

Chapter 1: Citizen engagement

Key messages

Increased complexity of need, increasing demand, and an emphasis on citizenship and citizens' rights is shifting the focus of health and social services to the broader determinants of health and wellbeing. The result at a practical level is collaboration with a broader range of partners based on:

- enhanced opportunities for individual agency (both for people accessing services and those providing support)
- an emphasis on place-based health and collective responsibility for health and wellbeing
- a network of supports that are embedded in and build on existing community networks
- expanded scope and increased fluidity of service delivery
- more adaptive and personalised practice
- altered demand for services through improved community capacity to respond to MH&A need.

The direction of collaborative change is away from traditional hierarchies, organisational solutions, and transactional and regulative approaches, towards equity of expertise, community solutions, and co-creation of support opportunities.

Effective support is *in situ*. It responds and adapts to the person as much as is possible, and it builds on existing social capital: family, peers, whānau, institutions, knowledge, and community.

Introduction

Collaboration in a MH&A context and the future of MH&A services is centred on purposeful, organic and collaborative partnerships between citizens and their support networks. *On Track* (Platform Trust & Te Pou o Te Whakaaro Nui, 2015) and *Towards Integration* (Platform Charitable Trust, 2012) describe an evolved service environment determined by support needs, context, and the intentions and aspirations of people accessing services. In this evolved environment, service delivery is embedded in communities, interconnected with whānau, fluid and adaptable, equitable, and most of all, effective.

This model for the future represents a “paradigm shift” (Roche & Skinner, 2005, p. 4) in the intent and delivery of MH&A services in New Zealand. This section explores this paradigm shift, looking at ways that partnerships and collaborative capability might manifest in a service context. What does an expanded range of partnership opportunities look like for people accessing services? These opportunities are reviewed in terms of citizen engagement, co-design of services, Whānau Ora, and place-based health and community development. This is followed by a series of examples to provide context for the theory.

The Five Year Forward View is ... quite clear about the need for a 'radical upgrade' in prevention and public health, a blurring of care settings and silos, and a more diverse delivery model that has citizen voice and experience at its heart (New Local Government Network & Collaborate, 2016, p. 6).

Citizenship

An exploration of citizen engagement in the context of MH&A services needs to be grounded in a clear understanding of what citizenship means for people accessing health and social services. The United Nations (2006) *Convention on the Rights of Persons with Disabilities* emphasises “full and equal enjoyment of all human rights” for people with physical, mental, intellectual or sensory impairments, because of the disabling effects of “society’s barriers and prejudices”.

Hamer, Finlayson and Warren’s (2014) review of attitudes towards citizenship discusses how the biomedical context of MH&A services restricts opportunities for full citizenship for people accessing services. The authors argue that mental health practitioners often lack understanding of the “oppressive social structures that impact on service user’s status” and limit personal realisation of citizenship rights (p. 209). Assumptions by professionals around people’s competence or insight also restrict choices and place conditions on citizenship.

Citizenship is predicated on opportunities for “personal agency”, including the right to take risks and the possibility of failure (Hamer et al., 2014, p. 703). A recovery focus uses a strengths-based approach that supports people as citizens and allows for personal agency. Hamer and Finlayson (2015, p. 703) state:

Partnerships that support mutual understanding, responsibility and collaboration for treatment planning are one way of reducing the conditions on their citizenship status.

Ideas of citizenship also apply to individuals as members of society (Durie, 2002). Sir Mason Durie’s (2002, pp. 597-598) analysis of the components of citizenship for Māori include:

- rights of an individual to participate in general society
- partnership rights conferred through Te Tiriti o Waitangi, and
- indigenous rights that support Māori rights to “participate in Māori society”.

The implication of these three components is that the state has an obligation to support citizenship based on concurrent realities: individual “equality and democratic rights, participation in society, including te ao Māori”, and the Treaty relationship between Māori and the Crown (Durie, 2002, p. 600). The effect of these approaches across government policy is a strategic emphasis on Māori succeeding as Māori (Comer, 2008). *He Korowai Oranga: Māori health strategy* (Ministry of Health, 2014) guides the direction of the health and disability sector to achieve the best health outcomes for Māori and weaves these three notions of citizenship throughout. The key elements of *He Korowai Oranga* are wai ora (healthy environments), whānau ora (healthy families), and mauri ora (healthy individuals). The strategy has a number of guiding features, including Māori control over their own health and wellbeing, equity, community development, Māori participation, and cross-sectoral effectiveness.

Citizenship confers rights around individual, social and cultural agency. In a MH&A context, these rights necessitate a partnership approach and the creation of opportunities for individuals and communities to determine the shape, nature and context for support frameworks. This review emphasises citizenship rights as the foundation for developing the individual practitioner collaborative capability and shifts in organisational culture and behaviour required to realise the MH&A sector’s broader aspirations around developing collaborative capability and integration across traditional boundaries.

