Uru Rauhī, Mental Health & Addictions Cluster

Relational Model of Care

2019-2023

URU RAUHĪ Who we are

Te Wao nui a Tāne – "The Great Domain of Tāne"
The imagery of trees reflects our cultural understandings of social relationships, our inter-connectedness with each other and the natural environment.

Te Wao nui a Tāne represents unity, as all trees, vegetation, bird and insect life originated from the atua (god) Tāne, all are inter-related and often inter-dependent. People were not created until after all these living life forms and thus are seen as junior to them, this is often why you will hear Māori refer to rākau/trees as their tuākana or senior. It is a statement of whakapapa.

Pū Rongoā – Origin of medicinal knowledge and practice.

The domain of Tāne provided nourishment for the mind, body and soul through the provision of kai, rongoā and ancestral knowledge, protocols and practice of Kaitiakitanga maintaining the balance for a sustainable ecosystem.

Uru Rauhī, Mental Health & Addictions
Uru is a grove (of trees), or refers to standing in or entering into the bush.

Rauhī is the collective energy derived from the gathering together, to gather together, foster, protect and care for.

"He taonga rongonui te aroha ki te tangata"
Goodwill to others is a precious treasure

This whakataukī specific to Rangitāne encapsulates giving respect and sincere assistance to others.
The Kōwhai, our symbol, signifies durability, strength and heralds change, renewal, recovery and new beginnings.

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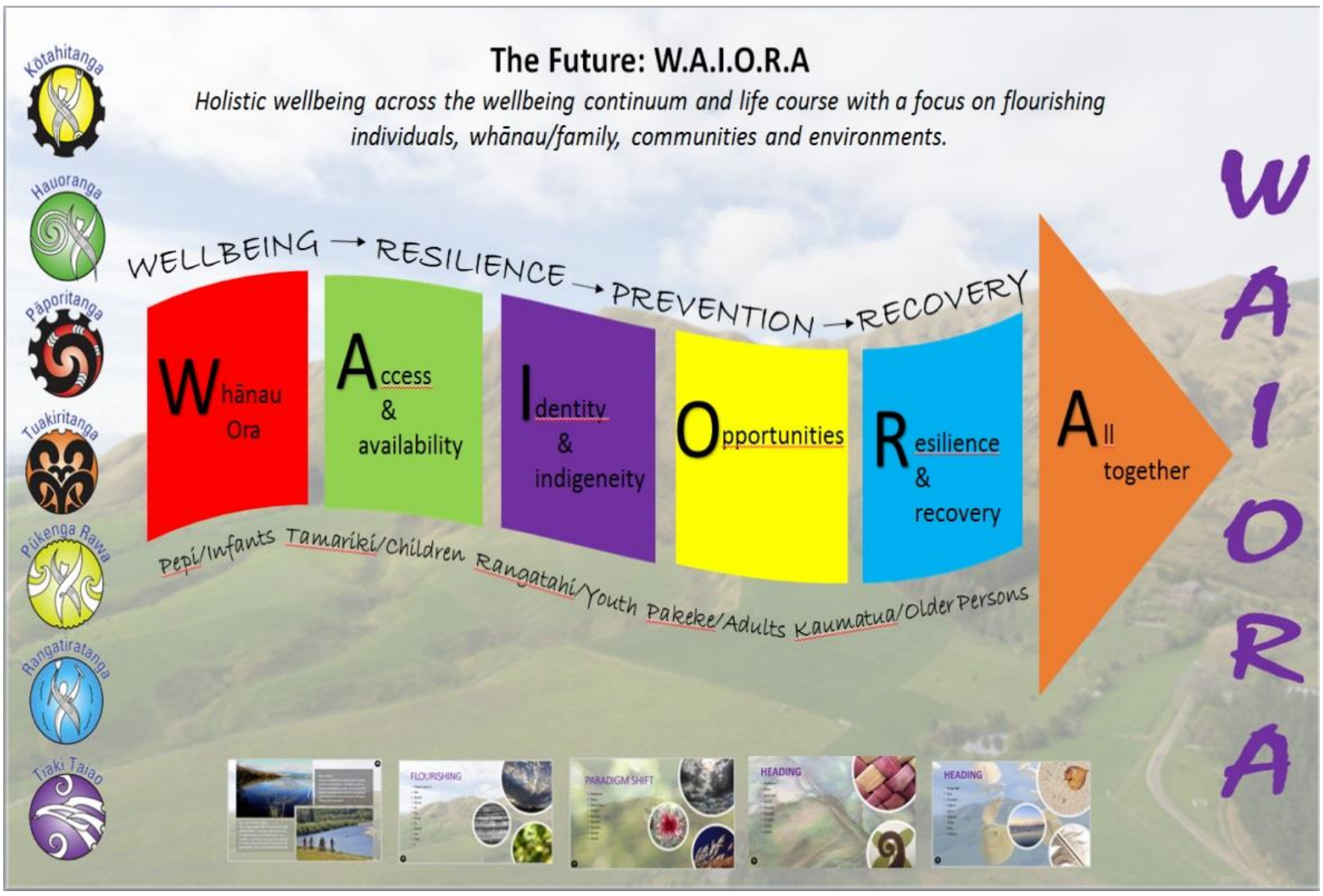
MODEL OF CARE – A PROGRAMME OF CHANGE

