

**Summary of
feedback from
New Zealand leaders
who attended the
IIMHL Leadership
Exchange
in 2015**

Accelerating Change Towards Mental Health, Well-Being and Inclusion

Contents

Match: E Mental Health (University of British Columbia, Vancouver)	1
Match: Council of Clinical Leaders (New York)	2
Match: Shifting the Paradigm - Mental Wellness and Indigenous Knowledge: Transformation, Measurement and Implementation (Vancouver)	2
Match: Children and Youth (Ottawa, Ontario)	4
Match: Homelessness and Mental Health (Vancouver)	4
Match: Social Determinants of Health (Vancouver)	5
Match: Opioid Use: Risks, Prevention and Harm Reduction (Vancouver)	6
Match: Integration of Disciplines (Washington)	7
Match: Community Crisis Response and the Crisis Pathway (Downtown East Side - DTES - Vancouver)	8
Match: Mental Health Literacy - Department of Behavioral Health & Intellectual disAbility Services (Philadelphia)	9
Match: Community Action for Suicide Prevention (Vancouver)	11
Match: Self-directed Care (Boston)	11
Other information about Integration in Primary Care (post Exchange visits)	12

Summary of feedback from New Zealand leaders who attended the IIMHL Leadership Exchange in 2015

Thank you to all who completed their report. I have summarised reports and combined them where two people went to the same match. I have also included information from the "Host Match Summaries" (host written summaries of the match content) and additional links where possible.

Host Match Summaries: <http://www.iimhl.com/>

Janet Peters
March 2016

Key points, actions and 'Host Match Summary' post IIMHL

Match: **E Mental Health (University of British Columbia, Vancouver)**

Key Points

- Within the eMental health match there were sessions on the paradigm shift in practice required to embed the use of web and mobile technologies towards patient empowerment, early support and sustainable care.
- There was a range of online demonstrations of different e tools with New Zealand featuring through the John Kirwan Depression Journal <http://www.depression.org.nz/?gclid=Cj0KEQIAxMG1BRDFmu3P3qjwme MBEiQAEz SDLhpinAyw5PwPIY80rkcnmBZUQ0RXaTOLy5K6zQb60olaAl698P8HAQ>
- The New Zealand SPARX gaming programme for depression for youth
- The SWELL app <http://www.swelltoolkit.com/app>
- There was discussion on the scope of future mental health care using web and social media, and the opportunities for change in the current mental health care system. New Zealand had been seen as a leader in eMental Health however there is a sense the momentum has reduced.

Actions

- One of the reasons for this change is thought to be the lack of a strategy and framework for eMental Health at a national level.
- A follow-up meeting of the NZ contingent before the TheMHS Summer Forum might help with ideas.

Host Match summary: <http://www.iimhl.com/>

Match: Council of Clinical Leaders (New York)

Key Points

This group has been meeting for seven years with a focus on identifying a set of indicators that could be used for international benchmarking to inform service improvement and is coordinated by Dr Harold Pincus, Professor of Psychiatry, Columbia University.

Prof. Harold Pincus notes there have been nearly 20 publications on the different phases of this project. A number of other New Zealand representatives have attended this meeting in previous years including Robyn Shearer and Mark Smith from Te Pou. The project has occurred in three phases to try and refine the number of KPIs and the definitions.

The main challenges have been the complexity of operationalising within and across the differing health systems, with diverse data collection systems and varying indicator definitions – especially for countries with limited Mental Health Informatics availability. The bulk of discussions focused on those measures currently reported by five or more countries. Attempts to reduce the shortlist to a smaller number of KPIs that are consistently collected and defined have been unsuccessful to date and further research will be done on three shortlisted indicators (28 day readmission rate, 7 day follow up and average length of stay).

The Group has also been looking at what outcome and recovery measures are being used across the participating countries (NZ, Australia, England, US, Canada, the Netherlands, Sweden). Our closest allies for future development are Australia and England because of the similarities in our systems and ambitions. At the New York meeting I was able to present an overview of what is happening in NZ on behalf of the KPI Programme and Te Pou. New Zealand is performing well internationally in terms of infrastructure and investment in informatics and benchmarking.

Actions

The next steps identified for the IIMHL Clinical Leaders International Mental Health Indicator Project are:

- Short term effort: deep dive benchmarking of a limited set of measures which focus on inpatient care (target timeline: March 2016)
- Long term effort: include deep dives on a broader set of additional candidate measures as proposed by the group (target timeline: IIMHL meeting in Sydney, 2017)
- Recovery ontology/taxonomy
- Survey on use of measures
- Collaboration with other organisations (i.e. OECD, WHO/Global Mental Health Research Network and others)

Since the New York meeting the NHS Benchmarking Network team in the UK have been in touch to progress the “deep dive” work for a shortlist of high value indicators so we will be continuing our involvement over the coming months.

Host Match Summary: http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Clinical_Leaders.pdf

Match: Shifting the Paradigm - Mental Wellness and Indigenous Knowledge: Transformation, Measurement and Implementation (Vancouver)

Key Points

- “I was privileged to attend three stages of the exchange – the Wharerata Group, followed by a two-day indigenous exchange and the Combined Meeting meeting.”