Personalised approaches

The UK place-based health manifesto *Get Well Soon* describes an “arc of citizen engagement”: a continuum of ways that organisations and services can engage with the public (New Local Government Network & Collaborate, 2016, p. 37; citing Involve (2005) as a source). This arc is shown in Figure 1.



Figure 1: Five steps on an arc of citizen engagement

Source: New Local Government Network & Collaborate (2016).

The *Get Well Soon* authors state that organisations commonly engage with the public at the “inform” and “consult” end of the spectrum. They argue that instead “the core of every clinical and professional interaction with individuals” should be based on personalised approaches to health and social service delivery (p. 37). The authors argue that a personalised approach centres on “individual agency, community capacity and social capital” to build a more health-empowered population (p. 35). The benefits include shifting health focus away from reactive, acute, hospital-based services to proactive, less institutional, community-based health and wellbeing services.

The New Zealand Productivity Commission (2005) report *More Effective Social Services* states that empowering clients to make “core choices” improves client wellbeing, but that the system needs to change to allow this to happen. System changes include a shift in the balance of power away from funders and services, the development of mechanisms such as improved funding flexibility, provision of information to support client empowerment, and a shift in attitudes of many providers and government officials. The reforms proposed by the productivity commission are intended to develop client pathways focussed on employment, physical and mental health, and social connections, access to services better matched to need and context, and empowerment through improved information and choice around services (p. 24).

Co-design

Co-design of services is a key feature of the collaboration literature. Co-design utilises the person accessing a service as a design specialist based on their personal expertise (Sanders & Stappers, 2008 n.p.). Co-design allows people to participate in the design of public services in order to better respond to increasing complexity, build trust in government, develop greater responsiveness, relevance and effectiveness of services, and develop social capital (Bradwell & Marr, 2008). Co-design is a way of working together that emphasises:

- equal partnership
- shared decision-making
- innovation
- integration (Co-design Initiative, 2016, p. 9)

Co-design blends community engagement and participatory design and places people accessing services at the centre of design and delivery of services, minimising the power imbalance between different stakeholders. **Co-design is best used in “complex services where expertise and information is widely dispersed, and where it is crucial to build wider support for, and ownership in, the service design”** (New Zealand Productivity Commission, 2015, p. 134).

In the context of integrated services for vulnerable people, Superu has used the Human Services Value Curve (Oftelie & Leadership for a Networked World, 2014) to **describe “generative” processes and outcomes that are based on multi-stakeholder co-creation of resources, services and partnerships to “address the underlying determinants of community health and wellbeing”** (Social Policy Evaluation and Research Unit, 2015, p. 3). **Generative responses develop “healthy communities by co-creating solutions for multi-dimensional family and socioeconomic challenges and opportunities”** (Oftelie & Leadership for a Networked World, 2014, p. 5).

A major challenge for the co-design movement in the context of health services provision is recognising:

The profound cultural, identity and practice challenges posed by co-production at every level and in every area of health system functioning and health professional practice (Dunstan, Lee, Boud, Brodie, & Chiarella, 2009, p. 49).

The co-design process requires what Dunstan et al. (p. 49) call “a co-productive health professional” who has a mixture of technical skills and soft skills, including being good at listening, trusting the capacity of people accessing services to contribute to their own care, and a commitment to equity of relationship between health professionals and citizens.

Bradwell and Marr’s (2008) international survey of co-design of public services showed co-design has moved from a theoretical perspective to a practical approach across a wide range of international public services. However, their review of co-design in Australia and New Zealand found evidence of a narrower, “customer-service” type of collaboration.

Looking at co-design in a more concrete context, the New Zealand Productivity Commission (2015) argues the current system of access to social services fails to respond to variation in the capacity of individuals to coordinate their own services. The authors represent this variation using the diagram in Figure 2.

