could help. I then rang someone I knew at the hospital and she put me on to someone who could meet with me urgently to do an assessment at my home. I was thankful but by this time four hours had passed"

OBSERVATIONS

We need to build on existing community relationships, strengths, knowledge and network resources. If the ecosystem is more joined up then services become easier to navigate, access improves, wait times reduce and expertise is easily accessible.

Accessing services is difficult. Whānau feel that wait times are too long when they are experiencing distress or reaching out for help, and that instead of services being responsive they are often told they need to refer elsewhere and are left trying to navigate a complex system on their own.

We need to acknowledge that 80% of whānau utilising Mental Health and Addiction services will never see the inside of an in-patient treatment unit. Therefore there is a need for greater integration of services, in order to provide a more seamless and joined up experience for whānau when they are navigating between primary and secondary spaces.

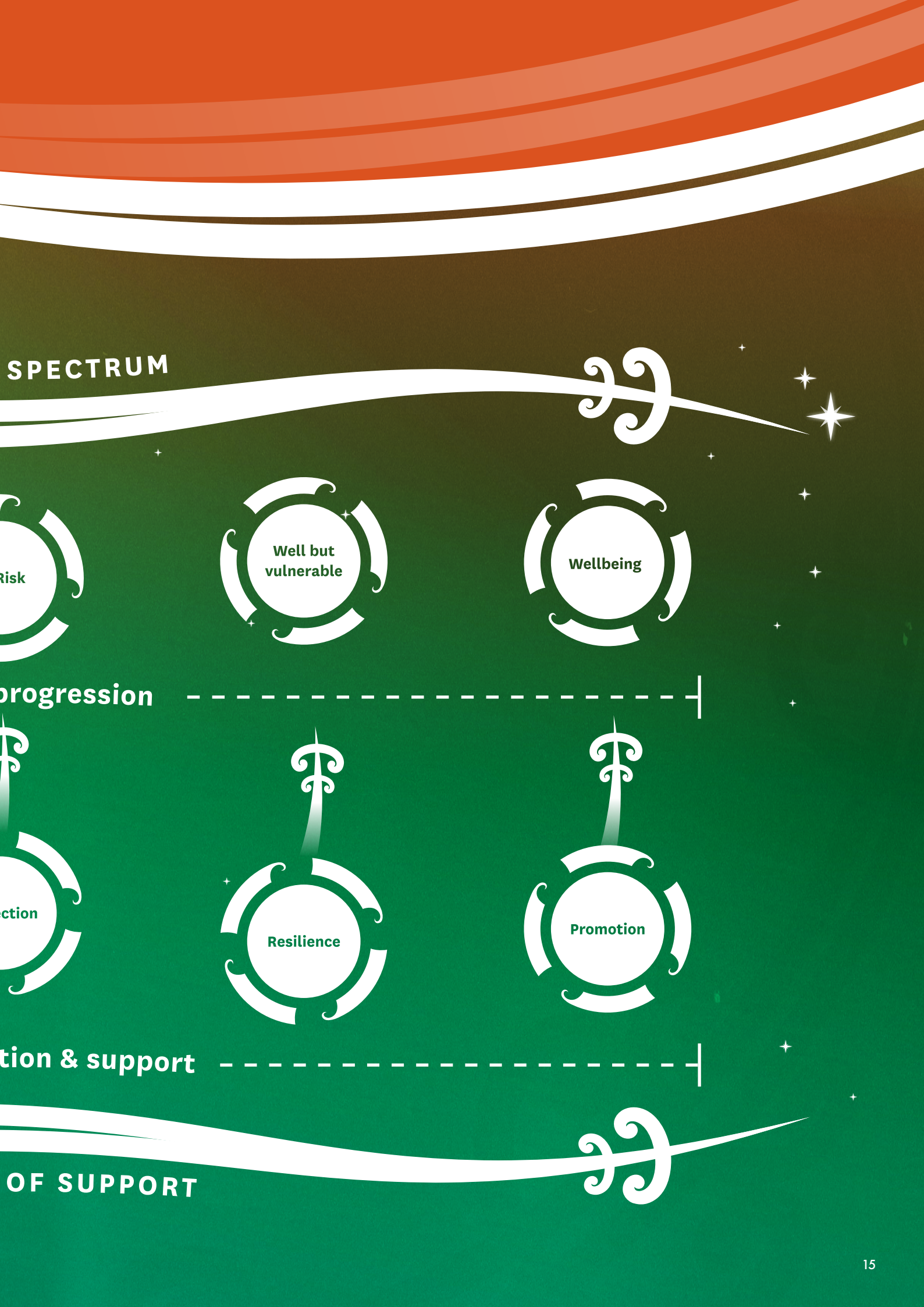
RESEARCH SAYS

Services need to be connected and coordinated with other service providers and embedded within communities so that they are more agile, flexible and whānau centred
(Durie, 1994, 2001; Mental Health Foundation, 1992; Waitangi Tribunal, 2019)

Current health strategies continue to explicitly highlight the importance of holistic and cultural approaches in terms of models of care, assessment and treatment interventions within the Mental Health and Addiction sector, however, services do not reflect Kaupapa Māori approaches unless they are being provided by an iwi-led organisation
(Durie, 1994, 2001; Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021).

National strategies identify that whānau need to be the co-producers of their care with shared decision making to ensure that all aspects of their culture and wellbeing are connected, respected and valued
(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021).

