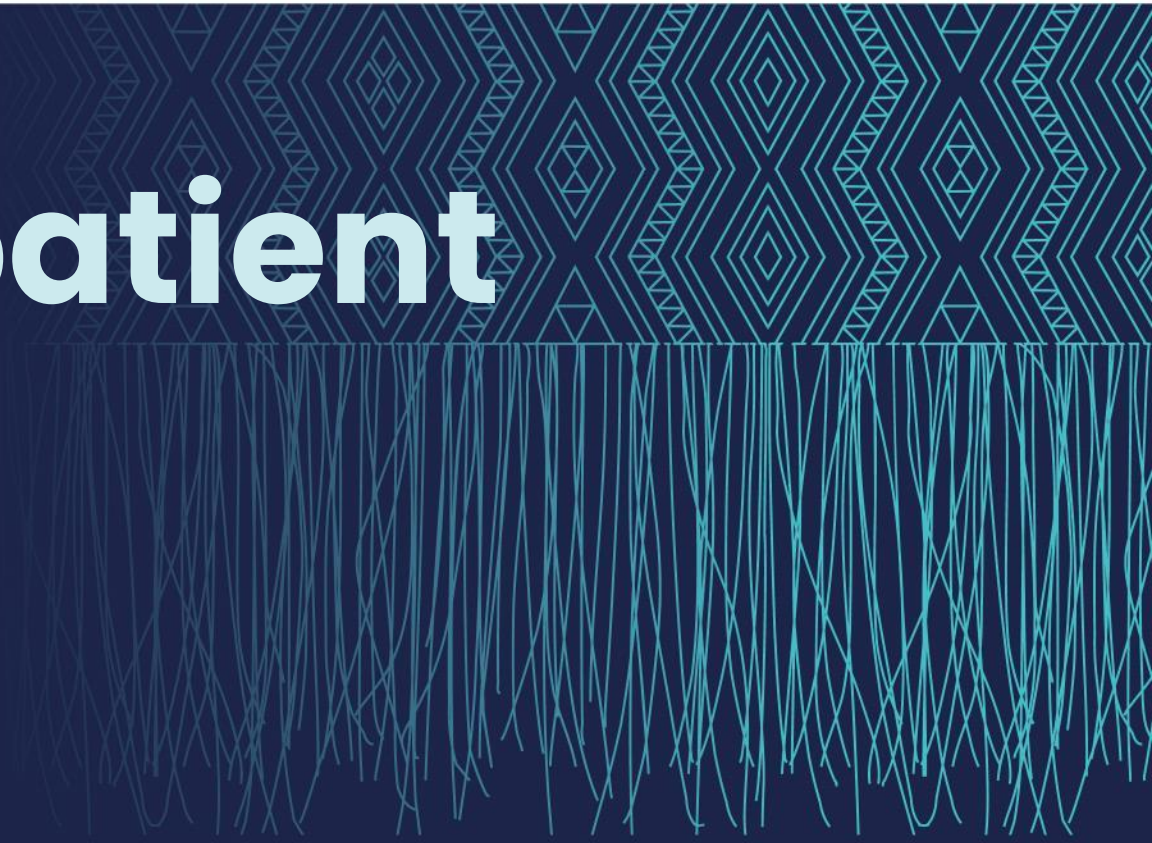
Te Whatu Ora
Health New Zealand

Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addiction and
Intellectual Disability Service

Adult acute inpatient model of care

November 2022



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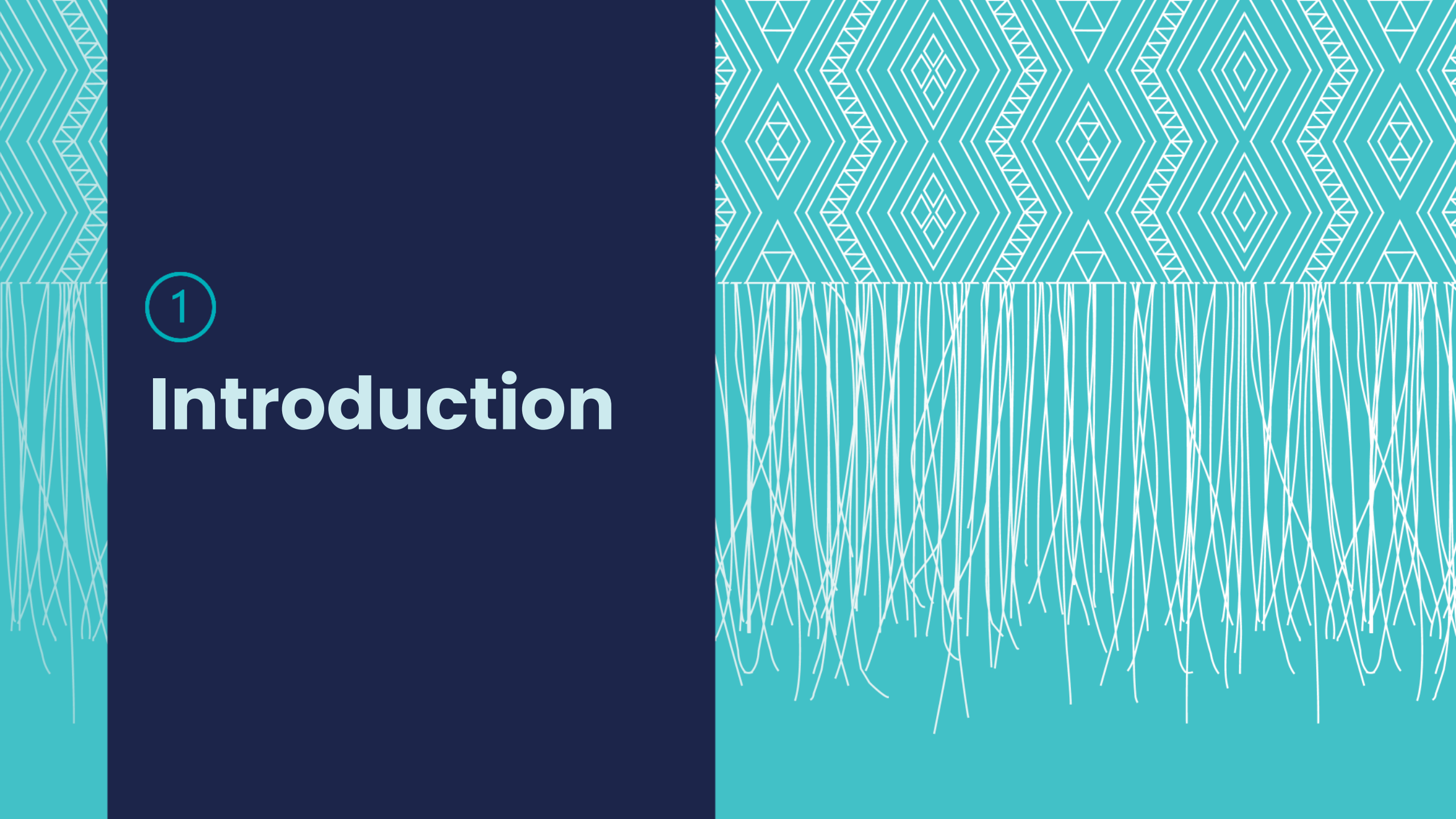
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Introduction

Introduction

We have embarked on a project to build a new facility at Hutt Hospital, one of two units that support the adult acute inpatient service for the Capital, Coast, Hutt Valley and Wairarapa population.

The facility will respond to the needs of those that cannot be adequately treated in a community-based setting by providing 24-hour mental health assessment and treatment services for adults who are experiencing serious mental health concerns. The new facility will form part of an integrated care pathway for tāngata whaiora who require care and treatment as a result of their mental illness.

This document is intended to provide a high-level model of care that will inform facility design – a 'living document' that can be revisited as the thinking evolves and we work with our partners to refine our approach. We have a new opportunity to work with Te Aka Whai Ora and the Iwi Māori Partnership Board as these structures are embedded.

