

Rising to the Challenge

The Mental Health
and Addiction Service
Development Plan
2012–2017

Citation: Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

Published in December 2012 by the
Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-478-40230-8 (print)
ISBN 978-0-478-40231-5 (online)
HP 5604

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Minister's foreword

As Associate Minister of Health I am keenly aware of the inter-relationships between all aspects of health and wellbeing. These are no more evident than in the field of mental health and addiction.

Since the 1990s the mental health and addiction sector has been through significant growth and rapid change, not only in relation to the range of services available, the way they are provided and the strong emphasis on a culture of recovery, but also in terms of the expectations of people who use services, their families and whānau, and communities. The service changes have only been possible through the efforts of an innovative and energetic sector that is willing to make continual improvements and never stand still. Despite all the improvements over recent years, service quality and the level of access to services remain variable for people with mental health and addiction issues. It is essential we continue to make changes, with a renewed focus on earlier and more effective responses, improved outcomes, better system integration and performance, increased access to services, effective use of resources and stronger whole-of-government partnerships.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 provides further impetus for mental health and addiction services to increase national consistency in access, service quality and outcomes for people who use services, for their families and whānau, and for communities. It sets a service development pathway with clear actions to be achieved over the next five years, so that all New Zealanders can be confident that publicly funded health services are working in ways that achieve the most effective outcomes for those who most need them and that make the best use of public money. It reflects the key concepts of the Government's approach to health, and recognises the roles within, and external to, the health sector. It also recognises the contribution that the health sector makes to other key initiatives such as Drivers of Crime, Whānau Ora, Vulnerable Children and Welfare Reforms.

The goals and actions in this Plan reflect the input from a range of people in the mental health and addiction sector, and in other agencies. This gives me confidence that the sector, jointly with other agencies, will rise to the challenges set out in the Plan.

Achieving the actions in this Plan will require strong leadership. It will also require effective partnerships at all levels, recognising that everyone has a role to play in ensuring a well-coordinated effort and response to the challenges set out in the Plan.

Hon Peter Dunne
Associate Minister of Health

Acknowledgements

In presenting *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*, I would like to acknowledge all those who took the time to share their thoughts on how we might achieve the Government’s vision for ongoing improvements in the delivery of mental health and addiction services in New Zealand.

Thank you to all the stakeholders in the mental health and addiction sector, and in other sectors, who have contributed to this Plan. Many people with mental health and addiction issues have taken the time to provide their views, and this input, along with that of family and whānau members, has been critical in creating a plan that will advance the ability of publicly funded services to support resilience and wellbeing.

The input from people working in health services reflects the high levels of dedication and commitment within the sector. The fact that our discussion process attracted such thoughtful feedback from a wide range of stakeholders is a testament to your collective determination to see mental health and addiction services delivered in ways that meet the needs of those who engage with these services. The relationship between mental health and social wellbeing is echoed in many of your comments and provides a strong basis for a healthier society.

The Plan is not only intended for use within the mental health and addiction sector. It embodies the concept that good mental health and wellbeing are key aspects of the ways in which we live, work and play in the communities we share.

Once again, thank you for your involvement in developing this Plan. I look forward to your ongoing involvement in implementing the priorities identified in this document.

Kevin Woods
Director-General of Health

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Vision

All New Zealanders will have the tools to weather adversity, actively support each other's wellbeing, and attain their potential within their family and whānau and communities. Whatever our age, gender or culture, when we need support to improve our mental health and wellbeing or address addiction, we will be able to rapidly access the interventions we need from a range of effective, well-integrated services. We will have confidence that our publicly funded health and social services are working together to make best use of public funds and to support the best possible outcomes for those who are most vulnerable.

Introduction

Overview

This Plan sets the direction for mental health and addiction¹ service delivery across the health sector over the next five years. It articulates Government expectations about the changes needed to build on and enhance the gains made in the delivery of mental health and addiction services in recent years. It outlines key priority actions aimed at achieving further system-wide change to make service provision more consistent and to improve outcomes both for people who use primary² and specialist³ services and for their families and whānau. Mental health promotion, prevention and destigmatisation will be critical to achieving the vision; for this reason, the Plan includes actions in these areas.

1 In this document the term ‘addiction’ is used broadly to encompass alcohol and other drug issues, spanning the full spectrum of severity, from mild issues through to more serious addiction.

2 Including general practice teams, school-based health services, prison-based health services, and other first point of contact community health services provided by non-governmental organisations (NGOs).

3 Comprising all district health board (DHB) and NGO mental health and addiction services either funded from DHB ring-fenced mental health and addiction funding or directly funded by the Ministry of Health.

Context

The case for change

Several national documents have to date collectively provided the impetus for improvements across the mental health and addiction sector. Two publications in the mid 1990s set the initial direction: New Zealand's National Mental Health Strategy, *Looking Forward* (Ministry of Health 1994); and the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998). Further impetus has come from successive national strategies and policies (see Appendix I), as well as from additional funding.

Since the early 1990s there has been significant transformation in the way that mental health and addiction services are provided. The focus has shifted from institutions to support and treatment in local hospitals, the community and people's homes. There has also been an increasing emphasis on early intervention and on a culture of recovery, the process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential (Substance Abuse and Mental Health Services Administration 2012). This focus has made a significant difference to people's experience of services, and will continue to be a fundamental cornerstone for future change.

These two decades of significant growth and change have resulted in:

- > a significant increase in investment in mental health and addiction services, from \$270 million per year in 1993/94 to \$1.2 billion per year in 2010/11, when the total spending on mental health and addiction services was 9.5 percent of the total Vote Health budget⁴
- > 51 percent growth in access to specialist services, from 87,724 people in 2002/03 to 132,682 in 2010/11⁵
- > the closure of the institutions and significant expansion of community-based services. By 2009/10, 76 percent of mental health and addiction funding was being spent on community services,⁶ with the remainder spent on inpatient services⁷
- > the development of a strong non-governmental organisation (NGO) sector. By 2010/11, the total number of people accessing NGO service was 31,792 and 24 percent of mental health and addiction funding was being spent on these services.⁸ Today NGOs provide a wide range of support and clinical services and play a significant and integral role in addressing people's mental health and addiction issues
- > the development of culturally specific services
- > a focus on supporting recovery for people with the highest needs
- > strong involvement of service users in service planning and delivery
- > increased support for and involvement of families and whānau in service planning and delivery
- > the development of a range of primary mental health and addiction initiatives throughout the country
- > the roll-out of Like Minds Like Mine, a national programme to counter stigma and discrimination against people with mental illness.

4 Specialist mental health and addiction funding sourced from Mental Health Spend figures prepared by Mental Health Group. Vote Health actual expenditure sourced from Ministry of Health Corporate Finance, including Capital and Departmental Expenditure.

5 PRIMHD, PP6 report.

6 Includes non-Blueprint funding.

7 Blueprint Report 2009/10.

8 Blueprint Report 2009/10.

The pace and scale of change in strengthening and improving services have been remarkable, but we cannot stand still. Whilst there has been significant growth, development and improvement of services, these remain variable around the country. In addition, Māori continue to more frequently experience mental health and addiction issues (Oakley Browne et al 2006), inpatient admission, seclusion and compulsory treatment (Ministry of Health 2012a) than other groups. We also continue to have:

- > one of the highest rates of youth suicide in the developed world
- > high rates of the use of seclusion, with variation between district health boards (DHBs)
- > high rates of the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992, with variation between DHBs
- > variation in access to services especially for children and youth
- > variable waiting times for access to mental health and addiction services
- > variable alignment and integration between services provided by DHBs and those provided by NGOs
- > variable integration between specialist services and primary care
- > limited and variable primary mental health responses for people experiencing common but debilitating mental health and addiction issues and no ability to measure access to these primary mental health responses
- > gaps in responses for people with co-existing mental health and addiction problems, and those with co-existing mental health issues and disabilities
- > variability in the quality of specialist inpatient facilities.

To tackle these challenges, significant changes are needed to better meet the needs of those in our communities who use our services. We must take the time to consider cutting-edge practice and how we ensure that it takes place in all services across New Zealand.

In June 2012 the former Mental Health Commission launched two new documents that represent advice to Government based on a sector-informed vision:

- > *Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be* (Mental Health Commission 2012a)
- > the companion document *Blueprint II: Improving mental health and wellbeing for all New Zealanders: Making change happen* (Mental Health Commission 2012b).

These two documents emphasise the need to continue to make changes in order to meet future needs. The key themes are earlier and more effective responses, improved equity of outcomes for different populations, increased access, increased system performance, effective use of resources and improved partnerships across the whole of government. These directions are underpinned by a continued emphasis on recovery and wellness, with an additional focus on building resilience to effectively deal with future adversity.

Whilst recent years have seen major growth in funding and services, we have now entered a time of significant financial constraint. The economic and financial environment during the next two to five years is such that there will be very limited new funding within Vote Health. Any new funding that does become available is likely to be tightly directed towards specific services. Therefore, to achieve the changes needed, our major focus must be on using our current resources more effectively and increasing productivity. This will enable us to focus our attention on early intervention and strengthening primary–specialist integration.

Government priorities

The Government is focused on developing a better-performing public sector. The expectation is that the health sector will become more innovative, efficient and focused on delivering what New Zealanders really want and expect. At the same time, public services will have a sharper focus on costs and ensure value for money.

This Plan builds on and incorporates broader work reflecting the following Government priorities:

- > Youth Mental Health Project
- > Vulnerable Children work stream
- > Drivers of Crime work programme with a focus on conduct disorders and alcohol and other drugs
- > Youth Forensic Services development
- > Suicide Prevention Action Plan implementation
- > Whānau Ora initiatives
- > Welfare Reforms.

Because mental health and wellbeing are not created in a vacuum, this Plan also challenges all government services to think about how we can work together so that the communities we serve can be guaranteed consistent and seamless services. It acknowledges that many other issues impact on mental health and wellbeing, such as income, housing, education and employment, which is why boundaries must be broken down and greater cooperation between government agencies is expected. Achieving the vision articulated in this Plan will require a whole-of-government response including building on existing and emerging approaches to cross-sector planning, funding and service delivery, such as social sector trials. The work already under way in the priority areas listed above will progress the public sector's efforts to work collaboratively to improve mental health and wellbeing in New Zealand.

Blueprint II and the Service Development Plan

As noted above, the Blueprint II documents have provided an invaluable resource that has informed and shaped the development of this Plan. Many of the 'calls to action' outlined in the Blueprint II documents have been addressed in this Plan along with the key themes of improved outcomes, stronger integration, increased access, earlier intervention and shorter waiting times.

The documents differ somewhat in their focus. The Blueprint II documents cover a 10-year period, span health and social services and signal wider social responsibilities. On the other hand, this Plan has a five-year timeframe and a narrower focus on prioritised actions for the health sector.

There is one important difference between this Plan and the Blueprint II documents. This Plan uses four population groups and considers the specific additional needs of groups most disadvantaged by disparities in outcome (across all of the four population groups), whereas Blueprint II uses eight population clusters based on a 'life course' approach. The four population groups used in this Plan are:

- > people with low-prevalence conditions and/or high needs⁹
- > infants, children and youth with high-prevalence conditions
- > adults with high-prevalence conditions¹⁰
- > older people with high-prevalence conditions.

9 Psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions.

10 Mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms.

These four groups have been used because each group is largely discrete, whereas there is significant overlap between the clusters used in the ‘life course’ approach. There is also currently better baseline information available on the four groups, which can be used to understand, compare and improve performance and quality, including outcomes.

The Plan does not, however, lose the key messages that the ‘life course’ approach highlights, and reflects the focus on intervening at critical points in the lives of people with mental health and addiction issues where there is an opportunity to make a real difference by intervening early. So while the eight population clusters have not been used, the ‘life course’ approach has heavily influenced the prioritisation of service developments in this Plan, and particularly the emphasis on earlier intervention.

This Plan

Goals and actions

The primary focus of the Plan is to assist health services across the spectrum, from health promotion through primary care and other general health services to specialist mental health and addiction services, to collectively take action to achieve four overarching goals which arise from the context identified above. The four overarching goals are summarised in Table 1 below.

Table 1: The ABCD overarching goals and desired results

Overarching goal		Results we wish to see
A	Actively using our current resources more effectively	Increased value for money
B	Building infrastructure for integration between primary and specialist services	Enhanced integration
C	Cementing and building on gains in resilience and recovery for: <ol style="list-style-type: none"> i. people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions) ii. <ol style="list-style-type: none"> a) Māori b) Pacific peoples, refugees, people with disabilities and other groups 	Improved mental health and wellbeing, physical health and social inclusion Disparities in health outcomes addressed
D	Delivering increased access for: <ol style="list-style-type: none"> i. infants, children and youth ii. adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms) iii. our growing older population 	Expanded access and decreased waiting times in order to: <ul style="list-style-type: none"> • avert future adverse outcomes • improve outcomes • support their positive contribution in the home and community of their choice

For each goal, the Plan:

- > describes the desired results and the high-level measures of these
- > describes the prioritised actions for policy makers, planners and funders, mental health and addiction service providers (DHB and NGO) and primary care providers
- > identifies which of the prioritised actions can be implemented by making changes to existing services and which will require reprioritisation of existing funding, demographic funding (if available) or previously approved, targeted Government funding for specific services.

