Pathways to Support

Executive Summary

This project maps pathways to treatment and support in the mental health and addiction sector across Otago and Southland and identifies perceived barriers and bottlenecks present in these pathways. This project is completed as a part of the situational analysis section of the Southern District Health Board’s Mental Health and Addiction Planning Project and is prepared by the project coordinator, Steve Catty.¹

Information was gathered from all contracted mental health and addiction services through responses to an electronic survey and by face-to-face and phone interviews with service advisors across the region.

A map of hypothetical pathways through mental health and addiction services throughout Otago and Southland is presented in the body of this report, showing high-level pathways across the whole region, with detail presented in further pathway maps. These pathways identify entry points into the mental health and addiction system, level of service and possible pathways between services. Perceived barriers and bottlenecks, identified both by services and by people who have used these services, are then discussed.

High-level pathways show people most-often access services through emergency services (Emergency Psychiatric Services in Dunedin or Southland Mental Health Emergency Team in Invercargill) or through their GP or private counsellor. From these entry-points, people can be referred into primary mental health services, community mental health teams, specialist secondary services or, if more severe, into inpatient services. If referred into inpatient services, people generally exit through the community mental health teams. Once managed by a community mental health team, people can go through a formal needs assessment process to access broader NGO and community support services, including supported accommodation, community support, respite, day programmes and home support services. People with a diagnosed mental illness can also self-refer into community supports and day activity programmes throughout the community.

The general themes of barriers and bottlenecks within the system include:

- **systematic barriers to entry into the mental health system**, including restrictive entry criteria into secondary services, lack of services for people with moderate mental illness and restrictive cost of GP visits;
- **systematic barriers to exit out of services**, including services not wanting to or able to discharge clients to less intensive support for a variety of reasons;
- **stigma**, both societal stigma embodied in the person accessing services and systematic stigma from the services provided;

¹ Any correspondence about this project can be addressed to the Southern DHB’s Portfolio Manager (Mental Health and Addiction), Gemma Griffin at gemma.griffin@southerndhb.govt.nz
• philosophical differences in secondary and NGO/community models of care, where secondary services work to a ‘psychiatric’ or medicalised model of care where NGO/community services work to a ‘mental health’ or holistic model of care;

• lack of knowledge-sharing, use of services use and (in some cases) lack of services;

• lack of effective discharge/transition planning, resulting in anxiety around discharge process and inflated caseloads;

• lack of early intervention services and utilisation of natural supports, resulting in more people accessing more intensive and expensive services in the long run;

• lack of integration between mental health services and addiction services, including self-medication of mental illness, the addictiveness of prescribed drugs and shared-care treatment plans.
Appendix 1: Copy of ‘Pathways to Support’ Survey
Introduction

This project aims to map pathways to treatment and support in the mental health and addiction sector across Otago and Southland and to identify perceived barriers and bottlenecks present in these pathways.

To achieve this aim, a ‘Pathways to Support’ survey (attached in Appendix 1) was sent to all mental health and addiction organisations contracted to the Southern DHB. Organisations self-identified their service lines and completed a survey for each service line in their organisation. An excellent rate of response was shown, where 74 of the 79 contracted services (94%) completed the survey or responded with information about their pathways to support.

A second set of information was obtained from service advisors through face-to-face, telephone and email interviews with service advisors across the region. Service advisors responded to questions about experiences accessing, moving through and exiting mental health and addiction services, and what common barriers and/or bottlenecks are experienced when engaging with services.

A map of hypothetical pathways through mental health and addiction services throughout Otago and Southland is presented, showing high-level pathways across the whole region, with detail presented in further pathway maps. These pathways identify entry points into the mental health and addiction system, level of service and hypothetical pathways between services. Perceived barriers and bottlenecks, identified both by services and by people who have used these services, are then discussed.

This project is completed as a part of the situational analysis section of the Southern District Health Board’s Mental Health and Addiction Planning Project and is prepared by the project coordinator, Steve Catty. Any correspondence about this project can be addressed to Steve at mhapp@xtra.co.nz or to the manager of the Mental Health and Addiction Planning Project, Southern DHB Portfolio Manager (Mental Health and Addiction) Gemma Griffin, at gemma.griffin@southerndhb.govt.nz.
Pathways

While it is possible to map hypothetical pathways into, through and out of mental health and addiction services, people typically receive support from multiple services over long periods of time, which has been characterised more as an “expanding and contracting balloon of services.” People generally access a huge variety of secondary, NGO and community supports at any point on their pathway, accessing each of these services to a greater or lesser degree. At best, these services form a “collaborative support package”, supporting the person to progressively less intensive support as the person progresses towards wellness; at worst they form a disconnected and duplicative set of supports that do not address the needs of the person pushing them towards more severe illness.

General high-level pathways are described and mapped below, then separate pathway diagrams are presented for Dunedin-based, Otago Child and Youth, Rural Otago and Southland pathways. The following symbols are used in the service pathways maps:

-  is a self-referral point that does not require a diagnosed mental illness;
-  is a self-referral requiring a diagnosed mental illness;
-  is a self- or family-referral into a child and youth service;
-  Solid lines indicate referral pathways with a direct pathway between services;
-  * Dotted lines indicate referral pathways recently added to service specifications that are not currently used;
-  is the numbered reference of services in the service descriptions;
-  Services are colour coded where green is primary and private services, blue is secondary services and red is NGO and community services.

As mapped below, people most-often access services through emergency services (Emergency Psychiatric Services in Dunedin or Southland Mental Health Emergency Team in Invercargill) or through their GP or private counsellor. From these entry-points, people can be referred into primary mental health services, community mental health teams, specialist secondary services (including secondary addiction services) or, if more severe, into inpatient services. If referred into inpatient services, people generally exit through the community mental health teams. Once managed by a community mental health team, people can go through a formal needs assessment process (either as part of the community mental health team or through an independent needs assessor) to access broader NGO and community support services, including supported accommodation, community support, respite, day programmes and home support services. People with a diagnosed mental illness can also self-refer into community supports and day activity programmes throughout the community.

The main high-level regional differences are:

- Southland Integrated Services Model for secondary services with single point of entry
- Otago community needs assessor
- Otago early intervention services
- Otago primary mental health (moderate) service
- Otago multiple points of entry (primary mental health (moderate), community needs assessor, student health service)
Figure 1. Service Pathways – General
Figure 2. Service Pathways – Dunedin-based
Figure 3. Service Pathways – Otago Child and Youth
Figure 4. Service Pathways – Rural Otago
Figure 5. Service Pathways – Southland
Pathway Descriptions – Otago

Individual services described below are Emergency Psychiatric Services (EPS), community mental health teams, primary mental health services, needs assessment services, then six service groups are described with access pathways: inpatient services, secondary specialist services, supported accommodation, community support, day centres/programmes, and group/individual supports. Lastly, regional services, addiction services and child youth and family services are described.