The Wharerata Group

- This group continues an ongoing dialogue by indigenous groups between IIMHL gatherings and the 2015 gathering was no exception. A MOU had been drawn up prior to the exchange and circulated to some of the original rōpū who developed the Wharerata Declaration at the 2009 exchange in Aotearoa. The Wharerata Group met prior to the 2015 exchange to discuss the feedback and confirm the MOU which included the ongoing IT support required to host the Wharerata Group website and an array of learning opportunities between the exchange events.
- The Wharerata Group is a network to support Indigenous leaders working in mental health and addictions, and provides a forum for sharing successful practices for Indigenous people. Thunderbird

Partnership Foundation along with the First Nations Health Managers Association hosted a special workshop on Reconciliation in Mental Health, in September 2015. Indigenous leaders and allies in mental health and addictions came from around the world to contribute to the discussion on what works.

- Leaders recognised that the adoption and implementation of wellness-focused models is still a work in progress, and requires partnership across diverse sectors before full-scale change can occur. The group consensus suggested that collaboration should be led by Indigenous leaders who engage with their communities to determine what wellness means in a local context, because Indigenous knowledge is central to the work of describing wellness. International Chair Rose LeMay of the Wharerata Group closed the event with a vision of reconciliation, a time in the near future when Indigenous have equitable mental health as do any other peoples.

Shifting the Paradigm

- Following the Wharerata hui I attended the two-day exchange Shifting the Paradigm held at the Musqueam First Nation Cultural Centre in Vancouver. The exchange provided the opportunity to connect and share ideas and best practices with the goal of contributing to the dialogue about shifting perspectives on mental health from illness to wellness.
- Leaders recognised that the adoption and implementation of wellness-focused models and measuring wellness is still a work in progress and requires partnership across diverse sectors. The group consensus suggested that collaboration should be led by indigenous leaders who engage with their communities to determine what wellness means in a local context, because indigenous knowledge is central to the work of describing wellness.
- These sentiments were shared by Justice Murray Sinclair who discussed law as a tool for reconciliation. He warned that unless the law is utilised to unearth the truth it could also be used as a tool to suppress reconciliation.
- Elder (Dr) Jim Dumont presented an Indigenous Wellness Framework utilising indigenous knowledge, similar to Te Whare Tapa Wha.
- Dr Brenda Restoule, chairperson of the First People's Circle of Wellness (Thunderbird Partnership - <http://nnapf.com/about-tpf/scope-of-work/>) followed with her views on Indigenous inclusion and cultural competence in mental health, suggesting a move away from silos through funding models, and recognition and honouring of Indigenous strengths. Dr Restoule said that culturally competent systems move away from focusing on individuals to working with whānau and communities. This would be considered as whānau ora in the New Zealand context. It was at this exchange that Judi Clements from the Mental Health Foundation of New Zealand and I presented on how we each contribute to measuring wellbeing.

Examples of resources from the Match:

Healthy Minds, Healthy People: a 10-year Plan to Address Mental Health and Substance Use in BC
http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use 10- year Plan
http://www.fnha.ca/Documents/FNHA_MWSU.pdf

Actions

- After the exchange I have met a representative of the MOH who is interested supporting the Wharerātā group and the mahi that occurs behind the scenes. The MOH could provide support and assistance but is unclear what that looks like. A meeting with the Wharerātā roopu (NZ) will be called in the new year to clarify the relationship with MOH.
- Manaaki Ora would be willing to host the Wharerātā roopu in 2017.
- Professor Jerry Diller has requested an interview on working with Māori that will be included in the sixth edition of his book Cultural Diversity, a Primer for the Human Services. A Skype session is being discussed in February 2016.
- Holly Echohawk and David Alonzo (short film/documentary makers) requested an interview on workforce development and the implementation of cultural competencies, similar to that of Ted talks. I will be notified prior to it being uploaded to the net.
- Matua Raki – the final newsletter for the Addiction sector included an article about my experience/learnings from the IIMHL exchange. <http://www.matuaraki.org.nz/news/iimhl-and-iidl-vancouver-2015/725>

Healing our spirits worldwide (HOSW) – 15-19 November 2015 <http://hosw.com/>

Many of the people I connected with during the IIMHL exchange also attended the HOSW conference where we were able to continue some conversations. It was good to have these connections and celebrate some of the indigenous work that is occurring.

Host Match Summary http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Shifting_The_Paradigm.pdf

Match: Children and Youth (Ottawa, Ontario)

Key Points

- The International Child and Youth Mental Health Community keep in touch regularly via a couple of annual global teleconferences which the Werry Centre coordinate to share information, ideas and resources.

Issues discussed during the match:

- spreading good practice outside their silos
- developing cross agency coordinated plans
- working with young people coming out of detention
- making youth services such as early psychosis more family friendly
- expanding single session family therapy
- youth suicide
- changing the age limits for services
- and developing mental health services in schools

These issues were dwarfed by the Swedes' revelation that Sweden was currently dealing with the arrival of 6000 asylum seekers a week, a number of whom are unaccompanied children who have witnessed and been through unimaginable trials. <http://www.iimhl.com/files/docs/20160204c.pdf>

Granville Youth Health Centre in Vancouver - this Inner City Youth Program provides Health, Mental Health and Addiction services to the many homeless youth in Vancouver. They have been successful in obtaining beds and apartments for these young people, which has been critical to starting to get things on track. Some of the apartments are on the top floors of brand new buildings.