Characteristics of clients of the social services system

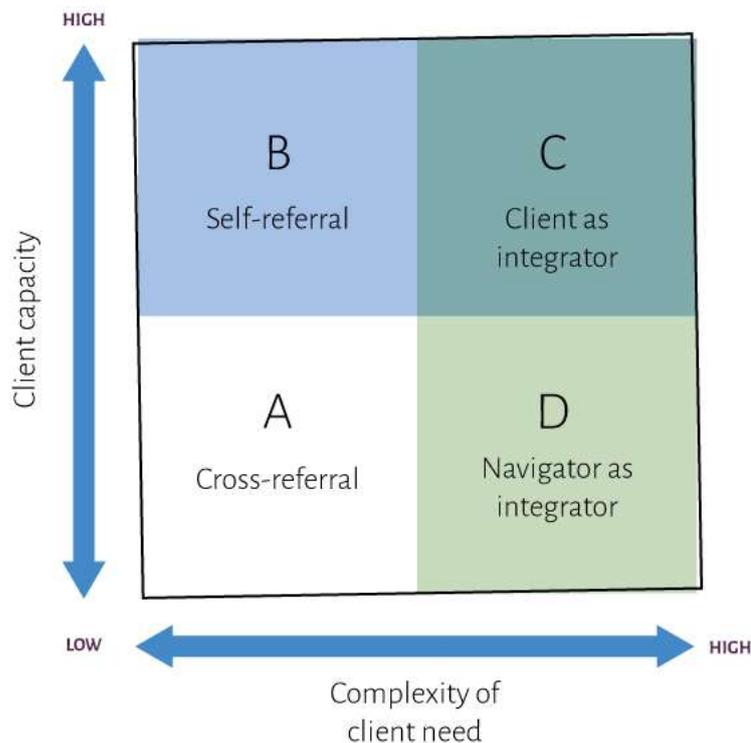


Figure 2: Characteristics of clients of the social services system

Source: New Zealand Productivity Commission (2015).

The group in Quadrant C are described as people with often “complex and inter-dependent needs [who have] the capacity to coordinate the services they require” (p. 53). The term ‘co-production’ is used at a more micro level by the commission to describe the process of clients “tailoring services to meet their own needs” (p. 134). The commission states there is considerable scope in New Zealand for developing “client-directed service models” that offer people scope to budget hold, and select how, and when and from whom they receive services. The commission outlines a number of international examples of client-directed service models (pp. 279-280).

Place-based health

The place-based health agenda in the UK is driven by a shift towards “systems of care” to respond to increasing demand, financial constraint and pressure on services, as well as risks around increasingly siloed behaviour by health agencies and organisations (Ham & Alderwick, 2015, p. 5). The argument is that providers need to collaborate and work together in communities of place to respond to the wider determinants of health: social, economic and environmental. The emphasis on place assumes that most health care provision is local and that integration works best at clinical and service levels (and not so well at an organisational level). Place-based health forces consideration at a local system level rather than “trying to address system problems with organisational solutions” (Kippin & Fulford, 2016, p. 5).

Get Well Soon (New Local Government Network & Collaborate, 2016, p. 40) describes place-based health as a process of understanding local health challenges and opportunities. They describe better use of “social and neighbourhood networks” involving local authorities, schools, businesses, housing providers, community

organisations and local people, to improve health and wellbeing. The authors reflect on two different questions to demonstrate the reasoning behind place-based health. The first is “What health services do you want?” versus “What would help you enjoy life more?” (p. 10). The former is likely to elicit a clinical response: the latter a response around home, family, community, work, or aspirations. Place-based health is underpinned by a system that allows the second question to be achieved, based on the integration of health, local government, housing and other services, and a preventative approach, within a geographic area. Place-based health is also based on an assumption that broad groups of people will be able to collaborate, in community contexts, to develop more local support around health and wellbeing.

Adebowale, Kippin and Billiald (2015 n.p.) describe a paradigm shift, based around place-based “new models of care that transcend existing institutions”. They argue for three shifts in focus to bring about this change:

- responding to demand through a much more profound understanding of community resources
- framing productivity and outcomes away from organisations to collaboration in communities
- a redefinition of patients as “collaborators” and development of collective social responsibility for outcomes.

Community and community-led development¹

Place-based health, as a sphere of changing practice, overlaps with substantial research and resources around community development initiatives to improve health outcomes. Community development is an enormous area of research and thinking, but is only touched on lightly here. There are many resources available around community development as it links to health outcomes.²

Inspiring Communities *Learning by Doing* (2013b, p. 7) emphasises the importance of “community resilience and neighbourhood strengthening” as critical contributors to mental wellbeing and “feeling safe, supported and connected to the people and environment around us”. *Learning by Doing* also explains that community-led development is enhanced through the presence of more active citizens and purposeful support for enhanced collaborative practice.

Mattesich and Rausch’s (2013) research in the US on collaboration success factors highlighted that community development agencies found they could only improve health outcomes when they worked across sectors and engaged with communities, including having leaders deeply rooted in their communities and community ownership of approaches and outcomes. Participants noted the importance of mechanisms for “active listening” and long-term strategies for engagement outside of traditional ways of engaging with communities (p. 8).

Whānau Ora

The New Zealand Productivity Commission (2015, p. 335) explains that the responsibility of government under Te Tiriti o Waitangi is to “create opportunities for Māori groups to exercise mana whakahaere (authority) in delivering social services”, including devolving commissioning decisions to Māori. Whānau Ora represents a comprehensive opportunity to provide integrated services and respond more effectively to whānau aspirations.