SCOPE OF OPERATIONS


SPECTRUM
Risk
Well but vulnerable
Wellbeing
progression
ction
Resilience
Promotion
tion & support
OF SUPPORT

3 CHANGING THE NARRATIVE

The community has identified the need for services to shift away from the use of deficit based language which is dominated by the historical stigma associated with mental health and addiction, and moving toward a wellbeing/wellness narrative. Changing our language and narrative to one of wellbeing allows the system to consider whai ora and whānau as people rather than as an illness. The diagnosis narrative immediately insinuates whānau have limited self-efficacy and power to move toward a state of wellbeing. That their challenges are subjective and easily resolved through a medical lens. For some this is the case, but for many it is not and can be felt as confronting, or demeaning. When the narrative changes to one of wellbeing, the types of questions we ask, and when we ask them, can quickly create safe space for new conversations, improving the type of connection needed for high trust, empathy, and compassion - consistently.

COMMUNITY SAYS

> "Saying I'm sick or unwell objectifies who I am as a person. We are talking about a person who shares the difficulties life poses for us all at times. The term treatment must go as it suggests that something is wrong with me as a person, it's inhumane and it objectifies people".

> "Health presentations rarely occur in isolation; therefore, improving health and wellbeing outcomes requires a whole of system and whole of person approach that considers core health issues in conjunction with social determinants and social context".

> "The current language allows me to only seek help for things related specifically to my mental health or addiction (criteria dependant). It does not allow services to take into account that there might be multiple things happening in my life which may be affecting my overall wellbeing, and that by addressing these this may actually improve my overall mental health".

OBSERVATIONS

Many whānau perceptions of the health system are that they feel they are turned away when they seek help for their loved one's or feel that their concerns and distress is not heard or regarded by health professionals, or that they are judged and negatively stereotyped.

One of the main themes for change was the people's desire for services to see them as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self.

Stigma and discrimination related to mental health and addiction issues, remains prevalent across the community and continues to be a barrier to whānau seeking help from mental health and addiction services, general hospital services and some community agencies.

RESEARCH SAYS

Changing the narrative from 'I have a mental illness/mental health problem' to 'I am surviving difficult circumstances in the best way I can' is an essential step towards helping us move towards greater wellbeing *(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021).*

It would be more accurate to say that 'we all have feelings' and that at times, those feelings can be overwhelming, however, they do not come from nowhere *(Government Inquiry into Mental Health and Addiction, 2018; Ministry of health, 2021).*

Diagnosis conceals these links by locating problems within the individual, while holistic human-centric approaches show us that their roots lie in the growing inequalities of a Western society, and the resulting disconnection from our emotions, from each other, and from the natural world *(Durie, 2001; Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2021).*

4 INCORPORATE THE CLINICAL MODEL INTO A HOLISTIC MODEL OF CARE

The Mental Health and Addiction sector continues to largely adhere to approaches that are paternalistic and centred around a clinical model of care, ultimately dictating that mental disorder is a disease. The current model of care does not allow for a holistic focus where whānau are considered an essential component of engagement, decision making, advocacy and support. A holistic model of care, much like a Te Ao Māori perspective, acknowledges a continuum of care is needed with a range of services available that recognises peoples' wider social needs, increasing options for whānau. An integrated holistic model of care points us toward earlier interventions, cultural security and practice, and peer support. When we think about the 'whole' person and their context we begin to expand access so whānau have the support they need to recover and regain their wellbeing.

This is also inclusive of prioritising community-based services so closer-to-home support becomes accessible. More community-based collaboration helps to remove stigma for those whānau who distrust agencies, or feel uncomfortable engaging within a mainstream environment. A holistic model of care is inclusive of more peer support, cultural practices, and preventative measures. The fluidity of mental wellbeing is dependent on the environment, the culture of that environment, and its ability to assist whānau find the right type of support, quickly. Closer to home and closer working relationships between services and sectors should be easy to do if we think about *every front door as a wellbeing experience*.

COMMUNITY SAYS

"Mental illness and addiction issues are generational in my whānau and on both sides, so we know how to look after our people and what they need. What they need is not what they can get from services when they are only being seen once a week or fortnight and the focus is on medication".

"Whanaungatanga, if you don't or can't make that connection and build that trust, then services will be of no use no matter how good they are. People won't engage when whanaungatanga isn't the foundation of contact".

"We can't keep working and sitting in spaces where we don't challenge the current model of care being wrong. It doesn't fit our community, there needs to be more focus on collaboration, holistic models of care and Te Ao Maori practices. Staying quiet and doing nothing about this is killing our people and our workforce".

"We need to be radical, let's look at the core or basis that informs the system as it stands and challenge the current nature of it. Values are important and humanistic. Systemic change is of value to improving the system and if done without bias changes the narrative to one that is person centric. The current system as it stands does not allow this".

OBSERVATIONS

There are clear power and control imbalances, poor engagement, and unrealistic expectations of care when clinical focus and therapeutic interventions are based solely within a medical model. Partnership approaches with whānau within holistic models of care are much more likely to reduce these barriers to engagement with services.

Repeated exposure to risk means that risk adverse behaviours become a bias when clinicians are managing their intuition around what the risk is. We start making assumptions as to the degree of risk we believe is present therefore our approaches become punitive or restrictive.

We need a holistic model of care which reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model within Mental Health and Addictions, and provides measures to minimise compulsory and coercive treatment.