Resources

<http://www.excellenceforchildandtheyouth.ca/> and <http://www.daretodreamprogram.ca/>

Actions

- Experiences reported in the Werry Centre's newsletter 19/10/15
<http://us7.campaign-archive1.com/?u=8d1c6e5734aca7d0a6b696144&id=bf25f349e2&e=175aeeb308>

Host Match Summary: http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Children_and_Youth.pdf

Match: Homelessness and Mental Health (Vancouver)

Key points

- 'Housing First' is well-researched as the most effective strategy to deal with homelessness – i.e. get a house then wrap services around the person. <http://www.housingfirsttoolkit.ca/>
- The five principles of Housing First are:
 - Immediate access to permanent housing in addition to flexible, community based services
 - Consumer choice
 - Recovery orientated supports
 - Individualised and person driven supports
 - Social and community integration
- Our learnings have taught us that housing clients first, and then working alongside them to address mental/ physical health, addiction, relationships and employment needs works. So often clients are expected to be 'mentally well, abstinence from alcohol and illicit drugs' before they are considered for housing services.
- Sam Tsemberis, who developed the American/Canadian model of Housing First and co-host of the exchange, visited New Zealand soon after to speak at the CHA conference. <http://cha-impact.co.nz/>
- *"This exchange was a fantastic opportunity to listen to others opinions and share our experiences. I must applaud the Mental Health Commission of Canada for their organising of our exchange and enabling us to experience the plight of the homeless first hand, visit several innovative programs and allow time for participants to discuss what this might mean for their respective countries."*

Actions

- Since returning, Dr Sam Tsemberis, CEO and founder of Canada's Pathways to Housing National and developer of Housing First has toured New Zealand presenting the Housing First model. During his tour,

- he has made connections with other housing providers and because of our involvement in the exchange, has asked Comcare to join the other organisations to build on the Housing First concept within New Zealand.
- This led to interest from others around New Zealand and a Housing First Community of Practice is being developed between agencies interested to further the work in New Zealand and retain fidelity with the model.
 - Information is also being shared within our organisation, which is a provider of Emergency Housing for the DHB and post-earthquake short term housing for homeless individuals in Christchurch.
 - *"The learnings have enabled me to initiate discussions around risk adverse practice and paternalistic health care obstructing clients' progress through mental health systems and assist clinicians within clinical services to consider discharge planning much earlier than they would have with the knowledge that there is a skilled NGO workforce who are able to provide support in partnership with clinical teams."*
 - We are refining our service provision and sharing this with other providers around New Zealand to improve outcomes for vulnerable homeless people, the majority of whom are severely impacted by mental illness and addictions.
 - For example: we are reviewing intake criteria, supports provided and skill sets of staff working in the area. We are more proactively seeking a joined up approach from the often multitude of workers involved in various aspects of a person's life. We are changing our approach to care rejection and seeking different ways to build relationships and positive outcomes.
 - As Health and MSD recognise the importance of a home as the foundation to improved wellbeing, and take a more active involvement in this space, we have opportunity through forums and advisory work in both arenas to share our learnings from both our local experience and the international experience to shape developments in New Zealand. We were particularly interested and impressed at the collaboration seen in Canada between health providers and social service agencies around housing and employment as recognised as fundamental building blocks for improved mental wellbeing.

Links: Insite (supervised injection site) <http://supervisedinjection.vch.ca/>

Portland Hotel Society <https://www.phs.ca/Index.php>

Video <http://athome.nfb.ca/#/athome>

Host Match summary:

http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Homelessness_and_Mental_Health.pdf

Match: Social Determinants of Health (Vancouver)

Key Points

- This attendee gave a comprehensive outline of her learning needs to the host. Unfortunately the host of the match did not deliver on these and delegated the Match at the last minute to another agency.
- The absent host did offer two PowerPoint presentations: <http://www.iimhl.com/files/docs/20160202a.pdf> and <http://www.iimhl.com/files/docs/20160202b.pdf>

Instead the following services were visited:

- HIPPY is the acronym for the Home Instruction for Parents of Preschool Youngsters. HIPPY Canada has been operating in Canada for the last 15 years and is based on the principle of mothers helping other mothers (peer support) in home settings. It focuses on coaching low income immigrant, Aboriginal and other high need families to prepare children aged three, four and five years to succeed when they go to school. <http://hippycanada.ca/>
Software used: <http://www.socialsolutions.com/case-management-software/>
- **Crabtree Corner** is a YWCA Metro Vancouver programme in the Downtown Eastside that offers a range of services including transitional housing for expecting and new mothers with substance use issues, child care, parenting programmes, a hot meal programme, a community kitchen, education and support around fetal alcohol disorder and a violence prevention service. <http://ywcavan.org/programs/crabtree-corner>
- In addition, a pregnancy outreach programme called '**Sheway**' is co-located in the same building as Crabtree Corner. The programme provides health and social service supports to pregnant women and women with infants under 18 months who are dealing with drug and alcohol issues. The focus of the program is to help the women have healthy pregnancies and positive early parenting experiences. <http://sheway.vcn.bc.ca/>
- The **Carnegie Community Centre** has provided social, educational, cultural and recreational activities for the benefit of the people of the Downtown Eastside since its opening in 1980. <http://vancouver.ca/people-programs/carnegie-community-centre.aspx>

- Founded in 1978, **the DEWC** is one of the few safe spaces within the Downtown Eastside that is exclusively for women and their children. <http://dewc.ca/>

Overall takeaways: Minimal barriers to entry – almost no eligibility criteria, apart from gender; Use of a peer workforce to staff the centre; Development of tailored solutions for people who have complex problems; Provision of soft entry points (e.g. a hot meal).

