Blueprint II Feedback Submission from the ARC Group

Organisation: The ARC Group

Contact Name: Steve Catty

Contact email: steve.catty@pactgroup.co.nz

Interest in the MH&A Sector: NGO Service providers

The ARC Group

The ARC Group is a national alliance of regionally-based leading NGOs that provide mental health services. We aim to support members' provision of exceptional services, strengthen members' competitive position, and enhance their leadership capabilities and their strategic development opportunities. ARC Group members are connected by a common purpose. Each has risen out of their communities; each believes that communities must be at the heart of mental health services; services must be defined by, and responsive to, community needs. We are committed to influencing and shaping future service development that enhances community mental health and well-being.

Members of the ARC Groups are: Walsh Trust in Auckland, Wellink in Wellington, Comcare in Canterbury and Pact in Otago, Southland and the West Coast. See the attached ARC Group flyer for more details.

Change 1 - An outcomes-oriented, whole-of-population, life course

The 'Next Wave' model of the life course approach generally aligns with our holistic NGO perspective, although we note that it is not one we explicitly model in our services yet. We also note that NGOs contributed via Platform to the development of the 'Next Wave' model and that it is also central to the BPII model.

We agree that the five proposed outcomes are a good approach. When talking about a "whole-of-population" approach, the consultation document does not emphasise one of the most important point made in the supporting documentation, namely "the critical requirement of maintaining the health and wellbeing of the population" (BP II Working Paper, p 17). To achieve this requires two essential components: communities developing their own capacity to be resilient (including accepting difference that people experiencing mental illness present); and accessible, low-threshold early intervention mental health services. While these are somewhat elucidated in the second change, this shift in focus from "the 3%" to the whole population's mental health is a fundamental one.

We suggest also that a responsive mental health system would either formally incorporate aspects of the wider social services sector (e.g. MOU's with other networks) so that people would find engagement more straightforward; or promote the development of community services that take an

holistic whole of person/family/whānau approach as appropriate to the life course requirements of the target populations.

<u>Change 2</u> - A system of care that is people centred, responsive, timely and integrated, builds resiliency and is recovery focused

> ***This approach is critical for the success of a comprehensive mental health system and aligns strongly with the ARC Group's preferred model of care.***

We believe that this approach is critical for the success of a comprehensive mental health system. This change aligns strongly with a model of care that the ARC Group has actively advocated for over the past 15 months, locally branded as "MH3" (the third, post-deinstitutionalisation model of mental healthcare) which was originally based upon Trieste's model of community-based mental healthcare. In this model services – including specialist clinical services – start in the community, then lift as needed to non-community based (and more costly) environments. Some of the fundaments of this model include:

- access to services is open, and easy (ie. people access services 24 hours per day 7 days per week, and see someone); people need not be in crisis or requiring emergency services;
- placing far less emphasis upon the need for expensive hospital beds – staff avoid reliance upon inpatient treatment and treat people in the community (beds are empty and generally used for short stays of 3 - 7 days);
- upholding the citizenship and rights of people accessing services; the use of compulsory treatment is minimal (in Trieste the level is 7 per 100,000 population, compared to 130 per population in New Zealand);
- flexible services that are fully integrated throughout the mental health system and effectively integrated with the wider networks of social services;

The approach applied in Trieste (and acknowledged by the WHO) critically challenges some of the fundamental (and costly) foundations upon which New Zealand's service delivery approach has been based. This can potentially begin some important conversations that will lead to our own local alternative system. In this regard the NGO sector, unique to New Zealand and envied by many other jurisdictions offers a potent contribution to an alternative future for community-based mental health services provision.

For further detail on our advocacy for this model of mental healthcare, please refer to the three attached documents A community-based mental healthcare system, Applying Trieste model to NZ and MH3 presentation.

From risk to opportunity

> ***Changing so the perceived "high risk community setting" is recognised as a place where people have the opportunity to regain their mental health.***

A paradigm shift is required in order to change the thinking of the mental health sector from "risk" to "opportunity." This requires mental health clinicians to shift their perception of the community from being a high risk setting to being a place where people have opportunity to regain their mental health and with clinicians taking informed risk. This change in perception allows people to recover in their communities over the longer term once they have received short-term specialist invention (if indeed their illness requires such intervention); when people are empowered to receive long term support from the NGO community sector and from informed and supported natural supports. The wider mental health sector needs to consider psychiatry as a partner, tool and valuable contributor to individual and community well-being, rather than the arbiter, dominant and defining agent of well-being and treatment. We believe this paradigm shift is a necessary prerequisite to the six areas of change identified in this section.

