Blueprint II

Improving mental health and wellbeing for all New Zealanders

How things need to be

**This document is available on the
Health and Disability Commissioner's website:**

www.hdc.org.nz

1. Treaty Implications

As the founding document of New Zealand, Te Tiriti o Waitangi must be acknowledged and its principles incorporated in all aspects of health services provision for all New Zealanders, and in particular for tangata whenua. The Mental Health Commission acknowledges the significance of the Treaty as the original blueprint for interactions between the Crown and tangata whenua.

1.1 Article One

Article One places an obligation on the Crown to consult and collaborate with iwi, hapu and Māori, as tangata whenua, in order to determine their attitudes and expectations with regard to the functions and operation of 'good government'.

With regard to the public funding and provision of mental health and addiction services, this requires meaningful consultation with Māori, and Māori involvement in the planning of those services.

1.2 Article Two

Article Two guarantees Māori rights of ownership, including non-material assets such as te reo Māori, Māori health and tikanga Māori, and confirms the authority of iwi, hapu and Māori, as tangata whenua, over their own property, assets, and resources. Article Two establishes the principle of tino rangatiratanga – self-determination and jurisdiction for Māori communities and organisations – such that they can manage their own property, assets and resources. This article directs agents of the Crown to negotiate directly with iwi, hapu and whānau with regard to policy which impacts on them.

Tino rangatiratanga can be acknowledged through specification of kaupapa Māori services and providing Māori with increased opportunities to create and implement strategies and services which will improve mental health and addiction services, and mental health and wellbeing outcomes for Māori.

1.3 Article Three

Article Three guarantees Māori the same rights of citizenship and privileges as British subjects, including the rights of equal access to mental health and addiction services, to equal health and wellbeing outcomes and to access mainstream mental health and addiction services which meet the needs of Māori.

Blueprint II provides a strong call for equity of participation, access, and outcomes, and acknowledges that while there has been a significant improvement over the past decade, these goals are not being achieved at present.

2. Mihi

E tū ake nei tō tātou whare whakahirahira

Ko Ranginui e tū ake nei hei tuanui

Ko Papatūānuku e takoto nei hei whāriki

Ko te reo me ngā tikanga hei tāhuhu

Ko te iwi hei poutokomanawa

E tū e te whare e!

Hei whakairi i ō tātou wawata, ō tātou tūmanako, ō tātou moemoeā!

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There stands our house in all its grandeur

The sky is its roof

The earth is its carpet

Our language and culture is its ridge pole

And the people stand at its centre

Stand erect!

So that you may house our hope and dreams within!

3. Foreword from the Mental Health Commissioners

Since the launch of *Blueprint for Mental Health Services in New Zealand: How things need to be* (1998)[1], support for people with complex and enduring mental health and addiction problems and their family and whānau has come a long way. There has been major investment in developing specialist services based on recovery models that have gained international recognition. It is now timely to focus on what needs to happen over the next decade.

Blueprint II builds on past achievements and provides a pathway to a future in which mental health and wellbeing becomes everybody's responsibility. It is widely accepted that everyone is responsible for managing their own physical health and fitness, and we need the same acceptance of responsibility for mental health and wellbeing. It is the only way individuals and their families and whānau can improve their ability to weather adversity and to achieve their own aspirations. At the same time, we need to greatly expand access to services by doing things differently and making the most of all our collective resources.

Blueprint II is based on the concepts of people-centred and people-directed recovery and resiliency as core values and creates an environment where all of us involved in mental health and addiction can do more with the funds, workforce, infrastructure and energy we already have. It builds on our considerable strengths in specialist services and provides direction and support to create better access and responses across the life course and across the broader health and social sectors.

The expert advice from the sector and feedback from the consultation process has provided a sound foundation for determining how the future needs to be and how to make it happen.

As this is the Mental Health Commission's final publication, we would like to pay tribute to everyone who has supported us and our work over the past 16 years. We are entering a new phase of development for mental health and addiction services with the disestablishment of the Commission and the transfer of our core functions to the Office of the Health and Disability Commissioner. Responsibility for championing the themes in Blueprint II will need to be taken up by as many individuals and organisations as possible in order that these changes happen.

"Tawhiti rawa atu to tatou haerenga te kore haere tonu, maha rawa atu o tatou mahi te kore mahi tonu," Ta Hemi Henare

We have come too far not to go further, we have done too much not to do more.

Lynne Lane	Ray Watson	Bice Awan
Chair Commissioner	**Commissioner**	**Commissioner**

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1   Mental Health Commission. November 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington: Mental Health Commission.

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4. Executive Summary

Blueprint II champions a bold new vision to improve the mental health and wellbeing of all New Zealanders. It is a ten year vision that encompasses all of government and provides guidance on what is required to meet future needs and how to make the changes called for.

It is independent, evidence-based advice from the Mental Health Commission that has been informed by engagement with the health and disability sector and with consumers and their family and whānau.

Why change is needed

The first Blueprint[2] successfully championed the recovery approach and the drive to provide access to services for the 3% of people most seriously affected by mental health and addiction issues.

We are now increasingly aware of the needs of those who have a lower level of need but whose mental health and addiction issues impact significantly on their overall health and their ability to function at home or at work. We are also more aware of the significant benefits of early recognition and response, as well as the importance of working across the whole health sector and other government agencies to achieve the best outcomes for people and for society.

We still have one of the highest rates of youth suicide in the developed world and inequalities in mental health and addiction outcomes for Māori and Pacific people.

What Blueprint II will achieve

The Blueprint II vision "mental health and wellbeing is everyone's business" sets the stage for a future where everyone plays their part in protecting and improving mental health and wellbeing. It is founded on the understanding that mental health and wellbeing plays a critical role in creating a well-functioning and productive society.

When Blueprint II is implemented:

- People who have mental health and addiction issues will not have to wait for support at a level of intensity that matches their need.

- People and their family/whānau will be partners in the care process.

- People and their family/whānau will experience support that is designed around their needs and where every contact with a service supports their return to health, functioning and independence.

- People's mental health and addiction issues will be recognised and treated early across the whole life-course.

- More people will experience good mental health as a result of cross government and community action to enhance the protective factors that determine mental wellbeing (for example, social inclusion, income, employment, education, housing, and absence of discrimination).

- Differences in outcomes for different population groups will be significantly reduced.

- We will have transformed our system performance and reduced the average cost of care, resulting in significantly increased access to services for a much broader range of people.

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2   The Mental Health Commission. November 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington: The Mental Health Commission.

Blueprint II priorities

Blueprint II identifies eight priorities:

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

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

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

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

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

- **Promoting wellbeing, reducing stigma and discrimination:** Promote mental health and wellbeing to individuals, families and communities and reduce stigma and discrimination against individuals with mental illness and addictions.

- **Providing a positive experience of care:** Strengthen a culture of partnership and engagement in providing a positive experience of care.

- **Improving system performance:** Lift system performance and reduce the average cost per person treated while at the same time improving outcomes.

Making change happen

We need to do things very differently if we are to extend access to a broader range of mental health and addiction responses and develop a no wait system which provides early and timely responses. The results that Blueprint II is seeking can't be achieved by making minor changes.

We need to make substantial changes to the level and mix of services provided as well as where and when we intervene. It means a greater role for primary care and changes in the way our workforce is used. An important component of this change will be the full implementation of a 'stepped care' approach – intervening in the least intensive way from self care and across primary, community and specialist services to get the best possible outcomes.

The mental health and addiction ringfence has helped the sector grow and improve access rates and services, particularly for people with the highest level of need.

To support the changed models of care and to extend access to a broader range of people, the ringfence now needs to be modified. More flexibility in the way that ringfenced funds can be used will help extend access and integration. And a move from an historical to a population-based ringfence will better reflect the size, makeup and need of each DHB. At the same time it will be important to put in place a results-based performance framework and new performance targets to provide assurance that the new flexibility is being used to best effect.

In 3–5 years, when the new performance framework is in place and working well, the need for continuing the ringfence should be reviewed.

This document, *Blueprint II: How things need to be*, has a companion document, *Blueprint II: Making change happen*. It provides practical guidance on how to make Blueprint II a reality and is available online at **www.hdc.org.nz**.

Measuring progress

The two key statutory roles of the Mental Health Commissioner, as part of the Office of the Health and Disability Commissioner, are monitoring and advocacy. Promoting Blueprint II and monitoring progress on its implementation will be a priority. This will include sector visits and regular public reporting against a set of indicators that provide information on achievements at both a population level and a service level.

5. From Blueprint to Blueprint II

The first Blueprint,[3] published in 1998, successfully championed the recovery approach and the drive to provide access to services for the estimated 3% of people most seriously affected by mental health and addiction issues. We now have one of the better specialist mental health and addiction sectors in the world.

The time has come to broaden our focus. We have new knowledge about what works and what does not, and our environment has changed and will continue to change. Blueprint II is an independent, sector-informed vision that aims to build services that meet our future needs. It also provides guidance to the mental health and addiction sector, the broader health sector and inter-agency partners on how to make the changes needed over the next decade.

Like the original Blueprint, Blueprint II is not government policy. It is independent advice from the Mental Health Commission to Government – and it is guidance from the Commission to government agencies.

The Ministry of Health is leading the development of a five-year *Service Development Plan*,[4] which will articulate government policy on developments in health-funded services. *The Service Development Plan* is expected to be informed by Blueprint II.

Together, Blueprint II and the *Service Development Plan* will help the broader health and government sectors build on their current strengths to address future challenges.

5.1 Acknowledging our success to date

Over the past two decades New Zealand's mental health and addiction sector, guided by progressive national strategies and policies, has been improving the way it meets the needs of service users and family/whānau.

The mid to late 1990s saw the publication of the National Mental Health Strategy, *Looking Forward,* (1994)[5] together with its action plan, *Moving Forward* (1997)[6] and the Mental Health Commission's *Blueprint* (1998). Collectively these made mental health and addiction a priority for the Government and supported the sector to:

- Steadily grow access to specialist services and to grow sector capacity and infrastructure.

- Strengthen the voice of service users and their say in how services are planned and developed.

- Shift the mix of care, with far fewer people 'treated' in institutions and many more supported in their recovery within the community.

- Grow the non-governmental (NGO) sector including Māori and Pacific providers.

- Move from relative under-investment in mental health and addiction services.

From 1994 to 2005 the sector's focus was necessarily on people most severely affected by mental health and addiction issues (the '3%') and the specialist services that supported them. There was also growing acknowledgement of the significant impacts of mental health and addiction right across society, the needs of those with mild and moderate symptoms, and the importance of early intervention, prevention and the

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3   The Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington: The Mental Health Commission.
4   Ministry of Health. 2012. *Draft Service Development Plan.* Due for publication December 2012.
5   Ministry of Health. 1994. *Looking Forward. Strategic Directions for the Mental Health Services.* Wellington: Ministry of Health.
6   Ministry of Health. 1997. *Moving Forward. The National Mental Health Plan For More and Better Services.* Wellington: Ministry of Health.

promotion of mental wellbeing. The mental health and addiction strategy *TeTahuhu (2005–2015)*[7] and its associated action plan, *Te Kokiri (2006–2015)*,[8] sought to significantly broaden the focus of the mental health and addiction sector to move beyond the most severely affected. It also identified the need to integrate mental health and addiction services into the broader health system and across social services.

Since 2005 there have been some significant developments, including an increasing number of primary mental health initiatives, highly successful mental health promotion and self-help activity (for example, the destigmatisation campaign, 'Like Minds Like Mine'[9] and the National Depression (fronted by John Kirwan), ongoing increases in access rates to specialist services (which now sit at a national average of 3.1%) and a greater focus on addiction services (both as part of, and separate from, mental health services). In addition, other government agencies have increased their focus on mental health and addiction; for example, launching initiatives influencing the drivers of crime, improving outcomes for children in care and young people, and assisting people with mental health and addiction issues back into the workforce.