¹ Note the definitions of these terms in the terminology section – with the key difference being community-led development’s focus on “place, cross-sector collaboration and inclusion of system change” (Inspiring Communities, 2013b, p. 15: footnote 11).

² For example, Volume 30 of the *Health Affairs Journal* (2011) devotes the entire edition to research on links between community development and health.

Whānau Ora combines all four features discussed so far: citizen engagement, co-design of services, place-based health and community development. It also has a cultural dimension of Māori succeeding as Māori, and of relationships between whānau and providers based on whakapapa (genealogy) or whanaungatanga (kinship relationships) (Taskforce for Whānau-Centred Initiatives, 2010). Feedback to the productivity commission during the development of *More Effective Social Services* identified additional “collective duties of care” arising from manaakitanga (hospitality) and rangatiratanga (the right to exercise authority) (New Zealand Productivity Commission, 2015, pp. 329-330).

The productivity commission emphasises that the New Zealand system of social services needs to be flexible around responding to Māori aspirations and service preferences, and much more nuanced in its understanding of Māori social organisation. The Taskforce for Whānau-Centred Initiatives outlined a series of principles underpinning the development and delivery of whānau-centred services and empowered whānau. These principles include:

- relationships between all stakeholders based on equity, trust, respect, a strengths-based approach, and belief in the worth of each other
- whānau wellbeing, based on the needs, support, aspirations of, and solutions identified by whānau
- adequate time to develop and strengthen relationships, engagement and knowledge
- whānau-centred services based on “integrated multi-service delivery”, early intervention and prevention, collaboration, and flexibility and innovation of delivery
- success measured on the basis of whānau experience and knowledge
- strategic leadership responsibilities of iwi within tribal territories, and on behalf of providers, to identify priorities, hold government accountable, support cultural development and work collaboratively to “benefit whānau wellbeing” (Taskforce for Whānau-Centred Initiatives, 2010, pp. 39-41).

How do theories of citizen engagement work in practice?

The examples provided below give context to citizen engagement, co-design, place-based health, community development, and Whānau Ora, in the design and delivery of services. The examples demonstrate a range of macro and micro ways of thinking about collaboration, integration and collective responsibility for health and wellbeing outcomes. They also demonstrate citizenship in action: opportunities for individuals to have much more control over and involvement in decision-making, through personalised approaches, services delivered and embedded in communities, and utilisation of neighbourhood resources and networks. The examples range from citywide, broad-based objectives, to small-scale local opportunities to work with individuals and their communities.

Personalised approaches

The 3-conversation model

A personalised approach should start with a conversation with a person about their personal goals and outcomes. A good example of this type of conversation comes from the work of UK-based OLM Systems (Newman, n.d. n.d.), which has collaborated with the West Berkshire Council to implement a 3-conversation model to replace the existing triage-assessment-referral approach to accessing care services. The 3-conversation model is mapped out as follows.

Conversation 1: How can I connect you to things that will help you to get on with your life – based on your assets, strengths and that of your family and neighbourhood? What do you want to do? What can I connect you to?

Conversation 2: When people are at risk, what needs to change to make you safe and regain control? How do I help to make that happen? What offers do I have at my disposal, including small amounts of money and using my knowledge of the community to support you? How can I pull them together in an 'emergency plan' and stick with you (like glue) to make sure it works?

Conversation 3: What is a fair personal budget and where do the sources of funding come from? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning? (Newman, n.d. n.d.)

Newman states there are rules associated with the 3-conversation model.

- All options in conversations 1 and 2 must be explored before progressing to conversation 3.
- **Certain terminology and ways of working are banned for example, “triage”, “assessment”, “referrals”, and “waiting lists”.**
- Staff must co-produce a ground-up way of working within this model.
- Data must be collected daily about what employees are doing and there must be opportunities to reflect on practice with peers.
- Staff must get to know the neighbourhoods and communities within which people accessing services live and work.

The result of implementing this model for the West Berkshire Council has been a significant reduction in the number of long-term care packages required, compared to other teams operating using existing methods. OLM Systems report that council employees prefer the 3-conversation approach, even though interactions tend to take longer and staff initially felt “de-skilled” and more vulnerable through being more personally involved in people’s lives. Employees say they have a much better understanding of people, their families and their community context. They feel more pro-active and are able to see things through to a more satisfying conclusion. People accessing services report much greater satisfaction with the process, they no longer have to repeat their story multiple times, they have more autonomy throughout the process, and are more quickly able to access support.