Met Johnny Morris, Senior Director, Policy, Research and Planning at the British Columbia branch of the Canadian Mental Health Association - the Canadian Mental Health Association is one of the oldest continuing voluntary health organisations in Canada. Takeaways: A supportive policy framework is important and social cohesion matter! <http://www.cmha.ca/>

Actions

- I have often referred to these (and other) aspects of service delivery in my discussions with MH&A sector leaders about the implementation of change to NZ services
- Not via IIMHL, the “Collective Impact Summit” was excellent (in the week after IIMHL). “Collective impact as a promising approach to community change”
http://tamarackcci.ca/resource-library/collective-impact/collective-impact-johnkania?__hstc=96422787.bacc6ed25752517ffe82d70727b20edf.1454377985490.1454377985490.1454377985490.1&__hssc=96422787.1.1454377985490&__hsfp=3029315197

Article: http://ssir.org/articles/entry/collective_impact

Host Match Summary: Not provided

Match: Opioid Use: Risks, Prevention and Harm Reduction (Vancouver)

Key Points

- Addiction medicine specialists reminded us that alcohol is still the primary substance contributing to hospitalisation apart from tobacco.
- Insite is located in a very run down and poor neighbourhood of East Vancouver and homelessness is endemic among people who have a range of co-existing mental health, addiction and other health problems, including a high prevalence of HIV/AIDS. The sheer scale of the number of people living on the streets was overwhelming as was the clear poverty, unwellness and the very open drug use and dealing. Despite this, there is a clear sense of community and identity amongst the people in the area and peer workers at Insite provided links to this community and up-to-date information about current risks.
- The opioid using scene in Vancouver is marked by the ready availability of cheap heroin, about NZ\$12 a ‘hit’ or NZ\$75 a gram, and the emergence of locally manufactured fentanyl that is sold as heroin resulting in a recent spike in overdose deaths. The take home naloxone packs, which cost about NZ\$50 to produce and which take a maximum of 10 minutes to learn how to use, are a direct pragmatic harm reduction response to both the availability of cheap heroin and the lack of quality control in the manufacture of fentanyl.
- The location of Insite in an area of great need is intentional and as such it has become a hub for health providers to attempt to engage with people who have a range of mental health and addiction problems but do not normally access services. The harm reduction ethos is paramount at Insite as they support some of the most disenfranchised people in Vancouver, a significant proportion of whom are First Nation people. Insite is one of the primary outlets for the take home naloxone packs.
- The actions of the medicinal cannabis providers in Vancouver had effectively decriminalised cannabis use as dispensaries had doctors on call who could write a prescription for cannabis for virtually anybody who walked into a dispensary. They had concerns about the lack of regulation and quality controls associated with this de facto decriminalisation of cannabis, especially because dispensaries have different motivations for existing (i.e. profit vs medicinal value).
- Addiction has been one of the most significant impacts of colonisation and subsequent intergenerational trauma. Some countries, such as Canada and the UK, appear to include addiction as a mental health problem so do not separate the issues – at least on a policy and discussion level – though they appear to remain separate on a treatment level. For others, such as Australia and the US, funding and therefore policies and treatment are very separate.

Actions

- Reported in Matua Raki newsletter December 2015
http://www.matuaraki.org.nz/uploads/files/resource-assets/MR_newsletter_Dec2015_WEB.pdf and
<http://www.matuaraki.org.nz/news/iimhl-and-iidl-vancouver-2015/725>
- The presentations and discussions highlighted that in New Zealand we are fortunate that funding and management has been integrated for the past 20 years and that this has helped services to begin to develop collaborative practices and models of integrated care.
- To note: AMHOIC conference Nov 2015 – workshop (lack of data about people who have co-existing problems)
<http://www.matuaraki.org.nz/news/AMHOIC-conference-rising-to-new-heights/699>

Host Match Summary: Not provided.

Match: Integration of Disciplines (Washington)

<http://www.integration.samhsa.gov/about-us>

Key Points

- The exchange provided an opportunity to learn about the initiatives that are underway to integrate primary care and specialist mental health and addiction services in the USA. A lot of these initiatives have been largely assisted by federal funding that has been made available through the health care reforms. The National Council of Behavioral Health has a role to fund, co-ordinate the different integration initiatives and has a focus on supporting workforce development initiatives. Featured video:
<http://www.integration.samhsa.gov/>

Describe how you shared information and learning gained during the Exchange - what did you share, with whom and what was the outcome?

- The development of these initiatives in the USA provide a valuable example of the impact of a change of policy on services. The USA have parity legislation which appears to strengthen policy reforms.

What (if any) changes have you made to services, knowledge or practice as a result of your Exchange?

- The knowledge from the exchange has been largely used as part of discussions with other providers or to inform initiatives at a national level rather than directly within a particular service. The learning from the exchange has provided greater knowledge about how integrated services have developed internationally. The exchange resulted in an increased understanding of the issues, challenges and success around integration and first-hand experience of fully integrated services.
- The visits to services highlighted some of successes around workforce development and what has made some of the initiatives successful. This has contributed to understanding some of the workforce development challenges and potential role Te Pou may have as further integration initiatives develop here.