5.2   Building on our success

We are now at a critical point in the evolution of the mental health and addiction sector. The population of New Zealand is changing: overall, it is increasing in size and ethnic diversity and aging. The health promotion and public health initiatives (for example, 'Like Minds Like Mine') that have been in place for a number of years continue to change people's expectations of services, their knowledge of what is available and how to seek help.

The argument for continuing to invest in mental health and wellbeing is strong. There is increasing awareness that:

- Mental health and addiction issues are more common than typically recognised. The personal impacts of poor mental health are higher than any other group of diseases, and the societal impacts reach far beyond just the affected individual or the health sector.

- Early recognition and treatment of mental health and addiction issues can significantly reduce the negative impact on people, their families and whānau, communities and wider society.

- The mental health and addiction sector has a role to play in forming strong links and partnerships with agencies that are addressing broad government objectives where mental health and addiction issues play a significant role; for example, reducing sickness benefits.

- There is a strong link between poor mental health, addiction and poor physical health. In the words of the World Health Organization[10] "there is no health without mental health". Treating one area in isolation limits the benefits that can be achieved.

- The personal impacts of mental health and addiction disorders are significant: they are the leading cause of disability and result in significantly reduced life expectancy. It is estimated that people with severe mental illness live an average of 10 to 15 years less than people without mental illness.[11]

- We have one of the highest rates of youth suicide in the developed world.[12]

- Mental health and addiction outcomes for Māori and Pacific people prevent them experiencing the same levels of wellbeing as the rest of the population.

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7   Ministry of Health. 2005. *TeTāhuhu: Improving Mental Health*. Wellington: Ministry of Health.

8   Ministry of Health. 2006. *TeKokiri: The Mental Health and Addictions Action Plan 2006–2015*. Wellington: Ministry of Health.

9   Ministry of Health. 2012. *'Like Minds Like Mine'*. www.likeminds.org.nz.

10   World Health Organization. 2001. *Mental Health: New Understanding, New Hope*. Geneva: World Health Organization.

11   Chang C-K, Hayes R D, Perera G, Broadbent M T M, Fernandes A C, et al. 2011. "Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London." *PLoS ONE*. 6(5): e19590. doi:10.1371/journal.pone.001959

12   Ministry of Health. 2012. *Suicide Facts: Deaths and Intentional self harm hospitalisations 2009*. Wellington: Ministry of Health.

The combined impact of these factors will require the sector to increase access to organised mental health and addiction responses over the next 10 years. Increasing access is relatively easy if we increase resources. But as we know, the constrained fiscal environment is expected to continue for some time.

We have a choice. We could continue as we are: delivering specialist support to those who access services and working on areas that still require improvement. Or we can be bold, in the same way that the initial Blueprint was bold, and commit to a vision and a road map for change that will create a 'new wave' of development for the mental health and addiction sector.

This 'new wave' is built on an understanding of the interaction between mental health and addiction, physical health and a person's social context. It provides insight into how a person's context and history can shape their mental health.[13]

We are not starting from scratch. New Zealand has already begun to embrace this 'new wave'. People with experience of mental health issues or addiction already have greater involvement in designing and improving their own treatment plans. We have improved our focus on preventing mental illness and intervening earlier and there is a growing awareness of recovery, resilience and Whānau Ora models. We have a broad range of modern services, including peer support, and successful health promotion programmes. There is growing awareness across government agencies of the role they can play in improving mental health and wellbeing; for example, in areas such as housing, income and work. There is also awareness that mental health and addiction issues in some people can impact on educational achievement, crime and sickness benefits; for example, of the 58,000 on sickness benefits, 41.5%, or 24,070 people, have psychological or psychiatric conditions as the main incapacity or reason for being on the benefit.[14] For the 84,000 on the invalid's benefit this is 30.4%, or 25,536 people.[15]

5.3   Vision

Blueprint II's vision is to make mental health and wellbeing everyone's business. It is a vision founded on a common understanding that mental health and wellbeing plays a critical role in creating a well-functioning and productive society. It is a vision for a future where everyone plays their part in protecting and improving mental health and wellbeing.

Whole of...

Government   Health   Community   Family / Whānau   Person

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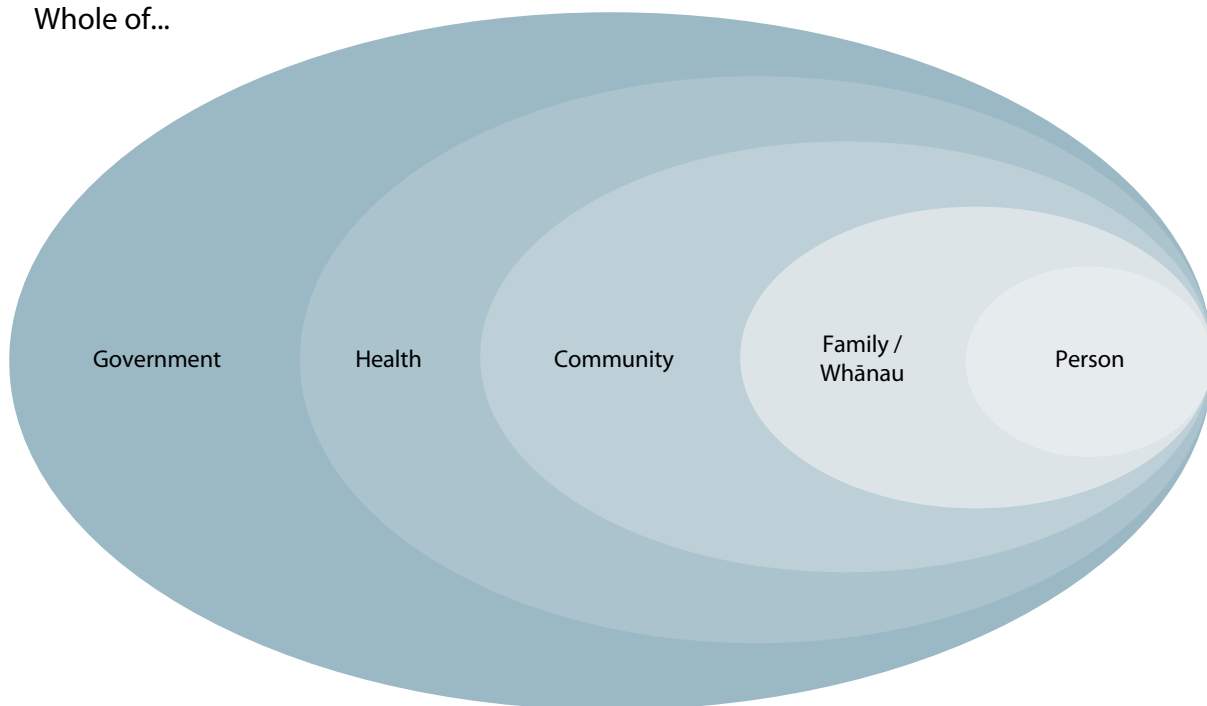
13   World Health Organization. 2003. *The Mental Health Context.* Geneva: World Health Organization.
14   Centre for Social Research and Evaluation. 2012. *National Fact Sheet – Sickness Benefits.* Wellington. Ministry of Social Development.
15   Centre for Social Research and Evaluation. 2012. *National Fact Sheet – Invalids Benefits.* Wellington. Ministry of Social Development.

This is a vision where:

- People, families/whānau and communities are well informed and have the tools to actively develop their own ability to weather adversity.
- Primary and other general health care services support resilience, recognise emerging problems early and provide the supports and interventions to enable people to recover rapidly.
- Mental health and addiction responses support and enable recovery and full participation.
- Publicly funded agencies work together to make the best use of their collective funds to achieve the best possible outcomes and where governments of the day create a policy environment that supports this joined-up approach.

5.4   Principles

The recovery approach articulated in the initial Blueprint has guided service development over the past decade for those most severely affected by mental health and addiction issues. Blueprint II reinforces and strengthens the recovery principle alongside the principles of resiliency and a people-centred and directed approach.

A people-centred and people-directed approach

A people-directed approach is one where there is real partnership between people with mental health and addiction issues, their family/whānau and their service provider. This model is already well developed in New Zealand. Blueprint II seeks to make it stronger. There is a need for stronger partnerships, self-determination, information, and involvement in providing services, shaping and overseeing policy and being part of services development at a national level. There is evidence across the broader health sector of significant benefits from partnerships between health services, health professionals and services users, their families/whānau in clinical quality and outcomes, the experience of care, and the business and operations of delivering care (including reduced costs).[16][17][18][19] And from a human rights perspective it is essential.

A people-centred approach is one where responses are designed around a person's needs rather than around the needs of those providing service. It is one where every contact a person and their family/whānau have with services uses a recovery approach and supports their engagement and care for their own mental health and wellbeing.

Recovery and resiliency

Resiliency is the capacity of individuals to cope well under adversity. A resiliency approach encourages individuals to build the capacity to care for their own mental health. It encourages social inclusion as an important tool for reducing the impact of mental health and addiction issues and supports families and communities to take part in that process.

Recovery is commonly defined as living well in the community with natural supports. Recovery does not always mean people will return to full health or retrieve all their losses, but people can and do live well despite this. The description of recovery continues to evolve. Destination notes that "the recovery philosophy stresses hope, self determination, full citizen participation and a broad range of services and resources for people with mental disorders".[20] *Our Lives in 2014* describes recovery as being something that happens "when we regain personal power

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16   Meterko M, Wright S, Lin H, et al. 2010. "Mortality among patients with acute myocardial infraction: The influences of patient-centred care and evidence-based medicine." *Health Services Research. 45(5p1): 1188–1204.*
Charmel P, Frampton S. 2008. "Building the business case for patient-centred care." *Healthcare Financial Management.* March 62(3): 80–5.
17   Boulding W, Glickman S, Manary M, et al. 2011. "Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days". *The American Journal of Managed Care.* 17(1): 41–8.
18   DiGiola A, Greenhouse P, Levison T. 2007. "Patient and family-centred collaborative care: An orthopaedic model." *Clinical Orthopaedics and Related Research.* 463(13–19).
19   Arbuthnott A, Sharpe D. 2009. "The effect of physician-patient collaboration on patient adherence in non-psychiatric medicine." *Patient Education and Counseling.* 77(1): 60–7.
20   Mental Health Advocacy Coalition. 2008. *Destination: Recovery: TeŪngaki Uta: Te Oranga.* Auckland: Mental Health Foundation of New Zealand.

and a valued place in our communities. Sometimes we need services to support us to get there".[21] These core definitions need to be expanded for people with addictions and for different age groups.

For people with addiction problems, recovery involves an expectation or a hope that they can and will recover. It is a process, not a state of being. It includes both abstinence and harm minimisation approaches that have evolved over time, allowing people a choice to adopt the approach that best represents their world view.

For many older people, especially those with progressive disorders, recovery may be better described by the concepts of 'quality of life' and 'dignity'. For children and young people, resiliency is more important than recovery, and recovery needs to focus on ensuring that developmental milestones appropriate to the child continue to be attained. When Blueprint II uses the term 'recovery' it covers all these elements.