RESEARCH SAYS

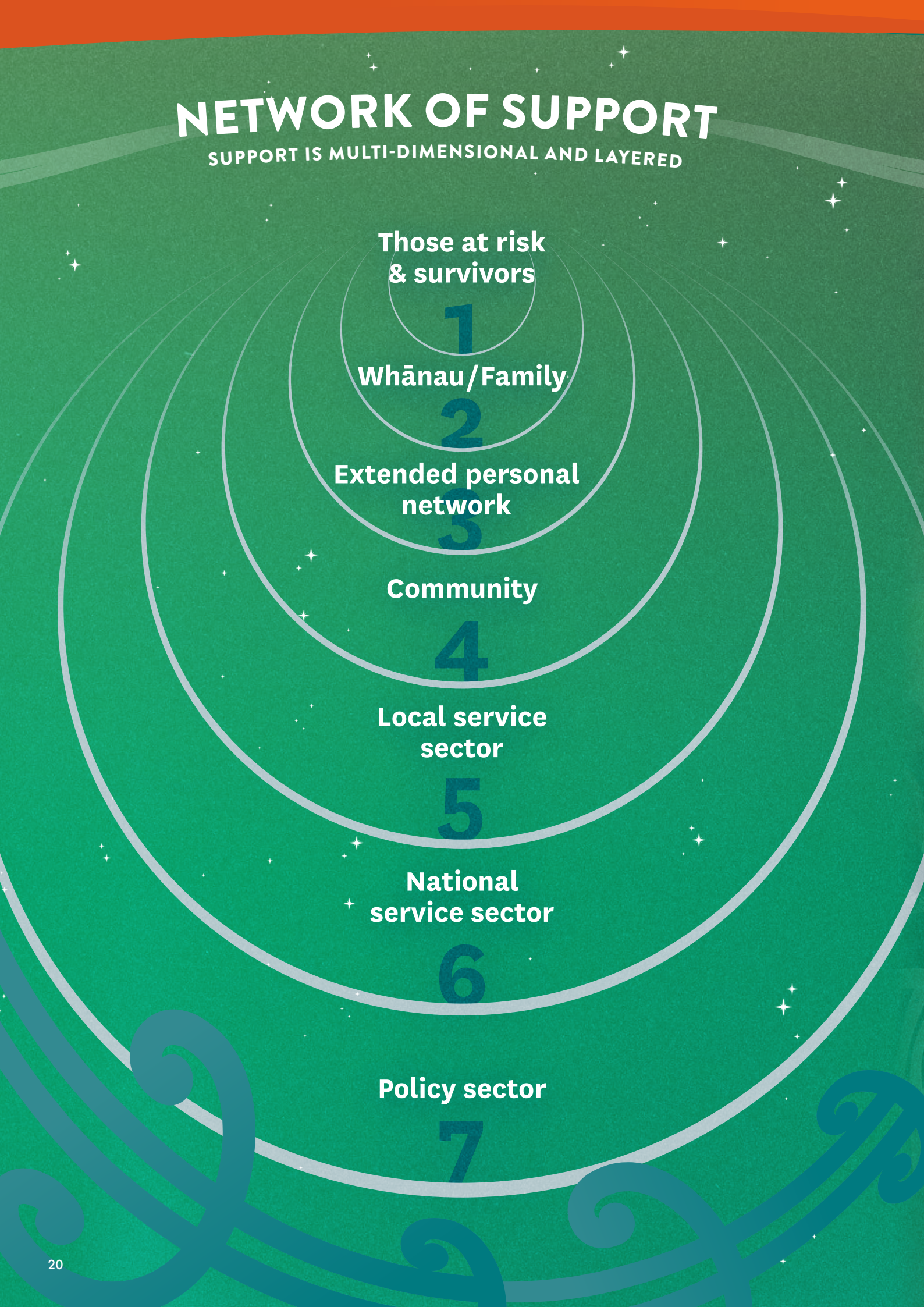
The current biomedical approach to those experiencing Mental Health and Addictions, focuses on a person's biological aspects, eliminating factors such as psychological, environmental, and social influences as generally non-relevant *(Procter et al., 2017; Smith, 2019; Tew, 2005)*.

There is a focus on reducing symptoms and immediate risks rather than considering the whole person and their contextual circumstances and associated social determinants as having any bearing on mental distress *(Durie, 2011; Evans et al., 2017; Procter et al., 2017; Smith, 2019; Tew, 2005)*.

Treatment interventions are more likely to be tailored towards managing a disease or disorder rather than supporting the person as a whole. An overarching view is that a paradigm shift is required to move services from acute and crisis response to one with a focus on prevention and early intervention *(Government Inquiry into Mental Health and Addiction, 2018; Morrison-Valfre, 2017).2018; Ministry of Health, 2021)*.

NETWORK OF SUPPORT

SUPPORT IS MULTI-DIMENSIONAL AND LAYERED




FIRE EXIT

5 ENSURE A WELL WORKFORCE AND WORKPLACE WELLBEING

Mental Health and Addiction workers are passionate about their jobs and are committed to helping people recover, even to the point of jeopardising their own health and wellbeing. The sector must prioritise a well workforce so kaimahi feel re-energised to provide quality [time-rich] services to whānau and the wider community. The Mental Health and Addictions workforce should role model and reflect wellness.