1 Emergency Psychiatric Services

EPS receives up to 20 referrals a day from anywhere including self- and family-referred. People accessing the service can be of any age and do not need a diagnosis; they may have diagnosed or suspected mental illness and may have alcohol/other drug substance abuse.

EPS is one of the main entry points into mental health and addiction services in Otago, hence people may be accessing services for the first time. If they have previous accessed services, they may or may not be under the Mental Health Act in the community (under a community treatment order).

EPS’s function is to provide a psychiatric assessment with a brief intervention, then to refer onto other services. These services typically include:

- Community mental health teams {2}
- Admitted to an inpatient ward (either voluntarily or under the Mental Health Act) {5}
- A specialist mental health team {6}
- Youth Speciality Services {13.1}
- Community Alcohol and Drugs Service {12.1}
- To their GP or a primary mental health service {4}
- Crisis respite through an NGO {7}

2 Community Mental Health Teams

People are generally referred to the community mental health teams from primary mental health services {4}, GPs, EPS {1} or having come from mental health inpatient wards {5}. If first accessing services, a person would not be under the Mental Health Act, but if they had come through the inpatient wards they are like to be on a community treatment order. People will potentially access the whole range of mental health services while being managed by the community mental health teams, including Miramare {3}, NGO supported accommodation {7}, NGO community support {8}, community day programmes {9}, community support groups {10} and natural community supports (such as churches and sports clubs, friends and family/whānau).

If the person is under the Mental Health Act they are required to be under a psychiatrist and PDN so have no current alternatives to the community mental health teams or inpatient wards. Discharge is ideally planned with multi-agency teams, the person and their family; if the person is removed from the Mental Health Act, however, they will likely cease to engage. After discharge, people generally return to their GP’s management and continue to access any of the services accessed during community mental health team management.
3 Needs Assessment Services

Three needs assessment teams fulfil the needs assessment function of the greater Dunedin area; two within secondary mental health services (one within each community mental health team) and one community-based organisation (Miramare). The access pathways to the needs assessment teams are significantly different depending on whether they are community-based or based within the mental health teams, but in both cases the needs assessment teams are ‘gatekeepers’ for a variety of services within the system, such that these services cannot be accessed without authorisation from a needs assessment team. These services are:

- Personal care, Household management and night sits (Dunedin Home Support Services, Healthcare Otago, Home Support Services Otago, Presbyterian Care, Nursing NZ, Homecare 2000)
- Home Support Mental Health/NGO community support {8} (e.g. Pact, CBCT, Carroll Street Trust)
- Packages of Care (Pact Women’s Service, Koputai Lodge {7})
- Carer Support (person’s choice who provides including natural supports)
- Planned Respite (Pact, Koputai Lodge {7})
- House and Recovery services Daytime/Responsive night support (“level 3” NGO Supported Accommodation {7}, specifically Pact, CBCT, Carroll Street Trust)
- House and Recovery Services Daytime/Awake night support (“level 4” NGO Supported Accommodation {7}, specifically Pact, CBCT, Carroll St, Hulme House and St. Clair Park)
- Special arrangement/ Special funded (person specific)
- Long term Residential Bed (Pact, Norwood Street Residence, Forbury House {7})

Since the secondary needs assessment teams are an internal function of the community mental health teams, access pathways for these team match those for the community mental health teams. Here the needs assessment functions to augment the work of the community mental health teams in which they sit.

Miramare receive referrals from multiple sources including self- and family-referred, GPs, EPS {1} and other mental health and addiction services. Referrals are most often received from someone other than the person’s main clinical case manager. Miramare is the only needs assessment service for children in Otago.

Adults could be accessing a wide variety of services prior to contact with Miramare, including Ashburn Clinic {6.7}, Corpac {10.3}, Provider arm addiction services {6.7}, Provider arm adult mental health services {2, 6}, Family Mental Health Service {4.2} and Otago Mental Health Support Trust {10.1}. As well as these DHB-funded mental health and addiction services, adults could be accessing a wide variety of non DHB-funded services such as Plunket, Family Care and Family Start.

Prior to contact with Miramare, children could also be accessing a wide variety of services, including the CBCT’s youth residential service, Te Whakaruruhau {13.3}), Youth Speciality Services {13.1} or CAFMHS {13.2}, Mirror Counselling {13.3}, Family Mental Health Service {4.2} and Otago Youth Wellness Trust {13.4}. As well as these DHB-funded mental health and addiction services, children could be accessing or referred by education services, Child Youth and Family Services, Youth Justice and Paediatrics.
People accessing Miramare NASC are often seriously involved with a number of services before, during and after support from Miramare, including any variety of any of services throughout the mental health and addiction sector in Otago, as well as a host of non-DHB-funded services. As stated above, people can only access the ‘gatekept’ services listed above if they are supported by Miramare or another NASC team. Once a person has exited from Miramare services, they are no longer able to access these services. Often people will not be accessing any of these services but still be supported by Miramare to receive a variety of supports.

4 **Primary Mental Health**

4.1 **Southern PHO Brief Intervention Services**: People enrolled in Southern PHO practices across the region can access this service, which provides six to eight one-to-one therapeutic sessions. Sessions typically provide talking therapies, as well as specific coaching in, for example, coping strategies and activity scheduling. People would access these services by referral from their GP or practice nurse. People with moderate mental illness would typically not receive these services, instead be referred onto secondary services.

4.2 **Family Mental Health Service**: The Family Mental Health Service provides both adult and child mental health support services to people with mild to moderate mental illness throughout the greater Dunedin area. People receive services for six to eight months and referrals are received from anywhere, typically from GPs but also self-referred or from schools. The centre provides services for the higher-needs end of the mild-to-moderate range, which otherwise has difficulty accessing services (as discussed in the ‘Barriers and Bottlenecks’ section, below). The Centre often providing co-care with secondary services such as Youth Speciality Services {13.1} and liaises with the community mental health teams {2} to identify the appropriate level of service for the person accessing services. The Centre also refers out to a wide range of community services (such as women’s refuge and Salvation Army services, e.g. the Bridge Programme {12.3}) during and after receiving services from the Centre.

4.3 **Student Health Services**: These services are provided to students of the University of Otago (enrolled population of 18,000 people) and provide counselling and education services for students with mild to moderate mental illness. While accessing these services, people can also be managed by the community mental health teams {2} (if the illness is more severe) as well as other university services such as the chaplaincy service or disability services.