Family Mosaic - personalised support

Family Mosaic is a social housing provider in London, UK. In 2016, they published results from a three-year study comparing health and wellbeing outcomes for 433 tenants aged over 50 who received different health and wellbeing interventions in a randomised control trial. The three different interventions were as follows.

- Group 1 – Tenants received no additional support (the control group).
- Group 2 – Tenants were directed to health and wellbeing services by their local housing manager.
- Group 3 – Tenants “received intensive personalised support from a dedicated health and wellbeing support worker, including being accompanied to relevant local services” (Family Mosaic, 2016, p. 4)
- The findings show that Group 3 interventions resulted in a significant drop in planned hospital usage and emergency GP visits. The results were more prominent in participants identified as very vulnerable. The interventions had no significant impact on acute hospital usage. Many people in the study whose health and wellbeing improved were not previously involved with any local or community health services. The authors argue that the capacity for their staff (who already knew the tenants) to have a positive impact was a result of pre-existing relationships based on trust, a conscious and purposeful decision to connect with tenants, a commitment to supporting tenants in their own home, and a commitment to networking and linking tenants with the services they needed.

- Tenants overwhelmingly responded to having someone to talk to and take an interest in them. The authors discussed challenges around encouraging independence, rather than developing dependency and noted the importance of the specialist skill set in the person providing support. Family Mosaic is exploring opportunities to provide physical space for health hubs to provide health and recreational services for their housing tenants.

The navigator role in New Zealand

There is considerable support in the literature for the development of more personalised and facilitated access to services. This is particularly apparent in New Zealand through the work of the Productivity Commission, Superu, Network 4, and the Taskforce for Whānau-Centred Initiatives.

The productivity commission advocates strongly for the development of “navigator” roles in New Zealand health and social services to better support the most vulnerable people. In the commission’s model, the navigator facilitates access to services via a budget-holding mechanism and works with individuals or with whānau to determine what services are best going to meet people’s needs. The success of the navigator role is dependent on their having cultural and geographic ties, and building a relationship of trust, with the person (or their family or whānau or community). Navigators collaborate with the person needing support and their family and whānau, and allocation of services is based on outcomes agreed by the person accessing services, the navigator and the funder.

Navigators are already being used in Whānau Ora or whānau-based initiatives. Superu describe the features of whānau navigators as being “well-versed in and respected for their knowledge of tikanga and te reo Māori and with extensive community knowledge” (Social Policy Evaluation and Research Unit, 2015, p. 12). An example is the Kaitoko Whānau initiative that implemented whānau navigator roles in 2009. The whānau navigators are hosted by existing Māori providers, and work with vulnerable whānau to assess their needs and aspirations and develop a plan to achieve a range of goals and aspirations (Kennedy, Paipa, & Cram, 2011, p. v).

Co-design

Large-scale co-design examples

Co-design at a system and place-based level (a generative approach) was developed in San Diego County in the US through the development of an integrated child welfare, behavioural and public health agency. The county used a generative approach to develop a 10-year plan to “repurpose” existing budgets to provide wrap-around health and social services, incorporating education, literacy, housing and other socio-economic spheres of influence (Oftelie & Leadership for a Networked World, 2014, p. 18).

In Australia, the Brisbane Primary Health Network used co-design to develop a mental health intervention through the Partners in Recovery programme (Cheverton & Janamian, 2016). Stakeholders in the co-design process included specialist MH&A services, primary health providers, emergency services, social services, people accessing services, and their families and carers. More than 100 organisations were involved in the development phase, and workshops with stakeholder groups identified key outcomes of the model. Twenty-two organisations formed a working collaborative and from this a management committee was formed. Consumer and carer representatives met regularly with CEOs and senior managers of agencies to share experiences and map out service initiatives. Feedback was provided to all stakeholders through social media, newsletters, website and annual forums. The primary health network provided backbone support, but otherwise power was shared equally and the process operated as a high-trust model.

The co-design model expanded to consider practical approaches to improving an individual's journey across the primary and secondary interface. A wider advisory group, including disability services, police, emergency services, housing and homelessness agencies, has been established to develop better integration responses. Further collaborative work has occurred with community pharmacies, employer groups, and the development of stepped-care housing and support models. Consumer evaluators are currently reviewing the project. Early reports show a significant reduction in unmet need and improvements in connecting to services. The major challenges reported are around the time commitment in co-design processes, and the difficulty for agencies in **giving up “long-held models of care that may work for individual agencies but are not effective from a systems perspective”** (Cheverton & Janamian, 2016, p. S40).

Some smaller-scale co-design examples

Research in the UK (Freire & Sangiorgi, 2010) compared four completed co-design health projects, and evaluated the extent to which the projects transformed healthcare systems and processes. The projects were for:

- 1) self-managing diabetes (Agenda Cards).
- 2) motivating people to conduct healthier lives (Activmobs).
- 3) engaging people not connected with primary care services (Open Door).
- 4) improving care for people with multiple sclerosis (Enable).

