Litmus

Ngā poutama oranga hinengaro-mahitahi| Mental Health and Addiction Quality Improvement Programme outcomes evaluation

Te Tāhū Hauora | Health Quality & Safety Commission

27 October 2023

Contents

Executive summary

Introduction

This report presents the evaluation findings of Ngā poutama oranga hinengaro-mahitahi | The Mental Health and Addiction Quality Improvement Programme (the Programme).

In July 2017, Te Tāhū Hauora launched the Programme. The Programme was initially for five years and extended for two years.

This Programme uses a quality improvement methodology to:

- improve consumers, family, and whānau experiences of mental health services
- reduce variability in the access to and quality of mental health services
- build skills and a culture of quality improvement leadership in the mental health sector
- share learning across service providers and encourage quality improvement and safety
- measure the impact and effectiveness of quality improvement initiatives.

The Programme aims are progressed through five projects:

- Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion: Safety and dignity for all – launched in 2018 and is ongoing.
- Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions – launched in 2018 and completed in 2022.
- Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumers, family, and whānau experience – launched in 2019 and completed in 2022.
- Te whakanui ake i te hauora ā-tinana | Maximising physical health – launched in 2021 and is ongoing.
- Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing – launched in 2022 and is ongoing.

Purpose and design of the evaluation

This evaluation will inform the future delivery of the Programme. The evaluation assessed how well the Programme has influenced the system to improve consumers, family, and whānau experiences, enhance equity and reduce variability in service outcomes.

The evaluation focused on the relevance of the Programme to the mental health and addiction sector, how well it was delivered to achieve its aims and how well the Programme achieved its intended outcomes. The evaluation also considered how Te Tāhū Hauora could further influence the system to improve consumers, family, and whānau outcomes.

The evaluation engaged with 34 Te Tāhū Hauora personnel, national stakeholders, the Programme's Te Hiringa Kounga Māori and Consumer Advisory Group members, and Te Whatu Ora district quality improvement project teams (district project teams). The evaluation also included a documentation and data review.

Evaluation findings

The Programme performed at a good or excellent standard in all focus areas. Its key strengths are 1) the relevance of projects to the mental health and addiction sector, 2) modelling of best practice quality improvement methods, 3) alignment with Te Tiriti o Waitangi and having an equity focus, 4) meeting the capability needs of district project teams and 5) district project teams using learning to provide better and more equitable outcomes for consumers, families, and whānau.

Key focus area	Performance indicator	Performance
Relevance	The Programme focuses on projects of high importance.	Excellent
	The Programme aligns with health sector strategies and priorities.	Excellent
	The Programme aligns with Te Tiriti o Waitangi.	Excellent
	The Programme has a strong equity and consumer focus.	Excellent
	The Programme used a proven quality improvement methodology.	Excellent
Implementation	The Programme has been implemented well.	Good
	Advisory groups contributed well to the delivery.	Good
	The Programme met the capability needs of district project teams.	Excellent
Outcomes	District project teams acquired and are using quality improvement learning.	Excellent
	District project teams are applying learning to improve responsiveness to Māori.	Good
	District project teams are applying learning to reduce inequities for Māori.	Good
	District project teams are applying learning to engage consumers, families, and whānau.	Unsatisfactory

Future directions

Stakeholders unanimously agreed that Te Tāhū Hauora should continue to have a role beyond June 2024 to influence the mental health and addiction system to improve consumer, family, and whānau outcomes. This includes having continued involvement in eliminating seclusion, maximising physical health and improving medication management and prescribing for consumers, families, and whānau.

Conclusion

The Programme fills a critical gap in the mental health and addiction sector. It is highly relevant to the mental health and addiction sector, focuses on sector priorities, uses proven quality improvement methodology, and practice improvement is evident. However, further investment is needed to achieve system change.

Introduction

In July 2017, Te Tāhū Hauora launched Ngā poutama oranga hinengaro-mahitahi | Mental Health and Addiction Quality Improvement Programme (the Programme). The Programme was initially for five years and extended for two years.

Programme aims

This Programme aims to:

- improve experiences of consumers and their families and whānau have with mental health and addiction services
- reduce variability in the access to and quality of mental health and addiction services so consumers receive the same high-quality care
- build skills and a culture of quality improvement leadership in the mental health and addiction sector workforce and strengthen leadership
- share learnings across service providers and encourage quality improvement and safety
- measure the impact and effectiveness of quality improvement initiatives.

Governance and management of the Programme

The Programme is governed by Te Tāhū Hauora and funded by the previous district health boards[1]. Four programme-specific stakeholder advisory groups oversee and advise the Programme:

- The Leadership Group provides clinical, cultural, quality, safety, and consumer advice to inform the Programme's strategic direction. The group has broad sector representation.
- Te Hiringa Kounga Māori provides quality advice from the Māori perspective, providing effective relationships and information sharing with national and local networks.
- The Consumer Advisory Group provides advice from a lived experience perspective and incorporates the perspectives of consumers and families.

Te Tāhū Hauora plans, coordinates and delivers the Programme. Many team members work part-time, combining their work with clinical or leadership roles across Aotearoa New Zealand. The Programme coincided with the COVID-19 pandemic, and the team supported the Covid-19 All of Government Response. Team members were also seconded into establishing the Mental Health and Wellbeing Commission.

[1] In April 2021, the Government announced that the system of District Health Boards was to be abolished and replaced by a single agency called Te Whatu Ora (Health New Zealand).

The Programme uses a quality improvement methodology

The Programme uses co-design and quality improvement methodologies to plan and implement quality improvement projects with Te Whatu Ora district-led project teams to implement changes at scale.

The quality improvement approach is aligned with the Institute of Healthcare Improvement's collaborative breakthrough series methodology and experience from the Scottish Patient Safety Programme. The methodology uses improvement science to test evidence-based changes and interventions locally, measure the impact of these changes, and, if successful, work with other services to implement the changes more widely.

The Programme undertook five quality improvement projects

The Programme designed and delivered the following five quality improvement projects:

- Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion[2]: Safety and dignity for all – launched in 2018 and is ongoing.
- Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions – launched 2018 and completed in 2022.
- Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumers, family, and whānau experience – launched in 2019 and completed in 2022.
- Te whakanui ake i te hauora ā-tinana | Maximising physical health – launched in 2021 and is ongoing.
- Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing – launched in 2022 and is ongoing.

Programme logic model

Te Tāhū Hauora developed the following logic model for the Programme. The model describes how the Programme influences the mental health and addiction system to achieve positive outcomes for consumers, families, and whānau.

[2] Seclusion is the practice of placing a mental health consumer in a room from which they cannot exit freely.[2]

Ngā poutama orangahinengaro-mahitahi / Mental health and addiction quality improvement programme logic model [v3 11/09/2023]

Programme aim: The Te Tāhū Hauora Health Quality & Safety Commission team will partner with Te Whatu Ora district teams in the mental health and addiction (MHA) sector to: (1) improve the experience of MHA services for consumers, family, whānau and staff; (2) build sector capability in leadership and quality improvement; (3) reduce inequity and variability in access to, and quality of, MHA services so consumers, family and whānau receive the same high-quality care no matter who or where they are; (4) measure the impact and effectiveness of quality improvement initiatives.

Situation

The Health Quality & Safety Commission is working with Te Whatu Ora districts to deliver a 7-year district-funded MHA quality improvement programme (June 2017 – June 2024).

The work of the programme is spread across five priority areas:

- Zero seclusion: Safety and dignity for all
- Connecting care: Improving service transitions
- Learning from adverse events and consumer, family and whānau experience
- Maximising physical health
- Improving medication management and prescribing.

Assumptions

The programme receives funding to continue its work.

Addressing inequities is core to MHA QI programme activities.

Inputs

Team
- MHA QIP team including MHA professionals, consumers, Māori view, data and quality improvement (QI) expertise

Leadership and partners
- MHA QI programme leadership group, Te Hiringa Kounga Māori, Consumer advisory group, MHA Quality improvement network
- Internal partners: Commission programmes
- External partners: Te Whatu Ora districts, MHA Directorate MoH, national quality and risk manager group, Te Pou

Funding
- Funding to deliver the programme

Te Whatu Ora district staff, consumers, family, whānau
- Consumers, family and whānau willing to engage in co-design work
- Staff engaging in co-design and programme work
- Consumer, family and whānau advisors
- Improvement advisors

Infrastructure and resources
- Website
- Information technology (IT)
- Facilities such as offices

Activities

Capability building
- Action learning sessions on co-design and QI methodology
- Focus on equity and experience data
- Shared learning and networking opportunities
- Zoom 'just in time' coaching sessions for project teams
- On-site coaching for project teams
- Collaborative learning sessions

Resources
- Co-design and quality improvement resources circulated to district project teams
- Interviews, blogs and stories from subject matter experts and consumers

Leadership engagement
- Support for middle management
- Events for MHA sector leadership

Data
- Support QI and project measure development
- Visible data for learning
- Project team storyboards

Outputs

Leadership and QI skills
- Everyone involved understands their role in improvement and has the skills to fulfill their role
- Leadership support
- District champions
- Te Tiriti o Waitangi equity framework

Collaborative learning
- Renewed energy for QI
- Co-design and QI capability building
- QI coaching
- Team planning
- Change package/bundle – clinical, cultural and consumer

Site visits
- Programme team visits to district project teams as required

District teams
- Effective improvement work at the point-of-care led and coached by skilled staff

Mid-programme evaluation
- Shared understanding of progress made
- Direction corrections as needed

Outcomes

Short term (1-2 years)

- Greater knowledge and application of the Model for Improvement and co-design
- A focus on equitable outcomes
- A focus on consumer engagement
- Understand current system performance and opportunities for improvement
- Engagement of stakeholders in co-design work
- Effective engagement with project teams (participation in MHA QI programme)
- Effective use of data for learning
- Time and space to work on improvement
- Participants feel local ownership of QI work
- Participants collecting and analysing their own data for improvement
- Engaged sponsors and middle managers

Intermediate (2 - 3 years)

- Decreasing equity gap
- Embedding consumer input into service improvement
- District teams achieve 85% reliability for processes they are actively working to improve
- 75% of districts have fully implemented changes appropriate to the care setting in which they are working
- At least one team per region will demonstrate improved care process through an improvement project related to the programme
- Increased co-design and QI capability in the MHA sector
- Increased QI work across MHA services
- Engaged MHA sector leadership and management

Long term (4 - 5 years)

- Decreasing equity gap
- Improved consumer, family, whānau and staff engagement and experience
- Sustainable QI infrastructure and culture to support continuous improvement
- Organisational changes made to accommodate improvements and make changes a permanent part of daily work
- Districts demonstrate use of QI learning and spread
- 100% of district project teams will reach 5.0 on Project self-assessment scale*
- 75% teams will reach 5.5 on Project self-assessment scale
- 50% teams will reach 6.0 on Project self-assessment scale

* Project self-assessment scale. Modified from Institute for Healthcare Improvement. 2004. Assessment scale for collaboratives. Boston, MA: IHI

Evaluation aim and approach

Te Tāhū Hauora committed at the outset of the Programme to undertake an outcomes evaluation. The Programme also undertook a formative and process evaluation in September 2020.