The actions in most sections of this Plan are universal, aimed at improving outcomes for all people with mental health and addiction issues. However, there are groups within New Zealand who experience significant and unnecessary disparities of outcome in relation to mental health and addiction issues. The actions in section 4 of this Plan aim to further progress efforts to address these disparities. These actions are additional to the actions in other sections; for example, progress in reducing disparities for Māori will be addressed not only by the specific actions in section 4 but also by actions across all other areas.

Successful achievement of our four overarching goals will rely on the considerable knowledge, experience and expertise of the health workforce. For this reason, the closing section of this Plan is dedicated to supporting and strengthening that workforce.

Roles and responsibilities

Realising the vision and achieving the goals outlined in this Plan will require the combined effort of the health and social service workforce. More than that, it will need the contribution of a ‘workforce’ beyond the public sector: communities that are inclusive; businesses that attend to the mental health and addiction issues of their employees; people, families and whānau who support one another; and people themselves playing an active role in preventing and recovering from mental health and addiction issues through self-management, because improving mental health and wellbeing is everyone’s business.

All New Zealanders will need to: look after their own mental health and wellbeing; support infants, children and young people in their social and emotional development and build their resilience so that they can weather future adversity; support people who are experiencing mental health or addiction issues; and better inform others who would stigmatise or discriminate against those people. In these ways all New Zealanders can create inclusive communities that play their part in supporting recovery.

New Zealanders with mental health or addiction issues must lead their own recovery, have personal power and take up a valued place in their family or whānau and communities. In addition, service users have a vital role to play in participating in and leading at all levels of the system they use, including planning, funding and delivery of services.

Hapū, iwi and the Māori community have an important role in shaping the way in which communities and services respond to people experiencing mental health or addiction issues and in supporting recovery for Māori who use services.

Families and whānau have a fundamental role in supporting recovery and wellness and their participation in service planning and delivery will be critical to the successful implementation of this Plan.

The Ministry of Health will have a key role in leading the implementation of this Plan across the health sector and in linking with other government agencies to ensure a whole-of-government approach to improving mental health and wellbeing in New Zealand.

DHB planners and funders will have a critical role in ensuring that the priorities in this Plan are incorporated into service planning for their local population, as well as in leading change and tracking progress locally.

DHB providers have a major role in implementing the actions in this Plan. They will need to commit to working in partnership with NGO providers to continually improve the services they provide. In addition, they will need to use their knowledge and capability to support primary care providers and the wider health workforce to identify and address mental health and addiction issues.

NGO providers have a crucial role in implementing this Plan. They will need to commit to working closely with their DHB partners to improve outcomes for people with the highest needs. They will also need to use their skills and experience to work alongside DHB and primary care providers in delivering seamless, well-integrated services.

Primary care providers, including general practice teams, school-based health services, prison-based health services, and first point of contact community health services provided by NGOs, are critical to the success of this Plan. It is essential that primary care providers recognise mental health and addiction responses as a core component of their work and that they respond to these issues as equally important to physical health needs. Primary care providers will also need to work closely with DHB and NGO mental health and addiction services to implement a stepped-care approach that is seamless and well-integrated, enabling people to easily access the services they need.

Health Workforce New Zealand (HWNZ) has a vital role to play in developing the future mental health and addiction workforce. It will therefore use this Plan to inform its own planning for changes to workforce composition or competencies. In addition, **other organisations responsible for workforce development** will use the Plan to inform their work to build the mental health and addiction workforce.

Other government agencies can have a substantial impact on the lives of people with mental health and addiction issues. Therefore they will also need to actively engage in implementing the Plan to ensure a whole-of-government response to mental health and addiction issues. This response is particularly important where these issues are associated with experience of injury or trauma, or compounded by wider social issues such as those related to income, housing, education, employment or offending.

Guiding principles

The following principles will guide all people and organisations that have a role in working with people who experience mental health and addiction issues. To successfully address the challenges ahead health and social services will need to:

- > actively challenge stigma and discrimination wherever they are encountered
- > value communities as essential resources to support family and whānau wellbeing and the effective delivery of services
- > expect recovery and work in a way that will support it and that will build future resilience
- > engender hope by demonstrating a belief in the talents and strengths of service users
- > form authentic partnerships with service users at all levels and phases of service delivery
- > promote the participation and leadership of service users at all levels
- > personalise services to the particular needs of the service user and their family and whānau
- > strive to uphold the human rights of service users and their families and whānau
- > respect diversity and demonstrate cultural competence
- > encourage and support positive participation by families and whānau

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- > when working with Māori, take a whānau ora approach
 - > work collaboratively, transcending service boundaries and boundaries between government sectors.

Implementing the Plan

While all New Zealanders, including all government agencies, share the responsibility for implementing the Plan, the health sector has an essential role. The Ministry of Health will use existing DHB accountability and monitoring mechanisms to progress the implementation of the Plan. There is also an expectation that all DHBs and NGO and primary care providers will actively work to use their existing resources more effectively and take a proactive role in progressing implementation of the Plan.

Because communities around the country differ in the local population needs and mix of services they are starting with, the Plan does not prioritise actions or prescribe the sequence in which they are to be implemented. Each year, during the annual planning process, the Ministry of Health will ask each DHB to clearly articulate which of this Plan's prioritised actions have already been implemented in its area and which actions it proposes to implement during the coming year. Any approved actions for implementation along with milestones and timelines for completion will be formalised in each DHB's annual plan.

The Ministry of Health will require all regional and annual plans to:

- > include initiatives aimed at improving the use of current resources and the expected results from these initiatives
- > include initiatives aimed at addressing the priority actions in this Plan
- > describe the change management approach that will support the implementation of service developments and system improvements
- > clearly identify the proposed source of any additional resource (eg, discontinuing services that have been proven to be relatively ineffective; releasing resources by meeting needs in more cost-effective ways; additional demographic funding (if available) or previously approved, targeted Government funding for specific services).

The Ministry of Health will annually monitor progress with implementing this Plan and make the results available on its website.

Organisational leadership and change management capability will be critical in leading the substantial changes required to implement this Plan. These factors will also be important to ensure that the workforce can access the ongoing development and support that will be needed.

Monitoring progress

Over the next five years the Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and key performance indicators (KPIs). Once agreed these will be used to measure progress in implementing this Plan. Until then, New Zealanders can expect to be able to monitor progress through a few key measures that fit into four overarching themes.

-
1. Better use of resources/value for money
 - > Increase the percentage of time workers spend in direct service delivery.
 - > Increase the number of consult liaison contacts from specialist services to primary care.
 2. Improving primary–specialist integration
 - > Increase access to primary care response for people with mental health and addiction problems.
 - > Reduce waiting times to specialist services.
 - > Increase access to specialist services for all age groups.
 3. Cementing and building on gains for people with the highest needs
 - > Reduce and eliminate the use of seclusion in mental health inpatient settings.
 - > Increase access to specialist services for youth offenders.
 - > Increase employment and education opportunities for people with low prevalence conditions.
 4. Intervening early in the life cycle to prevent later problems
 - > Reduce waiting times for child and youth services.
 - > Increase access to child and youth services.

Rising to the challenge

Whilst there has been significant transformation in mental health and addiction services over the last two decades we continue to face a number of challenges. There is still much work to be done before we can give all New Zealanders confidence that they can access high-quality mental health and addiction services.

The challenge before us is to work within a constrained economic and financial environment to implement the actions and achieve the goals outlined in this Plan. It will be important to ensure that change is managed well and effectively and that the health sector has the capacity and capability to manage and implement the required changes.

Most importantly, health services will need to work alongside individuals, families, whānau and communities, so that:

- > young people have a healthy beginning and can subsequently flourish
- > all people can learn and draw strength from the challenges they face
- > people with mental health or addiction issues can rapidly recover when they are unwell
- > social isolation or exclusion as a result of adverse experiences and illness become a thing of the past.

1 Actively using our current resources more effectively

Expected result

Increased value for money in ring-fenced, publicly funded mental health and addiction services.



1.1 Rationale

Whilst recent years have seen major growth in funding and services, New Zealand has entered a time of significant financial constraint. The economic and financial environment during the next two to five years is such that there will be very limited new funding within Vote Health. Any new funding that does become available is likely to be tightly directed towards specific services. Therefore, achieving many of the changes described in this Plan will require a major effort to deliver better value for money and improve system performance.

Any resources released for alternative use by the efforts described in this section can then be applied to implementing the priority actions. These actions will expand access, deliver earlier intervention, strengthen primary–specialist integration and build on the gains in resiliency and recovery among those who have the highest needs.

The actions set out in this section aim to improve the use of current resources by:

- > improving accountability for achieving better outcomes and for appropriate and efficient use of ring-fenced funding
- > providers sharing meaningful information to compare and improve performance, and to learn from effective practices and innovations
- > better aligning funds spent by DHBs on mental health and addiction services with local population need
- > renewing providers' focus on making best use of resource through maximising the amount of staff time spent in direct service delivery, choosing interventions that are efficient and effective, and actively reviewing the duration of service use so that services are discontinued when they are no longer needed.

Information about access, service delivery, outcomes and consumer satisfaction has become significantly more widely available over recent years, and has been used to good effect through activities such as the national KPI project. As a result, some of the infrastructure necessary to improve value for money and system performance is already in place, and will form an invaluable foundation for future efforts.

1.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

DHB accountability measures

- > monitoring the percentage of time that mental health and addiction workers spend in direct delivery of services.

Other key performance indicators

- > monitoring average length of stay for relevant services (separately for mental health and for addiction) including:
 - people receiving clinical services/treatments in the community
 - people receiving community support
 - people receiving residential rehabilitation/treatment
 - acute inpatients
 - other (longer-term) inpatients

- > comparing funds spent by each DHB on mental health and addiction specialist (including NGO) services for its population with its mental health population-based funding formula (PBFF).

1.3 Priority actions

This section describes priority actions for the next five years to improve effectiveness, increase efficiency and productivity, and enhance accountability. Table 2 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 2: Actively using our current resources more effectively: priority actions

Action	Accountability
Enhance accountability by setting targets	Ministry of Health
Expand use of validated outcome measures	Ministry of Health
Develop and oversee the implementation of a planning and funding framework	Ministry of Health
Develop a nationally consistent set of performance indicators for specialist mental health and addiction services	Ministry of Health
Nationally share information about performance, innovation and effective practice	Ministry of Health
Better align funds spent by DHBs on mental health and addiction services with local population need	Ministry of Health
Increase accountability for extending the scope of ring-fenced funding	Ministry of Health
Improve specialist service performance using national performance indicators and service user feedback	DHBs and NGOs
Maximise the percentage of staff time spent in direct service delivery	DHBs and NGOs
Provide services in ways that are efficient (as well as effective)	DHBs and NGOs
Actively review duration of service use to ensure it aligns with need and best practice	DHBs and NGOs
Improve service effectiveness	Ministry of Health, DHBs, NGOs and primary care providers

The Ministry of Health will:

Enhance accountability by setting targets

Improve accountability for implementing this Plan and achieving the intended results by setting targets and embedding the accountability measures described in this Plan into the accountability documents of DHBs and primary health organisations (PHOs).

Expand use of validated outcome measures

Ensure that existing outcome measures are widely used and reported using the Programme for the Integration of Mental Health Data (PRIMHD), and look to introduce other validated outcome measures, such as outcome measures for Māori and consumer outcome measures.

Develop and oversee the implementation of a planning and funding framework

Lead the development of a planning and funding framework to improve the consistency of services funded, enhance the quality of decision-making by planners and funders, and form the basis of workforce development for people entering the planning and funding workforce. The framework will provide guidance about service configuration, planning methods and results-based funding, as follows:

Service configuration

- > confirm which services should be delivered at a national or regional level¹¹ and identify the minimum level of services to be delivered within each local DHB area. This work will:
 - build on previous work led by the National Health Board
 - balance the drivers of more centralised delivery (eg, economies of scale, low demand, high specialisation or technology, consistency) with the drivers of more local delivery (eg, access, relevance to local communities, specific local population needs, family, whānau and community engagement, social inclusion, consumer choice, innovation)
- > describe how wider clinical leadership will play a role in clinical governance over regional and national services
- > describe planning and funding mechanisms for national and regional services.

Planning methods

- > identify the factors that will inform decisions about services to be funded, including:
 - population needs (eg, demography, rurality, local factors impacting on population health)
 - current and emerging evidence of service effectiveness (identified in consultation with clinical partners)
 - existing services and models of care
 - provider performance against outcome measures and other KPIs and accountability measures
 - stakeholder views on services and gaps, including the views of communities, population groups, service users, families and whānau, clinical leaders, health services across the spectrum and government agencies
- > describe mechanisms for engaging stakeholders in the planning process.

