IIMHL 2013: Workshop Notes

During the IIMHL Network Meeting there were thirteen workshops held. The focus of these was to: discuss and document:

- *best practice*
- *challenging issues for the future*

Each workshop had two facilitators and a scribe. Below is the information collected from each.

Contents

1. Indigenous and Other Cultures

Facilitators: Rose Scones Le May & Moe Milne

Scribe: Carole Maraku

Issues

- Access – having to leave area and community to get services
- Ownership of services or cultures – 'locally' owned or imposed?
- Effectiveness – do services work? Indigenous knowledge
- Do services reflect what "people" want or what funders/government wants?
- Holistic integration – social determinants break down silo thinking/doing
- Political will and making influencing decisions from a cultural/clinical framework
- System based issues – relationships – personalities
- Lack of understanding – i.e. peer pressure (importance of Powhiri)
- Entry criteria – from secondary services (NASC) – clinical not holistic
- Media
- Remote, suicide issues – empowerment
- Language barriers – understanding the system
- "We don't have the funding for that" – "I am not funded to cover that" - $ not people
- Whakapapa – "Keeping momentum going"
- Lack of political voice
- Employment – Housing – Benefits – Attitudes – Discrimination

Intergenerational impact – histories

- Accessibility – appropriate/available
- Cultural: health literacy; lack of resources, funding/contracts
- Political: different levels of government – pass the buck
- Accountability: community shift
- Output focussed, not outcomes
- $$ still sit in hospital services
- No Te Tiriti o Waitangi acknowledgement

Workforce development

- Ageing workforce
- Reliant on kaupapa services rather than main stream competencies

- NASC – referrals – only decision-makers
- NZ - Whanau Ora
- Funding needs to transfer to community's development – goal posts shift

Solutions

- Shared interests
- Collaboration between agencies
- Learning across systems and countries
- Funding follows purpose
- Community development approach
- Leaning to tolerate learning
- Partnerships
- Active participation

2. Systems of Care & Wrap-Around Approach

Facilitators: Bruce Kamradt & Trish Davis & Dr Bronwyn Dunnachie

Scribe: Dr Bronwyn Dunnachie

Approximately 50 participants joined a lively discussion which followed brief presentations by the facilitators on the philosophy of System of Care Service Delivery, and examples of the Wrap- Around approach, both nationally and internationally, inclusive of the whanau ora approach in New Zealand.

Key issues

- Wraparound Services provide a comprehensive service to children and families in a collaborative, cohesive, outcomes-effective and cost-effective manner
- Wraparound incorporates a philosophy of values and beliefs, which include being strengths based, family focused, and culturally competent. Whilst Wrap-around is complex to measure from an evidence-based perspective, it has been established as a promising, evidence-informed practice.
- This approach to service delivery is being promoted at an across- Ministry level, and identified as a key strategy in the opening conference speech offered by the Honourable Peter Dunne.

- The Whanau ora approach in New Zealand has been championed by the Honourable Tariana Turia. Whanau are at the centre of service delivery. A description of the outcomes of the Whanau ora approach is available on MOH website.
- The High and Complex Needs Unit in NZ provides another example of local System of Care influenced service delivery.
- The Strengthening Families initiative was also presented as a System of Care approach

Barriers and possible solutions in NZ to System of Care service delivery include:

- Current funding model- Planners and Funders present in the audience supported the potential for changes to be made in contracting processes
- Across-Sector/across Ministry initiatives need 'amping-up'
- Current understandings regarding information sharing need challenging- The concept of one-plan/one 'sign-off' for information-sharing was proposed
- The issue of transparency in service delivery was raised with regards to collaboration- i.e. services being prepared to be openly held accountable for their quality of service-delivery and the effects of this on collaboration, but this was not viewed as insurmountable.

Further information on the Milwaukee model was made available through a key-note presentation offered by Bruce Kamradt on the final day of the conference.

3. Employment Solutions

Facilitators: Helen Lockett & Jane Melton

Scribe: as above

The Group identified a number of challenges and solutions (outlined below) which were common across the IIMHL members. We felt that there was a need for sharing what works across member countries and in particular the development of a framework of employment solutions which show how to include multiply agencies and use integrated funding arrangements to enable people with mental health and addictions to both stay in work and return to work.