Purpose of this evaluation

The evaluation was designed to assess how well the Programme has influenced the mental health and addiction system to improve consumers, family, and whānau experiences, enhance equity and reduce variability in outcomes of mental health and addiction services.

The evaluation encompasses the entire period of the Programme, from its inception to the present day. The Evaluation Team developed an Evaluation Plan to guide the evaluation, which drew on the Programme's logic model.

Key evaluation questions

The evaluation was designed to answer the following key evaluation questions.

- How relevant is the Programme to the mental health and addiction sector?
- How well was the Programme implemented to achieve the Programme aims?
- How well is the Programme achieving its intended outcomes?
- How could Te Tāhū Hauora continue to contribute to improving consumers, family, and whānau experiences and outcomes?

Engagement

The Evaluation Team engaged with 34 Te Tāhū Hauora personnel, national stakeholders, Te Hiringa Kounga Māori, the Consumer Advisory Group, and district project teams.

A semi-structured discussion guide informed the interviews and hui. The Evaluation Team conducted engagement virtually. Interviews and hui were video recorded, and each engagement lasted up to 60 minutes.

Engagement with national and Programme stakeholders

Te Tāhū Hauora and the Evaluation Team identified national and Programme stakeholders to interview. We undertook 22 interviews with national and Programme stakeholders, as follows:

- Six interviews with national stakeholders who hold mental health and addiction sector leadership, governance, regulatory and consumer roles.
- Nine interviews with stakeholders involved in the governance and delivery of the Programme.

- A hui with four Te Hiringa Kounga Māori members and three Consumer Advisory Group members.

Engagement with district project teams

Te Tāhū Hauora and the Evaluation Team developed a framework to select a sample of four Te Whatu Ora districts considering:

- Geographical spread, including North Island and South Island.
- The size of the population served, i.e., small, medium, and large districts.
- The population demographics, including ethnic diversity.

Te Tāhū Hauora guided the selection of districts to ensure the sample covered the variation within the Programme to the extent possible.

Districts provided the Evaluation Team with a list of project team members to interview. The evaluation team selected 12 stakeholders from the list to interview. These included:

- Project sponsors
- Clinical advisors
- Consumer and family advisors
- Quality improvement facilitators.

Documentation review

The Evaluation Team reviewed the following documents:

- Te Tāhū Hauora Board and Programme Leadership Group papers and minutes (July 2017 and November 2021).
- Mid-Programme Evaluation of the Mental Health and Addiction Quality Improvement Programme (September 2020)
- Project charters and evidence reviews for the five projects.
- Project close report for Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions.
- Project close report for Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumers, family, and whānau experience.
- Selected programme resources, presentations, and papers.

Refer to Appendix 1 for the bibliography.

Outcomes data

The Evaluation Team reviewed monitoring data for national seclusion, Connecting care and Learning from adverse events and consumer, family, and whānau experience projects. Due to the stages of later projects, no outcomes data is available for Maximising physical health and Improving medication management and prescribing.

Limitations to the evaluation

The Evaluation Team is confident this report reflects the available data. However, the following limitations are noted.

- The evaluation findings need to be considered in relation to the available resources for this evaluation. The resource did not allow for more districts to be included in qualitative interviews or to survey all Programme stakeholders.
- District project teams were more familiar with Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion: Safety and dignity for all, as this project has been implemented across the Programme's timeframe.
- At the time of the evaluation, two projects were closed: Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions and Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumer, family, and whānau experience. Since it had been some time since these projects had closed, districts put forward project team members who were less familiar and involved with these projects.
- The evaluation method did not include interviews with consumers, families, and whānau who have used the services. Ngā Poutama Consumer, family, and whānau experience survey was conducted in 2019. However, due to measurement challenges, the survey could not be replicated. While the evaluation focused on how well the Programme influenced the system, it cannot assess whether the Programme has improved consumers, families, and whānau experiences.

Analysis and synthesis

The Evaluation Team transcribed all interviews, coded all transcripts, analysed interview data, and analysed the documents and available data. The Evaluation Team also held analysis workshops and a sensemaking workshop with Te Tāhū Hauora on 31 August 2023 to present key themes.

Evaluation judgements were made by analysing evidence under each key focus area and synthesising the findings against the performance indicators.

The Evaluation Team used a rubric to define the difference between various performance levels for each indicator.

Rubric applied to evaluative judgements

Excellent	All aspects of indicators of success were realised, with very positive outcomes and few, if any, negative comments.

Good	Most aspects of indicators of success were realised, with evidence of noticeable positive outcomes and few neutral or negative outcomes.
Unsatisfactory	Some aspects of indicators of success were realised, some negative outcomes, a mix of comments, not noticeably positive.
Poor	Few aspects of indicators of success were realised, and evidence of positive and negative outcomes skewed towards the negative.

Evaluation framework

Key focus area	Evaluation question	Indicators of success
Relevance	How relevant is the Programme to the mental health and addiction sector?	The Programme focuses on projects of high importance.
		The Programme aligns with health sector strategies and priorities.
		The Programme aligns with Te Tiriti o Waitangi.
		The Programme has a strong equity and consumer focus.
		The Programme used a proven quality improvement methodology.
Implementation	How well was the Programme implemented to achieve the Programme aims?	The Programme was implemented well.
		Advisory groups contributed well to the delivery.
		The Programme met the capability needs of district project teams.
Outcomes	How well is the Programme achieving its intended outcomes?	District project teams acquired and are using quality improvement learnings.
		District project teams are applying learnings to improve responsiveness to Māori.
		District project teams are applying learnings to reduce inequities for Māori.
		District project teams are applying learnings to engage consumers, families, and whānau.

Findings

Programme relevance

Indicator	Performance	Explanation
The Programme focuses on projects of high importance.	Excellent	The Programme focuses on five quality improvement projects of high importance to the mental health and addiction sector.
The Programme aligns with health sector strategies and priorities.	Excellent	The Programme aligns with Te Tāhū Hauora health strategic priority areas, Te Whatu Ora mental health and addiction services, other entities, and standards.
The Programme aligns with Ti Tiriti o Waitangi.	Good	Te Tāhū Hauora, the Programme's Kaumatua and Māori Cultural Advisor and Te Hiringa Kounga Māori provide mechanisms for ensuring the Programme aligns with Te Tiriti o Waitangi.
The Programme has a strong equity focus.	Good	An equity focus is embedded through the Programme, particularly for Māori. However, not all project charters had a strong equity focus.
The Programme focuses on the voices and experiences of consumers and families.	Good	The Advisor, Consumer and Family Engagement and the Consumer Advisory Group provide mechanisms for including the voices of consumers and families.
The Programme uses co-design and a proven quality improvement methodology	Excellent	The Programme is an internationally recognised quality improvement methodology adapted for Aotearoa New Zealand.

Did the Programme focus on projects of high importance?

Projects selected have comprehensive buy-in from the mental health and addiction sector. Former district health boards identified the priority projects for the Programme to focus on. Stakeholders participating in the evaluation agreed that the selected priority areas are and continue to be high priority.

Evidence reviews informed all projects. This evidence identified factors and practices, cultural approaches, and opportunities for improvement.

The following demonstrates the importance of each of the five projects.

Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion: Safety and dignity for all

This quality improvement project aims to continue to work with the mental health and addiction sector to eliminate seclusion in mental health and addiction services. Seclusion is traumatic and harmful for consumers, whānau, visitors and health workers. Eliminating seclusion in mental health has been government policy for over a decade.

Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions

This quality improvement project looked at ways to improve the processes around care transitions between mental health and addiction services to ensure consumers, families, and whānau receive continuous quality care as they move between health providers. Poor care transitions are linked to negative care experiences for consumers and whanau.

Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumers, family, and whānau experience

This quality improvement project focused on improving the ability of organisations and the mental health and addiction sector to learn and heal from mental health and addiction adverse events. This included improving the experiences of consumers, family, whānau and staff and the safety culture for staff involved in mental health and addiction adverse event reviews.

Te whakanui ake i te hauora ā-tinana | Maximising physical health

Evidence shows people with severe and enduring mental health challenges can live up to 25 years less than others due to preventable diseases. This quality improvement project is designed to improve the reliability of timely monitoring, screening, and treatment for cardiovascular disease (CVD).

Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing

Due to the limited timeframe for this project, it involves working with a few districts to test the 'Optimise medicines on transition assessment tool'. The tool will help community mental health team managers and case managers identify consumers who need additional support with their medicines on discharge from mental health and addiction in-patient services. Once tested and refined, the assessment tool will be made available to the sector by June 2024.

How well did the Programme align with health sector strategies and priorities?

The Programme aligns with all four of Te Tāhū Hauora strategic priority areas:

1. Improving the experience for consumers, family, and whānau.
2. Embedding and enacting Te Tiriti o Waitangi, supporting mana Motuhake.
3. Achieving health equity.
4. Strengthening systems for high-quality services.

The Programme is aligned with Te Whatu Ora mental health and addiction services, Office of the Director of Mental Health and Addiction Services and Ngā Paerewa Health and Disability Services Standard. The latter reflects the shift towards more person and whānau-centred health and disability services.

Individual projects also align with non-government organisations, including Te Pou, the Mental Health Foundation, the Heart Foundation and the Equally Well Collaborative.

In 2015, the UN Committee Against Torture published a report on Aotearoa New Zealand, highlighting concerns about the persistent use of seclusion in mental health facilities and making recommendations for its limitations and, in some cases, prohibition. Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha Zero seclusion: Safety and dignity for all aligns with and responds to the UN Committee Against Torture.

> '[The Programme] is relevant on many levels. We are doing something that the sector wants and are responding to their concerns about the quality of services in mental health. Having improvement programmes which have been paid for and are supported by the sector are important.' (National stakeholder)

How well did the Programme align with Te Tiriti o Waitangi?

Te Tāhū Hauora has applied Te Tiriti o Waitangi principles to the Programme through its commitment to enacting and embedding Te Tiriti o Waitangi in all its teams, workstreams and programmes.

Under the leadership of the Programme's Kaumatua and Māori Cultural Advisor and advice from the Programme's Te Hiringa Kounga Māori, the Programme has developed tools and Te Ao Māori approaches to support Māori consumers and whānau better. These tools and approaches include Te Tiriti o Waitangi Equity Framework, Māori driver diagrams and a kaupapa Māori cultural kete. Te Whare Tapa Whā also guides individual projects.

The kaupapa Māori framework and tools were developed part way through the Programme and were not in place during the Programme's establishment.

How well did the Programme design consider consumers and have an equity focus?

The Programme has mechanisms for informing its work, building capability and developing leadership through the voice and experiences of consumers, families, and whānau.

Programme roles, including the Advisor, Consumer and Family Engagement and the Kaumatua and Māori Cultural Advisor on projects, ensure a strong focus on consumers, families, and whānau. The Programme also includes advisory mechanisms, e.g., Te Hiringa Kounga Māori and the Consumer Advisory Group.

The Programme has also identified the need for a consumer kit to enable consumer and family interventions, practices and values and to complement the clinical bundle[3] and cultural kete[4] included in the Zero seclusion change package. The change package gathers, defines, and describes successful interventions that will contribute to improving health outcomes and equity and reducing the use of seclusion in mental health inpatient units. The package includes mātauranga Māori change ideas and Western clinical interventions. (HQSC, 2022c).

An equity focus is embedded throughout the Programme and projects, considering the impact of continuing inequity and implicit bias in the system, particularly for Māori

What was the quality of the Programme's methodology?

The Programme uses co-design and recognised quality improvement methodologies to plan and implement quality improvement projects with Te Whatu Ora district-led project teams and implement changes at scale.

The quality improvement approach aligns with the Institute of Healthcare Improvement's collaborative breakthrough series methodology and experience from the Scottish Patient Safety Programme. The methodology uses improvement science to test evidence-based changes and interventions locally, measure the impact of these changes, and, if successful, work with other services to implement the changes more widely.

Aotearoa New Zealand has used this methodology for other national programmes, including Target CLAB Zero21 and Orthopaedic Enhanced Recovery After Surgery.

However, unlike other previous national programmes, there was no pre-established change package (e.g., a clinical bundle or cultural kete). The Programme, therefore, added a co-design phase before the quality improvement phase.

> 'Incidents and pressures were happening in mental health and addiction services. We argued very strongly for an overarching quality improvement programme. Encouraging a just culture within mental health and addiction

[3] The clinical bundle includes change ideas that the groups consulted identified as contributing significantly to a reduction in seclusion and inequity (e.g., sensory modulation, pōwhiri), (HQSC, 2022c)
[4] The cultural kete includes mātauranga Māori approaches and interventions, and some non-Māori interventions wrapped within kaupapa Māori processes and approaches that district project teams are testing. The Programme will include successful kete elements in the collection of evidence as it builds knowledge in this area. (HQSC, 2022c)

services focuses on not trying to ping people but identifying systemic issues that can be addressed through quality improvement methodologies.'
(National stakeholder)

Implementation of the Programme

Indicator	Performance	Explanation
The Programme was implemented well.	Good	All five projects began or are complete. The Programme delivered all aspects of quality improvement capability building and improved engagement with leaders. The Programme faced some obstacles in monitoring outcomes data.
Advisory groups contributed well to the delivery.	Good	The Programme engaged well with Te Hiringa Kounga Māori and the Clinical Leadership Group. These engagements benefitted activities and resources. However, the Programme did not connect with the Consumer Advisory Group to the same extent.
The Programme met the capability needs of district project teams.	Excellent	The Programme created a safe, supportive, constructive learning environment for district project teams. The learning was also relevant to the teams' projects. However, several challenges outside the Programme's control affected participation in capability building.

How well was the Programme delivered?

The Programme successfully began or completed all five projects.

The Programme implemented all five in-patient and community-focused projects. Projects started at different times across the seven years and are at various stages of completion.

- Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion: Safety and dignity for all started in early 2018. This project is in the monitoring phase.
- Te whakanui ake i te hauora ā-tinana | Maximising physical health started in the middle of 2021. This project is in the quality improvement phase.
- Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing started in the middle of 2022. This project is in the rollout phase.
- Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions started in late 2018. In late 2020, Te Tāhū Hauora supported the project's transition to previous district health boards.
- Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumers, family, and whānau experience started in late 2019. In late 2020, the project gradually transitioned to previous district health boards, with support from Te Tāhū Hauora until late 2022.

The Programme successfully delivered quality improvement capability-building.

The Programme delivered various mental health and addiction sector quality improvement capability-building activities and resources. These included learning sessions/workshops on co-design and quality improvement methodologies, capability-building and leadership modules, and managing the Quality Improvement Network.

From June 2020 to 2021, Te Tāhū Hauora rolled out e-learning resources to increase awareness and understanding of implicit bias for mental health and addiction health professionals. These workshops aimed to change individual awareness and understanding of implicit bias to improve mental health and addiction practice.

The Programme also developed:

- Te Tiriti o Waitangi/ Equity Framework
- The Māori Mental Health Service Cultural Driver Diagram
- The Kaupapa Māori Cultural Kete.

The Programme improved its engagement with leaders.

Commitment from clinical and non-clinical leaders to local district project teams helps embed quality improvement change ideas[5] into mental health and addiction services. The mid-term evaluation recommended that Te Tāhū Hauora improve the engagement and capability building of mental health and addiction general managers, service managers and clinical leads.[6] The

[5] Change ideas' refers to the ideas within a quality improvement project that are going to change to make an improvement.
[6] Francis Health, 2020

Programme responded by enhancing its engagement with mental health and addiction sector clinical leaders across Aotearoa New Zealand, including:

- hosting events for clinical leadership (e.g., the 2023 National Mental Health and Addiction Clinical Director's hui)
- providing nine scholarships for mental health and addiction Clinical Directors for an executive peer learning programme
- providing local capability-building support.

The Programme responded well to the challenge of COVID-19.

During COVID-19, the Programme quickly adapted from in-person learning events to digital formats, and video conferencing and training content was modified for online delivery. Feedback indicates stakeholders were appreciative of the shift to online. However, most reported the absence of face-to-face learning during the COVID-19 pandemic impacted Te Tāhū Hauora and project teams' ability to form relationships and networks.

The Programme faced challenges in monitoring outcomes for all projects.

The Programme routinely collects and monitors data on seclusion, including disaggregated ethnicity data. This data has been beneficial for showing insights and helping district project teams enhance their practice.

However, outcomes were not clearly defined and proved difficult to measure for Connecting care: Improving service transitions and Learning from adverse events and consumer, family and transitions and improvement outcomes. Analysis of adverse events was also dependent on staff and consumer survey data.

The Programme learned from these challenges. Te Tāhū Hauora has undertaken significant work to build nationally consistent indicators to measure outcomes for Te whakanui ake i te hauora ā-tinana | Maximising physical health and Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing projects. This considered approach meant these projects started later than planned.

How well did the Programme seek and use expert advice?

The Programme benefitted from an expert and engaged Clinical Lead, Kaumatua and Clinical Advisor and Advisor, Consumer and Family Engagement.

The Programme sought and used the advice of Te Hiringa Kounga Māori well. This group oversaw activities, progress, and challenges, guided project activities, and contributed to resources.

The Programme also met regularly with the Mental Health and Addiction Leadership Group to share progress and challenges and seek input.

The relatively recent Advisor, Consumer and Family Engagement vacancy contributed to the Consumer Advisory Group not being as well connected to the Programme as the other groups. Some newer group members were less familiar with the Programme and whether consumer perspectives were built into the Programme.

How well did the Programme meet the capability needs of district project teams?

District project teams found learning engaging.

Te Tāhū Hauora modelled a just culture through learning. Events were safe and supportive, providing a constructive learning environment for district project teams. District teams were very positive about facilitators' and presenters' theoretical knowledge and practical skills at learning events. They reflected sessions had a good balance between presentations and hands-on work. They also commented positively about the facilitators' timekeeping, which recognised and respected busy teams.