Results-based funding

- > describe the way in which funding mechanisms can be used to enhance the achievement of results through:
 - service agreements that contain measures of success (including outcome measures, accountability measures, KPIs and other quality measures)
 - service agreements that reinforce achievement of intended results and more collaborative working
 - funders who provide regular feedback for providers on their performance against their measures of success

11 Examples of potential national or regional services include forensic mental health services and services for people with mental health conditions combined with specific disabilities (eg, an intellectual disability or impaired hearing).

-
- > describe the way in which the Nationwide Service Framework can support DHBs to flexibly meet local need while also enabling the Ministry of Health to understand and compare the use of public funding across DHBs
 - > describe how funders will monitor service provision to ensure compliance with relevant standards, identify contributions made towards achieving the desired outcomes, and use this information to inform funding decisions
 - > outline work with other sectors to jointly fund services in order to maximise the return on government investment.

Develop a nationally consistent set of performance indicators for specialist mental health and addiction services

Following on from the work of the national KPI project, the Ministry of Health will lead the evolution of a nationally consistent set of high-level KPI measures of system-wide performance (including outcomes, outputs, inputs and disparities), incorporating KPIs for providers of services for children and young people. This project will identify ways in which KPIs can be used to improve system performance. The new set of KPI measures will be developed in consultation with a wide range of stakeholders, including service providers across the spectrum, planners and funders, service users and families and whānau.

It is anticipated that the majority of these measures will be obtained through existing data collection processes, such as the national PRIMHD. The Ministry of Health will oversee the collection of data to enable reporting against any new essential measures. In addition, it will lead a review of PRIMHD standards in order to improve data collection at a national level.

The Ministry of Health will also oversee the generation of meaningful information for providers, funders and the Ministry to show how the system is performing, and to compare funder performance and performance across like providers.

Nationally share information about performance, innovation and effective practice

Further develop mechanisms to share information nationally about system-wide performance and accountability measures and about effective innovation, emerging evidence and promising practice both within New Zealand and internationally.

Better align funds spent by DHBs on mental health and addiction services with local population need

To improve alignment between funding levels and population need:

- > plan for the next mental health survey to update *Te Rau Hinengaro* (Oakley Browne et al 2006)
- > where there is national variation in delivery and funding of services (eg, antipsychotic medications), work with DHBs to agree on a nationally consistent approach and clearly identify the funding applied to these services by each DHB and whether such funding has been included within the ring-fence
- > compare each DHB's expenditure with its mental health PBFF and establish a mechanism to address any disparities, ensuring service coverage for all four population groups identified in this Plan
- > as part of the overall review of the PBFF, update the mental health PBFF based on updated general Census information, new utilisation information, information on unmet need and ring-fenced inclusions/exclusions
- > maintain the current percentage of PBFF expenditure on ring-fenced mental health and addiction services across New Zealand
- > retain the mental health and addiction ring-fence and review its value in 2017, once the nationally consistent performance framework for mental health and addiction systems has been developed and implemented.

Increase accountability for extending the scope of ring-fenced funding

The purpose of ring-fencing mental health and addiction funding is to ensure that Government investment in specialist mental health and addiction services is applied to services for people with the highest level of need. The ring-fence was put in place after a period of substantial disinvestment in services for this group of people.

Because the scope of the ring-fence has recently been extended to include a wider range of services, accountability mechanisms for this expanded use need strengthening, to avoid further unwarranted disinvestment in services for people with the highest needs.

The Ministry of Health will put in place mechanisms to ensure that any further application of the ring-fenced funding beyond the original scope for the ring-fence will require Ministry approval. To gain that approval, DHBs will need to:

- > clearly identify the services on which it currently spends its ring-fenced funding (access, inputs and outputs, by service type)
- > provide evidence that it is meeting the needs of people with low-prevalence conditions and high needs
- > propose services for the use of ring-fenced funding:
 - that are consistent with the priorities identified in this Plan and
 - for which there is no other more suitable alternative source of funding (eg, capitation funding for responses expected to be part of ‘business as usual’ in primary care)
- > specify the proposed services in terms of access, inputs and outputs
- > commit to reporting actual delivery against all services funded using ring-fenced funding (access, inputs and outputs).

Mental health and addiction services (NGO and DHB) will:

Improve specialist service performance using national performance indicators and service user feedback

Improve service delivery by:

- > participating in national KPI forums
- > implementing regional KPI forums (in which planners and funders and representatives of service users, families and whānau also participate) to continue benchmarking work between national KPI meetings
- > implementing local mechanisms to benchmark like services
- > combining benchmarking information with important contextual information and routinely collected feedback on service delivery from service users
- > using this combined information and quality improvement methodologies to improve performance, address disparities and eliminate unwanted variation.

Maximise the percentage of staff time spent in direct service delivery

Review current use of staff time, and support changes that ensure that the percentage of staff time spent in direct service delivery is in line with best practice internationally. Direct delivery will include consultation liaison contacts, where these relate to a particular individual, family or whānau experiencing mental health or addiction issues.

Provide services in ways that are efficient (as well as effective)

Work with clinicians to support them to choose more efficient service delivery mechanisms, such as:

- > group therapy and classes to support wellbeing, where these have been shown to be at least as effective as individual interventions
- > brief interventions and e-therapies, where these have proven to be effective
- > use of technology in service delivery, such as follow-up texts and telephone calls, or telemedicine in partnership with primary care in rural communities
- > consultation liaison services to general health care providers (including primary care and general hospitals).

Actively review duration of service use to ensure it aligns with need and best practice

Support staff to actively review duration of service use to ensure that people access mental health and addiction services only for as long as they need those services.

Improve service effectiveness

Improve service effectiveness including cultural effectiveness through:

- > funding and planning that reinforces the achievement of outcomes as well as outputs and inputs
- > service benchmarking and continuous quality improvement that focuses on outcomes
- > research (by universities, DHB research centres and Crown research institutes) and evaluation (organised by funders and providers) focusing on the achievement of outcomes
- > staff who, through forming respectful partnerships, support service users to identify their own outcomes and to track their own progress, and who actively seek feedback from service users, families and whānau about what has been helpful and what has not, in order to shape their own practice.

2 Building infrastructure for integration between primary and specialist services

Expected result

Enhanced coordination and integration between primary and specialist services through developing infrastructure.

2.1 Rationale

Specialist mental health and addiction services have grown significantly over recent years. In 18 out of the 20 DHBs, access to these services has reached the 3 percent of the population originally targeted in the *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998). Additional funding has since been dedicated to various primary mental health initiatives around New Zealand.

Despite these investments, current access to all of the services across the continuum for mental health and addiction is unknown; in many areas services continue to operate in a fragmented manner; and primary care providers point to a significant shortfall in responses to high-prevalence mental health and addiction issues. Greater coordination and integration are required through a shared systems response. This would involve primary and specialist services collectively agreeing on how they will work together and support one another to provide seamless, effective services for people experiencing mental health and addiction issues.

The Government's focus on enhancing health system integration, including the development of integrated family health centres, provides an opportunity to increase national consistency and better integrate responses to mental health and addiction issues across the primary–specialist continuum. To capitalise on this opportunity, policy makers, funders and service providers first need to address infrastructural barriers to enhancing coordination and integration between primary and specialist services.

The actions in this section aim to prepare for improved coordination and integration between primary and specialist services by addressing some of the practical barriers to integrating services. These barriers include a lack of office space available, differences in eligible populations, separate information technology (IT) systems, variable workforce capability and a lack of monitoring of mental health and addiction responses within primary care settings.

2.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

Primary care and DHB accountability measures

- > monitoring access and contacts for mental health and addiction issues within primary care (Ministry of Health–funded primary mental health initiatives and general primary care)
- > monitoring primary care consultation liaison contacts by specialist mental health and addiction services.

Other key performance indicators

- > tracking progress in implementing demonstration sites for the integration of primary and specialist IT systems.

2.3 Priority actions

This section describes priority actions for the next five years to address infrastructural barriers to enhancing integration between primary and specialist services. Table 3 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 3: Building infrastructure for integration between primary and specialist services: priority actions

Action	Accountability
Support fit-for-purpose service configurations	Ministry of Health, primary care providers and DHBs
Integrated IT system development	Ministry of Health
Enhance collection and reporting of primary care information	Ministry of Health and primary care providers
Enhance confidence and capability of the primary care workforce	HWNZ and primary care providers

Support fit-for-purpose service configurations

The Ministry of Health, primary care providers and DHBs will:

- > provide sufficient space for on-site delivery of specialist services within integrated family health centres, larger practices and other primary care locations
- > simplify relationships between DHB clinical teams and primary care providers; for example, by addressing issues in relation to differing eligibility criteria between DHB geographically based populations and PHO enrolled populations.

Integrated IT system development

The Ministry of Health will work with DHBs, NGOs and primary care providers to ensure that IT systems are developed and implemented to support better integration of specialist mental health and addiction and primary care services. The *National Health IT Plan* (National Health IT Board 2010) sets out a vision in which all New Zealanders have a core set of personal health information available electronically to them and their treatment providers, regardless of the setting.

Those people in need of longer-term care will have a single, shared care record developed by them, their family or whānau and their health professional(s) across the continuum of primary care, DHB and NGO services. This record will define mutually agreed problems, goals, actions, timeframes and accountabilities for all those involved. Progressing these developments will support the planned stepped-care approach to meeting mental health and addiction needs across primary care, DHB and NGO services.

Enhance collection and reporting of primary care information

To monitor the outcomes and impact of responses by the integrated health system to mental health and addiction need, the Ministry of Health will work with primary care to identify a set of meaningful information about primary mental health responses. The Ministry of Health will also work with primary care to agree on a mechanism for collecting and reporting the agreed information. This process will begin with the Ministry of Health-funded mental health initiatives in primary care and later include all mental health and addiction activity delivered in primary care.

The agreed information will be used to inform performance improvement, address disparities and eliminate unnecessary variation. This information will supplement information on all mental health and addiction activity that is already gathered from DHB specialist services and NGOs through PRIMHD, the national mental health and addiction information collection system.

Enhance confidence and capability of the primary care workforce

In preparation for greater integration between primary and specialist services, there is a need to enhance the skills and confidence of the primary care workforce in relation to mental health and addiction issues. In particular, workforce development effort will focus on building:

- > a multidisciplinary primary care workforce that includes mental health expertise
- > that workforce's ability to identify and address mental health and addiction needs and to deliver brief, effective interventions.

3 Cementing and building on gains in resilience and recovery for people with low-prevalence conditions and/or high needs¹²

Expected result

Measurable improvements in mental health and wellbeing, physical health and social inclusion among people with low-prevalence conditions and/or high needs.

¹² Psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions.

3.1 Rationale

People who experience serious mental illness or addiction issues can lead full lives and have valued social roles. Historically, however, they have experienced: significant and unnecessary disparities of outcome in relation to mental and physical health; social exclusion; a significantly reduced life expectancy; high rates of unemployment; and housing difficulties (UK Department of Health 2011).

Significant gains have been made over the last two decades in improving outcomes and services for people with moderate to severe mental health or addiction issues. However, further work is needed to address the disparities often experienced by this group and to ensure that service use does not compound them. To build on the gains of the past, services will need to strengthen their efforts to:

- > engage well and form respectful partnerships with service users and their families and whānau
- > exercise caution when prescribing medications that have significant adverse physical effects
- > reduce and eliminate the use of seclusion and restraint (including pharmacological restraint)
- > support and promote social inclusion.

The actions set out in this section aim to improve outcomes for those who are most adversely impacted by mental health and addiction issues. It focuses specifically on implementing effective services for people whose needs have not been consistently well addressed by previous service developments. This group includes people experiencing social exclusion and physical ill health, people involved with the justice system, people who are unable to work, people using methamphetamine or opioids, mothers and fathers with mental health and addiction issues, people at risk of suicide and people who are hospitalised for mental health issues.

3.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

DHB accountability measure

- > monitoring the percentage of people with low-prevalence conditions in employment or education.

Other key performance indicators

- > monitoring the number of people in the low-prevalence and high-needs group
- > monitoring the number of people with low-prevalence conditions using specialist services who are enrolled with primary care
- > monitoring expenditure for a DHB population on adult mental health inpatient services as a percentage of total expenditure (population view) on adult specialist mental health services (including NGO services)
- > monitoring seclusion within mental health inpatient settings.