Future focus, protecting gains
Build on the gains made to date and embrace the new wave

Holistic and whole system
Mental health and wellbeing is critical to a well functioning and productive society

Equity
Improve equity for Māori, Pacific people and vulnerable populations

People, family/whānau–centred and directed resiliency and recovery

Accountability and evidence
Use the evidence to support outcome and results based accountability

Wellbeing
Strengthen focus on prevention, promotion, and early intervention throughout life

Productivity and sustainability
Improve the performance of the sector to ensure value for money

Figure 1: Principles underpinning Blueprint II

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21   Mental Health Commission. 2004. *Our Lives in 2014*. Wellington: Mental Health Commission.

6. Directions

To put the principles into action we must:

1. Respond earlier and more effectively to mental health, addiction and behavioural issues.
2. Improve equity of outcomes for different populations.
3. Increase access to mental health and addiction responses.
4. Increase system performance and our effective use of resources.
5. Improve partnerships across the whole of government.

6.1 Respond earlier and more effectively to mental health, addiction and behavioural issues

There is strong evidence to show that responding earlier and more effectively can improve people's lives, avoid negative impacts on society and reduce the level and intensity of demand for services arising later.[22][23] It is also clear that mental health and addiction issues can impact on people at different times throughout their lives: responding earlier will mean different things for children, youth, adults and older people.

Blueprint II introduces a 'life course' approach to help show that early response is important for everyone and that intervening at key moments can have a positive impact over time.

The life course approach allows us to look at the critical points in the development of mental health, addiction and behavioural issues where we can intervene earlier and more effectively. It covers the whole life course, from before birth through to older people. In particular, it focuses on the eight most common points in the lives of people with mental health, addiction and behavioural issues where there is an opportunity to identify issues and to make a real difference by intervening early.

To be successful, the life course approach requires responses from the whole health sector, the broader social, education and justice sectors, as well as the mental health and addiction sector.

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22 Fonagy P, Target M, Cottrell D, Phillips J and Kurz Z. 2000. *A review of the outcomes of all treatments for psychiatric disorder in childhood.* MCH 17–33.
23 Merry S, Woulds T, Elder H, Guy D, Faleafa M and Cargo T. 2008. *CMDHB Infant Mental Health Report.* Auckland: Counties Manukau District Health Board.
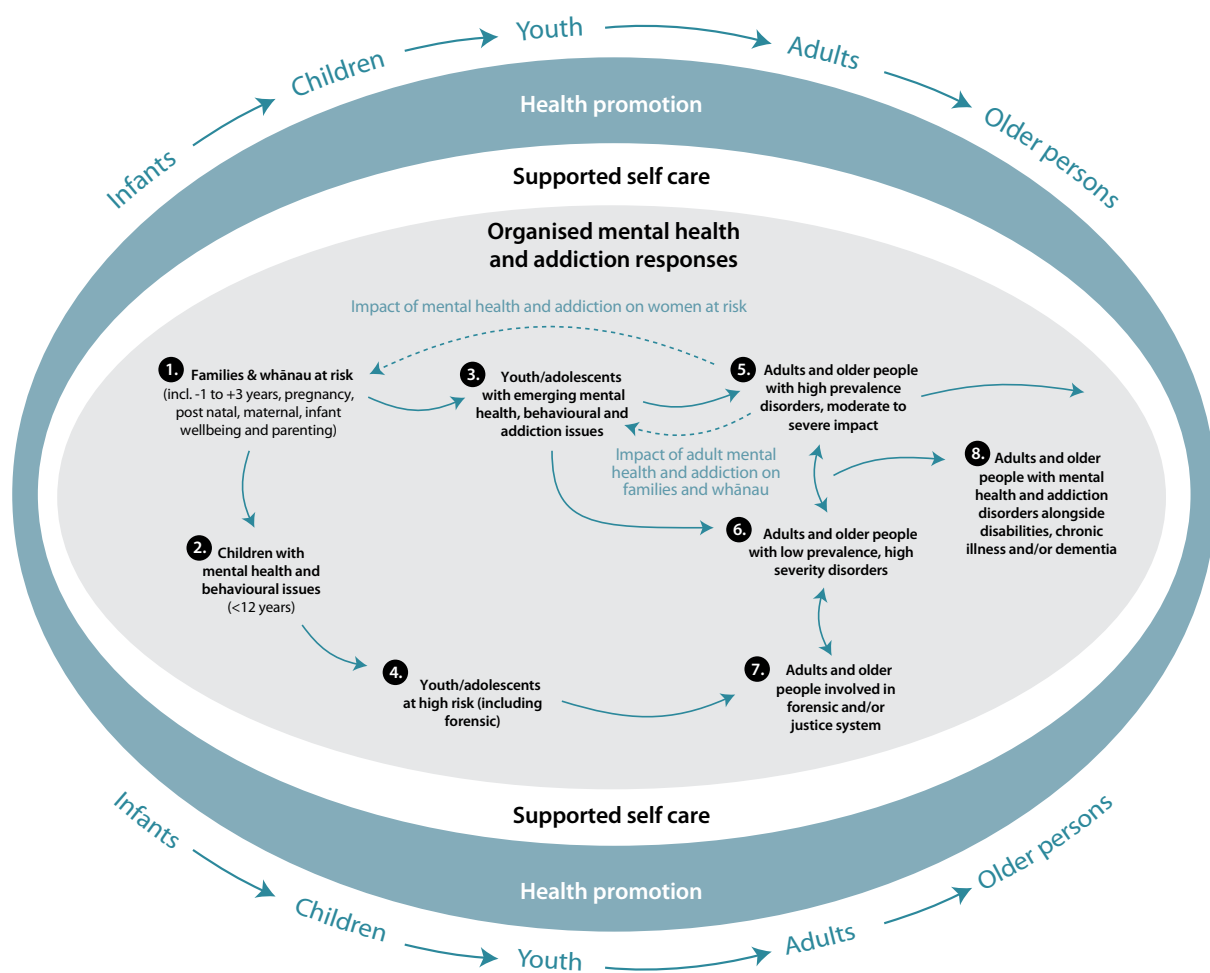
Figure 2: Life course approach

The life course approach can also focus our thinking about the opportunities we have at different ages and stages to support people, families and communities to be resilient and to weather adversity. This is the domain of health promotion and supported self care – the two outer sections of the diagram above.

For example, for older people, effective health promotion and self care would include physical exercise programmes, social support and activities, home visits, volunteering and attention to spiritual needs.[24]

Health promotion and self care is not an area where the mental health and addiction sector can take sole responsibility. It needs a broader support base including people, their families, communities, and employers alongside the health and wider social sector.

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24   Ministry of Health. 2011. *Mental Health and Addiction Services for Older People and Dementia Services.* Wellington: Ministry of Health.

The eight clusters covered by the life course approach and the impact of intervening at these points are:

1. Families/whānau at risk (-1 to +3 years, pregnancy, post natal, maternal and infant wellbeing, parenting)	The perinatal and infant years have a direct impact on later success in life. There is an opportunity to intervene early to support families/whānau to provide the foundation for good mental health and resiliency.
2. Children with mental health and behavioural issues	Preschool to prepubescent (less than 12 years) children with behavioural disorders (including attention deficit and hyperactivity disorder, oppositional defiance, milder forms of developmental and learning disorders and conduct disorders) and their family/whānau. It represents an opportunity to provide parenting support and early intervention to substantially improve participation in education and to reduce the risk of youth and adult mental health and addiction issues and crime.
3. Youth/adolescents with emerging mental health, behavioural and addiction disorders	Youth experience a significantly higher rate of mixed anxiety, depression and alcohol and drug use which has a significant impact on mental health and wellbeing for this group. It represents an opportunity to intervene earlier and reduce the risk of subsequent adult mental health and addiction issues.
4. Youth/adolescents at high risk (including forensic)	This cluster focuses on youth with significant mental health, alcohol and drug and behavioural disorders and represents an opportunity to intervene in a pathway that has the potential to lead to life-long mental health and addiction issues. It includes youth who are at risk of, or already involved with the forensic mental health or justice systems. Interventions for youth with significant mental health, alcohol and drug and behavioural disorders provide an opportunity to reduce the risk of them experiencing life-long mental health and addiction issues.
5. Adults and older people with high prevalence disorders, moderate to severe disorders	Adults and older people with anxiety, depression, drug and alcohol abuse, and medically unexplained symptoms often have co-existing medical conditions, resulting in high use of health services. It represents an opportunity to increase the resiliency of this population, reduce the costs of secondary and tertiary medical/surgical services provision and reduce the society-wide burden of poor health, loss of employment and loss of independence.
6. Adults and older people with low prevalence, high severity disorders	Adults and older people with severe mental health and addiction conditions, particularly where they are enduring, are at risk of substantially reduced life expectancies, higher morbidity and reduced social and employment participation. Intervening with more evidence-based effective interventions, in particular talking therapies and supported employment initiatives represents an opportunity to strengthen recovery, reduce morbidity and improve social inclusion.

7. Adults and older people involved in forensic and/or justice system	Where high severity mental health and addiction issues overlap with criminal behaviour, it represents an opportunity to support more comprehensive and integrated responses across the justice system and mental health and addiction services. This results in better health, reduced reoffending, reduced benefit use and increased employment.
8. Adults and older people with mental health and addiction disorders alongside chronic illness and/or dementia	For adults and older people there is an opportunity to integrate mental health and addiction interventions with health and wider social sector responses to maintain functioning and independence and to slow decline.

These opportunities for improving mental health outcomes for these eight population groups are all connected: more effective earlier action reduces the level and intensity of demand for services arising later.

The use of this framework does not imply that, for example, every child with a conduct disorder will become an offender, or that parents with mental illness are placing their children at risk. What the framework does is use the evidence base to identify those groups of people who are most at risk and where intervention can be successful at a population level. For example research tells us that for the 5–10% of children with the most severe conduct and behavioural problems, early intervention has the potential to reduce adult crime activity and associated poor life outcomes for those children by 50–70%.[25]

6.2   Improve equity of outcomes for different populations

Mental health and addiction outcomes vary widely across different population groups in New Zealand. These groups include Māori, Pacific peoples, refugees, lesbian, gay, bisexual and transgender people, people who are deaf, people in detention, people with intellectual disabilities, and people who live in rural areas. The outcomes are based on a complex mix of socioeconomic, ethnic, cultural, environmental and geographic factors.

All New Zealanders should have the same opportunity to achieve mental health and wellbeing. Sustained efforts are required to achieve more equitable outcomes for those groups.

There is no single way to ensure improved outcomes for different population groups. Many have their own distinctive world views and there are unique ways of meeting their needs. A balance is needed between providing services that are tailored for a particular group's needs, while ensuring that a breadth of mainstream services are still available.

Poverty, inadequate housing, low levels of education and unemployment put people at greater risk of developing mental health and addiction issues: "the conditions people face in their lives shape whether they feel safe, secure and supported at home and in their communities".[26] Collaborative efforts across a range of sectors are required to address the social determinants of mental health.

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25   Heckman J. 2000. *Invest in the Very Young.* Chicago, Illinois: Ounce of Prevention Fund and University of Chicago Harris School of Public Policy Analysis.

26   Mental Health Commission of Canada. 2012. *Mental Health Strategy for Canada.* Canada: Mental Health Commission of Canada.

6.2.1 Māori

The findings from *Te Rau Hinengaro 2003/04*[27] show that Māori have higher overall rates of mental health disorders than Pacific people and non-Māori people and that this higher level of need for services is not currently being met. Sustained, ongoing efforts are required to develop pathways of care, environments and a workforce that are more effective for Māori mental health service users and their whānau. Whānau Ora brings together Māori aspirations around mental health and provides an approach which builds whānau capability and provides support for Māori families to achieve their maximum health and wellbeing.[28]

For services to be effective for Māori they need to:

- Meet the broader health and mental health needs of the service user in the context of their whānau.

- Understand the circumstances of the service user's life and goals.