> 'They've had very good educators at the presentation days. I found them motivating and stimulating. Good teachers with good skills in PDSAs [plan-do-study-act cycles], and things I've never heard of before.' (District project team)

District project teams found learning relevant to their projects.

District project teams considered the quality improvement methods and tools learnt in the sessions applied to their projects. These methods and tools helped broaden teams' understanding of how quality improvement could improve consumers, family, and whānau experiences, enhance consumer outcomes, improve cultural safety, reduce inequities, and increase efficiencies. Teams found learnings, e.g. the Te Tiriti workshops, beneficial, particularly once they were immersed in projects and learnings were more tangible.

District project teams considered co-design, driver diagrams, the plan-do-study-act (PDSA) cycle, the clinical bundle and the cultural kete applicable to their projects to understand route causes and implement changes effectively. Teams also found learning about data and monitoring useful.

District project teams enjoyed the networking component of capability building.

Teams valued sharing with other district project teams nationwide and gained improvement ideas for their services. District project teams also valued participating with and learning from various participants in learning sessions, including clinicians, Māori, consumers, quality improvement specialists, and data analysts. In addition, networks were strengthened amongst local district project teams, which fostered engagement and collaboration after learning sessions. A few project team members commented that this positive networking is unique to mental health and addiction services.

> 'It's helped the sector to focus on quality improvement. They've also strengthened networks. It's not just networks based on disciplines; we all come, whānau advisors, consumer advisors, quality managers, project managers, nurses, and nurse leaders. It's a cross-sector networking opportunity that they provide, which doesn't happen anywhere else in that same way.' (District project team)

In-person visits fostered communication and trust.

District project teams considered Te Tāhū Hauora visits and virtual meetings valuable. These sessions enabled teams to receive support relative to their context, challenges, and successes. These sessions also allowed teams to discuss specific challenges they did not have time to or feel comfortable sharing with other district project teams in workshops. These sessions were also more manageable for more team members to attend, as they did not need to travel.

Furthermore, face-to-face visits fostered a greater personal connection between the Te Tāhū Hauora and district project teams. Visits also raised the profile of the Programme (and mental health and addiction services in general) with senior leaders, who could attend parts of these meetings.

> 'I can fire off questions to Te Tāhū Hauora without fear of setting something off, and then we get audited. Our questions can be scary, but I found Te Tāhū Hauora supportive.' (District project team)

Participation in capability building was affected by several challenges.

Several factors have made participating in capability-building events challenging for district project teams. District project teams spoke of staff shortages, geographical barriers, and travel costs to attend events.

Participating in capability building is particularly challenging for small and provincial teams travelling to main centres. While Te Tāhū Hauora has moved from holding national to regional events, attendance remains difficult for many district project teams.

Some teams have also experienced technical barriers, e.g., computer access and Zoom accounts.

Programme outcomes

Indicator	Performance	Explanation
District project teams acquired and used quality improvement learnings.	Excellent	District project teams acquired awareness, understanding and skills in quality improvement. Teams understood the importance of clinical, cultural and consumer perspectives. Teams understand the importance of measurement.
District project teams are applying learnings to improve responsiveness to Māori.	Good	District project teams are in the early stages of applying learnings to improve responsiveness to Māori.
District project teams are applying learnings to reduce inequities for Māori.	Good	Māori equity is at the forefront of thinking. However, more work is needed in practice, delivery, and applying the whānau voice in services.
District project teams are applying learnings to engage consumers, families, and whānau.	Unsatisfactory	Consumer, family, and whānau engagement principles were applied across projects. However, variation is present, and more work is needed to improve consumer, family, and whānau engagement locally and nationally.

How well did district project teams acquire learnings?

District project teams acquired awareness, understanding and skills in quality improvement.

District project teams reported feeling more knowledgeable and confident about using quality improvement methods and tools in their projects, such as the Model for Improvement, driver diagrams and the PDSA cycle. Teams use a common language and feel more confident using tools in regional learning sessions and when working on their projects.

Te Tāhū Hauora has noticed a positive lift in district project teams' knowledge, understanding and use of quality improvement methods and tools. For example, in the recent Te whakanui ake i te hauora ā-tinana | Maximising physical health project workshops, teams were more confident including driver diagrams in storyboards[7].

> 'The encouragement through [Te Tāhū Hauora] presentations. I've got driver diagrams coming out of my ears, and I know how to do them. Initially, there was a lot of confusion, but now we use different dialogue in our forums. That's a reflection of quality.' (District project team)

District project teams understood the importance of clinical, cultural and consumer perspectives.

Through the learning sessions, district project teams understood the benefits of including clinical, cultural and consumer perspectives in their projects' design, quality improvement and monitoring phases. Tools developed by the Programme facilitated this mind shift, for example, tools to reduce inequity for tangata whaiora and whānau in mental health and addiction services.

District project teams understood the importance of measurement.

The Programme reinforced the importance of measurement and evaluation to district project teams. Teams understood the importance of data for identifying areas needing improvement, making decisions based on data, and identifying patterns and variations in practice, e.g., days and times when seclusion events occur.

> 'I think we've learnt a lot about measurement. We've learnt much about where we can measure and what we might focus on. You can't measure the world, but you can know if you're making a difference.' (District project team)

[7] The storyboard highlights key aspects of a quality improvement effort by documenting the project from beginning to end. It generally includes a description of the following: the problem, the methodology and QI tools used, key metrics, lessons learned and the plan for sustaining improvement.

District project teams were motivated to improve.

The Programme motivated district project teams to improve consumer, family, and whānau outcomes locally and nationally. In particular, teams reported a willingness and commitment to achieve zero seclusion locally and across Aotearoa New Zealand. Working together nationally created camaraderie where district project teams shared challenges, change ideas, and learned from each other to achieve better consumer, family, and whānau outcomes.

How well are teams applying learnings to improve Māori cultural responsiveness?

District project teams are in the early stages of applying learnings to improve responsiveness to Māori.

District project teams are committed to improving service responsiveness to tangata whaiora Māori and whānau. However, teams recognised they were in the early stages of developing practice changes and processes within their teams and services.

District project teams use Māori driver diagrams to outline processes and relationships to support outcomes for Māori. They also involve Māori stakeholders in co-designing and trialling change ideas that have come about using the Programme's Kaupapa Māori cultural kete. Some change ideas included developing processes for Powhiri, cultural assessments, and greater whānau involvement. Through active projects, district project teams were also working to enact kaupapa Māori values into the mental health and addiction workforce.

Teams are also working with Māori stakeholders (Māori providers, iwi, Māori leaders and services within their organisations) to design and implement these change ideas and coordinate services. A few teams are working to build their Kaupapa Māori workforce by recruiting more Māori into in-patient units and increasing cultural competence training.

> 'It's one of the challenges but also one of the opportunities because you're working with a very diverse population, and we have a diverse workforce. One of our challenges within our workforce is we have a very low level of Māori staffing. We need to build the number of Māori staff working with us.' (District project team)

How well are teams applying learnings to reduce inequity for Māori?

Māori equity is at the forefront of thinking. However, more work is needed in practice and delivery.

District project teams acknowledged Māori equity as a critical focus requiring national and local commitment. Māori equity is at the forefront of most teams' thinking and planning. However,

some district project teams spoke about how they continue to shift unconscious bias[8], particularly among some clinical staff. More work is therefore needed to shift unconscious bias.

District project teams apply a strong Māori equity focus in Zero seclusion project work. District project teams are reminded of inequities when reviewing disaggregated seclusion data showing Māori and non-Māori seclusion rates.

Te Hiringa Kounga Māori felt that while district project teams tended to include Māori consumers in planning and decision-making, more work is needed to build the whānau voice and whānau-centred design into mental health services.

> 'I worry sometimes about the whānau voice being negated within the Programme. I don't see it being front and centre. I see lived experience acknowledged often, but I sometimes worry about the whānau voice.' (Te Hiringa Kounga Māori)

Organisational structures and commitment to enable equitable practice varied in districts. Some district project teams have organisation-wide Māori equity plans and Māori executive leadership positions to drive this work. However, other districts did not have these structures and supports.

> 'We've got lots of work to do in that space. By no stretch of the imagination, we're where we need to be, but we're on the journey, and everyone is engaged and involved in understanding equity.' (District project team)

> 'I think the conversation has changed. We're thinking about the treaty, obligations, and needs around equity differently.' (District project team)

How well are the teams applying learnings to improve consumer, family, and whānau engagement?

The extent to which district project teams applied consumer engagement principles varied.

Consumers, family, and whānau engagement principles were applied across projects. However, the extent of consumer involvement varied. For example, in some district project teams, consumers, families, and whānau identified the issues and potential solutions and contributed to decision-making. In other teams, consumers, family, and whānau only provided feedback on services, products and tools. Variation in consumer involvement depended on what was in place in districts to support consumers, family, and whānau engagement and what was set nationally through the projects.

District project teams discussed how local structures, resources and relationships enabled consumer involvement in co-design activities and service implementation. Enablers included:

[8] " Unconscious bias refers to a bias that we are unaware of and which happens outside of our control. It is a bias that happens automatically and is triggered by our brain making quick judgements and assessments of people and situations, influenced by our background, cultural environment and personal experiences." - Equality Challenge Unit UK: Unconscious Bias in Higher Education Review 2013. They can occur when we make fast judgements, are tired or under pressure. Often, they may be incompatible with our conscious values and considered actions.

- Consumer, family, and whānau roles, networks, and governance and leadership within the district (e.g., consumer leadership group, consumer liaison team, family and whānau advisors)
- Investment for consumers, family, and whānau engagement and capability building (e.g., koha, funded positions, upskilling and training for consumers to take part meaningfully, preparing clinical teams to onboard consumer input)
- Relationships with providers, especially in smaller districts (e.g., provider-run consumer cafes).

