Blueprint II

Improving mental health and wellbeing for all New Zealanders

Making change happen

A companion document to Blueprint II: How things need to be

June 2012
Mental Health Commission

Contents

Purpose of This Document

This document is intended as a companion to *Blueprint II: How things need to be* and should be read alongside it. It is not intended as a standalone document.

Blueprint II: How things need to be provides a broad overview of the changes needed within the mental health and addiction sector over the next decade. It is intended for a broad readership. *Blueprint II: Making change happen* may also be useful to a broader audience but is directed at people working in the sector.

This document should be seen as a living document. It represents our best collective knowledge of what is needed today to start making the changes necessary to realise *Blueprint II: How things need to be*. It will evolve over time.

Overview

Section I: New Zealand Triple Aim – A framework for sustainable service development

This section provides an overarching framework based on the New Zealand Triple Aim, to ensure that the priorities in Blueprint II cover all the elements needed to achieve better outcomes at both an individual and population level and to achieve a sector that is sustainable in the longer term.

Section II: Taking action

Guidance on how to implement each of the priority areas in Blueprint II includes:

- The rationale for each area.

- The populations that each area targets.

- Detailed actions to achieve results.

Section III: Making change happen

This section provides recommendations about how we can collectively support the change leadership and processes required to make Blueprint II happen. It provides a framework for supporting change, service development and leadership and includes some practical tips on how to get started by building on what we already know and do.

Section IV: What will success look like

As well as describing what success looks like this section provides an initial framework for national, regional, district and individual service providers that will help them to assess their relative strengths and opportunities in each action area.

It also provides more detail on a broad monitoring framework that will enable us to track progress and achievements against our outcomes and provide insight into using this information to support a culture of innovation and evaluative learning. The KPI project and its framework of peer accountability is also discussed in more detail.

Section V: Mental health and addiction really is everyone's business

Strong leadership and oversight is needed to implement Blueprint II. This section outlines the roles across all areas of the Blueprint II vision including people, family/whānau, communities, all of health and all of government.

Appendix 1: Investment and sustainable resourcing

Blueprint II makes recommendations on changes to the way we organise funding and accountability for the mental health and addiction sector. This section provides background and more detail about how this could work.

Appendix 2: Implement effective system change approaches

This appendix provides information on evidence-based change approaches.

Appendix 3: Contributors

This appendix lists those who have contributed to the development of Blueprint II.

Appendix 4: Glossary

This appendix defines technical terms used in the document.

# 1. New Zealand Triple Aim – A Framework for Sustainable Service Development

Blueprint II: How things need to be describes how our approach, systems of care and results need to evolve over the next decade.

This evolution will be driven by our growing knowledge about mental health and addiction issues, including a greater understanding of prevalence, inequalities and need, and its impact on the lives of people and their families, on health, social, education and justice services, and on society as a whole.

Change is already being seen in emerging person and family-centred models of care that strengthen a culture of partnership, improve the timeliness of treatment, enable better treatment choices and lower the risk of harm.

It is also being driven by rising pressure on resources across the whole of the health system. Current workforce and financial resources are not sustainable as health needs change in the face of an ageing population, economic pressures and global demand for health skills. Blueprint II requires investment in services across specialist, community, primary and general health to be as effective as possible.

To make change happen we need a framework that supports simultaneous, sustainable development across all of these domains. Therefore Blueprint II adopts the 'New Zealand Triple Aim' model which has wide acceptance by central agencies – the Ministry of Health (including the National Health Board (NHB)), the National Health IT Board, the National Health Committee, Health Workforce New Zealand, District Health Boards (DHBs), Health Benefits Ltd and PHARMAC – as an overarching approach to guide improvement of health services.[1]
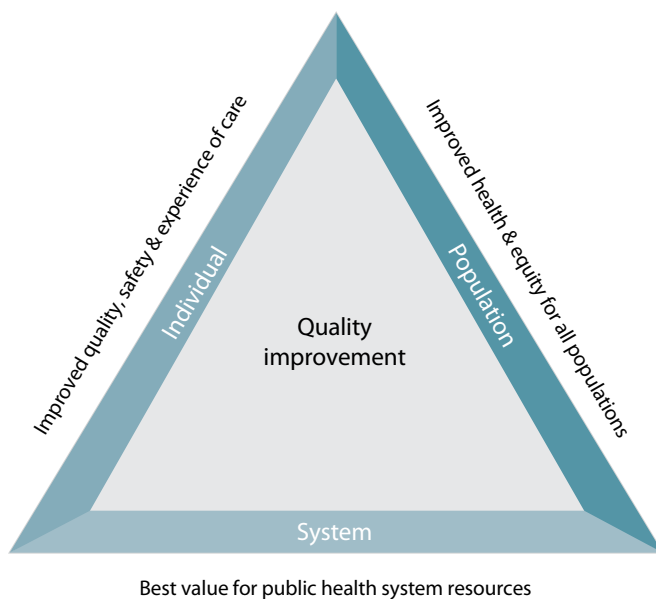
Originally developed by the Institute for Healthcare Improvement (IHI) the Triple Aim model has three concurrent goals: better care for individuals, better health for populations and lower per-capita costs. The New Zealand Health Quality and Safety Commission, in partnership with the NHB, has agreed on a New Zealand Triple Aim, which is the simultaneous implementation of:

- Improved quality, safety and experience of care.

- Improved health and equity for all populations.

- Best value from public health system resources.
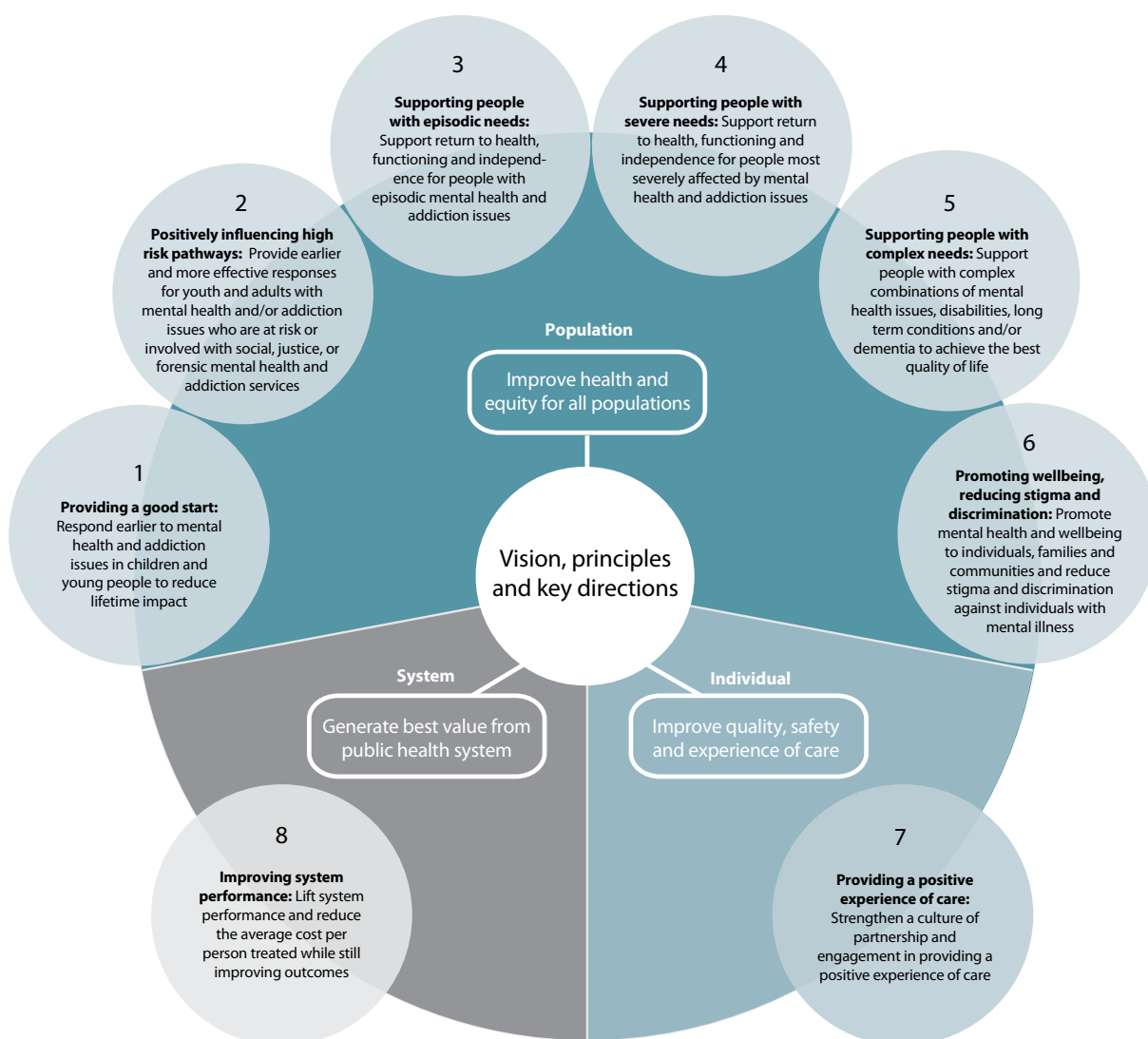

Best value for public health system resources

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1   Ministry of Health. 2012. *Improving the System: Meeting the challenge: improving patient flow for electives. A Toolkit for District Health Boards.* Wellington: Ministry of Health.

The triple aim approach has been used effectively to simultaneously achieve improvements to the experience of care and the health of populations while reducing the cost of health care.[2] It is also the framework used by a range of DHBs to guide improvements in systems of care across general heath, providing a common platform of capability which can support the more focused mental health and addiction improvements of Blueprint II.

Blueprint II's approach to making change happen uses the New Zealand Triple Aim as a framework to ensure there is an appropriate balance across the eight priority areas. Balance will result in improved mental health and addiction outcomes at an individual and population level, and a sustainable sector in the longer term.

1.1 Linking the Triple Aim and priority areas

The diagram below shows how the eight priority areas map onto the three domains of the New Zealand Triple Aim. In reality the eight priorities are tightly interrelated. Effective use of the triple aim enables us to leverage the opportunities for simultaneous action within and across each priority.

3 Supporting people with episodic needs: Support return to health, functioning and independence for people with episodic mental health and addiction issues

4 Supporting people with severe needs: Support return to health, functioning and independence for people most severely affected by mental health and addiction issues

2 Positively influencing high risk pathways: Provide earlier and more effective responses for youth and adults with mental health and/or addiction issues who are at risk or involved with social, justice, or forensic mental health and addiction services

5 Supporting people with complex needs: Support people with complex combinations of mental health issues, disabilities, long term conditions and/or dementia to achieve the best quality of life

1 Providing a good start: Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact

6 Promoting wellbeing, reducing stigma and discrimination: Promote mental health and wellbeing to individuals, families and communities and reduce stigma and discrimination against individuals with mental illness

Population — Improve health and equity for all populations

Vision, principles and key directions

System — Generate best value from public health system

Individual — Improve quality, safety and experience of care

8 Improving system performance: Lift system performance and reduce the average cost per person treated while still improving outcomes

7 Providing a positive experience of care: Strengthen a culture of partnership and engagement in providing a positive experience of care

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2   Berwick D M. (2008). "The science of improvement". *Journal of the American Medical Association (JAMA);* 299(10):1182–1184.
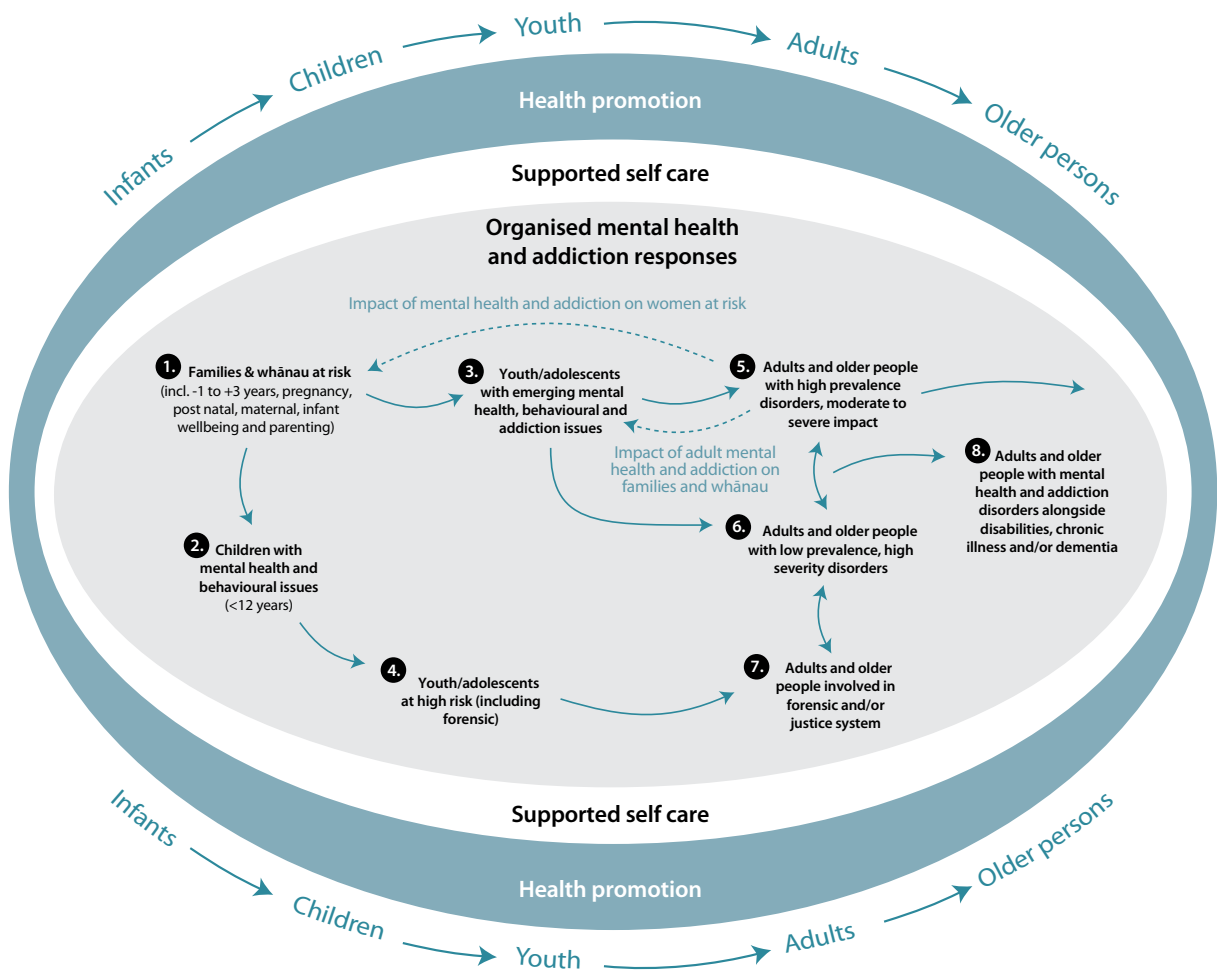
1.2 Life course

Blueprint II introduces a 'life course' approach which looks at the critical points in the development of mental health, addiction and behavioural issues where we can intervene earlier and more effectively. It covers the whole life course, from before birth through to older people.

In particular, it focuses on the eight most common points in the lives of people with mental health, addiction and behavioural issues where there is an opportunity to identify issues and to make a real difference by intervening at these points during a person's life.

Figure 2: Life course approach

The first five priority actions described in the next section relate to specific populations across this life course.

2. Taking Action

Blueprint II: How things need to be describes eight priority areas that are needed to achieve the Blueprint II vision. This section provides additional detail on the eight priority areas, including:

- The rationale for each area.
- Populations that the area targets.
- Detailed actions to achieve results.

It also provides guidance on how to make the changes required.

2.1   Priority 1: Providing a good start

Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact.

Figure 1: Populations covered in life course by this priority area
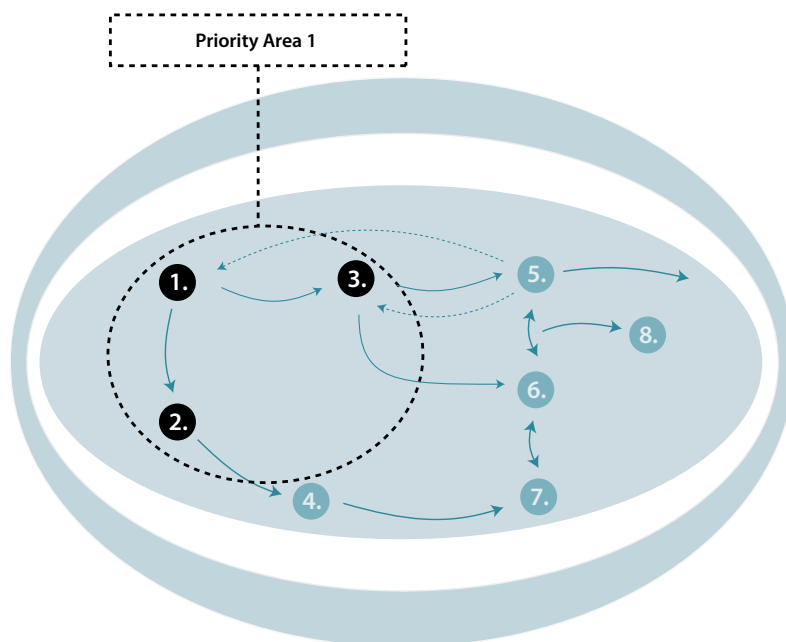
The first priority area focuses on infants, children and young people from vulnerable families and whānau. It takes a coherent approach to increase the capability of families and their communities to support positive infant and child development.

Blueprint II calls for an integrated response to parenting support and early recognition and management of mental health, addiction and behavioural issues across health, education, and care and protection settings for children.

Action is needed in the following areas:

- Support positive infant and child cognitive, social and emotional development by increasing awareness, increasing health literacy and increasing the capability of families/whānau and their communities.
- Reduce the impact of parental mental health and addiction issues on infant and child development.
- Increase access rates for vulnerable families to effective developmental assessments, parenting support and mental health and addiction responses.

- Increase access and early responses for children (5–14 years) with interrelated developmental, behavioural and mental health issues.

- Increase access and early responses for youth (15–24 years) with emerging behavioural, substance abuse and mental health issues.

Rationale

There is growing evidence of the lifelong impact that early adversity (from early pregnancy through the first years of life) has on social, emotional and cognitive development.[3] The risk of later problems is well known and includes mental disorder, chronic medical conditions and disengagement from education, work and society. Conversely, creating a secure environment for infant development provides the foundation for greater mental health resiliency.

Maternal stress and mental health issues, alcohol and drug use, conflict and violence, neglect, and chronic exposure to severe socio-economic stress can all have adverse impacts on children and young people. Focusing on positive parenting and family/whānau engagement and taking active steps to address maternal mental health and addiction issues and family violence, can be effective in improving outcomes and reducing down-stream costs to society and services.[4]

There are clear benefits of agencies intervening early to deal with preschool to puberty aged children with pervasive developmental disorders, attention-deficit/hyperactivity disorder, conduct or mixed conduct/emotional disorders. It leads to substantially improved child educational participation and a reduced risk of later mental health and addiction problems and anti-social behaviour or offending.[5]

The young adult period is characterised by a rapid rise in the prevalence of anxiety, depression, and drug and alcohol use issues. Young adults experience low rates of recognition of mental health and addiction needs due to stigma, lack of awareness, social isolation, and reluctance to seek help through conventional health, education or social services. At its most severe, the combination of factors can lead to significant risk of self harm and suicide.

We have not achieved the targets for investment for children and young people that are recommended in the original Blueprint. Progress has been hindered by the tendency to create hard inclusion/exclusion boundaries around services based on presenting diagnostic or severity; a lack of development in primary mental health services, especially for children; and a lack of parenting support and behavioural services. In addition, work is still needed to build workforce capability across the range of health, social, community, education and statutory services.

The initial Blueprint signalled a need for a substantial increase in specialist service response rates for children and youth. The access targets differed by age group – 1% for 0–9 year olds, 3.9% for 10–14 year olds and 5.5% for 15–19 year olds. Growth in access has developed more slowly than for adults. Current access rates remain well below target, although the gap has been closing in more recent years. The latest 2009/10 data shows a 0–9 year access rate of approximately 0.7%, 10–14 year old rate of 2.5% and 15–19 year access rate of 4.4%.[6] Access rates for Pacific children and youth remain substantially less than for Māori or the population as a whole.[7]

Children and young people access a wide range of services across the whole of government. This includes specialist mental health services, primary care, privately purchased psychological services, programmes supported by the Ministry of Social Development (such as services for vulnerable families and children in care) and school-based services supported by the Ministry of Health and the Ministry of Education.

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3   Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Wellington: Office of the Prime Minister's Science Advisory Committee.

4   Mental Health Commission. 2012. *Mental Health and Addiction Service Delivery: Implications of Emerging Practice.* Wellington: Mental Health Commission.

5   Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Wellington: Office of the Prime Minister's Science Advisory Committee.

6   Ministry of Health. 2012. *Mental Health Service Usage 2009–10 Provisional Results.* Wellington: Ministry of Health.

7   Mental Health Commission. 2011. *Child and youth mental health and addiction.* Wellington: Mental Health Commission.

Populations

This priority area focuses on:

- Mothers and infants from pregnancy to three years.

- Children and young people from preschool-age to puberty.

- Young adults (18–24 years).

The prevalence of mental health and addiction disorders in children and young people is high. Dunnachie[8] reported that 18% of New Zealand 11-year-old children are affected by a mental health disorder. By secondary school 27% of students are affected by depression and anxiety, with 10.6% experiencing significant symptoms, with substantially higher rates for females than males. The period of greatest growth in prevalence is between the ages of 15 and 18[9] where prevalence peaks at 29% for any mental health disorder and 7% for serious disorders, substantially higher than at any other period in life.

Mental health issues in youth commonly coexist with alcohol or drug problems.[10] The prevalence of hazardous drinking exceeds 50% for 18–24 year old males. Prevalence rates for cannabis use are approximately 40% for 16–18 year olds.[11]

Conduct disorders or severe antisocial behaviour disorders affect up to 10% of youth and are characterised by aggressive, delinquent, dishonest, and disruptive behaviours.[12] The majority are male.

The prevalence of self harm, suicidal ideation and suicide among young people is high by international norms, especially for females. 20% of secondary school students report self harm in the past 12 months and 4.7% report a suicide attempt in the same period.[13] In 2009 the suicide rate for males aged 15–24 years is 29 per 100,000, more than four times higher than the rate for females of the same age at 7 per 100,000, and the highest rate in the OECD. The rate of male youth suicide increased rapidly between 1985 and 1995, peaking at 44 deaths per 100,000 males in 1995. After that time the rate trended downwards until 2003 and has been highly variable since then. By comparison, the rates of female youth suicide showed a general increase between 1960 and 1996 when they peaked at 14.3 per 100,000 and since then have been highly variable. The Māori youth suicide rate in 2009 was more than 80% higher than for non-Māori.[14]

Results needed

1. Support positive infant and child cognitive, social and emotional development by increasing awareness, increasing health literacy and increasing the capability of families/whānau and their communities.

Most families create positive environments for infant and child development. But we have yet to translate the weight of evidence on the lifelong impact of adversity through the early years of life into a coherent public health/health promotion approach, as we do, for example, with our investment in improving immunisation rates.

Blueprint II calls for:

- The mental health and addiction sector to take a lead in developing comprehensive cross-sector health

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8   Dunnachie B. 2007. *Evidence-Based Age-Appropriate Interventions: A Guide for Child and Adolescent Mental Health Services (CAMHS)*. Auckland: The Werry Centre.

9   Ministry of Health. 2007. *Te Raukura: Mental Health and Alcohol and Other Drugs: Improving Outcomes for Children and Youth*. Wellington: Ministry of Health

10   Dunnachie B. 2007. *Evidence-Based Age-Appropriate Interventions: A Guide for Child and Adolescent Mental Health Services (CAMHS)*. Auckland: The Werry Centre.

11   Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. Wellington: Office of the Prime Minister's Science Advisory Committee.

12   Advisory Group on Conduct Problems. 2009. *Conduct Problems: Best Practice Report*. Wellington: Ministry of Social Development.

13   Mental Health Commission. 2011. *Child and youth mental health and addiction*. Wellington: Mental Health Commission.

14   Ministry of Health. 2012. *Suicide Facts 2009. Deaths and Intentional Self Harm Hospitalisations*. Wellington: Ministry of Health..

promotion, health literacy and self help/self care support for positive infant and child cognitive, social and emotional development. The sector should work alongside partners who are active in positive parenting practices, family violence prevention and intervention, and early child education.

2. Reduce the impact of parental mental health and addiction issues on infant and child development

Infants and children are particularly vulnerable when raised in families with combinations of risks that include:

- Foetal adverse impact from pregnant mothers with addiction problems.

- The impact of parental addiction on emotional attachment and infant development.

- The impact of conflict and violence.

- The impact of pregnancy on mothers with pre-existing mental health issues, including a risk of increased stress and potential complications due to adverse effects of psychiatric medications on the foetus (such as lithium, anticonvulsants mood stabilisers, antipsychotics).

- Increased risk of onset of depression and/or anxiety during or after birth, or exacerbation of prior conditions.

For very young children the intervention point is as much about improving parental mental health and parenting skills as it is working directly with the young child. Maternal and perinatal mental health and addiction issues are estimated to affect 15–20% of early childhood environments. Maternal mental health and addiction issues affect 16% of women[15] and infant mental health issues affect between 16–18% of infants.[16]

Blueprint II calls for:

- Increased access rates for children of parents with mental health and addiction issues.

- Better skills and knowledge of general practice, maternity, Well Child and family/whānau support services in how to recognise mental health and addiction issues and how to use brief advice and interventions, self care and referral pathways.

- High priority to be given to screening for mental health and addiction problems early in pregnancy and prioritising access for mothers to effective brief interventions during the perinatal period.

- Targeted responses through established mental health and addiction services for the much smaller proportion of children born to parents with more severe mental health and addiction problems. This will reduce risks and increase parents' capability to generate good outcomes in the critical early years.

3. Increase access rates for vulnerable families to effective developmental assessments, parenting support, and mental health and addiction responses

Vulnerable families are identified through an increasing range of processes during pregnancy, from Well Child checks, Whānau Ora assessments or through social agency or cross agency programmes such as Strengthening Families. Every touch point with services is an opportunity to make a difference. Many of these opportunities fall outside mental health and addiction services. But co-ordination and alignment across sector partners, including mental health and addiction services where appropriate, is needed to ensure effective responses are provided.

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15   Morton S, et al. 2012. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families: Report 2: Now we are born.* Auckland: Growing Up in New Zealand.

16   Ministry of Health. 2011. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand.* Wellington: Ministry of Health.

Blueprint II calls for:

- Improved engagement of pregnant women in antenatal care, in particular with development of outreach and intensive community based multi-disciplinary team support directed at those most at risk of poor outcomes.

- Access to support and parent training programmes provided by Child Youth and Family (CYF), Ministry of Education and other agencies, especially for those at risk.

- Early recognition and integrated perinatal, Well Child, family/whānau and community-based mental health and addiction responses, to less severe maternal mental health and addiction problems. This earlier recognition and response will result in better outcomes.

- Increased access to self help resources, peer, community and NGO support. This will reduce variation in access to support for rural and low decile populations.

- Increased access to brief interventions in primary care and specialist mental health and addiction services as well as educational and social sector settings.

- Integrated assessment and co-ordinated responses which may include navigator roles, pooled funding across services and agencies. For example: 'One family, one plan, one case worker, one health record'. This will result in fewer gaps in care, targeted response, less waste, efficient use of resources and improved staff productivity.

4. Increase access and early responses for children (5–14 years) with interrelated developmental, behavioural and mental health issues

Substantial gaps between the level of need and current access levels have been identified for children aged between five and 14.

The *Green Paper for Vulnerable Children*[17] 2012 estimates that at any one time 15% of children are "particularly vulnerable. That is, without significant support and intervention they will not thrive, belong or achieve". Child Youth and Family estimates that only 20% of children in its care with an identifiable mental health disorder receive mental health and addiction services.[18] This is a sub-set of a larger group exposed to lesser levels of neglect, emotional abuse or violence – approximately 25% of children have a Child Youth and Family record by the age of 18. Based on the Dunedin and Christchurch longitudinal studies,[19] approximately 4.5% of primary and intermediate school children demonstrate conduct disorder/severe antisocial behaviour at any one time.

While we do not have exact figures for current access levels, in 2009/10 access to specialist services was provided to approximately 2% of the 5–14 year age group. In conjunction with the growing evidence in support of intervening with this group as early as possible, we must increase access early responses for children aged 5–14 years.

Blueprint II calls for:

- Increased access rates for children 5–14 years.

- Increased focus on cross sector action to develop effective approaches for children with complex issues.

- A 'whole of child' outcomes approach designed to reduce the barriers and gaps generated by different agency frameworks and access criteria.

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17 Ministry of Social Development. 2011. *Every child thrives, belongs, achieves: The green paper for vulnerable children.* Wellington: Ministry of Health.

18 Rankin D. 2010. *Mental Health Services for Children and Young People in the Care of Child, Youth And Family.* Wellington: Department of Child, Youth and Family.

19 Boden J M; Fergusson D M; Horwood L J. 2010. "Risk factors for conduct disorder and oppositional/defiant disorder: Evidence from a New Zealand birth cohort." *Journal of the American Academy of Child & Adolescent Psychiatry.* 49(11): 1125–1133.

- Collaboration across the mental health and wider health sector, to better support the full range of needs of children exposed to care and protection issues.

- Development of shared care and liaison models of support.

- Provision of primary and community delivered family-engaged interventions, parent training, problem solving skills, family supported cognitive behavioural therapy (CBT).

- Incorporation of trauma informed therapies into routine practice.

5. Increase access and early responses for youth (15–24 years) with emerging behavioural, substance abuse and mental health issues

Evidence shows that the period post puberty to early adulthood is the period of greatest risk for development of mental health and addiction issues.[20] It also represents the period with the greatest opportunity to reduce the impact of mental health and addiction issues through effective and focused early interventions when issues are mild to moderate in severity.

The prevalence of combined anxiety and depression increases significantly following puberty, particularly for females. There is a similar significant increase in hazardous drinking, drug use and normalisation of risky behaviour. High levels of co-morbidity between addiction and other mental health issues means that the majority of young people who need more intensive mental health services will also need addiction responses.