- Recognise a Māori world view in service delivery.

- Be culturally appropriate.

- Address the barriers to Māori accessing mental health and addiction services.

- Increase access for Māori to appropriate mental health and addiction services.

6.2.2 Pacific peoples

The findings from *Te Rau Hinengaro* also show that Pacific peoples carry a higher burden of mental illness than the general population. The profile in relation to Pacific peoples' mental health and addiction is complex, with compounding risk and protective factors that are different from other ethnic groups. Access rates to services are low compared to need, particularly for Pacific children and adolescents. When Pacific peoples do access services, evidence shows it tends to be a later presentation, at the more severe end of the continuum.

Pacific peoples' world views and identity are based on a collective approach, governed by a complex set of interrelationships between individuals, their families and communities.

Over the past decade Pacific models of mental health care and the philosophical value systems that underpin them have been developed. These models emphasise the importance of understanding Pacific concepts such as the use of language, family and spirituality as a key component of Pacific models of care that exist alongside the physical, mental and social aspects of a person's wellbeing.

For services to be effective for Pacific peoples they need to:

- Meet the broader health and mental health needs of the service user in the context of their families.

- Understand the circumstances of the service user's life and environment.

- Recognise Pacific world views in service delivery.

- Be culturally appropriate.

- Address the barriers to Pacific peoples accessing mental health and addiction services.

- Increase access for Pacific peoples to appropriate mental health and addiction services.

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27   Oakley Browne M, Wells J, Scott K (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.
28   Mauriora Ki Te Ao – Living Universe Limited. 2010. *Whānau Ora Integrated Services Delivery.* Wellington: Ministry of Health.

6.3   Increase access to organised mental health and addiction responses

The original Blueprint focused on reaching a section of the population with the highest and most complex mental health and addiction needs – estimated to be 3% of the population in 1998. There is now growing acknowledgement of:

- The wider prevalence of mental health and addiction issues with significant impacts right across society.

- The impact of less severe mental health and addiction issues on people's overall health and their ability to function at home and at work.

- The importance of early intervention, prevention and the promotion of mental wellbeing.

Organised mental health and addiction responses

Recovery and resilience focused responses provided by the health and other sectors and covering self care, primary, community and specialist settings. To be counted as an organised response it must be planned, reviewed and measured. For example, using an online self help programme would not qualify if it was self initiated; it would qualify if it was part of a planned and monitored response through primary care.

As a result, Blueprint II broadens the definition of the mental health and addiction sector to include primary care and broadens the delivery of responses beyond those most severely affected. It calls for earlier identification of mental health and addiction issues in primary care, and access to effective responses through stepped care delivered across the wider spectrum of services. Blueprint II envisages a future where no one will be turned away because they do not fit criteria for services. This will require greater access to effective organised mental health and addiction responses than we have achieved to date. Blueprint II also identifies the need to integrate mental health and addiction services into the broader health system and across social services.

This broader approach has significant implications for access to organised mental health and addiction responses. The initial Blueprint used the epidemiological evidence then available, across six age groups and four levels of service to calculate a set of 'likely' access targets for each age group. The result of this modelling was confirmation that the 'best current estimate' of the percentage of the total population who needed access to publicly funded specialist mental health services in any six months period was 3%. The mental health and addiction sector needs to maintain and increase responsiveness to people with the highest needs. But given the growing evidence of prevalence and impact and the demonstrated benefits of early intervention – both early in the life-course and early in the development of mental health and addiction issues – it is clear that the new integrated mental health and addiction system where no one is turned away will move us well beyond the '3%'. It will also increase access to effective responses delivered in primary care as well as in specialist settings.

We need goals to shift the focus from 'accessing services' to 'responding in ways that make a difference in people's lives'. These goals should drive:

- Increased recognition of people and families/whānau at high risk of mental health or addictions issues.

- Provision of organised mental health and addiction responses across primary and community settings as well as specialist services (stepped care).

- Models of care that ensure people can access the right services when they need them.

- Effective partnerships with cross-sector partners and recognition of their contribution to meeting the mental health and addiction needs of our population.

- The best use of all the resources we have available, including those within the wider general health sector and beyond.

- How we respond to need across the life-course.

While this is a complex task we must start to clarify the magnitude of change required and use this to prioritise action.

Blueprint II has initiated work to start this goal-setting process. To date this work has explored some of the evidence on prevalence and need across the various population clusters. Preliminary work to describe the level of prevalence that should be supported by some form of organised response is included in Appendix 1. A high priority during 2012/13 will be to work with experts to review the evidence and refine these into a set of goals that are meaningful, relevant and reflect the calls to action contained in Blueprint II.

We then need to use these goals to define what 'organised responses' mean across diverse settings, and design smart ways to measure activity to close the gaps. Currently access to organised mental health and addictions responses in primary care is not reported and this will need to change if we are to track changes in access to primary care.

Neither primary nor specialist settings currently identify people's 'life course', so if goals are to be set for organised responses by life course group, there would need to be a mechanism for collecting this information for each person each time they access services (because these will change over time).

You can check progress at **www.hdc.org.nz**.

6.4   Increase system performance and the effective use of resources

The first Blueprint was developed at a point where mental health and addiction services were significantly underfunded. Alongside detailed resourcing plans, it has laid the platform for a significant increase in funding since 1998 and we now have a well-funded public mental health and addiction service compared with other countries.

The fiscal environment today, and for the foreseeable future, is predicted to be tighter and more difficult.

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

The results needed cannot be achieved by making minor changes to the way we do things now.

6.4.1 Stepped care

> *... one of the more powerful approaches which enabled the most effective use of available resources has been the development of 'stepped care'* [29] [30]

The mental health and addiction sector needs to fully implement the 'stepped care' approach – intervening in the least intensive way to get the best possible outcomes. Stepped care is a structured mechanism for achieving increases in efficiency. The use of this model must span primary, community and specialist services and create opportunities for collaboration with other organisations; for example, those in the social welfare, education and justice sectors.

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29   Bower P and Gilbody S. 2005. "Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review." *The British Journal of Psychiatry*. 186(1): 11–7

30   National Institute for Clinical Excellence. 2009. *Depression: Treatment and Management of Depression in Adults, Including Adults with a Chronic Physical Health Problem*. London: National Institute for Clinical Excellence.

A stepped care approach involves:

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

- Making available interventions with differing levels of intensity.

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

- Entry and exit at any point.

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

- Having clear referral pathways between different levels of intervention.

- Supporting self care as an important aspect of managing demand across primary, community and specialist care settings.
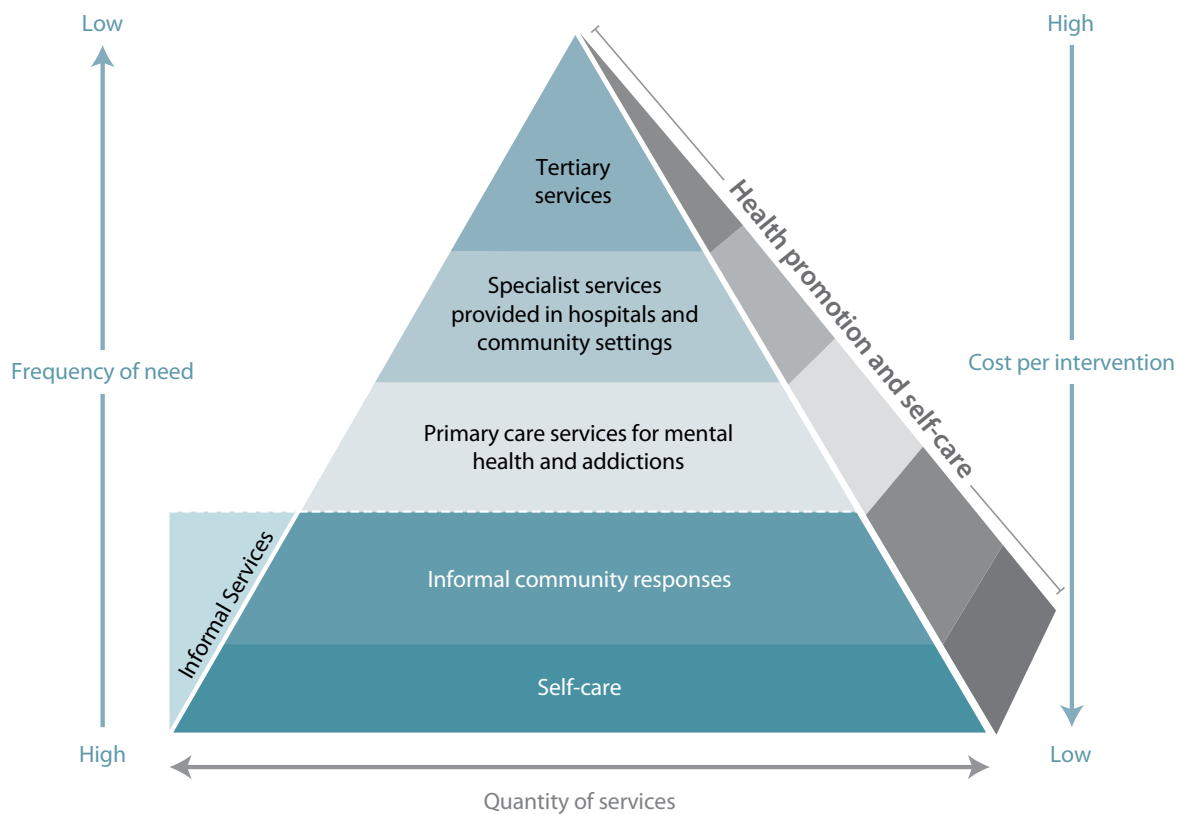
Source: Adapted from the World Health Organization.[31]

Using the stepped care model should result in an integrated response – where people receive support that is appropriate and timely – and holistic packages of care that bring together support across sectors and silos.

As part of implementing the stepped care approach we need to reconsider what services are provided, and where they are provided. We need less provision of services that are known to add limited value (for example, generic or standard case management[32] [33]) and more provision of services that are known to add value (for example, talking

31 World Health Organization. 2008. *Integrating Mental Health into Primary Health Care: A Global Perspective.* Geneva: World Health Organization.

32 Simpson A, Miller C and Bowers L. 2003. "Case management models and the care programme approach: how to make the CPA effective and credible." *Journal of Psychiatric and Mental Health Nursing* 10(4): 472–83.

33 Smith L and Newton R. 2007. "Systematic review of case management." *Australian and New Zealand Journal of Psychiatry* 41(1): 2–9.

therapies). We need to ensure that clinical expertise is more accessible to support community and primary care. Through this reorientation of the specialist mental health and addiction workforce we can greatly increase access rates and shift the focus to intervening earlier in the life course. Over time this will prevent downstream increased need and enable gradual reinvestment in earlier intervention.

6.4.2　A 'no wait' system

Early and timely responses matter for mental health and addiction. A fast access 'no wait' system that meets needs earlier and less intensively can restore people back to their own support structures faster. Conversely, non-responsive services with barriers to entry can lead to longer duration of service support that is costly and ineffective.

> **'No wait' means …**
>
> - No one waits to get in.
> - No one waits to get out.
> - Practitioners don't wait for referrals to be actioned.

Driving for a responsive 'no wait' service will ensure prompt access to services, reduced escalation and loss of resiliency, as well as highlighting systems blockages and constraints that place pressure on the evolution of a better stepped care system.

A responsive 'no wait' system provides support earlier in onset, earlier in crisis or relapse, and is capable of providing a 'just in time' step up in support when really needed (see Priority 7). It will enable clinicians and users to feel confident in stepping down or out of continuing specialist care.