Diminished wellbeing as a result of workplace/job stress and pressure can limit capability and capacity to respond effectively, reducing mental and emotional bandwidth, moderating one's ability to express/feel empathy, and not being fully present to one's own wellbeing, let alone others. What further impacts staff performance is the period of time people stay in a state of diminished wellbeing. This can accumulate into toxic stress thereby reducing executive function (flight or fight mode: inability to make good decisions; reduced communication skills; poor relationship building, low mood, and limited brain and physical capability to forward plan and think outside the box).

Workplace wellbeing should prioritise the mental wellbeing and health of those working with whānau experiencing distress, or suicidal behaviours. Better workforce health and wellbeing has been a repetitive call for change from practitioners. Promoting a well workforce helps the sector to better respond to the complexities, to meet demand while operating in large scale change, such as the national health system reform. More importantly, it shows an ecosystem that cares about growing collective wellbeing by valuing peoples' efforts, experiences and aspirations.

Plans that are designed through a human-centred lens with teams and management as co-designers will help to uncover the root causes for a mentally distressed/unwell workforce so actions/solutions can be designed. Workforce wellbeing plans should take into consideration the importance of quality reflective practice, real time feedback loops, best practice supervision, and how to achieve *quality* downtime.

PRACTITIONERS SAY

> "We need to expand our workforce. More peer-support workers, community-based workers, and Māori and Pacific support services are required to meet the needs of this rohe".

> "Kaimahi feels obligated to meet workload demands, key performance targets and documentation requirements. This on top of a strong sense of responsibility to make sure whānau are having their needs met often means that kaimahi prioritises these over clinical and cultural supervision ".

> "We need role models and mentors to support new kaimahi coming through the services to navigate the current complex and risk driven system so that they can develop self-confidence and competence when working with whānau".

> "The rurals have significantly more difficulty accessing expertise in a timely manner due to locality issues and travel. This often means time delays and extended periods of distress for some whānau when they are needing to access crisis services or other specialist roles. Reduced resources in the rural spaces often means that at times the job can feel isolating and risky".

OBSERVATIONS

The workforce highlighted the importance of collaborative care in terms of being more responsive to the population's needs, and needs of any already stretched workforce. This included primary and secondary inter-sectoral services becoming more streamlined and integrated; to reduce disparities and decrease the negative experiences of whānau and services.

We can see that kaimahi are tired and burnt out, they have high caseloads and significant work demands therefore don't have enough time to spend with whānau. This is having a significant impact on work satisfaction and their ability to feel as though they are positively contributing to whānau's journey through services.

RESEARCH SAYS

Workforce objectivity and effectiveness are vulnerable to personal stressors and clinical challenges that may be introduced by whānau. When compromised, our workforce is only as good as the safety nets we construct around ourselves in our work. Supervision and peer consultation are integral parts of this safety net
(Government Inquiry into Mental Health and Addiction, 2018; Mental Health Commission, 2012; Ministry of Health, 2020).

Functional relationships, whānau, work life balance and satisfaction, financial security, personal growth and development, social and cultural equity and the ability for workplaces to prioritise recruitment and retention are all significant factors in determining kaimahi wellbeing
(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021).

Clinical supervision allows kaimahi to meet with more experienced providers to discuss cases, treatment strategies, and other important topics (Te Pou o Te Whakaaro Nui, 2015). Frequent and complex interactions with distraught whānau members can be inherently distressing, so a key aspect of clinical supervision is often helping professionals learn to compartmentalise their own emotions and practise better self-care
(Te Pou o Te Whakaaro Nui, 2015).

6 COLLAPSING THE SPACE BETWEEN POLICY AND PRACTICE

Policy, if informed by whānau with lived experience and Mental Health and Addiction practitioners, can assist the system to course correct, contract or expand. Policy is one of the conditions for change. Policy can hinder the innovation mindsets, attitudes, and actions because the dominant centrally driven system directs practice at arms length. This means the reality and the root causes of complex issues are almost impossible to overturn or transform.

Policy that is developed with rich actionable intelligence and examples of lived experience should support local innovations and regional transformation, all of which feeds into a global community of practice. Policy-makers at all levels should have direct line of sight and comprehension of the policy impacts on the grassroots reality and the collective's ability to achieve equitable outcomes, and a continuum of support. Policy should be community-up.

Community-up informing of policy means policies become dynamic rather rigid, unless required. The closer policies are to the lived realities of whānau and practitioners the more likely the flow on effect enables the collective to achieve a unique regional continuum of support, a holistic model of care [whānau-centred], equitable health outcomes. To achieve this there needs to be Te Tiriti o Waitangi in practice, appropriate and justified redirection of resource flow, and locally-led innovation.

COMMUNITY SAYS

> "Current policies do not speak to what we actually provide on the ground floor. Contacts and statistics that are captured and reported to the Ministry of Health or to funders and contract managers are not reflective of the time or tasks we do with whānau using services".

> "Holistic approaches mean trauma-informed care is prioritised within service provision, however, this is not evidenced within actual policy and procedures for most clinical environments".

> "Kaimahi are limited when it comes to thinking outside of the box in terms of accessing services and interventions for whānau. We are bound by service specifications and reporting requirements often meaning that whānau reach the point of crisis rather than having access to early intervention and prevention because they don't meet service criteria".

> "Stigma and discrimination is embedded within our current model and policy. We need to completely change the culture of service provision, practices, professional structure and service outcomes".

OBSERVATIONS

Health services continue to prioritise government key performance indicators, the biomedical model and specialist expertise within policy and practice over that of the needs of whānau who are at the centre of care. Mental Health and Addiction service specifications currently set out the services that our hospitals are required to fund, although this is not the sole reason that our current system is oriented to high-end, acute and specialist services. It does reflect and reinforce the policy decisions that have led services prioritising whānau with the most severe needs meaning opportunities for early intervention are often missed.