Complex social, peer and interpersonal interactions alongside mental health and addiction issues can increase the risk of harm and limit help-seeking behaviour. Increasing peer influence in adolescence requires a shift to a targeted youth/adolescent approach. Family/whānau therapies are less effective for this group as are group therapy approaches that are effective in adult services. Addressing the needs of this group will require greater attention to early recognition and providing support pathways to effective treatments.

Over the past decade there has been successful progress in lifting access rates to specialist services for this group to 4.4%. However, this access rate is barely enough for a group comprising high risk, forensic and youth justice challenges. Access to lower intensity primary and community based responses need to be substantially increased to address the estimated 15–20% prevalence rates of moderate to severe, non forensic, but still harmful mental health and addiction issues.

Blueprint II calls for:

- Increased access rates for people aged 15–19 years and 19–24 years (excluding those with a forensic or justice system involvement covered in Priority Area 2).

- Engagement with young people to find out what sorts of services would improve access and increase take-up.

- Increased access to effective and comprehensive youth health services (for example, school-based services and youth 'one stop shops').

- Building skills and knowledge of staff working with youth in primary care, other general child and youth health services, community and education settings. This will enable early identification of emerging issues, provision of advice, direction to self care tools, brief interventions or referral to additional support/services as required.

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20   Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. Wellington: Office of the Prime Minister's Science Advisory Committee.

- Continued development of e-therapies as independent support tools and as part of a programme of support for primary or school-based services that can provide continuity and escalation of support if required.

- Increased primary and community screening of youth for mental health and alcohol and other drug issues, and assessment of psychological and social functioning. There will be provision of, or referral to, interventions ranging from brief advice, motivational/problem-solving through to more focused interventions for mental health and dependency issues.

- Continued development of capacity to respond to the lower prevalence but high risk situations associated with suicide, eating disorders, early psychosis, and severe addiction issues.

2.2   Priority 2: Positively influencing high risk pathways

Provide earlier and more effective responses for youth and adults with mental health and/or addiction issues who are at risk or involved with social, justice, or forensic mental health and addiction services.
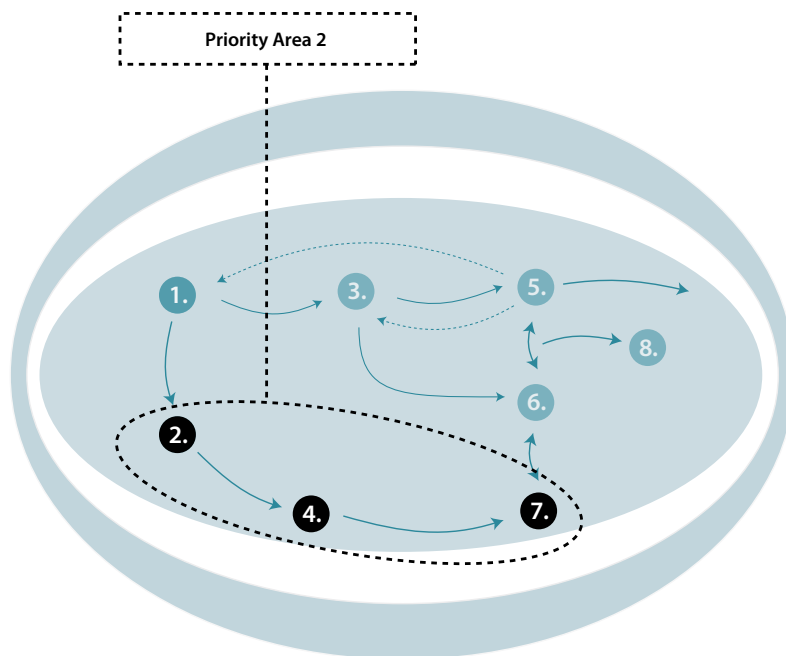
This priority area responds to children, youth and adults with mental health and addiction issues who are at risk of, or already involved in, the care and protection or justice system.

This priority area represents an additional level of response to the youth and adults identified in the previous section who have compounding risks of mental and behavioural issues which may escalate in severity and impact. The 'life course' approach means that actions for Priority Area 1 are closely linked.

Action and results are required across the following areas:

- Develop integrated responses with sector partners to reduce the likelihood of negative outcomes for children, youth and their families, including children in care with emerging problems and a high need for support.

- Increase access to youth oriented alcohol and other drug (AOD) services, child and adolescent mental health services (CAMHS) and forensic services as part of an inter-sectoral approach for youth with complex needs and emerging risk.

- Systematically address mental health and addiction issues for people within forensic services, prison and equivalent community-based sentences.

- Provide effective support for the pathway to recovery and resiliency from forensic services to community support.

Rationale

While evidence exists for compounding high risk pathways at a population level,[21] [22] [23] it is not able to predict outcomes for individuals. Many individuals will transition well to adulthood, for example the majority of youth with emotional control problems, antisocial behaviour or hazardous drinking generally cease this behaviour in early adulthood.[24] For others mental health and addiction interventions can be effective both as health treatments in their own right and as support tools that can help divert or mitigate the risk and impact of criminal behaviour.

This priority area focuses on:

- early, preventative responses for children with combinations of mental health and antisocial behaviour visible early in life;

- risk reduction responses for youth with combinations of mental health, addiction and early stages of offending;

- and management/recovery responses for youth and adults with mental health and addiction issues in the justice or forensic mental health system.

By focusing on the concept of a pathway towards compounding risk, Blueprint II is building on the founding principles of the Mason Report[25] that established forensic mental health services in New Zealand, and seeking to extend these 'upstream' to help create a systematic response that intervenes earlier across the continuum of risk development.

Blueprint II is not suggesting that dealing with behavioural issues becomes the responsibility of mental health and addiction services. Mental health and addiction responses are only one contributor to the wider goal as part of a 'whole of society' and 'whole of government' response. Substantial action is underway within multiple current government initiatives, such as Vulnerable Children, Addressing the Drivers of Crime, inter-sectoral action for mental health for children in CYF care, as well as initiatives in youth forensic services and prison mental health services. But at present there is no overarching cross-government strategy for children and youth and no clear responsibility for the various components required to provide the full spectrum of services needed to address this issue.

Longitudinal studies describe two high-risk pathways.[26] [27]

The first arises relatively early with a small group of children at increased risk of negative psychological outcomes during their development, which is associated with risk factors including exposure to severe or constant family socioeconomic stress, parental psychopathology, negative parent-child relationships, parental separation and child maltreatment.[28]

Child maltreatment can have an impact on early development with issues including conduct disorder, depression and anxiety, suicidal behaviours and substance abuse. Manifest need is relatively easy to identify in early childhood and school settings. The behaviour tends to be persistent and generally worsens as children get older, meaning that responding to need at this stage of life can have substantial benefits.

21   Boden J M, Fergusson D M, Horwood L J. 2010. "Risk factors for conduct disorder and oppositional/defiant disorder: Evidence from a New Zealand birth cohort." *Journal of the American Academy of Child & Adolescent Psychiatry.* 49(11): 1125–1133

22   Fergusson D M; Horwood L J; Ridder E. 2005. "Show me the child at seven: The consequences of conduct problems in childhood for psychosocial functioning in adulthood." *Journal of Child Psychology & Psychiatry.* 46(8): 837–849.

23   Stein S, et al. 2011. "Developmental and Behavioural Disorders Through the Life Span." *Paediatrics.* 128 2) 364–373.

24   Fergusson D, Boden J. "Alcohol Use in Adolescence" in: Gluckman, P. 2011. Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Wellington: Office of the Prime Minister's Science Advisory Committee, 235–255.

25   Mason K. 1996. *Inquiry Under Section 47 of the Health and Disability Service Act 1993 in respect of Certain Mental Health Services.* Report of the Ministerial Inquiry to the Minister of Health Hon. Jenny Shipley. Christchurch.

26   Fergusson D M; Poulton R; Horwood L J; Milne B; Swain-Campbell N; Baxter J. 2003. *Comorbidity and Coincidence in the Christchurch and Dunedin Longitudinal Studies.* Report for the New Zealand Ministry of Social Development, the Department of Labour and the Treasury.

27   Poulton R. 2010. *Drivers of Crime: What can the evidence tell us?* Wellington: Ministry of Justice.

28   Rankin D. 2010. *Mental Health Services for Children and Young People in the Care of Child, Youth and Family.* Wellington: Department of Child, Youth and Family.

Many of these children come to the attention of CYF and are part of the population of children in care. Over 80% of these children have a diagnosable mental health condition.[29] The positive opportunity for this group is that early intervention with children and their families, as described in Priority Area 1, can have a substantial impact on reducing downstream risk[30]. For more established and severe mental and behavioural health issues a range of family/whānau and 'whole of person' responses can be effective across the spectrum of severity – the challenge is building the capacity to address the need.

The second high-risk pathway emerges in adolescence for a much larger group – with the rise of drinking, drug usage, peer supported antisocial behaviour in combination with steep onset of anxiety and depression (noted under the rationale for Priority 1). For most, this behaviour diminishes in early adulthood but for a smaller proportion the escalation into the justice system involvement marks a potential pathway of compounding escalation of risk. The positive opportunity for this later group lies in effective early diversion and treatment for underlying mental health and addiction issues as part of a wider community and social response that includes improving education and employment and reducing the impact of antisocial peer associations.

There could be a third pathway more likely to develop in adulthood with the effect of serious substance abuse, addiction and/or co-occurring mental health issues contributing to aggressive or violent behaviour which requires secure support – contributing to demand for forensic level mental health services.

A large proportion of children, youth and adults within the high risk pathways are Māori. Young Māori are twice as likely to experience a mental disorder as young non-Māori. Prevalence rates for substance misuse and conduct disorder are two and three times higher for Māori than non-Māori.[31] Between 40–60% of youth who have offended have mental health and/or alcohol and other drug disorders. More than 75% of those appearing before the Youth Courts are Māori.[32] While the drivers for this are complex, with a large proportion of this attributable to the wider impact of socio-economic deprivation, family/whānau circumstances and social environment,[33] [34] it clearly represents an ongoing challenge to ensure that our systems of response are appropriate and effective for this population. We will collectively fail if this is not achieved.

Effective action depends on aligned action across mental health and addiction and specialist services in care and protection, education and justice to provide a range of appropriate responses to clearly defined need at key intervention stages along the pathway. Our inter-sectoral partners have made a start. This includes developments in addressing conduct disorder, mental health services for children in care, youth diversion from courts to treatment, screening for mental health and addiction in prisons and investment in primary mental health care for offenders.

Populations

This action area is primarily focused on youth and adults with severe mental health and addiction issues who, through risk to themselves or others, are engaged with social, justice or forensic mental health services. It includes:

- A relatively small group of children with severe mental health and behavioural issues who will generally be identifiable through engagement with CYF, through problems at school, or through disengagement from education, training or employment.

- Youth, particularly Māori youth, with mental health and addiction issues involved with youth justice services.

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29 Rankin D. 2010. *Mental Health Services for Children and Young People in the Care of Child, Youth and Family*. Wellington: Department of Child, Youth and Family.

30 Wouldes T; Merry, S; Guy, D. "Social and emotional competence: Intervening in infancy Use in Adolescence." In: Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. Wellington: Office of the Prime Minister's Science Advisory Committee, 35–48.

31 Oakley Browne M; Wells J; Scott K (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

32 Fergusson D M; Horwood L J; Swain-Campbell N. 2003. "Ethnicity and criminal convictions: results of a 21-year longitudinal study." *Australia and New Zealand Journal of Criminology*. 36, 354–367

33 Department of Corrections. 2007. *Over-representation of Māori in the criminal justice system: An exploratory report*. Wellington: Department of Corrections.

34 Cunningham C; Triggs S; & Faisandier S. 2009. *New Zealand crime and safety survey 2006: Analysis of the Māori experience*. Wellington: Ministry of Justice.

- Adults in prison and community custodial sentences who have diagnosable mental health and addiction issues.
- Youth and adults requiring forensic level care.

Results needed

1. Develop integrated responses with sector partners to reduce the likelihood of negative outcomes for children, youth and their families, including children in care with emerging problems and a high need for support

It has become increasingly clear across a range of longitudinal studies that the antecedent conditions for future negative outcomes can be detected early in childhood – with up to 10% of children potentially at risk.[35] Research suggests that if successful early intervention occurs for the 5–10% of children with the most severe mental health, conduct and behavioural problems, there is a potential for a 50–70% reduction in later adult criminal activity and associated poor life outcomes.[36]

Troubled children and youth with mental health and behavioural issues or exposure to trauma have in the past been disadvantaged by the separate silos of action and responsibility that operate across education, CYF and Child and Adolescent Mental Health Services (CAMHS). A 2010 analysis of the children in CYF care showed that while 65% had a diagnosable mental health or behavioural disorder condition and 40% a mental health disorder, only 7% were accessing specialist mental health services.[37] The consequences of not addressing these complex issues are tragic. People who have been engaged with CYF account for over 80% of those who commit serious offences and are imprisoned by age 20.[38]

At this more intensive end, promising developments are underway to more systematically address the mental health and addiction needs of children in CYF care with more integrated responses across CYF and CAMHS and more intensive clinical support services, with the government providing additional resources to increase effective access rates.

However there is a wider level of access needed if we are to have the impact envisaged by Blueprint II. This will require better training and awareness among social workers and carers to recognise, within the context of an understanding of child development, early manifestations of mental health and addiction problems. It will require a concerted effort to address the multiple layers and fragmentation of services that contribute to barriers or delays in access.[39]

It will need continued work with schools to build on the innovative examples of school counsellor and youth worker-led, CAMHS supported programmes that aim to both address clinical issues and resiliency development by working with the child, their family/whānau and their school or peers. Again this is an area that has increasing government attention within the Youth Mental Health Initiative which supports a range of developments including strengthening the school-based capacity to recognise and respond to mental health issues in low decile schools.[40] Systems that pick up those who have early difficulties and are not in the school system for whatever reason will be essential.

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35   Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Wellington: Office of the Prime Minister's Science Advisory Committee.
36   Poulton R. 2010. *Drivers of Crime: What can the evidence tell us?* Wellington: Ministry of Justice.
37   Rankin D. 2010. *Mental Health Services for Children and Young People in the Care of Child, Youth and Family.* Wellington: Department of Child, Youth and Family.
38   Centre for Social Research and Evaluation. 2011. *Flow rates from Child, Youth and Family to the Department of Corrections.* Wellington: Ministry of Social Development.
39   Rankin D. 2010. *Mental Health Services for Children and Young People in the Care of Child, Youth and Family.* Wellington: Department of Child, Youth and Family.
40   Department of the Prime Minister and Cabinet. 2012. *Prime Minister's Youth Mental Health Project.* Wellington: Department of the Prime Minister and Cabinet.

Often however, the issue is not lack of family/whānau engagement with services but service engagement in an uncoordinated manner, meeting narrow service-defined needs rather than understanding the issues that confront children and families – from the basics of food, poor housing, overcrowding, poor parental health and wellbeing, to high risks of victimisation from crime and violence.

These complex issues are the focus of emerging Whānau Ora initiatives integrating the mobilisation of whānau strengths and capability with more tuned, responsive and integrated service support. This presents the mental health and addiction sector with an opportunity to marry Whānau Ora's focus on the social context with support from evidence-based responses. These generally favour community-based systemic, multidimensional and targeted approaches which ensure that a young person's behavioural mental health and/or alcohol or other drug issues are dealt with in a comprehensive way.[41]

Blueprint II calls for:

- Continued active development of inter-sectoral partnerships using the commitment and energy of high-profile initiatives to create a whole of system understanding and leadership across critical intervention points of the high risk pathway.

- A commitment across government sectors and agencies to prioritise funding to increase access to effective mental health, addictions and behavioural interventions delivered as an integrated system across the full range of settings of school, health, social and community services.

- The mental health and addiction sector to actively support the development of Whānau Ora and the adaptation and integration of evidenced-based interventions within the relationships and context of Whānau Ora.

2. **Increase access to youth oriented alcohol and other drug (AOD) services, child and adolescent mental health services (CAMHS) and forensic services as part of an inter-sectoral approach for youth with complex needs and emerging risk**

In 2009/10 there were approximately 40,000 police apprehensions of 10–16 year olds. The large majority of these are handled by non-justice alternatives but over 10,000 youth are referred for action through CYF and the youth justice system. Of these, approximately 4,000 appear before youth courts each year.[42]

The evidence suggests that between 40–60% of youth offenders will have mental health and alcohol or drug issues, with higher proportions among those remanded.[43] Most will have more than one issue or diagnosis with high prevalence of coexisting mental health and addiction issues.

The Werry Centre report[44] clearly identified that the first step in providing support to young people in the justice system with mental health and addiction issues is: "Identification of those problems which increase the risk of negative outcomes. The greater percentage of these young people have not been identified or treated in their communities and workers within the justice system have reported struggling to identify or manage this group of young people."

An issue central to effectively shifting youth away from a high-risk pathway is the ability to distinguish situations of deep concern from extremes of otherwise normal adolescent development which may have brought them into contact with the justice system. A large proportion of risk behaviour in youth ceases in early adulthood. Effective identification and triage to a range of mental health services is critical for managing demand.

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41   The Werry Centre. 2009. *Mental health & alcohol and other drug screening, assessment and treatment for Youth Justice populations: A Literature Review.* Auckland: The Werry Centre.
42   Ministry of Health. 2011. *Youth Forensic Services Development.* Wellington: Ministry of Health.
43   The Werry Centre. 2009. *Mental health & alcohol and other drug screening, assessment and treatment for Youth Justice populations: A Literature Review.* Auckland: The Werry Centre.
44   The Werry Centre. 2009. *Mental health & alcohol and other drug screening, assessment and treatment for Youth Justice populations: A Literature Review.* Auckland: The Werry Centre.

It is also important to ensure that inadvertent harm is not caused through pathologising youth mental health and addiction issues that do not materially contribute to compounding behaviour, risk of harm or offending. Building common and shared assessment, systematic screening and triage approaches that are usable across a wide range of settings was identified by the report as a critical development task.

It is clear from a range of recent reports and initiatives that a comprehensive 'stepped care' system, tuned for youth and young adult needs and integrated into cross-sector delivery mechanisms, is required. Many of the building blocks are in place in schools, CYF-funded services, initiatives such as youth offending teams, and CAMHS and youth forensic services.

Recognising that the needs of youth/young adults, and the required response pathways, are likely to differ from adults who have the same diagnosis is a major first step highlighted in the Gluckman Report[45] and in the Prime Minister's Youth Mental Health project. Over time we must examine the current service configuration for the 50% of youth currently accessing mental health support through adult services, to ensure they are getting the best age and stage appropriate care.

The Youth Forensic Mental Health development initiative announced in late 2011 aims to increase capacity for screening, triage, assessment and treatment for youth in CYF, youth justice residences and prisons. It develops a national youth secure acute forensic service.

This represents a strong platform for developing an effective diversion and secondary risk prevention response where the high-risk pathway becomes clearly visible early in the process of offending behaviour development.

This clearly needs to be supported by approaches that ensure successful transition back into the community for youth offenders who have been detained in either a hospital, residential or institutional setting. Without this, interventions tend to have short-lived effects as young people return to unchanged home and community situations.

Creating a system that works for Māori youth will be critical to achieving success given the high prevalence rates described above.

The 2009 Werry report[46] provided a review of the literature on programmes and services offered in New Zealand to address Māori youth offending. It concluded: "Many young people and their whānau do not receive appropriate programmes and service, with gaps identified in: mental health services; counselling services; alcohol and other drug counselling and programmes; alternative education opportunities; direct crisis support; intensive residential programmes; affordable accommodation for homeless young people; holistic services; affordable recreational activities; educational and vocational training; life skills programmes; opportunities for young people on remand to engage in programmes; legal and court support; and well-resourced, Māori-developed and Māori-focused programmes."[47]

The review identified that there is limited research relating to what works to reduce Māori youth offending, although research to date identifies that an underlying critical factor is whānau involvement and addressing issues of culture and identity.

A start has been made on developing a comprehensive, tiered youth mental health system that meets the needs of high-risk youth. But more work needs to be done to understand, design and develop this area. It should be made a key priority for development over the next 10 years. Critical to this succeeding will be active engagement of CAMHS to support the follow-up treatment and care of young offenders with issues such as ADHD, anxiety or depressive conditions.

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45   Gluckman P, et al. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Wellington: Office of the Prime Minister's Science Advisory Committee.

46   The Werry Centre. 2009. *Mental health & alcohol and other drug screening, assessment and treatment for Youth Justice populations: A Literature Review.* Auckland: The Werry Centre.

47   The Werry Centre. 2009. *Mental health & alcohol and other drug screening, assessment and treatment for Youth Justice populations: A Literature Review.* Auckland: The Werry Centre.

This is an area that will benefit substantially from a joined-up 'whole of government' investment-led approach since the costs of achieving this will be substantial within mental health and addiction but the benefits in terms of reduced costs to other parts of Government will be even more substantial. The challenge will be to mobilise combined resources to achieve this outcome. The mental health and addiction sector will need to be an active partner in this process, to help guide development, support effective interventions delivered across a wide range of settings, as well as using its specialist skills and services directly as required.

Blueprint II calls for:

- Development of a nationally consistent, integrated and comprehensive stepped system of care for high-risk youth that spans the continuum from early recognition primary/community level services through to secure forensic services and actively supported transition back to community.

- Consistent use of screening tools to identify early mental health and addiction problems in this group (similar to the tool about to be rolled out for adult prisoners).

- A substantial increase in effective access rates to ensure all youth involved with the justice system who have mental health and addiction issues are able to access an appropriate level of response.

- Continued investment in nationally and regionally supported partnerships and system level co-ordinated development across CAMHS, forensic mental health and addiction services, youth justice, CYF and social services.

- Continued support for processes of shared learning, evaluation and research to build understanding of what works for different cultures, particularly Māori youth, and the translation of these learnings into effective services in both mainstream and more focused responses.

3. **Systematically address mental health and addiction issues for people within forensic services, prison and equivalent community-based sentences**

Forensic mental health services are a highly specialised part of the continuum of mental health services bridging the boundary between the mental health and criminal justice sectors, helping to manage serious mental health conditions in a variety of settings including prisons, courts, specialised inpatient units and the community. Since the 1996 Mason report, which laid the foundations of New Zealand's forensic mental health services, we have made substantial progress. New Zealand is recognised as one of the world leaders in forensic service delivery for those most severely affected by mental health and addiction issues.

However, substantial gaps in access and support remain that prevent us from claiming to have systematically addressed the mental health and addiction issues for people within forensic services, prisons and equivalent community-based sentences.

Prison and youth justice numbers have been growing rapidly as have non-custodial community sentences such as home detention. The latest data may indicate a levelling off in growth but this is not clear cut.

A national study of psychiatric morbidity in New Zealand prisons[48] highlights prevalence rates of 15% for male schizophrenia, 4–7% for bipolar disorder, 40–50% for depression, 20% obsessive compulsive disorder (OCD), 45% post-traumatic stress disorder (PTSD) and up to 90% for substance use.

The 2008 Auditor General Report[49] identified gaps in service provision including timely access to inpatient services; services for those with mild to moderate illness; forensic inpatient services for women; services for those with personality disorders; and services that were responsive to Māori.

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48   Brinded P J; Simpson A I F; Laidlaw T M; Fairley N; Malcolm F. "Prevalence of psychiatric disorders in New Zealand prisons: a national study". *Australian and New Zealand Journal of Psychiatry* 2001; 35: 166–183.

49   Office of the Auditor-General. 2008. *Mental health services for prisoners.* Wellington: Office of the Auditor-General.

This has led to a substantial wave of development that is poised to substantially reshape cross-agency responses and the beginnings of the systematic approach that Blueprint II envisages for the next decade. Within the prison setting these include: the implementation of screening; development of primary mental health services and brief interventions within prisons; and development of new prison based models of care for prisoners with more severe mental health and alcohol and other drug issues.

For parole and non-custodial sentences, recent changes to offender management systems are starting to highlight the ongoing challenges of addressing the mental health and addiction needs of offenders and the potential impact on risk of harm and risk of reoffending. These are costs and consequences that contribute substantially to justice system costs where the large proportion of the prison population are repeat inmates.

The challenge to the mental health and addiction forensic sector is to shape an effective service mix and capacity that can both support these initiatives and respond to likely flow-on effects of increasing demand for intensive forensic services. This needs to be achieved within relatively limited and constrained resources of a specialist workforce, facilities and mental health funding. There are substantial risks of increased wait times and ongoing delays in accessing treatment, particularly in areas such as Auckland where prison population growth and acuity mix are already putting services under pressure.

This challenge is compounded by the variety of roles forensic services play: the justice system in assessment and liaison support and as a tertiary level support; general mental health services for people with aggressive or violent behaviour requiring secure residential care.

Blueprint II calls for:

- A systematic, whole of system, national cross-agency approach to planning and developing a balanced mix of responses and capacity across the continuum of support.

- Continued investment in regional planning and service development to optimise the effective use of the combined agency resources, using shared integrated pathways and models of care.

- A whole of government initiative to explore how a multi-year future investment approach[50] to developing a full spectrum of mental health and addiction services can be afforded within a tight fiscal environment.

4. Provide effective support for pathway to recovery and resiliency from forensic services to community support

Clients of forensic services have a combination of serious offending and severe mental illness. Typically there are complex family and whānau presentations, a history of poor work skills, social exclusion, co-morbidity with drug and alcohol use, traumatisation and poor education. There is often community stereotyping and antagonism.

This presents substantial challenges to making a recovery-oriented transition pathway out of forensic services. Patients potentially end up staying in the forensic inpatient service for a long time due to lack of rehabilitative capacity, or supported community accommodation in the general mental health service. This can result in poor outcomes for people, higher costs, and diversion of limited forensic skills away from critical roles at the 'front end' of forensic services.

How the transition is supported matters. From a services perspective there is anecdotal evidence of a wariness and reluctance of general mental health teams to engage with patients who have been labelled as 'forensic'. This could be from a sense that 'forensic' patients should remain in the service on an ongoing basis or a concern about the risks and responsibilities for caring for an offender with mental health problems, or a perceived lack of skills. United Kingdom data suggests that who provides the outreach transition support matters. If community

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50 That is, similar to that used within the Social Welfare Working Group (2011) *Reducing Long-Term Benefit Dependency*, that identified the whole of government benefits of increasing mental health and addiction support for unemployed and sickness beneficiaries as part of a comprehensive review of the benefits system.

forensic support is provided from within the forensic service, escalations tend to be back to a secure unit whereas if this is provided from a general mental health service these tend to go to a general inpatient bed.[51]

From a client perspective, what is needed is an assertive, structured support that helps transition back to community living, particularly support with step down housing. It should build opportunities and support people to reconstruct their lives. People attempting to leave the high-risk pathway need particular attention. This includes relapse prevention planning and resiliency development from peer based services. This is particularly important for people with alcohol problems because these can frequently trigger reoffending and violent behaviour, and drive readmission.

Blueprint II calls for:

- A national initiative to map the pathways from forensic services to recovery and resiliency in community settings, to understand the blockages and systematically act to streamline the flow.

- Investment in forensic step down/step out transition and rehabilitation functions (with consideration to embedding in general adult services rather than as a parallel service to general mental health) in order to free specialist capacity to be responsive earlier in the forensic pathway.

- Integration of assertive forms of community support integrating housing, employment and addiction treatment.

2.3   Priority 3: Supporting people with episodic needs

Support return to health, functioning and independence for people with episodic mental health and addiction issues.
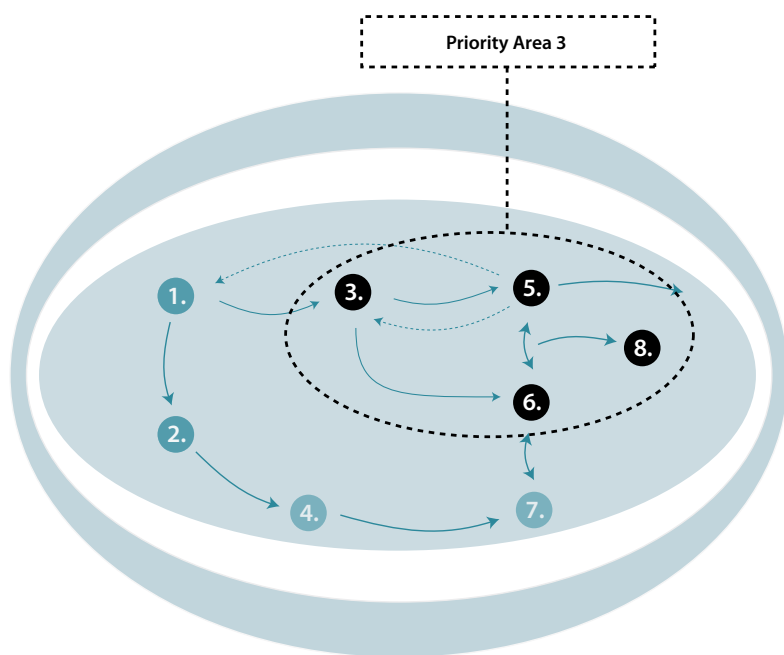
"*Employment tends to be followed by greater well-being, reduced symptoms of mental illness, more compliance with medication, lower relapse rates, better quality of life, and increased social contact and use of leisure time. Identifying successful supported employment services and propagating these throughout the country, as well as clarifying the funding responsibilities for such services, would lead to significant improvement in individual and community wellbeing.*"

This priority addresses the needs of young adults through to older people with episodic high prevalence disorders including anxiety, depression, drug and alcohol abuse, and medically unexplained symptoms. These can sometimes be complicated by the combined impact of early life adversity and current stresses relating to some or all of: unemployment, poverty, lack of social support, family violence and cultural dislocation.

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51   Centre for Mental Health. 2011. *Pathways to unlocking secure mental health.* London: Centre for Mental Health.

This priority area focuses on all New Zealanders having good information on how they can best manage and increase their positive mental health throughout their lives (see also Priority Area 7), accessible self care support, providing effective primary and community-based responses and building and maintaining resiliency for those on the pathway to recovery. This will keep people well, manage risks and minimise the need for intensive or crisis care.

There are three areas of action:

- Strengthen the National Depression Initiative to further reduce the impact of depression.

- Promote accessible supported self care.

- Provide effective primary and community-based responses to rising distress.