Problems / Challenges

- Skills deficits amongst mental health practitioners – needs educational solutions
- Labour market constraints
- Funding silos - need integrated funding streams across government departments

- No coherent framework / standards of practice for employment solutions across regional areas which cover multiply agencies
- Mental Health systems themselves can prevent employment solutions
- Stigma and Discrimination (in mental health services as well as in general population including employers)
- Legislative processes
- Employment not seen as a clinical solution – so not used (an attitude problem)
- Some countries have no employment policy to guide commissioning processes
- Rigid definition of work – can be anxiety provoking for people who use services rather than look at part-time, flexible hours arrangements

Solutions

- Keep profiling why we need to drive employment solutions – primarily to support citizenship of people who experience mental ill health
- Public health, trade unions, employees, Employment Development Centres / Department of Work and Pensions
- Leadership commitment, shared outcome objectives
- Credible standards set at Government level for workplaces (note: see Canadian standards)
- Articulating arguments for evidence based employment solutions in terms of financial gains rather than solely on health gains.
- Social marketing of evidence based interventions
- Ensure that we evaluate outcomes of employment programmes and disseminate findings
- Review the bigger picture to see the potential of employment solutions and to agree actions
- Work with employers to enhance understanding of benefits of supporting people who experience mental ill health in their workplace and to seek solutions
- Routinely reporting formal metrics of the employment status of people who use health services and the employment interventions / solutions that have been offered and the employment outcomes achieved
- Modelling best practice as employers ourselves and supporting other organisations with their employment solutions.
- Societal values / pledge to support employment for all – community / cultural element
- Intentional peer support in the workplace
- Bespoke anti-stigma campaigns in communities and amongst the mental health workforce around employment capabilities and solutions
- Dynamical systems theory for cultural change
- 'Champion' referrals to evidenced based programmes e.g. IPS (Individual Placement and Support)
- 'Fit notes' rather than 'sick notes' at primary care level to maintain people in work and which clearly outline adjustments / accommodations which would be needed (if relevant).
- Curriculum for training all mental health practitioners to include the importance of facilitating employment solutions and the evidence -Mental Health training in the workplace particularly.

4. Clinical Excellence

Facilitators: Ken Thompson and Mark Smith

Scribe: Mark Smith

What is the problem with clinical excellence? What is the solution?

- Mandates rigidly insulate us from cradle to grave. Irrespective create gaps (i.e. ageing populations 14-17's black hole, different silos, substance set MH as opposed to BP). Solution – to have MH/subs use pulled in together.
- Variance of service experience. Bad to excellent. Gaps, what evidence/time struggle, built in efficiencies.
- Patient experience (patient define) what is the gap. Poorly constructed pathway -"what is an excellent outcome for me?"
- Bring CE to scale of BP. What is the maximum standard?
- Issue is not engaging people in their recovery.
- Be mindful of person and their support network/family.
- Look at all social determinants of health, look at balancing the whole person.
- Couple of useful words – intensify service and intensify practice/support system and open up time and space.
- Clinical best practice (CBP) – what tools and assessments determines their definition of what that means as a CE.
- Medical model is impoverished view not usually helping people. No engagement.
- Social vs. medical model.
- Cultural marriage best possible skills and clinical knowledge of what they see as wellness.
- CE defined by itself. Starts with outcomes or goal achieved or vision that one is looking for. May need clinical and blend with other services that may support the goal.
- Evidence based practice – what is the core.
- CE - isn't static, constant learning
- It has to be measureable
- Problem is silos do not include other disciplines

Best outcome – who is it?

- The person's outcome is another case need to be heading as a start.
- Measurement is a number of different things – process of getting there is my part.
- MH social elements are intertwined can/should be looked at all levels of supports/health/social.
- Too often don't check the data and imbed in quality improvement measures should come from the variety of data focus.