If policy reflected a whānau ora and holistic models of care, then services would also prioritise and consider the whole whānau's needs in terms of positively effecting positive generational impact.

If we are to take a broader lens to people's wellbeing, we must orientate the workforce towards understanding the impact of trauma and the socioeconomic determinants of health, including enabling staff to focus on 'prevention as intervention'. This needs to be incorporated into current policy and practice to ensure kaimahi have the ability to take a wellbeing approach.

Policies and procedures are reflective of a medical and business model rather than being a whānau centred and community needs driven model of care. This is problematic as the current models don't fit with the ethos of holistic person centred care which is the theoretical framework of care for most health professionals.

RESEARCH SAYS

Centrality of whānau and significant others needs to be explicit within service specifications, operational policy and procedures to ensure that whānau and significant others are part of the decision making process of loved ones utilising Mental Health and Addiction services *(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021)*.

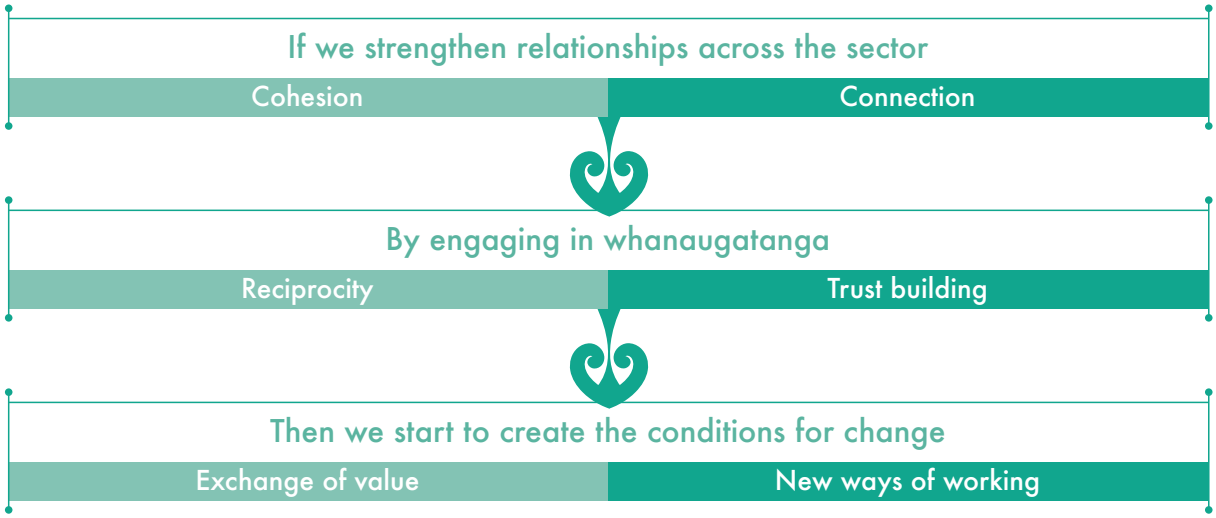
Strong communities provide a foundation of support which is vital for mental wellbeing, the system needs to acknowledge the importance of fostering community-led solutions and have these explicitly outlined within local policy and strategy to ensure collective approaches *(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021)*.

The current discrepancy between policy and practice across Mental Health and Addiction services continues to present as a foundational barrier to practise and change *(Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2020, 2021)*.

RECOMMENDATIONS

ACTIVATING THE PRIORITIES LOGIC

WHANAUNGATANGA



START UP ACTIONS

Step One

Organisations engage in whanaugatanga process.

Step Two

Sector-wide leadership and middle management design the roadmap using staff feedback loop to inform the direction.

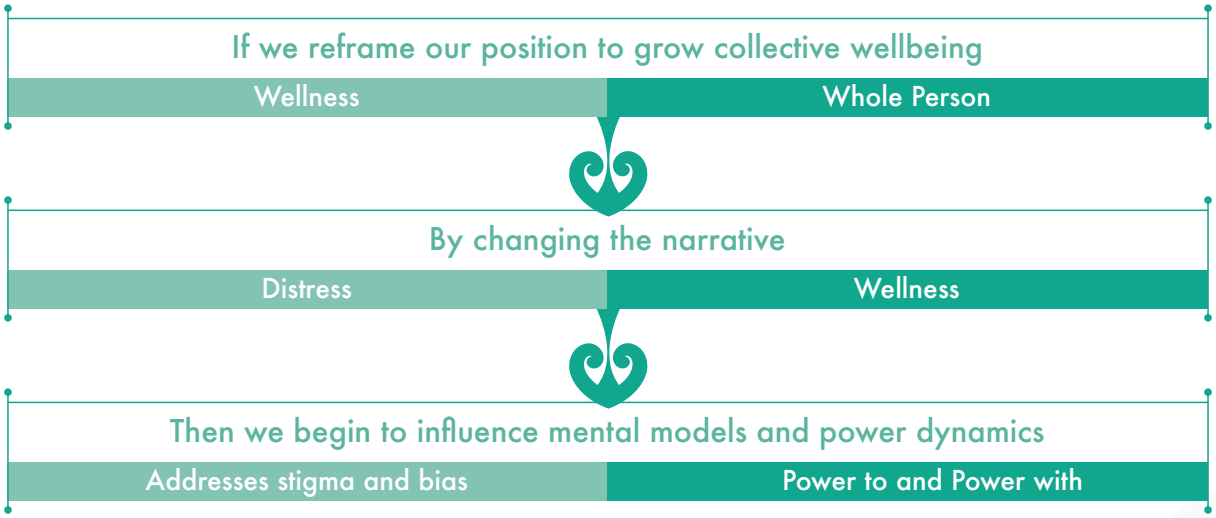
Step Three

Collective Impact approach co-designed for implementing the Collaborative Design priorities.