Rationale

Since the original 1998 Blueprint our understanding of the true prevalence of mental health issues has increased substantially. Te Rau Hinengaro identified that 21% of New Zealanders have had diagnosable mental health and/or addiction issues in the previous 12 months. For many of these people (8%) the issues are relatively mild, and for most their innate resiliency, together with support from family and friends, or assistance from primary health care, is sufficient to return them to living and functioning well.[52] For approximately 10–12% of the population the issue is moderate to severe, and the impact can be substantial. Without access to effective intervention this can lead to persisting or recurring mental illness, associated poor physical health, progressive dysfunction in social and family relationships and employment, and increased risk of the development of co-morbidities such as alcohol or drug dependency.

For most people with conditions considered moderate to severe the first level of health response is typically a general practitioner (GP). Until recently GPs largely had limited choices for providing support.

For depression or the typical mixed anxiety/depression, psychotropic drugs have been the most readily available treatment. Between 2004 and 2007 the level of prescribing of these drugs rose significantly, [53] [54] with the most recent PHARMAC data indicating the continuation of this trend.[55] The challenge is that this drug treatment is only one element of 'evidence-based' treatment for these conditions. To ensure optimal outcomes requires a more systematic approach to treatment including phone support/monitoring, use of recall systems to ensure follow-up, supported self-management, access to interventions such as cognitive behavioural therapy (via e-therapy tools or face-to-face).

Similarly in the treatment of addictions there is increasing evidence of the effectiveness of brief motivational and problem-solving interventions in primary care settings. Research has shown that as little as three to five minutes of advice from a healthcare professional can help patients reduce their drinking which can be as effective as more extended interventions. They can be delivered equally effectively by a range of health care workers, including medical, nursing and social work professionals. Increased levels of support can be effectively delivered through brief interventions in one-on-one or group settings, highlighting that engagement and motivation are at least as influential on outcomes as specific interventions and systems of care.[56] [57]

The elements of a more effective and cost-efficient organised primary mental health response are already in place. Scaling up of these elements will be critical to the success of Blueprint II, as will the integration of a spectrum from low-intensity supported, self care to progressively more intensive primary, community and specialist responses – a 'stepped care' model. Ensuring better specialist support in primary care and reducing barriers to accessing specialist advice and brief intervention are particularly critical elements in the shift required.

52   Oakley Browne M; Wells J; Scott K (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
53   Exeter D; Robinson E; Wheeler A. 2009. "Antidepressant dispensing trends in New Zealand between 2004 and 2007." *Australia and New Zealand Journal of Psychiatry.* 43(12):1131–40.
54   PHARMAC. 2010. *Annual Review 2010*. Wellington: PHARMAC.
55   PHARMAC. 2011. *Annual Review 2011*. Wellington: PHARMAC.
56   Mental Health Commission and Alcohol Advisory Council. 2008. *Getting it Right for People with Co-existing Addiction and Mental Health Problems*. Wellington: Mental Health Commission.
57   Todd F C. 2010. *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems*. Wellington: Ministry of Health.

Relatively small steps towards this model will provide a selection of services that can flexibly respond to both the needs of people with high prevalence conditions as well as meeting some of the episodic/recurrent support needs of those with severe mental health conditions (as described in the next priority area).

Populations

This priority area is focused on the spectrum of young adults through to older people, who have a high-prevalence mental health condition.

Results needed

Action and results are required across three areas:

1. Strengthen the National Depression Initiative to further reduce the impact of depression

New Zealand has an emerging world class capability in encouraging the recognition of depression and providing support through the National Depression Initiative. This initiative aims to reduce the impact of depression by aiding early recognition, appropriate treatment and recovery. It focuses on strengthening individual, family and social factors that protect against depression and improves community and professional responsiveness to depression.[58]

The key strategies of the programme include: building social and physical environments that protect people from depression; encouraging people to recognise and become more responsive to depression; improving the capability of health professionals to respond appropriately to people seeking help with depression; co-ordinating public health, primary health care and mental health services; and developing a research, monitoring and evaluation capability to build a learning culture.

Blueprint II calls for:

- Continuation and strengthening of the National Depression Initiative.

2. Promote accessible, supported self care

Blueprint II encourages the development of a coherent spectrum of supported self care initiatives. These include self-directed self care as an adjunct to health services support, whether from primary care or more specialised community and specialist support.

The last decade has seen the development of a variety of ways of using internet-based support tools in mental health and addiction. Such tools can be used as a means for therapists to keep in touch with patients; for presenting text-based information (and/or video or audio information); self-assessment tools; self-management tools; relapse prevention tools; for facilitating internet-based peer support; and tools for delivering cognitive behavioural therapy via the internet (e-CBT).

Systematic reviews and evaluations of e-CBT and other self-care e-therapies highlight a number of benefits for public health. Preliminary evidence shows that they provide a scalable, low-cost way to reach a large population.[59] [60] They have the ability to reach rural and remote groups, and individuals who may not otherwise access mental health support. They also have the potential to better manage the gap between the demand for mental health care and the ability to supply it, and to prevent deterioration of sub-clinical symptoms.

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58   http://www.health.govt.nz/our-work/mental-health-and-addictions/national-depression-initiative

59   Hollinghurst S; Peters T J; Kaur S; Wiles N; Lewis G; and Kessler D. 2010. "Cost-effectiveness of therapist-delivered online cognitive-behavioural therapy for depression: randomised controlled trial." *The British Journal of Psychiatry: The Journal of Mental Science* 197(4): 297–304.

60   McCrone P; Knapp M; Proudfoot J; Ryden C; Cavanagh K; Shapiro D A; Ilson S, et al. 2004. "Cost-effectiveness of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial." *The British Journal of Psychiatry: The Journal of Mental Science* 185: 55–62.

Even a minor improvement in depression symptoms could have a large impact on the disease burden of depression if the treatment is safe and low cost.[61] [62] [63] [64]

Blueprint II calls for:

- A comprehensive approach to the development of self care options for mental health and addiction in national policy and service design.

- Increased availability of a comprehensive range of evidence based e-therapy solutions.

- Continued research and evaluation of e-therapy tools to meet the specific needs of populations of concern.

3. Provide effective primary and community-based responses to rising distress

For the vast majority of people the primary healthcare sector is their main point of contact with the health system. Research suggests that a third of people who consult a GP have a mental health or addiction problem at the time of consultation or have experienced one within the past year. It costs less and is more effective to identify and address these issues early in a primary care setting with the ability to increase the level of care if needed.

For those who access primary care with mild to moderate distress the current first line in treatment is most often a combination of general support and medication, despite little evidence for effectiveness of medication in mild to moderate conditions. There is a wide variation in prescribing rates (beyond that attributable to underlying prevalence rates), low usage of standardised tools to monitor progress and a continued risk of side effects. Increased access is needed for more effective approaches such as brief problem-solving, motivational interviewing, and more resource-intensive talking therapies such as CBT. Similarly, brief interventions in primary care for hazardous and harmful drinking have demonstrated effectiveness and need more widespread deployment.

For more complex issues and higher levels of distress, ready access to specialised input advice, consultation, and brief intervention, is needed. Providing this through a more integrated primary, social and community-based support can be effective, lower cost, and better at maintaining people's strength and resilience. Our current structures and policy rules prevent integration. However, by increasing availability of specialist advice and support to primary and non-governmental mental health services, the demand on outpatient and inpatient specialist care can be reduced.[65]

For older people, depression can result from grief, loss, loneliness, reaction to medications and the impact of increasing disability and loss of function. Depression affects 15–20% of older people, with 3% suffering from severe depression. Depressed older people are at increased risk of developing chronic disease and older people who suffer from chronic disease are more likely to become depressed. Treating mental illness such as depression in older people is as effective as in younger people.[66] There is a risk that older people won't talk about their issues, minimise their issues or struggle to articulate them. There is also a risk that others, including health professionals normalise depression as just being part of old age.

61   Andersson G; Cuijpers P. 2008. "Pros and cons of online cognitive-behavioural therapy." *The British Journal of Psychiatry: The Journal of Mental Science* 193(4): 270–1.
62   Spek V; Nyklícek I; Smits N; Cuijpers P; Riper H; Keyzer J; Pop V. 2007. "Internet-based cognitive behavioural therapy for subthreshold depression in people over 50 years old: a randomized controlled clinical trial." *Psychological Medicine* 37(12): 1797–806.
63   Tait R J; Christensen H. 2010. "Internet-based interventions for young people with problematic substance use: a systematic review." *The Medical Journal of Australia* 192(11): S15–21.
64   Titov N. 2007. "Status of computerized cognitive behavioural therapy for adults." *The Australian and New Zealand Journal of Psychiatry* 41(2).
65   Kates N; McPherson-Doe C; George L. 2011. "Integrating mental health services within primary care settings: the Hamilton Family Health Team." *The Journal of Ambulatory Care Management* 34(2): 174–82.
66   Ministry of Health. 2011. *Mental Health and Addiction Services for Older People and Dementia Services.* Wellington: Ministry of Health.

Blueprint II calls for:

- Best practice guidelines on the use of medication for mild and moderate anxiety and depression that includes information on when to prescribe, use of standardised tools to monitor progress and the monitoring of side effects.

- Increased access to more effective approaches in primary and community settings such as brief problem solving, motivational interviewing and talking therapies such as cognitive behavioural therapy.

- Increased access to brief interventions in primary care and community settings for hazardous and harmful drinking.

- Increased availability of specialist advice and support to primary and NGO mental health and addiction services to reduce demand on outpatient and inpatient specialist care.

- Maintain and build resiliency through active recognition and response to depression for older people (see Priority Area 5 for more details).

2.4 Priority 4: Supporting people with severe needs

Support return to health, functioning and independence for people most severely affected by mental health and addiction issues.
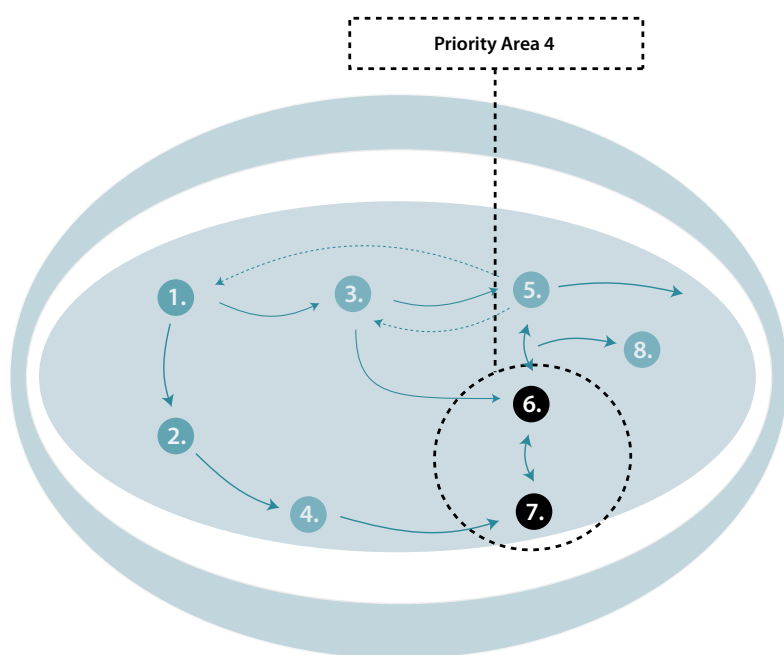
"I have worked with many people who were considered chronically mentally ill and beyond hope of recovery and yet they moved towards recovery once they had someone who listened to and tried to understand them; who treated them as normal; who never stopped believing in their ability to recover; who let them struggle with the consequences of poor choices; who laughed with them; who had expectations of them; and who reignited long extinguished hope by establishing truly meaningful goals."

This priority area focuses on people (young adults to older people) severely affected by mental health and addiction issues.

Actions and results are required across five areas:

- Deeper engagement with Māori and Pacific communities and others with specific cultural needs in the design, alignment and integration of mental health services.

- Reducing access barriers and process delays to achieve earlier and more effective responses to the onset of severe mental health and addiction conditions or episodes of need.

- Increasing the engagement and partnership with people, family and whānau in collaborative planning, action and resiliency development.

- Developing easier pathways through specialist and non-governmental services with a focus on supporting progress towards recovery, independence and resilience.
- Increasing the physical health and wellbeing of people with severe mental health and addiction disorders.

Rationale

Most people severely affected by mental health and addiction issues need relatively intermittent, short-term intensive clinical help, as and when needed, combined with support to rebuild their lives. A relatively small proportion of people have both severe and enduring issues which may need ongoing support or different forms of support from specialist services.

For both groups, strengthening the recovery focus means reorienting our systems of support so that all service responses assist with progress towards the goal of living with independence and confidence in the community.

People severely affected by mental health and addiction issues are exposed to a high risk of very poor mental health, physical health and social outcomes such as employment, housing and social participation. We have made substantial gains since the Blueprint I in terms of access, reduction in distress and increase in safety and security for this vulnerable population. However in many respects these remain our most disadvantaged populations with the most adverse outcomes.

This does not need to be the case. Our current systems of support are still evolving and the next steps provide the potential for substantial gains. This includes:

- Strengthening effective engagement of mental health services with communities in addressing the causes of disparities in mental health and wellbeing. For example, through community health literacy, increasing recognition and increasing alignment with cultural needs.
- Developing the capacity to respond earlier when existing strengths and resiliency are intact and complexity is lower. Under these circumstances treatment is often more effective and achievable at a lower cost.
- Services developing the capacity to understand individual situations, including their needs and strengths. This will lead to responses that are personalised and part of an effective therapeutic partnership.
- Services that better utilise the strengths and capacity of family, whānau, friends and colleagues to support those affected. Where these strengths are not used there is a risk that people will be disengaged from their own sources of strength, suffer increased social isolation and generate a downward spiral of loss of resiliency and compounding symptoms.
- Shifting the 'norm' so that people with complex support needs are assisted within their own home, including at times of crisis, rather than in inpatient settings. This will have the advantage of building resiliency in natural environments and minimising the risk of inadvertent undermining of strengths and capacity.
- Mitigating the inadvertent harm our services and treatments may cause. This may result from inappropriate use of compulsion, seclusion and restraint, the adverse physical side effects of medications, isolation from community and culture, or simply through creating dependency on mental health service and clinical relationships.
- Using evidence about the effectiveness of social inclusion and work alongside treatment of clinical symptoms in order to achieve the best outcomes.
- Increasing use of peer support to help people navigate complexity and develop self care capacity.
- Consistently using approaches that enable people with severe mental health issues to maintain good mental and physical health within normal primary based health care.

Populations

This priority area is focused on young people, adults and older people with mental health and addiction issues who are experiencing severe symptoms, or in acute distress, and loss of ability to function. The Te Rau Hinengaro[67] mental health survey found that 4.7% of the adult population met the criteria for a diagnosis of severe mental health disorder in the previous 12 months. Not all of these will need support through mental health services in the course of any one year. The same survey found that 58% of those with a serious disorder made a mental health related visit to mental health or general health services. Many of those with a diagnosis of a severe disorder may only have episodic need that is better handled through the systems of care described in Priority Area 3. Conversely a proportion of the 9.4% of the population categorised as having a mild disorder may experience symptoms of severe distress and need additional care.

Results needed

Actions and results are required across five areas:

1. Deeper engagement with Māori, Pacific communities and others with specific cultural needs in the design, alignment and integration of mental health services

Success in addressing mental health and addiction issues cannot be achieved in isolation from the social and cultural context within which people live. While progress has been made, the relative prevalence rates and impact of severe mental health and addiction issues among Māori, Pacific and vulnerable communities such as migrants remain high. Those receiving care may experience lower rates of access to effective treatments, greater use of intrusive seclusion and restraint and longer lengths of stay.

It is important that our systems of care encompass wider aspects of good health, including physical and spiritual health, cultural and social participation and employment, while providing appropriate, accessible and high quality mental health and addiction services.

This requires a continued effort to deepen engagement with mental health and addiction services with cultural specialists and community-based support. A whole of system response is needed where mental health and addictions services can play their part; whether this is to enhance the responsiveness of general services, provide population specific responses, or be a part of developments such as Whānau Ora which will require participation in holistic models of care.

Blueprint II calls for:

- Greater investment in partnerships with Māori, Pacific and other communities in the design, alignment and integration of service responses with cultural and community-based support.

- Greater support for shared learning, evaluation and research processes to build understanding of what works for different cultures and how this can be translated into effective mainstream or specific cultural services.

- Development of a range of services to meet local requirements and to provide choice. All services need appropriate cultural capability to provide culturally specific services in partnership with the communities involved.

- Ongoing investment in efforts to reduce inequalities by providing access to evidenced-based therapies, and strategies to reduce the relatively high use of responses that cause harm such as seclusion and restraint.

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67   Oakley Browne M; Wells J; Scott K (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.

2. Reduce access barriers and process delays to achieve earlier and more effective responses to the onset of severe mental health and addiction conditions or episodes of need

Access barriers and delays in response both increase the risk of deterioration and harm as well as increase later complexity and the cost of treatment. One of the major priorities of Blueprint II is to achieve a responsive 'no wait' system that provides support earlier in onset, earlier in crisis or relapse, and is capable of providing a 'just-in-time' step up in support when really needed (see Priority Area 7). This will enable clinicians and users to feel confident about stepping down or out of continuing specialist care.

While substantial progress has been made in responsiveness to severe acute needs, the capacity to respond earlier to emerging severe non-acute needs is less well developed. Responding early in onset requires greater collaboration between primary care and specialist mental health services to enable earlier recognition, prompt assessment and advice that can lead to early intervention treatment and support.

Responding earlier in developing crisis or relapse requires streamlining the pathway from home or peer support through to accessible, direct support in primary and community settings without the requirement for specialist outpatient or administrative review.

Blueprint II calls for:

- Development and widespread deployment of consultation/liaison models between primary and specialist services to build shared capability to recognise and respond to the early signs of onset of potentially severe conditions.
- Development of the capability and capacity of early intervention treatment teams to provide evidenced-based treatment and responses.
- Streamlined assessment and access pathways to and from specialist support to reduce access delays and barriers for those with emerging or reoccurring needs.
- Elimination of the administrative barriers to direct access to community and NGO support from self referral and primary care.

3. Increase the engagement and partnership with people and their family/whānau in collaborative planning, action and resiliency development

Blueprint II's core principle of person-directed care means that services need to form partnerships with mental health consumers and their family/whānau, (or close friends), so that they can direct and lead their own pathway to resiliency and recovery with advice and support from services. This cannot be achieved without a commitment to joint collaborative planning, and to developing a deeper understanding of people and their situation needs and strengths.

It requires a bold rethink of how we undertake assessments and planning, how we personalise our responses, provide real choices and options across our packages of care, utilise the inputs of a wider network including other agencies, and how we use processes such as case management so that they are effective in promoting recovery and building resiliency. Technology can help. Already a large proportion of users of online self support tools are those with severe mental health needs. Self care, personalised care and shared care planning tools are being implemented in other parts of the health sector – mental health needs to be part of these developments.

Families and close friends are the natural support systems and best placed partners in effective therapeutic relationships with service users: physically, emotionally and economically. We need to be more responsive and flexible in providing a range of services that enhance family capability and those natural supports. We need to understand the limits of family support and help retain family resiliency when severe mental health or addiction issues create undue stress or harm within families. This requires a partnership with family/whānau that respects their understanding of the situation, utilises their depth of knowledge, builds on their strengths, motivation and capabilities and focuses on what matters to them as part of a collaboratively developed recovery plan.

Priority Area 7 focuses on a number of system level changes to create this partnership across the mental health and addiction system. For people with severe mental health and addiction needs there are a number of more specific requirements.

Progress has been made in the inclusion of family/whānau or people's close networks of support in the processes of assessment and care and the development of relapse prevention plans. However, much more can be done to ensure that what matters to service users and families, their view-points, issues, needs and goals are central to these processes.

Experience of this partnership approach in other areas of mental health (for example, the Choice and Partnership Approach model[68]) shows that by focusing on identifying the client and family's own objectives, and collaboratively thinking about what might help achieve these objectives, services can generate better results, reduce access delays and achieve better, more focused use of specialist and community resources.

There is a substantial opportunity to strengthen family inclusive practice in addiction services. For example, by focussing interventions on family inclusive practice from the first engagement; offering group-based interventions in alcohol and other drug services that immediately provide an opportunity for peer support and engagement; providing regular 'family and friends' groups to work with families (even when clients fail to engage), promoting change and resilience in families and helping them connect to alcohol and other drug sector support such as Narcotics Anonymous and Alcoholics Anonymous, or other local self-help groups such as local churches.

Blueprint II calls for:

- Development of a national values and principles based framework for user/family directed care that is represented within a set of service commitments to users and their family/whānau[69] – backed by monitoring and improvement advisory support to make these real for people and families facing severe mental health and addiction issues.

- Development of partnership approaches across all services that actively engage service users and their families as informed partners in the options, plans and decisions for support.

- Development of the infrastructure that supports a shared, goal-oriented partnership recovery and resiliency plan that integrates self-directed, clinical and social support.

- Development and full utilisation of shared collaborative recovery and relapse resiliency planning approaches and tools that enable clients and family to actively participate in planning and action.

4. Enhance pathways through specialist and NGO service support with a focus on supporting progress towards recovery, independence and resilience

People with severe mental health and addiction issues have mixes of episodic and reoccurring or ongoing needs. This creates challenges for how services support pathways towards recovery without creating longer term dependency.

In the past our systems of care, contracting and funding mechanisms in mental health and addiction have inadvertently tended to reinforce longer term engagement with secondary or non-governmental services. This has provided effective acute and intensive support for the majority of episodic short-term needs but has been less effective in moving people with recurrent or more enduring need towards independence and resiliency.

By contrast, addiction services have tended to use service models based on multiple episodes of care supported by ease of access and alignment with self care peer groups to match the cycles of progress and relapse that

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68   The Mental Health Foundation. 2009. *Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England*. London: The Mental Health Foundation.
      Naylor, C, Bell, A. 2010. *Mental health and the productivity challenge.* London: The Kings Fund.
69   For one potential example see the 'No Needless' promises to service users developed by Onyett. 2006 "Daring to Dream: Learning the lessons of Leadership for Service Improvement in Mental Health Services." *Leadership in Public Service.* Vol 2: issue 4.

typify an addiction recovery path. Within addiction services a relatively small group of people have substantially complex needs and situations and use a disproportionate level of resources. They require a much more co-ordinated multi-layer response.

Blueprint II calls for a 'whole of system' approach with more flexible use of steps and tiers of response that support the movement or flow towards recovery, independence and resiliency. Many of the components of this approach are already developed or emerging such as:

- Highly accessible, integrated acute or intensive specialist and community support for short term episodic needs.

- Partnerships with family/whānau and natural support networks, to provide home-based acute treatments that minimise the loss of resiliency from trauma, isolation or stigma.

- 'Alternative to admission services' based on community assessment and provision of options for home support or community residential based support as alternatives to inpatient care.

- Recognising the complex interrelationship between mental health issues and addiction needs by integrating responses.

- Provision of better step down or step out pathways to peer support and primary care services or to self support. These need to support people to regain resiliency and support relapse prevention.

- More active and assertive outreach support for the smaller proportion of people with more enduring issues. This will aim to restore independence through building social inclusion, housing and employment.

Better management of the transitions between the steps and settings of support will be essential. The transition out of specialist secondary services and non-government support services will require particular care since there are a wide range of influences that make this problematic. These include clinical concerns over residual risks and users' concerns over changes in relationships or perceived barriers to re-entry. We have made significant progress with establishing step-down services in community and peer support with good outcomes and demonstrated cost effectiveness.[70][71] These need to be further developed.

There is also a case for better collaboration across primary care and community care in directly managing the mental health needs of people currently engaged with specialist or NGO services who are stable, represent low risk and could be supported in lower intensity, shared care arrangements within primary care. By deploying specialist liaison services to primary care and stepped care service designs, primary care-based support can provide high quality care to consumers with severe but stable mental health needs.

Most of the components of an effective stepped care model have already been developed. What is needed is the systematic integration of these components into a coherent approach to pathways to recovery and resiliency that will provide better outcomes for people and better use of resources across the system as a whole.

Blueprint II calls for:

- Development of response pathways for people with severe mental health needs that enhance progress towards recovery and resiliency.

- Continued investment in the development of more integrated responses to the combinations of mental health issues and addiction needs.

- Development of recovery through increased investment in programmes that actively support the return to community based sources of resiliency, including employment and housing.

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70   Basset T; Faulkner A; Repper J; Stamou E. 2010. *Lived experience leading the way: Peer support in mental health*. London: Together for Mental Wellbeing.
71   Naylor C; Bell A. 2010. *Mental health and the productivity challenge.* London: The Kings Fund.

- Development of an integrated self care, primary, community and specialist shared care service framework, that enables people diagnosed with severe but stable mental health and addiction conditions to live well and to manage most stresses within their community and supported by primary care. This would be backed up by additional support if and when needed.

5. Increase the physical health and wellbeing of people with severe mental health and addiction disorders

People with severe and enduring mental health conditions, such as schizophrenia, bipolar disorder or major depression, are more likely to have a range of general health risk factors including smoking, poor nutrition, excess weight and limited exercise. They are also likely to experience substantially higher rates of morbidity and mortality from common metabolic conditions such as cardiovascular disease and diabetes.

Many of these risk factors are exacerbated by the medications prescribed for mental health conditions. Generally, the level of medical care provided for this group is substantially less than the general population as they face barriers to access, lower rates of screening and diagnosis and more fragmented care if diagnosed.[72]

National Institute for Clinical Excellence (NICE)[73] guidelines recommend that primary health is best placed to improve the physical health of people with severe mental health conditions. This requires an integrated approach across primary health and specialist mental health services, an approach that has been seen as problematic within New Zealand's existing service configurations and funding structures of both primary care and mental health services. GPs perceive that they 'lose their patients to specialist services'[74] while specialist services are concerned about difficulties in enrolling patients in primary care, cost barriers to access or limitations of brief consultations to meet the complex needs of people with severe mental illness.

However, a number of existing 'business as usual' primary care mechanisms could be better utilised to improve this situation. For example, strengthening the use of programmes such as Care Plus as a means of providing regular physical health services, and the inclusion of targets for systematic screening and management of the physical health needs of people diagnosed with severe mental health conditions. Use of general practice liaison roles has demonstrated effectiveness in improving primary care capacity to look after the health needs of people with mental illness.[75]

Blueprint II calls for:

- Systematic, regular physical health checks and screening for those diagnosed with a severe mental health or addiction issue where there is evidence of high risk of poor physical health.

- Prioritising the systematic application of a long-term conditions approach to the medical care management of all patients with high severity mental health and addiction issues within primary care services.

- Development of formal liaison roles between specialist services and primary care to better meet physical health needs and to manage the effects of psychotropic medication.

- Integration of physical health as an explicit part of a single, shared recovery and resiliency plan.

72   Roberts L; Roalfe A; Wilson S; Lester H. 2007. "Physical health care of patients with schizophrenia in primary care: a comparative study." *Family Practice.* 24(1): 34–40.

73   National Institute for Health and Clinical Evidence. 2009. *Core Interventions in the treatment and management of schizophrenia in adults in primary and secondary care. Guideline update (CG82).* London, United Kingdom: National Institute for Health and Clinical Evidence. The British Psychological Society and The Royal College of Psychiatrists. 2010. *The NICE guideline on core Interventions in the treatment and management of schizophrenia in adults in primary and secondary care.* London: British Psychological Society.

74   Dew K; Dowell A; McLeod D; Collings S; Bushnell J. 2005. "This glorious twilight zone of uncertainty': Mental health consultations in general practice in New Zealand." *Social Science & Medicine* 61 (2005) 1189–1200.

75   Rodenburg H; Bos V; O'Malley C; et al. 2004. "General Practice care of enduring mental health problems: an evaluation of the Wellington Mental Health Liaison Service." *New Zealand Medical Journal.* Vol 117 No 1202.

2.5   Priority 5: Supporting people with complex needs

Support people with complex combinations of mental health issues, disabilities, long-term conditions and/or dementia to achieve the best quality of life.

This priority area focuses on people who have mental health and addiction issues that coexist with disabilities, other chronic illness and/or dementia. In many cases these will be older people, but not always.

The challenge with each of these three groups is the complexity generated by the overlapping and interacting effects of coexisting conditions. It increases the risk that mental health issues will be masked or overlooked, leading to substantially poorer health, loss of independence, and increased costs to families, health and social services.

Action is needed in the following areas:

- Integrate responses for people with coexisting mental health and disability issues to encourage them to lead full and rewarding lives.

- Maintain or extend resiliency by actively recognising and responding to older people who have depression alongside long-term conditions, as they engage with wider health services.

- Integrate mental health and addiction, dementia and aged care support responses to reduce or slow loss of functioning.

- Integrate mental health and addiction responses with long-term condition management to increase effectiveness of medical care and reduce morbidity.

Rationale

Mental health issues often coexist with disabilities, long-term physical conditions or dementia. This substantially decreases health status, increases service utilisation and generates premature and excess mortality. It also complicates what are often already complex demands on self or family care, support and treatment.

There is a substantial risk of mental health issues being masked by the symptoms of disability or dementia. There is also a risk that mental health issues are normalised as part of living with a disability, of ageing or being unwell.

The overlapping needs of this group are frequently complex and require co-ordinated and integrated responses. Mental health and addiction responses can often play a critical role, directly addressing mental distress or indirectly facilitating self care and social engagement. Both responses are likely to have a positive impact on the coexisting physical conditions.

Populations

People with disabilities and neurodevelopment disorders

The 2006 Disability Survey[76] established that 17% of the population have a long-term disability, 10% of those aged 0–14 years, 9% of those aged 15–44 years, 20% of those aged 45–64 years and 45% of those over 65. Many people are living well in spite of the constraints of their disability and are able to access mental health and addiction services in a similar fashion to non-disabled people. But there are subgroups of particular concern.

Approximately 1% of the population have an intellectual disability. Mental illness in people with intellectual disability tends to be poorly recognised, with a tendency to believe that the problem is 'behavioural' – caused by the intellectual disability rather than due to mental illness. It is estimated that up to 40% of people with intellectual disabilities also have a co-existing mental health problem.[77] [78]

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76   Statistics New Zealand. 2007. *2006 Disability Survey.* Wellington: Statistics New Zealand.
77   Cooper S; Smiley E; et al. 2007. "Mental ill-health in adults with intellectual disabilities: prevalence and associated factors." *The British Journal of Psychiatry* 190(1): 27–35
78   Perkins C. 2007. "Mental Illness in people with intellectual disability." *New Zealand Family Physician* 34(5): 358–362.