3.3 Priority actions

Actions within existing resources

This section describes the priority actions for the next five years to make better use of current resources for people with low-prevalence conditions and/or high needs. Table 4 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 4: People with low-prevalence conditions and/or high needs: priority actions

Action	Accountability
Enhance social inclusion opportunities	Ministry of Health
Ensure robust planning for adult forensic mental health services	Ministry of Health
Measure outcomes and use this information to improve the funding and delivery of services	Ministry of Health
Continue to take action to address methamphetamine use	Ministry of Health
Review perinatal and infant mental health services	Ministry of Health and DHBs
Reinforce evidence-informed prescribing	Ministry of Health and Health Quality and Safety Commission
Enhance social inclusion opportunities	DHBs and NGOs
Support service users in their role as parents	DHBs and NGOs
Work to prevent suicide among people known to mental health and addiction services	DHBs and NGOs
Reduce and eliminate the use of seclusion and restraint	DHB providers
Promote wellness planning and support people to self-manage	DHBs and NGOs
Improve service effectiveness through respectful engagement and partnerships with service users	DHBs and NGOs
Ensure services are sensitive to past experiences of trauma	DHBs and NGOs
Strengthen participation and leadership of service users at all levels	DHBs and NGOs
Increase participation of families and whānau at all levels	DHBs and NGOs
Improve physical health and wellbeing	DHBs, NGOs and primary care providers
Enhance interventions for opioid dependence	DHBs, NGOs and primary care providers
Work collectively to improve coordination	DHBs, NGOs and primary care providers

The Ministry of Health will:

Enhance social inclusion opportunities

Work to enhance social inclusion for those people whose lives have been most disrupted by low-prevalence conditions (in terms of both mental health and addiction). This work will involve:

- > continuing national efforts to reduce stigma, including continuing and refreshing of the Like Minds Like Mine programme,¹³ with consideration given to incorporating addiction into the programme
- > working with the Ministry of Social Development to find ways to expand support for employment and educational opportunities
- > working with Housing New Zealand and DHBs to better understand housing issues for people with low-prevalence mental health and addiction issues, with a view to collaborative work to better address needs in the future
- > working to ensure mental health and addiction services are coordinated more closely with justice agencies.

Ensure robust planning for adult forensic mental health services

Work with the New Zealand Forensic Psychiatry Advisory Group (NZFPAG) to build on existing review processes and update information on current use of adult forensic mental health services.

In addition, work with NZFPAG and adult mental health and addiction services to develop a framework for the most effective mix of joined-up responses across the mental health and addiction system for people involved with the justice system. This framework will pay particular attention to the needs of Māori and other population groups currently not well served (eg, women). It will also address interfaces between forensic and general mental health services in relation to people with high and complex needs, including those involved with the justice system.

Measure outcomes and use this information to improve the funding and delivery of services

Continue to work with DHBs and NGOs to implement mechanisms for consistently identifying service users who have low-prevalence conditions and/or high needs for the purpose of learning more about the effectiveness of services in addressing their needs. For this group of people, continue to gather information about their goals, the services they use and the outcomes achieved, including self-determined outcomes. Methods for collecting and using this information will include Knowing the People Planning or other similar mechanisms.

In addition, ensure this information is combined with people's feedback about the services, and collectively used to improve outcomes and service delivery and inform decisions regarding investments.

Continue to take action to address methamphetamine use

Continue to take action to reduce harm from methamphetamine use through implementing the Government's *Tackling Methamphetamine: An action plan* (Policy Advisory Group 2009). Such action will include enhancing access to treatment and detoxification services, and maintaining a website for those concerned about methamphetamine use.

¹³ Like Minds Like Mine is a Ministry of Health-initiated national programme to counter stigma and discrimination against people with mental illness.

Review perinatal and infant mental health services

With DHBs, review perinatal and infant mental health services and ensure the needs of women experiencing an acute mental health issue within the first 12 months postpartum are appropriately addressed, including the needs of their infants and any other children. Part of this work will be to review the options for acute care, including inpatient, residential and home-based services, taking into consideration the guidance in *Healthy Beginnings* (Ministry of Health 2012b).

Reinforce evidence-informed prescribing

Work with the Health Quality and Safety Commission to develop a mechanism for reviewing differences in prescribing patterns for psychiatric medications. In addition, support a programme to share information nationally with the specialist and primary care workforce about evidence-informed prescribing that includes both the short-term and long-term outcomes of medication use.

Mental health and addiction services (NGO and DHB) will:

Enhance social inclusion opportunities

Work to enhance social inclusion for those people whose lives have been most disrupted by low-prevalence conditions (mental health or addiction). This work will involve:

- > increasing service flexibility so that community living supports are available wherever a person chooses to live; not only in inpatient and residential settings
- > working with Housing New Zealand, private landlords and real estate agencies to find ways to:
 - expand access to affordable accommodation options within communities
 - support people to maintain their existing housing
- > developing strong cross-sectoral relationships between forensic mental health services, mental health and addiction services, the courts, the Department of Corrections and youth justice
- > strengthening working relationships and responsiveness between mental health and addiction services and the New Zealand Police
- > providing a seamless transition of care and minimising stigmatisation for people who are leaving forensic mental health services.

Support service users in their role as parents

Have systems and programmes in place to support mental health and addiction service users who have dependent children in their role as parents. This will include:

- > having systems for identifying service users who are parents and working with parents to identify any parenting support they require
- > facilitating access to parent education and support programmes
- > ensuring advance plans for acute episodes incorporate consideration of children's care and safety, including access and visits during hospitalisation.

Work to prevent suicide among people known to mental health and addiction services

Collectively implement plans to decrease the incidence of suicide among those people known to mental health and addiction services, and have systems and processes in place to respond effectively to suicide clusters when they emerge.

Reduce and eliminate the use of seclusion and restraint

Support the inpatient workforce to reduce and eliminate the use of seclusion and restraint (including pharmacological restraint), based on national and international best-practice examples.

The following five actions are also more widely applicable to all services, and not solely to those for people with low-prevalence conditions.

Promote wellness planning and support people to self-manage

Enhance people's ability to manage their own wellness by re-focusing staff time and providing all staff with recognised training in encouraging and supporting people to develop and use their own wellness plans.

Improve service effectiveness through respectful engagement and partnerships with service users

Enhance partnerships with the people who use services by supporting them to make informed choices, taking a holistic approach, implementing collaborative note writing and recovery planning and proactively involving friends, family and whānau. Forming respectful partnerships with people using the services and their families and whānau will be essential to service effectiveness because, no matter how potentially effective services or interventions are, their actual impact will be largely determined by the choices made by the person using them.

Ensure services are sensitive to past experiences of trauma

Work to ensure that staff in all services are aware of the high incidence of past trauma among people with mental health and addiction issues (Cusack et al 2006), inquire about trauma histories, are sensitive to trauma-related issues and avoid re-traumatisation of people who use the service.

Strengthen participation and leadership of service users at all levels

Take action to strengthen the participation and leadership of service users at all levels and in all aspects of service delivery including:

- > organisational leadership
- > system-wide planning
- > service evaluation
- > providing feedback on service delivery
- > a wide range of workforce roles, including peer support.

Increase participation of families and whānau at all levels

Take action to ensure families and whānau participate in all aspects of service delivery including:

- > assessment, treatment and recovery planning
- > service planning and evaluation
- > providing feedback on service delivery
- > workforce and leadership roles
- > family-to-family support.

Mental health and addiction services (DHB and NGO) and primary care will:

Improve physical health and wellbeing

Work to protect and improve the physical health and wellbeing of people with low-prevalence conditions and to promote healthy lifestyles. This work will include a particular focus on improving the health of people prescribed medications that cause adverse physical health and/or problematic side-effects, such as excessive weight gain.

Enhance interventions for opioid dependence

Ensure interventions for opioid dependence promote harm reduction by maximising access to opioid substitution treatment and retention, supporting recovery and comprehensively addressing people’s wider needs, including their physical, emotional and social needs. This will include extending the use of primary care that is well supported by specialist services to deliver interventions for opioid dependence.

Work collectively to improve coordination

Work to ensure people who access a range of services within the mental health and addiction sector and across other government agencies experience a seamless, collaborative network of services. Closer partnerships and alignment will be developed between:

- > DHB and NGO mental health and addiction services
- > mental health services and addiction services to seamlessly address co-existing problems
- > specialist services and primary care
- > mental health and addiction services and other government agencies.

Use of reprioritised, demographic or previously approved government funding

The services summarised in Table 5 and described below are Government priorities for making better use of public funds. As the availability of these services currently varies around the country, this list offers a guide to DHBs so that they can apply any resources for new services to address local gaps in relation to these priorities.

Table 5: People with low-prevalence conditions and/or high needs: priority services

Service	Accountability	Funding source
Self-management education	DHBs	Reprioritised or demographic
Peer support services	DHBs	Reprioritised or demographic
Employment specialists	DHBs	Reprioritised or demographic
Early psychosis intervention	DHBs	Reprioritised or demographic
Youth-focused forensic mental health services	Ministry of Health	Previously approved government funding allocated
Dedicated treatment programmes for repeat impaired drivers (Drivers of Crime: alcohol work stream)	Ministry of Health	Previously approved government funding allocated
Acute inpatient alternatives	DHBs and NGOs	Reprioritised or demographic
Prioritised forensic adult mental health services developments	Ministry of Health and DHBs	Reprioritised or demographic

Self-management education

DHBs will fund the delivery of self-management programmes (including e-therapy programmes, which are supported through a national governance framework, self-management education and programmes provided by peer support specialists). These programmes will equip people with the knowledge and skills to manage their condition and minimise its adverse impact on their life, and to work in partnership with services to enhance their wellbeing.

Peer support services

DHBs will fund the delivery of peer support services across a range of settings and will ensure staff employed in these services have access to recognised peer support training. They will take great care to ensure the essential features of the peer support role are preserved whenever it works alongside or within other mental health and addiction services.

Employment specialists

For service users who are most adversely impacted by mental health or addiction issues, DHBs will increase access to employment specialists delivering evidence-informed individual placement and support services, with the aim of increasing the percentage of people who are either in employment or advancing their education. Employment specialists will work closely with Work and Income and other services that support employment as part of a joined up, cross-agency approach to addressing employment issues for this group of people.

Early psychosis intervention

DHBs will enhance access to evidence-informed, youth-friendly, early psychosis intervention services that engage well, avoid unnecessary hospitalisation, prescribe with care, are culturally respectful, and preserve and improve social inclusion. They will also expand the age range of such services to provide continuity of care through to adulthood.¹⁴

Youth-focused forensic mental health services

The Ministry of Health will lead work to develop comprehensive youth-focused forensic mental health services that are non-stigmatising and developmentally and culturally appropriate for young people involved with the justice system, including:

- > court liaison
- > community-based forensic mental health and addiction services with in-reach into Child, Youth and Family youth justice residences and youth prisons, and transitional support back to general mental health and addiction services
- > a youth-friendly, secure forensic inpatient alternative that provides a safe environment for youth involved with the justice system who have significant mental health and/or alcohol and other drug issues, so that they can address those issues in ways that are age-appropriate and non-stigmatising
- > access to kaupapa Māori interventions for Māori youth, who are over-represented in the youth forensic population.

Dedicated treatment programmes for repeat impaired drivers

The Ministry of Health, through 'Drivers of Crime' funding, will establish dedicated treatment programmes for repeat impaired drivers referred by the courts. These programmes will enhance those already available through DHB and NGO services.

Acute inpatient alternatives

DHBs will fund community-based alternatives to inpatient care, based on national and international best-practice examples.

¹⁴ Services will cover an age range from date of onset through to 25 years of age, to optimise engagement and trust at this critical life stage.

Prioritised forensic adult mental health services developments

DHBs will develop prioritised services across the mental health spectrum for those people involved with the justice system who are not well served currently. These services will be in line with the framework to be developed by the Ministry of Health, the New Zealand Forensic Psychiatry Advisory Group and adult mental health and addiction services, as described in the Ministry of Health actions listed above.

In addition, the Ministry of Health will work with the Department of Corrections to help develop an evidence-informed approach to identifying and meeting needs associated with mental health issues for people within prisons. This approach will include prison screening to identify needs, and an integrated stepped-care approach to meeting the identified needs through prison health services,¹⁵ with access to consultation liaison advice and support from forensic mental health services¹⁶ and clear referral pathways for those with serious mental health problems.

¹⁵ Funded through Vote Corrections.

¹⁶ Funded through Vote Health.

4 Cementing and building on gains in resilience and recovery for Māori and for Pacific peoples, refugees, people with disabilities and other groups

Expected result

Consistent mental health and addiction outcomes for all.

4.1 Rationale

The actions in most sections of this Plan are universal, aimed at improving outcomes for all people with mental health and addiction issues. However, there are groups within New Zealand who experience significant and unnecessary disparities of outcome in relation to mental health and addiction issues. For this reason, this section outlines the additional actions necessary to progress efforts to address these disparities.

Māori

As a population group, Māori experience the greatest burden due to mental health issues of any ethnic group in New Zealand. The national mental health prevalence study, *Te Rau Hinengaro* (Oakley Browne et al 2006), showed that Māori experience the highest levels of mental health disorder overall and are also more likely to experience a serious disorder and co-morbidities than other groups.

Māori are a comparatively young population. In 2006, one in three was under the age of 15 years and about half were under 23 years – age ranges when mental health issues commonly first occur. This population structure means the impact of unmet mental health need in younger people will be greater among Māori. Māori are also disproportionately represented among low socioeconomic groups: two-thirds live in deprivation deciles 7 to 10.

Analysis has shown that if Māori had the same age structure and level of socioeconomic privilege as people in other groups, their rates of mental disorder would still be higher (Oakley Browne et al 2006).

Despite improvements in service provision over the last few decades, including the availability of some kaupapa Māori services, Māori experiencing mental health issues tend to present to health services at a later stage and with more severe issues than non-Māori.