The term 'tāngata whaiora' will be used to describe people using mental health services.

Model of care

A model of care is a multifaceted concept that broadly defines the way health services are delivered. It describes how services deliver best practice care by applying a set of principles across identified clinical streams and supporting pathways through care for people who access services. The model of care is the foundation that guides what we do and how we practice.

Developing the model of care

The acute inpatient model of care seeks to:

- develop a contemporary acute model of care to inform facility design
- enable service improvements in preparation for the new facility
- engage with a wide range of stakeholders in the planning and design
- inform a design that enables flexible use of space to support enhanced therapeutic opportunities and less restrictive practices
- improve health and wellbeing outcomes through a therapeutic environment that recognises and supports cultural identity.

This model of care was developed with support from Sapere Research Group and input from stakeholders gained in three hui held in August and September 2022.

1. Workshop one: vision, values, principles.
2. Workshop two: world café workshop exploring five key themes that emerged from workshop one.
3. Workshop three: consumer journey mapping.

In total over 60 people participated across the model of care hui.

The hui were supplemented by a series of interviews with key informants to further explore thinking around components of care and development needs.

Document format

This document is structured into three main sections.

Context

Strategic alignment, research and innovation, about the service and the wider change programme.

Our future model of care

- Purpose and values
- Principles of care
- Inpatient pathway
- Workforce.

Enablers and change

Digital enablement, workforce development and change programme.

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Context

CONTEXT

National and local strategies

This section provides an overview of relevant national and local strategies that provide important strategic context for the adult acute inpatient model of care.

He Ara Oranga Government Inquiry into Mental Health and Addiction[1]

The purpose of the Inquiry was to identify unmet needs and develop recommendations for a better mental health and addiction system in New Zealand. The Inquiry aimed to set a clear direction for the next five to ten years that Government, the mental health and addiction sectors and the whole community can use to make it happen.

Repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992[2]

He Ara Oranga recommended the repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.

Government accepted the recommendation and since 2019 has been working on immediate, short-term improvements under the current legislation, alongside work to understand what issues need to be addressed in creating new mental health legislation.

Mental Health and Wellbeing Commission[3]

The establishment of Te Hiringa Mahara was recommended by He Ara Oranga to contribute to better and equitable mental health and wellbeing outcomes.

Kia Manawanui Aotearoa – long-term pathway to mental wellbeing[4]

Kia Manawanui Aotearoa – long-term pathway to mental wellbeing is the Government's high-level plan for transformation over the long term. Kia Manawanui sets out five interconnected focus areas across a continuum of mental wellbeing. While a stronger focus on promotion and prevention will have long-term benefits, Kia Manawanui identifies the need to design, resource and support our specialist services adequately so that they can effectively contribute to the pae ora of those with the highest needs.

Te Pae Tata – interim New Zealand health plan[5]

The Interim New Zealand Health Plan notes that a specialist service network will drive improvements in quality of care, access to care, patient experience and equity of outcomes for specialist mental health services, supported by the National Mental Health System and Services Framework. It also prioritises progressing the facility builds that have been approved.

Te Pou[6]

Te Pou Is a national workforce centre for mental health, addiction and disability in New Zealand. It aims to improve the lives of people with mental health, addiction and disability needs by connecting the people working with them, tāngata whaiora, tāngata whaikaha and their whānau, with knowledge, resources, training, and information. Te Pou supports the national mental health Key Performance Indicators.

Mental health and addiction quality improvement programme[7]

Five priority areas identified by the mental health and addiction sector were included in the Health Quality and Safety Commission mental health and addiction quality improvement programme during 2017–2020.

1. Zero seclusion: safety and dignity for all.
2. Connecting care: improving service transitions.
3. Learning from adverse events and consumer, family and whānau experience.
4. Maximising physical health.
5. Improving medication management and prescribing.

CONTEXT

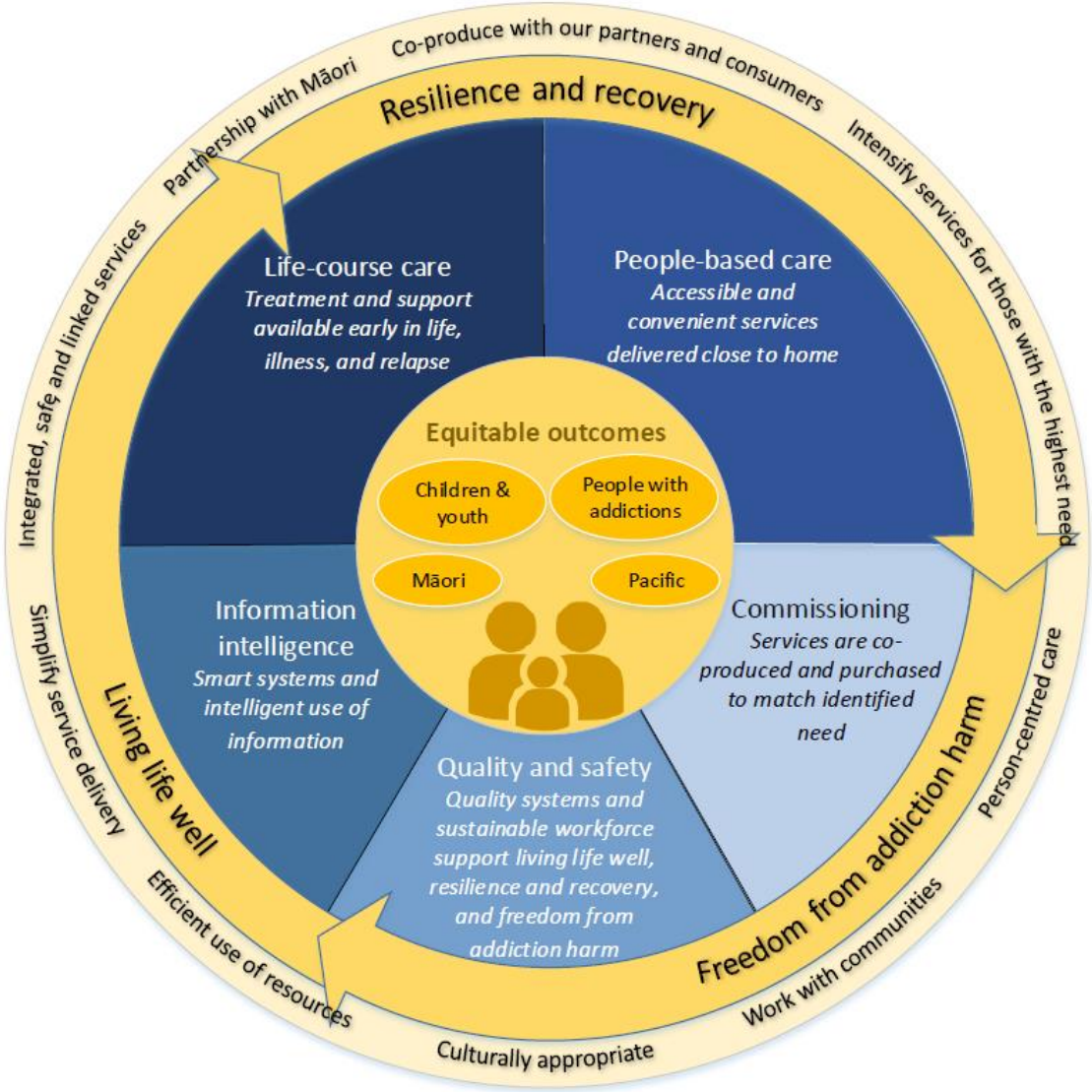
National and local strategies

Living Life Well: A strategy for mental health and addiction 2019–2025[8]

Living Life Well is a strategic plan that describes how the (former) three DHBs plan to transform mental health and addiction services between 2019 and 2025 to improve the mental health and wellbeing of all people across the Wairarapa, Hutt Valley, and Capital & Coast regions. The plan provides guidance on what is required to meet the future needs and how to make the changes required. It brings together the strategic aims of the three DHBs, building on previous work, such as The Journey Forward 2005–2011 (Capital & Coast DHB), Whakamahingia (Hutt Valley DHB), and To Be Heard (Wairarapa DHB), into a single document for health and MHA services.