People who are deaf, with profound hearing loss from early childhood, represent a subset of people with both severe disability and different linguistic/cultural communication needs. Research suggests that prevalence of mental health disorders in the deaf are approximately twice the general population.[79] Contributing to this is the cultural isolation of people with major communication difficulties, denial of educational and employment opportunities, high documented levels of childhood abuse and estrangement from families of origin.[80]

A third group of people are those affected by neurodevelopment disorders including autism and related conditions, as well as severe forms of cerebral palsy.

A fourth group are those affected by traumatic brain injuries, which carries a greatly increased risk of co-morbid mental illness.

Older people facing late age depression/anxiety and dementia

The New Zealand population is ageing and the demand for mental health services by older people will continue to increase dramatically in the future. Currently, older people comprise just over 10% of the general population, but in 20 years this will grow to 21%, and will continue to grow.[81] Depression and dementia are the most common mental health issues affecting older people in New Zealand and together account for 60–75% of referrals to mental health services.[82]

The prevalence of depression among older people is 15–20% but this increases with age, with 40% of over 80 year olds affected.[83] [84] There is also a strong link between the incidence of other medical illnesses, cognitive, and functional impairments and depression with 15–40% of medical inpatients affected and 36% of patients in geriatric rehabilitation clinics.[85]

The prevalence of dementia substantially increases with age: at 60, less than 2% of the population suffers from dementia, but by 85 years of age more than 30% are affected.[86] Currently there are 41,000 people diagnosed with dementia in New Zealand. This number is expected to rise substantially in the future, with a doubling to 75,000 by 2026, and a tripling of current numbers to 147,000 by 2050.[87]

People of all ages with complex long-term physical health conditions combined with mental health or addiction issues

Many older people with a mental disorder also have a co-morbidity or existing illness or disability.[88] There is evidence that up to two thirds of general admissions of older people to hospital also have a co-morbid mental disorder.[89] These mental health issues can often go unrecognised because they are overshadowed by more immediate physical complications.

79   Bridgman G; Macpherson B; Rako M; Campbell J; Manning V; Norman-Kelly T. 2001. *A National Epidemiological Survey of Mental Illness in the New Zealand Deaf Community, Proceedings of the 5th European and 2nd World Conference on Mental Health and Deafness, 18th–21st October 2000*. Copenhagen: University of Copenhagen.
80   Bridgman G; Dugdale P; Witko J. 2001. *Deaf Awareness Training Workshop – Participant's notes*. Wellington: Deaf Association of New Zealand.
81   Statistics New Zealand. 2007. *National Population Projections: 2006 (base) – 2061*. Welllington: Statistics New Zealand.
82   Tynan D. 2008. *An Examination of the Evidence for Models of Service Delivery: Mental Health of the Older Adult (Including Dementia) and Addictions*. Waitemata: Waitemata DHB.
83   Tynan D. 2008. *An Examination of the Evidence for Models of Service Delivery: Mental Health of the Older Adult (Including Dementia) and Addictions*. Waitemata: Waitemata DHB.
84   Richards D A; and Suckling R. 2009. "Improving access to psychological therapies: phase IV prospective cohort study." *The British Journal of Clinical Psychology / The British Psychological Society* 48(4): 377–96.
85   Tynan D. 2008. *An Examination of the Evidence for Models of Service Delivery: Mental Health of the Older Adult (Including Dementia) and Addictions*. Waitemata: Waitemata DHB.
86   Oakley Browne M A; Wells J E; and Scott K M (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
87   Alzheimer's New Zealand. 2008. *Dementia Economic Impact Report*. Wellington: Alzheimer's New Zealand.
88   Richards D A and Suckling R. 2009. "Improving access to psychological therapies: phase IV prospective cohort study." *The British Journal of Clinical Psychology / The British Psychological Society*. 48(4): 377–96.
89   Tynan D. 2008. *An Examination of the Evidence for Models of Service Delivery: Mental Health of the Older Adult (Including Dementia) and Addictions*. Waitemata: Waitemata DHB.

This vulnerability is compounded by the separation of important streams of support: mental health, dementia support, medical care, disability support and home/residential support. All are interdependent yet function within different service and funding streams.

People with long-term conditions such as chronic respiratory disease, diabetes or heart disease are two to three times more likely to experience mental health problems than the general population.[90] Those with co-occurring mental health and addiction and medical conditions experience substantially poorer clinical outcomes and lower quality of life. For example, depression increases mortality rates after a heart attack by three and a half times. People with long-term conditions also incur significant costs for health services. For example, patients with chronic lung disease spend twice as long in hospital if they also have a mental health problem.

In addition, there are wider financial implications for individuals, families and the economy. People with both a long-term condition and a mental health problem are less likely to have a job than those with a physical illness, take twice as many sick days, and are more likely to rely on informal care, which in turn leads to family members taking time off work.[91]

Where a mental health problem is identified alongside a physical health illness, the two have traditionally been treated separately. Services are often designed around conditions rather than patients. A growing volume of research suggests that more integrated approaches (closer contact between professionals responsible for patients' mental and physical health), can improve outcomes while also reducing costs.

Results needed

1. **Integrate responses for people with coexisting mental health and disability issues to encourage them to lead full and rewarding lives**

People diagnosed with both mental health and severe disability experience common patterns of need and response from existing systems of care:

- Their needs are complex and often expose them to multiple and frequently unconnected regimes of assessment and management.

- They are likely to have lower levels of access to positive sources of strength and resiliency including education, adequate housing, employment, safe communities and social inclusion.

- They are more likely than their nondisabled peers to have experienced trauma and abuse.

- If mental health issues are present they may be unrecognised, ignored and untreated because the symptoms are judged to be 'just' part of the disability.

- Because of the interaction of factors described above, people with reduced capacity as a result of their disability are more likely to have challenging or aggressive behaviours. This may further marginalise and isolate them. In more severe situations, it could lead to inappropriate use of the justice and forensic systems to cope with needs that would be better handled elsewhere.

- Treatment pathways are more likely to include long-term medication to help manage challenging behaviour. There could also be more limited use of psychotherapies or social inclusion to support recovery.

Improving performance in this area requires system changes that better recognise mental health and addiction issues, improve the integration of responses as part of a programme of support in community/primary and secondary level care, while building specialised tertiary level support capability at a regional level.

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90   NICE. 2009. *Depression in Adults with Chronic Physical Health Problems: Treatment and management.* London: National Clinical Guideline Centre.
91   Centre for Mental Health. 2010. *The Economic and Social Costs of Mental Health Problems in 2009/10.* United Kingdom: Centre for Mental Health.

The current wave of disability support development focuses on developing better responses to individual needs and situations through partnership approaches. This includes integrated assessment, planning and shared decision making, personalisation of support with individualised packages of support and intensive forms of case and care management.

A 2010 Mental Health Commission report[92] identified 'relationships' among service providers as being critical success factors in enabling mental health and addiction service providers to be effective partners alongside other forms of support for people with disabilities. The relationships are between "the mental health sector and social agencies such as Work and Income, Housing New Zealand and workplaces; intra-sectoral relationships between specialist and community services, DHB provider arm services and NGOs; and DHB funders and planners and all contract holders".[93] Service designs need to enable and support relationships to happen efficiently and effectively.

The original Blueprint acknowledged that there are specific specialised skills, capability and capacity that are needed to support the complexity of co-existing mental health and addiction issues and severe disabilities. Efforts to build this capacity have had mixed success with difficulties in building and maintaining a critical mass of highly specialised skills for specific disability types.

As with many areas of specialised tertiary care, future solutions will have to include a mix of regional tertiary level capability and national networks of specialists who can support regional and local services.

Blueprint II calls for:

- Mental health and addiction and disability support service policy makers to align their policies on partnerships and individualised approaches at a national level. This needs to include reducing barriers to shared funding of individualised responses to complex needs across disability and mental health funding streams.

- Mental health and addiction and disability support services at a local level to focus on integrating funding and service delivery to address poorly met needs of people with co-existing mental health and addiction and disabilities. In particular, this needs to occur where treatment in forensic services or long term medication use increases the risks to long-term health outcomes.

- Continued development of regional tertiary level support capability, to provide centres of expertise and capacity that support specific needs.

- Capacity in national centres of expertise to provide remote specialised support.

2. Maintain or extend resiliency for older people by actively recognising and responding to depression

Many older people with co-morbidities and disabilities do not often interact directly with mental health services. Frequently, mental health problems are masked by other issues or ignored as just part of the ageing process. This is particularly an issue for depressive symptoms, which are more likely to go unrecognised among elderly than in younger populations.[94]

Increasing our responsiveness to signs of depression and anxiety provides a relatively simple high value leverage point to address the conjunction of common mental health problems and disabilities (both age related, such as stroke, and prior or ongoing disabilities).

Given the high number of elderly patients with symptoms of depression, anxiety, confusion, or cognitive impairment, training of health professionals to recognise the signs of these mental health problems is important.

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92   Mental Health Commission. 2010. *Services under Challenge: Critical Success Factors in Meeting High and Complex Needs of People in Mental Health Care*. Wellington: Mental Health Commission.
93   Mental Health Commission. 2010. *Services under Challenge: Critical Success Factors in Meeting High and Complex Needs of People in Mental Health Care*. Wellington: Mental Health Commission.
94   Tynan D. 2008. *An Examination of the Evidence for Models of Service Delivery: Mental Health of the Older Adult (Including Dementia) and Addictions*. Waitemata: Waitemata DHB.

So too is integration of mental health services for older people with other services, and screening for conditions such as depression, anxiety, dementia and delirium for at-risk patients.[95]

If recognised earlier, the use of brief interventions and active engagement of family and friends has demonstrated effectiveness and can act to maintain or extend the duration of resiliency and functional capability.

Blueprint II calls for:

- The development of a programme of systematic, opportunistic screening for depression and anxiety when older people experience a significant health event (for example, diagnosis of a condition, hospitalisation or entry to residential care or rehabilitation) along with access to primary care based interventions, including psychological therapies.
- The early proactive involvement of family and friends to help support and maintain resiliency.

3. Integrate mental health and addiction, dementia and aged care support responses to reduce or slow loss of functioning

The future impact of dementia on mental health services for older people will be one of the defining aspects of the next decade of mental health development. Under-diagnosis of mental health and addiction issues in older people and late or delayed diagnosis of dementia contribute to poor outcomes, loss of independence and increased use of relatively expensive health and residential services.

Partnerships with family/whānau and care givers will be critical. These people are best placed to observe the emerging, often subtle changes in capacity and functioning of people affected by dementia. They can also provide the support that enables people to effectively compensate for declining function. In more advanced stages of dementia or a related disability the impact on carers becomes substantial. Their mental health becomes critical for maintaining resiliency of the patient/carer relationship, especially when many will also be elderly and have their own health risks.

Dementia is predicted to become the largest single resource use area in the health sector. Evidence indicates that approximately 40% of elderly acute medical bed usage relates to dementia and depression – the largest single driver of total use.[96] Mental health and addiction interventions in these areas can generate better health outcomes at a lower cost to health and social support systems, by maintaining independence or delaying the onset of higher cost care and support.

Currently there are a mix of services, funding mechanisms and governance structures that split responsibility for complex care across geriatric health and mental health services, disability support and residential care facilities. Integrated responses to improve recognition, reduce barriers and reduce fragmentation will result in improved outcomes within constrained resources.

The 2011 Ministry of Health guideline[97] recommends that all DHBs adopt a consistent set of principles and approaches to the development of an integrated system of care, including:

- Development of a tiered model of care from mental health promotion, targeted risk reduction, primary based service assessment and treatment through to more specialised shared care and intensive treatment levels.
- A focus on early detection and responses to dementia, including a shared responsibility for dementia by primary and secondary mental health services for reducing the burden of related mental health or addiction issues. This should include early onset dementia from non age-related causes such as alcohol or neuro-degenerative diseases.

95   Ahuriri-Driscoll A; Rasmussen P; Day P. 2004. *Mental Health Services for Older People.* New Zealand Health Technology Assessment report.
96   Anderson D, et al. 2009. *The need to tackle age discrimination in mental health: A compendium of evidence.* United Kingdom: Royal College of Psychiatrists.
97   Ministry of Health. 2011. *Mental Health and Addiction Services for Older People and Dementia Services.* Wellington: Ministry of Health.

- An integrated service pathway based on a comprehensive mapping across the continuum of services and implementation of appropriate integration approaches across each boundary and transition point.

- A partnership approach, with well-defined shared roles and responsibilities across mental health services and specialist health of older people services. This should be backed by clearly defined planning, liaison and more flexible integrated support to ensure that no gaps exist in people's support needs.

- A more explicit approach to funding alignment and service responsibility across mental health and addiction and health of older people specialist services.

Blueprint II supports a partnership approach that uses an integrated, stepped care continuum across home, primary, community and specialist service settings.

Blueprint II calls for:

- Increased recognition of early and emerging signs of dementia in primary care, general health services and residential care. Access to advice and brief interventions for both service user and their family/caregiver.

- Urgent implementation of the Ministry of Health guidelines for integrated services to meet the rise in demand and to reduce the loss of functioning and independence that will drive increasing costs for families, health and social services.

4. Integrate mental health and addiction responses with long-term condition management to increase effectiveness of medical care and reduce morbidity

Recent research suggests that at least 30% of people with long-term physical health conditions also have mental health issues such as depression, anxiety, and substance abuse.[98] Within specific conditions, such as chronic obstructive pulmonary disease, the association is even stronger with prevalence rates up to three times the general population.[99] Viewed from a mental health perspective nearly half of people with a mental health problem will have a long-term physical health condition.[100] These can lead to significantly poorer health outcomes and a reduced quality of life.[101]

The Mental Health Network report[102], NHS Confederation 2012, *Investing in emotional and psychological wellbeing for patients with long-term conditions,* points out the substantial cost to the health system as a whole. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12% and 18% of all expenditure on long-term conditions is linked to poor mental health and wellbeing. People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities.

Integrating mental health support into chronic disease management and rehabilitation is an effective strategy to reduce health system costs.[103] For example, addressing psychological issues within chronic obstructive pulmonary

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98   Cimpean D; Drake R E. (2011). "Treating co-morbid medical conditions and anxiety/depression." *Epidemiology and Psychiatric Sciences.* Vol 20, no 2, pp 141–50.

99   NICE. 2009. *Depression in Adults with Chronic Physical Health Problems: Treatment and management.* London: National Clinical Guideline Centre.

100 Naylor C P; Parsonage M; McDaid D; Knapp M; Fossey M; Gallea A. 2012. *Long term conditions and mental health: The cost of co-morbidities.* London: The Kings Fund.

101 Moussavi S; Chatterji S; Verdes E; Tandon A; Patel V; Ustun B. 2007. "Depression, chronic diseases, and decrements in health: results from the World Health Surveys". *The Lancet.* Vol 370, no 9590, pp 851–8.

102 Mental Health Network. 2012. *Investing in emotional and psychological wellbeing for patients with long-term conditions.* United Kingdom: NHS Confederation.

103 Naylor C; Parsonage M; McDaid D; Knapp M; Fossey M; Gallea A. 2012. *Long term conditions and mental health: The cost of co-morbidities.* London: The Kings.

disease management saw a reduction in accident and emergency presentations and hospitalisation rates which translated into a fourfold saving over the costs of the mental health support.[104]

A systematic approach to integrate mental health and addiction responses with long-term conditions management is required. This will increase effectiveness of medical care, reduce morbidity and reduce system wide costs. It should include support for:

- Screening for the presence of mental health issues.

- Provision of cost-effective mental health interventions that reduce morbidity and requirements for readmission to more expensive hospital-based medical care.

- Outreach services to those who are poorly engaged with lower levels of community-based and primary care, along with increased capacity to address issues of psychosocial complexity.

Blueprint II calls for:

- Development of a systematic approach to integrate mental health and addiction responses with long-term conditions in national policy, funding decisions and service development and delivery across primary and secondary general health, and within mental health services.

- Systematic screening of people with long-term conditions and frequent hospital admissions to identify mental health and addiction issues and responding to their needs.

- Long-term condition management programmes that systematically identify mental health and addiction problems and respond to these needs.

2.6   Priority 6: Promoting wellbeing, reducing stigma and discrimination

Promote mental health and wellbeing to individuals, families and communities, and reduce stigma and discrimination against individuals with mental illness.

The focus of this action area is to increase the number of people who enjoy good mental health by enhancing protective factors and diminishing the factors that put people at a greater risk of mental health and addiction problems.

Action is needed across the following areas:

- Work to reduce stigma and discrimination through the continuation of Like Minds Like Mine.

- Promote lifelong learning through school-based mental health promotion programmes.

- Promote mental health literacy and self-help programmes for consumers and families/whānau.

- Create work-based mental health promotion programmes.

- Support people experiencing mental illness in their working lives.

- Provide lifestyle interventions with a focus on increased physical activity, good nutrition and reduction in alcohol consumption.

- Provide community mental health promotion programmes, including a focus on the natural environment.

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104   Howard C; Dupont S; Haselden B; Lynch J; Wills P. 2010. "The effectiveness of a group cognitive-behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease." *Psychology, Health and Medicine.* Vol 15, no 4, pp 371–85.

Rationale

Resilient mental health and freedom from the adverse impact of addiction play a critical role in the health of our population. The World Health Organization describes mental health as a state of wellbeing in which the individual realises their full potential, can cope with the normal stresses of life, can work productively and contribute to their community. It can also be described as the degree to which a person feels positive and enthusiastic about their life.[105]

Not everyone who is exposed to known risk factors has poor mental health outcomes. The research community is gradually gaining a better understanding of the factors that make people more resilient and protect some individuals and groups from mental illness. The emerging literature suggests that strong social and cultural networks, social participation, social support, positive relationships, cohesive communities and the natural and built environment all contribute to building resilience and mental health at both individual and community levels.[106]

The determinants of mental wellbeing include: income, access to resources, educational level, employment, housing, stress, social inclusion and discrimination.[107] Improved wellbeing will involve actions to create living conditions and environments that support people to be mentally healthy.

To achieve this, collaborative efforts are needed across government sectors and with non-government partners at national, regional and local levels. This includes the health, education, social welfare, housing, labour and justice sectors. Multi-sectoral actions at all levels to create conditions for people to take control over their lives are more likely to result in greater social and economic progress than the health sector acting alone.

Over the next decade the World Health Organization expects depression and anxiety to be the second leading cause of disability. If depression and anxiety reach the predicted levels in New Zealand this is likely to create a significant additional burden for the health system and affect the prosperity of the whole country.

Mental health promotion seeks to raise the levels of mental health and wellbeing in the population.[108] [109] To achieve this, both an individual and a population approach is required. This action area primarily focuses on the population approach. Evidence shows that an individual approach alone will not have sufficient effect in reducing the overall numbers with mental health and addiction disorders. By taking a broad, population-based approach it is possible to achieve small improvements in the average level of mental health and wellbeing across the whole population.[110]

There is good evidence internationally of the cost effectiveness of prevention programmes in the area of mental health. A review of the evidence identified the following five ways to wellbeing: connect with people around you; be active; take notice of the world around you; keep learning and give something to others.[111]

The rationale for preventing mental illness and addiction and promoting mental health and wellbeing is therefore worthwhile as mental health and addiction problems not only have high prevalence rates but are often of long duration and adversely affect people's lives.

The potential benefits of enhancing mental health and wellbeing are likely to include:

- Reduced levels of illness.

- Reduced levels of criminal offending.

105 Manderscheid R W; Ryff C D; Freeman E J; McKnighty-Eily L R; Dhingra S; Strine T W. "Evolving Definitions of Mental Illness and Wellness." *Preventing Chronic Disease.* 2010;7(1). http://www.cdc.gov/pcd/issues/2010/jan/09_0124.htm.

106 Friedli L. 2009. *Mental health, resilience and inequalities.* Copenhagen: World Health Organisation.

107 Manderscheid R W; Ryff C D; Freeman E J; McKnighty-Eily L R; Dhingra S; Strine T W. "Evolving Definitions of Mental Illness and Wellness." *Preventing Chronic Disease.* 2010;7(1).). http://www.cdc.gov/pcd/issues/2010/jan/09_0124.htm.

108 Keyes C L M. 2010. "The Next Steps in the Promotion and Protection of Positive Mental Health." *Canadian Journal of Nursing Research.* Vol 42 No 3, 17–28.

109 Keyes C L M; Dhingra S S; Simones E J. 2010. "Change in level of positive mental health as a predictor of future risk of mental illness." *American Journal of Public Health.* 100 (12), 2366–2371.

110 Huppert F A. 2009. "A New Approach to Reducing Disorder and Improving Well-Being." *Perspectives on Psychological Science.* 4: 108 DOI: 10. 111/j. 1745–6924. 2009.01100.

111 New Economics Foundation. 2008. *Connect, Be active, Take notice, Keep Learning, Give. Five ways to wellbeing.* London: New Economics Foundation.

- Better health behaviour.

- Better personal relationships and family cohesion.

- Increased social participation.

- Increased productivity.

- Improved educational performance.

- Improved employment prospects.[112]

Populations

The actions in this section are designed primarily for the whole or parts of the population, in the context of everyday life, in settings where people live, study and work. It is important to clearly identify the needs of vulnerable populations – such as Māori, Pacific peoples, children, young people, refugees, people with disabilities, older people and those living with poverty – so that programmes are designed specifically for these populations as well as for the whole population in order to avoid increasing inequalities in mental health. Programmes should be comprehensive, take into account the wider determinants of health, use a mix of skills and be collaborative in nature and long in duration.

Results needed

1. Work to reduce stigma and discrimination through the continuation of Like Minds Like Mine

People with mental illness and addiction problems experience stigma and discrimination from a range of places. This is a barrier to recovery. Stopping discrimination and treating people with mental illness and addiction with respect and equality is just as important as providing treatment. Challenging the attitudes that lead to stigma and discrimination and improving public understanding of mental illness has been shown to be effective. The Like Minds Like Mine programme was designed to change attitudes and behaviour in society through a comprehensive programme that works at many levels. Like Minds Like Mine is a national public education programme first launched in 1997 and aimed at reducing the stigma and discrimination faced by people with experience of mental illness. It has received international recognition and many awards for the breadth, creativity, and effectiveness of the campaign. The evidence gathered throughout this campaign clearly indicates that significant progress has been made and that there is a strong case for its continuation.[113]

Blueprint II calls for:

- Continuation and strengthening of the Like Minds Like Mine programme.

2. Promote lifelong learning through school-based mental health promotion programmes

Schools have a crucial educational role in fostering the healthy social and emotional development of their students. They also have a role in creating a sound psychosocial, nurturing environment within school that is child friendly.

Promoting mental health in schools has been shown to be effective where the focus is on life skills training. These skills include critical thinking, communication, interpersonal skills and problem solving which improve emotional, social and cognitive skills, and strengthens resilience of children and young people. Taking a whole school approach, such as the Mentally Healthy Schools programme[114] which involves teachers, students and their

112 Friedli L; Parsonage M. 2009. *Promoting mental health and preventing mental illness: the economic case for investment in Wales.* Wales: Mental Health Promotion Network.

113 Ministry of Health. 2012. Like Minds Like Mine. www.likeminds.org.nz

114 Bennett S; Coggan C. 2009. *A Comprehensive Evaluation of the Mentally Healthy Schools Initiative.* Wellington: The New Zealand Mental Health Foundation.

families, is showing promise in preventing mental health problems, improving academic performance, improving emotional and social functioning and reducing health-damaging behaviours and bullying.[115]

Providing education that responds to the reality of children's lives and establishing connections between school and family life promotes self esteem and self confidence in children, thus improving their mental health.[116]

The evidence shows that strengths-based programmes that enhance protective factors and reduce risk factors are most likely to be effective.[117] Mindfulness programmes are being used in schools internationally. They enable students and teachers to gain a clearer understanding of how thoughts and emotions impact on health, improve concentration, conflict resolution and empathy.

Blueprint II calls for:

- Strengthening and expanding school-based mental health promotion programmes such as the Mentally Healthy Schools programme.
- Develop mindfulness training programmes for schools and introduce mindfulness practices into schools.

3. Promote mental health literacy and self-help programmes for consumers and families/whānau

There is growing evidence that interventions which promote advocacy and self-help, and provide psychosocial information, support networks and relaxation advice have a range of benefits for mental health and wellbeing.

Families/whānau, neighbours and co-workers can all be a source of support and assistance to the person experiencing mental health and addiction disorders. However they need the knowledge and understanding of the disorder to support their family member to help themselves to move along the path to recovery.

New Zealand has an emerging capability in encouraging the development of mental health literacy and the use of helplines and online tools. This provides a platform for developing a more comprehensive approach to mental health literacy and self-help programmes available in homes, workplaces and community settings.

Blueprint II calls for:

- Development of a comprehensive approach to mental health literacy and self-help programmes available in homes, workplaces and community settings.

4. Create work-based mental health promotion programmes

Promoting mental health in the workplace has a range of health and social benefits, improves productivity and reduces costs.[118] Mental health and addiction problems may not be necessarily caused by the work environment, however there is much that can be done to improve the working environment to minimise the adverse effects on mental health. The key factors which have been identified that directly impact on mental health in the workplace are: high demands imposed on employees combined with low control among those facing these demands; lack of support and unclear or inconsistent information from supervisors; job insecurity; and effort-reward imbalance.[119]

The workplace is a good setting for action to improve mental health as people of working age spend on average 7–8 hours a day at work. To be effective mental health promotion in the workplace must focus on the organisation and management practices as well as individual stress reduction.[120] Programmes which focus on

115 Friedli L; Parsonage M. 2009. *Promoting mental health and preventing mental illness: the economic case for investment in Wales.* Wales: Mental Health Promotion Network.
116 World Health Organisation. 2001. *Strengthening Mental Health Promotion, Mental health is not just the absence of mental disorder.* Fact Sheet No 220. Revised November 2001. Geneva: World Health Organisation,.
117 Ball J. 2010. *Review of Evidence about the Effectiveness of Mental Health Promotion Programmes Targeting Youth/Rangatahi.* Wellington: Mental Health Foundation.
118 Department of Health. 2001. *Making it Happen: A guide to delivering mental health promotion.* London: Department of Health.
119 Ferrie J E. 2007. *Work, stress and health: Findings from the Whitehall 11 study.* London: Cabinet Office/University of London.
120 Department of Health. 2001. *Making it Happen: A guide to delivering mental health promotion.* London: Department of Health.

creating mentally healthy and productive workplaces and encourage taking breaks and exercise, flexible working hours, awareness training for managers, early identification of mental health problems and better access to help are all components of an effective workplace mental health promotion programme.[121]

There is an opportunity for the health sector to take leadership in this area and to introduce programmes which promote and support psychological wellbeing in the workplace. A number of organisations such as the Mental Health Foundation and DHB public health units already have programmes which provide training and resources to enable workplaces to be mentally healthy. However there is room to further develop and spread these programmes and provide ongoing support to organisations to maintain behaviour change.

Blueprint II calls for:

- Development of a comprehensive approach to workplace mental health promotion programmes.

- Introduction of a follow-on programme to provide support and reinforcement to organisations that have become mentally healthy workplaces.

5. Support people experiencing mental illness in their working lives

The right to work is a fundamental human right which provides not only a source of income, but has the potential to satisfy social, intellectual and personal needs and is integral for a life of human dignity.[122] Ensuring people who have experienced mental illness and addiction are able to work and have jobs is a priority. In general, employment is good for mental health and unemployment is bad for mental health.

Employment has been identified as an important factor in the recovery of people with mental illness and is generally associated with better mental health. The key objective of this action area is to ensure people with mental health and addiction disorders retain their jobs and work productively.[123]

One of the key factors which prevent the development of, or worsening of, mental health disorders is a supportive mentally healthy work environment and an effective manager who supports their workers, provides adequate feedback and recognises their work achievements.[124] The components described in the work-based mental health promotion section are also relevant to supporting people experiencing mental illness in the workplace, with a particular emphasis on early identification and accessible treatment of mental health problems, and effective rehabilitation for those who need to take time off work.

Creating an environment where people with mental illness can gain rapid access to treatment and rehabilitation and are supported to return to work will require the introduction of specific training for key managers and referral systems that facilitate rapid access to services.

Blueprint II calls for:

- The introduction of workplace training programmes on how to support people experiencing mental illness to enter and remain in the workforce.

6. Provide lifestyle interventions with a focus on increased physical activity, good nutrition and reduction in alcohol consumption

There is growing evidence that lifestyle factors such as increased physical activity, good nutrition and moderating

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121 Friedli L; Parsonage M. 2009. *Promoting mental health and preventing mental illness: the economic case for investment in Wales.* Wales: Mental Health Promotion Network.
122 Human Rights Commission. 2010. *Summary of Human Rights in New Zealand, Right to work.* Wellington: Human Rights Commission.
123 Organisation for Economic Co-operation and Development. 2011. *Sick on the job? Myths and Realities about mental health at work.* Organisation for Economic Co-operation and Development.
124 Organisation for Economic Co-operation and Development. 2011. *Sick on the job? Myths and Realities about mental health at work.* Organisation for Economic Co-operation and Development.

alcohol intake have a positive effect on mental health. Lifestyle changes offer significant advantages for patients because they can be both effective and cost effective.[125]

Physical activity has been shown to prevent depression, reduce anxiety and enhance self esteem.[126] Recent reviews of the evidence show the importance of nutrition in mental health and wellbeing.[127] A nutritious diet has been shown to improve moods, academic achievement and anti-social behaviour.

The role of alcohol in mental illness and addiction has been well documented. The Institute of Alcohol Studies notes: "There is a close relationship between alcohol problems and mental health. People with mental health problems are at raised risk of alcohol problems and vice versa."[128]

A combination of mental health promotion programmes at a population level that focus on lifestyle factors plus brief interventions for individuals is likely to contribute to improving the mental health and wellbeing of the population.

Brief interventions to reduce alcohol consumption, green prescriptions for physical activity and dietary advice are all interventions which are effective and available in the primary care setting. The focus for the future is to provide mental health and lifestyle advice routinely in both health promotion and primary care settings.

Achieving behaviour changes in these areas requires a commitment and motivation to change; the knowledge, tools and opportunity to change; and the support and encouragement of families/whānau, the community and the mental health sector to change and to maintain that behaviour change.

Blueprint II calls for:

- Routine availability of brief interventions to reduce alcohol consumption, green prescriptions for physical activity and dietary advice in both health promotion and primary care settings.