Key additional benefits for New Zealand services from your learning?

- As a number of the integrated initiatives are in the early or development phase in New Zealand the information gained from the exchange has provided a broader knowledge to contribute to similar initiatives here. What was particularly useful was having information shared from a number of different perspectives – the funder, policy advisors, workforce development, primary care provider and an NGO mental health provider. This demonstrated the breadth of how integration has occurred in the USA and will be invaluable to inform the different developments in New Zealand.
- As part of the exchange we gave a presentation to around 20 staff working at the National Council. This was well received and was an opportunity for them to increase their knowledge about New Zealand mental health and addiction services.

Actions

- Following our visit we have started discussing with policy makers and other health leaders how parity laws could assist us here. We will continue these conversations through 2016.
- The National Council has an annual “Hill Day” where its members convene in Washington DC and visit Capitol Hill and highlight the key issues for mental health and addiction. Printed information is shared with ministers and this has often influenced ministers advocating and leading change for mental health and addiction. Information has been shared with Platform Trust with the suggestion that New Zealand could have an annual “Hive Day”.
- Resources that the National Council have developed for the integration initiatives have been shared with providers that we have had contact with that are involved in planning integrated initiatives/services. These resources have included video clips, workforce competencies, quality standards and examples of practice such as ‘warm hand over’. These have been distributed via individual email or on a discussion forum.

- Equally Well presentation to MHCGG – date tbc, Pharmacist peer group – 30 Oct 2015

Resources

- US report on current efforts to integrate primary and behavioral health care
<http://www.integration.samhsa.gov/resource/health-worker-shortages-and-global-justice-milbank>
- Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness <http://www.integration.samhsa.gov/integrated-care-models/Integrating-Primary-Care-Report.pdf>
- Core competencies for Integrated Behavioural Health and Primary Care
<http://www.integration.samhsa.gov/workforce>

Host Match Summary

http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Integration_of_Disciplines.pdf

Match: Community Crisis Response and the Crisis Pathway (Downtown East Side - DTES - Vancouver)

Key Points

- DTES has a population of poor, aging peoples, with significant drug-taking and homelessness is common, and people with co-existing physical and mental health problems common; and a significant indigenous population. The overall aim of Vancouver City (our equivalent of a City Council) and all agencies is to ensure the best possible care for people who experience mental health/homelessness and physical health problems by diverting people from Police and Justice systems into Health by having clear policy about the interactions between Health, Police and Justice.
- Vancouver City has won awards for planning.
<http://vancouver.ca/news-calendar/city-of-vancouver-recognized-for-excellence-in-planning.aspx>

Three programmes that involve Health, Police and Justice and supported by the City of Vancouver:

1. **Mental Health Emergency Services/Car 87/Car 88 Program ("MHES/Car 87").** MHES/Car 87 is a program that has been in operation for over 30 years, in which a mental health nurse and a police officer together respond to calls to assess individuals in crisis for mental illness, and to provide referrals, follow-up and emergency intervention where required.
2. **Assertive Community Treatment (ACT) Teams.** ACT is a program which has been in operation since 2011 in which VPD and VCH have partnered to provide community-based assessment and treatment services to individuals within the community who have serious mental illnesses and/or substance abuse disorders. Unlike the emergency-based MHES/Car 87 program, ACT teams have a set caseload of clients. VCH staff provide health care and treatment, while VPD officers assist VCH staff in carrying out the care plan, ensuring safety of staff and clients, and assisting clients with navigating the criminal justice system where necessary (e.g. helping a client to deal with outstanding warrants). *Note: After the programme's first year of operation, ACT clients had a 70-per-cent reduction in emergency department visits, a 61-per-cent reduction in criminal justice involvement and a 23-per-cent reduction in incidents of victimisation, according to the Ministry of Health. The five teams, which each cost about \$1.6-million annually, can take on a total caseload of 420 people.*
3. **Assertive Outreach Team (AOT).** AOT is a new partnership between PHC, VCH and VPD designed to provide intensive case management for individuals within the community who have serious mental illnesses and/or substance abuse disorders. The AOT teams work on a similar model as the ACT teams, but with a focus on short-term stabilisation and risk mitigation. The programme is also similar to MHES in that VPD and health care staff are paired in a police car, and VCH/PHC staff may be able to view a client's information in PRIME on the car's laptop. Information sharing will work similarly to the MHES/Car 87 model, in that information-sharing requirements are driven by crisis intervention rather than a fixed caseload of clients, and therefore will relate primarily to staff and public safety.
 - We were impressed with how strongly people were diverted from Police and Justice to Health and Housing and the training that Police received. Inspector Howard Tran, who is in charge of Vancouver's Police Mental Health Unit said:

"It is mandatory for all police officers in the province of British Columbia to complete the Crisis Intervention and De-escalation Course (CID). All members must take this every three years and members using Tasers, less lethal or in specialised response units like "SWAT" team, have to do it every year. On top of this, each agency is responsible for providing whatever additional training they see fit. We equip our Mental Health Unit members (ACT, AOT, Car 87) with additional training in the form of HCR-20 and Mental Health First Aid. The most important training however, is on the job with the clinicians and peer support workers. Nothing beats hands on experience coupled with a good dose of empathy and compassion. We are looking at developing curriculum to align with the Mental Health Commission of Canada's "TEMPO" framework". <http://vancouver.ca/police/>

- Part of the match involved attending the Mayor's Task Force on Mental Health and Addictions meeting scheduled for the Tuesday afternoon. Informal networking with Task Force members after the meeting allowed for more opportunities to talk to people from a diverse range of sectors, including health and housing executives, Vancouver Police Department and city staff, non-profit housing and service providers, Aboriginal (sic) leaders, and people with lived experience.