This document outlines the Model Of Care for the Mental Health and Addictions System and is underpinned by the name, Uru Rauhī, and the whakataukī gifted to us as a cluster. This encapsulates the work documented in Realising WAIORA, He Ara Oranga; the Mental Health & Addiction Inquiry, and summarised further in the Health & Wellbeing strategy and action plan of the cluster.

Of the population we serve of 180,000 people of whom 20%+ are Māori, and 18% are over 65 years, it is estimated that 34,000 people per year would benefit from an intervention to support mental health and wellbeing. We know our population is growing and ageing and this needs to be considered in our planning. Currently, people find it difficult to access services or know where to go for help and wait lists mean that help is not readily available. There is insufficient capacity in the system and fragmentation which results in consumers having to repeat their stories multiple times and little coordination of care. A focus on a 'medicate and manage' approach to date has resulted in a lack of access to effective interventions and people getting 'stuck' in the system. A steady increase in acute presentations and levels of distress experienced within our communities is a strong indicator that we need to redress the gaps in our system which focus on early interventions, wellness and holistic care. Inequities in health outcomes for Māori are well documented and funding allocations for kaupapa services to date are reflective of this inequity.

The current environment, including the structural changes to the DHB and the integrated service model, provides an opportunity to review and update our model of care to fit the needs of consumers and their whanāu and to make mental health & addictions a rewarding and satisfying area in which to work. We have well established networks and a strong cluster alliance group in Unison to support this change as well as clear mandate from iwi, the community and our consumers to change how we do business.



Relational Model of care – Whanaungatanga

As indicated in our name (ingoa), our core purpose is to bring people together to support those when they are at their most vulnerable. It is our role to bring people to a place of healing, care and nourishment and to reconnect them to their community. Sometimes this means holding hope for someone until they are ready to manage this themselves and it often involves rebuilding connections for people that will sustain them into their future. It involves supporting people and their families to establish wellness plans that are holistic, inclusive of their world views and which articulate their view of recovery. To have flourishing whānau and well communities we need radical change to a people centred, whānau focused delivery system which is, mana enhancing, community driven, transparent, flexible, responsive, innovative and honours te Ao Māori and indigenous knowledge

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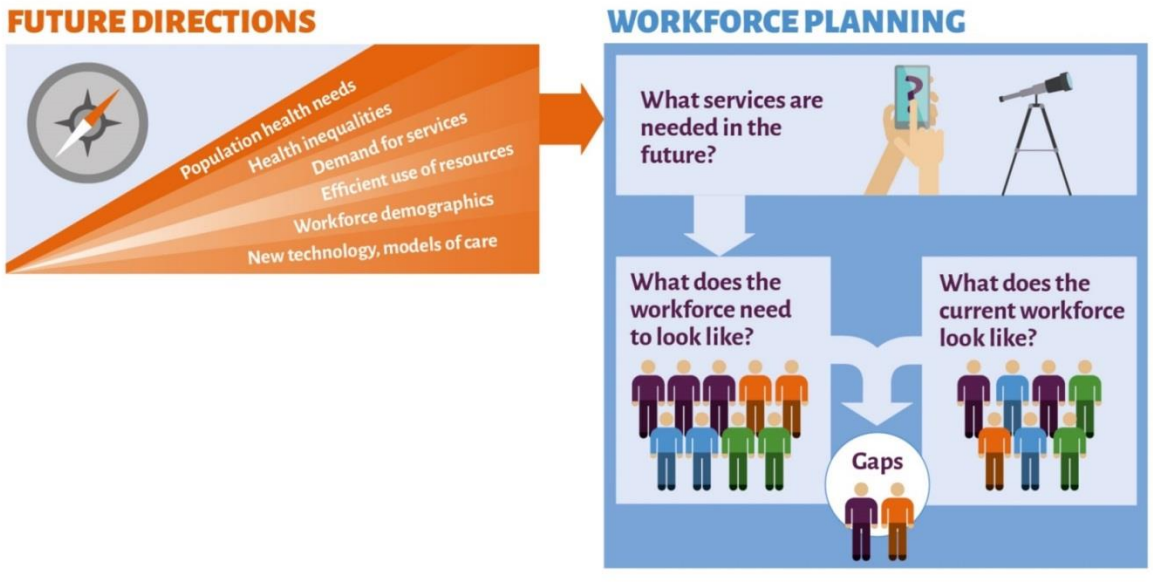
People – O matou iwi