7. Provide community mental health promotion programmes, including a focus on the natural environment

Community cohesion with high levels of trust, reciprocity and participation have a positive impact on mental health and wellbeing.[129] Strengthening community mental health and wellbeing requires the development of strong partnerships at local government level and across agencies; strengthening community engagement; identifying leaders with a shared understanding of mental health; and providing these leaders with skills and resources to champion and develop community-based mental health promotion programmes.[130]

There is growing evidence of the mental health benefits of the natural environment. The environmental predictors of poor mental health are noise, overcrowding, personal safety, social isolation and damp housing. Protective factors include being in green open spaces, opportunities to socialise and to be entertained. People living in the most deprived areas are most likely to be affected by these environmental risk factors.[131]

Community initiatives that promote health have an opportunity to develop innovative ways to support mental wellbeing in the community by providing programmes based around spending time in green spaces, physical activity, outdoor pursuits, gardening, social events, developing safe streets and housing insulation schemes. New Zealand has a range of community programmes such as community restoration and school gardening programmes, and at a national level, Neighbours Day and Mental Health Awareness Week.

Many of these programmes are well run by individual organisations however, to have a greater impact collaborative, joined-up approaches are needed across the whole community.

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125   Walsh R. "Lifestyle and Mental Health." *American Psychologist*. Advance online publication. doi: 10.1037/a0021769.
126   Department of Health. 2001. *Making it Happen: A guide to delivering mental health promotion*. London: Department of Health.
127   Walsh R. "Lifestyle and Mental Health." *American Psychologist*. Advance online publication. doi: 10.1037/a0021769.
128   Institute of Alcohol Studies. 2007. *Alcohol & Mental Health*. Cambridge: Institute of Alcohol Studies.
129   Friedli L. 2009. *Mental health, resilience and inequalities*. Copenhagen: World Health Organisation.
130   NHS Confederation. 2011. *Public mental health and well-being – the local perspective*. London: NHS Confederation.
131   Friedli L; Parsonage M. 2009. *Promoting mental health and preventing mental illness: the economic case for investment in Wales*. Wales: Mental Health Promotion Network.

It is important to build evaluation into existing and new approaches so that we learn what has worked and what has not and grow the evidence base in relation to community mental health promotion initiatives.

Blueprint II calls for:

- Development of comprehensive collaborative, co-ordinated community initiatives based on modifying the environmental risk factors and enhancing the protective factors for community mental health and wellbeing.

- Build evaluation into existing and new initiatives to help grow the evidence base.

2.7 Priority 7: Providing a positive experience of care

Strengthen a culture of partnership and engagement in providing a positive experience of care.

The previous priority actions focus on broad population groups and the need for early intervention to prevent or reduce the future impact of mental health, addiction and behavioural issues.

This action takes a more person and family/whānau-centred approach, making sure every contact a person and their family has with services uses a recovery approach, promotes safety and facilitates movement through their journey. It requires a much stronger focus on engagement and partnership. It also requires delivery of timely, appropriate and effective responses for people and their family/whānau that build recovery and resiliency.

Studies have demonstrated significant benefits from partnerships between health services, health professionals and service users, their families and whānau. Such partnerships benefit clinical quality and outcomes, the experience of care, and the business and operations of delivering care (including reduced costs).

> *"Imagine a world where most people experience optimal wellbeing, and the assets that go with it, such as better health, greater productivity, better relationships and greater resilience in the face of life's challenges. Imagine too, that most people diagnosed with mental distress experience optimal wellbeing, and the assets that go with it, because they have what they need to enable their recovery."*
>
> Mental Health Commission. 2008. Destination: Recovery

Blueprint II calls for stronger partnerships with consumers and family/whānau to improve self-determination, information and involvement in providing services, shaping and overseeing policy and being part of service development at a national level.

Action and results are needed across the following areas:

- Build a strong culture of engagement and partnership.

- Provide timely, dependable support when needed.

- Take every opportunity to make a positive difference in the pathway to recovery and resiliency.

- Provide responsive and equitable experience and outcomes for poorly served populations.

- Minimise harm and improve safety.

Rationale

New Zealand has a rich history in the development of the consumer/service-user voice in determining their own recovery as well as in providing services, shaping and overseeing policy and service development at national, regional and local levels. We have still not reached the full potential of that partnership but we have a strong foundation from which to build. Similarly, for family/whānau partnerships the foundations are there – but this is a newer development.

Consistently, service users and family/whānau express the need for stronger partnership, self determination, information and involvement as key to a better experience of care and outcomes. There is growing evidence demonstrating the importance of partnerships between health services/health professionals and service users and their family/whānau. Studies have demonstrated significant benefits from such partnerships in clinical quality and outcomes, the experience of care, and the business and operations of delivering care (including reduced costs).

We need to deliver improved experience by consumers and family/whānau as a fundamental element of achieving better outcomes. We have made some progress but many people still experience services that are not consistent in their attention to these aspects of recovery.

There is growing recognition of a holistic approach to meeting the needs of consumers, particularly in relation to their family/whānau situation, employment, housing and social connectedness, as well as the biomedical components of a person's condition. Development of self-management, peer support, and electronic resources provide wider opportunities for active personal leadership, choice and participation, which are key components of a consumer's journey to recovery and resiliency.

Emerging innovations in Whānau Ora show that significant differences can be made if there is a better understanding of the needs of a person and their whānau. For Māori and other populations, whānau support can lead to positive health outcomes, better educational attainment and social development.

Exceptionally good experience is described by Institute of Healthcare Improvement as "care that is consumer/service users centred, safe, effective, timely, efficient and equitable", with measures for each so that organisations can work in partnership with families and consumers/service users to self assess how they are doing.[132] Other definitions include features such as quality, access and reliability. They note five primary drivers to improve the experience of care as leadership, staff hearts and minds, respectful partnerships, reliable care and evidence based care.

A positive consumer and family/whānau experience starts with:

- Partnerships with consumers/service users and families/whānau. Engagement is a key factor to successful outcomes for people.

- All six aims of quality care: patient-centred, safe, effective, timely, efficient and equitable.

- Consumer/service users and family/whānau-centred care in all settings of health and health care, and at all levels (environment, organisation, team systems, individual experience).

- Whole system actions to ensure consistency of experience across the whole system. Isolated actions to improve experience will only provide localised results, with little transfer to entire experience across all settings, and limited sustained success.

Populations

This priority area includes every person who has contact with mental health and addiction services and their family/whānau. It has a focus on people and their experience of the responsiveness and outcomes of their care.

Results needed

1. Build a strong culture of engagement and partnership

Consumer and family/ whānau engagement and partnership

There is a need to optimise every opportunity to build and strengthen consumer and family/whānau engagement. Engagement and healthy respectful relationships with consumers/service users are key factors

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132 Balik B; Conway J; Zipperer L; Watson J. 2011. *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

to successful outcomes for people and must be at the heart of every interaction. Holding hope and optimism, expecting recovery and recognising personal strengths, uniqueness and the impact of trauma on a person's life all contribute to building stronger engagement. Choice, partnership and actively leading and contributing to decision making are critical.

> *"I know this is happening when I am treated with warmth, respect and honesty – when people listen to me, treat me as an equal, and support me – and when I don't have to fight all the time to get what I want to help me recover and live my life the way I choose to."*

Strong and effective engagement and partnership with family/whānau is equally important. We need to recognise that families and close friends, particularly for Māori and Pacific communities, are the best partners to engage with alongside service users. We need to build our capability to engage with whānau with active and timely support from cultural advisers and to enable them to contribute to treatment planning through use of whānau hui. Family/whānau engagement and partnership must include provision of information, and supporting wellbeing and health to assist families stay together and sustain healthy relationships. This will better enable family/whānau to support service users in their recovery journey.

There is strong and growing evidence to show that consumer and family experience-centred care is not only a fundamental value, but also essential in the improvement of clinical, financial, service and satisfaction outcomes.[133] The Institute for Health Care Improvement (IHI) promotes partnerships with consumers/service users and families/whānau as the foundation of excellence. They provide a series of tools, processes and frameworks that assist leaders and organisations to adopt patient and family-centred care.[134]

> *"People experiencing mental illness and addiction tell us that being shown respect and kindness by mental health and addiction workers is really important to their recovery. What you think, say and do can have an enormous impact on the recovery of anyone experiencing mental illness and/or addiction. People working in services with the right knowledge, skills, values and attitudes make all the difference."*

Organisations need to build service user and family partnerships, engagement and person-centred, person-directed care into quality and safety programmes. This needs to be supported by a workforce strategy that focuses on values, skills and attitudes. In New Zealand this has been led by the implementation of Let's Get Real [135] and this should continue to be a focus.

Blueprint II calls for:

- Support for consumers and their families to be fully engaged and active partners in the choice and pathway of response.

- Organisations to build service user/family partnership, engagement and person-centred/person-directed care as a priority strategy into quality and safety programmes.

- Consumers and families to work in partnership with services to establish and self-assess progress against measures for people-centred, people-directed, safe, effective, timely, efficient and equitable care.

- Every interaction between service providers and service users and their families to be anchored in a respectful partnership.

Partnership and engagement at staff and team levels

The benefits of effective teamwork and high levels of staff engagement are well documented. In implementing

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133 Greene J, Hibbard J. 2011 "Why Does Patient Activation Matter? An Examination of the Relationships Between Patient Activation and Health-Related Outcomes." Journal of General Internal Medicine. published online Nov 30, 2011, DOI: 10.1007/s11606-011-1931-2.

134 Balik B; Conway J; Zipperer L; Watson J. 2011. *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

135 Ministry of Health. 2008. *Let's get real: Real Skills for people working in mental health and addiction.* Wellington: Ministry of Health.

Blueprint II, the diversity of the workforce will change as will the way that teams work. Sometimes members of teams will not share the same location. We need to learn from existing examples of high performing teams that operate in a variety of forms, ranging from teams working together in one place, to virtual and networked teams or whole system care teams, with the centre being the service user and family/whānau.

Gallup research has shown that effective employee engagement has a dramatic impact on staff wellbeing and healthy workplaces.[136] Engaged employees are more productive, profitable, safer, create stronger customer relationships and stay longer with their organisations. Staff need to be able to contribute to and shape local work processes, feel valued, be able to use and develop their skills and talents and have good workplace relationships.

Blueprint II calls for:

- Staff, teams and agencies to work together to achieve high performing team outcomes across the system of care with consumers and family/whānau at the centre of the team. They can work collaboratively with each or as one.

- Implementation of proactive employee engagement and workforce development strategies.

Partnerships across general health and social sectors

Achieving resiliency and recovery requires us to create a system of care that supports people to develop and retain their own capability to live well. New responses are required across primary care and social sector partners to promote destigmatisation, early recognition and situational and culturally attuned responses that encourage help seeking and self care.

Each of the priority areas described throughout Blueprint II requires mental health and addiction services to strongly align their efforts with partners in general health and across the social and justice sectors. The impact of housing and employment on mental health and wellbeing is well documented in previous priority areas. Increasing resiliency, early recognition and practical support to enable young families to thrive cannot be achieved without alignment. Reducing the impact of mental health and addiction issues will require effective partnerships across government agencies.

Strengthening relationships between agencies is needed to understand where the most gain can be made by working together. Working together will require integrating service responses and clinical pathways. In areas of high interdependency, such as child and youth or addiction and justice, there may be times where there is a step further towards common infrastructure, including aligned funding and information capability.

Partnerships and engagement at local level need to happen:

- Between primary and secondary care.

- With agencies such as community probation services, prisons, school counsellors, drug courts, CYF, Ministry of Social Development, local law enforcement and local community services.

- Between secondary mental health and addiction services and other areas of secondary health services.

These are particularly important to achieve the broader health and system benefits identified in Priority Area 3.

Blueprint II calls for:

- Shared care plans to support collaborative recovery planning as the basis for communication between all agencies, to clarify the service user and their family's view and inform information flow between clinicians.

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136   Gallup. 2005. "Unhappy Workers Are Unhealthy Too." *Gallup Business Journal.* http://businessjournal.gallup.com/content/14545/gallup-study-unhappy-workers-unhealthy-too.aspx.

- Navigator/co-ordinator roles with a mandate to co-ordinate where there are multiple layers and contributors to shared care plans. These are most often best located in primary care or NGOs, occasionally in secondary specialist services.

- Funders to incentivise collaboration through their contracting processes, particularly across mental health and addiction services.

- Funders and planners across government agencies to develop collaborative contracting to support improved outcomes across the life course (Priority Areas 1–6).

2. Provide timely, dependable support when needed

When needed, our system of care should provide fast access to a range of responses using 'close to home' primary and community settings and brief focused interventions where it is appropriate and possible. We need to organise across services and teams in a way that provides 24/7 access, enables walk in, 'no wait' appointments, utilises the benefits of peer support and group work and provides options for support outside of usual office hours.

A responsive, no wait system

Early and timely responses matter in mental health and addiction. A fast, no wait system that meets needs earlier and less intensively can restore people back to their own support structures faster. Conversely, non-responsive services with barriers to entry can lead to longer durations of service support that is both costly and ineffective. Driving for a responsive, no wait approach will ensure prompt access to services, reduced escalation and loss of resiliency, as well as highlighting system blockages and constraints that place pressure on the evolution of a better tiered system of care.

Implementing a 'stepped care' approach (described in Priority Area 8) can contribute to reducing response delays by providing a structured system of care with an integrated range of steps or tiers of support across primary, community and specialist services. By improving the organisation of flow up and down the 'steps' the system can make the best use of available resources. For example, the flexible access to community resources from primary care implemented in Canterbury has demonstrated reduced access delays.[137] However it requires attention to the balance of capacity at each step to ensure that blockages do not develop in unexpected places.

'Closer to home' responses

Our current community mental health and addiction resources are a success story of the last decade. The current system of care has been oriented towards support for specialist services with access requiring a pathway through specialist care, requiring time, co-ordination and use of scarce skills. Meeting the outcomes of Blueprint II will mean increasing recognition, assessment and treatment 'closer to home' within primary and community settings in order to achieve early, timely and appropriate responses. We need to:

- Reorient community support to provide responses alongside, and accessible from, primary care to shorten the response pathway for people and increase access to services.

- Bring specialist expertise closer to primary care; for example, through liaison roles for assessment and 'see and treat' models of care. This will result in faster responses and reduced pressure on outpatient care.

- Ensure funding arrangements support early identification and access to support between services. For example, a national alcohol and other drug helpline with a national profile to improve access in rural areas and promote help seeking behaviour.

- Fund home-based delivery as a natural support system of care that responds to family and is culturally responsive.

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137   Canterbury District Health Board. 2011. *Canterbury District Health Board Annual Report 2010/11*. Christchurch: Canterbury District Health Board.

- Look for cost-effective use of resources across the whole of the sector by working smarter, more co-ordinated and collectively.
- Utilise the strengths of non-governmental providers in delivering community-based, peer-based support hours.

Integrated responses across mental health, addiction and behavioural disorders

Our understanding of the widespread prevalence of addiction and its impact has developed substantially over the last decade. With high levels of co-occurrence between addiction, mental health and behavioural disorders we need a better balance between providing specialist expertise in each area and integrating responses to provide more holistic and effective responses to co-occurring problems.

Service models need to strongly promote collaboration and integration to minimise the number of places people need to go to access different types of assistance, such as integrated health centres, hub and spoke models and joint provision and addiction services embedded in other services such as probation services or primary care services. Local services need to develop integrated and mutually well understood integration pathways. Examples include integrating local peer support workers and consumer liaison staff inside services and continuing to develop drug treatment units inside the prison system that are integrated with non-prison mental health and addiction service systems.

Systems and layers of stepped care need to operate as one, to avoid both duplication and people falling through the gaps of care and communication. Again, navigation and co-ordination roles are critical when multiple parties are contributing to the recovery journey of the consumer and their family/whānau.

Blueprint II calls for:

- Reliable care where the whole system (hospital and community systems) delivers 24/7 responses that can be accessed without unreasonable waits or long delays.
- Use of a stepped care approach at all times.
- Improved flows along pathways to resilience and recovery.
- Joined-up services across partners in general health and social sectors with common goals and policies and processes that enable integration, collaboration and shared resourcing.
- Minimising processes or siloed funding streams that can create blockages, barriers and delays to accessing appropriate supports.

3. Take every opportunity to make a positive difference in the pathway to recovery and resiliency

Every opportunity should be taken to support a person's own resiliency and that of their family/ whānau. This means maximising any opportunity and making every face-to-face contact count and actively contributing to recovery and building resilience. Focused use of evidence-based treatment and therapies in partnership with self-management are effective and efficient. For example, combinations of e-therapy resources with short defined interventions and specialist therapies.

Self care and resilience support

People need to be supported to develop and retain their own capability to live well. New responses are required across primary care and social sector partners to promote destigmatisation, early recognition and situational and culturally attuned responses to encourage help seeking and self care. Consumer and family-centred services that can respond most appropriately need to build capacity for self care and promote resiliency and wellbeing. This requires support for services to engage in health promotion activities such as talking to the community, reducing harm and supporting early engagement with services.

We can promote resilience in service users and their families by supporting their engagement with services and resources in the community and make this an active part of what a mental health and addiction specialist service does. This was covered in more detail in the previous Priority Area 6.

Evidence–based care

Consumer journeys and clinical pathways need to be grounded in what literature, research and emerging practice indicates produces best results. Use of clinical, outcome and self assessment measures is an effective way to regularly monitor progress. Use of such measures is very powerful for the service user and practitioner to gauge progress, or not, and to make relevant changes.

Using evidence will lead us to develop services that are safe, that address concerns, where communication is open, care is co-ordinated and integrated through the use of shared care plans and everyone has the information they need, including the service user and their family.

Evidence supports the benefits of strengthening the social context around people including family/whānau, activity with friends, the health benefits of workplaces and the role of peer support networks. While episodic and intensive acute needs cannot always be anticipated, enhancing the planning and cross-system continuity of care for responding to relapses is important for supporting recovery and minimising loss of resiliency.

At every opportunity services need to support engagement and the creation of collaborative goal-setting and provide self-management tools as part of the package; for example peer support, psycho-education, whānau education, problem-solving skills, advice on the importance of routine, diet and managing distress. Services need to offer group-based interventions that provide peer engagement, hope and sharing of experiences that support resiliency. Clearly articulated clinical pathways should describe the range of clinical and support interventions that consumers and family/whānau can expect to access and the likely time it may take to achieve the greatest gains.

Care plans should be informed and 'owned' by the service user and their supports. A culture of communication should be developed with a service user's GP after every review or change in treatment. There needs to be liaison between specialist services and primary care and it is important for primary care to provide timely responses to physical issues.

Improved flows along pathways to resilience and recovery

To date our system of care has emphasised access rather than progress on a pathway towards recovery. Better understanding of the results we are achieving is emerging through a structured process of measurement. Detailed review processes have highlighted that some people are inappropriately 'stuck' in the system while opportunities to reduce dependency and increase resiliency are available. Using measurement to underpin pathway planning and to ensure timely and reliable action is needed. Monitoring the results achieved, together with the duration of care will ensure we have a system of care that uses the right mix of responses and resources to accelerate recovery.

Where longer-term support is needed, our systems of care must retain the focus on pathways to recovery; minimise the risk of people becoming stuck and isolated by their engagement with ongoing mental health and addiction care; ensure good integration with medical care; and support social inclusion, housing and employment where possible.

We must provide the most productive, effective and efficient service provision through timely responses, clear, collaborative goal-setting and tiered responses to assist in improving the flow of a person's recovery journey. There is a small group of people that sometimes get 'stuck' in secondary specialist and non-governmental services for longer than they need to. To address this we need proactive regular reviews, in partnership with consumer, family/whānau, primary care and non-governmental partners.

At the day-to-day service level, we need to be much more focused on providing access without delay and ensure provision of therapy at the right level of intensity, regular review of outcomes and actively supporting discharge.

We need to enable 'fast in, through and out services' with the ability to come back for a 'top up' if needed. Use of group interventions for responding to those with mental health and addiction needs is an effective and efficient way to increase access, utilise the benefits of peer support and enable the potential for on-going support with peers after groups finish. Use of psycho-educational, e-available resources and peer support needs to be more widely available.

We need to recognise those with high, enduring needs (estimated at 0.06% of the population) who require assertive outreach, tiered support and fast responses when needed across the whole system – not just from one service. Specialist teams should not hold on to service users; service users should not be dependent upon specialist teams. Therefore teams need local knowledge of support services and agencies that can engage, respond and support service users. Examples of support services and agencies include services for the homeless, sex workers, support for daily living and families – such as Strengthening Families, Kina and other community programmes.

We need to better tackle the complexities which act against recovery, and support whole of sector responses on housing, training and work.

Blueprint II calls for:

- Mental health and addiction responses that are dedicated to helping measurable, planned progress towards recovery and resiliency.

- Mental health and addiction responses that are effective, integrated and that support the particular needs of people with complex mental health and addiction and physical health needs (such as housing, social participation, income and employment needs).

- Clearly articulated evidence-based consumer journey pathways with regular use of self-assessment and outcome measures to monitor and encourage flow through the recovery journey.

- Widespread up-skilling and provision of talking therapies within a stepped care model.

4. Provide responsive and equitable experience and outcomes for poorly served populations

New Zealand is a culturally diverse community. Within any community people are diverse in terms of ethnicity, age, disability, gender, sexual orientation, religion and spirituality. Our services and systems need to take account of people's uniqueness and need and work to eliminate the blocks, barriers and discrimination that may make accessing services challenging.

Systems of care need to ensure that they contribute to addressing the drivers of inequalities for critical population groups. We need to achieve more equitable outcomes and experience for particular groups of people and communities, including those with high needs, Māori, Pacific people, former refugees and people living under economic deprivation. We need to continue to develop and research focused cultural models of care and services.

This section focuses primarily on Māori and Pacific communities who experience particular health inequalities. Māori and Pacific people need to be able to access culturally focused Māori and Pacific services as well as culturally safe mainstream services (including consumer-run services). There are a number of emerging models in New Zealand. There is also development of cultural competencies generally for the workforce and emerging roles for cultural advisers, taurawhiri and kaumatua. We must ensure that those people who experience enduring mental health and addiction needs have equitable access to a spectrum of evidence-based treatments, including talking therapies.

For Māori

It is important that our systems of care are able to deliver results that matter from a Māori perspective of health, going beyond the immediate clinical parameters to encompass wider measures of good health. Health services must pursue recovery and good health, not simply the removal of symptoms.

- **Primary health services:** In the area of early engagement or promoting early access to health services, consideration should be given to the involvement of Māori health providers. Many of these services have excellent skills in connecting with 'hard to reach' whānau and encouraging them to access services.

- **Secondary level services:** The involvement of Māori community workers or social workers at this level of service delivery can be instrumental in ensuring that Māori are connected into the best range of health and social services.

- **Tertiary level services:** Doctors and other health professionals must continue to develop greater awareness of the cultural diversity and the place of Māori in New Zealand, and develop appropriate cultural competencies.

- **Whānau Ora:** Emerging innovations in Whānau Ora show that significant differences can be made if there is a better understanding of a person's total needs and the needs of their whānau.

For Pacific peoples

Pacific people experience higher rates of mental disorder than the general New Zealand population. In any 12-month period, 25% of Pacific people will experience mental illness compared to 20.7% in the general New Zealand population. This includes high frequency of admissions for psychotic disorders, a high rate of involuntary admissions, higher rates of substance-related disorders, rising suicide rates, and twice as many referrals to forensic services.

Practical application of holistic models means treating the whole person through integration of services, particularly primary mental health care, with a focus on increasing access rates. Whānau Ora may also play a role for Pacific mental health, by working across government agencies to take care of other social issues impacting on mental health for Pacific people, such as poor housing.

Over the past decade, Pacific models of mental health and the philosophical value system that underlies them have been incorporated into 'by Pacific for Pacific' led mental health services in New Zealand. Research has shown[138] [139] that uniquely Pacific techniques adopted by Pacific service providers have included the 'roundabout' rapport building approach, understandings of spirituality, the cultural value of group therapy, the use of Pacific language and hospitality practices, the privileging of interpersonal relations, building trust and rapport between consumer, families and service workers, and understanding the importance of the spirit of a person to his or her mental health.

More Pacific people access mainstream services than Pacific services. However, the capacity to meet the needs of Pacific people and their families must be enhanced.

Blueprint II calls for:

- Continued development, research and implementation of culturally specific models of care as a choice, and/or to compliment mainstream mental health and addiction services.

- Development and use of cultural outcome measures.

- Workforce development that ensures that values, attitudes and skills of staff are non-discriminatory and provide safe, effective and responsible service appropriate to the unique characteristics of people.

- Cultural leadership being an active part of the governance of services, making connections with communities and guiding the development of culturally specific interventions and services.

The aim is for a significant reduction in the variation of outcomes and experience for Māori and Pacific people.

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138 Agnew F; Pulotu-Endemann FK; Robinson G; Suaalii-Sauni T; Warren H; Wheeler A; Erick M; Hingano T; Schmidt-Sopoaga H. 2004. *Pacific Models of Mental Health Service Delivery in New Zealand ("PMMHSD")* Project. Wellington: Health Research Council and Mental Health Commission.

139 Southwick M; Warren H; Lima I; Solomona M; 2008. *Searching for Pacific Solutions – a Community-Based Intervention Project to Minimise Harm from Alcohol Use.* Wellington: Alcohol Advisory Council of New Zealand, Health Research Council of New Zealand and Accident Compensation Corporation.

5. Minimise harm and improve safety

The evidence is mounting that a significant number, if not the majority, of people experiencing significant mental health and addiction problems and accessing services for help have also experienced trauma. Often responses to stress and distress can be highly influenced by previous trauma.

There are a number of areas of practice and service delivery that we need to change and improve to ensure that people are not inadvertently traumatised or re-traumatised. Our focus here is on:

- **Ensuring good physical health:** Promoting healthy lifestyles and reducing the inequalities in life expectancy. This includes promoting smokefree environments and proactively offering assistance to quit smoking, access to advice about diet and nutrition and encouragement of regular physical exercise. Much of this is covered in Priority Area 4.

- **Ensuring safe use of medicines:** Especially for those who require long-standing psychotropic medications including provision of good information on medicines, their safe storage and use, monitoring and assistance with managing side effects and strategies to assist with taking medication regularly.

- **Reducing use of coercion and promoting the goal of coercion-free environments:** Includes the early identification of problems and early engagement and intervention; the development of strong partnerships with consumers and family/whānau; development of skills and techniques to assist in the management of agitation and distress to help with minimising the use of seclusion and restraint; and reducing the frequency and duration of use of the Mental Health Act where possible.

- **Promoting strong partnership, collaborative recovery and engagement:** To be used as a tool for enabling consumers to plan for their safety, provide alternative strategies for responding to crisis and minimising relapse.

Good physical health

The physical health care needs of people using mental health services are proactively met especially for those service users who have prolonged contact. The evidence and responses to this are covered in Priority Areas 4 and 5. In particular, key elements here include primary care, making sure there are regular physical checks (annual at least), promotion of active healthy lifestyle and wellbeing principles with access to programmes that assist in developing new, healthier habits. These habits include being active, good nutrition and eating well, doing things you enjoy, connecting with others, lifelong learning and giving time and easy access to programmes that assist in stopping or minimising harmful habits, in particular smoking, alcohol and use of illicit drugs.

Ensuring safe use of medicines

Having sufficient information about treatment options, including the place of medication in treatment is important for all people accessing mental health and addiction services. Information about medication treatments should be available in a form that helps service users and their families/whānau make informed decisions about consent to treatment, including information about the ongoing monitoring of the benefit and possible adverse side effects of treatment.

Consistent approaches need to be further developed to ensure safe use of medication. This should include arrangements for the safe prescribing, dispensing, storage and administration of medication. It will be useful to continue to develop systems that help prevent unwanted interactions between prescribed medications and over the counter products, to help the coordination and oversight of prescription medication management and for medication reconciliation between various parts of the health system.

Consideration should be given to developing further strategies to assist people to keep taking medication reliably, for whom it is an important component of their recovery and maintenance of wellbeing.

Monitoring systems to ensure that potential adverse effects associated with medication use need to be well developed and implemented effectively. This will involve good co-ordination between mental health practitioners and their colleagues in other parts of the health system. The role of primary care, and in particular GPs as the 'medical home' of people, should be emphasised and supported in assisting this important element of safe use of medication.

Reducing use of coercion and promoting the goal of coercion-free environments

A significant number of people who seek help for addressing mental health and addiction needs have also experienced trauma. For some, it involves multiple types of trauma on multiple occasions. Trauma-informed services seek to recognise the prevalence of trauma and ask what has happened to a person (rather than what is wrong) and then to attempt to not re-traumatise people through the response they receive from services. In particular, we want to focus on minimising use of restraint and seclusion in hospital environments and providing access to safe alternatives. Coercive interventions cause trauma and can re-traumatise people.

Instead, we need strategies that assist service users to find different responses to stress and their distress through neutral, personalised plans. The key elements include working closely with people to compassionately plan for their safety, to recognise early triggers as part of a crisis plan and to learn alternative ways to manage stress and to calm distress (e.g. sensory modulation techniques). The focus is on collaboration not compliance and developing a culture that utilises trauma sensitive tools and techniques.

Use of compulsory treatment is another area where trauma-informed systems of care could make a difference.

Promoting strong partnership, collaborative recovery and engagement

As covered earlier, we need strong partnerships, collaborative recovery planning and engagement as a foundation and tool for enabling consumers to plan for their safety, provide alternative strategies for responding to crises and to minimise intensity and/or frequency of relapse. Key elements are:

- Strong engagement and partnership in developing collaborative recovery plans. This assists in minimising frequency and intensity of relapse.
- Understanding the unique triggers and signs of relapse.
- Developing personalised responses that include individuals and their family/whānau and resiliency tools.
- Prompt, compassionate service responses.

Advance directives assist service users to advocate for the responses they find most helpful, where they are still able to have some control over decision-making about their treatment regardless of ill health. The aim should be to work toward minimising compulsion, except to ensure safety for the duration of the emergency in the least restrictive environment and with the least invasive treatment.[140] Early recognition, fast timely responses and collaborative planning can assist greatly in achieving this. Planning for safety should be a proactive and collaborative process. Shared care plans and those responsible for contributing and co-ordinating should ensure that there is a 'current' safety plan, relapse plan and/or advance directive in place for people who do experience episodic acute relapses and/or require ongoing support.

Blueprint II calls for:

- Active engagement of consumers and their support networks in managing their safety and security.
- Trauma-informed, coercion-free mental health and addiction services.
- Physical health programmes that assist with staying well and keeping well.
- Active partnership between mental health and addiction services and service users and family/whānau to provide access to programmes to eliminate or minimise harmful habits and behaviour.

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140 Mental Health Commission. 2004. *Our lives in 2014. A recovery vision from people with experience of mental illness.* Wellington: Mental Health Commission.