Change 3 - Creating a step change in performance that maximises the results we achieve from our limited resources of energy, time, capability and money

The challenge inherent in this approach is the capacity of our sector to achieve a substantial increase in access to services, presumably within the current (or further constrained) resources. Achieving this level of improvement will require discipline and focus. On the basis of what gets measured gets done, KPI's for the sector (aligned with points 1-5 on page 13 of the consultation document) could include: (1[1]) evidence that planners and funders of MH services are purchasing increased volumes of services from the non-regulated workforces and decreased volumes from the regulated workforces; (2 & 4[2]) ensuring that service utilisation rates reflect the local population demographic mix; (3[3]) % of referrals that demonstrate open access to services (self referrals); and (5[4]) participation in multidisciplinary meetings including community, primary and secondary services representatives.

[1] "Increases in the non-regulated workforce, including peer support, supported by effective workforce development."

[2] "Increasingly responsive services that are more culturally appropriate, engaging respectfully with people and their families" and "Improved and increased access for all age groups."

[3] "A responsive "no wait" system."

[4] "Increased confidence in recognising problems and acting in ways that help, right from the front line social sector agencies through primary care and specialist medical services to specialist AOD and MH services."

Current innovations in the sector

There are services and approaches currently operating in the sector that do not require new approaches, but rather build on existing innovations, as stated in this section of the consultation document. Current Innovations in the NGO sector which fit this bill are as follows:

1) Peer led services: These services have the capacity to shorten engagement processes through readily accessible and meaningful shared experience of mental illness, also to speed up access to support. Working examples include:
   - A wide range of peer support services throughout Comcare services in Canterbury, including Warmline (a telephone peer support service), supported employment peer support (assisting people to step into education, training or work), prison peer support workers in Christchurch Women's prison, and community peer support (as an alternate or adjunct to community support work);
   - "Jigsaw" – an intentional peer support service provided by WALSH Trust, provided through one-to-one services that are integrated within mental health support services, and through self-help groups that are facilitated by peers and respond to emerging issues;
   - Pact's West Coast and Southland intentional peer support services, provided to people progressing towards independence within or from Pact's community and supported accommodation services.

Current Innovations in the sector

1. Peer-led services
2. Modern supported accommodation
3. Linking brief interventions with long-term community-based support
4. Increased use of multidisciplinary teams
5. Supported employment services
6. Maintaining natural supports
7. Integrated physical health programmes

2) Modern community-based accommodation and support services: The ARC Group members have been developing a progressive model of support and accommodation which focuses on "the lightest touch necessary" to provide both accommodation and support services. We are moving away from the "group home" concept towards individual flatting opportunities, allowing individuals to maximise their skills and move towards independence. This includes wherever possible a separation between the provision of social/behavioural support from the provision of housing. Examples of these services include:
   - Pact's supported accommodation services, where people live semi-independently in service-owned, co-located apartments, with clinical and daily support available as necessary.
   - A range of Comcare housing services, from social housing tenancies (with Comcare as the supportive landlord) to housing facilitation (assisting and advocating for people through the process of setting up independent rental tenancies), to specialist AoD housing.
   - WALSH Trust's accommodation packages of care, with fully-independent tenancy agreements.

3) Linking brief interventions (from both primary and secondary services) with long-term community-based supports in order for service users to maximise the benefits of their brief interventions through well-informed, sustained lower-intensity support. Working examples of this are:
    - Pact's collaboration in Balclutha with the Southern DHB, who provides clinical support to people Pact supports in the community. This has developed into a Nurse Practitioner role, where a specialist mental health/AoD nurse works across the community mental health team and Pact's Community Centre to provide integrated shared-care plans and client files, providing the most comprehensive care within a community setting.
    - Comcare's Community support Access Pathway (CAP) service, designed post-earthquake to improve timely access to support services for mental health consumers. Comcare's CAP Coordinator receives all referrals for mental health and addictions community support services, triages them for urgency, seeks further clinical information and allocates referrals to the region's community support services with a zero wait list (ensuring there is flow through service so capacity matches demand). This service has been extremely successful with GPs, who previously had to wait for their client to deteriorate in order to access services via secondary care.

4) Increased use of multidisciplinary teams incorporating community, primary and secondary services so that planned intervention and support is more readily accessed with minimal duplication of effort; Christchurch's Residential and Enhanced Mobile Option Group (ROG) is a clear example of this type of innovation. The ROG was established post earthquake to cut out the barriers to access into residential services created by ineffective NASC services. The ROG is a clinically-led collaboration between Canterbury DHB and the four leading NGO providers in Canterbury. All referrals from secondary services for residential services and complex packages of care are processed through the ROG, which has a small service coordination team who ensure that plans are implemented and regularly reviewed. The benefits to all parties are: rapid decision making and access to services, minimal wait lists, providers being required to actively work with clients and move them through the system to ensure access is maintained, regular oversight of provision of services, and most importantly the reconnection between NGO providers and clinicians to openly discuss referrals and people's needs without the third party of NASC staff channelling communications.