Need for strong leadership:

- Individual treatment/ consumer feedback quality of life measure.
- Team approach/ multi-disciplinary.
- Issue of hanging on to model. Need to scale up the data nationally. Need to ask the hard questions. "What are the point of MH services and clinical interventions?"
- First "do no harm" but can't always solve all person's problems.
- Supporting recovery and resilience of persons.
- CE common threads – senior management leadership enables clinician's data consumer voice – what stops us from doing these things.
- Preventative care first starts.
- Need good bedside manner/respectful.
- Silos of MH by itself is an issue.
- Social engagement.
- Remoteness.
- Taking CE out of MH world.
- CE where does it start/uncollected families.
- What is important in this as a family? Do we know our connection? That is the beginning /foundation engaged in service design.
- Leadership helps to make this possible protection.
- Well in self as a healer awareness.
- Foresight looking down the road.
- Need to have an idea of best outcome – vision/goal.
- Funding 'wisdom' in practice and how do we honour individual wisdom/spiritual care in indigenous groups.

What are the elements of BP/CE?

Challenging issues:

- Defining CE.
- Measuring it, the right thing.
- Statistical thinking and funding.
- Changing face of workforce to engage them in looking at solutions. All kinds of players, community support professionals.
- Stop being different.

5. Using Information Technology

Facilitators: Steve Lurie and Lorna Murray

Scribe: Steve Lurie

Steve provided a summary report on the match on data, indicators and quality to help kick off a discussion:

- Sessions focused on the collection and use of data at the organizational and systems level.
- New Zealand is trying to change their focus from information collection to information use. They have developed some framing questions:
- Purpose/questions: does what we do match what we should be doing, what should we be doing? How well are we doing, what are we doing?
- The NZ KPI process was described, including the process for sector engagement, indicator selection and benchmarking. 13 core indicators and 40 supplementary indicators have been developed and HONOS is used to measure change in patient functioning across DHB services.
- NZ has also had a project dating from the early 2000's. (Knowing the People Planning KPP) which has focused on high need service users. Found that process changes such as having treatment plans for 90% could lower admissions by 26%
- The NGO sector is collecting data but it not linked to hospital data. Many lack infrastructure, but larger organizations such as Pathways are developing electronic health records, with service user portals and are staring to use the WHOQOL (quality of life instrument) to measure recovery and drive service planning. Capacity needs to be increased to frame quality improvement questions, and use data collected for service improvement. WHOQOL is available in 39 languages, is culturally appropriate and seems to align well with the Camberwell assessment and service planning that are being used in the UK, Australia and Ontario (OCAN)
- The potential to use big data and clinical decision support to drive care and professional training was also explored.
- Finally the IIMHL Clinical Leaders MH indicators project was presented, though there was little time for discussion and interaction. Concern was expressed about the continuing focus on hospital based measures and the challenge of data availability to assess systems in terms of their recovery orientation, social inclusion, employment and housing.

Can we think outside the box and try to measure the areas identified in the MH strategies across countries?

For example:

- Is access to primary care changing/improving?
- Is access to mental health supports increasing in workplaces and schools?
- Is access to peer support increasing?
- Is the mental health share of health and social care funding increasing?

- Is the rate of homelessness among people living with mental illness decreasing?
- Are rates of compulsory treatment changing (decreasing)?
- Are the numbers of people with mental illness involved with the justice system changing as countries focus on diversion?

Issues: as discussed by the group

How information is used to assist in recovery:

- Data exchange
- Use of video technology
- Website innovations
- Online MH services
- Online decision support
- Use of technology for tx, knowledge exchange, clinical tool to reduce waitlist
- Clinical tool and service user information
- Planning / decision making
- One idea that will improve services
- Information use for quality improvement