Step Four

Concurrent demonstrations of improved partnership and collaboration across the region shares learnings, insights, progressive wins, informing larger scale system change.

CHANGING THE NARRATIVE



START UP ACTIONS

Step One

Peer support and practitioner design team identify and suggest immediate changes to the narrative.

Step Two

Walk through and socialisation across sectors to agree and adopt immediately.

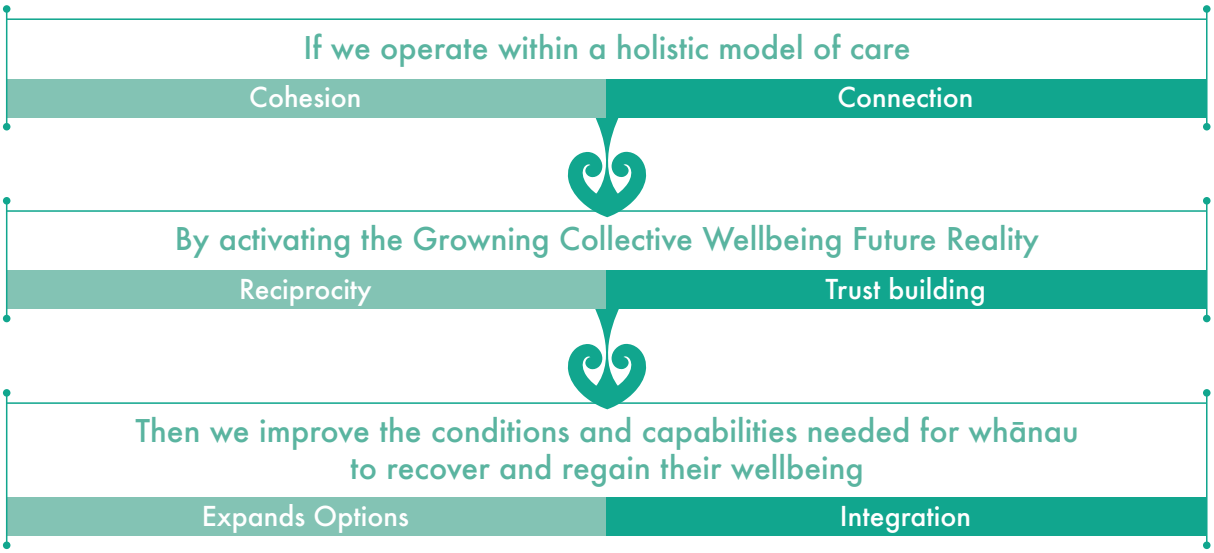
Step Three

Communications requirements identified, planned, and activated.

Step Four

Engagement points that diminish wellbeing identified and reframed, redesigned.

INTEGRATED MODEL OF CARE



START UP ACTIONS

Step One

Create a logic model and theory of change to clarify the intention. Walk-through, socialise, iterate.

Step Two

Organisations/ teams who believe they already have a holistic model of care to capture and share their learning, insights, and evidence.

Step Three

Build the collective body of knowledge and evidence.

Step Four

Leverage existing early stage opportunities to prototype and test small scale demonstrations in both rural and urban areas.

WORKFORCE WELLBEING

If leaders enhance and protect workplace wellbeing

Prioritisation | Values and Validates

By committing to workforce wellbeing

Human-centred Design | Cause and Effect | Resource Flow

Then the sector can genuinely reflect and role model wellbeing in practice

Without Compromise | Job Satisfaction

START UP ACTIONS

Step One

Peer support and practitioner design team identify and suggest immediate changes to the narrative