2.8   Priority 8: Improving system performance

Lifting system performance and reducing the average cost per person treated while still improving outcomes.

We need to use our resources more effectively and efficiently. This will require a radical increase in the overall performance of the system (better and increased flow); effective and efficient use of resources (energy, time, skills, capability and money); and better value for money overall (the right level, type and intensity of response). Changes to the current mental health and addiction funding and accountability frameworks are needed to enable changes in the mix, level and focus of services.

Action is needed in four areas:

- Lift system performance across three interrelated levels: day-to-day care delivery; the organisation of services; and the whole system including other government agencies.

- Implement a stepped care approach to change the mix, level and focus of services to maximise their efficiency and effectiveness.

- Change the current mental health and addiction funding and accountability frameworks to enable the changes needed in the mix, level and focus of services.

- Make best use of our workforce.

Rationale

The original 1998 Blueprint started at a point where mental health and addiction services were significantly underfunded. Alongside detailed resourcing plans, it has laid the platform for a significant increase in funding since 1998. The fiscal environment today, and for the foreseeable future, is predicted to be tighter and more difficult.

The future vision is based on the premise that resourcing of the sector will be maintained at current levels. We cannot let investment levels slip if we hope to maintain the gains that have already been made in the mental health and addiction sector. However, more investment will be needed in key areas, such as child and youth, addressing the demands of an increasing prevalence of dementia and in reducing the burden of long-term unemployment. To achieve this, the sector will need to significantly increase overall system performance and in turn reduce the average cost per person supported.

The results needed cannot be achieved by making minor changes to the way we do things now. The sector will need to continue to identify areas where further investment will allow significant improvements to be made.

Results needed

1. **Lift system performance across three interrelated levels; day-to-day care delivery; the organisation of services; and the whole system including other government agencies.**

Day-to-day care delivery: At the level of day-to-day care delivery what we do, who does it and how efficient we are will be critical issues for lifting system performance:

- **What we do:** mental health and addiction services are rich in emerging models of care that can potentially transform productivity; for example through new models of care that leverage people's own capacity for self care, broadening the capacity of wider health workforce to use brief mental health and addiction interventions in their normal practice, and utilising lower intensity interventions such as peer support, e-therapies or brief talking therapies in primary and community settings.

  By strengthening the focus on measured progress towards recovery and resiliency we can increase the productivity of existing core specialist services; enhancing clinical effectiveness and reducing variation in practice.

- **Who does what:** With workforce consuming the large majority of resources in mental health and addiction services 'who does what' is critical to effective productivity. Organising services, teams and roles so that all our workforce, (including people and their family/whānau), are operating at 'the top of their scope of practice' will be essential.

  Organising care to appropriately use lower intensity services, ensure continuity of care for easy step up or down and monitoring service usage duration will need to be routinely part of day to day care delivery measurement and performance improvement.

- **How efficient we are:** With skilled workforce time being our most constrained resource increasing the proportion available for high-value client-facing activities is perhaps the most direct way of lifting system performance available to the sector. With benchmarking data on 'time to care' becoming more available it can be used to guide efforts to reduce low-value time requirements and use capacity released to increase access to care.

The organisation of services

The same approach to creating systems of care to support resiliency and recovery described in the previous section can be used to lift system performance in the organisation of services. Three areas are critical at this level:

- **Prompt access to early responses:** In general, fast access enables earlier and lower intensity responses that minimise disturbance to people's support structures; for example, maintaining continuity in employment. Streamlined access can reduce 'do not attend' rates, reduce the need for multiple assessments and care co-ordination, reducing waste in the processes of care.

- **Effective integration of tiered services and pathways of care:** We have made substantial progress in developing a range of peer-based, community and specialist services but have yet to integrate these across low intensity self care, group interventions, primary care and social services. Both local and overseas experience show that integration of tiered services and pathways of care can better utilise the resources in the system, enabling increased access and more effective response. While a fully-fledged tiered service model will require investment in service models and workforce capability, fast progress towards this can be achieved by removing existing policy and operational barriers; for example, reorienting community support to provide access from primary care.

- **Management of episode of care service duration and 're-admission':** Mental health and addiction pathways will always exhibit individual variation but actively managing support duration can benefit both individual recovery and system productivity. The proviso is that shorter durations of support are achieved through strengthening resiliency and connections to social support structures, otherwise readmission rates or frequent service needs will negate the productivity benefits.

Whole of sector/cross sector

To achieve the 'how things need to be' outcomes and systems of care described earlier it is clear that we must get better at working in partnership; within the sector, with wider general health and with social and justice sector agencies and organisations. The aim is to increase system performance and leverage the combined resources that mental health and addiction brings to the table alongside these partners.

This will be challenging. The original Blueprint provided a pathway for investment in mental health and addiction services in part by being very focused on the population it served, and thereby specifically excluding populations that were seen as other agencies' responsibility. This siloed approach will not result in achievement of population outcomes or overall system performance.

Making Blueprint II work will require people across the sector to engage creatively in the challenging task of weaving together the component parts of a new value-for-money system in ways that are practical and effective. It will require a new form of distributed sector network leadership, one that embodies the intelligence of service users, clinicians and service operations that can act alongside central agencies as a partner in system level transformation.

The diagram below outlines proposed ideas for creating this step change across the three layers of system performance. Some of the core ideas include:

- One system multi-funded – aligning resources and integrating responses across health and social sectors.
- A fast access 'no wait' system that meets needs earlier, less intensively and can restore people back to their own support structures faster.
- Reducing variation in clinical practice, safety and quality.
- Increasing clinical time to care through reducing waste.
- Organising roles and teams so that everyone is operating at the top of their scope.
- Response pathways provide fast assessment and direct access to the least intensive, most effective, closest to home response possible.
- Organising care into integrated stepped or stratified layers of care.

Blueprint II calls for:

Day-to-day care delivery:

- Use stretch 'time to care' goals as a stimulant for high value quality and performance improvement in day-to-day service activities.
- Use relative recovery improvement benchmarking – for example, as emerging through the primary mental health initiative, the national KPI project or within the knowing the people planning process – to stimulate changes in practice and model of care.

The organisation of services:

- Use of a 'no wait' prompt access goal as a stimulant to accelerating the development of service tiers which can offer more responsive assessment and assess and treat models of care.
- Use of duration-of-care benchmarking to identify where capacity may be released through better attention to step down or step out pathways.

The whole of sector:

- Increasing the national and regional investment in the development of national performance measures with a tighter focus on application towards whole of system performance development.
- Opening engagement with sector partners such as Child, Youth and Family and the Department of Corrections who are implementing their own mental health and addiction initiatives, to identify how mutual outcomes can be achieved through cross-sector action.

2. Implement a stepped care approach to change the mix, level and focus of services to maximise their efficiency and effectiveness

Stepped care is a structured mechanism for achieving increases in efficiency. The use of this model must span primary, community and specialist services and create opportunities for collaboration with other organisations such as social welfare and justice.

A stepped care approach involves:

- Using the least intrusive treatment required to meet the presenting need.

- Making available interventions with differing levels of intensity.

- Matching people's needs to the level of intensity of the intervention.

- Entry and exit at any point.

- Using robust tools to routinely collect outcomes data to support people's journey into, through and out of services.

- Having clear referral pathways between different levels of intervention.

- Supporting self care as an important aspect of managing demand across primary, community and specialist care settings.
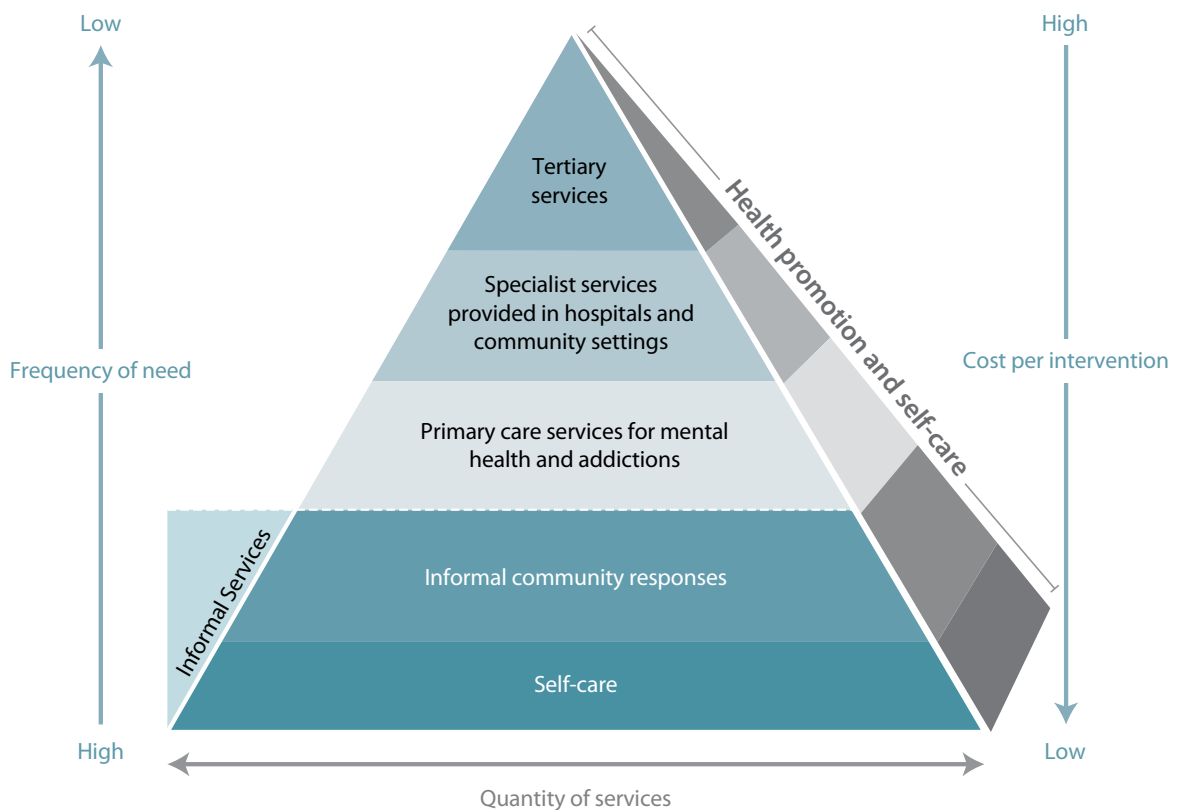
Using the stepped care model should result in an integrated response – where people receive support that is appropriate and timely – and holistic packages of care that bring together support across sectors and silos.

Implementing stepped care requires a major rethink of how the boundaries and interfaces between primary, community and secondary care are designed and managed. Within New Zealand's mixed model health services structure this requires creation of a much more robust shared infrastructure, particularly between primary and specialist services, an issue that is substantially larger than the mental health sector alone. However the mental health and addiction sector can be a much more active participant in current wider policy initiatives (for example, through the development of integrated health centres and networks) focused on building greater capability in primary care and the interface with secondary services.

Substantial experience in implementing stepped care at a pilot level has demonstrated its effectiveness in New Zealand settings.[141] The shape of national policy and service development requirements have been

141 National Centre of Mental Health Research, Information and Workforce Development. 2012. *Talking therapies: where to next?* Auckland: The National Centre of Mental Health Research, Information and Workforce Development.

developed in a number of national documents, notably the Ministry of Health 2009 guidance paper *Towards Optimal Primary Healthcare*[142] and the 2011 *Guidelines for development of mental health and addiction services for older people and dementia services*.[143] From a primary health and community perspective it is important that there is a high level of coherence and commonality of approach to stepped care across all the range of services that they will deal with, rather than each service developing its own flavour or variant.

Some of the ideas that have been flagged by the sector that will assist in making these changes include:

- Clearly articulated clinical pathways and consumer journeys, based on evidence, across all levels of care and organisation, developed as system wide pathways.

- Utilising process improvement tools such as Lean Process, Six Sigma, CAPA, Capacity Planning and scheduling to streamline and optimise process pathways.

- Making transparent the flow and blockages of people through clinical pathways/consumer journeys.

- Developing different pathways for different levels of need.

- Enabling quick access to expertise and information – across health and other services.

- Ensuring quick access when needed: consumers/service users and family/whānau can access services 'just in time' rather than stay 'inside services' in case they need them.

- Information being available in real time and accessible to inform decision making and ensure that people do not get stuck in services.

- Developing cross-agency relationships and protocols.

Many of the changes in this section mirror changes already flagged in previous sections. However, their focus in this section is about reducing costs in the system.

Blueprint II calls for:

- National, regional and DHB policy, funding and service design to formally endorse and implement a stepped care approach across all service areas adapted to meet the requirements of their population.

- The redevelopment of service frameworks, planning tools and funding specifications to facilitate the implementation of stepped care.

- Active engagement of the mental health and addiction sector in primary health led developments in integrated systems to create high-value, platform-building initiatives that support sustainable infrastructure development.

- Active development and support for using the most cost-effective options, including self care/management and responses provided through wider primary and community health services.

- Development of specific opportunities where stepped care can provide service users with better, faster and more convenient entry into, through and out of services.

- All agencies and professional organisations involved in workforce development to support the changes in practice scope and skills required to implement stepped care and enable better use of the workforce (working at the top of their scope).

- Working across the cross sector and with intersectoral partners to generate the best use of our combined resources and capacity.

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142   Ministry of Health. 2009. *Towards optimal primary mental health care in New Zealand: A discussion paper.* Wellington: Ministry of Health.
143   Ministry of Health. 2011. *Mental Health and Addiction Services for Older People and Dementia Services: Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age.* Wellington: Ministry of Health.

3. Change the current mental health and addiction funding and accountability frameworks to enable the changes needed in the mix, level and focus of services

To support the move to a stepped care, no wait, integrated approach, we will need different funding, contracting and commissioning arrangements.

The ringfencing of mental health and addiction funding has served the sector well. It has protected and increased the level of investment in critical mental health and addiction services for our most vulnerable high-need users. Greater flexibility is now needed so that DHBs and service providers can make the most effective use of the funding available, easily integrate services across primary, community and specialist care, and implement a stepped care model.

But removing the current ringfence would put hard-won investment gains at risk. To make it safe to remove the ringfence, we need a highly visible outcomes-based performance framework, reinforced with strong DHB accountabilities. The mental health and addiction sector should aim to achieve this outcomes-based approach, and removal of the funding ringfence, within the next five years.

In the meantime we can improve the current ringfence by allowing more flexible use of funding. A start has already been made through the inclusion of some primary care initiatives. We also need to move from the current historical basis for calculating the ringfence to one driven by outcomes and which better reflects the needs of a DHB's different population groups.

Blueprint II calls for:

- Initiating a review of the current ringfence and its definition to ensure that it is fit for purpose to support innovation and flexibility while protecting the gains already made.

- Building on current work, such as the national KPI project to develop a mental health and addictions outcomes and results-based accountability framework.

Further detail can be found in Appendix 1: Investment and sustainable resourcing to improve mental health.

4. Make best use of our workforce:

The key resource we have available to us is our workforce. The collective skill, experience, expertise and knowledge of our workforce is strong and, with excellent training and development structures, continues to develop. With workforce using the large majority of resources in mental health and addiction services, 'who does what' is critical to improving productivity. Increasing the proportion of time available for high-value client-focused activities is perhaps the most direct way of lifting system performance available to the sector – reducing low-value use of time and releasing capability to increase access to care.

This means that we need to organise our workforce differently, including being more discerning about who coordinates care and who supports people depending on the degree of clinical and/or support need. We need to ensure that the skills and expertise of our workforce are aligned to support models of care such as stepped care. This has already started with, for example, specialist mental health nurses working in NGOs and primary health organisations using psychologists, mental health nurses and, in one case, a psychiatrist.

Organising services, teams and roles so that all of our workforce (including service user and family/whānau workforce) are operating at the 'top of their scope' will be essential. In practical terms this means that we must always be asking 'who is the best person, with the right skills and expertise to do the job', and ensuring we use the diverse skills across a range of roles as best we can.

The future will be different from today, so we need to ensure that our workforce continues to evolve to implement new methods of care delivery – that is, online and the places where people are supported, hospitals, GPs, at home, at work, on the phone or via the internet.

We must ensure the workforce has the essential capabilities by investing in training at the right level and intensity across the system: primary; secondary and tertiary. This means workforce development is built as a tiered system of responses to service users and their families.

To support day-to-day care delivery we need to:

- Increase the diversity of the team workforce, with the smallest numbers of highly specialised clinicians working to the top of their scope.

- Invest in training to provide individual and group interventions at the right intensity, to support recovery and support for family/whānau.

- People have individual training plans and performance management systems that support the service's capacity to deliver the right response at the right time.

- Ensure that consumer advisors, family advisors and peer support workers are an essential and valued part of the delivery of care.

To support organisation of services we need to:

- Develop capacity and capability of secondary services to work collaboratively with NGO and primary providers to provide assessment, focused interventions, specialist case management and consultation.

- Develop roles to support 'navigation' of complex support for people and families.

- Create opportunities for team training based on mapping the capabilities needed to serve the local population, recognising the core skills and knowledge of the team.

- Continue to develop core skills such as those included in Let's Get Real, specialised skills to support evidence based interventions and knowledge and skills around promoting positive mental health and wellbeing.

- Foster advanced practitioners' skills and expertise to support the core practice of other team members.

To support whole of system functioning we need to:

- Set up relationships and systems to respond to other parts of the sector with advice and information. No one part of the system holds all the solutions.

- Move towards NGO support services and primary care led service provision with specialists providing guidance and advice in a specialist and support role.

- Continue to support workforce development and ensure that our workforce development capacity (that is, workforce programmes, unions, professional bodies) have a coherent vision of future workforce involving partnerships which develop a flexible, skilled and multi-disciplinary workforce.

3. Making Change Happen

The challenge to implementing Blueprint II is to improve access and outcomes, which requires change at a time when resources are constrained and are likely to remain so for some time. Any changes must also be embedded and sustainable if we are to realise the vision of Blueprint II.

To support making change happen Blueprint II proposes a sector-led capability development approach to sustainable change. This approach has four levels. Each level builds on the strengths developed at the previous level and, together, all four levels form the capability needed to sustain the changes required across all priority areas.

- **Level 1: Maintain/optimise:** Maintain a core mental health and addiction level of capability and initiate the first steps towards lifting system performance and value for money; for example, mapping and identifying existing services and gaps.

- **Level 2: Build critical system components:** Progressively develop those system components that focus on areas of high leverage (substantial benefit in access and care and impact on whole of system productivity).

- **Level 3: Develop effective mix and balance:** Build a mix and balance of services and capacity across all relevant agencies that are effective and provide high value for money.

- **Level 4: Realise synergies across the system:** Realise the integrated and systemic approach with processes of care and support that have high fidelity, repeatability and efficiency.

Blueprint II – 10 year realisation pathways
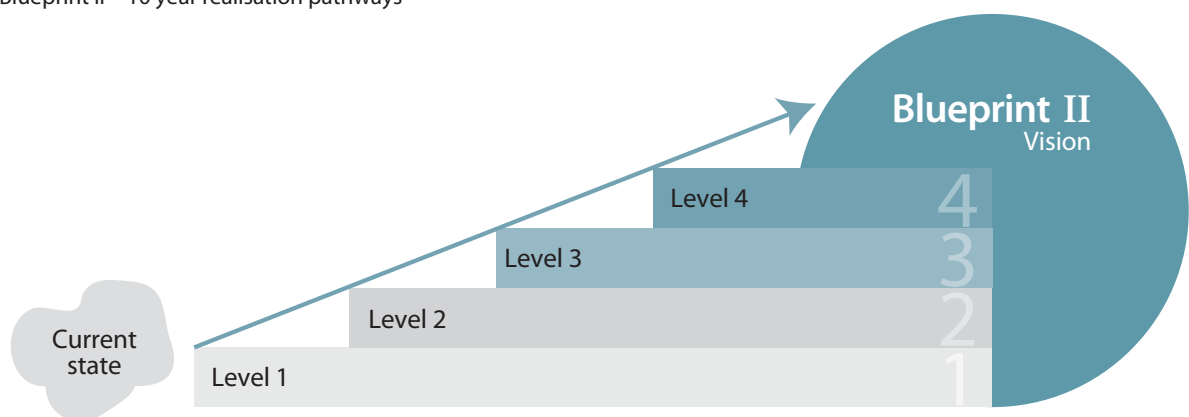
It is recommended that the Mental Health Commissioner work with the sector during 2012/13 to develop this framework in order to use it as part of the ongoing monitoring of change towards realising the vision of Blueprint II.

While a framework is useful, to make change happen we must get started. We must create starting points that are based on where we are right now, that build on our strengths, that strengthen connections across system, that prepare and develop our workforce and are based on strong, robust, evidence-based approaches to change. Detail on a selection of evidence-based approaches to change can be found in Appendix 2.

3.1 Making a start across three levels

There are three levels where change must start to happen: (1) sector, (2) system and (3) whole of government.

3.2 Supporting sustainable sector-led change

Depending on where you are at, change may well start in different places, or have different emphasis. But as a minimum change should cover the following:

- **Generate a mandate for change and develop sense of urgency**

  It is critical that steps are taken to work with boards, chief executive officers and people in key leadership roles to develop the support and commitment to change. It is also important that a clear mandate is obtained to start making changes and to secure the resourcing (time and money) required.

- **Establish a change leadership executive**

  Bringing together a group of people to lead and champion the changes required is important. These people must have the ability to make key decisions and have access to resources to be able to support the decision-making process. This group should cover the health funding continuum and include as a minimum the following roles: funding, DHB clinical director and/or general manager, primary care and NGO representation, and consumer/family and cultural involvement.

- **Establish overarching cross-system leadership mechanisms**

  The leadership executive should create space to interface with the wider network of stakeholders required to own the change process. This should include wider mental health and addiction stakeholders, wider health and other government agencies. To realise the vision of Blueprint II we must involve a wide range of stakeholders who can make change happen in other parts of the system. Mental health and addiction funders have a particular role to work with funders in other government agencies to jointly commission new ways of working.

- **Communicate and engage with workforce and consumers**

  With any change, the people that will make it happen and be affected by it are the workforce and consumers. Briefing and engaging the workforce on the future and ensuring that people are at a similar level of understanding is important and needs to be managed and co-ordinated.

- **Map and measure the current system**

  Before starting on any journey it is important to know the base we are starting from. Hence one of the first steps in any approach to change should be to map and measure the current system. To help, frameworks such as the life course, Triple Aim and results-based accountability should be used. A baseline of data should be established in order to support the ongoing benchmarking of information, services, interventions, volumes and activity. Stakeholder and process (or care pathway) mapping is also very useful at this point.

- **Develop a coherent multi-year change plan**

  The changes required to realise the Blueprint II vision are complex. It is important that a coherent, agreed plan is developed with a wide range of stakeholders. Stakeholders must support this plan and resources be available to support it. This plan is likely to cover multiple years and therefore will require both long and short term perspectives. As a minimum a change plan should:

  - **Clearly describe the desired model of care and the core design components on which it is based.** This should include stepped care, range of interventions, primary/secondary/tertiary interface, care pathways, and components of collaboration and integration.

- **Describe the workforce changes and development required.** This should include plans for how to understand and build on the strengths of the current workforce, what the workforce/skill gaps and how to close them, and how to understand if people are working to the top of their scope in the rights places of work with the right terms and conditions.

- **Outline what relationships are required across agencies and the sector and how to develop and/or strengthen them.** This should include plans for how to use stakeholder forums and opportunities for people to connect across the system.

- **Describe how to support joint cross sector commissioning for key population groups.** This should include plans for how to create shared cross sector commissioning and service development opportunities for key population groups.

- **Provide detail on how to create early wins and build on them.** This should be informed by a review of each priority action area for places to start and calls to action to test. There should also be plans to build on what is working well now as a starting point for closing gaps and prioritising gaps through alignments with Ministry of Health service development priorities and other Ministry programmes where momentum is building.

- **Describe how to facilitate the thinking and any changes required to funding flows and the contracting environment.** This should include how you plan to create opportunities to enable different drivers for commissioning.

- **Outline plans to enhance and/or build towards a sustainable support infrastructure.** This should include how to set in place programme-developing, effective information system infrastructure so that information sharing and communication across agencies works to support integrated care and experience for consumers and families/whānau.

- **Create a culture of performance and peer monitoring.** This should include plans for how to share information on performance and outcome measures to create an environment of continuous improvement through peer monitoring and review.

3.3   Supporting system wide change

Depending on where you are at, change may well start in different places, or have different emphasis but as a minimum should cover the following:

We must spread existing innovation

Throughout priority areas 1 to 8 there are substantial building blocks of well-established evidence, good practical experience or emerging innovative initiatives that can take us forward. By mapping our current systems of care and using a structured approach to comparing the 'as is' to Blueprint II's 'how things need to be' we will be able to rapidly identify the high priority, high leverage changes that can take us forward. Fortunately most of the needed innovations are already emerging; the task is to learn, spread, scale and integrate in a focused way rather than innovate from scratch.

To implement Blueprint II we need to identify the small number of innovative system of care developments that can initiate the step-change in performance needed, and apply effective system change approaches to ensure that these are implemented.

Two examples of where there is already innovation in redesigning and streamlining the way that services work in New Zealand are the Choice and Partnership Approach (CAPA) embraced by Child and Adolescent Mental Health Services; and the Productive Community model designed by the NHS in Britain. Both of these tools achieve significant and lasting improvements, predominately in improving access and reduced waiting times, improving the quality and consistency of care delivered, and reducing costs. Redesign improvements are best driven by staff themselves, by empowering them to ask difficult questions about practice and to make positive changes to the

way they work. Principles such as the CAPA '7 Helpful Habits'[144] support systems thinking and service monitoring to demonstrate the improvements in performance and productivity. This promotes a continuous improvement culture that aligns well with other continuous improvement processes such as Key Performance Indicator trend analysis and Lean Thinking or Six Sigma methodologies.

There is considerable evidence on how to implement change from literature and research on change as well as by feedback from consumers and family/whānau, knowledge of clinical leaders and providers, and learning from current innovations and exemplar services. Some ideas on implementing changes are outlined in more detail in Appendix 1.

We must strengthen leadership to engage in whole system thinking and collaboration

Our leaders need to become very skilled in whole system thinking and collaboration. This includes leadership at all levels and across the whole sector, including consumers, family/whānau, clinicians, DHBs, primary care, non-government providers and across broader government. The main role of leadership in implementing Blueprint II will be to:

- Create connections, alignment and commitment to shared goals of Blueprint II.

- See the boundaries of our systems and organisations as new frontiers to be crossed, reshaped and invigorated.

- Know how to value and make the best of difference, uniqueness and specialism.

- Resolve differences and build commonalities to bring new opportunities and innovations, fresh learning.

- Build on strength and evidence and do more of what works for people.

Leaders need to make effective use of existing networks, forums and cross-sector opportunities. They need to bring together expertise, experience and passion to build momentum, share learning, challenge existing ways of doing things and collaborate.

The focus needs to be on building capability for collaboration across all levels, at both personal and organisational leadership, with a primary focus being on collective motivation and accountability for delivering better outcomes for our communities. Leaders need to become 'whole system literate' with a really good understanding of how systems operate, to feel discomfort and comfort in leading in this environment. Discomfort will help them to drive change and not settle for silos and restrictions. Comfort with complexity, ambiguity and some unpredictability will enable them to cross boundaries to engage proactively with others in developing new and productive partnerships.

In this future, leaders' roles are to build bridges, build new maps, to enable connections across the variety of boundaries that exist. They need to reframe boundaries that some see as restrictions, limitations, silos or restraints to organisational and team boundaries as being the point at which connections can be made for new learning, innovations and new solutions.

Centre for Creative Leadership[145] promotes leadership as a social process that provides direction, alignment and commitment to achieve shared vision or goal. This is never more so than now for moving forward the shared vision of a whole system response to improving the mental health and wellbeing of New Zealanders. Relationships, connection and collaboration are critical in the weaving of group boundaries into an interlaced and integrated whole system that is more than the sum of its parts – whether that be around individuals and their family/whānau, at the broader district/locality/regional level or working nationally.

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144 The '7 helpful habits' are: handle demand, extend capacity, let go of service users and their families, process mapping, flow management, use of care bundles and look after staff.
145 Ernst C; Chrobot-Mason D. 2011. *Boundary Spanning Leadership. Six practices for solving problems, driving innovation, and transforming organizations.* Greensboro: Centre for Creative Leadership.

For leaders of organisations/networks across the government, health, communities, family/whānau and consumers, some ways of structuring thinking about this different kind of leadership within your organisation include:

> *Our leaders need to be skilled in whole system thinking and collaboration*

- Where is your organisation, network, leadership team at its most successful in terms of collaboration and connections? How could you build on this?

- As a leader, where do you have opportunities to work collaboratively with leaders from other organisations both within the health system and across other government agencies? As a leader how could you take that relationship to another level?

- Where are the areas of greatest opportunity to create new connections and bridges that would assist in moving forward change described in Blueprint II?

- What other forums where agencies are meeting that are not mental health addiction service specific could you link in with? How do staff across various teams and agencies get to understand where they 'fit', their unique contributions and their common ground?

- What are the roadblocks and how could you shift them?

The challenge for many is to navigate a number of boundaries at the same time.

There needs to be appropriate support to do this. Health care navigators and co-ordinators are all roles developed over time in various agencies to do this but are often duplicated across agencies. Whānau Ora models offer clear opportunities to streamline and integrate responses around families and communities. Successful models are emerging around integration and collaboration across primary/secondary services, primary/NGO services, NGO/secondary services and across NGO provision.[146]

Ways of strengthening connections and supporting whole system transformational change include:

- Clarify and forge common ground: emphasise what is held in common, how boundaries can be framed, creating ways to connect rather than separate, strengthen linkages and connections that unite.

- Grab opportunities to connect in different ways, create space to experiment and explore new ways of working.

- Develop options along continuum of linkages, collaboration and integration, that work to strengths of organisations and staff: address barriers to collaboration across system.

- Develop joint programmes (funding projects, integrated services), training and service improvement capabilities.

- Clarify and give whole system support to navigation and co-ordination roles. Be clear about their differences, and what you expect from them. Where the role includes co-ordination and initiating of support resources they need a clear mandate across a system to reduce 'hoops and bureaucracy'.

We must strengthen national and regional mental health and addiction networks

National and regional mental health and addiction networks can carry out two critical functions in implementing Blueprint II:

- Sharing and discussing innovation and best practice.

- Providing robust advice on mental health and addiction sector planning, resource allocation and service change.