The strategy aligns the needs of people using mental health and addiction services with their whānau, the communities they live in, and the services and groups that respond to their needs. It is based on a people-centred approach in which individuals, whānau and communities are served by, and able to participate in, trusted health services that respond to their needs in humane and holistic ways. The strategy has a focus on people's needs and enables individuals, whānau and communities to collaborate with health practitioners, health care service providers, and cultural specialists.

The diagram summarises the Living Life Well strategy, placing equitable outcomes for all at the centre and outlining the two strategic directions of Life-Course Care and People-Based Care, along with the three enabling directions related to Information Intelligence, Quality and Safety, and Commissioning.



CONTEXT

Māori leadership in the reformed health system

In the reformed health system, iwi, mana whenua and Māori communities will help guide the system and its partners to deliver services and solutions to meet community needs and aspirations. Iwi Māori Partnership Boards will be the Te Tiriti o Waitangi partner for the health system to bring whānau Māori voices into service planning for their area. They will be supported by Te Aka Whai Ora to undertake their functions.

Te Tiriti o Waitangi

We recognise that Māori experience unfair and avoidable inequities in terms of mental wellbeing. Te Whatu Ora Capital, Coast and Hutt and Te Whatu Ora Wairarapa are committed to upholding the principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal. The Waitangi Tribunal's 2019 Hauora report recommends a series of principles that have been adopted by Whakamaua: Māori Health Action Plan 2020-2025.[4] We will work to uphold these principles through:

- supporting tino rangatiratanga and recognising Māori self-determination
- improving equity for Māori and all people through more holistic approaches to create an inclusive and equitable service
- active protection. Acting to achieve equitable health outcomes for Māori and actively protecting mātauranga Māori
- options. Ensuring the service is provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models
- working in partnership with Māori.

Equity as a key priority

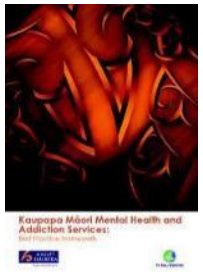
He Ara Oranga[1] found inequities in mental wellbeing were evident for Māori, Pacific peoples and other groups including disabled people, rainbow communities, rural communities, young people and older people.

During the Mental Health and Addiction Inquiry,[1] whānau who are admitted to acute mental health services spoke in their submissions about being further traumatised and adversely affected by the system itself.

- Māori are disproportionately represented in secondary mental health services and inpatient units.
- Māori in Capital & Coast and Hutt Valley were significantly more likely than non-Māori to be subject to a compulsory inpatient treatment order (Office of the Director of Mental Health and Addiction Services, 2022).
- Nationally, Māori were more likely than non-Māori to have been secluded, have more seclusion events and longer periods of seclusion on average (Office of the Director of Mental Health and Addiction Services, 2022).

Our inpatient model of care will be guided by strategic documents aiming to achieve equity including national and local Māori, Pacific and disability strategies/plans, and kaupapa Māori best practice frameworks.

> In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.



CONTEXT

Emerging innovation and research

The model of care for the adult acute inpatient service will be influenced by innovation, and current and future trends emerging in technology, equipment, systems and processes. Our model of care will be dynamic and able to respond to changes that inform contemporary best practice. As evidence emerges, the service will be open to new therapies and the environment will be flexible and able to support changing needs.

This section highlights some emerging evidence. A formal literature review has not been undertaken.

Kaupapa Māori models of psychological therapy provide a different perspective of wellbeing from a Western perspective. This affects the clinical care of Māori with mental illnesses. Treatments based around a Māori worldview are more suited to Māori.

Trauma-informed approach is about understanding what has happened to a person and their whānau, rather than focusing on what is wrong with a person. A trauma-informed approach recognises and understands that trauma can negatively affect whānau, groups, organisations and communities, as well as individuals.

Sensory modulation (Whakaāio ā-rongo) is a tool that supports trauma-informed approaches and reduction of restrictive practices. Sensory modulation involves supporting and guiding people in using senses such as sight, sound, smell, touch, taste and movement to self-manage and change emotional state. Examples of tools are music, essential oils, rocking chairs, weighted items and massage chairs. The use of sensory tools supports individuals to learn self-soothing techniques and change their current emotional and behavioural responses to a stressful situation.

Zero seclusion and least restrictive care. Seclusion and restraint are traumatising experiences for people receiving mental health care. Reducing and working to eliminate seclusion and restraint has been a primary action in Mental Health and Addiction Services in New Zealand. Te Pou, with support from the Ministry of Health, has developed a range of evidence-based tools to support inpatient services to reduce seclusion and restraint.

Safewards model[10] is an evidence-based model developed in the UK to improve safety for service users, staff and others in inpatient mental health services. The model includes the theory of conflict and containment and ten interventions focused on improving staff and service user relationships and reducing situations that lead to conflict and restrictive practices. Research indicates that implementation of Safewards can lead to reduced rates of assault, conflict, seclusion and restraint.

Safewards complements SPEC training and the sensory modulation work currently underway in MHAIDS and would assist the service in its journey towards zero seclusion.

Other trends include increased capacity and capability for community-based crisis response and acute care management; increased service continuity and collaboration between inpatient, specialist community and primary care; increased integration of mental health services with physical health services.

Digital trends include transition to electronic health records; use of decision support tools and enhanced IT support for consumer and general practitioner communication and improvements to referral; assessment processes supported by centralised co-ordination of referrals, improvements in scheduling systems, and electronic health records.

Environment and facility design although under-researched, there is a relationship between facility design and outcomes which form an important component of a model of care. Facilities must be flexible enough to change use and functionality over time. Some design specifics include promoting autonomy and choice to provide privacy and support safety.

CONTEXT

About the service

The Mental Health, Addiction and Intellectual Disability Service provides secondary services across Wellington, Porirua, Kāpiti, the Hutt Valley and Wairarapa, as well as some central region and national services.

MHAIDS services include a number of inpatient units – acute units for both adults and young people, long-term rehabilitation, older persons, intellectual disability and forensic – as well as needs assessment and service coordination, crisis response and a range of community services to meet the needs of tāngata whaiora.

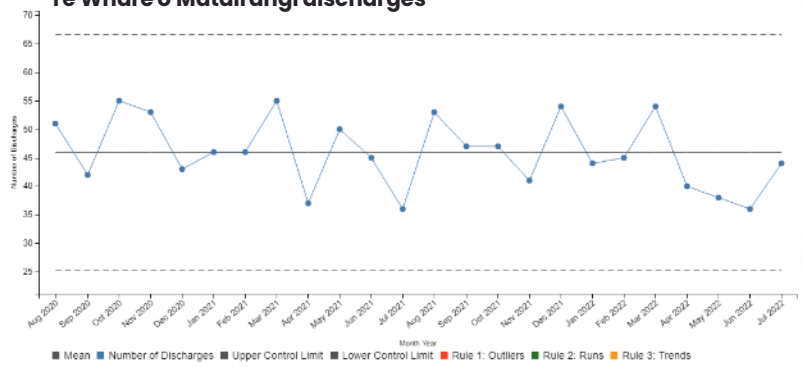
Te Whare Ahuru Acute Inpatient Unit (24 beds) and Te Whare o Matairangi Inpatient Unit (29 beds) provide 24-hour mental health assessment and treatment service for adults aged from 18 upwards who are experiencing serious mental health concerns.

The focus is on recovery and returning people to their usual life with community support if needed. We aim to provide the best possible clinical care in a respectful, supportive, safe and caring environment.