5 **Inpatient Services**

People would typically access inpatient services via EPS {1}, community mental health teams {2}, or (if on medical wards) then via the psychiatric liaison services {6.4}. People admitted to an inpatient ward are typically admitted to ward 1a acute inpatient services or 9b secure services. If a person did not want to be admitted, the risk they pose to themselves and/or others would be assessed; if low risk, they may be offered respite care; If their risk is considered to be high, the Mental Health Act would be invoked and the person would be admitted to the most appropriate environment, which would likely be ward 1a acute inpatient services or ward 9b, a locked unit.

5.1 **Ward 1a Acute inpatient services, Dunedin Hospital**: Ward 1a provides 14 acute adult beds and 2 youth beds. The majority of people are admitted as voluntary patients but some are under the
Mental Health and Addiction Planning Project – Pathways to Support (draft, 18 May 2011)

Mental Health Act. A hypothetical person would be admitted to the ward in crisis and posing a potential or actual risk to themselves or others and would stay on the ward for 8-12 days. If a person is considered to require a longer stay in inpatient services they will be transferred to 9b or 11.

5.2 Ward 9a Forensic inpatient services: Ward 9a provides a 13-bed inpatient unit at Wakari hospital for people who have severe mental illness and have committed a significant crime. See Forensic Services {6.1} for more detail.

5.3 Ward 9b Secure acute inpatient services: Ward 9b provides 7 acute beds and 10 intensive care beds, with the majority of people being admitted under the Mental Health Act. A hypothetical person would stay on the ward for 15 days (but with a broad range in lengths of stay from a few hours to over a year); the majority of people then return to the management of a community mental health team, with one in five people being transferred to sub-acute rehabilitation in ward 11 {5.4}.

5.4 Ward 11 Sub-acute rehabilitation: Ward 11 provides 24 sub-acute rehabilitation beds for people who are likely to have ‘severe and enduring’ mental health needs and may also have another diagnosis such as additions or physical illness. Typically people come to ward 11 under the Mental Health Act from an acute ward then are transferred when symptoms/behaviours are less intense (likely still under the Mental Health Act), staying in ward 11 for an average of two months (again, with a broad range in lengths of stay). Whilst in the ward, people would typically be accessing other services such as day centres {8} as well as support from their community mental health team {2} and friends and family/whānau. If the person wants to be discharged, a clinical review is held; if it is not reasonable to use the Mental Health Act to detain them longer then they are discharged to their community mental health team, supported accommodation {7} or community support {8}.

After leaving inpatient services, people could be referred to:
- Community day programmes
- Outpatients groups {6.5}
- Community mental health teams {2}
- Specialist services {6}
- Needs assessment (community mental health teams or Miramare) {3}
- NGO’s supported accommodation {7}
- SF for family support etc {10.2}

6 Specialist Services

Specialist inpatient services include forensic services, ward 10a intellectual disability services and ward 6c mental health services for older people. Other specialist services include, Te Oranga Tonu Tanga, Psychiatric Consultation Liaison Service, Psychiatric Outpatients Services and Ashburn Clinic.

6.1 Forensic Services (Ward 9a, Community Forensic, Court and Prison Liaison services): Forensic services are regional services that provide a 13-bed inpatient unit at Wakari hospital, plus community forensic services and court and prison liaison services. Referrals are received by these services from police, the courts and EPS {1} for people who have severe mental illness and have committed a significant crime; they will be under the mental health act, will be assessed through EPS {1} and treated within the forensic inpatient unit or supported by the community forensic PDN in the
general inpatient wards (5), in prison or in the community in supported accommodation (7) depending of severity of their illness and their criminal charges. The person would remain under the care of the forensic service until they were deemed suitable to enter into a shared care arrangement with the general community mental health team (2) and a transfer of care.

6.2 Intellectual Disability Services (ward 10a, consult liaison, Behaviour Support Services): These services provide specialised clinical support to people with an intellectual disability and significant challenging behaviour that has brought them to the attention of the criminal justice system. People are referred from LifeLinks (a Christchurch-based community needs assessor), the police or courts, or from their supported accommodation provider (either Pact (7) or Community Care Trust (7)).

6.3 Te Oranga Tonu Tanga: This service is part of the specialist mental health group and employs nine Kaioranga Hauora Māori; the Kaioranga work alongside all specialist secondary services while utilising the kaupapa and tikanga of Te Oranga Tonu Tanga. Services include but are not limited to EPS (1), the community mental health teams (2), the inpatient units (5), community alcohol and drug (CADS) (12.1), youth specialty services (YSS) (13.1), Child Adolescent Family Mental Health Service (CAFMHIS) (13.2), early intervention in psychosis service (6.6) forensic services {6.1}, intellectual disability services {6.2}, Mental health services for older people {6.7} and the rural mental health teams (11).

6.4 Psychiatric Consultation Liaison service: People thought to have a mental illness affecting a physical condition are referred to this service by their GPs, by the medical inpatient wards or their midwife. The service assesses and advises on diagnosis and treatment for people.

6.5 Psychiatric Outpatients Services: People with moderate to severe mental illness receive case management (assessment, treatment and case coordination) and/or a group psychotherapy programme through this service. It is accessed primarily through EPS (1), ward 1a (5.1) or the community mental health teams (5) and people will continue to access the services of the community mental health teams and their GP throughout.

6.6 Early Intervention in Psychosis Services: People accessing this service are young people (18-30 years old) experiencing their first episode of psychosis, generally having received acute psychiatric intervention from EPS (1) prior to accessing, with continued collaborative care. Once a person’s treatment goals are reached (or their three-year period is reached) they are transitioned to the care of community mental health teams or their GP.

6.7 Mental health services for older people (ward 6c, community services, day programme): People can access these services who are 65+ years old who have an age-related mental illness. People are often on community treatment orders and are referred from aged-care needs assessors, their GPs, or through other mental health services.

6.8 Ashburn Clinic: Receives referrals through SDHB pathways and overflow from inpatient wards. (No further information.)

7 NGO Supported Accommodation

People are referred into Dunedin supported accommodation services through any of the needs assessment teams, who retain case management and have the mandate to review services people
receive. People often access supported accommodation after being released from inpatient services \(5\) and are typically under a community treatment order.

While living in supported accommodation, people access a wide range of services throughout the mental health and addiction sector, as well as a variety of social, community and natural supports (e.g. family, GPs, health and disability advocacy, day programmes \(9\) and support groups \(10\)). Typically people will have been assigned a PDN to provide some case management function through the community mental health teams \(2\).

People would go through different processes to exit supported accommodation depending on the provider, but would generally be decided in a multi-agency team, including the provider, the clinical teams and the needs assessors. After leaving supported accommodation, people may retain their support from community mental health teams \(2\) and needs assessors \(3\), as well as access community support \(8\), or may cease to receive support from the mental health system.