New Zealand

- NZ Mindlink Project – service user information – data mind to get information on CTO – how to balance service improvement / privacy /confidentiality
- NZ KPI Project – individual information is anonymised
- Need for rules on how information can be used, rules can be quite variable
- Service user access / portals should be mandatory
- Use of ipads for community support staff
- Cheryl Forchuk's project Canada – access through iphones http://www.lfpress.com/2013/03/20/mental-health-patients-track-their-own-moods-in-research-project
- In NZ text messages regarding appointments - not allowed in Ontario
- Many NGOs in NZ don't have infrastructure to transmit secure information. Can't send emails (by law)
- Service user consent re texting etc.?
- Using online training isn't financially supported by funders
- OCAN integrated assessment reader and privacy issues (Ontario) discussed https://www.ccim.on.ca/CMHA/OCAN/default.aspx and https://www.ccim.on.ca/IAR/default.aspx
- NZ KPI now allows for international comparisons about service delivery in various districts
- NZ KPI project data published on NDSA website, now getting NGO data – helping coordinate this system http://www.ndsa.co.nz/OurServicesWhatWeDo/MentalHealth/KPIFramework.aspx

If I had a million dollars

- Invest in accessible pad for frontline workers to enter and use clinical data
- Build a culture of clinical support rather than resistance to data collection
- Circulate clinical data to teams
- Don't be target driven, rather understand what you are collecting
- Public private sector partnership to make myrecord.com available to service users

- Improve information exchange between primary health care and mental health
- Spend dollars in change management / staff training – define meaningful data
- Improve information literacy
- Give clients access to computers etc.

6. Workforce

Facilitators: Dr Michael Hoge & Robyn Shearer

Scribe: As above

The facilitators first reviewed potential content areas for workforce innovation as identified during the recent Exchange on workforce development. Participants then were divided into three groups and instructed to identify one workforce solution or best practice to highlight for other delegates to the Network Meeting. Each group, working independently, chose to highlight a unique foundational principle for workforce development in mental health and addictions, citing some specific examples of the principle. The principles and examples are as follows:

Broadening the Concept of Workforce.

The first group emphasized the importance of broadening the workforce in terms of its composition. They envisioned a workforce of the future in which clinically trained graduate level professionals constituted an important, though less dominant portion of the workforce. In this evolving workforce there would be greater representation from and training or "upskilling" of peer support workers, psychosocial rehabilitation providers, and individuals with undergraduate degrees in fields such as psychology. Such initiatives are in progress in most countries, but Ontario was cited as one example. Building this workforce requires identifying core competencies for each group, followed by effective training, supervision, and support. This trend to broaden the workforce is driven by both philosophies of care and the economics of mental health and addictions treatment.

Systematic planning and development.

The value of sustained planning and implementation of workforce development strategies was emphasized by the second group. Great importance was placed on a combination of national or regional leadership in planning, combined with local ownership in identifying needs, setting goals, and managing a continuous process to strengthen the workforce. Examples of this approach cited by the group included the work of the Alaska Mental Health Trust Authority, supported by WICHE and the Annapolis Coalition, as well as the role played by Te Pou in guiding workforce development activities in New Zealand. This breakout group also identified "grow your own" strategies as a key best practice in developing a workforce that is committed to a life of service in local communities.

Competency Development.

The third group centred its attention on the importance of competencies in the development of the workforce. Members of this group emphasized the need to identify common or core competencies as well as specialty competencies for the different sectors of the workforce. Devising and implementing strategies to evaluate the competency of workers was also highlighted, using techniques such a live observation, video recordings, and the use of actors in simulations. The use of supervision after initial training was considered paramount in achieving skill adoption. Also prioritized was the identification of strategies to promote the adoption of competencies once identified. Best practices cited included an Australian initiative in which consumers evaluate workers, as well as Te Pou's *Let's Get Real* initiative in New Zealand.

7. Family/Whanau

Facilitators: Christine Zander-Campbell and Mike Seward

Scribe: As above

copmi.org.nz
Definition of family
Definition of whānau

Homelessness and housing

- Impact on families
- Looking at solutions
- Need for flexible arrangements
- Family consulted and kept together
- Relapse/frequent admission – discharge with little or no planning
- Lack of consideration by clinician of family environment when discharging people
- Better provision here in Auckland for housing though established housing trust: needs to be more capacity created for this.
- Inconsistent application even across NZ

FAMILIES HAVE A RIGHT TO SUPPORT!

Family involvement in prison settings

- Provision of a "Halfway House" for family and children of inmates can be located in proximity of prison (maintaining mother/child connection).