Districts faced challenges involving consumers in projects without the above enablers. A few district project teams also noted a lack of consumers, family, and whānau volunteer time was affecting consumer input.

More work is needed to enhance consumer involvement locally and nationally.

Some consumer and family staff on the district project teams felt more work was needed to improve consumer involvement. While attitudes were generally shifting, some district project teams felt some clinical team members did not fully value the consumer experience and did not include consumers in core activities (e.g., reviews of seclusion incidents and adverse events). Some consumer team members also reported a greater need for a lived experience voice at national and regional forums. The perception was these forums could be more weighted to input and feedback from clinical perspectives.

Paid peer support workers have recently become part of some mental health and addiction in-patient units. Some stakeholders considered peer support workers an important lever to involve lived experience perspectives in projects and services. However, some members of the Programme's Consumer Advisory Group had concerns that peer support workers would overshadow other lived experience voices and involvement.

Some members of the Consumer Advisory Group reported the Programme also needed to focus on the lived experience of Pasifika and their families, in addition to Māori.

> 'It is project by project, depending on the people involved. But because we've been involved for so long, we now have a developed place within those teams. A lot of the time, it is co-designed and coproduced, and some of the time, we are an end-thought, and it's a tick-box exercise.' (District project team)

How well is the Programme contributing to mental health system improvements?

The Programme is contributing to some positive system improvements.

Project data and close reports show some positive system improvements have been made through the Programme. We include figures on these improvements and technical definitions in Appendix 2 and 3.

Zero seclusion: Safety and dignity for all project data[9] shows improvements in rates and duration of seclusion for all ethnicities. Zero seclusion data shows since the Programme; there has been a sustained reduction in seclusion rates for all ethnicities across all in-patient units nationally. Additionally, there has been a reduction in the total hours of seclusion per month for all ethnicities.

Connecting care: Improving service transitions project data also shows some improvements. At the national level, data showed improved transitions across the 15 districts with adult in-patient units. During the testing period, there was an improvement in the proportion of consumers discharged from acute mental health in-patient services who received community follow-up within seven days of discharge. This equated to an increase of between five and six consumers followed up in a given month. The increase in the median for all ethnicities was 0.8 per cent. However, there was still more work to improve equity for Māori. The Programme has made some improvements for Māori.

Some national-level system improvements for Māori have been noted in projects. For instance, nationally, the Zero seclusion project has seen a decrease in mean monthly seclusion rates for both Māori and non-Māori/non-Pacific peoples:

- Māori: 7.84% at baseline period to 6.68% in the latest update, which is a 1.16% point reduction.
- Non-Māori/Non-Pacific: 4% at baseline to 3.06% in the latest update, which is a 0.94% point reduction.

This represents a clear narrowing of the equity gap. There has also been a significant decrease in mean monthly duration hours per inpatient for both Māori and non-Māori/non-Pacific peoples:

- Māori: 4.46 hours (4 hours 28 minutes) at baseline to 3.18 hours (3 hours 11 minutes) in the latest update, which is a 1.28 hours (1 hour 17 minutes) reduction (29%).
- Non-Māori/non-Pacific: 3.04 hours (3 hours 2 minutes) at baseline to 1.87 hours (1 hour 52 minutes) in the latest update, which is a 1.17 hours (1 hour 10 minutes) reduction (38%).
- However, there was no change in the equity gap over the period.

Zero seclusion project data has also shown a significant decrease in mean monthly duration hours per inpatient for Māori in forensic units, from 8.58 hours (8 hours 35 minutes) at baseline to 6.53 hours (6 hours 32 minutes) in the latest update, which is a 2.05 hours (2 hours 3 minutes) decrease (24%).

Data collected during the Zero seclusion project has been published by Australasian Psychiatry - 'Closing the equity gap as we move to the elimination of seclusion: Early results from a national quality improvement project' - written by Te Tāhū Hauora programme team members, including the Kaumatua/Cultural Advisor. A second article addressing ways to ensure co-design and quality improvement reflect indigenous perspectives is currently being prepared for publication.

[9] The zero seclusion data set used excludes Waikato and Hauora a Toi |Bay of Plenty. The data provided is otherwise complete up to May 2023.

These results represent encouraging progress, but much more work needs to be done to close the equity gap fully, and to reach the ultimate goal of zero seclusion.

Data on Connecting care: Improving service transitions also showed some improvements for Māori. At the national level, across 15 districts with adult in-patient units, there was a 0.4 per cent rise in the proportion of Māori discharged from acute mental health in-patient services who were followed up in the community within seven days of discharge. Māori, however, still had the lowest median follow-up rate of 79.8 per cent and were the only prioritised ethnicity group with a follow-up rate below 80 per cent.

Applying learning is affected by several challenges.

Several factors make it challenging for district project teams to apply quality improvement learnings. Teams with strong sponsorship and resourcing could apply quality improvement learnings as they received more project guidance and resources. Strong sponsors also provided credibility for teams' quality improvement projects.

District project teams also spoke about some challenges they have identified through their Zero seclusion: Safety and dignity for all projects, including no after-hours cultural support for whānau Māori, a lack of training and cultural supervision for clinicians and frontline staff, and a lack of commitment and investment from executive leadership to embed change. Some district project teams also reported they would like more support for iwi to be involved.

The Programme expected all districts to participate in projects within the same time frame. Larger districts had many sponsors and larger teams, including dedicated quality improvement facilitators and data specialists. However, smaller teams often have one sponsor, a few individuals working across projects and limited analyst capability. While the Programme team made themselves available to all teams for support as needed, smaller districts often found it more challenging to apply learnings.

Future directions for the Programme

Stakeholders unanimously reported Te Tāhū Hauora has an ongoing quality improvement stewardship role in the mental health and addiction system and gives independence and neutrality to the Programme. In addition, there are suggested critical focus areas for Te Tāhū Hauora moving forward:

Continue to focus on progressing to zero seclusion, maximising physical health and service transitions.

District project teams are committed to zero seclusion events, fearing progress could slip back without Te Tāhū Hauora support. Support is also needed to continue the momentum built through Te whakanui ake i te hauora ā-tinana | Maximising physical health quality improvement project. Stakeholders also reflected that more work is required in service transitions to improve experiences, variability, and equitable outcomes.

'Our culture hasn't shifted adequately yet. It's easy for the convenience of seclusion to sneak back in.' (National stakeholder)

'I firmly believe without [Te Tāhū Hauora], zero seclusion will go by the wayside. There will be a core group of us that will stay steadfast to the Kaupapa, but having Te Tāhū Hauora in place keeps us accountable.' (District project team)

Continue with the clinical, cultural, and consumer co-design approach and develop a consumer bundle.

Te Tāhū Hauora and district project teams reported the Programme benefitted from the quadripartite approach (clinical, cultural, consumer and quality improvement). Stakeholders identified a need for a consumer kit to support consumers, family, and whānau engagement and involvement in quality improvement initiatives. Furthermore, Te Tāhū Hauora could also develop a Pasifika cultural bundle and equity plan for the Programme.

More work is needed to enhance consumer engagement.

More work is needed in the mental health and addiction sector to enhance consumer engagement locally within district project teams. Te Tāhū Hauora is well placed to positively influence the mental health sector to grow effective engagement of consumers, family, and whānau.

Consider more support for data.

Stakeholders reported internal data expertise within Te Tāhū Hauora as critical in enabling indicator development and measurement of outcomes. Teams need ongoing support in projects to support data collection and monitoring. A few national stakeholders indicated that Te Tāhū Hauora should consider promoting data collected to initiate local management support. Te Tāhū Hauora should consider how it disseminates and mobilises information so it's visible for local management and leadership to initiate upstream quality improvement processes. Additionally, Te Tāhū Hauora should consider including both quantitative and qualitative data, particularly qualitative consumer, family, and whānau voice, when disseminating information across the sector.

Consider more engagement with local leadership and management to reduce barriers and embed practice changes and improvements.

District project teams highlighted enablers and challenges to implementing and embedding practice changes. Local leadership and investment are needed to enable system improvements consistently.

Continued emphasis on whānau Māori to continue shifting equity and cultural responsiveness.

Moving equity and system improvements requires policy and practice change and takes time. District project teams are in the early stages of applying learnings to improve responsiveness to whānau Māori. More time is needed to embed changes and assess effectiveness.

'[The Programme] is very much clinically focused. I haven't seen any projects specifically about bringing tāngata whaiora, the whaiora, or the whānau member to the front. I see a heavy focus on clinical and clinicians driving

these projects to benefit those that come into our service.' (District project team)

Partner with Te Aka Whai Ora and Te Whatu Ora.

A few stakeholders reported with health reforms, Te Tāhū Hauora should consider how it partners with Te Aka Whai Ora on the Programme in the future.

> 'Now, as we sit in terms of Te Aka Whai Ora, Te Whatu Ora, Manatū Hauora and the public health entities. So, what is their role going forward? So, in the mental health and addiction space from Te Aka Whai Ora, Oranga Hinengaro perspective, I think we would look for partnering relationships with HQSC. Also, Te Aka Whai Ora role is to monitor the system for improved equity.' (National stakeholder).

Conclusion

The Programme has been highly relevant to the mental health and addiction sector by focusing on projects of high importance, aligning with health sector strategies and priorities, aligning with Te Tiriti o Waitangi and having a strong equity focus.

The Programme has effectively improved quality improvement learning, capability building and leadership within the mental health and addiction sector. More work is needed to support data collection, especially in smaller districts with fewer resources to draw from.

The Programme and work of district project teams have contributed to practice improvements, though changes are not embedded, and more time is needed to address variability and assess system change. Some projects are ongoing, requiring continued focus and support.