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146 NgOIT. 2012. *Towards Integration: Building an integrated primary mental health and addiction service.* Wellington: Platform Charitable Trust.

To be effective in implementing Blueprint II these networks need to integrate leadership across a complex system with multiple organisations and groups.

There are a range of existing networks that are well established. We are proposing that these are strengthened to better support regional and DHB development and resourcing decisions. Networks need to involve leaders from clinical, policy, management, consumer, and families/whānau perspectives from across the sector including primary care, NGOs and DHBs and across government agencies.

3.4   Supporting whole of government change

Depending on where you are at, change may well start in different places, or have different emphasis but as a minimum should cover the following:

We must reinforce at the government level the importance of 'no health without mental health' by establishing whole of government expectations and targets

Ministerial leadership can help mobilise and focus sector effort by communicating through the formal channels that 'no health without mental health' matters and that lifting system performance is not optional.

The future envisaged in Blueprint II needs focus. What gets measured gets done. Currently there are no ministerial level targets for the mental health and addiction sector. This must change to support the effective leadership role that the Minister can play in the sector. Urgent agreement is needed on a coherent set of performance indicators and targets aligned to achieving the goals in Blueprint II. A subset of these measures could be considered for ministerial adoption which would signal the importance placed on mental health and wellbeing to the achievement of broader goals of government in areas such as employment, transition to adulthood and at-risk youth. Demonstrating this wider contribution will ensure the value of the mental health and addiction sector is routinely seen and understood.

Four areas stand out as potential candidates for ministerial targets that would help mobilise the system towards the future shape needed:

- An overall access target.

- A target that drives increased access and response to child and youth across mental health and addiction responses.

- A target that strengthens recovery and resiliency for adults through driving towards increased ability to gain or maintain employment.

- A target that emphasises service responsiveness and encourages development of new systems of care, for example establishing strong expectations on waiting times.

4. What Will Success Look Like?

How we will know we are making progress

To make progress means doing things differently. This will require significant change across the whole system, including models of care, workforce, data collection, culture, and consumers' expectations. To know whether we are being successful on the pathway towards realising the vision requires some markers along the way.

We will know we are being successful if:

- No one who seeks help waits for help.

- Support for infants and mothers, children and youth has increased significantly.

- Support for populations who experience inequality of outcomes has improved.

- The mental health and addiction sector has strong, productive partnerships with other agencies that are delivering tangible results.

- Changes have been made to models of care and workforce that enable more people to be supported within available resources.

To achieve this an understanding is needed of where we are starting from, where we want to be, how we are going to get there, and what impact the changes have had. This requires the development of measures that inform and guide on-going processes of sector-led change and development.

The approach that Blueprint II takes to measuring and driving performance needs to work for the system as a whole, including our partners across health and the wider social service, education and justice sectors. This approach has been guided by the New Zealand Triple Aim framework to simultaneously improve quality, safety and experience of care, improve health and equity for all populations and generate best value from public health system resources.

Within this overall approach we need a monitoring programme to provide a concise picture of progress in achieving the vision and outcomes of Blueprint II. The monitoring programme provides information that gives a cross government, whole of society picture of mental health and addiction in New Zealand. It may also improve service quality, assist in cross-sector policy development, identify areas for on-going and future action and research, and contribute to better informed public debate.

To monitor Blueprint II, routine tracking of progress through the regular collection of data to identify and measure change over time is required. A range of indicators have been selected on the basis that they are worth measuring; are measurable and meaningful for diverse populations; are understood and accepted by people who need to act; can galvanise action; are relevant to policy and practice; and reflect results of actions over time.

Using this data the Mental Health Commissioner, government agencies, funders, service providers, clinicians, and consumers will be able to track progress and collect evidence about what worked and what did not, so that improvements to service delivery can be made in the future.

It is important that the monitoring programme is capable of telling the story of progress at both population and service levels. The first level focuses on the results achieved at a population level in making progress towards

achieving the vision and outcomes. The second level focuses on results achieved at a service level and in particular on performance, benchmarking, and the quality and safety of services.

A preliminary set of indicators is included below. The Mental Health Commissioner will work with the sector during 2012/13 to refine the measures and indicators to ensure they help us understand what progress is being made.

4.1   Population level monitoring

This component of the monitoring framework provides high-level indicators drawn largely from the Mental Health Commission National Indicators Report. Data has been collected on most of the indicators for the past two years so over time it will be possible to assess the degree of progress that has been achieved.

These measures provide a whole of society picture and many government and non-government agencies will potentially contribute to making progress. The underlying determinants of mental health are complex and multi-faceted and require action at many levels across a whole range of government agencies, DHBs, NGOs, communities as well as the health sector. The measures are descriptive and will provide a basis for further in-depth research if required.

It is not possible to measure the individual contribution to achieving the outcomes, so this set of indicators endeavours to aggregate the contribution of everyone and show how collectively progress has been made on achieving the outcomes. Further work will be required in the future to develop measures which more accurately show progress in improving the mental health of the population, health services delivery and social inclusion.

Population level measures and indicators

Measure	Indicator
1. Access to services	The proportion of people who accessed mental health services in the last 12 months. *Source: Ministry of Health.*
2. Youth suicide	Age-standardised suicide death rate by gender and age group. *Source: Ministry of Health.*
3. Isolation	The proportion of people aged 15 years and over who have felt isolated from others in the last 4 weeks. *Source: New Zealand General Social Survey.*
4. Access to addiction services	The proportion of people who wanted help to reduce their level of alcohol or drug use in the last 12 months but did not receive it. *Source: New Zealand Alcohol and Drug Use Survey.*
5. Mental health and wellbeing	The proportion of people aged 15 years and over who reported that they were 'very satisfied' or 'satisfied ' with their life as a whole. *Source: New Zealand General Social Survey.*

6. Clinical outcomes	The proportion of people aged 15 years and over who scored 12 or more on the Kessler 10-item scale. *Source: New Zealand Health Survey.*
7. Housing	The proportion of people 15 years and over who are 'satisfied or 'very satisfied' with the housing they are currently living in. *Source: New Zealand General Social Survey.*
8. Involvement in decision making	The proportion of people who use mental health and addiction services who 'agree or 'strongly disagree' that their opinions and ideas are included in their treatment plan. *Source: National Mental Health Consumer Satisfaction Survey.*
9. Information and knowledge	The proportion of people who use mental health and addiction services who 'agree' or 'strongly agree' that staff provided their family with the education or supports they need to be helpful to them. *Source: National Mental Health Consumer Satisfaction Survey*
10. Employed and satisfied with job	The proportion of people aged 15–64 years who are employed and have been satisfied with their job in the last four weeks. *Source: New Zealand General Social Survey.*

It is important to note that these indicators are usually collected for people aged 15 years and over. The next step should be to develop indicators that are appropriate for those individuals under the age of 15 and, in some areas, over the age of 65.

Improving population level monitoring

The dataset above has been chosen because in most areas there is a baseline from which to measure future progress and the data is available. However, there may be other measures that fill gaps and better reflect progress in particular areas. One such area is life expectancy of people with mental illness and addiction. There is an opportunity to add specific new questions to the National Health Survey for the future.

It is envisaged that this dataset will evolve and be modified in line with sector priorities, available data, new and better measures which may replace or supplement those currently collected.

The dataset is made up of quantitative data currently and would be enhanced by the addition of qualitative data. Qualitative research into areas such as resiliency and service user and family experiences of services would provide a richer picture of progress.

The frequency of reporting will largely depend on the availability of the data, but a public reporting regime of every two years is recommended. This will enable comparison of change over time to be available in the public domain.

4.2 Service level monitoring

This component of the monitoring framework provides a range of indicators that can be used by the mental health and addictions sector to provide an overall picture of progress at the service level. It is not a dataset designed to monitor accountability. A much broader set of measures are required across several domains to build a picture of what has been achieved at specific service levels.

The purpose of monitoring at a service level is to:

- Demonstrate system and organisational performance improvements.

- Understand national and district levels of variation.

- Provide a basis for benchmarking service delivery.

- Bring about transformational change.

- Support continuous quality improvement.

The Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services (KPI) currently provides a quality and performance improvement framework for the specialist mental health and addiction sector. The framework has agreed performance targets and has provided a successful methodology for DHB and NGO providers to benchmark and utilise data to undertake quality improvement within their services. KPI participants have focused on specific clusters of indicators including continuity of care and productivity to demonstrate change to service delivery.

The KPI project currently has a focus on adult specialist services and will be broadened to the wider sector in the future.

Data available from the Ministry of Health mental health and addiction information collection, PRIMHD can also help paint a picture of what is currently occurring at a service level and measure achievement against the goals of Blueprint II.

During the consultation phase of Blueprint II, stakeholders clearly signalled the need for the sector to move away from an inputs or 'service recipe' model towards an outcomes-oriented approach that enables flexibility and supports innovation at all levels of the system. Stakeholders described the unique challenges of responding to their local populations, local political environment, priorities, workforce, evidence and service model ideas. Clearly each region, district and/or locality is unique. Monitoring progress can be achieved at multiple levels and aids in peer accountability through benchmarking, sharing examples of innovation and change, as well as interpreting trends and helping us to answer the question 'why is this happening?'.

The following set of measures and indicators are a sub-set of the KPIs for the mental health and addiction sector that are considered useful to assist the monitoring of progress against Blueprint II. The full set[147] can be used at district (DHB and NGO), service and team levels in addition to the existing national benchmarking streams.

Service level measures and indicators

Measure	Indicator
1. Access to services	• Client index (a classification of each service user at their first recorded contact with an organisation that indicates whether they are new, not seen in the last year, or seen in the last year). • NGO services investment. • Average length of acute inpatient stay. *Source: KPI Project.*
2. Continuity of care	• Pre-admission community care. • Total HoNOS score (inpatient) (measuring size of improvement or deterioration in adult service user outcome). • Post discharge community care. • 28-day acute inpatient readmission rate. • Average length of residential rehabilitation facility stay. *Source: KPI Project.*
3. Productivity	• Percentage of contact time with client participation. • Community service user related time. • Community treatment days per service user. *Source: KPI Project.*
4. Efficiency	• Child and youth clients accessing mental health and AOD services. • Relapse prevention planning. • DHB provider average bed occupancy rates. *Source: Ministry of Health.*
5. Organisational health	• Total staff turnover. • Sick leave usage. *Source: KPI Project*

Note: Many of the indicators listed above are able to be reported for DHB and NGO services and in some instances whole of sector reporting is possible to provide a systemic picture of performance.

As with the population level indicators, a public reporting regime of every two years is recommended. This will enable comparison of change over time to be available in the public domain.

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147   The full KPI set can be found at http://www.ndsa.co.nz/LinkClick.aspx?fileticket=u9p3cyK1I1U%3D&tabid=95.

Improving service level monitoring

An indicator is a measure that provides a summary of a condition or issue and allows the observation of progress or change. When measured over time, an indicator can give a clear picture of whether things are improving or declining with respect to the condition or issue it is being used to measure. Indicators are reported at different levels according to the performance they are seeking to measure. These levels include national, regional, district, organisational and individual team or practitioner level. The mental health and addiction KPI work reports indicators at a national organisational level so that nationally consistent comparisons can be made. District and team level investigation and reporting is undertaken by contributing DHB and NGO providers and enables an in-depth understanding of performance and the impact of quality improvement initiatives.

In order to help to reduce subjectivity in the selection of the indicators, they have been selected using the KPI criteria (adapted from the Australian criteria) which are used to evaluate the suitability of individual indicators and the overall set of indicators.

Criteria for individual KPIs

- Worth measuring.
- Measurable for diverse populations.
- Meaningful.
- Power to influence.
- Measurement over time will reflect results of actions.
- Feasible to collect and report.
- Demonstrable variation with potential for improvement.
- Technically sound.
- Minimises unintended consequences.
- Identifies inequalities.

Criteria for the entire set of KPIs

- Capable of leading change to support recovery.
- Cover the spectrum of mental health and addiction performance issues.
- Suitable for benchmarking.

In some areas there is no readily available data to support the development of indicators to help us tell the full story, so a nationally consistent set will need to continue to be developed over time. Qualitative research into areas such as the degree of change that has taken place from contracting for inputs and outputs to contracting for outcomes, understanding what level of change has occurred to models of care and other service changes would provide a richer picture of progress.

Recent consultation with the sector has suggested the following areas for future development of measures/indicators:

- Percentage of people with high need/low prevalence disorders receiving better services.
- Housing security and employment status for people with high need/low prevalence disorders.
- Percentage of people accessing priority services.
- Percentage of people with mental illness and addictions that are employed and/or in the education system.
- Percentage of people who use consultation/liaison and brief interventions to general healthcare services including primary care, prison-based care, maternity services, child/youth/family services, special education services and other general health services.

- Waiting times for services.

- Percentage of people accessing psychological therapies in primary care.

The KPI framework and methodology will expand its scope into child and youth and has the capacity to be applied across the broader range of mental health and addiction services and primary care and to develop indicators that align with changing need and policy direction. Blueprint II supports the use of the framework to assist with the measurement of progress and to highlight the success of the service responses.

The concept of setting national targets for population and service level measures has been considered, but currently this is difficult because in several areas there is only one to two years' data or no current data. It would be prudent to develop targets for the future, in key areas such as those identified above that have the support of the mental health and addiction sectors.

4.3 Supporting a culture of innovation and evaluative learning

To achieve the step change, Blueprint II is calling for innovative approaches to how we currently plan, design and deliver services. Innovation means a new way of doing something, which may refer to incremental, radical or revolutionary changes in thinking, products, processes or organisations. The prime goal of innovation activity is to bring about positive change to make someone or something better. The international literature considers that innovation is central to growth of outputs and productivity. Innovations can improve the quality and efficiency of work, enhance the exchange of information and improve the ability to learn and utilise knowledge and new technologies.[148]

Alongside innovation we need to create a learning culture which combines both monitoring and evaluation. Evaluation is needed to determine if an initiative has led to the expected results; has achieved genuine change; is financially sustainable; has resulted in lessons learned; has the ability to transfer learning to other areas; and should be spread to other areas.

A well-functioning monitoring and evaluation system provides strategic information to make good decisions for managing and improving programme performance, formulating policy, programme planning and meeting accountability requirements.[149]

If they are well-designed, evaluations should assist with strengthening services, using resources efficiently and effectively, and be a vehicle to share models of success. An evaluation for learning will assist with strengthening the initiative as well as organisational planning, and provide the agents for change with the information to guide ongoing change.[150]

4.4 Continuous quality improvement and accountability

There is growing evidence that people and organisations are more accountable and open with each other (as peers) through appropriate self assessment as an enabler for change. Emerging research is indicating that peer processes for accountability are a key performance influencer, often leading to greater levels of 'stand out performance' than traditional top down approaches.[151]

Complementing Ministry of Health, National Health Board and Health and Disability Commission monitoring and accountability mechanisms with a greater level of peer accountability is recommended. There are opportunities to build on existing processes, for example Mental Health Commissioner sector visits, national KPI benchmarking processes, sector interest/stakeholder groups to provide the foundations for a nationwide, whole of sector peer monitoring and accountability approach.

148 Organisation for Economic Cooperation and Development. 2005. *Oslo Manual: Guidelines for Collecting and Interpreting Innovation Data*. Third edition. Luxembourg: Organisation for Economic Cooperation and Development.
149 Global Fund. 2009. *Monitoring and Evaluation Toolkit*. Third edition. Geneva: Global Fund.
150 York P J. 2003. *Learning as We Go: Making Evaluation Work for Everyone*. New York: The TCC Group.
151 Grenny J. 30 May 2010. "Peer Accountability the Ultimate Performance Driver." *Jakarta Globe.* http://www.thejakartaglobe.com/opinion/peer-accountability-the-ultimte-performance-driver/377770.

A key strength of the KPI project has been the provider governance, ownership of information and commitment to the principles that guide the benchmarking process. Providers agree to any publication and alternative use of the data other than that mandated within the KPI project. We also recognise that supports and incentives, rather than coercion, are helpful in building a culture of transparency and continuous quality improvement, through self assessment, peer review and benchmarking.

Building a culture that supports and commits to public reporting will aid in improved accountability and transparency, and also ensure that services routinely monitor the quality of their performance and make this information available to all stakeholders, consumers, clinicians, service managers and policy makers, allowing for comparisons against national benchmarks. It is anticipated this approach would encourage a continuous cycle of quality improvement, leading to better outcomes for consumers.

5. Mental Health and Addiction Really is Everyone's Business

Blueprint II describes a vision where everyone plays their part in protecting and improving mental health and wellbeing. From whole of person through to whole of government, mental health and addiction really is everyone's business.

Whole of person

Everyone has a role to play in maintaining their own health and keeping well. It is common knowledge that we do many things to maintain our physical health, such as eating healthy foods, staying active and not smoking. We individually have a responsibility to take the same approach to mental health and addiction. We have a responsibility to seek help when needed and use the support available to support recovery and build resiliency. We all have a responsibility to see ourselves and others as 'whole people'.

The importance of taking a 'whole of person' approach in health and social services in New Zealand has been around some time. In 1982 Professor Sir Mason Durie developed a holistic health and wellness model named Te Whare Tapa Wha. The four elements of the model are:

1. Te taha hinengaro: mental health.
2. Te taha tinana: physical health.
3. Te taha whānau: family health.
4. Te taha wairua: spiritual health.

This approach ensures that all the elements that contribute to a person's health and wellbeing are taken into account.

Whole of family/whānau

The Mental Health Commission has long championed the need for supporting and including family/whānau in the decisions and care of their family member with mental health and addiction needs. This is because of the growing evidence of the importance of family/whānau support in keeping their loved ones well. Family/whānau need to be involved, and understand what is being suggested for their loved one. They also need to be able to freely offer their views and be part of the team providing support.

Whole of community

Strong communities and community networks are critical to being able to realise the Blueprint II vision. Communities and the people in them are the day-to-day eyes and ears to the real impacts of mental health and addiction issues. Communities also reap the rewards if we can get things right. Ensuring that communities are involved in the decisions that affect them is very important and that they have the information and knowledge to be able participate is crucial.

Communities must continue to champion programmes such as 'Like Minds Like Mine' to ensure that the gains made in raising the awareness of mental health and wellbeing issues are maintain and that communities see the key role they play in helping people keep well. NGOs also have an invaluable role in supporting people to keep

well and stay well. Their strong links to community are important factors to maintain. Blueprint II's vision highlights the need for increased community involvement and understanding of mental health and wellbeing – from improving prevention through to supporting recovery, building resiliency and assisted living.

Whole of health

If you work in the health and disability sector, you will know about the importance of working with others in the sector to benefit the health of consumers and their family/whānau. Relationships between primary care, emergency departments, mental health and addiction services, and secondary care services, for example, need to become even more linked up. Improving information systems will help, so too will improving relationships and connections between services. This will mean many people will never need to enter a mental health and addiction service because the preventative or early intervention required has been successful.

Those involved in the mental health and addiction sector have a critical role to play in making change happen. There will be some areas of the health and disability sector which will need their support to gain knowledge and shape their services to better meet the mental health and wellbeing needs of consumers and their family/whānau. The mental health and addiction sector also understands the importance of including consumer and family/whānau advice in the shaping of services, and this knowledge too, needs to be shared with others in the sector.

Whole of government

Fortunately there is already a sense of urgency around the need to change things to improve the mental health and wellbeing of New Zealanders by doing things differently. In many respects, the changes required are starting to happen, albeit with variation across the country.

Whole of government initiatives that run at the national, regional and local level will all be necessary. That means networks and relationships across sectors to connect information, knowledge and experience will be vital. Every government agency has a role to play in making this happen.

People working in the justice, education, social welfare, and health sectors have critical contributions to mental health and wellbeing, from developing national policy through to operational and front-line services.

5.1 Specific organisations and stakeholders

A range of stakeholders have roles to play to make change happen:

Health and Disability Commission

One of the reasons for the success of the initial Blueprint was the Mental Health Commission's ownership, advocacy and monitoring role to ensure it remained on the radar of the sector.

Blueprint II requires a similar host organisation. From July 2012 the functions of the Mental Health Commission will be integrated into the Health and Disability Commission.

From within the Health and Disability Commission the Mental Health Commissioner will be well placed to take on the role of supporting the ongoing development of Blueprint II and the 18-month to two-year implementation phase.

A detailed plan is required to ensure the ongoing monitoring, advocacy and implementation of Blueprint II remain high priority for the commissioner inside this new organisation.

Ministry of Health and the National Health Board

On its own the Health and Disability Commission will not have the resources or mandate to fully support the ongoing development and implementation required to achieve Blueprint II. The Health and Disability Commission requires strong partnerships across the sector. The initial partnerships required are with the Ministry of Health

and the National Health Board. This partnership will support the changes needed to policy settings and new guidelines for district annual plans.

Blueprint II represents a new opportunity for the Ministry of Health and the National Health Board to take on a sector leadership role across the sector and across government. This role would be reflected in the frameworks such as monitoring and accountability and approaches to performance monitoring.

It is important that the Ministry of Health:

- Continues to champion the development of the mental health and addiction sector and use its leadership role and relationships to help mobilise effective change.
- Identifies one or two mental health and addiction related health targets and drives DHB performance around these targets.
- Links with other government agencies to champion cross-sector outcomes and agree joint key performance indicators.

The National Health Board has a pivotal role in aligning investments in information architecture, information intelligence and service and clinical workforce required to ensure things are how they need to be.

DHB funders and planners

As the architects of the service system, DHBs and regional planning structures are critical to making change happen. They provide the local governance and change leadership needed to energise the sector and act at the catalysts for change. They have the resources and local leverage to support the realisation of the way things need to be.

Blueprint II signals a significant shift towards an outcomes-oriented view. To support this, a different orientation is needed to:

- Improve understanding of the populations they support (eight life course clusters).
- Incorporate the Ministry of Health's Service Development Plans[152] and Blueprint II's life course and population approach into planning.
- Understand and apply clinical evidence.
- Actively engage in service, performance and productivity development and implementation initiatives.
- Improve use of workforce – right person, with right skills, doing the right job.
- Transition NGO and other provider contracts to have fewer input based measures and more output and outcomes based indicators.
- Maintain and further develop local, district and regional networks.
- Support whole of system, cross service and organisation development.
- Actively look to support and lift the capabilities and competency of primary care and community NGO providers.
- Implement initiatives to further engage primary mental health.

NGO providers

NGO providers are critical to providing a full range of support to people with mental health and addiction needs. To make change happen requires NGO providers to continue to improve the services they provide as well as the relationships they have with funders and other providers including primary care and specialist services.

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152 The Ministry of Health is leading the development of a five-year Service Development Plan which will articulate government policy on developments in health-funded services.

- Actively engage in service, performance and productivity development and implementation initiatives.

- Actively look to support and lift the capabilities and competency of primary care and community providers.

- Form partnerships of consortia across providers to create efficiencies and to enable integrated delivery of services.

Specialist services

To realise the vision of Blueprint II there needs to a broadening of responses across primary, secondary and community services. It is important that in the process of broadening our responses the gains made over the last 10 years across specialist services are maintained, and that specialist services are seen, by themselves and others, as central to a well-functioning, coherent, holistic support system. In particular specialist services need to:

- Continue to see their role as broader than supporting just people with high needs.

- Use their experience and knowledge to support the wider workforce (GPs, nurses, Plunket, teachers) to support people with mental health and addiction needs.

- Spend more time on liaison and support functions with others.

- Maintain and develop new partnerships with other agencies.

- Provide specialist services closer to home.

Primary care

Primary care providers have a major role to play in realising Blueprint II. With one in four presentations in primary care having a mental health or addiction component it is critical that primary care embed day-to-day practices that put the mental health and addition needs of people on par with physical needs.

Primary care should:

- Recognise and respond to mental health and addiction need with the same level of importance as physical needs.

- Increase access to organised mental health and addiction responses in primary care.

- Actively engage in service, performance and productivity development and implementation initiatives.

- Work with specialist services to support shared care arrangements and the ability to provide step down support.

Appendix 1: Investment and Sustainable Resourcing to Improve Mental Health

Blueprint II recommends three key changes to funding arrangements to support its aims. This appendix outlines the background to those recommendations.

Current funding arrangements for mental health and addictions have largely met their aims to increase access and investment in health services

Funding for mental health and addiction services within the health sector is currently organised through a complex mix of:

- Population based funding.

- Annual Blueprint or priority project increments.

- Ringfenced funds for largely specialist mental health and addiction services.

With this funding, DHBs commission a range of services for their local population using a variety of nationally consistent contracts (often based on the Nationwide Service Framework for mental health and addiction) or specific local contracts.

These funding and commissioning arrangements were put in place to support the implementation of the initial Blueprint and broader mental health and addictions strategies. These arrangements helped to:

- Increase people's access to specialist services through a recovery-based model of care, particularly for the 3% of the population with severe conditions who need care each year.

- Increase investment to the mental health and addictions sector from a position of relative under-investment.

- Develop and increase a broader range of 'community' based services.

- Increase the capability, capacity and competence of the mental health workforce.

For the majority of DHBs in New Zealand the objectives of the initial Blueprint have largely been met. 14 out of 20 DHBs are at or above the 3% access target.[153] In addition, investment in mental health and addiction has come a long way.

Continuing current funding arrangements are not likely to meet the needs of Blueprint II and contemporary challenges

There are two key drivers to modify our approach to funding of the mental health and addiction sector: investment levels within tight fiscal constraints and the broader aims of this Blueprint II. These are discussed in turn.

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153   Ministry of Health. 2010. *Mental Health and Alcohol and Drug Sector Performance Monitoring and Improvement Report 2010/11*. Wellington: Ministry of Health.
Ministry of Health. 2009. *Mental Health and Alcohol and Drug Sector Performance Monitoring and Improvement Report 2009/10*. Wellington: Ministry of Health.

Investment within fiscal constraints

The traditional focus on increasing investment in the mental health and addiction sector has been shifting to more of a focus on maintaining investment in step with the rest of the health sector over the last few years and on reinforcing a focus on maximising the outputs and outcomes for that investment. This is being driven by the tighter fiscal environment as well as a sense that investment levels in mental health and addictions is now relatively similar to other health services.

The broader aims of Blueprint II – the need for flexibility, integration and interagency working

Meeting a person's health needs is often key to maximising quality of life. While important, health needs are only one component. The often used statement that consumers are also looking for 'a job, a house and a date on Saturday night' indicates that to achieve a high quality of life involves multiple areas of need across a range of organisations and services.

Funding arrangements aligned to organisational needs rather than a broader system view can mean that services can fall short of a holistic response to recovery and building resilience of consumers and their family/whānau.

When we take a broader system view of who funds mental health and addiction services currently, there is a significant portion beyond the current mental health and addiction ringfence (see the diagram below).

Combined with the broader aims of Blueprint II this mix is likely to continue or even increase, driving a need for greater flexibility and collaboration – both within the health sector and with other agencies.

Who currently funds mental health?
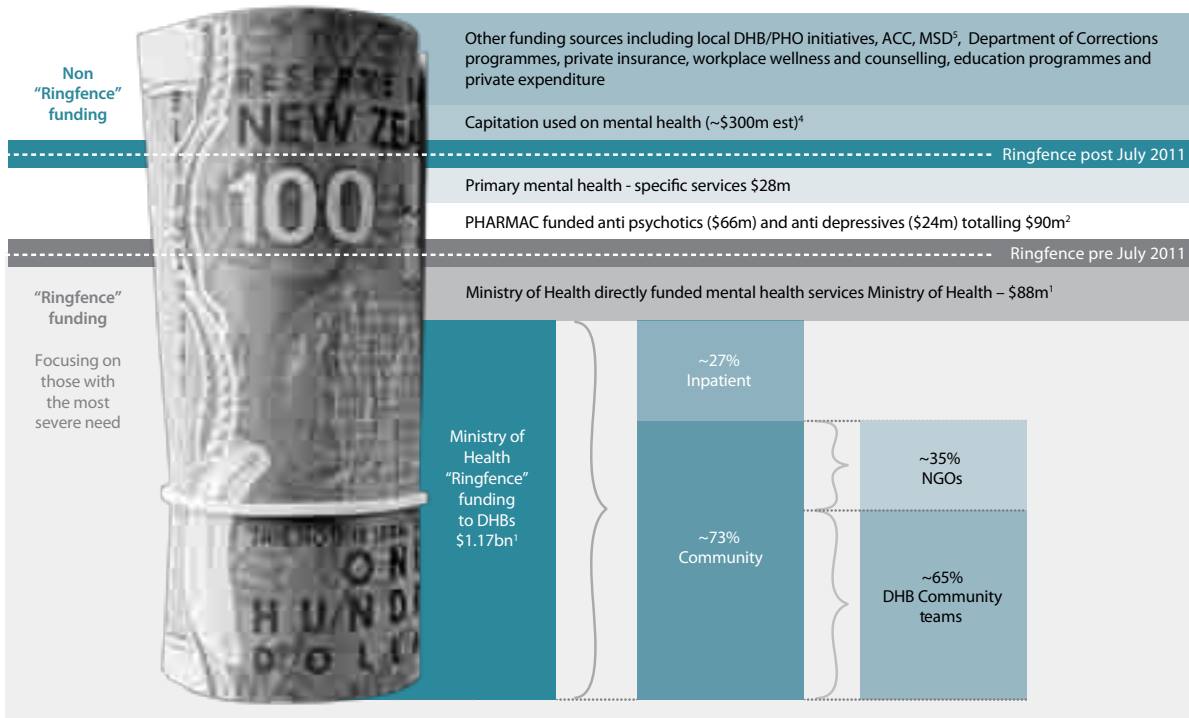
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1   Ministry of Health: 2010 *Mental Health and Alcohol and Drug Sector Performance Monitoring and Improvement Report 2009 / 10.* Wellington: Ministry of Health.

2   PHARMAC. 2010. – *Annual Review 2010.* Wellington: PHARMAC.

3   ACC. 2010 *Stocktake of Government Expenditure on Sexual Violence Services. Wellington: ACC.*

4   Health Workforce NZ. 2011 *Mental Health Workforce Report.* Wellington: Health Workforce NZ.

5   For example, mental health services for children in care.

Blueprint II outlines a vision based on:

- Responding earlier and more effectively to mental health, addiction and behavioural issues.

- Improving equity of outcomes for different populations.

- Increasing access to mental health and addiction responses.

- Increasing system performance and our effective use of resources.

- Improving partnerships across the whole of government.