These services are provided at various residential locations throughout Dunedin and are run by Pact, CBCT, Provider Arm DHB (Hulme House), Forbury House Trust, Carroll St Trust and St. Clair Park. Pact’s Miringa Whakaaro service also provides a taha Māori supported accommodation service.

In addition to full supported accommodation, Otago Accommodation Trust \(7\) and Carroll Street Trust offer supported landlord services and Pact and Koputai Lodge \(7\) provide planned respite services, typically provided on a regular basis to enable people accessing the service to stay out of hospital. Pact also provides two crisis respite beds (one capacity funded, one on a per-bednight basis) for respite services on an unplanned basis. These services are similarly administered by needs assessors but can also be referred into by EPS.

Both Pact and Community Care Trust also provide Regional Intellectual Disability Supported Accommodation Services (RIDSAS) for people with intellectual disability on a Regional Intellectual Disability Care Agency (RIDCA) community treatment order.

8 NGO Community Support

People access community support through a formal needs assessment, and can receive community support for anything from one month to many years. People can have previously been in inpatient services or have come through supported accommodation. Providers offering community support include Pact, CBCT and Carroll Street Trust. As with supported accommodation services, people typically are broadly managed under the community mental health teams \(2\) and can be accessing a vast range of services alongside community support, including day centres and day programmes \(9\) and support groups and individualised supports \(10\). A taha Māori community support service is also provided within Pact’s Miringa Whakaaro service.

9 Day centres and Day Programmes

People generally self-refer to these support services, and can have come from their GP or community mental health team. They can access these supports to whatever degree and for as long as they wish and can be accessing any combination of these services at a time. Alongside accessing these services, people are often under management of their community mental health team and involved with other services in the mental health and addiction sector, such as supported
accommodation (7) or community support (8) and the wider community of natural supports (e.g. community groups, churches, social clubs, family and friends)

9.1 Artsenta: People accessing Artsenta engage in the creative arts and can be informally referred from needs assessors, inpatient services or by word-of-mouth. Artsenta promotes themselves through newsletters, attending and hosting NGO meetings and pamphlet drops to services and community spaces (e.g. Community House).

9.2 Tapestry Clubhouse: (No information.)

9.3 Family Works (Presbyterian Support Otago): People access Family Works for a variety of services, including an activity programme, vocational support (Youthgrow) budget management (Total Money Management) and adult community support. People would typically access these services from one to three years, possibly longer.

9.4 Pact 420: People access 420 for vocational services, activity, support and cultural groups (in conjunction with Pact’s Māori Miringa Whakaaro service).

9.5 Provider Arm Mental Health Day Programme: (No information.)

10 Support Groups and Individualised Support

10.1 Otago Mental Health Support Trust: People accessing OMHST receive peer support, consumer advocacy and education, often through fieldworkers providing services in the community. The offices are open Monday to Friday 10am-3pm; in crisis situations (psychotic episodes or aggressive behaviour) they refer consumers to EPS, community mental health teams or police. About 30 people a month access the OMHST.

10.2 Supporting Families: Four Supporting Families (SF) groups exist throughout the region: SF Otago (Dunedin-based), SF Central Otago (covering Central Otago and the Lakes District), SF Waitaki (Oamaru-based) and SF Southland. These groups support families who are affected by mental health and/or AoD related issues. People can be informally referred to SF through inpatient services (5), NGO services, or the wider community.

10.3 Corpac: People access Corpac for budgeting and financial management/support, usually for a period of three to six months, as a part of their range of support services.

10.4 Volunteering Otago: People can access Volunteering Otago’s mental health support service to gain supported volunteering experiences within a variety of workplaces.

11 Rural Services

Secondary mental health and addiction services are located in Waitaki, Central Otago (Clyde with outreach services in Ranfurly, Cromwell and Wanaka) and Clutha. These secondary services generally provide a wider range of services than their Dunedin-based counterpart to people with a wider range of severity of illness, due to the lack of other services (support/counselling services) in their location. People can self-refer but the majority of referrals come through GPs. Other services used concurrently with these teams are predominantly community-based support groups and natural supports, however NGO services are available as follows:
• Waitaki has NGO community support workers and a limited (and under-utilised) planned respite service (11.6); no supported accommodation services.
• Balclutha has NGO community support workers, a day activity centre and a 5-bed supported accommodation services, all provided by Pact (11.6); no respite services.
• Central Otago has no NGO community support workers, supported accommodation or respite services. There is a limited community support worker service through the Central Otago Mental Health Service (11.2)

11.1 Waitaki Community Mental Health Services: This community mental health service incorporates emergency, adult community mental health, CAFMHS and CADS teams. People typically access GPs, needs assessment services (Miramare (3)), NGO Community Support (Pact (11.6)) Supporting Families (10.2), as well as natural supports (friends and family/whānau) while accessing the community mental health service.

11.2 Central Otago Community Mental Health Services: Provides case management (including assessment, treatment and case coordination) emergency services and community support workers, who may work with the person in the community.

11.3 Clutha Community Mental Health Services: Provides case management and emergency services. Works closely with Pact’s Balclutha-based services (11.6), co-managing people in the community and from Pact’s Link day activity centre. This service also has occasional contact with addictions worker in Clutha. After discharge, people would have their case managed by their GP and practice nurse.

11.4 Miramare Needs Assessment services: Available in Waitaki and Clutha districts as above (3), accessing respite, home support, and community support services. Home support services available in Waitaki are Dunedin Home Support Services and Healthcare Otago and available in Clutha are Healthcare New Zealand, Home Support Services Otago and Presbyterian Care.

11.5 Oamaru Mental Health Support Centre: The service provides support, rehabilitation and day activities on weekdays. People access this service as and when desired, alongside any other secondary, community or natural support services.

11.6 Pact Rural Services: People can access Pact community support in Waitaki and in Clutha districts, supported accommodation in Balclutha and the Link, a day activity centre based in Balclutha. Pact’s Balclutha services work closely with Clutha community mental health services (11.3).

11.7 Salvation Army Bridge Programme: as described below (12.3)

12 Addiction Services

12.1 Community Alcohol and Drugs Services (CADS): People can access CADS through any means, including self- and family-referrals, GPs, other mental health and addiction services. People use the service for an average of around 18 months (other than opioid substitution treatment (OST) services, which is indefinite) and can use any other service for support such as Moana House (12.2), Quitline, Salvation Army’s Bridge Programme (12.3) and the Pain Clinic. When a coexisting mental health
problem is present the person is assigned to a CADS mental health nurse, clinical psychologist, or consultant psychiatrist as appropriate, and may also utilise the community mental health teams (2).