People centred and family whānau focused

Our work (mahi) is about people working with people. It is the people who use services and those that support them who are the experts in their care and need to be at the centre of the system change. The overwhelming feedback from the community is that people experiencing distress want to feel welcome, safe and confident they have come to the right place and most of all to be seen as a person rather than a diagnosis. A model of care which focuses on relationships gives validation to the time it takes to meet people where they are at, to spend time with people and their families in order to understand what is important to them and what their priorities are for managing wellness. It means that co-development of any feature of the system is a core principal with consumers and their families at the centre. Ensuring that people have a positive experience means being focused on their needs and ***Doing the right thing – not the easy thing***

Workforce - Planning for wellbeing



Our current workforces are dedicated and committed professionals who work under some very challenging environments. Our workforce often experience frustration due to high vacancy rates, not being able to practice at the top of their scope or within their practice area and are constrained in their development due to lack of investment. Workforce surveys consistently indicate a sense of being overwhelmed with the volume of demand so not being as effective as they want to be to and a lack of confidence in cultural competency.

The solution to developing a workforce that can meet the needs of our community and focused on wellness is multi-faceted and will take considerable time to achieve. In addition to investment in the specialist workforce to enhance their capacity and capability to provide talking therapies and trauma informed care, a focus on rapidly increasing community wellbeing, whānau ora and peer support workers is critical. Inclusion of consumers and family members as an inherent part of the workforce in their own right will be reflected through development plans and opportunities for training.

Achieving an integrated system and relational model of care requires planning for multidisciplinary teams from across the spectrum and located across the continuum of care. Respect for the skills and experiences that each of the team brings, to ensure collaborative practice focused on the wellbeing of the person and their family is paramount.

Honouring te Ao Maori models of care and traditional practices with support to train and practice is a feature of this holistic and wellness focused approach in which people have genuine options for services from which to choose.

The wellbeing of our workforce is also a key success factor in this model as we cannot share what we don't have to give. Wellbeing initiatives and opportunities to showcase success across the cluster will be developed.

Right people Right Skills Right time

Innovation – ia Auaha

A key feature of a flexible and responsive system is to be able to innovate and try new things. A number of key projects are underway or being planned to enhance our ability to respond more effectively t people in crisis and to intervene earlier.

1. **ACUTE CARE PATHWAY [shorter term relationship]**

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At present our model of delivery for acute presentations are via the acute care team who are available 24/7. In outlying locations, community mental health teams manage crisis events during the day. Typically, people present in crisis either via the 0800 phone service, at the Emergency Department or Police. Assessments are conducted in several locations however assessing people who are significantly agitated presents problems due to a lack of appropriate secure spaces to undertake this. Following assessment people may be referred for support to the community team, their GP or may be admitted to the inpatient facility. A clear gap in the continuum of services is any alternative to inpatient, hospital level care and there is a heavy reliance on family and friends to support people who do not meet this threshold even though their loved one is in considerable distress.

It is critical that an easy to access and seamless service is available for those who experience a mental health crisis. This may not result in a traditional mental health diagnosis but does need to have a clear response that assists both the person and their family and whānau at that time. This will involve increased attention to collaborative working across teams and services, access points and increased awareness of where to go for help.

To shift the pathway for those in acute distress to align to an integrated system and relational model of care that is people centred, family focused and designed to be responsive to their needs, the following programme of actions are being undertaken:

Acute alternatives

Services which provide 24 hour supported living environments in the community to facilitate both planned and unplanned respite are needed in priority locations including Horowhenua and Tararua. Services which are operated primarily by peers, kaupapa Māori and those focused on young people will be contracted so that people have real alternatives to manage their wellness in the community and get back on track quickly. These services are part of a system which recognises that form time to time people will benefit from taking some time out to reset and reconnect with their recovery plans, culture and supports. Having services based in communities means relationships and connections are able to be maintained and give a safe space for people to potentially meet and engage regularly to support others in their journey.