The authors considered drivers and barriers for healthcare innovation and identified success factors for co-design processes. Their results indicated that successful co-design should be more than a person-centred approach. **Instead it must be “centred on the community of co-creation” in order to unravel the “professional-patient relationship”, which (echoing the findings of Dunstan et al. (2009)) they argue is one of the main barriers to the transformation of healthcare services (p. 9).**

The most successful projects reviewed were Activmobs and Open Door. Activmobs created opportunities for people to participate in the design of services, then used their ideas to implement and develop a service platform solution to support lifestyle change. Open Door engaged the whole co-design community to completely rethink **the core “assumptions of what a normal healthcare centre should be” (p. 9).**

Co-design is already used in the disability sector in New Zealand, with individualised funding packages available for a range of services in certain geographic areas. The *Enabling Good Lives* individualised funding model was rolled out in Christchurch in 2013, using a deliberate co-design approach to develop the demonstration model. The model is centred on individuals and families having one plan, developed around their strengths, preferences and aspirations, and control over pooled funding that enables them to access supports of their choice (Enabling Good Lives, 2016).

A review of the Christchurch Enabling Good Lives demonstration identified that the co-design process needed to be much more clearly understood by all parties, in particular that the principles and practice of shared decision-making needed to be very explicit in order to be implemented effectively. The other key lesson from the demonstration was that the implementation workload was much higher than expected, particularly around setting up funding and administrative systems, developing key roles, and understanding the model in the context of community development processes (New Zealand Productivity Commission, 2015).

The Australian National Eating Disorders Collaboration (Dunston et al., 2009) is a partnership between researchers, clinicians, people accessing services and their carers to develop resources for people recovering from eating disorders. The process of developing the resource involved an iterative series of conversations between

partners, utilising people's personal experience and specific expertise across an oversight group, a reference group, and a staff team. The end result is a module-based resource that is still evolving. See www.nedc.com.au

Co-design resources

Waitemata District Health Board (2010) has a Health Service Co-Design web resource to support health services undertake co-design processes to develop a new service, improve an existing service, or solve a specific issue. See <http://www.healthcodesign.org.nz/index.html>

The Co-design Initiative (2016) resource contains a number of practical examples of co-design in the Australian MH&A sector and links to other international co-design resources. See <https://auspwn.files.wordpress.com/2016/05/codesign-shared-perspectives-report-vf1-5-040616.pdf>

Place-based examples

The place-based examples below illustrate ways of reframing communities of place as catchments for planning responses to health and wellbeing challenges. The scale of the response can be large (for example, citywide planning to develop healthy communities), small (for example, localised integration supporting healthy communities), or adaptive (for example, de-centralised support across multiple sites). The central frame in all cases is thinking about health and wellbeing in the context of communities of place, regardless of whether that place is a city, a neighbourhood, a school, a marae, or a person's home.

The implication, in terms of collaborative capability, is that relationships and partnerships are with a much wider set of stakeholders and the notion of expertise is dispersed across more diverse environments.

On a large scale

The development of large-scale place-based initiatives revolves around frameworks that support individual agency and active citizenship. The King County³ Board of Health in the US developed *Guidelines: Planning for Healthy Communities* (2016b) to influence local land use and transportation planning and development that supported healthy choices for all people and communities. The guidelines outline community-planning elements that influence physical activity, nutrition, harmful environmental agents, active transport, injury and violence prevention, tobacco and alcohol use, mental health and wellbeing, and access to health care (Fleming, Karasz, & Wysen, 2010, p. 13).

King County has also recently published its *Draft King County Equity and Social Justice Strategic Plan 2016-2022* (2016a) developed in collaboration with county employees and community partners. The plan aims to shift county practices from reactive to proactive investment in equity (digital, economic, education, environment, health and human services, housing, justice and transportation) through coordinated cross-sector solutions. All government departments are legally obliged to consider equity and social justice objectives in their planning and decision-making processes (King County, 2016a).

The Association of Greater Manchester Authorities in the UK has developed a memorandum of understanding to guide health and social care integration, and implement health and wellbeing priorities. These priorities include:

- giving children and young people the best start in life

³ King County is in the US state of Washington and includes the city of Seattle, population 1.9 million as at the 2010 census. Source United States Census Bureau www.census.gov.

- supporting the community to improve their own health and wellbeing
- shifting health provision into community settings
- providing support based on right place/right time principles
- **“turning around the lives of troubled families”**
- improving mental health and wellbeing
- increasing employment and productive opportunities
- supporting independence for older people in their community (Manchester City Council Health and Wellbeing Board, 2015, pp. 1-2).