Pacific peoples

Pacific populations also have higher rates of mental health issues than the general population and have lower rates of mental health visits compared with other ethnic groups. The lower rates of mental health visits cannot be accounted for by the Pacific population structure, which means that another reason must explain the low service use (Oakley Browne et al 2006). Almost half of New Zealand's Pacific population is under 20 years of age, and this young population is increasing rapidly. It is mostly young Pacific people, rather than older Pacific people, who carry the burden of mental disorder, particularly severe forms of mental illness (Ministry of Health 2008b).

Refugees

Refugees are at substantially higher risk than the general population for a variety of specific mental health and addiction issues. They have up to 10 times the rate of post-traumatic stress disorder compared with the general population, as well as elevated rates of depression, chronic pain and other somatic complaints (Kirmayer et al 2011). Their increased vulnerability is related to their exposure to war, violence, torture, forced migration and/or exile.

People with disabilities and long-term physical health conditions

Disabilities and long-term physical health conditions can have a significant impact on mental health and wellbeing. Equally mental health and wellbeing can have a strong impact on the way that people deal with and respond to physical health conditions or disability. If not adequately addressed, mental health and addiction issues amongst people with disability or long-term conditions can lead to poorer health outcomes and reduced quality of life.

The prevalence of mental health conditions is higher among people with intellectual disability than the general population (Borthwick-Duffy 1994), and mental health conditions are often difficult to identify in this population. Many people working in the mental health field lack experience in working with people who have intellectual disability and a mental health condition (Kerker et al 2004).

Disproportionately more people with long-term conditions and co-morbid mental health problems live in deprived areas compared with the general population. They also have less access to resources of all kinds (Naylor et al 2012).

Other groups

Within New Zealand, the prevalence of mental health and addiction disorders is higher for people who are disadvantaged. This link holds true whether disadvantage is measured by educational qualification, household income or index of socioeconomic deprivation (Oakley Browne et al 2006).

There is growing recognition that within some parts of New Zealand other population groups experience disparities of outcome in relation to mental health and wellbeing; for example, some of the Asian communities.

New Zealand research has shown that prevalence rates for major mental health issues and addictions in the prison population are markedly elevated, and there are very high levels of co-morbidity with substance misuse in this group (Brinded et al 2001). For people who experience mental health and addiction issues and are involved with the justice system, there is a strong case for developing more comprehensive and coordinated responses across the justice system and mental health and addiction services with the aim of improving health outcomes, reducing offending and enhancing social inclusion (Mental Health Commission 2012a, 2012b).

The actions in this section are described separately for Māori and for Pacific peoples, refugees, people with disability and others. They aim to better address the needs of groups experiencing significant and unnecessary disparities by actively involving those groups in planning for and improving services and by focusing on preventing issues from arising, intervening earlier, strengthening collaboration between the services and agencies involved and developing specific services for particular groups experiencing disparities.

These actions will be complemented by actions aimed at strengthening the workforce. Workforce actions are described in the final section of this Plan and include developing a workforce that reflects the population served, strengthening cultural competence and building the ability to form effective therapeutic relationships with service users of all ethnicities, regardless of their other health challenges or disabilities.

4.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

DHB accountability measures

For Māori and Pacific peoples:

- > monitoring the percentage of people with low-prevalence conditions in employment and education
- > monitoring access to specialist services, distinguishing those with low-prevalence mental health conditions, those with high-prevalence mental health conditions, those with AOD issues, and within each group, those who require consultation liaison only
- > monitoring waiting times separately for mental health and for addiction services.

Primary care accountability measures

For Māori and Pacific peoples:

- > monitoring access to primary care responses for mental health and addiction issues through:
 - primary mental health initiatives
 - general primary care.

Other key performance indicators

For Māori and Pacific peoples:

- > monitoring the number of people in the low-prevalence and high-needs group
- > monitoring the number of people with low-prevalence conditions using specialist services who are enrolled with primary care
- > monitoring seclusion within mental health inpatient settings
- > monitoring average length of stay for relevant services
- > monitoring access rates to evidence-informed psychological therapies for mental health and addiction issues in primary care.

4.3 Priority actions for Māori

Actions within existing resources

This section describes priority actions for the next five years to make better use of current resources for Māori. Table 6 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 6: Māori: priority actions

Action	Accountability
Evaluate pilot kaupapa Māori programmes for substance misuse prevention	Ministry of Health
Fund mental health literacy programmes for Māori	Ministry of Health
Raise awareness so that whānau can better meet the social and emotional needs of infants	Ministry of Health
Actively involve Māori in service planning	DHBs and NGOs
Contribute to Whānau Ora initiatives	DHBs and NGOs
Work together to identify and address disparities for Māori	DHBs and NGOs
Evaluate service effectiveness for Māori and use this information to inform future funding and service development decisions	Ministry of Health and DHBs
Reduce and eliminate the use of seclusion and restraint for Māori	DHB services

The Ministry of Health will:

Evaluate pilot kaupapa Māori programmes for substance misuse prevention

Evaluate whānau-centred, strengths-based, collaborative, structured and interactive kaupapa Māori substance abuse prevention programmes for 10- to 13-year-olds at increased risk of substance misuse.

Fund mental health literacy programmes for Māori

Fund evidence-informed, culturally appropriate mental health promotion programmes for whānau, hapū and iwi. The aim of these programmes will be to increase awareness of how to recognise and respond to mental health and addiction issues.

Raise awareness so that whānau can better meet the social and emotional needs of infants

Ensure that programmes aimed at increasing awareness among families, whānau, hapū, and iwi of the importance of healthy social and emotional development in the first three years of life are culturally appropriate for, and actively engage, Māori whānau.

Mental health and addiction services (NGO and DHB) will:

Actively involve Māori in service planning

Actively involve tāngata whenua in planning for mental health and addiction services. Their involvement will give services the best chance of being well used by Māori, being experienced as helpful, and achieving the intended outcomes for Māori.

Contribute to Whānau Ora initiatives

Local mental health services for infants and children, including kaupapa Māori services, will approach local Whānau Ora providers to identify what positive contribution they could make to outcomes for whānau accessing Whānau Ora services. They will then work together to provide any agreed services.

Work together to identify and address disparities for Māori

Identify disparities for Māori related to mental health and addiction, work with tāngata whenua and with social services to make decisions that aim to address these disparities, measure the impact of these decisions on the disparities over time, and use this information to inform future refinements to investment mix and service delivery.

Evaluate service effectiveness for Māori and use this information to inform future funding and service development decisions

Measure and compare the performance of mental health and addiction programmes and services (in both mainstream and kaupapa Māori settings) in terms of access and outcomes for Māori relative to other population groups, and use this information to improve services.

Reduce and eliminate the use of seclusion and restraint for Māori

Support the inpatient workforce to focus on reducing disparities in the use of seclusion and restraint, which Māori experience at higher rates than other population groups.

Use of reprioritised, demographic or previously approved government funding

The service summarised in Table 7 and described below is the priority for making better use of public funds to address the needs of Māori in DHBs with a significant Māori population who are not achieving equitable outcomes.

Table 7: Māori: priority service

Service	Accountability	Funding source
Kaupapa Māori services	DHBs	Reprioritised or demographic

Kaupapa Māori services

Where the number of Māori who need a service is sufficiently high and Māori are not achieving equitable outcomes relative to other populations from mainstream service use, DHBs will offer kaupapa Māori services. They will also evaluate whether these services are more effective than mainstream services in addressing disparities in outcomes.

4.4 Priority actions for Pacific peoples, refugees, people with disabilities and other groups

Actions within existing resources

This section describes priority actions for the next five years to make better use of current resources for Pacific peoples, refugees, people with disabilities and other groups experiencing disparities in health outcomes. Table 8 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 8: Pacific peoples, refugees, people with disabilities and other groups: priority actions

Action	Accountability
Fund mental health literacy programmes in vulnerable communities	Ministry of Health
Improve the interface between mental health and addiction services and disability support services	Ministry of Health
Build collaboration between mental health and addiction services and justice services	Ministry of Health
Actively involve groups who experience disparities in health outcomes in service planning	DHBs and NGOs
Build the capability to address the needs of refugees	DHBs and NGOs
Evaluate service effectiveness in addressing disparities of outcome and use this information to inform future funding and service development decisions	Ministry of Health and DHBs
Enhance coordination between mental health and addiction and disability support services	DHBs and NGOs
Work together to identify and address disparities	DHBs and NGOs

The Ministry of Health will:

Fund mental health literacy programmes in vulnerable communities

Fund evidence-informed, culturally appropriate programmes aimed at increasing awareness of how to recognise and respond to mental health and addiction issues, for communities that have a high prevalence of mental health and addiction issues or a low rate of using health services or that are experiencing disparities in health outcomes. Where possible, these programmes will be linked to wider health literacy programmes.

Improve the interface between mental health and addiction services and disability support services

Conduct a review to identify and better understand any infrastructural or systemic issues that create a barrier to effective coordination and collaboration between mental health or addiction services and services that support people with disabilities.

In addition, undertake policy work to improve the interface between mental health and addiction services and disability support services, including services for children with developmental disorders. The aim of this work will be to ensure a coordinated, holistic response to the needs of people with co-existing mental health or addiction issues and physical or intellectual disabilities and to the needs of children with developmental disorders.

Build collaboration between mental health and addiction services and justice services

Engage with the Ministry of Justice to agree respective roles in relation to meeting the mental health and addiction needs of people involved with the justice system, and to identify ways to build collaboration and engagement between the justice and health services involved in meeting these needs.

Mental health and addiction services (NGO and DHB) will:

Actively involve groups who experience disparities in health outcomes in service planning

Actively involve communities and groups that have not historically experienced good health outcomes in planning for mental health and addiction services for their particular population or group. This involvement will give services the best chance of being well used by these groups, being experienced as helpful, and achieving the intended outcomes.

Build the capability to address the needs of refugees

Review and evaluate the effectiveness of current mental health and addiction services for refugees and develop plans to increase access and improve outcomes for this group.

Evaluate service effectiveness in addressing disparities of outcome and use this information to inform future funding and service development decisions

Measure and compare the performance of mental health and addiction programmes and services in terms of addressing disparities of access and outcomes between population groups and use this information to improve services.

Enhance coordination between mental health and addiction and disability support services

Enhance the interface between mental health and addiction services and disability support services in order to ensure a coordinated, holistic response to the needs of people with co-existing mental health or addiction issues and physical disabilities or intellectual disabilities.

Work together to identify and address disparities

Identify disparities related to mental health and addiction within the communities they serve, make decisions that aim to address these disparities, measure the impact of their decisions on the disparities over time, and use this information to inform future refinements to investment mix and service delivery.

Use of reprioritised, demographic or previously approved government funding

The service summarised in Table 9 and described below is the priority for making better use of public funds to address the needs of specific populations groups who are not achieving equitable outcomes.

Table 9: Pacific peoples, refugees, people with disabilities and other groups: priority service

Service	Accountability	Funding source
Population-specific interventions	DHBs	Reprioritised or demographic

Other population-specific interventions

In communities where a sufficiently large population group with mental health or addiction issues is experiencing disparities that are not being addressed by mainstream services, DHBs will offer population-specific services, programmes or interventions and evaluate whether these are more effective than mainstream services. These may include services for Pacific peoples, other ethnicities, Deaf people and hearing-impaired people, and refugees.

5 Delivering increased access for infants, children and youth while building resilience and averting future adverse outcomes

Expected result

Increased resilience and improved outcomes for young people with high-prevalence conditions through expanded access to integrated mental health and alcohol and other drug (AOD) responses, and decreased waiting times for these services.

5.1 Rationale

In recent years we have come to understand the important relationship between healthy social and emotional development in the first three years of life and later health and wellbeing. We now know that infants and toddlers who experience adverse events or do not have a positive early caregiver relationship are at greater risk for a range of mental and general health problems, both in the short term and later in life (Fergusson et al 1995; Loeber and Farrington 2000).

We know that mental health problems and substance misuse often first appear in adolescence: 75 percent of problems develop by the age of 24 years (UK Department of Health 2011). However, there is considerable lack of awareness, reluctance to seek help and under-treatment among young people. Families, whānau, schools and communities often lack the tools and information to help young people who are experiencing mental health and AOD issues.¹⁷ An ongoing cause for concern is New Zealand's high youth suicide rate relative to other developed countries (Office of the Prime Minister's Science Advisory Committee 2011).

Hidden mental health and AOD problems at a young age can have long-term detrimental effects. Yet there is good evidence that intervening effectively and early with infants, children and young people works, can avert more serious issues in the future and is highly cost-effective (Office of the Prime Minister's Science Advisory Committee 2011).

To improve the mental health and wellbeing of our young people, the Government has established a multi-sector, multi-faceted 'Youth Mental Health Project'. Led by the Ministry of Health, this broad-based programme will deliver evidence-informed, coordinated cross-sector responses to the mental health and AOD needs of the youth of New Zealand. A focus for this work will be on increasing access to mental health and AOD services for youth with emerging problems and on decreasing waiting times.

The actions set out in this section reflect a focus on intervening earlier in the lives of young people in order to strengthen their resilience and avert future adverse outcomes. They cover evidence-informed service provision, more flexible and responsive services across the spectrum of providers, greater cross-agency collaboration, earlier intervention for families and whānau with infants and children, and options to better meet the needs of youth across the full spectrum of health services, including services within schools.