6.4.3　Modify the way the sector is funded

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

The mental health and addiction ringfence created a specific funding pool to be invested in mental health and addiction services. The ringfence has helped the sector move from a position of relative underinvestment a decade ago, improving access rates and services, particularly for people with the highest levels of need.

We are now in different times. Investment levels in mental health and addiction services are relatively similar to other services, fiscal constraints are much tighter and, as outlined in this document, there is a drive towards changed models of care and extended access to a broader range of people. To support this, the mental health and addiction ringfence needs to be retained but modified.

Three key changes are needed.

First, to help extend access and integration, the ringfence needs to allow more flexibility in the way funds can be spent. It needs to enable a shift from its traditional specialist focus to other organised mental health and addiction responses including health promotion, self care, primary, community and DHB-provided services. This is largely in place already and simply needs to be further reinforced and supported.

Second, we need to move from the current historical basis for calculating the ringfence to a population-based one. This will better reflect the size, makeup and need of each DHB's population but still protect the investment gains made to date. Work to support this move could start within 2012/2013, but needs to allow several years for DHBs to transition.

Third, we need to shift DHB and provider accountability targets to a greater focus on the outputs and outcomes needed to achieve Blueprint II (including new response level targets). This will be a more effective driver of our investment mix within mental health and addiction services (inside the ringfence) and will potentially influence other health, disability and government services (outside the ringfence). It will give assurance that DHBs' new flexibilities are being used to best effect as well as supporting more integrated investment across mental health and addiction services, and with wider health and government services. The new results-based performance

framework and the first set of revised targets must be in place at the same time that the ringfence is modifed and incrementally improved over time.

Once these mechanisms are in place and monitoring of progress against targets is showing positive results, the Ministry of Health may wish to review the need for a ringfence. It is likely to take 3–5 years to reach this stage.

6.5   Improve partnerships across the whole of government

Mental health and wellbeing is everyone's business. Mental health, addiction and behavioural issues do not respect the organisational, professional and funding silos and boundaries we have created to manage our mental health, general health, accident, education, housing, social, community and justice services.

A desire for a new approach is emerging. It is grounded in a clearer understanding of the costs and consequences of our current fragmentation.

The mental health and addiction sector must be part of a whole of society, whole of government approach to address fragmented responses, service gaps and partial solutions.

There are many opportunities to work together. An example can be seen in the relationship between mental health and unemployment. There are demonstrable health benefits from being in work as well as health risks from being unemployed.[34]

There are similar opportunities to work together with education, child care and protection, prisons and support for the elderly to ensure that any investment achieves the best possible outcomes.

The mental health and addiction sector must participate as a partner in making this new approach work. The sector is well placed to take an increasing leadership role in creating and developing cross-government partnerships.

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34   Black, C. 2011. *Realising the health benefits of work.* Sydney: The Royal Australasian College of Physicians.

7. Priority Actions

The following priority actions have been identified to give effect to the key directions for the next 10 years:

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

- **Positively influencing high risk pathways:** Provide earlier and more effective responses for youth and adults with mental health and/or addiction issues who are at risk or involved in the justice system.

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

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

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

- **Promoting wellbeing, reducing stigma and discrimination:** Promote mental health and wellbeing to individuals, families and communities and reduce stigma and discrimination against individuals with mental illness and addictions.

- **Providing a positive experience of care:** Strengthen a culture of partnership and engagement in providing a positive experience of care.

- **Improving system performance:** Lifting system performance by improving outcomes while at the same time reducing the average cost per person.

The first five priority actions relate to specific populations across the life course. The last three are overarching and apply across the entire life course.

Each priority is summarised overleaf. A full description on how to give effect to these actions can be found in the companion document *Blueprint II: Making change happen*.
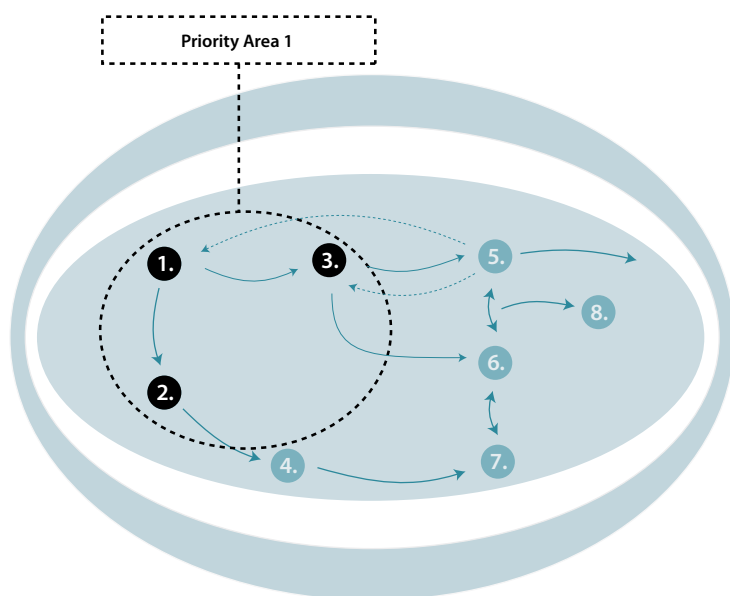
7.1 Providing a good start

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

Priority Area 1

This priority area focuses on mothers/infants, children and young people from vulnerable families/whānau. There is emerging knowledge and evidence of the lifelong impact of social, emotional and cognitive development from birth to three years. Creating a secure environment for infant development in the early years provides the foundation for mental health and resiliency in later life.

Maternal mental health and addiction issues affect 16% of women[35] and infant mental health issues affect between 16–18% of infants.[36] The prevalence of mental health and addiction disorders in children and young people is high. Dunnachie reported that 18% of New Zealand 11-year-old children are affected by a mental health disorder.[37]

We must increase the capability of families and their communities to support positive infant and child development through increasing awareness, health literacy and parenting support. We must also support better assessment and early responses for children in primary care and general child and youth services as well as education and child care and protection settings.

Maternal mental health issues, alcohol and drug use, conflict and violence, neglect and chronic poverty can result in an increased risk of later mental health and addiction issues. Provision of positive parenting and family engagement programmes (including the Triple P and Incredible Years programmes), combined with active steps to address family violence, maternal mental health and addiction issues is needed and has been shown to improve outcomes and reduce down-stream costs to both society and mental health and addiction services.

There are clear benefits of early intervention for preschool to puberty-aged children who have disorders such as attention deficit disorder, oppositional defiance, milder forms of developmental and learning disorders and conduct disorder. It results in improved educational participation rates and a reduction in later mental health and addiction issues, and criminal behaviour.[38]

We must increase access and early responses for children with interrelated mental health and behavioural issues by enhancing service partnerships across primary care, general child health services, the mental health and addiction sector and partners in education and child care and protection.

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

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

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

38   Heckman J. 2000. *Invest in the Very Young.* Chicago, Illinois: Ounce of Prevention Fund and University of Chicago Harris School of Public Policy Analysis.

The young adult period is characterised by a rapid rise in the prevalence of mixed anxiety, depression and, for some, drug and alcohol use. By secondary school age 27% of students are affected by depression and anxiety, with 10.6% experiencing significant symptoms.[39] Conduct disorders or severe antisocial behaviour disorders affect up to 10% of youth.[40] Mental health issues in youth are commonly accompanied by coexisting alcohol or drug problems.[41]

This age group experiences low rates of recognition because of a lack of awareness, social isolation or reluctance to seek help through conventional health, education or social services. At its more severe level, the combination of these factors leads to a sharply increased risk of self harm and suicide. We must increase access and early responses for youth with emerging behavioural, substance use and mental health issues by enhancing service partnerships across primary care, social services, school based support, dedicated youth health services and specialist mental health and addiction services.

7.2   Positively influencing high risk pathways

Provide earlier and more effective responses for youth and adults who are at risk or involved with social, justice, or forensic mental health and addiction services.
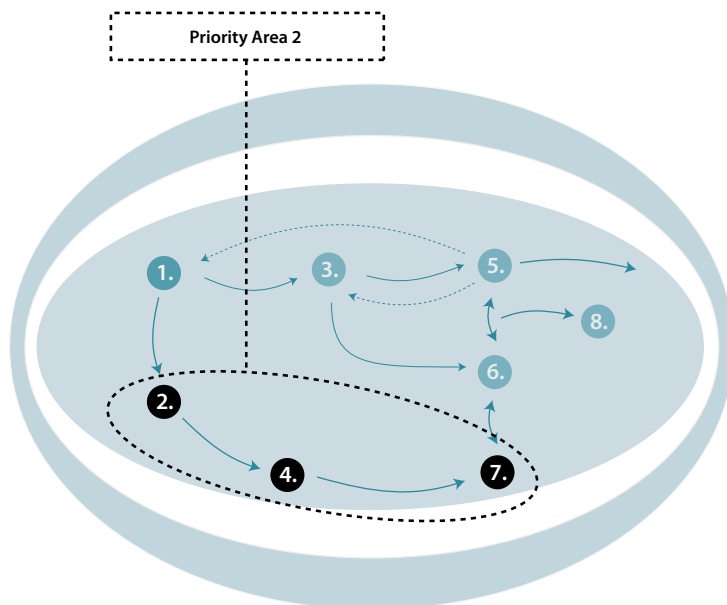
This priority area focuses on children, youth and adults with relatively severe mental health and addiction issues who are at risk or already involved with social, justice or forensic mental health services.

It calls for early, preventative responses for children with combinations of mental health and antisocial behaviour visible early in life, and risk reduction responses for youth with combinations of mental health, addiction and early stages of offending. It also includes management and recovery approaches for youth and adults with mental health and addiction issues in the justice or forensic mental health system.

For the 5–10% of children with the most severe conduct and behavioural problems, research suggests that early intervention has the potential to reduce adult criminal activity and associated poor life outcomes by 50–70%.[42] For this group we need to work with sector partners in education, childcare and protection to ensure a range of evidence-based responses for young people at key intervention points.

Evidence suggests that between 40–60% of youth offenders will have mental health and alcohol or drug issues with higher proportions among those remanded.[43] We need to develop a nationally consistent stepped system of care for high-risk youth that spans the continuum from early recognition, primary/community level services

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

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

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

42   Heckman J. 2000. *Invest in the Very Young*. Chicago, Illinois: Ounce of Prevention Fund and University of Chicago Harris School of Public Policy Analysis.

43   The Werry Centre. 2009. *Mental health and alcohol and other drug screening, assessment and treatment for Youth Justice populations*. Auckland: The Werry Centre.

through to secure youth forensic services that actively support transition back to the community. We need to continue to support shared learning, evaluation and research to build understanding of what works for different cultures, particularly Māori youth, and translate this into effective services.

We need to provide a full range of general health and mental health and addition services for people of all ages within forensic services, prisons and the equivalent community-based sentences, and an effective transition to community support services.

Mental health and addiction responses are but one contributor. Across all youth and adults who are at risk, or already involved in the justice system, effective action depends on mental health and addiction services, and specialist services in care and protection, education and justice aligning what they do. We need to jointly ensure a range of appropriate evidence-based responses are provided early and at key intervention points. Examples are the developments that have occurred in addressing conduct disorder, mental health services for children in care, youth diversion from courts to treatment, screening for mental health and addiction in prisons and investments in primary mental health care for offenders.