- In Canada: a stepped programme exists for people with mental health or addiction issues. Also high penalties for breaches and withdrawal of those privileges.

Inclusiveness

- **Value of** family input – generally don't value family as mental health services providers.
- Educating clinicians in the value of including family
- ADHB has continual survey process which has led to service improvement
- 17/20 DHB employ family advisors
- Families not involved in transition from secondary to primary care
- Use/promotion of advanced directives with regard to involvement of family
- Workforce development – training of inpatient staff
- Regular review with service user/inpatient re involvement of family as practice standard
- Role of family peers (W. Australia SFMI) – paid and voluntary: parent to parent model

8. Primary and Self-care

Facilitators: David Codyre and Patrick Geoghegan

Scribe: As above

Best practice

- Easy access to continuum of primary self-care options – barriers removed
- Pathways from primary care to arts and culture responses
- Universal access (innovation)
- More focus on prevention and health promotion
- More openness to holistic medicine
- Proactive healthcare that encourages regular check-ups and proactive interventions
- People feeling motivated to take responsibility for their own wellbeing
- Easy and immediate access to GP services (phone, email, internet)
- Access to primary care online
- Prevention focus
- Access via primary care/self-referral to holistic, health supporting options, e.g. exercise, diet etc.
- Building resilience
- Access to alternative ways of healing
- Person centred home care coordination co-management with specialists universal screening
- A heath system that respects a variety of health and wellbeing approaches, not just Western medicine

- Mixed care options etc. – alternate cultural, social
- Access to care with clear referral pathways
- Clinical pathways are constructed and used for each diagnosis
- Access to MH professionals in primary care
- Multiple entry routes to services
- Focus on wellness, recovery
- Operating hours don't meet needs of customers/patients
- Access to nurses for education and dietician for education around self-care.
- Specialists do all out patient work in community primary settings
- Early intervention focus and access across the lifespan
- No cost / low cost
- An affordable health system for all – highly accessible via person to person or e-practice
- Recognition of adversity / psycho – social determinants
- Primary care is the medical home for mental health with access to specialist advice
- Remove the idea of primary and secondary and wraparound the right people, right skills, right time
- Access to service – client remains in primary care, only going to secondary sector here for a specialist treatment, then back to primary. As for physical heath, so for mental health.
- Easy access of services
- Clients hold funds and choice! (E.g. a voucher system where clients shop around).
- Forward planning – advance statements.

Electronically-Enabled / E-health

- Personal, portable, accessible, health information
- Patient owned health record, on line, easy to access
- Health navigators both e-based and personal
- More e-based support systems
- Online consults: Skype, messaging.
- Shared record and note taking, Transparency.
- PH held record on-line.
- Collaborative care with a single electronic health record
- Cloud based health record
- Fully integrated person controlled e-health record
- On-line screening would assist to decide where in the health system is the best place to get the best health
- Comprehensive on-line primary care
- Shared health record across services
- Patient information on-line health care
- Information / tech solutions available on line
- Better use of electronic records with patient access to test results and records on line (with confidentiality protected)
- Ability to book appointments electronically
- Sharing health information between services (one centralised set of records)
- Virtual primary care places

Integrated Continuum of Holistic Services and Supports

- Define the concept of mental health, instead of making policy of strategy in medical treatment (MT) maintenance care in both primary and secondary mental health systems
- Bring in Hawaii declaration 1975 which laid down 10 principles for psychiatry to practice safe and ethical treatment
- System driven a psycho social approach
- Cultural health options integrated into primary care
- Use of cultural tools for wellness
- Service users design health system
- Values based services – people are more than their diagnosis
- Values based services
- Cultural and holistic wraparound approach
- Collaborative care – goals and treatment set and agreed to with client
- Best practice primary care health: attention to medical illness; prevention; health prevention.
- Move from primary care to wellbeing and community centres, co-locate health and social care and community building projects
- Holistic primary care
- One stop shopping in community – no silos
- Wellness hub activities and primary care
- Prevention
- Health focussed system rather than an illness driven system. Focus on community health and wellbeing
- Community hubs have a range of wellness activities
- Multiple treatment options (and information to inform patient choice)
- People who need more support have a PA (hours) to enable independent living
- Primary care much more health promoting oriented
- Wellbeing hubs or centre with both holistic health interventions and social activities
- Integration between primary, secondary and community services
- Change professional training of primary care to include more behavioural health
- Suite of interventions (not just meds reliant)
- Care continuum cradle to grave access – prevention leads to recovery
- Expand the suite of options available through primary care, e.g. dietician, physio, mental health
- Multiple treatment paths always offered
- Building understanding of primary care – it is not just GP's
- Holistic health care