5.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

DHB accountability measures

- > monitoring access to specialist services, distinguishing those with low-prevalence mental health conditions, those with high-prevalence mental health conditions, those with AOD issues, and within each group, those who require consultation liaison only
- > monitoring waiting times separately for mental health and for AOD services.

¹⁷ In this section the term 'alcohol and other drug' or 'AOD' is used instead of 'addiction', recognising that issues first emerge, but very seldom progress to addiction, in this age group.

Primary care accountability measures

- > monitoring access to primary care responses for mental health and AOD issues through:
 - primary mental health initiatives
 - general primary care.

Other key performance indicators

- > monitoring access rates to evidence-informed psychological therapies for mental health and AOD issues in primary care.

5.3 Priority actions

Actions within existing resources

This section describes priority actions for the next five years to make better use of current resources for infants, children and youth. Table 10 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 10: Building resilience and averting future adverse outcomes for infants, children and youth: priority actions

Action	Accountability
Continue to support health promotion activities to raise awareness of the importance of healthy social and emotional development for infants and toddlers	Ministry of Health
Pilot evidence-informed parenting programmes	Ministry of Health
Lead the cross-agency Youth Mental Health Project	Ministry of Health
Enhance the delivery and integration of specialist mental health and AOD services within primary care, schools and other child health services	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Enhance the responsiveness and flexibility of specialist child and youth mental health and AOD services	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Support a coordinated response to meeting the needs of children in care	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Support a coordinated, multi-agency response for youth with complex interagency needs	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Improve the responsiveness of schools and primary care, maternal, child and youth health services	Primary care, maternal, child and youth health service providers
Implement youth-centred models of care within primary care	Primary care providers

The Ministry of Health will:

Continue to support health promotion activities to raise awareness of the importance of healthy social and emotional development for infants and toddlers

Disseminate, via maternity and Well Child / Tamariki Ora services, information for parents, families and whānau on how to respond to the emotional and social needs of babies and toddlers and the impact of the quality of early caregiver relationships on later health and wellbeing.

Pilot evidence-informed parenting programmes

Lead a project to pilot evidence-informed, culturally appropriate primary care parenting programmes for families and whānau requiring parenting support or education, and evaluate their delivery.

In addition, use the outcomes of this evaluation to work with the Ministries of Social Development and Education to develop and implement a coordinated cross-sector approach to the delivery of multi-level, evidence-informed parenting programmes for families and whānau with infants and children, to be accessed based on level of need.

Lead the cross-agency Youth Mental Health Project

Lead the cross-agency Youth Mental Health Project, and implement those initiatives that the health sector is accountable for.

Specialist child and youth mental health and AOD services (NGO and DHB) will:

Enhance the delivery and integration of specialist mental health and AOD services within primary care, schools and other child health services

Provide support and advice to primary care, schools and other child health services, including:

- > consultation and liaison services (including one-off assessments)
- > prompt telephone advice
- > access to advice via telemedicine for primary care and general health teams in rural areas
- > urgent assessments for young people and their families and whānau in crisis
- > shared care arrangements that allow young people and their families and whānau to move quickly and efficiently between primary care and specialist services as their needs dictate
- > delivery of specialist services from schools and primary care sites, including youth one-stop shops, in combination with processes to ensure collegial working between specialist services, primary care and school-based guidance and health services
- > discharge planning that ensures effective hand-over to an identified primary care provider, with provision for ongoing specialist advice as needed.

Enhance the responsiveness and flexibility of services

Enhance the responsiveness and flexibility of specialist child and youth mental health and AOD services focusing on:

- > reducing waiting times for entry into specialist mental health and AOD services
- > providing kaupapa Māori services for Māori communities
- > delivering services from settings within the local community that are family, whānau and youth friendly, such as schools, youth-specific health services (including one-stop shops) and integrated family health centres
- > co-locating and integrating of mental health services and AOD services for youth

-
- > obtaining input from young people into planning and delivery of specialist mental health and AOD services
 - > developing dedicated roles and other options for youth and their family and whānau to provide peer-to-peer support
 - > proactively involving and supporting family, whānau and friends
 - > actively working to ensure young people remain engaged with age-appropriate, natural community supports.

Support a coordinated response to meeting the needs of children in care

Work with Child, Youth and Family to ensure a coordinated, collaborative approach to the delivery of services that identify and address the mental health and AOD needs of children in care.

Support a coordinated multi-agency response for youth with complex interagency needs

Contribute to a cross-sector response to the delivery of services for youth with high and complex mental health, AOD and other needs. This response will include dedicated, evidence-informed, intensive community services that are flexible and individually tailored to the needs of each young person and their family and whānau. It will also offer specific opportunities for young Māori to connect with, and draw strength from, kaupapa Māori approaches and programmes.

Primary care and other health services will:

Improve the responsiveness of schools and primary care, maternal, child and youth health services

Build the skills and knowledge of staff working in primary care, maternity services, general child and youth health services and within schools to enable them to recognise and respond effectively to the mental health and AOD issues of infants, children and youth, and their families and whānau. They will give specific attention to developing the capacity and capability of staff to:

- > identify emerging issues early (including by screening for postnatal depression and using HEEADSSS wellness checks for youth)
- > proactively involve and support family, whānau and friends
- > provide advice or brief interventions to address emerging mental health and AOD issues
- > recognise when specialist advice or referral is indicated.

Implement youth-centred models of care within primary care

Develop and implement youth-centred models of care within primary care services. Their aim will be to improve the responsiveness and effectiveness of services for youth experiencing mental health and AOD issues, including improving the integration with school-based health services, co-location of services in 'youth one-stop-shops' and wherever possible having the flexibility to respond to 'walk ins'.

Use of reprioritised, demographic or previously approved government funding

The services summarised in Table 11 and described below are priorities for making better use of public funds. As the availability of these services currently varies around the country, this list offers a guide to DHBs so that they can apply any resources for new services to address local gaps in relation to these priorities.

Table 11: Building resilience and averting future adverse outcomes for infants, children and youth: priority services

Service	Accountability	Funding source
Mental health promotion programmes focusing on how families and whānau can support infant social and emotional development and on youth mental health	Ministry of Health	Reprioritised existing funding
Electronic self-management tools for youth (Youth Mental Health Project)	Ministry of Health	Previously approved government funding allocated
Youth-specific prevention programmes	Ministry of Health	Reprioritised existing funding
Dedicated primary mental health and AOD programmes for youth (Youth Mental Health Project)	Ministry of Health	Previously approved government funding allocated
Specialist mental health services for high-needs families and whānau with infants	DHBs	Reprioritised existing funding or new demographic
Programmes for children of parents with mental health and addiction issues	DHBs	Reprioritised existing funding or new demographic

Mental health promotion programmes focusing on how families and whānau can support infant social and emotional development and on youth mental health

The Ministry of Health will implement universal health promotion campaigns aimed at:

- > raising awareness among the community, families and whānau regarding the importance of social and emotional development in the first three years, its impact on later health outcomes, and how to support healthy social and emotional development
- > raising the awareness of youth and their families and whānau regarding mental health and wellbeing, how to recognise and respond to issues, and when and where to seek help.

Electronic self-management tools for youth

The Ministry of Health will implement and evaluate a youth-specific e-therapy tool.

Youth-specific prevention programmes

The Ministry of Health and DHBs will review the evidence to identify effective, culturally appropriate, youth-focused prevention programmes for high-prevalence mental health and AOD problems. This information will be used to inform future decisions on the funding and implementation of evidence-informed prevention programmes for youth.

Dedicated primary mental health and AOD programmes for youth

The Ministry of Health and DHBs will use existing evidence to develop and pilot youth-specific, culturally appropriate primary mental health and AOD programmes (including school-based programmes) that identify and rapidly treat emerging mental health and AOD issues for at-risk youth before more serious issues develop.

Specialist mental health services for high-needs families and whānau with infants

DHBs will increase access to the specialist mental health services for families and whānau with infants (perinatal and infant mental health services) described in *Healthy Beginnings* (Ministry of Health 2012b). These services will deliver intensive, culturally appropriate, evidence-informed therapeutic programmes for families and whānau with the highest level of need. They will be delivered by staff who have the training, skills, support and dedicated time to deliver therapeutic programmes for families and whānau with children aged 0 to 4 years.

Programmes for children of parents with mental health and addiction issues

DHBs will implement and evaluate targeted, group-based psycho-education programmes that provide the children of parents with mental health and addiction issues (COPMIA) with information, peer support and tools to promote resilience, self-esteem and coping strategies. These services will work in conjunction with services that support parents with mental health and addiction issues.

6 Delivering increased access for adults with high-prevalence conditions¹⁸ while increasing service integration and effectiveness

Expected result

Improved outcomes for people with high-prevalence conditions through expanded access to integrated, effective mental health and addiction responses and decreased waiting times.

¹⁸ Mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms.

6.1 Rationale

One in five New Zealanders experiences a significant mental health or addiction issue in any one year (Oakley Browne et al 2006); yet there remains a high level of misunderstanding about these issues within our communities. Often mental health and addiction issues go unrecognised, and can consequently cause serious disruption to people's lives and wellbeing and can even jeopardise their survival. Two notable issues are depression, which makes the third-largest contribution to the burden of disease worldwide (WHO 2008), and the harmful use of alcohol, which is associated with significant health impacts and widespread psychosocial consequences, not only for the drinker but also for the wellbeing of others (WHO 2011).

For many people, the primary health care sector will be their first point of contact with the health system. Research suggests that one-third of people who consult a general practitioner have experienced a significant mental health or addiction issue within the past year (MaGPIe Research Group 2003). It costs less and is more effective to identify and address these issues early. For this reason, one of the Government's priorities is to have a more responsive, connected and integrated health service delivery approach, with shorter waiting times and improved outcomes.

Historically models of service delivery within primary care have limited the ability of these services to respond to the needs of people with mental health and addiction issues. There has also been variable access to specialist advice and back-up. Around New Zealand there continues to be variable integration between primary care and specialist mental health and addiction services, despite the significant growth in specialist service availability.

Section 2 of this Plan sets out the actions needed to put in place the infrastructure that will enable better integration between primary and specialist services. The actions in this section outline the changes to models of service delivery that will be necessary to expand access to, and better integrate, mental health and addiction responses for people experiencing high-prevalence conditions. Key actions in making this happen will be to further develop and strengthen the stepped-care approach. In this approach, services intervene in the least intrusive way, from self-care, right across the primary, NGO and DHB continuum, in order to get the best possible outcomes, enabling entry and exit at any point depending on the level of need. The aim of the stepped-care approach is to provide a seamless, integrated response whereby people receive support that is appropriate and timely, and access holistic packages of care that bring together support across sectors and silos (Mental Health Commission 2012a, 2012b).

Given the high incidence of substance misuse among people involved with justice services, this section also includes an action to better address the needs of people with addiction issues who are involved with the justice system.

6.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

DHB accountability measures

- > monitoring access to specialist services, distinguishing those with low-prevalence mental health conditions, those with high-prevalence mental health conditions, those with AOD issues, and within each group, those who require consultation liaison only
- > monitoring waiting times separately for mental health and for addiction services.

Primary care accountability measures

- > monitoring access to primary care responses for mental health and addiction issues through:
 - primary mental health initiatives
 - general primary care.

Other key performance indicators

- > completing a primary mental health and addiction service delivery framework
- > monitoring access to evidence-informed psychological therapies for mental health and addiction issues in primary care.

6.3 Priority actions

Actions within existing resources

This section describes the priority actions for the next five years to make better use of current resources for adults with high-prevalence conditions. Table 12 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 12: Increasing service integration and effectiveness for adults with high-prevalence conditions: priority actions

Action	Accountability
Develop and implement a primary mental health and addiction service delivery framework	Ministry of Health
Fund mental health literacy programmes	Ministry of Health
Develop a suicide prevention action plan	Ministry of Health
Enhance services to minimise gambling harm	Ministry of Health
Continue and refresh the National Depression Initiative	Ministry of Health
Enhance the delivery and integration of specialist mental health and addiction services within primary care	DHBs and NGOs
Enhance the responsiveness of specialist addiction services to justice services	DHBs and NGOs
Increase uptake of technology-based therapy programmes (e-therapies)	Primary care providers
Build capacity to respond to emerging mental health and addiction issues	Primary care providers and general health providers
Implement the primary mental health and addiction service delivery framework	Primary care providers

The Ministry of Health will:

Develop and implement a primary mental health and addiction service delivery framework

Develop a primary mental health and addiction service delivery framework that addresses mental health and addiction needs in primary care and recognises ethnic disparities. The service delivery framework will include a service matrix detailing the range and mix of primary care service types and interventions. It will be based on a stepped-care model that enables people to rapidly receive the level of care that is appropriate to their need.