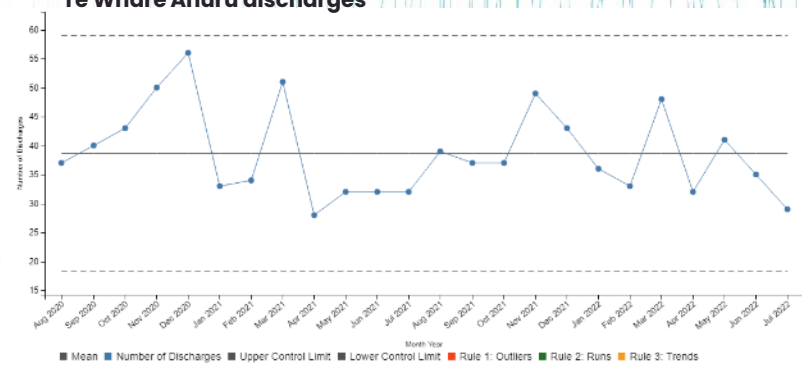
Inpatient snapshot

- On average (August 2020 to July 2022) Te Whare Ahuru had around 39 discharges per month, and Te Whare o Matairangi had around 46 discharges.
- Te Whare o Matairangi has been operating at over 100% occupancy (excluding people on leave).
- Almost one-third of acute inpatient admissions were Māori tāngata whaiora.
- Average length of stay was just over 20 days in Te Whare o Matairangi (with a median of 15 days).
- Average length of stay was just over 18 days in Te Whare Ahuru (with a median of 13 days).

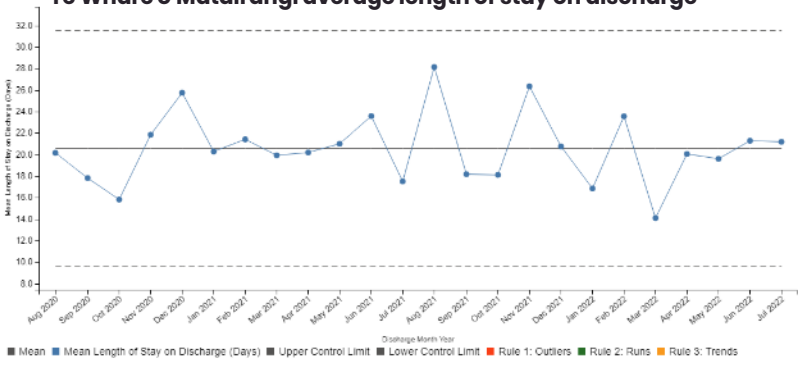
Te Whare o Matairangi discharges



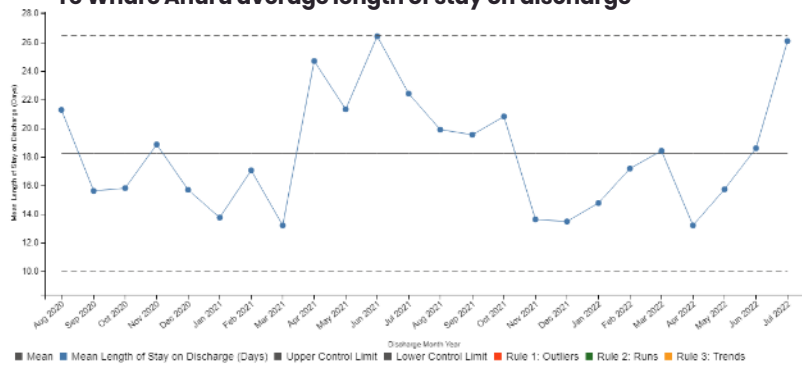
Te Whare Ahuru discharges



Te Whare o Matairangi average length of stay on discharge



Te Whare Ahuru average length of stay on discharge



CONTEXT

Future inpatient bed demand

MHAIDS has a low provision of adult acute inpatient beds per capita (16.3 beds per 100,000 adults aged 20-64 years) compared to the national rate (21.7 beds per 100,000 adults aged 20-64 years).

Te Whatu Ora Capital, Coast and Hutt has completed bed modelling to determine the number of adult acute inpatient beds required into the future. Modelling was broken down by general acute beds and intensive psychiatric care (IPC) beds.

Bed modelling suggests the need for around 63 beds across the two adult acute units by 2031

The bed model uses admission rates and length of stay (specific to different age groups) in a base year and projects bed nights forward based on expected demographic growth.

2018 is used as the base year as it is considered to provide the most recent view of the system when care delivery was stable.

People admitted to/discharged from general hospital wards under an acute mental health specialty were included, to capture overflow into other parts of the hospital.

Converting bed nights to number of beds required allows for the inpatient units to operate at 85% of total capacity on average. This benchmark is widely accepted as appropriate to maintain safety and enable flow and is recommended by the Royal College of Psychiatrists.

	At 85% target occupancy			At 90% target occupancy		
Beds required by	Acute beds	IPC beds	Total	Acute beds	IPC beds	Total
2021	36	24	60	34	23	57
2026	37	25	62	35	24	59
2031	37	26	63	35	24	59
2036	37	26	63	35	24	59
2041	39	26	65	37	24	61

3

Our future model of care

OUR INPATIENT MODEL OF CARE

What we are trying to achieve

Values

Participants in the purpose, values and principles workshop agreed that the existing organisational values were relevant to the acute inpatient service.

Manaakitanga – respect, caring, kindness, mana enhancing.

Kotahitanga – connection, unity, equity.

Rangatiratanga – autonomy, integrity, excellence.

Other values expressed:

Whanaungatanga (relationships), partnership (helping people succeed), pono (truth), tika (the right way to do things), hope, hauora (wellbeing).

Attitudes

Compassion, genuine, honest, open-minded, optimistic, client-focused, positive regard, collaborative, responsive, inclusive.

Acute inpatient care is one (short-term) component of a complete service continuum. This is underpinned by an integrated whole system approach where the relationship between the components of the continuum of care pathway is as important as the individual components. Where possible we work with respite and other community-based services to prevent admission to hospital.

The purpose of the acute inpatient service is to:

- provide an accessible, safe and therapeutic environment with 24-hour care for acutely unwell tāngata whaiora who cannot be supported clinically in the community
- provide increased support and intensive, specialist clinical treatment for acutely unwell tāngata whaiora (beyond what can be provided in the community) to recover (re-establish wellbeing/hauora)
- provide a service that reflects Te Ao Māori values and perspectives
- allow connections to the outside (e.g. whānau, community) to continue to support recovery
- support tāngata whaiora to reach their admission goals as quickly as possible
- facilitate transition out of acute care and back to the community, at the appropriate time, to continue their recovery journey at home.

The focus of the acute inpatient service is culturally responsive care and environments underpinned by safe, high-quality contemporary clinical practice. The service seeks to eliminate inequities experienced by Māori, Pacific peoples, disabled people and other groups.

Principles of care

Thematic analysis of the model of care hui discussion gives us a series of principles of care. Participants explored five themes in detail – many of the principles are cross-cutting across themes.

Welcoming with transparent and open communication

The service will ensure that everyone is made to feel welcome and free of judgement. We are aware of the stigma tāngata whaiora may experience and we do not contribute to this.

Communication with tāngata whaiora and whānau will be in a language they can understand. We understand the importance of the language we use and keeping it free from medical jargon as well as the importance of actively listening.

We have an open communication style that ensures everyone knows what to expect and has clarity about their stay and journey. From the outset we aim towards discharge.

Safety for all

Everyone feels safe because we meet the needs of the population we serve. We understand that being in control is a big part of what makes people feel safe.

We contribute towards people's recovery journeys, avoiding re-traumatisation and minimizing unintended negative consequences.

The facility will be a safe, secure and supportive environment for a diverse range of tāngata whaiora with dedicated and adaptable spaces or functional zones that allow appropriate separating of different cohorts (acuity, gender, vulnerability, etc.). All while maintaining a comfortable and supportive atmosphere that is conducive to recovery.