To achieve this vision, changes to the way services are delivered is needed. That is, greater levels of self management, greater delivery of specialist services alongside community and primary care services, enhanced services delivered within primary care and co-ordinated activities with other government organisations and businesses. These changes pose some challenges to current funding arrangements.

Challenges within current funding mechanisms

The following policy settings are creating barriers to implementing the changes needed:

- **The scope of the mental health and addiction ringfence.** Traditionally, mental health and addiction ringfenced funds were only to be used on specialist mental health services to meet the needs of people with the most severe conditions and high needs (estimated to be 3% of the population). The funds could not be used by any other health services (such as medicine), or to support those with mild-moderate conditions. This has been challenging for DHBs especially for those who have met the 3% target and want to fund better services for those with mild to moderate conditions, preventative activities or interagency activities. The Ministry of Health started broadening the scope of the ringfence in late 2011 to allow DHBs who had reached their 3% access rates greater flexibility in the use of the funds within their ringfence (but still to be spent on mental health and addiction services). Further, the inclusion of primary mental health and community anti-psychotics in the ringfence for 2011/12 has widened the scope further.

- **The way that the DHB ringfence is set each year.** Population based funding determines a DHB's overall funding but the ringfence is based on previous year's expenditure. So difficulties arise when:

  - DHBs accept additional targeted mental health and addictions funding greater than their increase in population based funding as those increments need to be found from within a DHB's overall population based funding in subsequent years, and

  - DHB's populations decrease in size or mix which means any increases in the mental health and addiction ringfence has to come from their broader budget.

  As a result of the current model mental health and addiction ringfence funding for some DHBs is now well in excess of the mental health component of their population-based funding, whereas for others it is well under.

The changes needed to support Blueprint II

Funding arrangements to support Blueprint II need to signal a broader approach, one that has greater alignment to populations and supports interagency activity and different models of care.

There are three key principles that guide the recommended changes in funding:

- **Protect the gains made to date.** Great gains have been made over the last decade through investment and service development in mental health and addiction services up to levels similar to other health services. There are significantly improved services, increased access for those most severely affected by mental health and addiction issues and increased range of community support options that

reflect diversity of our growing populations. We need to ensure that the investment and service gains are not lost.

- **Allow greater flexibility to achieve innovation, service shifts and collaboration** across multiple services and sectors to achieve the service shifts, outcomes and system performance indicated in this Blueprint II.

- **Drive a greater focus on outputs, outcomes and service shifts.** To support the implementation of Blueprint II the accountabilities and targets for DHBs and other agencies need to be based on outputs, outcomes and key service shifts. The Ministry of Health and DHBs would focus on key recovery and population targets with an expectation that these outcomes would increase year on year. Common outcome targets across government agencies would orient investment across multiple agencies to deliver a more holistic consumer response and system benefit.

  Some of the more traditional measures such as the number of FTEs/100,000 serving that group would be used to help share learnings nationally and regionally (for example, within the KPI project) but not be used as an accountability measure.

So do we still need a ringfence? Short term: yes; medium term: possibly

Given the aims and principles above do we still need a ringfence? In the short term a modified ringfence is recommended with a review in three to five years.

There are potential benefits of removing the ringfence but also potential risks. The benefits include the potential for greater flexibility and integration across all health services as well as giving DHBs greater overall flexibility to manage their allocated funds. However, there are significant risks that without clearer accountabilities, outcomes and stronger targets for mental health and addictions, that the significant gains in investment and improved outcomes for patients and family/whānau are reduced.

To safely remove the mental health and addiction ringfence three critical components must be in place:

- A robust outcome and outputs framework that can be accurately measured.

- A highly visible performance framework and clear targets for DHBs and providers which places emphasis on outputs, outcomes and key service shifts (rather than inputs). The framework needs to have incentives for good progress with implications for declining outcomes/outputs.

- A set of highly visible cross agency outcomes with strong accountabilities and targets to help align investment across multiple agencies to deliver better joined up outcomes for patients and family/whānau, particularly in key government priority areas (such as at-risk youth).

It is recommended that work begin on these critical components immediately. However, **in the interim the funding ringfence needs to stay in place to protect the gains made to date but with modifications.** With this in mind it is recommended that three key changes are made to funding arrangements to support Blueprint II. The need for a ringfence can then be reviewed again in three to five years.

Three key changes: flexibility, a population-based ringfence and targets/ accountabilities based on outputs and outcomes

Change 1: Flexibility

The first change would be to reinforce and potentially expand the recent moves to allow greater flexibility in how mental health and addiction ringfence funds can be invested. Ringfenced funds would still need to be spent on mental health and addiction services but with greater flexibility where alongside investments in speciality services, funds could also be spent on mental health promotion, primary care, and other community services to

name a few. DHBs will be able to orient their funds to the Blueprint II aims – for example, to fund services that will expand the groups served while maintaining services for high-needs patients.

This would need to be accompanied with progress against performance targets to show this greater flexibility is being used to best effect. This is outlined in change 3 below.

Change 2: Move to a population-based ringfence

The second change is to shift to a population-based ringfence rather than the current arrangement which is based predominantly on historic spend. Over time DHBs ringfence amounts would transition from their current levels to their estimated mental health and addiction population-based funding share. This would need to happen gradually because some of the key information needed to obtain an accurate mental health and addiction population-based funding still needs improving (for example, increased accuracy of PRIMHD and NGO data) and DHBs need time to transition.

Moving to a population-based ringfence will provide greater equity across DHBs and improve links between DHB population size, mix, needs and funding.

Switching to a population-based formula to set the target ringfence could happen within a year, however DHBs would need up to five years to transition from their current ringfence levels (see below). The technicalities of this shift are outlined below.

Setting the national quantum to be allocated

The first challenge is to identify the quantum of mental health and addiction funds at the national level that should be allocated via population-based funding to each DHB. This is currently done using the weightings from the last calibration of the population-based funding formula in 2006 (the last census) driven off individual DHB ringfences at that time. To maintain the relative amount of investment in mental health and addiction services input it is recommended that the mental health and addiction share is set at current levels and maintained over time. Currently the mental health and addiction share of population based funding is about 10% of Vote Health and 11–12% of total DHB population-based funding. By maintaining these percentages, as total DHB funding is increased, mental health and addiction funding at a national level will increase by the same proportions.

Identifying population-based, funding-based ringfence targets for each DHB

To move to a population-based mental health and addiction ringfence, the ringfence for each DHB would be made up of the mental health and addiction population-based funding share plus a portion of the overall funding for unmet need, in the same proportion that the mental health and addiction population based funding share amount is to the DHB's total population-based funding. This will enable some allocation for unmet need.

To reflect the increased focus on primary mental health it is recommended that the primary mental health funds currently held by the Ministry of Health are devolved to DHBs and included within the mental health population-based funding share. Now that these initiatives are established, it makes sense for this to be devolved and used within the overall ringfence, particularly given the greater flexibility articulated in change 1 above.

It is not recommended that anti-psychotic medications from the community pharmaceutical budget are included in the population-based ringfence targets or the expenditure against them as, relative to other areas, this is an area where DHBs have low levels of influence.

Transition arrangements for individual DHBs

Some DHBs currently spend much more on specialist mental health services than their population-based funding share and some spend much less. With any population-based ringfence, this would mean that, over time, DHBs that spend less would be expected to increase their investment in mental health and addiction and conversely others could potentially decrease their level of expenditure back to their population-based funding share amount.

To reflect the principles above of protecting the gains made to date and aiming to meet the key outcomes of Blueprint II it is recommended that further investment and/or disinvestment needs time and needs to occur in the context of the outcomes being generated locally. That is, if a DHB is spending less than their population-based share but continuing to increase its access targets and other key targets then they should not be required to increase investment each year, although they would be expected to do so over a five-year time frame. Similarly, if a DHB is spending more than their share but not achieving or growing their access targets and other key targets then they should not be allowed to disinvest.

The next calibration of the population-based funding is due after the 2013 census results are available, typically in 2014. This calibration will be able to use improved data, particularly within PRMHD and other areas. That may well alter population based funding values for each DHB. Therefore to allow a buffer, it is recommended DHBs spending more than their population-based funding would not be able to reduce their spend below an additional 5% of their population-based funding value. Similarly DHBs that spend less than their population based funding would be expected to increase their expenditure to 5% less than their population-based funding share value. Those DHBs between that +/- 5% buffer would be expected to maintain their relative expenditure at current levels.

A transition framework is suggested in the table below.

	DHB largely meeting their outcome targets and progress on service development	DHB not meeting their outcome targets and progress on service development
DHB expenditure UNDER their mental health population-based funding share	Expected to increase expenditure but allowed to transition slowly (five years) to their population-based share ringfence amount less 5% with increases in outcomes. Can be spent on a variety of service areas.	DHB closely monitored with expectations of increased investment to at least population-based funding share less 5% and improve outcomes.
DHB expenditure OVER their mental health population based funding share	Allowed to slowly decrease its expenditure but only to their population based share +5%. Plans and monitoring need to clearly articulate any service changes, particularly for those with low prevalence, high need disorders. Will need to continue to make progress against other outcome targets.	Not allowed to decrease its level of expenditure (after population and cost pressure adjustments). Given support and encouragement to learn from other DHBs and adapt services.

It is expected these transition arrangements will be negotiated between the DHBs and the Ministry of Health each year through the District Annual Plan process. Regardless however, it is expected that those DHBs spending below their population-based funding share would reach this new population-based ringfence amount within five years.

To support this population-based mental health and addiction ringfence some key elements need to be progressed including:

- The accuracy and reliability of the data used to generate the population-based funding formula. The population-based funding is due to be re-calibrated in 2015 using the 2013 census data. Greater accuracy of utilisation data (such as NMDS, PRIMHD, Primary Mental Health and NGO activity) and cost data for 2013 will greatly improve the accuracy of the population-based funding formula for mental health and addictions. Much of this work can be done through an expanded national KPI project.

- A sufficient number of key performance, service shift and output measures and monitoring need to be in place to guide the transition. This could be managed through broadening the scope of PRIMHD and the KPI project to confidently track outputs and outcomes.

- There needs to be reinforcement from the centre regarding the importance of mental health and addiction services, and the need for DHB Boards to maintain it as an outcome priority, for example, a health target and/or inclusion in the Minister's letter of expectation as well as promoting interagency outcomes at the national and local level.

- A decision support tool (currently being developed) which will be helpful in guiding DHB investment and funding allocation.

Change 3: A highly visible outcomes framework and targets

Arguably, the most important change in how funding is allocated and used is the outcomes and accountabilities that organisations are measured by which will drive investment both within health, providers and across other government agencies. We need to shift DHB and provider accountability targets to a greater focus on the outputs and outcomes achieved in step with this Blueprint II (for example, the broader access targets). This will be a more effective driver of our investment mix within mental health and addiction services (inside the ringfence) as well as other health, disability and government services (outside the ringfence).

This framework and targets will give assurance that DHBs new found flexibilities are being used to best effect, will guide their transition to a population-based ringfence as well as support more integrated investment across mental health and addictions and other services. The first set of revised targets and performance framework needs to be in place within a year and incrementally improved over the next three to five years.

The measures themselves need further development and are outlined in the monitoring sections within this document but are likely to include closer monitoring of access levels for each of the population groups, ages and ethnicities articulated in this document and monitoring against the eight action areas and service shifts articulated in Blueprint II. Any remaining use of the initial Blueprint resource guide and its associated expenditure target within any part of the sector should cease.

This outcomes framework and associated targets need to be highly visible. It will be against these that DHBs and other agencies will be held to account along with expenditure levels against population-based funding as one of many performance measures.

Funding arrangements between funders and providers

Following on from how funding is organised at the Ministry of Health/DHB level is how funding can be used to support and reinforce the outcomes and service shifts articulated in the Blueprint II vision. For example, improved efficiency in service delivery must be driven by a change of clinical practice locally between DHBs, their provider arm, NGO services and collaborations with other agencies. For these innovations to succeed a level of local funding flexibility and incentives are important, as well as local services networks and sound relationships between funders, providers and other agencies.

It is these changes in commissioning and performance measures that will help facilitate change. For example, one DHB recently reoriented the service expectations for a number of providers by focusing on face-to-face contact time rather than full-time equivalents. This contributed to increased outputs, access and service changes.

DHB Vignette

Somewhereville DHB is facing more financial pressure than ever. Its CEO is looking to make savings in mental health and addiction to help fund key initiatives such as the various employment agreements of previous years, particularly in medicine and surgery.

The DHB has just reached its 3% access target for mental health and addiction but is spending less than its mental health and addiction population-based funding share by 15%. During strategic planning and budgeting, the new ringfence rules mean the DHB is not able to require savings from the mental health and addiction budget. Instead a small amount of additional funding is invested in patients with co-morbid mental ill health and long-term conditions because this was identified as a key group of frequent admissions and ED attendances. This investment helped support the DHB's long-term sustainability.

The way that DHBs fund providers will help to:

- Create the necessary shifts in service loci (for example, inpatient to community where appropriate).
- Create incentives to drive improved outcomes.
- Create incentives to drive inter-sectoral collaboration.
- Drive greater levels of effectiveness and outputs for the funding being provided.

This will require:

- A level of local tailoring by each DHB and other funders of services based on shared learnings across these DHBs to achieve the results sought in the eight priorities.
- A review the reporting requirements within the Nationwide Services Framework to better reflect the national output and outcome KPIs, value for money and service expectations. This would help orient resources toward the outputs and outcomes outlined in Blueprint II.
- Sharing purchasing arrangements with other agencies funding mental health services.

Appendix 2: Implementing Effective System Change Approaches

To realise the vision outlined in Blueprint II will require substantial change to occur over the next 10 years. The evidence on effective change shows that action is needed at many levels to be successful. Each level needs to be aligned, with a common understanding of the context, values, issues and goals. This common understanding is provided by Blueprint II.

There are a number of different approaches to change. This appendix provides an overview of the evidence in relation to a number of approaches to change and outlines how to make change happen across three interrelated and connected levels: system, organisation and personal.

Change across whole systems or multiple organisations

When looking to achieve change across a system or multiple organisations we typically look at things such as innovation diffusion literature/initiatives, social movement theory (for example, The Tipping Point); complexity science and complex adaptive systems; economic theory (particularly macroeconomics), and certain leadership theories.

Innovations or new approaches (that is, changes) are often not taken up all at once. When many autonomous agents and organisations exist, there is typically some initial innovation and uptake by early adopters followed by the majority and finally laggards. [154]

As a reflection of that inflection point between early adopters and the majority, Gladwell described its features in *The Tipping Point* in 2000. He argued that this tipping point was facilitated by a few key individuals (connectors, technicians and salespeople) within a supportive context.

Lomas' summary[155] of the evidence on systems conducive to the spread of worthwhile innovation in 2008 include:

> "Priority from senior leadership, boundary-crossing intra- and inter-organisational interaction, reflective time, targeted persuasive communication, slack resources, and investments in social interaction – not just structures."

Mental health and addiction examples of change at this level include:

- The deinstitutionalisation movement which occurred in a few places initially, then progressively embraced the majority and now includes only a few laggards.

- The uptake of online CBT is rapidly increasing through high-profile support (for example, NICE guidance), high value for money in a fiscally constrained context and a number of early adopters.

- The New Zealand National Depression Initiative which is an example of a social movement that has managed to help destigmatise depression and mental health.

In summary, what is needed to support system level change includes:

- A clearly communicated common 'burning platform'.

- The right environment and incentives to support the direction of Blueprint II.

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154   Rogers Everett M. 1962. *Diffusion of Innovations.* Glencoe: Free Press.
155   Lomas J. 2007. *Formalised Informality: An action plan to spread proven health innovations.* Wellington: Ministry of Health.

- Networks to connect people to share information and experiences.

- Profiling, demonstrating, communicating effective change, innovations and early adopters.

- Credible leaders support these effective new innovations and practices.

- A supportive political and economic environment to promote change.

Change within Organisations

Achieving change within organisations has been extensively covered in management theory including theory on quality/continuous improvement and 'learning organisations'.

Lewin was one of the first authors on change outlining a three-stage process in 1947 where there is an initial unfreezing phase.[156] That then leads to a period of uncertainty when the change occurs and then a freezing period where the change is in place and becomes business as usual.

More recently, John Kotter, a frequently cited author in the area of organisational change, observed that 70% of all major change efforts in organisations fail because they don't take the holistic approach required. His 1996 book Leading Change outlined an eight-step process for successful change:[157]

1. Establish a sense of urgency.
2. Create a guiding coalition.
3. Develop a change vision.
4. Communicating the vision for buy in.
5. Empowering broad based action.
6. Create short term wins.
7. Never let up.
8. Incorporating changes into the culture.

Many of these concepts are incorporated into 'change management' disciplines particularly around project management and strategy implementation. That is, there is a planned destination and we have an end point that we need people to buy in to. These concepts work well when you have large amounts of control over your organisation and staff.

More contemporary change thinking has moved from 'planned' and 'managed' change to emphasis on emergent change. That is, as organisations we know we need to evolve to survive. Therefore the focus is about ongoing emergent change with an unknown destination rather than planned change.

This is reflected in work by Senge and others in relation to learning organisations where it is important to have a deep, whole of system, and sometimes mental and emotional, understanding of issues to overcome mental models to effectively achieve change.[158]

This ongoing emergent learning and improvement is emulated in key initiatives in relation to continuous quality improvement, lean thinking and 'Plan, Do, Study, Act' cycles. The Institute for Healthcare Improvement (IHI) promotes its collaborative methodology to tackle key issues. All of these approaches require supportive leadership. Different leadership styles often suit particular approaches to change more than others.

Mental health and addiction examples of change at this level include:

- The original Blueprint was an example of an initiative to support planned change within organisations.

- The national KPI initiative to support emergent change within each participating DHB. Key KPIs are

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156 Lewin K. 1947. "Frontiers of group dynamics." *Human Relations.* v1 5–41.
157 Kotter J. 1996. *Leading Change.* Boston: Harvard Business School Press.
158 Senge P. 1990. *The Fifth Discipline. The art and practice of the learning organization.* New York: Doubleday.

analysed and fed back to each DHB. They then meet periodically to present and discuss key results with each other through guided benchmarking and learning processes.

- The Mental Health Services within Counties Manukau DHB have been following a change programme for some 10 years now where there was initial urgency around bed shortages. They helped form a guiding coalition by reframing the problem and engaging key stakeholders. They collaboratively developed a future vision and communicated it, got some quick wins and now have a number of initiatives embedded as business as usual.

In summary, what is needed to support organisation level change includes:

- Planned change works well when you have control, emergent changes works well when people are connected, networked and there is less hierarchy.

- Access to improvement tools and methodologies such as toolkits and training to support 'Plan, Do, Study, Act' cycles, and the Productive Wards initiatives.

- Access to information, benchmarking and analysis to get a deep understanding of the system and issues (such as those seen within existing benchmarking processes).

- Supportive leadership and resources (primarily flexible use of existing resources).

- Staff with change capabilities and understanding.

Change within individuals

Achieving change within individuals has been extensively covered in various theories including behavioural theory including motivation, microeconomics and rational choice, learning, psychology, and marketing/communications. Stages of change models have been used to inform recently developed public health campaigns including ABC Smoking Cessation Education e-learning.

Behavioural theory and motivation

Much of the literature in the health sector relating to change within individuals is in relation to changing clinical behaviour and decision making. This is often with a view to reducing variation between clinicians and/or addressing gaps in practice where current practice is somewhat different to best practice. This is closely linked to quality improvement at the individual level and the delayed adoption of best practice (often seen in guideline implementation).

Much research has been undertaken around behaviour theory, learning and what motivates clinicians. For example, whether clinicians are pure economic agents or only motivated by an income threshold, or more vocational and altruistic drivers. The empirical evidence on what drives successful change is unsurprisingly a mixture of all elements. Therefore no single mechanism is that successful; for example, pure pay for performance or pure feedback.

Successful change requires a multi-pronged approach which typically includes:

1. Individualised feedback on performance (and how one compares to their peers).
2. Facilitation and mentoring to support interpretation and promote change.
3. Peer review and support.
4. Training in best practice supported by best practice information.
5. Decision support at point of care.
6. Incentives, which can be financial and non-financial.

Mental Health examples include the implementation of depression guidelines in New Zealand and associated resources.

Peer accountability:

Each region, district and/or locality is unique and Blueprint II offers a consistent framework of indicators to support stakeholders to make decisions. Blueprint II envisages routine benchmarking across teams, services and organisations as part of continuous learning and peer accountability. There is growing evidence that people and organisations are more accountable to and honest with each other (as peers) through appropriate self assessment and that this often leads to greater levels of 'stand out performance' than traditional top down approaches.[159] This approach encourages sharing examples of innovation and change, as well as interpreting trends and helping us to answer the question 'why is this happening?'.

In summary, what is needed to support individual level change includes:

- Access to personalised feedback (how one compares with peers).

- Facilitation, mentoring and peer review.

- Access to peer group sessions on current best practice.

- Education and training.

- Access to best practice bulletins/guidelines.

- Access to timely decision support for key clinical decisions.

- Incentives and recognition, financial and non-financial.

159 Grenny J. 30 May 2010. "Peer Accountability the Ultimate Performance Driver." *Jakarta Globe.* http://www.thejakartaglobe.com/opinion/peer-accountability-the-ultimte-performance-driver/377770.

Appendix 3: Contributors

Our approach to developing Blueprint II has been one of 'co-production', involving many in the sector under the guidance of an expert advisory group of sector leaders.

A literature review was carried out which, although not exhaustive, provided a broad view of emerging innovations both in New Zealand and overseas, as well as evidence of effectiveness and cost effectiveness of services for key population groups, services areas and specific speciality areas. This review provided valuable information to inform Blueprint II[160].

A consultation document was widely distributed and respondents asked to provide feedback on the core propositions and help shape the practical pathways of change and development. 184 submissions were received from a wide variety of respondents including consumers and family/whānau, service providers (DHBs, primary care and NGOs) and educators. An analysis of the submissions and the list of people who made submissions is available on **www.hdc.org.nz**.

Blueprint II also draws significantly on the findings of the Health Workforce New Zealand service review report Towards the Next Wave of Mental Health and Addiction Services and Capability,[161] as well as guidance documents from the Ministry of Health to the sector, including those on older people and dementia, primary care, the early years and youth forensic services and alcohol and other drug issues.

People involved in the development of Blueprint II

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Ian McKenzie	NDSA Networks, Northern Region
Judi Clements	Chief Executive, Mental Health Foundation of New Zealand

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160   The literature review is available on http://db.tt/uPlCwX5s.
161   http://healthworkforce.govt.nz/our-work/workforce-service-reviews/mental-health.

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Mental Health Commission and Project Team

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Sue Hallwright	Independent advice	Project
Sue Johnston	Contractor – independent	Project

Appendix 4: Glossary

7 Helpful Habits	A set of activities which are central to the CAPA approach in Child and Adolescent Services (CAMHS). The 7 helpful habits are handle demand, extend capacity, let go of families, process map, flow management, use care bundles, look after staff. These habits are now used across a range of mental health services not just CAMHS.
Addiction	The continued use of a mood altering substance or behaviour despite adverse consequences.
ADHD	Attention deficit hyperactivity disorder. A problem of inattentiveness, over-activity, impulsivity or a combination of these.
AOD	Alcohol and other drug.
Benchmarking	To evaluate or check something by comparison with the performance of others or with best practices.
CAMHS	Child and adolescent mental health services.
CAPA	The Choice and Partnership Approach is a clinical system developed by Consultant Psychiatrists Dr Ann York and Dr Steve Kingsbury. It is informed by capacity and demand theory and the development of a collective partnership between clinician and client that provides choice. For the clinician there is a shift in position from an 'expert with power' to a 'facilitator with expertise'.
Capacity Planning	Capacity planning is the process of determining the delivery capacity needed by an organisation or service to meet the demands for its products or services.
Care Plus	Care Plus is aimed at people with chronic health conditions, serious medical or mental health needs, or terminal illness. It provides extra funding to the primary care practice so that individuals can receive more intensive care.
CBT	Cognitive Behavioural Therapy is a form of psychotherapy in which the therapist and the client work together as a team to identify and solve problems. Therapists use the Cognitive Model to help clients overcome their difficulties by changing their thinking, behaviour, and emotional responses.
Cerebral palsy	An umbrella term for non-progressive non-contagious motor conditions that cause physical disability in human development, particularly in body movement.
Commissioning	A process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

Conduct disorder	A childhood and adolescent behavioural disorder characterized by aggressive and destructive activities that cause disruption in the child's environment.
Dementia	Loss of brain function which affects memory, thinking, language, judgement, and behaviour.
Determinants of health	The personal, economic, social and environmental factors that can influence the health status of an individual or population.
DHB	District Health Board. Government organisation responsible for providing or funding health and disability services in a defined geographical area.
E-therapy	Electronic therapy programmes aimed at helping people to resolve mental health or addiction issues.
Evaluation	A systematic process for collecting, analysing and using information to assess change that can be attributed to the intervention. It is a judgement about the value, progress and impact of an intervention.
Family	The service user's whānau, extended family, partner, siblings, friends or other people that the service user has nominated.
Forensic services	Services delivered in prisons, courts, community based and home based settings for people with mental health and/or co-existing mental health and addiction needs who are currently in the justice system.
GP	General Practitioner. A physician whose practice is not oriented to a specific medical specialty but instead covers a variety of medical problems in patients of all ages.
Health literacy	An individual's ability to read, understand and use health care information to make decisions and follow instructions for treatment.
Health promotion	A process of enabling people to increase control over and to improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.
Health Workforce New Zealand	The organisation responsible for the planning and development of the health workforce, ensuring that staffing issues are aligned with planning and delivery of services and that our health workforce is fit for purpose.
High prevalence conditions	Widespread conditions such as anxiety, depression, alcohol and drug issues, and medically unexplained symptoms.
Indicators	Measurable characteristics or variables which represent progress and are used to measure changes or trends over a period of time.
Integration	Coordination of services resulting in support that is seamless smooth and easy to navigate.
Interventions	An effort/activity to promote good health behaviour and/or prevent/improve or stabilise a medical condition.
IT	Information technology such as computers.

Kessler 10 item scale	The Kessler measure is a 10 item self-report questionnaire intended to obtain a global measure of psychological distress.
Kina	The Kina Trust supports organisations in development of family inclusive practices and programmes.
Lean Thinking	A quality and process improvement methodology, that emphasises consumer needs, improving quality, and reducing time delays and costs all through continuous improvement and employee involvement. At its core is the notion that it is critical to reduce waste throughout any system.
Let's Get Real	This is a workforce development framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.
Life course	All stages of life from prenatal to old age.
Mental health and addiction ringfence	Government mechanism to ensure that funding intended for specialist mental health and addiction services is used solely for those purposes.
Ministry of Health	Government agency whose functions are to provide strategic policy advice and ministerial services to the Minister of Health, monitor DHB performance and administer legislation and regulations.
Morbidity	The incidence of ill health in a population.
Mortality	The incidence of death in a population.
Nationwide service framework	A collection of definitions, processes and guidelines that provides a nationwide, consistent approach to the funding, monitoring and analysis of services.
Neurodevelopment disorders	These include autism, attention deficit hyperactivity disorder, learning disabilities, developmental delays and intellectual retardation.
New Zealand Triple Aim	An approach designed to simultaneously achieve improved quality, safety and experience of care, improved health and equity for all populations and best value from public health system resources.
NGO	Non-government organisations. Independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both government and the market.
Peer support services	Services that enable wellbeing, delivered by people who themselves have experienced mental health or addiction issues, and that are based on principles of respect, shared responsibility and mutual agreement/choice.
Perinatal	Of or relating to the time, usually a number of weeks, immediately before or after birth.
Prevalence	The total number of cases of a disease in a given population at a specific time.
Primary care	Essential health care that is universally accessible to people in their communities; the first level of contact with the health system.

PRIMHD	The Ministry of Health collection of mental health and addition activity and outcome data.
Psychological therapies	A group of therapies designed to improve mental health through talk and other means of communication.
Public health units	12 DHB-owned units providing regional public health services focused on environmental health, communicable disease control, tobacco control and health promotion programmes.
Recovery	Living well in the community with natural supports.
Relapse prevention plan	A plan that identifies early relapse warning signs of clients. The plan identifies what the client can do for themselves and what the service will do to support the client. Ideally, each plan will be developed with involvement of clinicians, service users and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each service user will know, and ideally have a copy of, their plan.
Resilience	The capacity of individuals to cope well under adversity.
Ringfence	See 'mental health and addiction ringfence'.
Self-management	Actions and decisions that people take to regain, maintain and improve their own health and wellbeing.
Serious mental health and or addictions	People who have serious ongoing and disabling mental illness and addiction issues, who require treatment from specialist mental health, alcohol and drug or other addiction services.
Service user	A person who uses mental health or addiction services. This term is often used interchangeably with consumer and/or tangata whaiora.
Shared care	Integrated health care delivery in which practitioners from more than one health service work in partnership to provide services to a service user and their family/whānau.
Six Sigma	A business management strategy which seeks to improve the quality outputs by identifying and removing the causes of errors and variability.
Social inclusion	The absence of barriers to full participation within a chosen community by a person or group.
Specialist services	Those mental health and alcohol and other drug services described in the National Service Framework and funded through the mental health ring-fence. This includes both DHB and NGO services.
Stepped care	An approach which uses the least intrusive care to meet presenting needs and enables people to move to a different level of care as their needs change.
Strengthening Families	A cross government programme where local support services work together to make sure families get all the services they need.

Talking therapies	Various forms of psychotherapy that emphasise the importance of the client or patient speaking to the therapist as the main means of expressing and resolving issues.
Targets	A set of national performance measures specifically designed to improve performance and to provide a focus for action.
Trauma informed therapies	Therapies specifically designed to address the consequences of trauma in the individual and to facilitate healing. This can include physical, sexual and psychological trauma.
Triple Aim	See 'New Zealand Triple Aim'.
Value for money	A term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it.
Well Child	A screening, surveillance, education and support service offered to all New Zealand children and their family or whānau from birth to five years.
Whānau	Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term whānau in this document is not limited to traditional definitions but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and each individual to define for themselves who their whānau is.
Whānau Ora	In this document Whānau Ora is used to describe government funded services or initiatives designed to place whānau at the centre and build on the strengths and capabilities already present within the whānau.
Whole of health	Includes all parts of the health and disability system including physical health services, disability services, mental health and addiction services and at all levels including self care, primary care, community care, specialist care and so on.
Whole of person	An approach which looks at all the needs of a person, including mental health and addiction needs, physical health, housing, employment, social supports, and so on. It can also be called a holistic approach.