Community Engagement and Cross Sector Work / Collaboration

- New strategies around training and monitoring GPs to non-medical options.
- Changes to health training – cross training?
- Education employment.
- Psycho social model, not medical model.
- Better resourcing of talking therapies.
- Recovery orientated primary: (i) Pursuing meaningful outcomes (ii) Support recovery self-care (iii) Support recovery mutual aid (iv) address emotional and psychiatric challenges (v) Non-judgemental / non stigmatising strength based (vi) engage person in service design.
- Social outcome opportunity services: (i) Housing (ii) Leisure (iii) Employment (iv) Education.
- Move to more holistic approach integrating physical, psychological and social care

- Services that are outcome focussed and end patient centred.
- $ Public money funds activities, not silos of services.
- Safe spaces.
- Doctors listen to and believe patients.
- Knowing your community.
- Forward planning / advice

9. NGO Innovations

Facilitators: Louise Carr and Carolyn Steele

Scribe: As above

Best Practice

Keywords / themes:

- Innovation
- Potential
- Inspiration
- Outcomes / Evidence
- Consumers
- NGO – Cost effective
- Local connectivity
- Community navigations
- System change
- Inclusiveness
- Added value
- Information – outcomes – knowledge
- Enable NGO's

Innovation around outcomes, IT, peer support services

PACT innovations – holistic outcomes, clinical working and non-clinical

Examples

- PACT – developed O/C tool for individuals. More meaningful etc. An agency to walk and support people and client management (IT/systems). Individuals keep their own records, watch progress, monitor o/c, produce reports for individuals. Peer support (WRAP) – individuals get more say in their own care.

- New Zealand huge range of activity called peer support often determined by contract between wide range of types of services – what is PS? How do we evaluate?
- WHOQLS – to measure outcomes. Useful but limiting.
- Australia, Queensland – Consumer companions "beneficial". Every agency forced to employ one consumer.
- Now – peer operated services level of confidence, acceptance across the community.
- Peer initiative programme. Agency wide methodology around ensuring safety across the workforce.

(Earthquake)

- Centralised pathways – cut out the need for referrals.
- Joined up working – getting all key players around the table, now part of business. Builds up trust, improves communication – in essence responding to need.
- Brings about cultural exchanges.
- In addition to systems response, investment from the indigenous people (Canterbury) to pull in NGO support, social, practical response. Unique innovation.
- Risk management plans works. Lessen – don't let risk be a reason not to innovate.

Comments

- Trying to get funders to understand what contracts and services are about.
- Getting clarity on peer support.
- Careful about managing peer support.
- Outcomes can be problematic, need objective and subjective measures.
- Ensuring the right supervision for peer support is in place to keep workforce "safe".
- How we change across to services following earthquake. Responding to increase in demand.
- Maintaining momentum after a crisis.
- Uncertainty.
- Capacity.
- Naive commissioning.

Brainstorming Challenges – all listed, then top six chosen

- Systems integration
- Funding
- Contracting
- RFP's
- Evidence
- Workforce expertise / capacity
- Outcomes / defining
- Disconnection
- Cultural clinical integration
- Contract compliance
- More for less
- Communication
- Sustainability
- Capacity

Top six

(1 = highest / 5 = lowest)

See tables below.