12.2 Moana House: Moana house provides 17 residential beds and 30 community support placements in Dunedin for people with serious addiction issues, often Māori, usually with co-existing mental illness, serious criminality and poor educational achievement. People can be accessing a variety of services including CADS (12.1), community mental health teams (2), 12-Step Fellowships and social supports such as WINZ and probation. People accessing Moana house services are typically not able to use other services due to their offending histories.

12.3 Salvation Army Bridge Programme: The Bridge Programme provides residential and day AoD treatment programmes throughout Otago (Dunedin, Balclutha, Alexandra and Oamaru). The service has open access, including self- and family-referred, the community mental health teams (2), CADS (12.1), courts, prisons and other NGOs. People can be accessing a variety of services while in the Bridge Programme including the above referring services, AA and NA, Salvation Army social work services (for housing placement and benefit issues), Women's Refuge and Miramare (3). The service also co-runs a regular family/whānau education session with CADS (12.1) and Moana House (12.2).

12.4 Ashburn Clinic: See (6.8)

13 Child and Youth Services

Children and young people generally access a package of services including any or all of the services below, as well as their GP, Youth Aid, Child Youth and Family Services (CYFS) (Youth Justice and/or Care and Protection), School/training providers, school counsellors, sexual health services and natural supports such as family/whānau, friends, youth groups and church. These young people are often case managed by Children Adolescent and Family Mental Health Services (CAFMHS) (13.2) if under 14 years old and Youth Specialty Services (YSS) (13.1) if between 14 and 20 years old. Young people accessing these services would typically have high and complex needs with suspected underlying mental illness and for several of the services will also have a moderate to severe alcohol and/or other drug addiction.

13.1 Youth Speciality Services (YSS): Young people (14-20 years old) access YSS generally through EPS (1), GP referral, courts, schools and NGO services for 6-12 months. Services include forensic staff, an addictions counsellor, an eating disorder team, a school liaison person and a day programme for youth not attending school. YSS has service collaborations with a range of youth services including Mirror Counselling (13.5), CBCT youth residential service (13.3), school counsellors, Christchurch Inpatient services, youth court and Child Youth and Family Services. After exiting YSS, young people would continue to access school counsellors, GPs and/or primary mental health services (4).

13.2 Children Adolescent and Family Mental Health Services (CAFMHS): Children (0-14 years old) and their family access these services for up to three years, in Dunedin and rurally in Clyde (Dunstan Hospital), Balclutha and Waitaki (as part of the rural community mental health services (12)). Typically referrals are received from GPs, CYFS, Plunket and schools. Families could be accessing a variety of services during and after receiving services from CAFMHS, including the referring agencies,
Family Works (9.3), Anglican Family Care, Miramare (3) for respite care and, if the parent is mentally unwell, adult mental health services (2)(5).

13.3 CBCT, Te Whakaruruhau Youth Residential Service: Te Whakaruruhau provides residential support for an average of three months to youth requiring this level of support. People would typically be referred by Child Youth and Family Services. After discharge, people would be supported through CBCT Child and Youth Community Support Service, accessed through a needs assessor (3).

13.4 Otago Youth Wellness Trust (OYWT): OYWT provides a wraparound service for young people (11-18 years old) who cannot engage with mainstream services and who often present with high and complex needs and/or addiction issues. OYWT receives referrals from anywhere, including self- and family-referred, CYFS, police and the courts. The focus of this wraparound service is to actively connect and support each person with an individualised package of services that best meet their needs, as described above.

13.5 Mirror Counselling: This service provides mental health and addiction counselling to children and adolescents for 8-12 weeks. Half of referrals to Mirror Counselling are self- or family-referred and the service is accessed as part of a package of services as described above.

13.6 Mirror Youth Day Programme: This service is available to young people with moderate to severe alcohol and other drug dependence who has high and complex needs. The service is provided in a modified therapeutic community model within a kaupapa Māori framework. People are typically referred to through other mental health or addiction services and have had involvement with Child Youth and Family Services (CYFS), police and/or youth court. This services is typically part of a package of services as described above.

13.7 Adventure development: Young people with moderate to severe alcohol and other drug dependence with coexisting mental illness/high and complex needs can access services including assessment, counselling, supervision and outdoor based therapy. This will be part of a package of services as described above.

13.8 CBCT Child and Youth Community Support: (No information.)

Family Mental Health Service: As described above (4.2).

Miramare: As described above (3).
Pathway Descriptions: Southland

1 Adult mental health services

1.1 Secondary mental health services: Secondary mental health services are provided in an integrated treatment model. Adult secondary mental health services include the full range of adult secondary mental health services including:

Inpatient, Community Mental Health Teams, Te Korowai Hou Ora, Southland Mental Health Emergency Team (SMHET), speciality services (forensic team, older person’s mental health, intellectual disability dual diagnosis, maternal mental health), Day Activity Centres, Consult Liaison with General Hospital, and Mental Health Needs Assessment services.

Services are provided in Invercargill, Wakatipu and Gore and are accessed either directly through SMHET or by way of referral to the Single Point of Entry (SPOE), which triages referrals into the range of services. Anyone can access the SPOE, including self- and family-referrals, where typical referrers would be GPs, primary mental health Brief Intervention Services {4.1}, NGO services and private counselling services. Also a variety of services would refer into the adult mental health specialty services, such as midwives referring to maternal mental health services and prisons or courts referring to forensic services (or drug and alcohol specialist services, detailed below {2.1}). Referrals within the adult mental health services are managed by way of Service Provision Frameworks (SPF) of each service. Inpatient and community mental health teams are integrated as one team, allowing streamlined transitions between these services.

1.2 Kakakura Needs Assessment: If people request a cultural needs assessment, Kakakura services are engaged to provide a kaupapa Māori needs assessment. Kakakura provides about one needs assessment per month, referring people through to NGO supported accommodation or community support (Pact {1.3} and Te Kotuku {1.4}), home support services (e.g. New Zealand Healthcare, Access Homehealth) and community groups such as the Disability Resource Centre.

1.3 Pact Southland Adult Services: People with moderate to severe mental illness can access supported accommodation, supportive landlord, planned respite and crisis respite services in Invercargill, and community support services throughout Southland (Invercargill, Gore, Queenstown, central and rural Southland). All referrals into or between services have required a formal needs assessment through a NASC team until recently, where referrals into community support are accepted from anywhere including self- and family-referrals and GP referrals. Crisis respite referrals come through SMHET. People come through and continue to access adult secondary mental health services {1}, particularly the community mental health teams. While utilising Pact’s adult services, people can access a range of services including day activity centres (run by adult secondary mental health services {1.1} and Inroads drop in centre (SF Southland {3.4}), smoking cessation through Nga Kete Matauranga Pounamu {2.2}, budget advice and other community natural supports.