5) Supported employment services: In New Zealand 80% of people on a sickness or invalid benefit due to mental illness, are estimated to want to work, and vocational services have been identified by mental health consumers as one of the top unmet needs. Employment tends to be followed by greater well-being, reduced symptoms of mental illness, more compliance with medication, lower relapse rates, better quality of life, and increased social contact and use of leisure time. Identifying successful supported employment services and propagating these throughout the country, as well as clarifying the funding responsibilities for such services, would lead to significant improvement in individual and community wellbeing. The Arc Group considers supported employment services as being at the leading edge of development in mental health services, and currently run supported employment services in each organisation:
    - Comcare's 'Jobconnect': Assists people to engage in training, skill development and open-market employment, including employer negotiation and client advocacy.

- WALSH Trust's 'EmploymentWorks!': Contracted by MSD, this service supports 100 people per year into open, competitive employment.
- Wellink Trust's 'Worklink': Assisting Wellink clients to find and keep the right job with planning, coaching and job searching and in-job support.
- Pact's 'PATHS': a collaboration between MSD, the Southern DHB and Pact, PATHS assists high-needs beneficiaries access and maintain training and employment opportunities.

See also the attached document, Supported employment in the mental health sector.

6) Maintaining natural supports: Utilising natural supports will become increasingly more important, allowing services to become the exception rather than the norm. This can include 'light touch' services such as Comcare's Home rescue (a responsive service that ensure a person's housing is secure and retained through a period of deteriorating mental health) and supported employment services (as above) that assist people to retain their job during periods of illness and recovery.
7) Strongly incorporating physical health programmes into mental health services will lead to improved individual and community mental health. An example of type of awareness is Comcare's 'Activelinks' service, providing targeted support to participate in physical activity, sport, recreation or leisure activity.

Organising roles and teams so that everyone is operating at the top of their scope

It is imperative that the mental health sector has robust discussion to clarify current and future scope of practice and to remove duplication of effort. Our vision of the sector is of long term mental healthcare provided within the person's community by natural supports and NGO supports, accessing short-term interventions and clinical oversight as necessary from primary and secondary services. A systems-wide model of this vision is shown in figure 1.

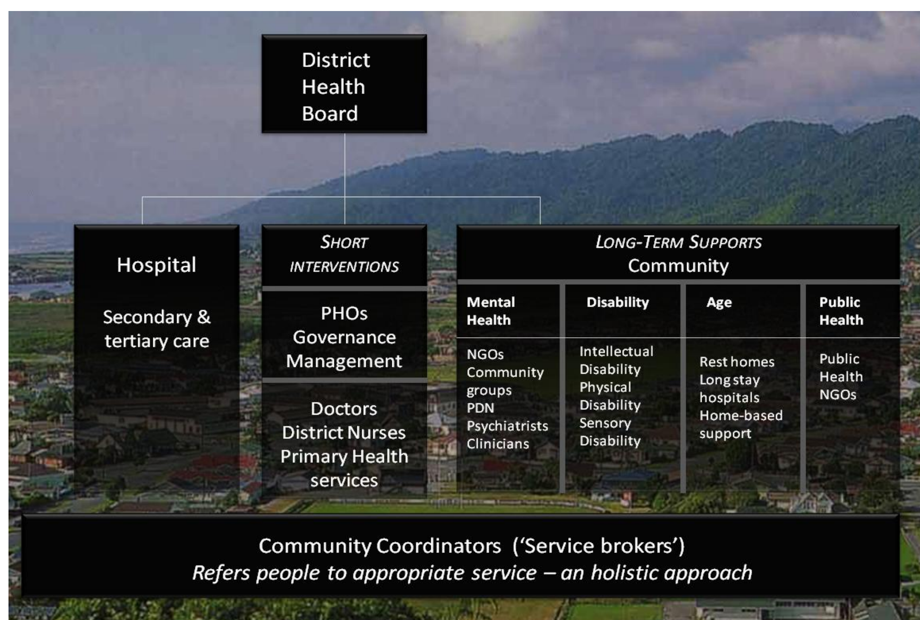

Figure 1. A systems-wide model of mental healthcare showing separation of long-term care from short term intervention

With specific reference to scope of practice in the workforce, what is most obvious to us on the community frontline is the significant and increasing overlap in practice of the support worker role and the community mental health nurse role. Community support workers in the NGO sector have developed significantly since the deinstitutionalisation process, and are now well trained with recognised qualification (the level 4 mental health certificate and the level 6 mental health diploma) whose scope of practice overlaps with nurse's scope of practice. This is an undervalued, underutilised well-trained – and significantly cheaper – resource within the community. If support workers' scope of practice were fully recognised, mental health nurses could move away from the overlapping practice (including community-based observations, administration, relationship building etc.) and focus their scope of practice on their more specialised skills, including specific pan-sector knowledge of mental health, addiction and psychopaediatrics. This allows nurses to provide significant clinical input into the lives of people accessing strong community support through NGOs in the community, making best use of an expensive resource by both support workers and nurses to operate at the top of their scope. See attached document, Support Worker and Nurse roles, for some work completed in this area to date.