Caring for all: Priority actions to address mental health and addictions, Report of Mayor's Taskforce, City of Vancouver, 2014 <http://vancouver.ca/files/cov/mayors-task-force-mental-health-addictions-priority-actions.pdf>

A Healthy City for all, Vancouver's Healthy City Strategy 2014-2025, Vancouver City, 2014

http://council.vancouver.ca/20141029/documents/ptec1_appendix_a_final.pdf

Actions

- Presentation to Waitemata Health's Senior Management Team and work with local Police in the region.
- After the match several reports were sent to the Ministry of Health and New Zealand Police.

The MHCC TEMPO report was sent to the New Zealand Police training department, Head Office as they are doing a project on mental health. *"TEMPO: Police Interactions A report towards improving interactions between police and people living with mental health problems, 2014"*

The following reports were sent to Dr John Crawshaw for his current work with NZ Police. The overall aim is to build good relationships among agencies and to divert people from Police and Justice systems into Health by having clear policy about the interactions between Health, Police and Justice.

- **Information Sharing Agreement:** Vancouver Coastal Health Authority, Vancouver Police Department and Providence Health Care Society
- **Privacy Impact Assessment (PIA) 2014 –13.** Information sharing with Vancouver Police Department regarding patients brought to hospital by police under the Mental Health Act
- Privacy Impact Assessment (PIA) 2014 – 13 VCH-PHC-VPD Joint Intervention Programs
- Letter of understanding

(All reports are available from Janet Peters)

Also information on a study was obtained. It looked at a group of local people and what predicts early death. With assertive and effective medical/psychological treatment people could live longer.

The Hotel Study: <http://www.iimhl.com/files/docs/20160204b.pdf>

Host Match Summary. http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Community_Crisis.pdf

Match: Mental Health Literacy - Department of Behavioral Health & Intellectual disAbility Services (Philadelphia)

Key Points

- DBHIDS <http://dbhids.org/> was reconstituted from three prior city agencies. Its responsibilities are for the mental health and substance abuse treatment for adults and children, ranging from acute-care to community support services to private practices.
- DBHIDS does not provide services. Firstly it helps establish, in partnership with the community, professionals, family, people using services, public policy, that leads to strategic planning around responding to behavioural health issues. DBHIDS then contracts for services with a range of outside agencies and providers. <http://dbhids.org/tools/recovery-transformation-papers/> and <http://dbhids.org/community/>
- A new Commissioner, Dr. Arthur Evans established a vision of a recovery oriented system after he was appointed in 2004. *"People would get 'fixed,' then discharged. We were identifying and then treating chronic illness with an acute-disease model."* This was seen as a very passive model /approach which was rejected. The service views clinicians, family, community members, and peers as being options, working together, as pillars of long-term support for a person. Rather than opting to make incremental changes in the existing system, DBHIDS chose a "transformational" strategy that linked a public-health model with individual care and support.

Keywords:

- Single Commissioner – policy, strategy / planning, commissioning of services
- Transformation – an overt statement of intent (a decade of transformation)
- Trauma Informed – practice and development
- Mental Health Literacy – public health / community engagement; a priority

- Recovery – a core and cohesive concept that connects and engages and normalises people’s experience of challenges in life
 - *“Our goal isn’t just symptom reduction. It’s recovery, and since people recover in a community, we also need a continuum of recovery support services like housing, education, social support, and employment.”*
 - People in recovery from mental illness or substance abuse also find a place in the department’s operations at every level, from the main office to the clinic. As well as offering alternative approaches to support, peers are available at points of change or transition, such as when a person first enters the service or leaves; they are also available where a person is in crisis.
 - A focus upon improving mental health literacy within the community through engagement was a priority. Mental Health First Aid was the flagship for achieving this; 1000s of community members (eg. employers / corporations, fire service, police force...) have utilised this option (an 8 hour workshop).
 - The success of the above is no better epitomised than in the annual Recovery Walk. Philadelphia is a city of 1.4 million people (not dissimilar to Auckland). This year, 25,000 walked through the streets of Philadelphia celebrating their own recovery and/or the recovery of those they care for/love. The Mayor was an active participant, acknowledging and celebrating his own recovery journey.
 - Persuading more traditional mental health professionals to embrace the recovery orientation wasn’t always easy. *“It challenges fundamentally the way clinicians view themselves, their role and people with behavioural health conditions and their potential,”* Arthur noted.
 - Because a recovery orientation encourages individuals to drive the process of their own recovery, it can be threatening to professionals accustomed to being in charge. *“People may resist certain treatments or reject professionals’ advice about their relationships - forms of pushback that are good for individuals but may trouble providers.”* A common response is for these individuals to then be labelled “difficult”, or “uncooperative”.
 - *“What we tell providers is that their professional role is enhanced in a recovery-oriented system because they have to have a much broader set of skills and much broader way of working with people”. “It’s relatively easy to help people manage symptoms; it’s much more complex to help people figure out a pathway in life.”*