The service will ensure it has the capacity to meet cultural, spiritual, gender and disability needs of individuals. We will undertake cultural assessments and recognise the need for privacy for cultural and spiritual practices.

The service will maintain appropriate occupancy and staffing levels so that overcrowding does not compromise the safety of anyone on the unit.

Person-centred care that is responsive to needs and provides options

The service promotes a wellness model that is inclusive of physical, mental, social and spiritual needs. Tāngata whaiora will be supported to maintain and restore activities of daily living through access to a diverse range of activity and multipurpose spaces.

Participation and partnership are central to all care. Everyone's voices are equal and heard. We take time to understand and be clear about what tāngata whaiora want and need. We think about who is in the person's network and who is needed to add value to their journey. Tāngata whaiora determine who needs to be involved in their recovery.

Our approach is proactive and responsive to individual needs with frequent review and reassess points along the journey.

Peer support workers are present in the unit and provide intentional peer support within the unit and a link with NGOs.

Care, therapies and treatment are focused on recovery and will be adapted to the needs of the individual and their whānau.

Access to good physical care is provided for all people. Routine screening and interventions are provided, and the unit is set up to support people with a range of physical health issues.

Inclusive, holistic, recovery focussed and skill building

Inclusion of whānau is a key focus and we are whānau focused in all that we do.

The environment will provide opportunities for active engagement between tāngata whaiora, whānau and staff to build rapport, trust and aid recovery.

We promote a holistic approach to restoring wellbeing.

Functions, treatment and processes consider a tikanga Māori approach to recovery as per Māori models of health and wellbeing.

Skill acquisition is promoted throughout the journey so people can learn to do things differently with continuity and transition through inpatient care and back to the community (e.g. social skills, group work and programmes and individual level support).

Principles of care

Taking the least restrictive approach

The environment provides the ability to contain the behaviour of tāngata whaiora who are unable to manage their emotional responses, without needing a high level of restriction. People are kept safe in a zero-seclusion model.

The service will be adaptable to the varying acuity needs of tāngata whaiora by providing low stimulus zones and areas for closer observation and implementation of de-escalation strategies as per the principles of least restrictive practice.

Practices enable staff to respond to challenging behaviour in a respectful and least restrictive way to reduce the risk of trauma.

Our approach is to reduce unnecessary restrictions as these can be unwelcoming and become triggers. In doing this tāngata whaiora can maintain control of personal spaces (e.g. locks, lighting, music, stimuli) and access to personal property (e.g. caffeine, charging devices).

Continuity and community connectedness

The goal of acute inpatient care is to support tāngata whaiora to reach a point where they can safely access other community mental health and addictions services that are closer to home. Focus on brief inpatient stays with necessary supports in place, including access to respite and other services, to facilitate return to the community.

Community connections will be maintained throughout the inpatient stay and/or established where they do not pre-exist.

The inpatient unit will be a welcoming environment with physical spaces that support the presence of community teams, NGOs, intersectoral partners (e.g. housing, Work & Income) and other community groups. Connection with social agencies would reduce the reliance on social workers and allow them to focus on care plans. Staff will develop relationships with community providers/groups.

Digital technology will support the virtual engagement of community teams/organisations. Tāngata whaiora will be supported to maintain relationships, employment, housing etc. during their inpatient stay.

Retaining a person's community support and connectedness to the community while an inpatient will allow smooth transitions between the two and more of a 'pull' model at transition back to community.

Continuity of clinicians, care and support will follow through the whole journey including inpatient and back out to the community on and post-discharge.

Crossover of staff between the community and the inpatient unit, with the community care team involved with inpatient care planning to ensure a seamless transition back home. In practice there will be interaction with case managers and other CMHT clinicians.

Community support workers may have the opportunity to be involved with the set-up of plans (e.g. occupational therapy plans) to continue support into the community. Complementary community programmes to follow up, maintain and build on skills learnt (e.g. therapeutic programme implementation embedded in the community).

Valued workforce

The inpatient unit is a desirable place to work because all our staff are valued and equal members of the team. We have a work culture that encourages and fosters respect, inclusion, collaboration, continuous improvement, innovation and leadership.

The working environment reduces risks and improves safety of staff and tāngata whaiora by providing clear lines of sight.

The services support enhanced integration and collaboration between the inpatient unit staff and community staff by providing spaces for co-location.

We will provide continuous workforce development and training opportunities to build capacity and capability through intentional training, mentoring, supervision and knowledge sharing.

Technology enabled

The inpatient service is digitally enabled, with tools that are clinically and culturally safe.

Staff have digital portable tools available for physical health monitoring and observations, sharing planning and progress notes, and connecting to the community teams.

Tāngata whaiora can engage with technology as part of orientation, information provision, daily living and connection, self-reporting on progress, feedback, etc.

The environment uses up-to-date technology including wireless/mobile, audio-visual capability, Pxyus machines for medication, access control, duress systems, etc.

OUR INPATIENT SERVICE MODEL OF CARE

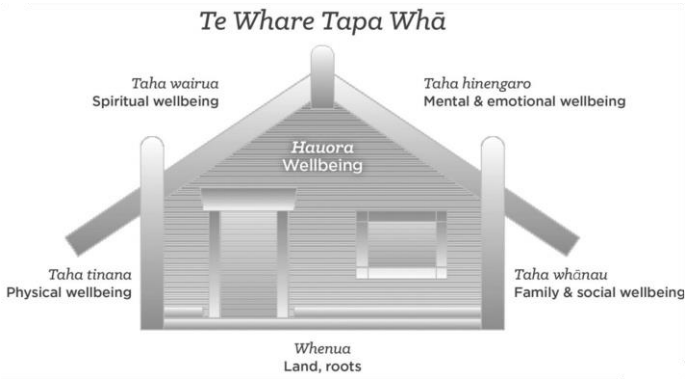
Culturally safe and responsive

Te Whare Tapa Whā[11] is a model developed by Tā Mason Durie that represents a holistic Māori view of wellbeing. It uses the symbol of the wharenui to illustrate the four cornerstones of wellbeing: taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health), and taha whānau (family health). For Pacific peoples, wellbeing encompasses mental, physical, spiritual, family, environmental, cultural and ancestral components, and includes cultural values that strengthen family and individual wellbeing, such as respect, reciprocity, collectivism and a focus on relationships.

Cultural framework

The adult acute inpatient service will put tāngata whaiora and whānau at the centre in all that it does, responding to the individual cultural context for tāngata whaiora under its care.

The adult inpatient model of care will operate within the overarching framework of Te Whare Tapa Whā[11] and the Meihana model.[12]



The Meihana model has its foundations in Te Whare Tapa Whā in addition to two further components – taiao (environment) and iwi katoa – overlaid with the concept of Māori beliefs, values and experiences. These models will be embedded into assessment and planning using specific tools.

The inpatient service will reflect a bicultural practice model that recognises the importance of achieving good outcomes for tāngata whaiora via an effective interface between Māori knowledge and Western clinical knowledge. In practice, there is likely to be a mix of specific cultural teams and collaborative arrangements with kaupapa Māori providers.

The inpatient service's cultural framework will be guided by the Kaumatua Kaunihera, and in future the Iwi Māori Partnership Board will provide additional connection to iwi and Māori communities.

Culturally specific activities/interventions offered include:[13]

- whanaungatanga
- whānau hui
- cultural assessment
- cultural therapy including wairua work
- waiata, kapa haka, te reo Māori, toi Māori, rongoā Māori, connection with land/natural environment.

Workforce and environment

Kaumatua (and potentially other cultural roles) will provide cultural leadership for Māori and enhance the service's ability to provide culturally responsive services. Kaumatua will facilitate relationships with Māori practitioners and identify options for healing and care. All staff require a baseline level of training in cultural competence and cultural safety, and application of cultural models (Te Whare Tapa Whā) will be a core competency. Cultural assessment will be undertaken by staff with cultural expertise.