Robust pan-sector discussion is required to clarify scope of practice, particularly with respect to support worker and nurse roles.

Acknowledgement of the significance of the proposed change

It does concern the ARC Group that Blueprint II does not directly acknowledge the significance of the change required to occur in order to realise this vision; it would be good to see some acknowledgement of the scope of changes proposed, the potential barriers to that change and responses to arguments for the status quo. We encourage the promotion of a bold approach so that Blueprint II contributes more clearly to Government-stated directions of better, sooner, more convenient health care.

The scope of the change required to implement this vision needs to be addressed.

Building an evidence-informed system change capability

We agree with a move towards a more evidence informed approach to system level change.

Developing effective sector leadership

We agree with the proposed areas to develop sector leadership. We strongly agree that this vision requires continued advocacy and championship, not only from the Office of the Health and Disability Commissioner but also from leaders in government and community sectors. Leaders will need to be most effective at discovering and utilising critical change points, and able to apply effective change management processes in order for the sector to realise this vision.

Guiding outcomes-oriented development and resourcing decisions

We strongly agree with Blueprint II's proposal to implement an outcomes model to support sector-led performance improvement. The challenge we foresee in implementing this model will be getting government buy-in, as (once the outcomes are defined) it is harder to control the way these outcomes are achieved throughout the sector (services having the power to say "this is the impact we are achieving").

We strongly agree with the proposal to implement an outcomes model.

Results based accountability provides a clear structure within which to build a sector-wide and population-wide outcomes model and has the benefit of being used in other governmental agencies such as the Ministry of Social Development. An alternative outcomes model developed in New Zealand that visually maps sector wide outcomes (the 'DoView' model of outcomes mapping; see http://tinyurl.com/otheory267) could also be a useful model to incorporate, as much of the governmental and wider social sector has already been mapped within this model and is currently being piloted across the mental health NGO sector (including Pact and Wellink services).

Evolving how we organise funding

We agree that funding organisation requires evolution. One of the main sector-wide issues that influences the NGO sector is the inequity in pricing between DHB provider arm services and NGO services. This is acknowledged in the Southern DHB planning and funding's recent draft mental health and addiction strategic plan, stating that "inequities in pricing also exist between DHB provider arm services and NGOs... Planning and Funding must develop a service mix that is equitable, sustainable and high quality" (p 13, *Raising Hope – Hapaia te Tumanako*, Southern DHB).

"Where do we start?" – supporting sector-led implementation

1. A people-centric approach: Ensuring services can be accessed quicker and more easily; this goal should inform service design and provision, rather than the present system where people need to adapt to meet the needs and/or limitations of the current system
2. A distracted system that is under stress is immediately "behind the 8-ball" in trying to provide effective and responsive services. Workforce development is not just about skills and training, but about job satisfaction, personal commitment to responding to the support needs of people who present to services, and engagement with the role, the job, objectives and the vision. Against a backdrop of contestable service provision, competition for scarce resources, it is a challenging proposition for staff to provide effective, efficient, innovative, responsive and compassionate services – that are "better, sooner and more convenient".
3. Engagement with the sector and the community must be fundamental to the provision of services. "Mental health" happens in the community, neither in a hospital nor in a "residential rehabilitation service". The mental health system needs to consider psychiatry

as a partner and tool and valuable contributor to individual and community well-being, rather than the arbiter, dominant and defining agent of well-being and treatment.

“Where do we start?” – better outcomes for vulnerable groups

1. Improved targeting of our effort is required. The cause of vulnerability is many pronged however addressing low income, poor educational attainment and sustained unemployment would arguably be the biggest single prevention investment that government could make. To achieve this, a cross sector approach linking social development, education and health agencies with those already engaged with vulnerable communities is essential.
2. Government and community must work together to greater effect. Partnership and collaboration by government with agencies and groups who are already connected and engaged with these populations (e.g. tribal runanga, Iwi authorities, churches, and community sector groups) should be mandatory so that together we can build capacity and at a practical level allocate effort and expertise to more efficiently and effectively achieve the desired results that are outlined in BPII.
3. We must break out of our euro-centric mode and urgently develop and articulate alternative, culturally informed understandings of mental ill-health that allow a broader ranges of responses to the distress that different peoples experience as well as enabling others to learn.

Attachments:

- ARC Group flyer
- A community-based mental healthcare system
- Applying Trieste model to NZ
- MH3 presentation
- Supported employment in the mental health sector
- Support Worker and Nurse roles