Manchester City Council’s overarching objective is to shift health outcomes from some of the worst in the UK to some of the best, through “a focus on prevention of ill health and the promotion of wellbeing” (p. 1).

The state of Virginia in the US has developed a plan for wellbeing for Virginia. One of the plan’s goals focuses on the system of health care: “with a strong primary care system linked to behavioural health care, oral health care, and community support systems” (Virginia Department of Health, 2016, p. 34).

The strategies identified to achieve this goal include the development of accountable communities of care, access to primary care via “patient-centred medical homes”, integration of primary care with behavioural health care, addiction and oral health care services, and reorganisation of health care payment systems around prevention and support for health and wellness (p. 34).

At a similar level in New Zealand, the Canterbury Clinical Network aims to transform the Canterbury health system through integrating health and social services, keeping people, families and communities at the centre of the system, and using devolved resources to improve health outcomes. The network supports people to take greater responsibility for their own health and wellbeing and enhances local services to provide continuity of care and maintain people’s independence at home and in their community (Canterbury Clinical Network, 2016).

At a more local scale

Network 4’s *Closing the Loop* (2016) vision for MH&A services amalgamates place-based health and co-design of service pathways. *Closing the Loop* advocates for development of fourth-wave health and social systems focussed on citizen wellbeing, integrated support, and effective outcomes. The authors argue that meaningful outcomes need to be based around services that are located close to home, easy to access and use, culturally appropriate, and available in a variety of settings. They advocate for “Healthcare Homes” that connect individuals with a wider health and social system, facilitating access and coordinating care.

An international example of a ‘healthcare home’ is the Brandywine Centre in Coatesville, Pennsylvania in the US. The Brandywine Centre is a collaborative organisation providing health and housing services for low-income residents. Services provided on-site include housing for low-income seniors, critical health care, dental care, paediatric behavioural health services, prenatal care, support for chronic disease management, mental health services, social services and interpreter services. The centre has a pharmacy, a children’s library and a community meeting space. The foundation that governs the centre provides nursing scholarships, college scholarships, youth mental health first aid courses, a youth intern programme, equity programmes, and health enrolment programmes for uninsured and unregistered residents (Brandywine Health Foundation, 2016a)

The guiding principles for the Brandywine Health Foundation are stewardship, equity, wellness, collaboration and leadership. The foundation’s strategic principles on collaboration and leadership state:

The health and well-being of our entire community requires meaningful collaboration between civic, government, education, business, healthcare, community-based organizations and the public in order to address a broad range of personal, social, economic and environmental factors that influence health status and health inequalities ... By strengthening and broadening community leadership and participation, we will engage stakeholders to find solutions for promoting improved healthcare and health outcomes for all. (Brandywine Health Foundation, 2016b)

The Loft service at Eastgate Shopping Centre in Linwood, Christchurch combines place-based health and co-location of services. Co-location is defined as agencies housed in one building but not necessarily providing coordinated services (Social Policy Evaluation and Research Unit, 2015, p. 5). The Loft development houses a range of social and health services to create a one-stop-shop family and community wellbeing centre. The intent is to develop collective capacity through shared location, better service accessibility and reduced complexity for people accessing services. The choice of location is important because of the existing high-volume public use of the site as a shopping mall and public library. The intent is also to provide hot-desk space for other agency staff (Police, Inland Revenue, and Ministry for Social Development) to maximise the provision of services locally (Aviva Family Violence Services, Barnardos, & Family Help Trust, n.d.).

The Kohitanga collective in South Auckland providing Whānau Ora services has implemented a number of service co-location and place-based changes to improve accessibility and to better support whānau needs. These changes included hosting external services on site (psychologist, drug and alcohol services, pharmacy services), developing relationships with additional services (credit union and budgeting services), expanding the scope of services (parenting programme), and expanding the range of services (educational support) (Te Puni Kōkiri, 2015, p. 81). The collective provides services across a range of sites including marae and local medical centres and is developing its capacity to provide alcohol and other drug, and mental health secondary services from community sites.

Kapiti Youth Support is a one-stop-shop provider of health and social services for youth aged 11 to 25 years. Like MH&A services provided in schools, youth services such as Kapiti Youth Support improve uptake of services by building relationships, establishing trust and providing a more seamless experience for young people accessing the service. Specialist services (e.g. child and adolescent mental health services offer services from the Kapiti Youth Support site, and the provider has working relationships with a range of community, health and social service providers (Aldridge, 2012, p. 74).