The physical environment will recognise and support cultural identity: whare whakatau to welcome and settle tāngata whaiora on the unit; generous whānau spaces; wayfinding, materiality and art which express the principles and values of Te Ao Māori; courtyards that allow connection to the natural environment, etc.

OUR INPATIENT SERVICE MODEL OF CARE

Inpatient pathway

Te Ara Oranga MHAIDS[14] describes the flow across services. Its purpose is to provide clear and consistent guidance for MHAIDS staff to ensure a standardised process for all people accessing services, across all MHAIDS services, from request for service, to service exit.

The following processes apply but are not limited to: access and orientation, assessment, plan, treatment/therapeutic activities/support, review processes and transfer of care (discharge).

Access and orientation

Welcome to the unit takes place in the whare whakatau, where practicable, or other dedicated admission area, with calming areas to settle and de-escalate. Tāngata whaiora are oriented to the unit, maximising digital (e.g. videos) and peer support to provide a safe, open and welcoming experience.

Assessment and planning

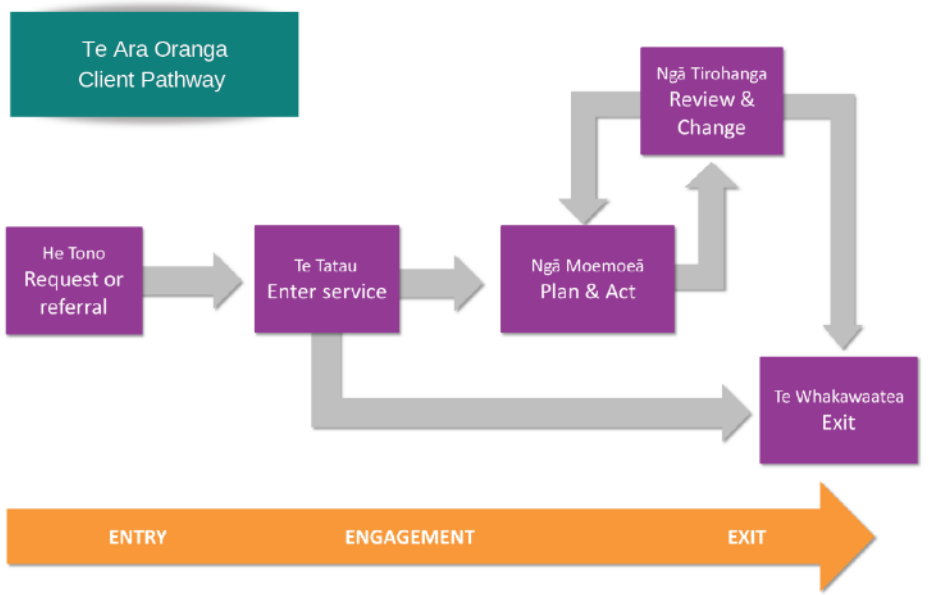
Assessment and planning is driven by needs of tāngata whaiora – principles of relationship and reciprocity and working in partnership with people to individualise goals and interventions. Cultural models will be embedded into assessment and planning using specific tools. A comprehensive system of managing safety (and risk) will be integral part of assessment and planning across the continuum of care.

Treatment, intervention, support

Treatment, intervention and support options will be specific to tāngata whaiora needs and circumstances. A comprehensive range of clinical, cultural and social responses will be available including: cultural and spiritual therapies, support and activities; pharmacotherapy and biomedical investigations and interventions; psychological treatments; sensory modulation; occupational therapy; recreational activities; peer support; meaningful activities to promote social skills and inclusion; activities of daily living; engagement with community services.

Review and transition

Transition planning starts on admission. Clear admission goals and transition criteria will ensure tāngata whaiora, their whānau, the admitting team and the inpatient team are all clear about what goals are being worked towards and the estimated length of stay. Transition will usually involve transfer to another MHAIDS service and/or NGO provider, and these partners must be involved in planning at the earliest opportunity. Transition supports are discussed with tāngata whaiora and their whānau.



OUR INPATIENT SERVICE MODEL OF CARE

More intentional, personalised care delivery

The future model of care will shift from being reactive to being intentional about care delivery, with different treatments, support and environments for different care trajectories. Inpatient service delivery will be more personalised to needs of individuals and cohorts and ensure return to the community is facilitated as soon as appropriate.

Relational practice

The acute inpatient service will implement the Safewards Model to enhance relationships on the unit (primarily nursing) and reduce restrictive practices (in addition to the Six Core Strategies). The Safewards model provides more time for staff to spend in meaningful engagement with tāngata whaiora.

Different trajectories of care

The acute inpatient model will identify and respond appropriately to different trajectories of care:

- short and longer stay tracks
- continuum of acuity.

Safe occupancy and flow will allow the team to identify the trajectory and be clear about estimated length of stay, and better respond with a care package for tāngata whaiora for whom a short stay is appropriate (and a longer stay may be harmful).

For example, voluntary admissions for tāngata whaiora with depressive or relational problems will have more focus on nursing care, psychotherapeutic element, and social work support.

Within the adult acute unit there will be the ability to deliver high-intensity and acute-intensity care. There will be flexible beds that can be used as either high or general acute depending on the needs of the inpatient cohort at the time.

There is a large proportion of compulsory admissions requiring a different approach. A high needs unit (sometimes called a High Dependency or Intensive Care Unit) will be a secure unit for tāngata whaiora under the Mental Health Act who are exhibiting severe symptoms of mental illness, particularly where this involves significant risk to themselves or others that can only be managed in a secure environment. A high needs unit offers a high degree of visibility and a higher level of individual care. It is expected that this unit will offer the most intensive biological treatment options and will have a correspondingly high level of nursing observations.

The environment goes from more highly defined spaces to open spaces with more social interaction. Tāngata whaiora will move from high intensity as soon as safe and clinically appropriate.

The unit will have the ability to operate some beds with associated living space in isolation, if necessary and agreed to by the individual, to ensure that tāngata whaiora with particular needs or vulnerability can be cared for safely within the unit.

Risk assessment and safety management

There will be a focus on providing a proportionate and respectful approach to managing risk and safety with a clear step-by-step process for offering prompt support to tāngata whaiora when their mental health deteriorates.

Risk assessments and recovery plans will be updated according to clinical need or at the minimum frequency that complies with national standards.

Integration with community mental health team

The inpatient service acknowledges the level of acuity being managed by Community Mental Health Teams (CMHTs). The new inpatient model of care seeks to strengthen connection between the inpatient unit and CMHTs. The unit will include spaces and activities so the CMHTs can be more intentional rather than routine visits with less purpose. There will be greater opportunity for CMHTs to be connected in clinical decision-making, including virtual connections.

Multi-disciplinary team (MDT) meetings

MDT meetings will make efficient use of people's time, undertake early transition planning (goals of care) and be used to focus on barriers to discharge. Effort goes into identification and planning up front rather than discharge planning towards the end of the stay.

Workforce – culturally diverse and responsive

Our service will have a workforce that is diverse, well trained, responsive and reflects our community and tāngata whaiora population.

The wellbeing of our workforce is a key success factor in this model of care making the inpatient unit a desirable place to work because all our staff are valued and equal members of the team.

Culturally diverse and competent

The service is working to support the recruitment and retention of a diverse workforce that reflects our community's demographics and diverse needs.

All our staff are trained to have at least a basic level of cultural knowledge/skills/competency (e.g. language, basic tikanga etc.) so they can provide appropriate cultural responses. We have guidelines that provide baseline requirements.

Tikanga is integral to the way we practice and integrated into the model of care.

Safe levels and mix of staffing

Our overall aim is to staff the unit with an appropriate level and mix of staffing, including clinical and non-clinical staff. Rostered shifts will provide continuous 24-hour a day clinical care with non-clinical staff providing cover for extended hours, seven days a week.

The value of the lived experience workforce is acknowledged, and we are committed to helping build this workforce for the future. The lived experience workforce will be present in all parts of the inpatient journey. Peer support and cultural support will be more available and accessible.