The framework will:

- > outline a service matrix and stepped-care model including requirements for clinical governance and oversight
- > describe the multidisciplinary primary care workforce in terms of skills and mix, including the role of service users within the primary care workforce
- > specify workforce supervision and support requirements along with credentialing expectations for roles specific to mental health
- > outline the infrastructure and tools necessary to support effective service delivery (eg, extended consultations, decision support tools and screening tools for primary care staff, and self-management tools for people using primary care services)
- > describe mechanisms to link with, and access input from, specialist mental health and addiction services (eg, phone advice, one-off assessments, consultation liaison, access to supports and shared care)
- > identify the service components that would be funded through usual primary care funding streams and those that may require specific primary mental health funding.

It is intended that the framework will be of use to planners and funders (both primary care and mental health and addiction), service managers and clinicians. It will provide a high-level overview of the core components of an effective, integrated response to mental health and addiction issues, while still allowing for a 'bottom-up' approach to service development based on local needs and preferences. The framework will be used to inform contract expectations that will be negotiated through existing processes with primary care and DHBs.

Fund mental health literacy programmes

Fund mental health promotion programmes that are evidence-informed, culturally appropriate and aimed at increasing awareness among all New Zealanders of how to recognise and respond to mental health and addiction issues within local communities. Where possible, these programmes will be linked to wider health literacy programmes.

Develop a suicide prevention action plan

Develop an all-age, cross-agency suicide prevention action plan that outlines an integrated approach to suicide prevention, with an emphasis on Māori, who have a significantly higher rate of suicide than other ethnic groups.

Enhance services to minimise gambling harm

Develop a national service plan for preventing and minimising gambling harm for the period 2013–2016.¹⁹

¹⁹ Implementation of the plan to prevent and minimise gambling harm is funded through the problem gambling levy, in line with the Gambling Act 2003.

Continue and refresh the National Depression Initiative²⁰

Work with the Health Promotion Agency to continue and refresh the National Depression Initiative, which forms part of the Government's commitment to addressing suicide prevention. This joint work will also involve increasing awareness of depression in order to increase help-seeking behaviours and self-management.

Mental health and addiction services (NGO and DHB) will:

Enhance the delivery and integration of specialist mental health and addiction services within primary care

As part of a stepped-care approach, provide support and advice to primary care and other general health services, including:

- > consultation and liaison services (including one-off assessments)
- > prompt telephone advice
- > access to advice via telemedicine or outreach services for primary care teams in rural areas
- > urgent assessments for people in crisis
- > shared care arrangements that allow people to move quickly and efficiently between primary care and specialist services as their needs dictate
- > delivery of specialist services from primary care sites, in combination with processes to ensure collegial working
- > consultation liaison from specialist perinatal and infant mental health services to primary care, lead maternity carers and well child services with clear referral pathways to specialist perinatal and infant mental health services, ensuring ease of access for those people with the most serious problems.

Enhance the responsiveness of specialist addiction services to justice services

Ensure that specialist addiction services work closely across the spectrum of justice services, including police. Their aim will be to ensure that people who are involved with justice services and have addiction issues receive timely, effective and streamlined access to addiction services.

Primary care and other health services will:

Increase uptake of technology-based therapy programmes (e-therapies)

Increase uptake of e-therapy programmes that are culturally appropriate, evidence-informed and aimed at enhancing self-help skills for preventing or managing mild to moderate mental health and addiction problems.

Build capacity to respond to emerging mental health and addiction issues

Ensure that clinicians working in primary care and other general health services are able to recognise and respond to mental health and addiction issues. Clinicians will need to have the skills, knowledge and support to:

- > screen and identify emerging issues early
- > proactively involve families and whānau
- > provide advice and/or brief interventions to address emerging issues, including hazardous drinking, depression and anxiety

²⁰ The National Depression Initiative is a Ministry-initiated project to reduce the impact of depression on the lives of New Zealanders.

- > recognise when specialist advice or referral is indicated
- > more accurately recognise postnatal depression through the use of evidence-informed screening tools.

Implement the primary mental health and addiction service delivery framework

Implement the components of service delivery from the primary mental health and addiction service delivery framework (referred to in the Ministry of Health accountabilities above) that will be funded through the usual primary care funding streams.

Use of reprioritised, demographic or previously approved government funding

The services summarised in Table 13 and described below are Government priorities for making better use of public funds. As the availability of these services currently varies around the country, this list offers a guide to DHBs so that they can apply any resources for new services to address local gaps in relation to these priorities.

Table 13: Increasing service integration and effectiveness for adults with high-prevalence conditions: priority services

Service	Accountability	Funding source
Self-management and wellness education in primary care	DHBs and PHOs	Reprioritised existing funding or new demographic funding
Expanded access to evidence-informed psychological therapies in primary care	DHBs and PHOs	Reprioritised existing funding or new demographic funding
Pilot dedicated drug courts (Drivers of Crime: alcohol work stream)	Ministry of Health	Previously approved government funding allocated
Improved responsiveness to the needs of new mothers with high-prevalence mental health or addiction issues	Ministry of Health and DHBs	To be determined

Self-management and wellness education in primary care

Primary care services will provide access to self-management and wellness programmes for people with emerging mental health and addiction issues. (These programmes will include e-therapy programmes, face-to-face individual and group programmes and programmes provided by people with lived experience of mental health and addiction issues.) Such programmes aim to promote wellness, build resilience and support people to develop and implement self-management plans.

Expanded access to evidence-informed psychological therapies in primary care

Primary care providers will further enhance and expand access to brief, evidence-informed psychological therapies in primary care through:

- > developing consistent, evidence-informed guidelines for eligibility, access, therapeutic models and duration of treatment
- > building workforce capacity and capability
- > ensuring equity of access based on population characteristics and need.

Pilot dedicated drug courts

The Ministry of Justice and the Ministry of Health will establish a dedicated alcohol and other drug court pilot through which people involved with the criminal justice system as a result of addiction issues will be able to access intensive treatment, supervision and support options to enhance their recovery and reduce drug and alcohol-related harm.

Improved responsiveness to the needs of new mothers with high-prevalence mental health or addiction issues

The Ministry of Health will work with DHBs and primary care to ensure there are programmes in place to better address the needs of new mothers with high-prevalence mental health or addiction issues including:

- > multifaceted primary mental health services, which include self-management tools, peer support, parenting support and individual and group-based evidence-informed psychological therapies
- > short-term practical supports for mothers experiencing mental health and addiction issues.

7 Delivering increased access for our growing older population while respecting and protecting their positive contribution

Expected result

Improved outcomes for older people with high-prevalence conditions through expanded access to integrated, effective mental health and addiction responses and decreased waiting times.



7.1 Rationale

Older people have a wealth of experience and talent, combined with sufficient time to make a substantial positive contribution to the communities in which they live. Mental health and addiction issues in older people can prevent this positive contribution and significantly reduce their quality of life. With the projected rapid increase in the number of older people within the population, addressing the mental health and addiction needs of older people will be increasingly important over the coming years.

Mental health and addiction issues in older people are often complicated by other issues, including social isolation and physical and cognitive conditions associated with ageing. This complex mix of inter-related issues means that often mental health and addiction issues go unrecognised in this group (Oakley Browne et al 2006).

For many older people, quality of life is linked to their health, family, whānau and social networks. Home and independence are also important: many people prefer to remain living in their own home as they age. For this reason, newer models of health care delivery are increasingly focused on supporting ageing in place so that people can remain in their own homes safely and comfortably.

Mental health and addiction services have an important role in supporting this change. However, around New Zealand there has historically been variable coordination and integration of primary care, health of older people's services and mental health and addiction services. Within the mental health and addiction sector there is considerable variability in the degree of focus on the needs of older adults.

Given all of these factors, the actions in this section aim to ensure that we have a connected and coordinated health service that recognises and responds early and effectively to mental health and addiction issues in older people, while optimising their ability to live in the home and community of their choice and to contribute positively to that community.

7.2 Measuring progress

The Ministry of Health will work with key stakeholders to develop an agreed set of outcome measures and KPIs. Once agreed, these indicators will be used to measure progress in implementing this Plan. Until then, the Ministry of Health will measure progress through:

DHB accountability measures

- > monitoring access to specialist services, distinguishing those with low-prevalence mental health conditions, those with high-prevalence mental health conditions, those with AOD issues, and within each group, those who require consultation liaison only
- > monitoring waiting times separately for mental health and addiction services.

Primary care accountability measures

- > monitoring access to primary care responses for mental health and addiction issues through:
 - primary mental health initiatives
 - general primary care.

Other key performance indicators

- > monitoring access rates to evidence-informed psychological therapies for mental health and addiction issues in primary care.

7.3 Priority actions

Actions within existing resources

This section describes the priority actions for the next five years to make better use of current resources for our growing older population. Table 14 summarises the priority actions and accountabilities. It is followed by a more detailed description of each action.

Table 14: Respecting and protecting the positive contribution of our growing older population: priority actions

Action	Accountability
Review funding streams for mental health services for older people	Ministry of Health
Promote wellness planning	DHBs
Proactively engage families and whānau	DHBs
Enhance the delivery and integration of specialist mental health and addiction services within primary care and health of older people services	DHBs
Ensure addiction services are responsive to the needs of older people	DHBs and NGOs
Enhance the responsiveness and flexibility of specialist mental health services for older people	DHBs
Enhance the responsiveness of primary care and general health services for older people with mental health and addiction issues	Primary care and health services for older people providers

The Ministry of Health will:

Review funding streams for mental health services for older people

Review variation in the current funding streams and service availability for mental health services for older people. It will then take steps to ensure national consistency in funding and PRIMHD reporting for these services.

Mental health and addiction services (DHB and NGO) will:

Promote wellness planning

Enhance older people's ability to manage their own wellness by re-focusing staff time and providing recognised training for all staff in encouraging and supporting people to develop and use their own wellness plans.

Proactively engage families and whānau

Ensure that mental health services for older people proactively involve and support family and whānau who wish to support a family member's recovery, so that their continued involvement reduces their family members' social isolation and encourages them to manage their own condition/wellness.

Enhance the delivery and integration of specialist mental health and addiction services within primary care and health of older people services

Provide support and advice to primary care and general health services for older people so that together they can better address the complex interrelationship between mental health and addiction needs and general health needs. In particular, the specialist services will:

- > provide consultation and liaison services (including one-off assessments and access to prompt telephone advice) to primary care, general health and aged residential care services
- > develop shared care arrangements that allow people to move quickly and efficiently between primary care and specialist services as their needs dictate
- > have processes to ensure collegial working with health of older people services, primary care providers and staff within aged residential care facilities.

Ensure addiction services are responsive to the needs of older people

Ensure that specialist addiction services work closely with mental health services for older people, and are able to respond to the needs of older people. Part of such responsiveness will be having staff who have specific knowledge of and skills in working with older people and their families and whānau. In addition, where need dictates, services will offer groups or programmes that are specifically tailored to the needs of older people.

Enhance the responsiveness and flexibility of specialist mental health services for older people

Enhance the responsiveness and flexibility of specialist mental health services for older people, focussing on:

- > ensuring a continuum of care that includes responsive community based services
- > assisting people to be in the best position to manage their condition/wellness and supporting them to develop their own wellness plans (including relapse prevention planning)
- > ensuring that mental health services for older people are available to people with age-related issues regardless of chronological age (this is particularly important for Māori, who, on average, experience age-related problems at a younger age than other population groups)
- > addressing the needs of people with low-prevalence conditions who are ageing, including by supporting continuity of relationships with their existing NGO or DHB service providers when appropriate
- > ensuring strong service-user leadership in planning and decision-making regarding service development and improvement
- > ensuring strong collaboration between NGO and DHB services, and with addiction services.

Primary care and health services for older people will:

Enhance the responsiveness of primary care and general health services for older people with mental health and addiction issues

Ensure that staff working in primary care, general health and aged residential care services are able to recognise and respond to mental health and addiction issues among older people. Staff will need to have the skills, knowledge and support to:

- > identify emerging issues early and the factors that can contribute to these issues, including social isolation
- > recognise the particular risks associated with alcohol use in this age group
- > provide advice and brief interventions to address emerging issues
- > recognise when specialist advice or referral is indicated.

Use of reprioritised, demographic or previously approved government funding

The services summarised in Table 15 and described below are Government priorities for making better use of public funds. As the availability of these services currently varies around the country, this list offers a guide to DHBs so that they can apply any resources for new services to address local gaps in relation to these priorities.

Table 15: Respecting and protecting the positive contribution of our growing older population: priority services

Service	Accountability	Funding source
Peer support services	DHBs	Reprioritised existing funding or new demographic funding
Specialist mental health advice and support for people with dementia	DHBs and Ministry of Health	Reprioritised existing funding or new demographic funding
Community alternatives to acute inpatient care	DHBs	Reprioritised existing funding or new demographic funding

Peer support services

DHBs will develop roles across a number of settings for well-trained peer support workers to work with older people experiencing mental health and addiction issues and their families and whānau.

Specialist mental health advice and support for people with dementia

DHBs will ensure older people with dementia can access specialist mental health expertise when needed. This specialist expertise will be delivered as an integrated part of a wider health sector response to the needs of people with dementia, aimed at supporting people to live well within the community of their choice.

In addition, the Ministry of Health will review the existing regional dementia advisory services in order to ensure they are working effectively and in line with agreed dementia pathways.