Horizontal integration

The discussion around citizen engagement and place-based health, focuses thinking around the location and manner of service delivery. It emphasises the capacity for services to be more responsive to, and adaptive around, meeting people's needs, as well as providing opportunities for people to more actively engage in and determine their own health and social outcomes.

The implications in terms of collaborative capability are around reframing who partnerships are with and in what context. The examples below act as prompts around expanded networking in communities of place. Other features for consideration include nimbleness and fluidity around the shape and nature of how services are delivered, the benefits of freeing up existing hierarchies or professional boundaries, and the necessity of embedding services in community contexts.

Co-location and place-based health can occur through the location of services in existing institutions. In Denmark, GP practice is more fluid, less anchored in traditional practice settings and uses co-location to

enhance collaboration across the primary/secondary interface. In Danish hospitals, GPs are employed part-time to support the coordinated management of people with multiple health needs and to facilitate transition of patients generally along their care pathway. In some instances, GPs are also attached to local social services in order to achieve greater integration between health and social care. GPs are expected to provide individual care, as well as develop system improvements to improve organisational integration. In Norway, GPs are also required to work in activities in school health and nursing homes (OECD reports on health care in Denmark and Norway; cited in OECD, 2016, p. 96).

Another example is the embedding of MH&A services in schools. There is considerable support for, and evidence in the literature of the success of provision of MH&A services in school settings (Ballard, Sander, & Klimes-Dougan, 2014; Grossman & Vang, 2009; National Association of School Psychologists, 2015; Powers, Swick, Wegmann, & Watkins, 2016; Taras, 2004). For example, Grossman and Vang (2009) cite multiple studies showing that youth accessed physical and mental health services much more frequently and proactively when services were co-located on school sites. *Closing The Loop* (Network 4, 2016, p. 24) includes an Auckland case study of nurses, GPs and psychologists housed in schools, with referrals made by teachers and school counsellors. The result has been increased uptake of services by students and improved ease of referrals into secondary MH&A services.

Odyssey House in Auckland provides an alcohol and drug treatment programme and delivers services across a **variety of settings: in individuals' homes, as part of residential services, in institutional settings such as schools and prisons, as well as in workplaces** (Aldridge, 2012, p. 78). Odyssey House has extended the reach of addiction interventions through the upskilling of primary care providers at an Auckland medical centre. Odyssey House specialists worked alongside primary care professionals to integrate addiction interventions into regular primary care practice (Network 4, 2016, p. 23).

The provision of Mental Health First Aid programmes by Ko Awatea in South Auckland is another example of fluid service delivery and the embedding of services in local community contexts. Counties Manukau District Health Board provides mental health first aid programmes to any adult living within its geographical area. The programme teaches lay adults in the community how to assist people who are developing a mental illness or are in a mental health crisis (Ko Awatea, 2015).

The Prime Minister's Youth Mental Health Project takes a population focus at a policy level but applies it across spheres of influence that are local and community-oriented. The project is currently implementing 26 initiatives across health, education, social development, **Whānau Ora and place-based locations.** The initiatives range from online tools, new school-based behaviour and wellbeing programmes, development of existing school-based **health, social and Whānau Ora services, youth-specific workforce training, development of youth-specific services, and improved access to existing MH&A services** (Ministry of Health, 2016b)

Superu's 2016 review *Going Digital to Deliver Wellbeing Services to Young People* considers opportunities for different ways of delivering services that are "devolved, user-centred and co-created" (Social Policy Evaluation and Research Unit, 2016, p. 2). The report notes the capacity of technology to overcome barriers to accessing traditional services, offer more democratic support options that are available closer-to-home, and provide enhanced opportunities for self-management.

Conclusion

Citizen engagement frames the idea of collaboration in two ways. First it looks at the responsibility of the MH&A sector to respond to individual citizens. What does a partnership based on equity and trust look like with individual citizens? The literature describes this in terms of partnerships with citizens based around personalised approaches to developing support options, individualised funding packages, or the use of navigators to personalise and guide access to services. The emphasis is on the rights of people accessing services to work in partnership when determining the shape and nature of support options.

The second way of looking at collaboration is around social citizenship. Citizens are situated in communities, and the context of those communities should determine the nature of the health and social sector response: whether it is planning for health and wellbeing at a city-scale, or local community-based responses, or adaptable **services that reach and impact on citizens in more effective ways. Whānau Ora inherently does both things; it sets up a system of support that responds to individual need, and at the same time establishes a support response around the individual in the context of their whānau and community.**

The implications for the MH&A sector are a workforce development approach that supports the development of a much wider set of collaborative skills, in particular:

- the capacity to work in partnership with individuals in a way that is meaningful and effective
- the capacity to collaborate in varied community contexts.

The section that follows explores the collaborative capability required to work in partnership with individuals and to collaborate across a range of community settings.