Over his 10 years in transforming services in Philadelphia, Arthur has concluded that the main barriers to change in mental health agencies are largely self-imposed. *“I’d say 80 percent of this work is conceptual; it’s about how we look at people. If I don’t believe this person can recover, no amount of resources can change that.”*
<http://www.iimhl.com/files/docs/20160204a.pdf>

- I also visited a “recovery school” for high school kids who were recovering from alcohol / drug addictions / abuse. The school followed, and had the same expectations as a mainstream school curriculum, but with the specialist knowledge / experience / resource to support kids’ recovery. When kids exited the school it was based around when they were confident to continue with their recovery, but was also timed to occur at the end of a semester to ensure schooling wasn’t unnecessarily interrupted.

Recovery Walks! 2015 – <https://www.recoverywalks.org/>

Healthy Minds Philly (DBHIDS’ public education site, dedicated to supporting and improving the mental health and well-being of all Philadelphians) – <http://www.healthymindsphilly.org>

Actions

Question: In New Zealand do we have:

- the infrastructure
- the need / desire
- capacity
- capability
- leadership

... to implement similar transformational change? What do we have? What more is needed?

Host Match Summary: http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Mental_Health_Literacy.pdf

Arthur Evans’ presentation at the IIMHL Combined Meeting

http://www.iimhl.com/files/docs/2015Vancouver/Evans-IIMHL-2015Vancouver-Managing_Change.pdf

Match: Community Action for Suicide Prevention (Vancouver)

Key Points

Suicide Prevention has been a focus for the Leadership Exchange with a need to focus both on improving the quality of mental health services and community led initiatives.

The objective of the match was to outline key elements of a systematic and evidence-based approach to suicide prevention in communities, including:

- the elements/aspects of effective, comprehensive suicide prevention community models; and
- the identification of roles and responsibilities for different players in communities.

It was our desired outcome that participants leave with concrete examples of best and promising practices and tools to begin or enhance suicide prevention activities in their communities.

The Zero Suicide Movement is the US led but now international drive to reduce suicide among mental health service users. The rationale is about improving quality of care and improving patient safety for this group have by far the greatest risk of any population group of suicide.

<http://www.slideshare.net/davidwcovington/zero-suicide-international-declaration-draft-01-september-2015?related=1>

The Community Suicide Prevention is a broader, even more challenging undertaking with key themes and approaches emerging from around the globe.

Presentations were made on the following subjects:

- 'Help for Life' Quebec's Strategy for Preventing Suicide (Jérôme Gaudreault, Association québécoise de prévention du suicide, Canada)
- Optimising Suicide Prevention Programmes and their Implementation in Europe (Ulrich Hegerl, University of Leipzig, Germany)
- Aboriginal Suicide & Critical Incident Response Team (Kim Montgomery, Okanagan Nation Response Team, Canada)
- Adolescent Suicide Prevention Program (Patricia Serna, North Central Community Based Services, USA)
- United States Air Force Suicide Prevention Program (Eric Caine, University of Rochester Medical Centre, USA)
- School-based Interventions (Richard McKeon, Substance Abuse and Mental Health Services Administration & Elly Stout, Suicide Prevention Resource Center, USA)
- Disruptive Innovation in Suicide Prevention (Eduardo Vega, Mental Health Association of San Francisco, USA)

Strategies:

- United Nation's Prevention Of Suicide: Guidelines for the Formulation and Implementation of National Strategies
- Scotland Suicide Prevention Strategy
- New Zealand Suicide Prevention Strategy
- Forging an Agenda for Suicide Prevention in the United States
- 'Help for Life' Quebec's Strategy for Preventing Suicide
<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1997/97-237-a.pdf>
- Making it Safer: A Health Centre's Strategy for Suicide Prevention
From: http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Suicide_Prevention.pdf

Actions

- Ministry of Health DHB suicide prevention two day meeting in October (12th & 13th) was an opportunity to share these learnings more broadly. Toolkit from Ministry:
http://www.health.govt.nz/system/files/documents/publications/suicide-prevention-toolkit-for-dhbs-feb15_3-v2.pdf
- "Zero Suicide: An International Declaration for Better Healthcare" has been drafted (via David Covington, US) <http://www.slideshare.net/davidwcovington/zero-suicide-in-healthcare-ppt-timeline-v1-0>

Host Match Summary: http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Suicide_Prevention.pdf

Match: Self-directed Care (Boston)

Key Points

"Self-directed care" (SDC) is an alternative way of delivery services that seeks to empower people by expanding their degree of choice and control in selecting services. It has been widely adopted internationally over

the last decade in community care for people with physical and cognitive disabilities and those who are ageing and has more recently been trialled in services for people with mental illness.

Key components of SDC are:

- Placing decision-making authority over services in the hands of people using them
- Providing support for people to assume this responsibility and assisting people to make plans for social inclusion, fitness, work etc
- Providing a personal budget to pay for goods and services to support their plans
- Expanding access to services to include non-traditional goods and services

Outcomes from demonstration sites have been positive and have included enhanced community integration and housing stability, reduced crisis service use and hospitalisation and increased satisfaction with life and with caregiver reliability and performance. Modelling undertaken to inform the Australian National Disability Insurance Scheme indicated that there may be savings from SDC across the spectrum of expenditure on health, social services and incarceration.