7.3   Supporting people with episodic needs

Support return to health, functioning and independence for people with episodic mental health and addiction issues.
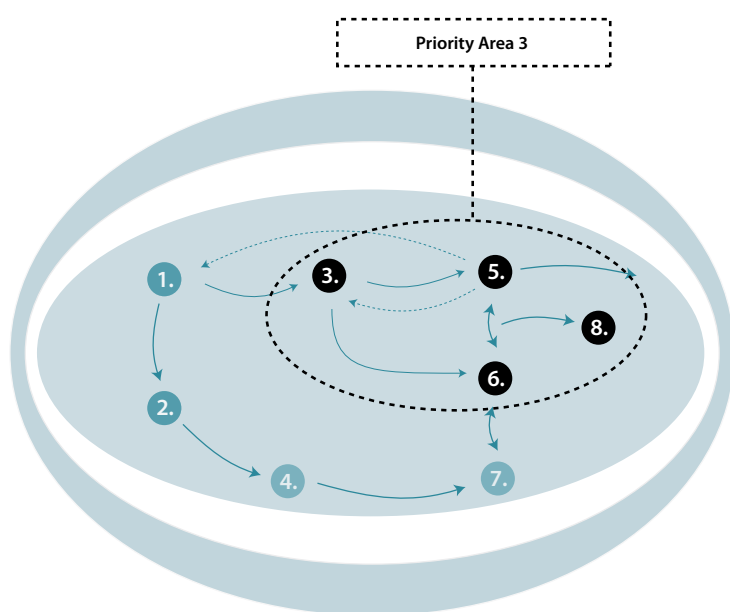
This group includes people (young adults through to older people) who experience episodes of high prevalence disorders including anxiety, depression, drug and alcohol abuse, and medically unexplained symptoms.

One in five people in New Zealand will experience a mental health or addiction problem over a 12-month period.[44] We need to do more to maintain good mental health, respond promptly to the early signs of distress, and build sources of resiliency in homes, communities and workplaces. We need to provide effective primary and community-based responses and build and maintain resiliency for those on the road to recovery.

Good mental health – as demonstrated in healthy relationships, meaning and purpose in life, balanced emotions, resilience and participation in society – is shown to significantly reduce the risk factors of developing mental illness.[45] New Zealand has an emerging world-class capability in encouraging the recognition of depression and support through the National Depression Initiative. The initiative aims to reduce the impact of depression by aiding early recognition, appropriate treatment and recovery. It focuses on strengthening individual, family and social factors that protect against depression and improve community and professional responsiveness to depression.[46] We need to continue to support and develop this programme.

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44   Oakley Browne M, Wells J, Scott K (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.
45   Keyes C L M, Dhingra S S, & Simones E J 2010. "Change in level of positive mental health as a predictor of future risk of mental illness." *American Journal of Public Health*, 100 (12), 2366–2371.
46   http://www.health.govt.nz/our-work/mental-health-and-addictions/national-depression-initiative.

We need to ensure that there is a coherent spectrum of evidence-based self care options available including mental health and addiction health literacy, e-therapies, and whānau and peer support.

Critical to the implementation of Blueprint II is increasing the role of primary/community responses. The elements of a more effective primary mental health and addiction response are already in place. Blueprint II calls for increased use of effective interventions in primary care including brief problem-solving consultations, motivational interventions or talking therapies such as cognitive behavioural therapy and phone support, and monitoring progress especially of people being treated with medication. For more complex issues, there needs to be increased availability of specialist advice and support to primary and community services.

At the other end of the continuum, there will be people who have been through the experience of a more severe episode of mental illness and/or addiction. To ensure early return to wellbeing and resiliency Blueprint II calls for increased use of peer support, collaborative relapse prevention and wellness action recovery planning and programmes to support return to employment.

Importantly, we need to ensure that there are a range of services which are culturally appropriate, particularly for Māori and Pacific people.

7.4   Supporting people with severe needs

Support return to health, functioning and independence for people most severely affected by mental health and addiction issues.
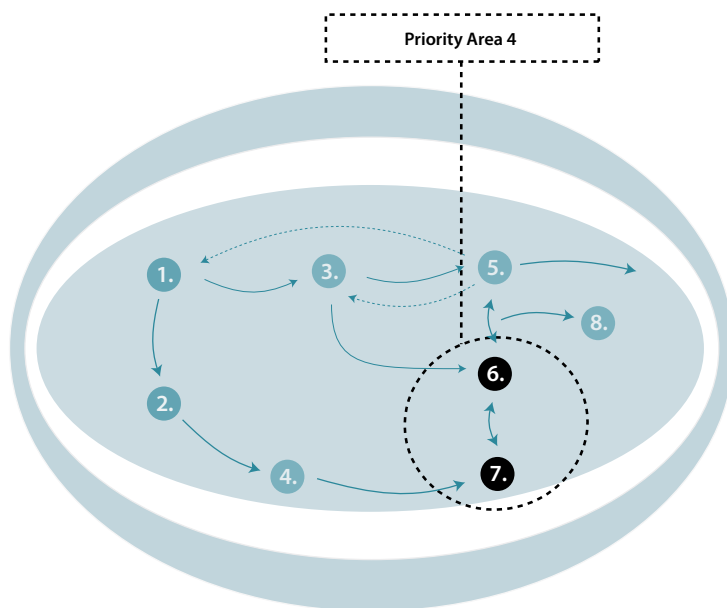
People (young adults to older people) severely affected by mental health and addiction issues often have poor physical health and poor social outcomes including employment, housing and social participation. This does not need to be the case.

While we have made substantial gains since the original Blueprint, our current systems of support tend to reinforce longer term engagement with specialist mental health and addiction services. We need to see long-term mental health and addiction conditions as being little different to long-term medical conditions; that is, as requiring periodic access to specialist advice and intervention, but with care remaining co-ordinated from primary care.

We need a much more 'whole of system' approach with more flexible use of stepped care responses that support the movement towards recovery, independence and resiliency. There are already existing good models of care that improve pathways through care and promote recovery, independence and resiliency. These should continue to be developed.

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

- Partnerships with family/whānau and natural support networks to provide home-based acute treatment that minimises loss of resiliency.

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

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

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

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

People with severe and enduring mental health conditions are more likely to suffer poor health and higher rates of morbidity and mortality than the general population. As a priority, primary care services need to apply a long-term conditions approach to their medical care management – an integrated approach between primary care and specialist services.

Success in addressing mental health and addiction issues cannot be achieved in isolation from the social and cultural context in which people live. As part of our response we must have a choice of culturally responsive services, delivered in partnership with communities.

7.5   Supporting people with complex needs

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

This priority area focuses on people with mental health and addiction issues alongside other long-term conditions and/or dementia. It covers:

- People with disabilities and neurodevelopment disorders (including autism and severe forms of cerebral palsy).

- Older people facing late age depression, anxiety and/or dementia.

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

Priority Area 5
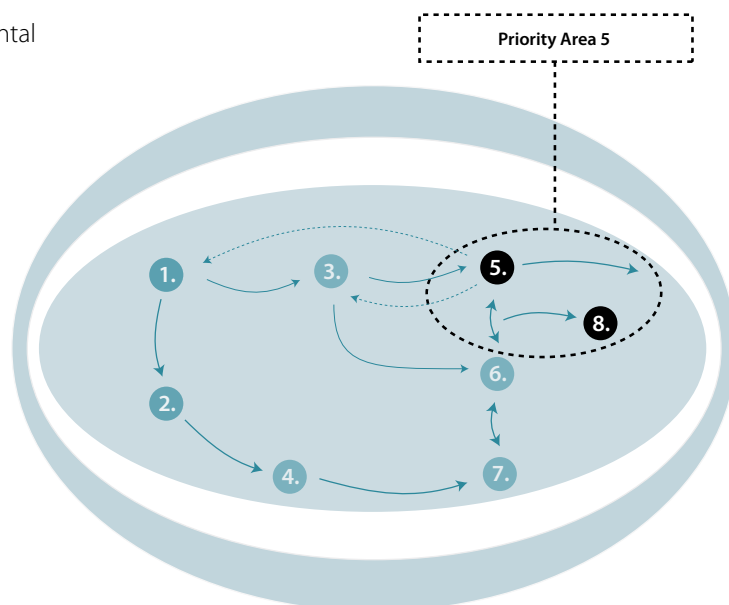
Evidence shows that 40% of people with intellectual disability also have a co-existing mental health problem.[47] These problems tend to be poorly recognised with a tendency to believe that the problem is 'behavioural' caused solely by the disability. Research suggests that prevalence of mental health disorders in people who are deaf are approximately twice the general population[48]. Integrating mental health and addiction and disability policy at a

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47   Cooper S, Smiley E, et al. 2007. "Mental ill-health in adults with intellectual disabilities: prevalence and associated factors." *The British Journal of Psychiatry*. 190(1): 27–35.
48   Bridgman G, Macpherson B, Rako M, Campbell J, Manning V, Norman-Kelly T. 2001. *A National Epidemiological Survey of Mental Illness in the New Zealand Deaf Community, Proceedings of the 5th European and 2nd World Conference on Mental Health and Deafness, 18th–21st October, 2000*. Copenhagen: University of Copenhagen.

national level, and funding and service delivery at a local DHB level, is a good starting point to improve outcomes for people with disabilities and neurodevelopment disorders.

The prevalence of depression among older people is 15–20% but this increases with age, with 40% of over 80-year-olds affected.[49] If recognised earlier, the use of brief interventions and active engagement of family and friends has demonstrated effectiveness and can act to maintain resiliency and the ability to function well.[50] Blueprint II calls for development of a programme of systematic, opportunistic screening for depression and anxiety when older people experience a significant health event and access to primary care based interventions including psychological therapies.

Many older people with a mental health problem also have an existing illness or disability.[51] There is growing evidence that people with co-occurring mental health and addiction, and medical conditions, experience substantially poorer clinical outcomes and a lower quality of life.[52] They are also costly for health services. For example, people with chronic lung disease spend twice as long in hospital if they also have a mental health problem. A growing volume of research suggests that more integrated approaches – with professionals responsible for a patient's mental and physical health working more closely together – can improve outcomes and reduce costs.[53] It is important to develop this approach for people who have chronic physical health problems alongside mental health and addiction problems in order to achieve improvements in physical health, mental health and wellbeing.

The prevalence of dementia substantially increases with age: at age 60, less than 2% of the population suffers from dementia, but by 85 more than 30% are affected.[54] By 2050 147,000 people in New Zealand are expected to be diagnosed with dementia.[55] Primary care, general health services and residential care need to increasingly recognise emerging signs of dementia along with access to advice and brief interventions for both the person with dementia and their family or caregiver. The Ministry of Health has developed guidelines that would result in the development of a partnership approach that uses integrated, stepped care across home, primary, community and specialist services for older people, including those with dementia.[56] Blueprint II fully supports this direction.

7.6   Promoting wellbeing, reducing stigma and discrimination

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

Mental health promotion applies to the whole population and focuses on enhancing the strengths and skills of individuals, communities and society as a whole. Healthy relationships, meaning and purpose in life, balanced emotions, resilience and participation in society, are shown to significantly reduce the risk factors for developing a mental illness.[57]

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

49   Tynan D. 2008. *An Examination of the Evidence for Models of Service Delivery: Mental Health of the Older Adult (Including Dementia) and Addictions.* Auckland: Waitemata DHB.
50   Doughty C. 2006. *Effective Models of Mental Health Service Provision and Workforce Configuration in the Primary Care Setting.* Christchurch: New Zealand Health Technology Assessment Clearing House.
51   Richards D A and Suckling R. 2009. "Improving access to psychological therapies: phase IV prospective cohort study." *The British Journal of Clinical Psychology / The British Psychological Society.* 48(4): 377–96.
52   Moussavi S; Chatterji S; Verdes E; Tandon A; Patel V; Ustun B. 2007. "Depression, chronic diseases, and decrements in health: results from the World Health Surveys." *The Lancet.* Vol 370, no 9590, pp 851–8.
53   Naylor C P, McDaid M, Knapp D, Fossey M, Gallea A., 2012. *Long term conditions and mental health: The cost of co-morbidities.* London: The Kings Fund.
54   Oakley Browne M, Wells J, Scott K (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.
55   Alzheimers New Zealand. 2008. *Alzheimers New Zealand 2008 Dementia Economic Impact Report.* Wellington: Alzheimers New Zealand.
56   Ministry of Health. 2011. *Mental Health and Addiction Services for Older People and Dementia Services.* Wellington: Ministry of Health.
57   Keyes C L M, Dhingra S S, Simones E J. "Change in level of positive mental health as a predictor of future risk of mental illness." *American Journal of Public Health.* 100 (12), 2366–2371. 2010.

addiction problems. The determinants of mental wellbeing include income, access to resources, educational level, employment, housing, stress, social inclusion and discrimination.[58] It involves actions to create living conditions and environments that support people to be mentally healthy.