Nursing and medical staff will be appropriately sized across the two units (according to best practice guidelines), and rosters will ensure there is an appropriate mix of senior and junior staff across shifts.

Providing roles that are currently not available/or filled and developing new roles will enable all staff to work at the top of their scope and allow more active engagement.

The following roles require particular focus: psychologist, occupational therapy (assistant), social work assistance, activity officer/diversional therapy.

Continuous workforce training and development

Investment in the development of the mental health and addiction workforce is key to ensuring the delivery of safe, efficient and effective services. Integrated care and treatment can be achieved through the establishment of a competent workforce, appropriately trained, who can recognise and respond to mental health and addiction issues.

Workforce development will be continuous and intentional. Development opportunities will be provided to build capacity and capability through training, mentoring, supervision and knowledge sharing. Staff training will be delivered to ensure cultural, disability and rainbow equity competence.

A work culture that fosters respect and innovation

Within our diverse workforce we share values and a work culture that encourage and foster respect, and support diversity, inclusion, collaboration, continuous improvement, innovation and leadership.

We are culturally aware, competent and responsive with an openness to continuously learn. We allow people to define themselves and acknowledge that one size does not fit all.

A safe working environment supported by technology

Along with safe staffing and continuous training, an environment that provides clear lines of sight is key to reducing risks and improving safety for staff and tāngata whaiora.

Dedicated spaces for co-location of inpatient unit and community staff will enhance integration and collaboration across the system.

Our workforce will be well equipped with mobile technology and an information management system that supports sharing of information, and tangata whaiora-driven personalised planning will be more efficient and safer.

OUR INPATIENT SERVICE MODEL OF CARE

Workforce – a multidisciplinary team that works at top of scope

A multidisciplinary team approach is known to maximise clinical effectiveness. The multidisciplinary team is made up of clinical and non-clinical staff, with a wide range of skills and experience in mental health interventions, treatment and support.

Our team will be flexible, adaptive and work together to ensure we take comprehensive and holistic view of the needs of tāngata whaiora and whānau and offer a range of skills and expertise to meet the needs and to support each other. This will enable us to provide a wide range of specialty inputs and resources for tāngata whaiora and a seamless service to tāngata whaiora which enhances continuity of care.

Establishing new roles and supporting all roles to work at the top of their scope will strengthen the care we provide by allowing more active engagement and better planned activities and care packages.

The profile of our future workforce

- Team managers
- Mental health nurses
- Nurse educators
- Nurse consultants
- Nurse practitioners
- Psychiatrists
- Pharmacists
- Clinical psychologists
- Social workers and assistants
- Physiotherapists
- Occupational therapists and assistants
- Dietitians
- Kaimahi (Māori health workers)
- Quality facilitators
- Needs assessors
- Counsellors
- Peer support workers
- Peer advocacy workers
- Kaumatua/kuia
- Cultural support workers
- Support workers
- Lived experience advisors
- Activities officers/diversional therapists
- Community liaison workers
- Students
- Non-clinical cultural workers
- Administrative support staff

4

Enablers and change

ENABLERS AND CHANGE

Significant changes from current practices

We asked participants at the future consumer journey mapping workshop to identify the radical changes from current state.

Below is the collection of changes that each of the workshop groups highlighted.

Culturally safe and responsive with access to kuia, kaumatua, chaplain

Relational, person-centred approach

Transparency, choice and options

Pre-admission facility for de-escalation and assessment

Short stay admission unit

Least restrictive/no seclusion or seclusion rooms

Safety (includes culturally safe)

Therapeutic, make [the inpatient unit] a therapeutic community

Environment looks and feels like home, feels safe and comfortable. Private suites with bathrooms, music, TV

Change in workforce – diversity, clinical and non-clinical, peer support significant role, appropriately trained, culture of respect and inclusion

Continuity and connectedness across the continuum of care. Community, less staff delineation – activities, cultural, buddies.

Kaupapa model of care - whānau led, accommodates and led by Māori values and principles

Holistic model of care rather than medical model

Whānau involvement in journey and working intensely with family, whānau/family systems approach with therapy for all. Restorative justice, mana restoring process at end of inpatient journey. Collective focus not individual one.

Intentional nature of the support that needs to be delivered

Streaming and different trajectories/tracks for different cohorts of patients

Ability to respond to new therapies/interventions

Prioritising staff recruitment and [increasing] personnel to manage this model

Profoundly respectful

No "patients"

Access to peer support workers on the unit each shift and throughout the process

Community Mental Health Teams having small case loads so they can have greater input with tāngata whaiora

A properly funded mental health service

More transitional housing facilities. Regular movement

No seclusion rooms

Better home-based treatment

Enablers

Key enablers include workforce recruitment and development, investment in digital and technology, ensuring a fit-for-purpose physical environment, clear links with clinical and non-clinical support, up-to-date governance and partnerships with strong leadership from Māori, Pacific and lived experience, using data and monitoring to inform a learning system.

Workforce recruitment and development

The model of care will require a workforce recruitment, training and development programme. Additional staff will be required (increased bed numbers) as well as new roles for which there may be a shortage of trained workforce. We will continue to engage with workforce development partners to proactively identify needs.

Training will be intentional, to support specific elements of the desired model of care, and continually refreshed.

The lived experience workforce will be adequately resourced to provide two functions: strategic advisory and connection to the wider lived experience sector (lived experience advisors), and peer support/advocacy functions.

Cultural positions and support workers need professional pathways and incentives for development. We need to think creatively about how we grow our workforce to become more representative of the community it serves.

Digital investment

Ongoing investment is required in digital infrastructure and solutions. The desired model of care will be enabled by fit-for-purpose, accessible and interoperable systems, supporting the workforce to practise in responsive ways, and enabling easy connection and communication. Wherever possible, regional or national solutions will be leveraged.

Fit for purpose environment

Physical environment – safe, welcoming, inclusive, meets accessibility needs of disabled people, flexible and changeable spaces, connected to community and environment, culturally responsive.

Contemporary, flexible and modular design allows for changes over time and allows separation of cohorts.

Clinical and non-clinical support/linkages

The inpatient service will have close connection with clinical services including ED, Crisis Resolution Service, anaesthesiology, pharmacy and physical health services.

Non-clinical support includes security, catering/food services, facilities maintenance, ICT, cleaning and waste management.

Governance and partnerships

The desired model of care is dependent on the participation of a range of providers, partners and community organisations. Participation will be enabled via robust clinical governance and whole-of-system leadership (a mechanism for facilitating connections that is wider than MHAIDS), as well as commitment to building relationships between services and individuals.

Ongoing co-design with partners is essential. Te Aka Whai Ora and Iwi Māori Partnership Boards will become important partners in future.

Monitoring and learning

MHAIDS will build on its existing analytical and other capability to embed the culture of a learning system. Ongoing monitoring will inform quality improvement and other initiatives. Key measures could include:

- reduction in length of stay and delayed discharges
- community/NGO involvement
- tāngata whaiora and whānau satisfaction and feedback
- access to a range of cultural interventions
- outcome measures for Māori
- whānau-tāngata whaiora partnership in recovery planning
- bed occupancy at or below 85% on average
- wait times for admission
- readmission rate
- rates of seclusion and restraint, serious incidents
- Health of the Nation Outcome Scales
- staff satisfaction, retention, recruitment time, sickness, etc.