Step Two

Walk through and socialisation across sectors to agree and adopt immediately

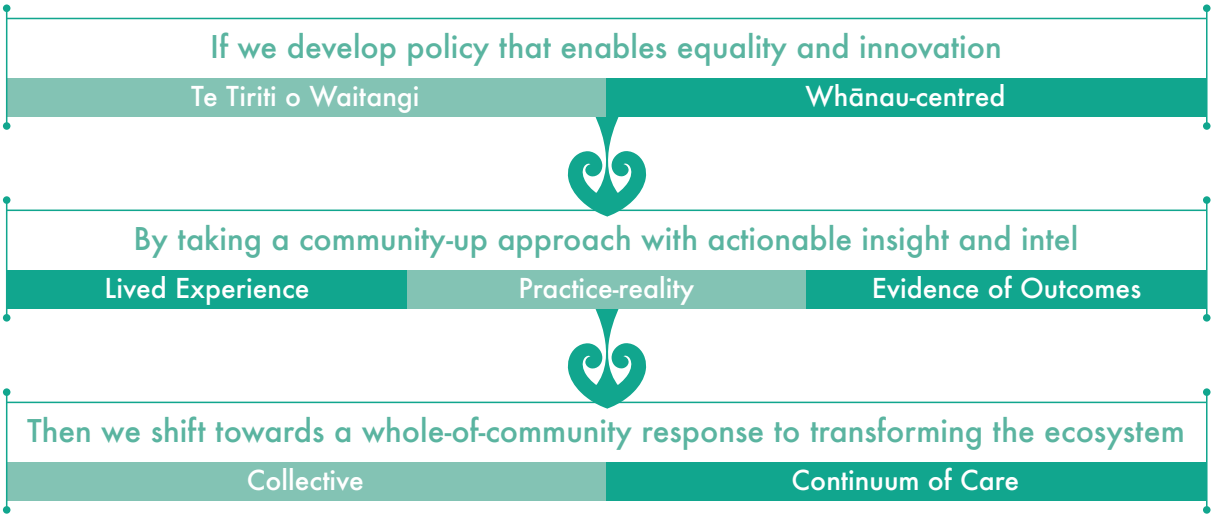
Step Three

Communications requirements identified, planned, and activated

Step Four

Engagement points that diminish wellbeing identified and reframed, redesigned

COLLAPSING THE SPACE BETWEEN POLICY AND PRACTICE



START UP ACTIONS

Step One

Identify relevant areas of policy development, improvement, and review recommendations that enable the Colab Design priorities.

Step Two

Sector leader engagement with relevant policy makers (local, regional, national) to socialise ideas and strengthen connections.

Step Three

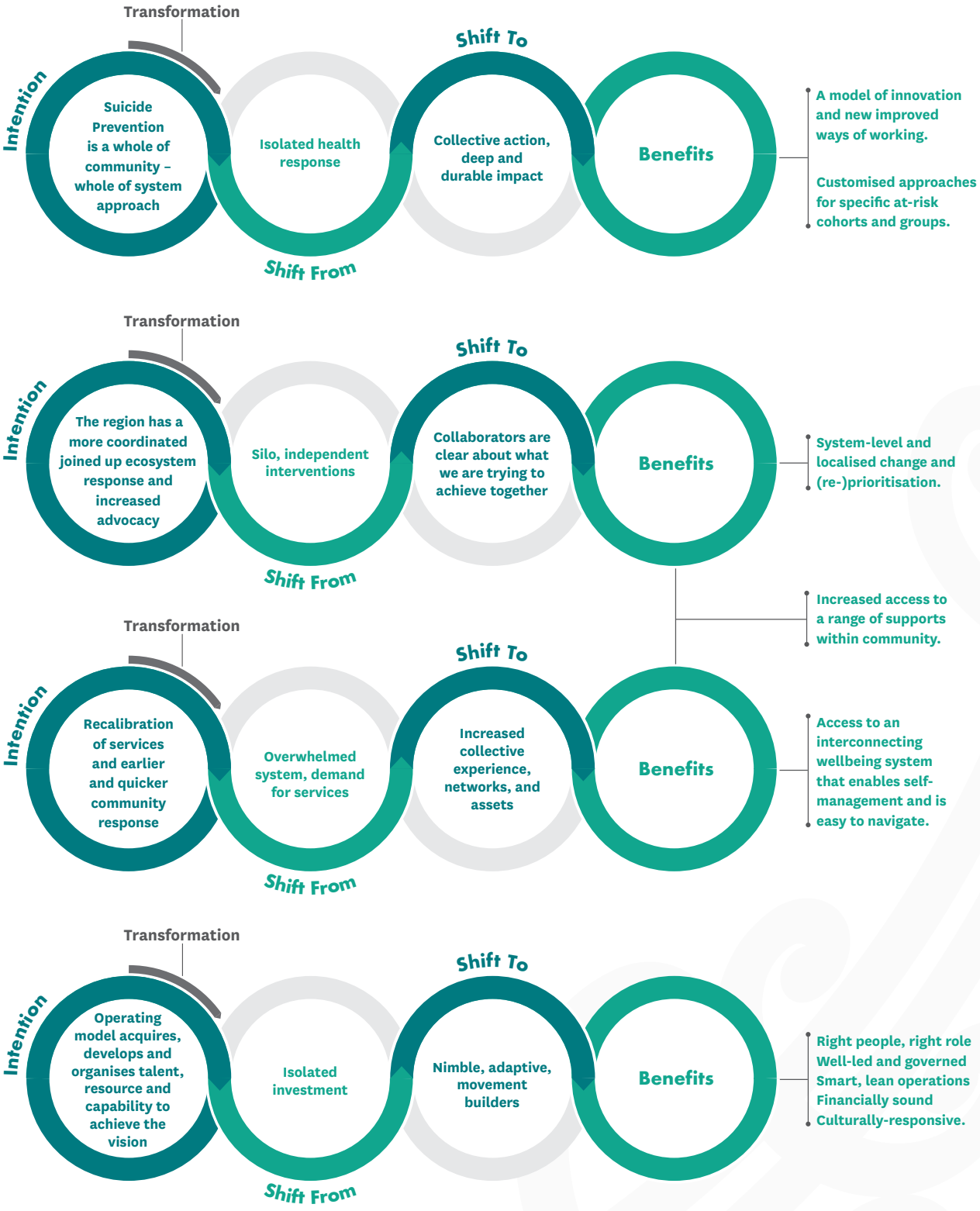
Identify and engage regional and national experts and forums for influencing policy developments – ensure membership.

Step Four

Agree and select policies to inform and influence.