Appendices

Appendix 1: Bibliography

Bensenmann, D. C., & Maxwell, D. (2021, November). MHA Programme Planning July 2022-June 2024: Update. Wellington: Health Quality & Safety Commission.

Carswell, D. P., & Pashkov, A. (2018). Evidence-Scoping Review - Service transition for mental health and addiction. Auckland.

Easthope, S., Thompson, B., Jiang, J., & Matthews, R. (2020). Mid-Programme evaluation: Mental health and addiction quality improvement programme.

Francis Health. (2020). Mid-Programme evaluation semi-structured interview questions.

Francis Health. (2020). Mental health and addiction (MHA) quality improvement programme evaluation survey.

Health Quality & Safet Commission. (2021). Maximising physical health | Te whakanui ake i te hauora ā-tinana project. Wellington.

Health Quality & Safety Commission. (n.d.). Connecting Care Project Charter. 2019. Wellington.

Health Quality & Safety Commission. (2017). Mental Health and Addiction Leadership Group Meeting Minutes. Wellington.

Health Quality & Safety Commission. (2018). Evidence Review Draft 1: Medication safety and the prescribing and medicines management process in. Wellington.

Health Quality & Safety Commission. (2019). Evidence review to inform the development of the mental health and addiction quality improvement programme 'Learning from adverse events and consumer experience' project. Wellington.

Health Quality & Safety Commission. (2019). Medication safety, prescribing and the medicines management process in mental health. Wellington.

Health Quality & Safety Commission. (2022a). Te Pūronga whakamutunga/Project Close Report: Te Tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhiwhitanga ratonga/Connecting care: Improving service transitions. Wellington.

Health Quality & Safety Commission. (2022b). Te whakanui ake I te hauora ā-tinana | Maximising physical health project charter. Wellington.

Health Quality & Safety Commission. (2022c). Zero seclusion: Safety and dignity for all – change package Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha – mōkī aroha May 2022 | Haratua 2022. Wellington.

Health Quality & Safety Commission. (2023). Te Whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki/Improving medication management and prescribing. Wellington.

Health Quality & Safety Commission. (2023). Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha. Wellington.

Health Quality & Safety Commission. (2023, August). Quarterly Update: from the mental health and addiction quality improvement programme. Wellington.

Health Quality & Safety Commission. (2023). Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki. Wellington.

Health Quality & Safety Commission. (n.d.). Learning from adverse events and consumers, family, and whānau experience / Te ako. Wellington.

Health Quality & Safety Commission. (2017). Ngā Poutama: mental health and addiction quality improvement seven-year programme overview.

Health Quality & Safety Commission. (2019). Mental health and addiction QIP Board Paper. Wellington.

Health Quality & Safety Commission. (2020). Learning from adverse events and consumers, family, and whānau experience / Te ako. Wellington.

Health Quality & Safety Commission. (2020). Learning from adverse events: Project Charter. Wellington.

Health Quality & Safety Commission. (2021). Example Driver Diagram - theory to reduce inequity. Wellington.

Health Quality & Safety Commission. (2021). Learning course evaluation: Mental health and addiction (MHA) Quality in action/Mahia to mahi-hikina te kounga. Wellington.

Health Quality & Safety Commission. (2022c). Tools and Te Ao Maori approaches to better support Maori. Wellington, New Zealand.

Health Quality & Safety Commission. (2023). Learning from adverse events: Project close report. Wellington.

Health Quality & Safety Commission. (2023). Mental Health in-patients graphs. Wellington.

Health Quality & Safety Commission. (2023). Ngā Poutama orangahinengaro/Mental health and addiction quality improvement logic model. Wellington, New Zealand.

Health Quality & Safety Commission. (2023). Ngā poutama orangahinengaro/Mental health and addiction quality improvement programme logic model v2. Wellington, New Zealand.

Health Quality & Safety Commission. (n.d.). Local district project team composition guidance. Wellington.

Health Quality & Safety Commission. (n.d.). Zero Seclusion data for Mental health and addiction QI evaluation - meeting notes.

Maxwell, D., To'a Fereti, W. K., & Evile, F. (2022). Mental Health and Addiction Quality Improvement Programme Pacific Strategy. Wellington: Health Quality & Safety Commission.

Roughead, L., Procter, N., Westaway, K., Sluggett, J., & Alderman, C. (2017). Medication Safety in Mental Health. Sydney, Australia.

Te Pou. (2020). Achieving physical health equity for people with experience of mental health and addiction issues: Evidence update. Auckland.

Te Pou o te Whakaaro Nui. (2018). Reducing and Eliminating Seclusion in Mental Health Inpatient Services: An Evidence Review for the Health Quality and Safety Commission New Zealand. Auckland: Te Pou o te Whakaaro nui.

Appendix 2: Zero seclusion figures

Note on the technical definitions of measures for the data and figures provided:

Denominator: is the same across all measures; the number of tangata whai ora who have experienced any bed night or seclusion event in the reported month.

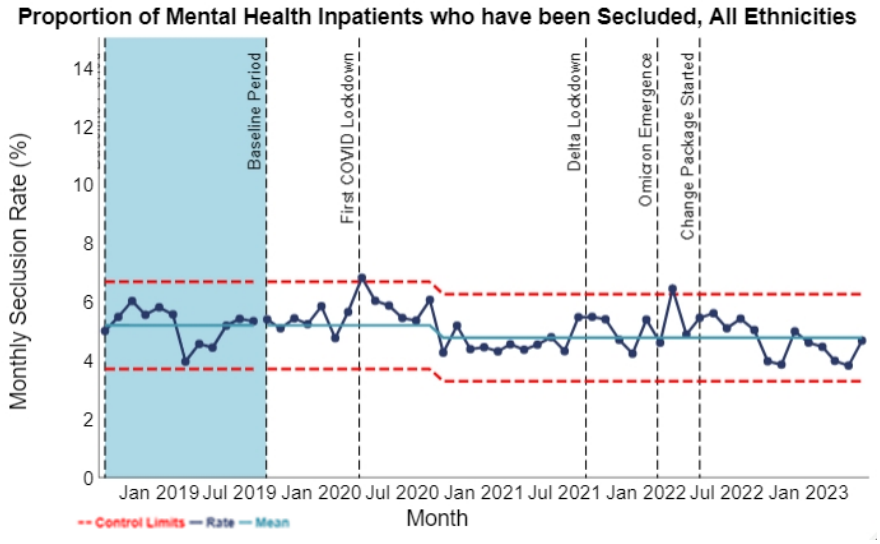
Numerator (Seclusion rate): number of tangata whai ora who have experienced a seclusion event in the reported month. Seclusion rate measure is expressed as this numerator over denominator as a percentage.

Numerator (Seclusion duration): Number of hours tangata whai ora were secluded in each month. Duration measure is expressed as this numerator over denominator as hours per inpatient in a month.

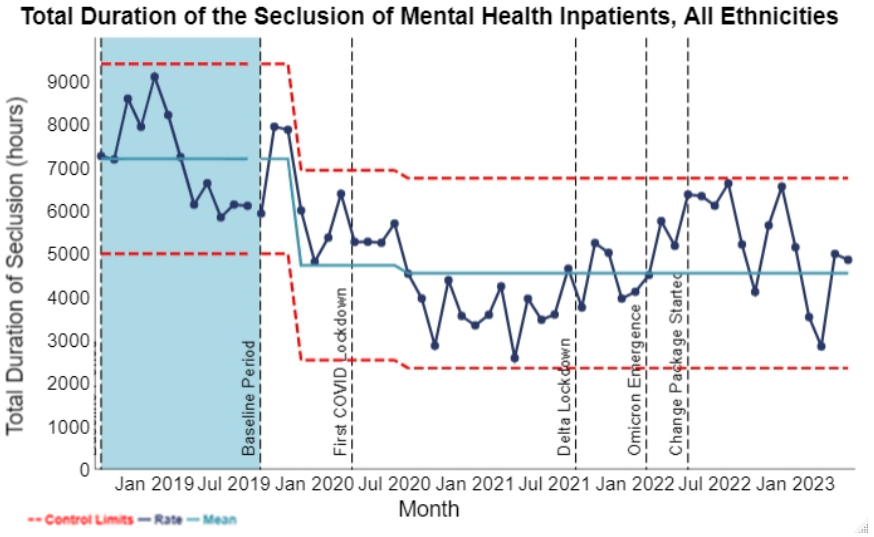
Baseline: all data is measured against a 'Baseline' - calculated as the median of the Measure values between September 2018 and August 2019 (inclusive).