ENABLERS AND CHANGE

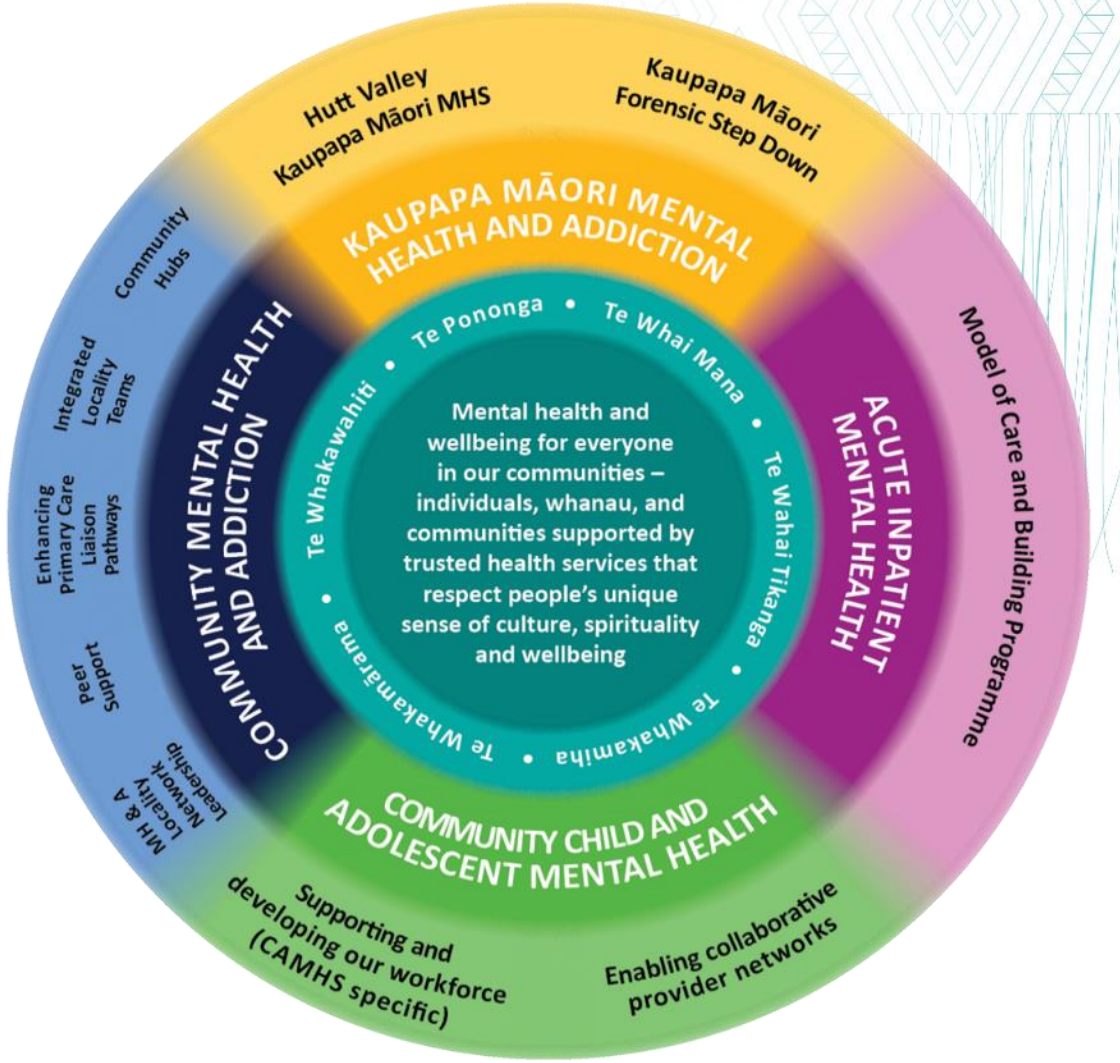
MHAIDS change programme

Te Whatu Ora Capital, Coast and Hutt is working with mana whenua, Māori, community leaders, people with lived experience, and our health and social sector partners, to transform mental health and addiction services.

We are working in partnership with Māori, honouring our commitment to Te Tiriti o Waitangi.

Our goal is that we avoid the need for acute admission where possible, by providing early supports and acute alternatives to admission. For the proportion of people that do require an inpatient admission, our goal is to support tāngata whaiora to reach a point where they can safely access other services and supports In the community and closer to home.

Therefore, it is important that the adult acute inpatient service operates as part of a whole system that extends beyond secondary services. A system that integrates with outreach (transition out) and crisis (step up) services and other alternatives to inpatient care to support early intervention and closer to home care in the community.

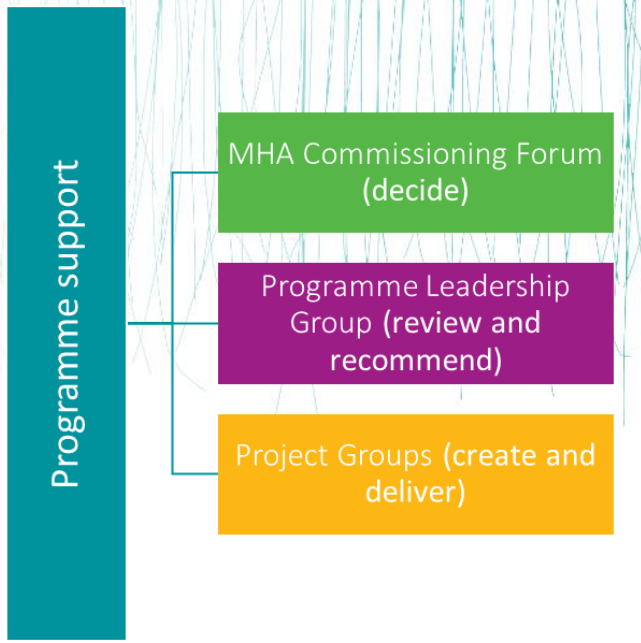


ENABLERS AND CHANGE

Overview of processes to undertake change management

The Mental Health and Addiction Change Programme[15] has an existing governance and programme/project structure. This provides the foundation for specific change management within the inpatient service. However, it is recognised that a culture shift is required to implement the new model of care and additional resource and effort will be required over some time. Further development and implementation of the adult acute inpatient model of care will need **dedicated change resource plus support for existing staff and leaders** to facilitate and participate in development work and training.

MHA Commissioning Forum	The MHA Commissioning Forum meets **monthly** and is responsible for providing overall direction to the programme and giving advice to the Chief Executive on its design and implementation.
Programme Sponsors	Executive Director, MHAIDS Executive Clinical Director, MHAIDS Director Māori Health 2DHB Director Strategy Planning and Performance
Programme Leadership Group	The Programme Leadership Group meets **fortnightly** and is responsible for the programme meeting its objectives, producing the agreed deliverables, and delivering the expected benefits.
Programme Director	Responsible for oversight of all project groups
Project Working Groups	Working groups will meet **weekly** and be responsible for the design, development and implementation of projects.
Programme Support	This group meets **weekly** with the programme sponsors and is responsible for programme delivery across projects and maintaining oversight.
Admin	Secretariat support to these groups will be provided by the Executive Assistant to Executive Director & Executive Clinical Director



5

Glossary, useful links & references

Glossary

Hauora – *wellbeing*
Iwi katoa – *wider support*
Kaimahi – *Māori health workers*
Kotahitanga – *connection, unity, equity*
Manaakitanga – *respect, caring, kindness, mana enhancing*
Mana whenua – *those with historic and territorial rights over the land*
Mātauranga Māori – *Māori knowledge, wisdom and skill*
Pono – *truth*
Rangatiratanga – *autonomy, integrity, excellence*
Rongoā Māori – *traditional healing practices*
Tāngata whaiora – *people with experience of mental illness*
Tāngata whaikaha – *disabled people*
Taiao – *environment*
Taha wairua – *spiritual wellbeing*
Taha hinengaro – *mental and emotional wellbeing*
Taha tinana – *physical wellbeing*
Taha whānau – *family and social wellbeing*
Tika - *the right way to do things*
Whanaungatanga – *relationships*
Whare whakatau – *welcoming area*
Whakaāio ā-rongo – *sensory modulation tools*

Useful links

Further information

This model of care document is currently a draft for review. It is intended as a living document that can be updated as thinking and planning evolves.

In the meantime, if you have any questions or would like to know more, please get in touch at:

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Te Whatu Ora
Health New Zealand

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