1.4 Kakakura, Te Kotuku: People with moderate to severe mental illness can access Kaupapa Māori supported accommodation, planned respite and community support services through a formal needs assessment {1.1}{1.3}. People in these services also use day and community support services
such as secondary day programmes, Inroads drop-in centre (SF Southland [3.4]) and Bainfield Organic Gardens [1.6].

1.5 Bainfield Park Residential Care: Bainfield Park has three mental health beds that are typically home for life for mature people (60+ years old), who have come from the inpatient mental health ward [1.1] or medical wards. They are referred through a needs assessor, GP, social worker or family/whānau referral. They will be case managed by the community mental health team [1.1] and access day activity programmes [1.1].

1.6 Bainfield Organic Gardens: People with mental illness can access day activities and vocational support through this service through any referral pathway including self- and family-referred. People accessing these services are likely to also be accessing any of the other adult mental health services listed above.

1.7 Southern PHO Brief Intervention Services: As described above [Otago 4.1]

2 Addiction Services

2.1 Drug and Alcohol Specialist Services: The SPOE team refer into the Drug and Alcohol Specialist Services, which can be accessed by all of the above mentioned services, and provide Alcohol and Drug Assessment, Treatment and consultation Services, as well as Opioid Substitution Treatment. People accessing these services can also access adult mental health day services, Alcoholics and/or Narcotics Anonymous, Salvation Army Bridge Programme [4.2], their GP and NGO community support groups.

2.2 Nga Kete Matauranga Pounamu: People with alcohol and other drug addictions receive wraparound kaupapa Māori services including nursing, social work, AoD, problem gambling, smoking cessation and disability advocacy. People may or may not have a mental illness and can access services through any referral pathways including self- and family-referred and will access services for an average of 9-12 months.

2.3 Salvation Army Bridge Programme: See Otago services [12.3]

2.4 Gore Counselling Centre: People with alcohol and other drug addictions and/or mental illness receive counselling support (on average 6-12 sessions) and can access services through any referral pathways including self- and family-referred, also from the Department of Corrections. This is often done in the context of continuing to be managed by the community mental health teams, also possibly getting support from Pact [1.3], their GP, the Ministry of Justice, the Department of Corrections, Work and Income, Child Youth and Family Services.

3 Youth, Family and Cultural Services

3.1 Child, Adolescent and Family Services (CAFS): Young people can access CAFS through any means, including self- and family-referrals, GPs, Child Youth and Family Services (CYFS), schools and paediatricians. The young person is typically in the services for six to 12 months, during which time they can be accessing a variety of services including DHB-funded services such as Pact Youth South services [3.3], Adventure Development [3.4], SF Southland [3.5], Te Korowai Hou Ora and mental health needs assessment services [1.1], as well as non-DHB funded services including CYFS, Special
Education, Resource Teacher for Learning and Behaviour, also natural supports of friends and family/whānau.

3.2 Number 10 (Youth Health One Stop Shop): Young people with mild-to-moderate mental health issues typically first access services through Number 10, a youth one-stop-shop that provides a variety of health and social services, and use Number 10’s brief counselling service or get referred to Southern PHO’s Brief Intervention Services {Otago 4.1}. Adventure Development {3.4} also runs youth addiction services from Number 10.

3.3 Pact Youth South: Young people throughout Southland can access residential services (Invercargill-based), community support, day activities and family/whānau support through Pact Youth South services. Services are accessed and level of support is changed through CAFS {3.1}. Residential services have typically been used with a strong respite focus, so young people will have several short-stay visits over a period of weeks. While accessing services, young people are also supported by a range of support services including schools, Family Works {Otago 9.3}, Strengthening Families, Group Special Education, and Riding for the Disabled.

3.4 Adventure Development: See Otago services {13.7}

3.5 SF Southland: See Otago services {10.2}. Also provides InRoads drop-in centre.

3.6 Pacific Island Advisory and Cultural Trust: This trust provides a range of health and social services for people of Pacific Island descent. Typically the people supported have moderate to severe mental illness and have been involved with the criminal justice system. Support from the trust comes formally through a free health clinic and informally through supports from elders in the community.

4 Rural Services

Services available in rural Southland, included in the service descriptions above, include the following:

- Southern PHO Brief Intervention Services (Wakatipu) {Otago 4.1}
- Adult Mental Health Services (Wakatipu and Gore) {1.1}
- Drug and Alcohol Specialist Service (Wakatipu) {2.1}
- Child, Adolescent and Family Services (Wakatipu and Gore) {3.1}
- Salvation Army Bridge Programme (Southland) {Otago 12.3}
- Gore Counselling Centre (Gore) {2.4}
- Nga Kete Matauranga Pounamu (Southland and Wakatipu) {2.2}
- Adventure Development (Southland wide) {3.4}
- SF Southland (Southland wide) {3.5}
Barriers and Bottlenecks

Several themes emerged when services and service advisors were asked to describe perceived barriers and bottlenecks in the mental health and addiction system. These include systematic barriers to entry and exit of the mental health system, cost of accessing services through a GP, stigma, lack of knowledge-sharing, lack of effective discharge/transition planning and lack of availability of early intervention support.

“It’s hard to get in…”

For emergency crisis entry into secondary services there appears to be little or no barriers to entry; through effective triaging at emergency services (EPS, and SMHET), people in crisis can typically access timely and appropriate care at emergency services and into inpatient services. In this case the typical pathway would be to present at emergency services, be admitted to the inpatient wards for a short period of time, then be referred into a community mental health team, being discharged once appropriate.

The main barriers to entry into secondary services are when a person is not in crisis but requiring support services. In this situation, presentation at emergency services may result in significant delays or in being turned away without further support. Likewise, delays in processing referrals into secondary services (community mental health teams in Otago and Single Point of Entry in Southland) have been identified as a barrier to support. This can be to the detriment of the person, who may become significantly worse in their illness and need to access more intensive (and expensive) services (this has been identified as a “not-uncommon” situation). Access into secondary services has hence been characterised as needing to “create a crisis” in order to access services.

Barriers to service at entry have been identified as a double-pronged barrier, namely that primary services deal with the milder end of the mild-to-moderate spectrum and secondary services deal with the more severe end of the moderate-to-severe spectrum. As such the middle of the spectrum falls into a gap: when trying to access primary services they are referred onto secondary community or inpatient mental health teams; when referred onto these teams (or self-referring through emergency services) they are not severe enough to access these services. The identified exception to this is in Otago the Family Mental Health Service, who specialises in these people (see Otago service description {4.2} above). When attempting to access secondary services via a GP referral in Otago, GPs have noted that referred people often do not meet entry criteria to secondary services and are often not even seen to be assessed. Similarly, people have experienced having their referral “pinballed” around secondary services, each not accepting the referral based upon restrictive entry criteria and referring to the next, to the detriment of the person’s mental health.
Secondly, accessing primary services is inhibited by having to pay for GP visits to then access primary mental health services. This means people tend to delay access, increasing severity of the illness meaning that treatment at this level will be less effective. At transition from secondary (inpatient or community) services, this means reluctance to be discharged back to primary care due to increased cost to the person. In the past this GP cost has been offset by a Work and Income subsidy which was poorly administrated and ineffective, though a more sophisticated subsidy scheme has been suggested as a possible solution to this barrier.