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

We need programs designed primarily for the whole or parts of the population in the context of everyday life in settings where people live, study and work. They should be comprehensive, take into account the wider determinants of health, use a mix of skills, be collaborative in nature and long in duration.

New Zealand already has an impressive track record in promoting mental health and wellbeing. An example is the Like Minds Like Mine national public education programme, aimed at reducing stigma and discrimination faced by people who have experience of mental illness. It has received international recognition and many awards for the breadth, creativity and effectiveness of the campaign.

The achievements to date provide a platform for further building a comprehensive approach to promoting mental health and reducing the stigma and discrimination faced by people who have experience of mental illness. Campaigns such as Like Minds Like Mine must continue, to further reduce stigma and discrimination and to develop campaigns to support employers and reduce discrimination in the workplace. There are also other informal mental health promotion initiatives which should be encouraged and supported.

Other priority areas include school-based and work-based mental health promotion programmes. The Mentally Healthy Schools programme, which involves teachers, students and their families, is showing promise in preventing mental health problems, improving academic performance, improving emotional and social functioning, and reducing health damaging behaviours and bullying.[59] Promoting mental health in the workplace has a range of benefits, including improving productivity and reducing costs.[60]

Employment has been identified as an important factor in the recovery of people with mental illness and is generally associated with better mental health. The objective is to ensure people with mental health and addiction disorders retain their jobs and work productively.[61]

There is growing evidence that lifestyle factors such as increased physical activity, good nutrition and moderating alcohol intake have a positive effect on mental health. Lifestyle changes offer significant advantages as they can be both effective and cost effective.[62] Brief interventions need to be routinely available to reduce alcohol consumption, provide green prescriptions for physical activity and dietary advice in both health promotion and primary care settings.

Programs building community cohesion with high levels of trust, reciprocity and participation have a positive impact on mental health and wellbeing.[63] There is also growing evidence of the mental health benefits of the natural environment such as green open spaces. Many of these programmes are well run by individual organisations in the community. To have more impact the challenge is to have more joined-up approaches across the whole community and to build evaluation into existing and new initiatives to develop the evidence base.

58   Manderscheid R W, Ryff C D, Freeman E J, McKnighty-Eily L R, Dhingra S, Strine T W. "Evolving Definitions of Mental Illness and Wellness." *Preventing Chronic Disease.* 2010, 7(1). http://www.cdc.gov/pcd/issues/2010/jan/09_0124.htm.
59   Friedli L, Parsonage M. 2009. *Promoting mental health and preventing mental illness: the economic case for investment in Wales.* Wales: Mental Health Promotion Network.
60   Department of Health 2001. *Making it Happen. A guide to delivering mental health promotion.* London: Department of Health.
61   Organisation for Economic Co-operation and Development, (OECD). 2011. *Sick on the job? Myths and Realities about Mental health at work.* Paris: OECD.
62   Walsh R. "Lifestyle and Mental Health." *American Psychologist.* DOI: 10.1037/a0021769.
63   Friedli L. 2009. *Mental health, resilience and inequalities.* Copenhagen: World Health Organisation.

7.7 Providing a positive experience of care

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

This priority strengthens the person and family/whānau-centred approach, making sure every contact a person and their family has with services uses a recovery approach and supports their engagement and involvement.

It emphasises the importance of the nature of the relationship between service users and providers. New Zealand has a rich history in recognising the consumer/service-user voice in planning recovery. Consumers and their families consistently express the need for stronger partnership, self-determination, information, and involvement in providing services, shaping and overseeing policy and being part of service development at a national level. This participation as a partner is seen as key to creating positive experiences and outcomes. Over the past decade our mental health sector has realised some of the benefits of involving consumers in services, and we know we could do better. Similarly, for families and whānau, the foundations are there, even though this is a much newer development.

Studies have demonstrated significant benefits from partnerships between health services, health professionals and service users, their families and whānau in clinical quality and outcomes, the experience of care, and the business and operations of delivering care (including reduced costs).[64][65][66][67][68]

Blueprint II calls for a partnership with service users and family/whānau in the journey to resiliency and recovery. Engagement and healthy, respectful relationships with consumers/service users are key factors in successful outcomes for people and must be at the heart of every interaction. Strong family/whānau engagement and partnership is also needed and must include provision of information and supporting wellbeing and health. This will enable family/whānau to support their family member in their recovery journey and maintain their own wellbeing.

Service users and their family/whānau must be informed partners in the options, plans and decisions for support.

In addition to these key partnerships, many of the other factors that contribute to a positive experience of care for people using services and their family/whānau have been identified in previous priority areas. These include fast access that is closer to home, improved flow-through services to ensure resilience and recovery, and services that are joined up across partners in general health and the social sector. This approach will ensure people's physical health needs and their housing, social participation, income and employment needs are all addressed. It is also critical to minimise harm and improve safety. Good physical health of people with mental health and addiction issues must be a focus, as must safe use of medicines and promoting coercion-free environments.

New Zealand is a diverse community in terms of ethnicity, age, disability, gender, sexual orientation, religion and spirituality. Services need to take account of people's unique needs, and work to eliminate the blocks, barriers and discrimination that may make accessing services challenging. Systems of care need to ensure that they contribute to addressing the drivers of inequalities for these population groups and that they reduce the variation of outcome and experience of care. Culturally specific models of care should continue to be developed as a choice and/or to complement mainstream services.

64   Meterko M, Wright S, Lin H, et al. 2010. "Mortality among patients with acute myocardial infraction: The influences of patient-centred care and evidence-based medicine." *Health Services Research* 45(5p1): 1188–1204.
65   Boulding W, Glickman S, Manary M, et al. 2011. "Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days." *The American Journal of Managed Care* 17(1): 41–8.
66   DiGiola A, Greenhouse P, Levison T. 2007. "Patient and family-centred collaborative care: An orthopaedic model." *Clinical Orthopaedics and Related Research* 463(13–19).
67   Arbuthnott A, Sharpe D. 2009. "The effect of physician-patient collaboration on patient adherence in non-psychiatric medicine." *Patient Education and Counseling* 77(1): 60–7.
68   Charmel P, Frampton S. 2008. "Building the business case for patient-centred care." *Healthcare Financial Management March* 62(3): 80–5.

7.8 Improving system performance

Lifting system performance by improving outcomes while at the same time reducing the average cost per person treated.

We need to use our resources more effectively and efficiently. This will require a radical increase in the overall performance of the system (better and increased flow), effective and efficient use of resources (energy, time, skills, capability and money), and better value for money overall (the right level, type and intensity of response).

Many of these improvements already form important components of the seven earlier priority actions. But using our resources more effectively and efficiently also needs to be seen as an important priority in its own right. To make the changes needed for a step change in the performance of the sector we must look at what we do in day-to-day care delivery, in the organisation of services and across the whole system, including other government agencies.

Mental health and addiction services are rich in emerging models of care that can potentially provide much better outcomes and transform productivity. These include new models that leverage peoples' own capacity for self care, broaden the capacity of the wider health workforce to use brief mental health and addiction interventions in their normal practice, and using lower intensity interventions such as peer support, e-therapies or brief talking therapies in primary and community settings.

As discussed earlier, stepped care is a structured mechanism for achieving increases in efficiency. The mental health and addiction sector needs to fully implement this approach which will span primary, community and specialist services and create opportunities for collaboration with other government agencies such as social welfare, education and justice.

7.8.1 Workforce

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

This means we need to organise our workforce differently, including being more discerning about who co-ordinates care and who supports people, depending on the degree of clinical and/or support need. We need to ensure the skills and expertise of our workforce are aligned to support models of care such as stepped care.

We need to organise so that all our workforce are fully utilising their skills and experience. In practical terms this means that we must always be asking who is the best person, with the right skills and expertise, to do the job, and ensuring we use the diverse skills across a range of roles at the top of their scope of practice. Support workers could take on the role of co-ordinating responses for those with enduring need and GPs co-ordinate responses for everyone else.

The future will be different from today, so we need to ensure that our workforce continues to evolve to implement new methods and places of care delivery, such as hospitals, NGOs, general practices, at home, at work, on the phone or on the Internet.

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

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

- Utilise the diverse skills of the team, with everyone working at the top of their scope of practice.
- Invest in training to provide individual and group interventions at the right intensity, to support recovery and support for family/whānau.
- Ensure people have individual training plans and performance management systems that support the service's capacity to deliver the right response at the right time.
- Ensure consumer advisors, family advisors and peer support workers are an essential and valued part of the delivery of care.

To support organisation of services we need to:

- Develop capacity and capability of secondary services to work collaboratively with NGO and primary providers to provide assessment, focused interventions, specialist case management and consultation.
- Develop roles to support 'navigation' of complex support for people and families/whānau.
- Create opportunities for team training based on mapping the capabilities needed to serve the local population, recognising the core skills and knowledge of the team.
- Continue to develop core skills such as those included in Let's Get Real, specialised skills to support evidence-based interventions and knowledge and skills around promoting positive mental health and wellbeing.
- Foster advanced practitioners' skills and expertise to support the core practice of other team members.

To support whole-of-system functioning we need to:

- Continue to support leadership development.
- Continue to develop planners and funders skills in effective commissioning.
- Set up relationships and systems to respond to other parts of the sector with advice and information. No one part of the system holds all the solutions.
- Accelerate the move towards specialists providing advice and guidance to NGO support services and primary care services.
- Ensure our workforce development capacity – such as workforce programmes, unions, and professional bodies – has a coherent vision of future workforce needs involving partnerships which develop a flexible, skilled and multi-disciplinary workforce.

7.8.2 Funding and commissioning

As outlined earlier, to support the changes needed we will need different funding arrangements. Blueprint II calls for greater flexibility in how the current ringfence can be used so that DHBs and service providers can make the most effective use of the funding available, easily integrate services across primary, community and specialist care, and implement a stepped care model. At the same time as this flexibility is introduced, a new results-based performance framework and targets must be in place to give assurance that this increased flexibility is being used to best effect and supporting more integrated investment across mental health and addiction services, and with wider health and government services.

New ways of commissioning services are also needed. DHBs are responsible for most of the planning and funding in the mental health and addiction sector. They need to make increasing use of their networks to provide them with robust advice on planning, resource allocation and service changes. These networks should include consumer, clinician and management perspectives from across primary, NGO and DHB services. Interagency partners may also be involved. Such networks are already in place in some DHBs.

The resource allocation decisions that will need to be made to implement Blueprint II are important and challenging. For this reason, a Decision Support Tool is being developed. The tool will aim to help service planners, funders and clinical leaders assess their population projections and needs, their service requirements and resourcing across a whole system. It will be designed to help decision makers test different scenarios of service configurations in a structured way.

8. What Will Success Look Like

How we will know we are making progress

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

We will know we are being successful if:

- No one who seeks help waits for help.