There are many differences in the way in which SDC has been implemented internationally and across the seven United States demonstration sites. These differences relate to: eligibility criteria; scope of goods and services; amount of funding, whether it is tied to specific goals, how it is accessed and for how long; who provides support for planning and the planning approach they use; and the extent of the involvement of peers.

There are challenges in budget-setting and management and in other aspects of implementation and the opportunity to discuss these and share experience and lessons learned are invaluable. There was a great deal of interest among match participants in further collaboration to continue to share information and compare results. (e.g. Scotland <http://socialcareideasfactory.com/>)

Some examples of lessons learned are:

- It may be easier to implement SDC on a small scale and then expand it than it is to implement it wider scale first
- Implementing SDC requires a cultural shift across the whole service system so that it is more responsive to the needs and wishes of people using services
- It is important that SDC does not remove access to essential services in times of relapse
- Careful consideration is needed to avoid creating perverse incentives (e.g. for year-end spending sprees or withdrawal of supports at critical transitions to wellbeing)

Where non-traditional supports are funded, effective monitoring is essential.

Actions

- Participants unanimously expressed an interest in, and a need for, continuing learning exchanges, even if they were only virtual. Charlie Barker-Gavigan from Social Care Ideas in Scotland graciously offered to utilise their existing Sherpa platform as the forum host (as they already have a mandate to foster international collaboration), and to take the lead in future exchanges on self-direction in behavioural health. For this to continue and grow additional funding would be needed.
- Five participants volunteered to work with Charlie Barker-Gavigan to develop, grow and coordinate the learning platform to improve ways in which knowledge, practice, understanding and evidence is used by peers, individuals, carers, practitioners, managers, planners, politicians, local and national government officials to deliver and support better personal outcomes with people and communities. For additional information contact Charlie at charlie@socialcareideas.org.uk

Host Match Summary:

http://www.iimhl.com/files/docs/2015Vancouver/Match_Reports/Funding_of_Self_Directed_Care.pdf

Other information about Integration in Primary Care (post Exchange visits)

- Visited Intermountain Healthcare in Salt Lake City <https://intermountainhealthcare.org/> and SouthCentral Foundation in Alaska to look at the approach these organisations have taken to integrate physical and mental health in primary care and to find out what the benefits and challenges have been.
- Intermountain has implemented Integrated Care Teams (ICT) across many of the primary practices in their organisation.
- They have taken a systematic approach with GP champions leading the way. The practices undertake a self-assessment as part of the planning and preparation for integrating mental health into the teams. They

then work through an adoption stage as the MH clinicians (nurses and psychiatrist) join the team for an increasing number of hours based on utilisation and progress to a fully functioning team that is achieving better outcomes for the patients, reduced variation among clinicians and financial benefits for the practices and broader health system.

The highlights of the Mental Health Integration Model at Intermountain include:

1. Leadership and Culture
2. Workflow Integration
3. Information Systems and Reports
4. Financial Cost of Care and Operations
5. Community Resources

The primary health services are also supported by specialist Mental Health Services for acute care. The focus we took was looking specifically at Mental Health and Addiction Services (referred to as Behavioural Health Services) as part of their integrated care teams and the approach they took to achieve this.

A key focus for SCF is the reference to customer owners instead of patients. The organisation has invested in their staff and all staff demonstrated clarity of the vision, mission, goals, operational principles (relationship) and core concepts (wellness). Workforce competencies underpin recruitment and expectations of all staff with a specific order of priority:

1. Customer care and relationships
2. Communication and teamwork
3. Improvement and innovation
4. Workforce development skills and attributes

CSF made a conscious move from a transactional approach to a service industry model. They have made a commitment to customer owners they will have same day availability for the range of people within the team they may need to see. There has been an emphasis on the environment from the customer perspective as well as to support flexibility of spaces for staff to utilise in the most efficient way.

Integrated Care Teams are set up with a ratio of one team per 1400 customer owners and include the following members:

- GP provider (conductor)
- Medical assistant
- Case manager -nurse
- Case manager support – admin

Shared across teams:

- Behavioural health consultant (BHC)
- Dietician
- Pharmacist
- Midwife
- Integrated psychiatry
- Traditional healers (tribal doctors) are also available to customers

One of the learnings from the SCF experience was the need for the blending of cultures with GPs being able to use psychiatry and Psychiatrists understanding primary care. The team culture is relational with an emphasis on continual redesign. The BHC's are masters level social workers with AOD capability. The focus of their work is on brief intervention with a focus on wellness - physical, emotional, mental and spiritual.

Teams are supported by an integrated information team who provide information to the teams in a meaningful way to support continuous improvement. SCF is able to demonstrate benefits of the Integrated Care Team approach by a 23% reduction in EC visits and 25% reduction in primary care visits.

Reflecting on these visits some of the **key takeaways** for us have been:

- Pushing forward with the integration agenda is the right thing to do
- Primary Care Clinical champions are key to successful Integrated Care Teams
- The importance of measurement – you can't improve what you can't measure!
- The benefits of Integrated Care Teams are demonstrated in the broader health system with fewer emergency department visits and reduced hospital admissions.