Systems Integration / Disconnection

Rate	Country	Solution
1	England	Better coordination and focus on collaboration
1	USA	Systems of care
1	NZ	Disciplines and populations need to blend to address silos
1	Australia	Opportunity for more partnerships at service development/planning level
2	NZ	
2	NZ	
2	NZ	Fund for collaboration
2	Australia	
2	NZ	
2	Australia	Time to meet each other
2	NZ	
3	Canada	Look at evidence, centralise pathways to care, embed primary care / partnerships
3	NZ	Care pathways
3	NZ	
4	NZ	Joint funding arrangements
4	NZ	
4	England	
5	NZ	

Contract Compliance / Funding Sustainability

Rate	Country	Solution
1	NZ	
1	Canada	Use social financing schemes
1	Australia	End three year cycles
1	NZ	Cross-government agreement on core requirements with specialist specs
1	NZ	
1	NZ	
1	NZ	
1	NZ	Fund for outcomes
1	Australia	Balance of funding between public and NGO services
1	NZ	
1	NZ	Co-operation
1	NZ	
1	NZ	Creative incentives
2	USA	Performance based contracting

2	Australia	The disability field shows us that you need heart and vision before dollars
2	NZ	Creative incentives
3	NZ	Fixed costs = fixed income
3	Australia	

Evidence / Outcomes / Defining Success

Rate	Country	Solution
1	England	Good comms/systems/clarity
1	NZ	
2	Canada	Multi country use of WHOQOL and Camberwell
2	NZ	
2	NZ	University partnership and hire evaluation staff
2	England	
2	USA	Results based accountability, better data systems
2	Australia	Better data systems
2	NZ	
2	NZ	
2	NZ	
2	NZ	Meaningful use
3	NZ	Funding for outcomes
3	NZ	
3	NZ	Decent tool and funding to analyse the data
4	NZ	
4	Australia	
4	Australia	
4	Australia	
5	NZ	Outcomes orientated & measurement based support

Cultural Clinical Integration / Competence

Rate	Country	Solution
3	NZ	
3	USA	
3	Australia	
3	NZ	Braided river approach and research
3	Australia	
3	NZ	
3	Canada	Look at www.enhanceontario.ca for examples of how to do clinical integration
4	NZ	
4	NZ	
4	NZ	
5	NZ	
5	NZ	
5	NZ	
5	NZ	
5	England	

Governance

Rate	Country	Solution
2	NZ	
2	NZ	About governance, not operations
2	NZ	Governance training for smaller NGOs
2	England	Clear measures
3	NZ	
3	NZ	Training, mentoring, support
3		Need governance that affirms and does not suffocate the informal and natural life people have
3	NZ	More person-centred leadership
4	USA	
4	Australia	
4	NZ	
5	NZ	
5	NZ	Representation from consumers / providers / family / whanau
5	Australia	Prospective Board members must be given extensive time in the service
5	Australia	

Workforce / Development Capacity and Capability

Rate	**Country**	**Solution**
1	NZ	Peer review, capability
1	NZ	
1	NZ	Value + invest
1	England	Capability F/W
2	NZ	Funding arrangements to support workforce investment
2	NZ	
2	NZ	Co-operation
2	Australia	Succession planning, career pathways / opportunities
2	USA	Competency frameworks, pre professional curriculum reform, integrated care (increase capacity of primary care)
2	England	
4	Canada	
5	NZ	

10. Prevention/Promotion

Facilitators: Judi Clements and Mary Evans

Scribe: As above

Key points emerging in discussion:

- Mental health service delivery often not well integrated and not sufficient regard to mental health promotion.

- People experiencing mental distress often end up lonely and isolate promoting mental health and wellbeing on a population base could be driver of change.

- Population base/public health approaches to mental health are not high enough on the agenda in any nation – even where policies have been developed good practice has not always been followed.

- Mental health promotion and prevention are different but linked and early intervention particularly in early years is crucial as clearly demonstrated by evidence.

- The nurturing of resilience in communities is empowering and can help address inequity.

- The development of autonomy and competence are key issues on both an individual and population base.

Useful resources to be aware of:

- US: National Register of Evidence-Based Programs and Practices: http://www.nrepp.samhsa.gov/

  a searchable online registry of more than 280 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment.

- UK: new economics foundation work on the 'Five Ways to Well-being': http://www.neweconomics.org/projects/five-ways-well-being

Scotland: 'see me' anti stigma campaign: http://www.seemescotland.org.uk/