For those older people who are living in aged residential care, and particularly those with challenging behaviour, DHBs may provide specialist mental health nurses and/or support workers to work alongside residential support staff for a brief period. The aim of their work would be to more fully assess need and to support residential staff to put in place plans that will maximise the amount of time that the person can continue living where they are without having to move in order to access a more intensive level of residential support.

Community alternatives to acute inpatient care

DHBs will develop community-based acute mental health services as an alternative to inpatient services for older people experiencing an acute mental health problem. This will include ensuring community-based mental health services for older people have the capacity to deliver more intense and more frequent services as an alternative to inpatient admission, and to enable the person to receive effective treatment in their own home. For those older people who are living in aged residential care, services may include providing nurses and/or support workers to work alongside residential support staff for a brief period in order to more fully assess need and support recovery in the person's usual home environment.

8 Supporting and strengthening our workforce

Expected result

A mental health and addiction workforce with the capabilities and motivation to implement this Plan.

8.1 Rationale

The successful achievement of the four overarching goals in this Plan will rely on the efforts of skilled and motivated staff working alongside service users and their families and whānau. It will require strong leadership, commitment to implementing the changes envisaged, change management capability, and the active engagement of the health, justice and social services.

Implementation of the Plan will require sufficient numbers of staff with the appropriate capabilities to deliver services that meet the needs of service users and their families and whānau. These staff also need to reflect the population they serve.

Achieving this will only be possible if staff have the appropriate education, training and supervision to deliver the future services described in the Plan and are valued and supported, and if the jobs that people do are sufficiently rewarding to make them want to stay.

Recently a review was commissioned to inform Health Workforce New Zealand about the future mental health and addiction workforce and training needs (HWNZ 2011). It provided a first step toward estimating future workforce numbers and competencies, identifying the implications for education, training and supervision, and developing a plan to address these needs.

8.2 Priority action

Health Workforce New Zealand will:

Develop a national workforce development plan

Work with a wide range of mental health and addiction stakeholders to develop a national workforce development plan. This plan will guide the health sector, including workforce development organisations, to develop the workforce needed to implement this Plan. The workforce development plan will identify:

- > the workforce, skills and competencies needed to deliver on this Plan, taking into consideration:
 - new ways of working to make best use of the workforce
 - new roles to complement existing staff groups
 - future services, changing demography and future demand for services
- > education, training and development required
- > strategies to recruit and retain people in the workforce, including strategies to address any specific workforce shortages
- > mechanisms for the Ministry of Health to track progress in implementing the workforce development plan.

In addition, take steps to ensure that education and workforce development organisations, regulatory bodies and colleges, health service managers and leaders, and members of the workforce are all aware of the workforce development plan and use it to shape their activities.

8.3 Summary of the Plan's workforce implications

Workforce competencies and workforce development priorities to support implementation of the Plan are summarised below. These will inform the content of the future national workforce development plan. In the meantime, they are intended to inform the work of education and workforce development organisations, regulatory bodies and colleges, health service managers and other leaders across DHB, PHO and NGO services (to guide their authorisation of employees' professional development requests) and members of the workforce (to guide and shape professional development choices).

Competencies

Competencies for people working across the spectrum of health services (primary care, general health, and specialist mental health and addiction) that will support implementation of this Plan include the ability to:

- > form effective partnerships with people who use the services and their families and whānau and/or support people, to enable self-management²¹
- > incorporate knowledge of tikanga, whānau ora and Māori models of care and cultural competence in working with Māori
- > incorporate cultural competence when working with other large ethnic groups within New Zealand
- > shape practices to be culturally appropriate for each person
- > undertake wellness planning
- > provide brief, effective, evidence-informed psychological therapies or motivational interviewing
- > provide trauma-informed service delivery
- > deliver stepped-care models of service delivery
- > work collaboratively (this ability will be strengthened through multidisciplinary training).

Workforce development priorities for specialist DHB and NGO services

Key workforce development priorities for the workforce in specialist mental health and addiction services (within DHBs and NGOs) that will support implementation of this Plan are:

- > enhancing understanding of the service-user perspective through the use of training for staff led by service users
- > better leveraging the limited specialist resource by developing the consultation liaison component from the specialist service workforce to general health (primary and specialist)
- > improving the capability of mental health and addiction specialists to address co-existing conditions
- > building capability for addressing physical health issues and for collaborating with general health services to address people's physical health needs
- > enhancing the understanding of needs of people with co-existing mental health or addiction issues and intellectual disability and developing skills to address these
- > developing capability to minimise use of seclusion and restraint in inpatient settings
- > ensuring the workforce supports self-management and recovery
- > re-focusing service delivery where evidence suggests existing practices are no longer the most effective

21 One of the seven real skills outlined in *Let's Get Real* (Ministry of Health 2008a).

-
- > strengthening use of the non-regulated workforce and NGO providers, particularly the provision of support for work, housing and social inclusion
 - > developing other roles that require briefer training periods for specific functions, and providing supervision for these from the existing workforce (substitution).

Workforce development priorities for primary care and the wider general health care workforce

Key workforce development priorities for the general health care (primary and specialist) workforce that will support implementation of this Plan are:

- > building the ability to identify and address mental health and addiction needs and deliver brief, effective, evidence-informed psychological therapies
- > building a multidisciplinary primary care workforce
- > expanding capability for general health and mental health and addiction services to collaborate in addressing people's physical health needs.

Workforce development priorities for managers, professional leaders, planners and funders, and policy makers

Key workforce development priorities for these groups that will support implementation of this Plan are:

- > building the capability to analyse and use information effectively to inform decisions about policies and investments, develop plans and improve services
- > implementing a workforce development programme to enable planners and funders to implement and monitor the planning and funding framework
- > leading the implementation of measures to improve service quality and productivity, such as the 'choice and partnership approach' and the '7 HELPFUL Habits of Effective CAMHS' (York and Kingsbury 2009)
- > developing the capability to lead the changes necessary to implement the service developments prioritised in this Plan, including fully engaging the workforce in planning and implementing change and supporting participation in events that provide opportunities for rapid transfer of knowledge about effective services and innovations
- > continuing to work towards a workforce that reflects the populations served across primary and specialist services
- > continuing to embed *Let's Get Real* (Ministry of Health 2008a) and Real Skills Plus (The Werry Centre 2009) in day-to-day workforce practices across all services.

Workforce development priorities for other agencies and sectors

The key workforce development priority for other agencies and sectors that will support implementation of this Plan is:

- > building the ability to recognise and respond to mental health and addiction issues.

Anticipated expansion in service delivery

Where this Plan signals increased service delivery and this expansion involves new expertise, appropriate education and training programmes will need to be put in place, such as peer support training.

Glossary

addiction	In this document the term ‘addiction’ relates only to alcohol and other drugs, and includes the full spectrum of severity, from mild issues through to more serious addiction.
AOD	Alcohol and other drugs.
benchmarking	The process of collecting and comparing information regarding inputs, outputs, quality and outcomes across like services and using this information to improve quality.
CAMHS	Child and adolescent mental health services.
consultation liaison	Advice and support from specialist services to other health care services regarding the mental health and addiction needs of an individual, family or whānau.
DHB	District health board.
direct service delivery	Significant contact with a service user and/or their family or whānau (eg, face-to-face, over the telephone, through emails) and significant consultation liaison contact with another health care provider regarding a person using their services.
e-therapy	Electronic therapy programmes aimed at helping people to resolve mental health, alcohol and other drug or addiction issues.
family	The service user’s whānau, extended family, partner, siblings, friends or other people that the service user has nominated.
HEEADSSS	Home, Education and Employment, Eating, Activities, Drugs, Sexuality, Suicide and Depression, Safety: a psycho-social assessment tool for use with adolescents.
high-prevalence conditions	Mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms.
HWNZ	Health Workforce New Zealand, the organisation responsible for the planning and development of the health workforce, ensuring staffing is aligned with the planning and delivery of services, and ensuring the health workforce is fit for purpose.
IT	Information technology.
kaupapa Māori services	Māori-centred services that are offered within a Māori cultural context.
Knowing the People Planning (KPP)	An evidence-based management approach that provides accurate, up-to-date information that can be used to identify service gaps, inform local-level planning and provide evidence for improvements to services for people with enduring mental health issues.
KPI	Key performance indicator.

Let's Get Real	A workforce development framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.
low-prevalence conditions	Psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions.
mental health literacy programmes	Programmes that aim to increase community knowledge and understanding of mental health and addiction issues in order to promote early recognition and appropriate help-seeking.
Ministry of Health	The government agency that provides strategic policy advice and ministerial services to the Minister of Health, monitors DHB performance and administers legislation and regulations.
multi-agency response	A situation in which one person, family or whānau is involved with a number of services across the health and social sectors (eg, health, justice, education and social services).
Nationwide Service Framework	A collection of definitions, processes and guidelines that provides a nationally consistent approach to the funding, monitoring and analysis of services.
NGO	Non-governmental organisation.
non-regulated workforce	People who have direct personal care interaction with service users but are not subjected to regulatory requirements under health legislation. Service-user interactions can be short term or long term, and the focus of care is restoration, recovery, rehabilitation, participation and independence across the service spectrum. (Note: use of the term 'non-regulated' in this report refers only to the lack of requirements under health legislation; people within non-regulated roles are commonly required to meet specified educational requirements, and their performance is regulated by employing organisations.)
NZFPAG	New Zealand Forensic Psychiatry Advisory Group.
PBFF	Population-based funding formula.
peer support services	Services that enable wellbeing, are delivered by peer support specialists and are based on principles of respect, shared responsibility and mutual agreement/choice.
peer support specialists	People who themselves have lived experience of mental health or addiction issues, who have received training to provide peer support, and who use their experience to enable recovery and wellbeing in others.
PHO	Primary health organisation.
primary care	Essential health care based on practical scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to and a central function of the country's health system, and is the first level of contact with the health system. Examples include general practice teams, school-based health services, prison-based health services and other first point of contact community health services provided by NGOs.

PRIMHD	Programme for the Integration of Mental Health Data: the national system for collecting information on service activity and outcomes data for individuals using mental health and addiction services.
problem gambling	Patterns of gambling behaviour that compromise, disrupt or damage health, personal or vocational activities.
recovery	The process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential.
refugees	In this document, the term “refugee” refers to all refugees and protected persons, and people who are either applicants for refugee and protection status or appealing against refusal of refugee or protection status, where those people are eligible for publicly funded health services.
resilience	The capacity of individuals to cope well under adversity.
ring-fence (mental health)	A government mechanism to ensure funding intended for specialist mental health and addiction services is used for those purposes.
self-management	Actions and decisions people take to regain, maintain and improve their own health and wellbeing.
service user	A person who uses mental health or alcohol and other drug 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 or whānau.
social inclusion	The absence of barriers to full participation within a chosen community by a person or group.
specialist services	In this document, the term “specialist services” refers to all those mental health and addiction services described in the Nationwide Service Framework and funded using ring-fenced DHB mental health and addiction funding or Ministry of Health funding. This includes both DHB and NGO services.
stepped-care	An integrated and seamless approach to health care delivery that involves intervening in the least intrusive way, from self-care right across the primary, DHB and NGO service continuum, in order to get the best possible outcomes, enabling entry and exit at any point based on need.
trauma-informed services	Services that ensure staff are aware of the high incidence of childhood trauma among people with mental health and addiction issues, inquire about trauma histories, are sensitive to trauma-related issues and avoid re-traumatisation of people who use them.
whānau	The use of the term ‘whānau’ in this document is not limited to traditional definitions but recognises the wide diversity of families 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, the term 'whānau ora' refers to an approach to service delivery that involves supporting Māori whānau to achieve their maximum health and wellbeing.
Whānau Ora	In this document, the term 'Whānau Ora' refers to government-funded services or initiatives designed to place whānau at the centre and build on the strengths and capabilities already present within a whānau.

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Appendix 1:

National strategy and policy documents since 1994

Looking Forward: Strategic directions for the mental health services (Ministry of Health 1994) and *Moving Forward: The National Mental Health Plan for More and Better Services* (Ministry of Health 1997)

Blueprint for Mental Health Services in New Zealand: How things need to be (Mental Health Commission 1998)

Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan (Minister of Health 2005), and *Te Kōkiri: Mental Health and Addiction Plan 2006–2015* (Minister of Health 2006)

Te Raukura: Mental Health and Alcohol and Other Drugs: Improving outcomes for children and youth (Ministry of Health 2007) and its companion document, *Whakarato Whānau Ora: Whānau wellbeing is central to Māori wellbeing* (Ihimaera 2007)

Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework, 2008–2015 (Ministry of Health 2008c)

Service Delivery for People with Co-existing Mental Health and Addiction Problems – Integrated Solutions (Ministry of Health 2010) and *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems* (Todd 2010)

Improving the Transition: Reducing social and psychological morbidity during adolescence (Office of the Prime Minister’s Science Advisory Committee 2011)

Youth Forensic Services Development: Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug and intellectual disability services for young people involved in New Zealand’s justice system (Ministry of Health 2011)

Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand (Ministry of Health 2012b)