“...and even harder to leave”

A common perception is that people are regularly maintained within a service well after they are ready to move on; a reticence to move people out of one’s own service and into another (typically less intensive) service, increasing/maxing out caseloads and ‘clogging up’ the system. This can occur at any point in people’s pathways, including secondary inpatient wards, community mental health teams, NGO supported accommodation and NGO community support. This has been characterised in several ways:

- People not wanting to lose their clinical case management due to the free clinical support they receive, otherwise having to pay for GP visits to access clinical support;
- Services not wanting to discharge a person “just in case something happens.” This is seen as a paternalistic approach by services, not empowering the person or enhancing their resilience;
- Secondary services not wanting to discharge a person so as to observe medication compliance or effects of a medication change (and not accessing the appropriate NGO support to do so);
- Secondary services maintaining dischargeable people on their caseload to maintain caseload numbers or maintaining people who are ‘easy to manage’; a reluctance to discharge from community mental health teams to GP care due to perceived lack of GP competence;
- People being on a community treatment order (CTO) hence requiring secondary services; unwillingness to revise CTO status. Use or threat of use of CTO to maintain people in services (overuse of CTO to keep people in service);
- NGO services maintaining people who are ‘easy to manage’ or well known, instead of discharging and making space for more difficult or lesser known people to access the service; NGO services ‘cherry picking’ easily-maintained people and leaving the more difficult people on waiting lists;
- Secondary services not utilising the broad range of NGO/community services available for people to be supported; instead relying on better-known services, specifically supported accommodation, and not discharging people due to perceived lack of these services;
- Internal needs assessment services not being engaged early enough or effectively enough to facilitate discharge from community mental health teams.
Conversely, difficulty has been noted in trying to exit people from services and this being inhibited by:

- Less-intensive support systems (GPs, Primary mental health or NGOs) being reticent to take over care due to the person’s perceived risk or difficult behaviour;
- The person or their family/whānau being anxious about discharging.

**Stigma**

Stigma of having a mental illness and of accessing mental health services has been identified by several services and by people accessing services. This has been characterised not only as societal stigma embodied in the person with a mental illness, but as systematically entrenched stigma held in place by services and people who run and work in these services, including taking a paternalistic attitude to people requiring services; once a person is in the system they can get treated as a part of the system (a set of symptoms, a diagnosis, a statistic) rather than empowered as an individual. This has been identified as a strong barrier to people accessing services in the first place, then a barrier to recovery once a person is in the system and a barrier to exit once a person is ready to leave services but kept on “just in case”.

**Philosophical difference in secondary and NGO/community models of care**

Secondary services are characterised as ‘psychiatric’ services, where NGO and community services are characterised as ‘mental health’ services. Where psychiatric (medicalised) services tend only to engage at the point when a person is unwell enough to require psychiatric intervention, mental health (holistic) services engage earlier and for longer, at a less intensive level, to keep a person well. This was demonstrated in much of the feedback as a point of contention, for example:

- In Southland youth services, CAFS discharges people from their service once their clinical treatment options have been exhausted, where NGO supports attempt to provide ongoing support for the person with their enduring mental illness. As CAFS is effectively the ‘gatekeeper’ for access to NGO support, once a young person is discharged from CAFS they must be exited from NGO support within six months, hence their support under the NGO’s mental health model of care is limited to the timeframes of the secondary service’s psychiatric model of care;
- Community mental health teams and sub-acute inpatient wards anecdotally have entry levels of a psychiatric model of care (with high entry thresholds) however their ongoing low-level care is then provided from a ‘mental health’ model of care, preventing a timely discharge into NGO and community services and perpetuating people’s “hard to get into, and even harder to leave” experiences secondary services.

**Lack of services / Lack of knowledge of services / Lack of knowledge-sharing**

In pathways to mental health support, lack of various services or limited capacity has been identified as a barrier to moving through services. On compiling feedback across the sector however, it has been difficult to ascertain whether there is an actual lack of service in this area or whether it is due to lack of knowledge about different services, brought about by lack of knowledge-sharing of available services and possible alternatives. For example, feedback from several inpatient services
have identified lack of supported accommodation as a barrier to people’s progress through pathways but NGO/community providers do not identify this as a barrier, rather that alternative services such as community support are under-utilised and less intensive options, such as comprehensive community support or supportive landlord services, are minimal or not available.

Several services, service advisors and consumers identified that community mental health teams and other specialist services did not inform people about (or refer into) the broad range of supports and services available in the community. Also ‘siloing’ of services was identified as a problem, where needs assessment teams only utilised a subset of available services when referring, depending on personal preference or knowledge.

Lack of appropriate services was noted in two areas:

- No inpatient mental health or addiction services for youth in Southland; Under 16s are typically admitted to the paediatric wards and 16-18 year olds are typically admitted to the adult mental health ward or sent to specialist youth wards in Christchurch away from all natural supports. (This is potentially a case of Lack of knowledge of services, where two regional inpatient youth beds in Dunedin could fill this gap.)
- No NGO community support, respite or residential services in Central Otago. Suggestions included devolving the community support worker roles from Central Otago Mental Health Services to part-fund broader NGO community support, residential and respite services. Also no available respite services in Clutha.

**Lack of effective discharge and transition planning**

Lack of effective discharge and transition planning has been identified as a cause both for unnecessarily high caseload levels and for people’s (and families’) anxieties when being discharged from services. Robust discharge planning would:

- empower people to focus on their envisioned wellness rather than their present illness, and to prepare them for their “life after services” from their time of entry;
- allow mental health services to focus upon the end-goal of a person’s engagement in their service and to manage caseloads with this focus.

**Lack of early intervention services and utilisation of natural supports**

A commonly identified barrier to maintaining wellness was a lack of early intervention identification and support, and services not effectively recognising and utilising natural supports. Primary mental health services noted a distinct lack of appropriate responses to people with moderate mental illness, who were too unwell to benefit from short-term brief intervention services but were not unwell enough to access the community mental health teams or inpatient services. Youth services also noted that mild to moderate mental illness in youth is often dismissed as behavioural, that conduct disorder is not addressed at its early stages due to restrictive entry criteria and that early addiction behaviour is seen as ‘normal’ for youth; these approaches dismiss early signs of illness and miss opportunities for early intervention. This regularly results in the person experiencing deeper illness and using more intensive and expensive services further down the line.
Lack of integration between mental health services and addiction services

Several sources have identified the inability of mental health services to effectively identify and manage (let alone address) addiction issues, especially when it comes to using alcohol and other drugs to self-medicate for mental illness. Conversely, the addictiveness of prescribed drugs for mental illness is not actively addressed in either service stream. Often people are excluded from mental health services (particularly community-based services) if their addiction issues overshadow their use of services, and addiction services do not address addiction concerns of people who are inpatients in the mental health services. Treatment plans for people who are accessing both streams of services are typically mutually exclusive.