All Ethnicities

All Ethnicities Seclusion Rates

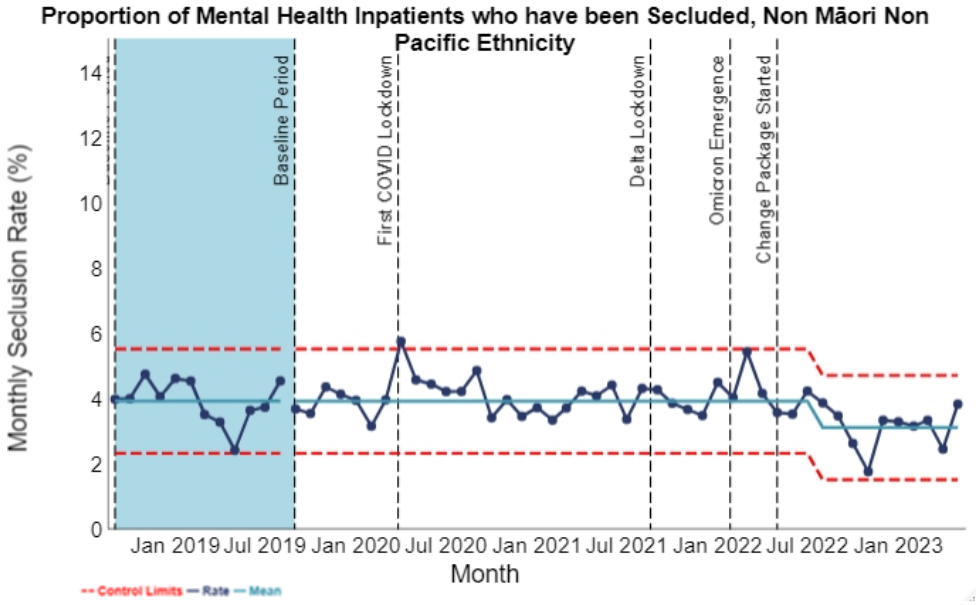


All Ethnicities Duration

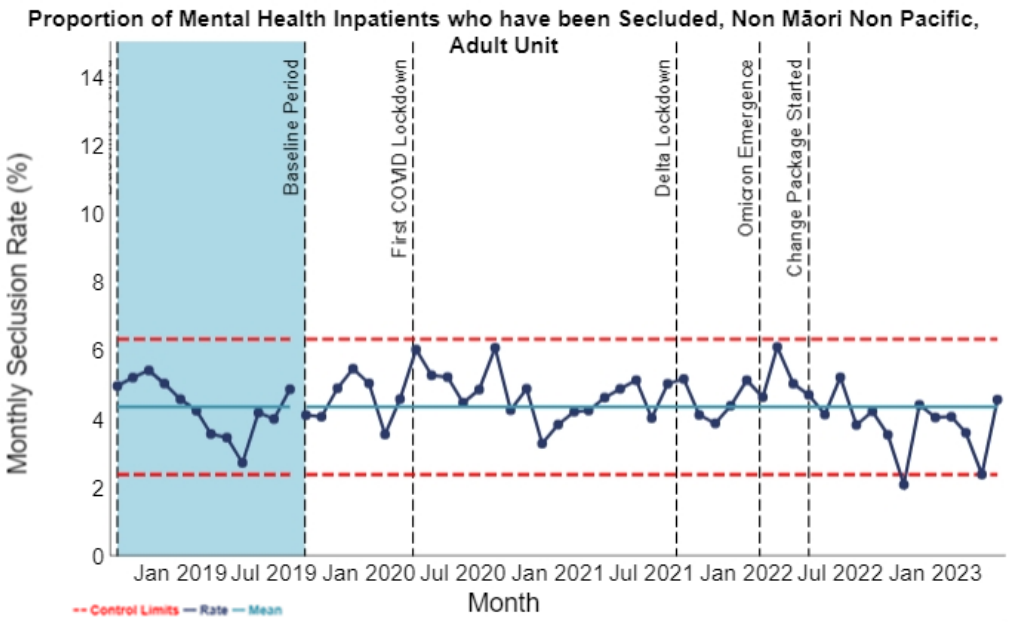


Non-Māori non-Pacific

Non-Māori non-Pacific seclusion rates

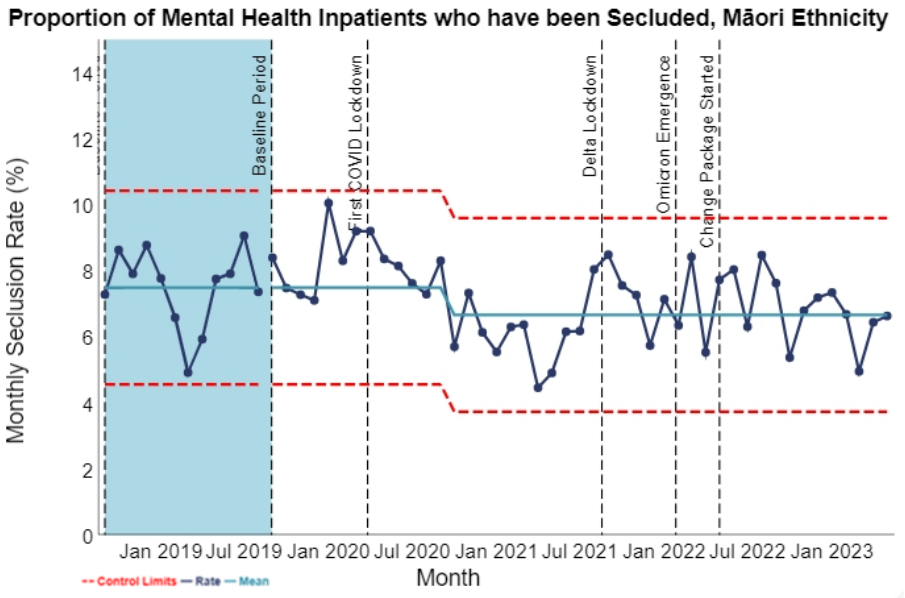


Non-Māori non-Pacific Adult Seclusion Rates

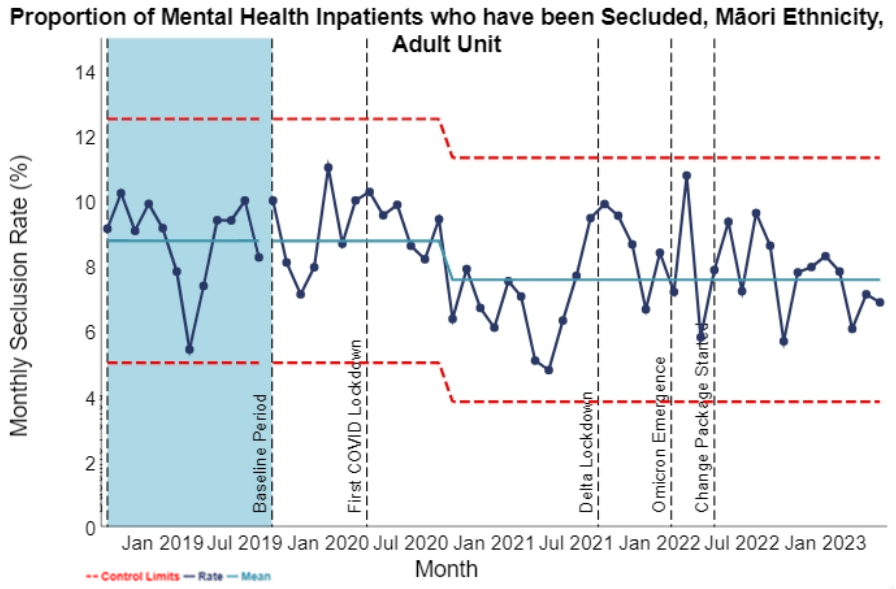


Māori

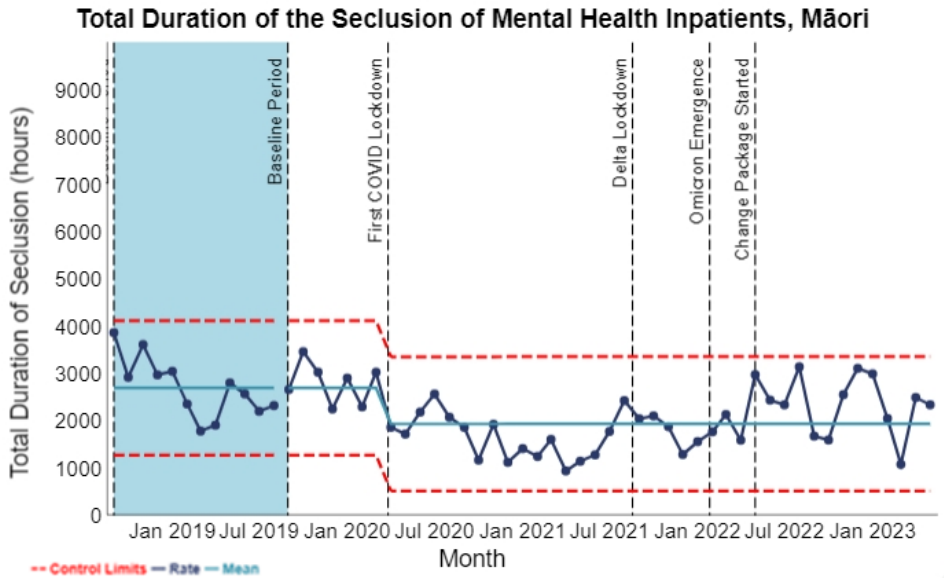
Māori Seclusion Rates



Māori Adult Seclusion Rates

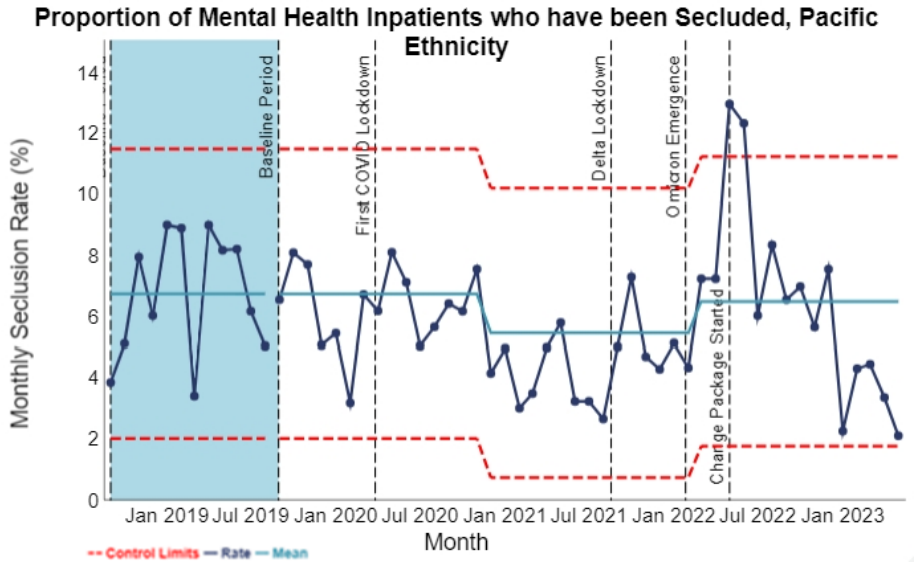


Māori Seclusion Duration

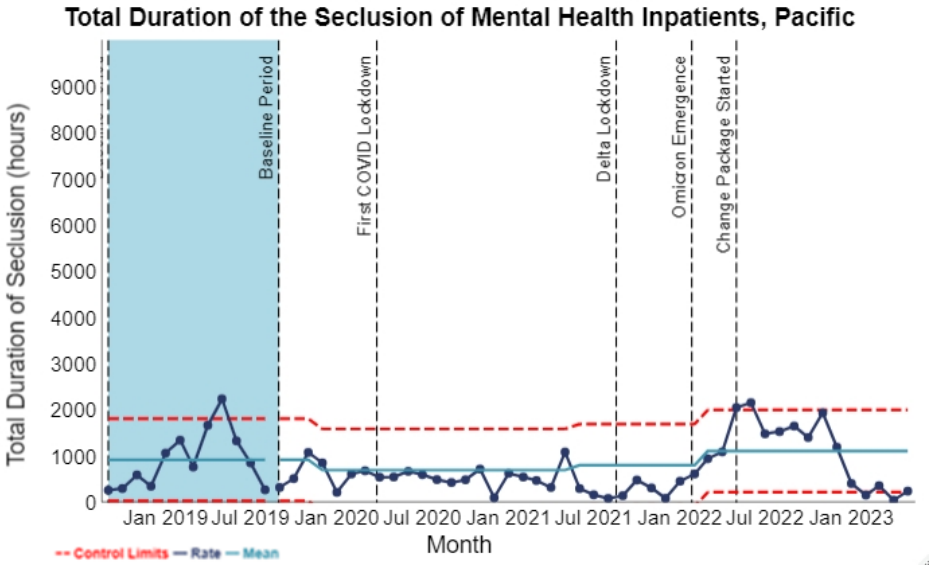


Pacific

Pacific Seclusion Rates



Pacific Duration



Appendix 3: Connecting care figures

Figure 4: Percentage of consumers with a seven-day follow-up after discharge for all ethnicities (national data)

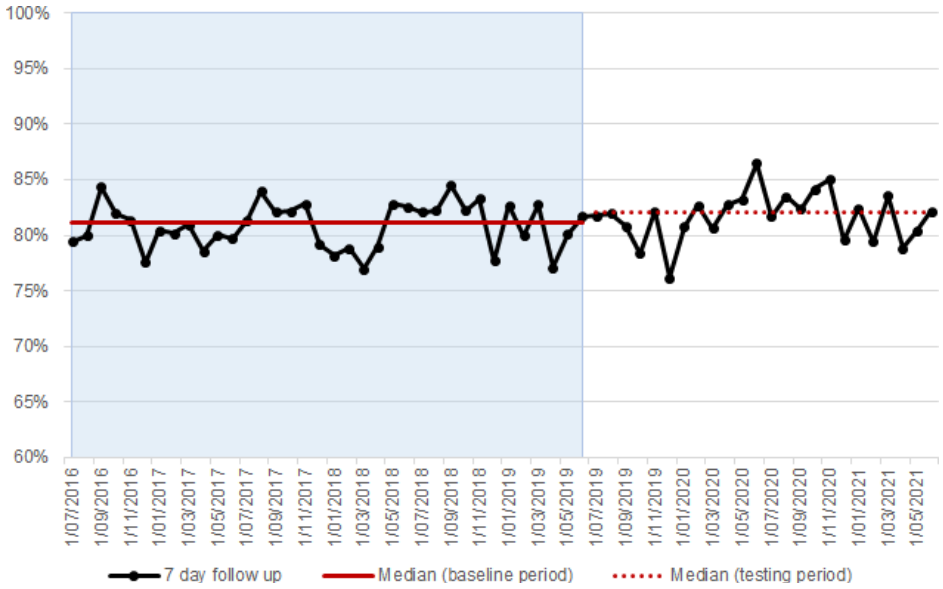