STRATEGIC SHIFTS

For a more coordinated response to occur a series of strategic shifts is described and prescribed



IMPLEMENTATION ENABLERS

- Backbone function: Collective Impact frame
- Whānau-centred, community-led innovation
- Collective agreement
- Strategic Leadership Group
- Critical Friends, Knowledge Holders, Experts
- Evaluation and Measures of Success
- Mindsets of Innovation and Six Conditions of Systems Change

MOVEMENT BUILDING: A COLLECTIVE IMPACT APPROACH

Containers for Change	Community Aspiration	Authentic Engagement & Partnership	Leverage and Momentum	Strategic Learning & Reflective Practice
Kaupapa-driven.	"Nothing about us without us!".	High trust, non-competitive principled.	Removes bureaucracy so pace and depth become viable choice.	Has real time feedback loops.
Values diversity, creates brave space.	Based on community values and goals.	Negotiates the exchange of value rather than funding-only approaches.	Understands and works to address systems change.	Maps the progressive wins.
Deeply cares about and works with those who have lived experience.	Includes those not in traditional seats of power.	Enables power-sharing.	Prioritises actions that generate movement.	Acknowledges assumptions and mental models.
Fails forward, learns by doing, disciplined in the chaos.	So ambitious it cannot be mistaken for BAU.	Facilitates collective intelligence and collective action.	Leans into tension, positive disruption.	Regular quality reflection to improve practice and wellbeing.
Storytelling.	Creating new narrative to inspire positive change.		Produces artefacts.	Disseminates actionable intel.
Biodegradable.				

Collective Impact 3.0 adapted to Aotearoa New Zealand context by CALLED and CIA (The Change & Innovation Agency).

Cabaj, M., & Weaver, L. (2016). Paper: Collective Impact 3:0. Tamarack Institute.

HORIZON SETTING

For the Collaborative Design of Mental Health and Addictions Service Delivery to scale beyond the short term an iterative horizon setting is required to ensure community and the ecosystem of services can build capability and capacity beyond the start-up phase. The horizons overlap and / or will operate concurrently as traction is gained.

First 12 months

Start Up Phase – convene, plan, design, coordinate collective impact

First two years

Establishment Phase – activate, learn and adapt, amplify models of success, evidence ecosystem response

Five years

Scale and Sustainability – collective ownership, prevention system active, community-driven, impact measured

REFERENCES

Baxter, J. (2008). *Māori mental health needs profile: a review of the evidence*: Te Rau Matatini.

Came, H., McCreanor, T., Manson, L., & Nuku, K. (2019). Upholding Te Tiriti, ending institutional racism and crown inaction on health equity. *New Zealand Medical Journal*, 132(1492), 61-66.

Durie, M. (1994). *Whaiora: Māori health development*: Oxford University Press.

Durie, M. (2001). *Mauri ora: the dynamics of Māori health*: Oxford University Press.

Durie, M. (2011). Indigenizing mental health services: New Zealand experience. *Transcultural Psychiatry*, 48(1/2), 24-36.

Evans, K., Nizette, D., & O'Brien, A. J. (2017). *Psychiatric and mental health nursing* (4th edition ed.): Elsevier.

Government Inquiry into Mental Health and Addiction. (2018). *He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction*: Government Inquiry into Mental Health and Addiction.

Kingi, T. K. R., Durie, M., Elder, H., Tapsell, R., Lawrence, M., & Bennett, S. (2017). *Maea Te Toi Ora: Maori Health Transformations*. Wellington, Aotearoa New Zealand: Huia Publishers.

Mental Health Commission. (2012). *Blueprint II: improving mental health and wellbeing for all New Zealanders*: Mental Health Commission.

Mental Health Foundation of New Zealand. (2020). *Submission on the draft disability employment action plan /c Mental Health Foundation, Mauri Tū Mauri Ora, Like Minds Like Mine, Hāpai Te Hauora Māori Public Health*: Mental Health Foundation of New Zealand.

Ministry of Health. (2020). *Whakamaua Māori Health Action Plan, 2020-2025*: Ministry of Health.

Ministry of Health. (2021). *Kia Manawanui Aotearoa: long-term pathway to mental wellbeing*: Ministry of Health.

Morrison-Valfre, M. (2017). *Foundations of mental health care* (6th ed ed.): Elsevier.

Procter, N. G., Hamer, H. P., McGarry, D., Wilson, R. L., & Froggatt, T. (2017). *Mental health: a person-centred approach* (Second edition ed.): Cambridge University Press.

Smith, D. (2019). *Medicine over mind: mental health practice in the biomedical era*: Rutgers University Press.

Te Pou o Te Whakaaro Nui. (2015). Supervision guide for mental health and addiction kaiwhakahaere/managers. Auckland, New Zealand: Te Pou o Te Whakaaro Nui.

Tew, J. (2005). *Social perspectives in mental health: developing social models to understand and work with mental distress*: Jessica Kingsley.

Waitangi Tribunal. (2019). *Hauora: report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-publication version ed.): Waitangi Tribunal

CALL TO ACTION

Chy Potaka-Osborne
Project Lead - Mental Health and Addictions
Collaborative Design

Waiora Whānau
Healthy Families Whanganui Rangitīkei Ruapehu,
Te Oranganui Trust.

133 Wicksteed Street, Terrace House – Level 4

cheyenne.potaka-osborne@teoranganui.co.nz

Mobile: 0274691014


healthy families
Whanganui Rangitikei Ruapehu
He oranga whānau
TE ORANGANUI
Te Whatu Ora
Health New Zealand