Further comments from the sector

What works well

When asked to feed back on what currently works well in the mental health and addiction services, the overwhelming majority of responses indicated positive relationships between individuals in the services. This could be through formal multi-agency meetings, formal referral pathways or memoranda of understanding/service level agreements, or informal relationships that “oil the cogs of the system.” Other points included:

- Services that had triage systems in place often commented that they worked well, enabling people to access services effectively.
- In Southland the Single Point of Entry was identified as having reduced the need of duplicative referral processes.
- When there was a high degree of collaboration between and awareness of available services, this was noted as a positive working culture, however these comments were heavily outweighed by networks that did not have this quality.
- The primary mental health service that has the capability to assess and treat people with moderate mental illness, co-manage caseloads with secondary services and refer into a broad range of community services.
- Services that incorporate discharge planning at entry find this a clear way of focussing people on achieving their goals to exit and to manage caseloads.

Some suggestions for improvement

1. Greater knowledge of support service, pathways between services and knowledge-sharing from services to people using services
2. Clear discharge planning and caseload oversight in order to discharge well people to primary case management in order to ‘unclog’ system
3. Increased primary/community-based capacity for people with moderate illness
4. Utilise the broad range of services post-inpatient services
5. Increase clinical capacity in the NGO sector
6. Devolve sub-acute inpatient services into NGO sector
7. Utilise new referral pathways (GPs, self- and family-referrals) into NGO community support
8. Form a single, independent needs assessment and service coordination (NASC) service to coordinate services and actively monitor discharge planning, service use and caseloads
9. Promote and utilise the contracted 0.2FTE psychiatric primary consult liaison service in Otago, currently not accessible, in order to strengthen GPs

10. Devolve the community support worker roles from Central Otago Mental Health Services to part-fund a NGO service providing community support, residential and respite services

11. Empower GPs to case-manage people who are relatively well; educate mental health services about ability for GPs to case-manage; build relationships between community mental health teams and GP practices

12. Maintain a single personal plan for each person, accessed and maintained by the multiple services treating and supporting the person; enhance communication and team-coordination functions of ‘case managers’ to facilitate shared care across support services
Appendix 1: Copy of ‘Pathways to Support’ Survey

1. Please provide the following details:

   Name of Organisation: Click here to enter name of organisation
   Name of Service: Click here to enter name of service
   Type of Support/Service Provided: Click here to enter type of service/support
   Personal Name: Click here to enter your name
   Position in Organisation: Click here to enter your position
   Email Address: Click here to enter your email address
   Phone Number: Click here to enter your phone number
   Size of service (number of people typically accessing your service at any one time): Click here to enter the size of your service
   Service Location(s): Click here to enter your service location(s)

2. Please think of a hypothetical person who is reasonably representative of most of the people who access your service. Write a profile that describes this ‘hypothetical person’ in a paragraph below, and then answer the following questions based on this ‘hypothetical person’.

   For example: “The hypothetical person who uses this service is a child who lives in Invercargill, who has a suspected moderate to severe emotional disorder, and has multiple support needs. The service is offered to the child in their context of their family/whānau.”

   Click here to answer

3. Immediately prior to accessing your service, what other services would this person likely be using?

   Click here to answer
4. How would this person first access your service?

- Needs assessor: Click here to list Needs Assessor(s)
- Other mental health or addiction service: Click here to list other service(s)
- Police
- Emergency Psychiatric Services/DAO (e.g. EPS, SMHET)
- GP
- Courts
- Self-referral
- Family/whānau referral
- Other: Click here to define answer

Please comment: Click here to answer

5. Is this person likely to be under the Mental Health Act?

Choose an item

6. What information comes with this person?

Click here to answer

7. How long would this person use your service for?

Click here to answer

8. If you have more than one service in your organisation, how would this person move between the services (e.g. acute to rehabilitation, residential to community support, one programme to another)?

- Informally
- Formally, through a referral process within the organisation
- Formally, through a referral process external to the organisation
- Formally, dependant on legal status change
- Other: Click here to define answer
- Not applicable (there is only one service in our organisation)

Please explain: Click here to answer

9. While utilising your service, which other services/supports does this person typically use (including other mental health and addiction services, other social and community services, informal supports from family/whānau/friends)?

Click here to answer
10. What process normally takes place when this person leaves your service?

☐ Planned exit once service is complete
☐ Person stops engaging with service
☐ Service's time limit reached
☐ Internal assessment identifies person no longer needs the service
☐ Multi-agency team identifies person no longer needs the service
☐ External case manager identifies person no longer needs the service
☐ Needs assessor identifies person no longer needs the service
☐ Other Click here to define answer

Please explain:  Click here to answer

11. Immediately after exiting your service, which other services would this person use?

Click here to answer

12. What information typically goes with this person when they exit your service?

Click here to answer

13. If this person required services but did not want to use your service, what alternative service(s) can they use? What would you do to facilitate this?

Click here to answer

14. If this person gave feedback about difficulties entering, using or exiting your service, how would this feedback be identified and followed-up?

Click here to answer

15. What barriers and bottlenecks external to your service can people face when they enter, use or exit your service?

Click here to answer

16. What barriers and bottlenecks within your service can people face when they enter, use or exit your service?

Click here to answer

17. What systems or services are currently in place that work well to support people to enter, use and exit your service?
18. What systems or services are not currently in place that might lead to better outcomes for people who access your service?

The following questions may have been answered earlier depending on how your service has identified the ‘hypothetical person’ who accesses your services/support. If this is the case, please write “N/A”.

19. How does a person who is Māori typically access and use your services? What would be different to the earlier ‘hypothetical’ person? Also, how does your service identify people’s cultural identity?

20. How does a person who is deaf typically access and use your services? What would be different to the earlier ‘hypothetical’ person?

21. How does a person who has co-existing mental health and addiction needs typically access and use your services? What would be different to the earlier ‘hypothetical’ person?

22. How does a person who does not speak English typically access and use your services? What would be different to the earlier ‘hypothetical’ person?

Thank you very much for completing this questionnaire. Please return this completed questionnaire to Steve Catty at mhapp@xtra.co.nz.