Figure 5: Percentage of Māori consumers with a seven-day follow-up after discharge (national data)

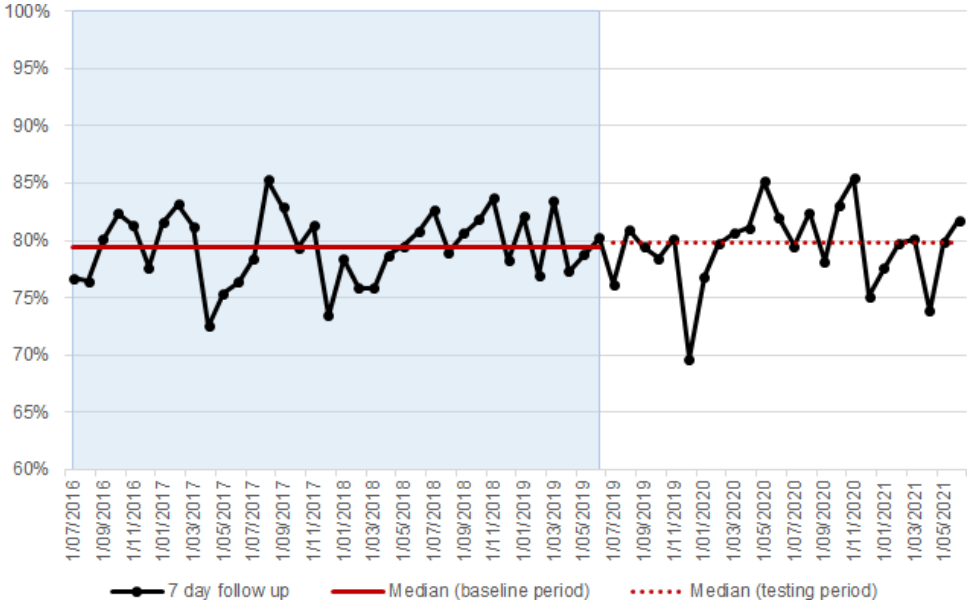
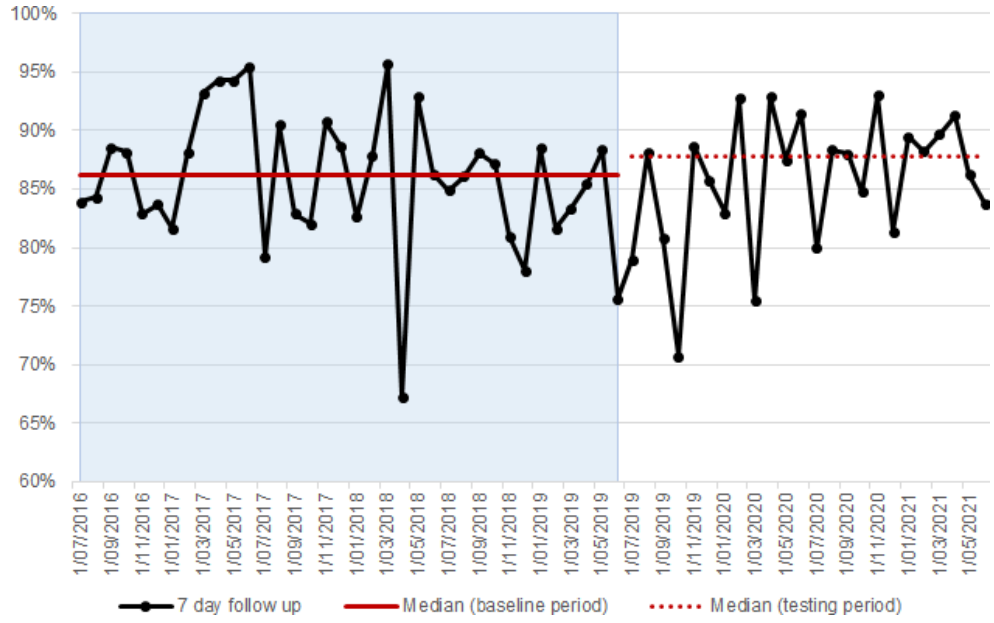
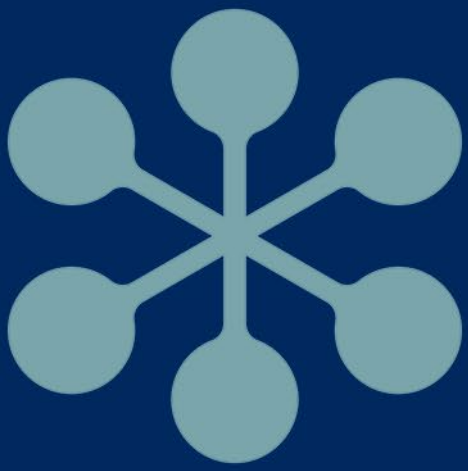


Figure 6: Percentage of Pacific consumers with a seven-day follow-up after discharge (national data)


100%
95%
90%
85%
80%
75%
70%
65%
60%
1/07/2016
1/09/2016
1/11/2016
1/01/2017
1/03/2017
1/05/2017
1/07/2017
1/09/2017
1/11/2017
1/01/2018
1/03/2018
1/05/2018
1/07/2018
1/09/2018
1/11/2018
1/01/2019
1/03/2019
1/05/2019
1/07/2019
1/09/2019
1/11/2019
1/01/2020
1/03/2020
1/05/2020
1/07/2020
1/09/2020
1/11/2020
1/01/2021
1/03/2021
1/05/2021
7 day follow up
Median (baseline period)
Median (testing period)



Litmus

P.O. Box 24181, Manners Street,
Wellington 6142, New Zealand
litmus.co.nz