These respite services also provide support for those discharged from inpatient care as a 'step down' to support slower re- integration for those who may need extra time, but not hospital level care. An internal study undertaken over the month of February 2019 which sought to understand the potential level of demand for this type of service and the impact on admissions to the inpatient facility found that there was consistent demand for respite (particularly in Levin). The impact of potential admissions to inpatient care was not as large as expected as only four people during that month were admitted to the ward would otherwise have been referred to a respite service had this been available. This brief study showed that while people are being appropriately admitted for inpatient level care, many people that would have benefitted from a respite level intervention were either referred to services that provide the supported house only or back to their home for outpatient follow up.

Home based treatment teams

In addition to an increase in options for respite care in the community, the development of home based treatment teams to actively support people on discharge from intensive inpatient services for a finite period of time is underway. Small multidisciplinary teams will work with people from their admission to a period following discharge back home to support both the individual and family members to action care plans and ensure that supports are well in place with warm hand overs to community based supports occur.

Over time, these teams will also be able to support people who contact crisis services in acute distress and who would benefit from having in home visits for a brief period to support rapid stabilisation and connection to appropriate resources that address the issue of concern.

Inpatient facility redevelopment

The ward 21 redevelopment project is underway and the key features of the new facility will align to the priorities expressed by consumers and their families. Based on projected population growth figures (NZ Dept of Statistics) over the next 15-20 years and the relative impact of increasing the number of alternative services in the community we would aim to build for a capacity of 28 people. The inpatient facility will cater for those who need the highest level of care and many are likely to have complex conditions. The inpatient facility however is part of the overall system and collaboration with multiple agencies and the increase of peer involvement in the ward is a priority.

Consumers, family members, iwi, staff and other stakeholders will be invited to contribute to this development. Key components of the redesign include:

- Warm and welcoming environment which makes use of natural light and space as well as access to Papatūānuku (the earth) and outside areas
- The facility is reflective of Te Ao Māori and incorporates tikanga Māori as determined by Mana whenua
- A sense of control over ones environment as much as possible
- A place which supports and facilitates family and whanau as the primary supports for people including space for them to stay alongside their family member
- The environment is conducive to wellness and recovery and is 'in community' as possible
- Access through the various pathways of entry (including the secure entry by police) are managed well from the perspective of the consumer
- Flexibility to allow for vulnerable groups including young people, trans people, people with intellectual disabilities and older people are able to be supported safely in designated areas.
    - Note: Mothers with very young babies will be supported in a facility that is set up for this purpose and which we already work with.
    - Note: Older Adult MH are undertaking a separate review of service delivery with the aim to enhance capacity in the community and reduce inpatient bed numbers.

Low threshold services

The introduction of low threshold services which are open to anyone to walk in and find information, get help and talk to someone will be one way we can reduce barriers to people getting help. Making these services operate as a community resource, open into the evenings and multi-functional (having café style space for example) will serve to reduce the stigma around mental health. The intent to establish these services in partnership with other allied agencies is part of the Unsion work plan.

Stewardship – Kia tiaki

Funding for the outcomes we want means committing to allocation of funding which seeks to address inequities. The current distribution of funding for services is heavily weighted to the DHB and is a factor of demand management at the intensive level of care. At least 30% of new funding will be allocated to kaupapa Māori based services, an increase from the current 5% spend. Valuing time to network, build and maintain strong relationships is fundamental to this model of care approach.

Funding for training and workforce development opportunities has been prioritised in order to progress the workforce development plan with a focus on:

- Increase talking therapies and working with trauma training to increase capacity to deliver effective interventions
- Training opportunities to be available for rongoa Māori and traditional models of care and wellbeing
- Community training opportunities in MH 101, Addictions 101 and suicide prevention
- Peer support worker training supported
- Intern models of training trialled
- Nurse practitioner roles to support nurse led initiatives

Information – kia whakamohi

An integrated system and relational model of care will be enhanced if people are able to connect and communicate easily. A workforce that is well equipped with mobile technology and an information management system that supports sharing of information and consumer driven personalised planning will be more efficient and safer. A programme of information technology improvements will be developed and wherever possible regional or national solutions will be leveraged.

Utilising and promoting the websites, phone services and self-managed programmes which support wellness will expand the offerings for consumers especially those who prefer to receive their support and engage in this way.

Success is not the work of one, but the work of many.
"Ehaka taku toa I te toa takitahi engari he toa takitini"

To build a bridge
To build a bridge, to begin, you must start,
Pull together and straight from the heart.
The foundation must be firm and strong,
Eradicating no one, all people belong.
Each structure has design and finesse,
The best materials, no more no less.
It's essential to set aside our differences.
To step to the future,
We must become one,
For a bridge with a gap in the middle is no good to anyone.

Consumer poem