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

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

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

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

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

The approach that Blueprint II takes to measuring and driving performance needs to work for the system as a whole, including our partners across health and the wider social service, education and justice sectors. This approach has been guided by the New Zealand Triple Aim[69] framework to simultaneously improve quality, safety and experience of care, improve health and equity for all populations and generate best value from public health system resources.

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

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

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69   The New Zealand Triple Aim has wide acceptance by central agencies in the health sector as an overarching approach to guide improvement of health services. This is detailed further in the companion document *Blueprint II: Making change happen.*

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

It is important that the monitoring programme is capable of telling the story of progress at both population and service levels. The first level focuses on the results achieved at a population level in making progress towards achieving the vision and outcomes. The second level focuses on results achieved at a service level and in particular on performance, benchmarking, and the quality and safety of services.

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

8.1   Population level monitoring

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

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

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

Population level measures and indicators

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

5. Mental health & wellbeing	The proportion of people aged 15 years and over who reported that they were 'very satisfied' or 'satisfied 'with their life as a whole. *Source: New Zealand General Social Survey.*
6. Clinical outcomes	The proportion of people aged 15 years and over who scored 12 or more on the Kessler 10-item scale. *Source: New Zealand Health Survey.*
7. Housing	The proportion of people 15 years and over who are 'satisfied or 'very satisfied' with the housing they are currently living in. *Source: New Zealand General Social Survey.*
8. Involvement in decision making	The proportion of people who use mental health and addiction services who 'agree or 'strongly disagree' that their opinions and ideas are included in their treatment plan. *Source : National Mental Health Consumer Satisfaction Survey.*
9. Information & knowledge	The proportion of people who use mental health and addiction services who 'agree' or 'strongly agree' that staff provided their family with the education or supports they need to be helpful to them. *Source: National Mental Health Consumer Satisfaction Survey.*
10. Employed and satisfied with job	The proportion of people aged 15–64 years who are employed and have been satisfied with their job in the last 4 weeks. *Source: New Zealand General Social Survey.*

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

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

8.2   Service level monitoring

This component of the monitoring framework provides a range of indicators that can be used by the mental health and addictions sector to provide an overall picture of progress at the service level. It is not a dataset designed for accountability purposes.

The purpose of monitoring at a service level is to:

- Demonstrate system and organisational performance improvements.
- Understand national and district levels of variation.
- Provide a basis for benchmarking service delivery.
- Bring about transformational change.
- Support continuous quality improvement.

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

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

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

During the consultation phase of Blueprint II, stakeholders clearly signalled the need for the sector to move away from an inputs or 'service recipe' model towards an outcomes-oriented approach that enables flexibility and supports innovation at all levels of the system. Monitoring progress can be achieved at multiple levels and aids in peer accountability through benchmarking, sharing examples of innovation and change, as well as interpreting trends and helping us to answer the question 'why is this happening?'.

The following set of measures and indicators are a sub-set of the KPIs for the mental health and addiction sector that are considered useful to assist the monitoring of progress against Blueprint II. The full set[70] can be used at district (DHB and NGO), service and team levels in addition to the existing national benchmarking streams.

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

Service level measures and indicators

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

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

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

9. Appendix 1: Response Level Estimates

We need to set new goals so that they motivate us to make the difference and impact that will realise the vision of Blueprint II. We need them to be broad-based goals that recognise cross-sector partner's needs and contributions. We need them to be realistic in terms of our resources and capacity while challenging us to transform the status quo.

A start to this process has been made. Modelling has been initiated to enable us to use data and consensus judgement to support the goal setting process. The initial response level estimates are shown below. A high priority during 2012/13 will be to work with experts and the sector to review the evidence and refine these into a set of goals that are meaningful, relevant and reflect the calls to action contained in Blueprint II.

Determining the optimal future level and mix of services across the life course, expressed as 10-year response level goals is a challenging task. We need to take estimates of the prevalence of complex, frequently overlapping issues. Not everyone with a mental health or addiction issue needs to access an organised service response, so we then need to translate prevalence information into estimates of service need and benefit across a spectrum of services that in 10 years' time should look very different to what we have today.

Indicative response levels by 2020 – estimates across life course

Population size:	172,853
12 mth prevalence/need:	20%
Response level:	50%
Organised responses:	17,285

Population size:	594,310
12 mth prevalence/need:	20%
Response level:	50%
Organised responses:	59,531

Population size:	3,798,347
12 mth prevalence/need:	20%
Response level:	20%
Organised responses:	151,934

Population size:	1,382,492
12 mth prevalence/need:	20%
Response level:	25%
Organised responses:	69,125

Health promotion

Supported self care

Organised mental health and addiction responses

Impact of mental health and addiction on women at risk

1. Families & whānau at risk (incl. -1 to +3 years, pregnancy, post natal, maternal, infant wellbeing and parenting)

3. Youth/adolescents with emerging mental health, behavioural and addiction issues

5. Adults and older people with high prevalence disorders, moderate to severe impact

8. Adults and older people with mental health and addiction disorders alongside disabilities, chronic illness and/or dementia

Impact of adult mental health and addiction on families and whānau

2. Children with mental health and behavioural issues (<12 years)

6. Adults and older people with low prevalence, high severity disorders

4. Youth/adolescents at high risk (including forensic)

7. Adults and older people involved in forensic and/or justice system

Supported self care

Health promotion

Infants Children Youth Adults Older persons

Population size:	715,243
12 mth prevalence/need:	15%
Response level:	60%
Organised responses:	53,643

Population size:	594,310
12 mth prevalence/need:	10%
Response level:	50%
Organised responses:	29,715

Population size:	3,798,347
12 mth prevalence/need:	0.6%
Response level:	100%
Organised responses:	22,790

Population size:	3,798,347
12 mth prevalence/need:	4.7%
Response level:	55%
Organised responses:	107,113

10. Appendix 2: How Blueprint II was Developed

Our approach to developing Blueprint II has been one of 'co-production', involving many in the sector under the guidance of an expert advisory group of sector leaders.

A literature review was carried out which, although not exhaustive, provided a broad view of emerging innovations both in New Zealand and overseas, as well as evidence of effectiveness and cost effectiveness of services for key population groups, services areas and specific speciality areas. This review provided valuable information to inform Blueprint II. [71]

A consultation document was widely distributed and respondents asked to provide feedback on the core propositions and help shape the practical pathways of change and development. 184 submissions were received from a wide variety of respondents including consumers and family/whānau, service providers (DHBs, primary care and NGOs) and educators. An analysis of the submissions and the list of people who made submissions is available on **www.hdc.org.nz**.

Blueprint II also draws significantly on the findings of the Health Workforce New Zealand service review report *Towards the Next Wave of Mental Health and Addiction Services and Capability* [72] as well as guidance documents from the Ministry of Health to the sector including those on older people and dementia, primary care, the early years and youth forensic services and alcohol and other drug issues.

10.1 People involved in the development of Blueprint II

10.1.1. Sector Leaders Expert Advisory Group

Name	Organisation
Ana Sokratov	Consumer representative
Dr Ceri Evans	Clinical Director and DAMHS Forensic Services, Canterbury DHB
Christina Henderson	Whānau Kaitautoko Advisor, Specialist MHS, Māori Mental Health, Canterbury DHB
Dr David Codyre	Primary Care, Clinical Service Design, Auckland
Dr Hinemoa Elder	Child and Adolescent Psychiatrist
Ian McKenzie	NDSA Networks, Northern Region

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71   The literature review is available on http://db.tt/uPlCwX5s.
72   http://healthworkforce.govt.nz/our-work/workforce-service-reviews/mental-health.

Judi Clements	Chief Executive, Mental Health Foundation of New Zealand
Kupa Kupa	Service Manager, Vakaola Pacific Community Health
Dr Lyndy Matthews	Clinical, Specialist, Royal College, Auckland
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Paul Ingle	Wise Group and Platform, NGO and Peak Body
Robert Steenhuissen	Manager, Community Alcohol and Drug Services, Auckland
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10.1.2. Other contributors

Name	Organisation
Annemarie Wille	National Clinical Directors and Managers Forum, Waitemata DHB
Emma Maddren	NDSA KPI Project Manager
Helen Lockett	Wise Group, Evidenced Based Supported Employment
Jo Chiplin	Ministry of Health representative
Dr John Crawshaw	Director of Mental Health, Ministry of Health
Memo Musa	Ministry of Health representative
Sir Professor Mason Durie	Senior Advisor, Te Rau Matatini
Professor Rob Kydd	Professor, Clinical Psychological Medicine, School of Medicine, University of Auckland
Robyn Shearer	Chief Executive, Te Pou
Trish Davis	Chief Executive, Te Rau Matatini
Hugh Norriss	Director of Policy and Development, Mental Health Foundation
Sue Hallwright	Independent Advisor
Various representatives	Te Pou o Te Whakaaro Nui

10.1.3. Mental Health Commission and project team

Name	Organisation	Contribution role
Lynne Lane	Mental Health Commission	*Project sponsor*
Bice Awan	Mental Health Commission	*MHC Board*
Noeline Stevenson	Mental Health Commission	*Project*
Ray Watson	Mental Health Commission	*MHC Board*
Saasha Everiss	Mental Health Commission	*Project*
Sue Shotter	Mental Health Commission	*Project*
Helen Wood	Seconded from Waitemata DHB	*Project*
Cynthia Maling	Seconded from Ministry of Health	*Project*
David Todd	Contractor – independent	*Project lead*
Deirdre Mulligan	Contractor – independent	*Project*
Joan Mirkin	Contractor – independent	*Project*
Kim Arcus	Contractor – independent	*Project*
Michael McGechie	Contractor – independent	*Project*
Nishadie Jayasekera	Contractor – independent	*Project*
Paul Stephenson	Contractor – independent	*Project*
Philip Gandar	Contractor – independent	*Project*
Sue Johnston	Contractor – independent	*Project*

11. Appendix 3: Glossary of Terms and Abbreviations

Addiction	The continued use of a mood altering substance or behaviour despite adverse consequences.
Benchmarking	To evaluate or check something by comparison with the performance of others or with best practices.
CAMHS	Child and adolescent mental health services.
Cerebral palsy	An umbrella term for non-progressive non-contagious motor conditions that cause physical disability in human development, particularly in body movement.
Commissioning	A process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.
Conduct disorder	A childhood and adolescent behavioural disorder characterised by aggressive and destructive activities that cause disruption in the child's environment.
Dementia	Loss of brain function which affects memory, thinking, language, judgement, and behaviour.
Determinants of health	The personal, economic, social and environmental factors that can influence the health status of an individual or population.
DHB	District Health Board. Government organisation responsible for providing or funding health and disability services in a defined geographical area.
Evaluation	A systematic process for collecting, analysing and using information to assess change that can be attributed to the intervention. It is a judgement about the value, progress and impact of an intervention.
Family	The service user's whānau, extended family, partner, siblings friends or other people that the service user has nominated.
Forensic services	Services delivered in prisons, courts, community based and home based settings for people with mental health and/or co-existing mental health and addiction needs who are currently in the justice system.

GP	General Practitioner. A physician whose practice is not oriented to a specific medical specialty but instead covers a variety of medical problems in patients of all ages.
Health literacy	An individual's ability to read, understand and use healthcare information to make decisions and follow instructions for treatment.
Health promotion	A process of enabling people to increase control over and to improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.
Health Workforce New Zealand	The organisation responsible for the planning and development of the health workforce, ensuring that staffing issues are aligned with planning and delivery of services and that our health workforce is fit for purpose.
Indicators	Measurable characteristics or variables which represent progress and are used to measure changes or trends over a period of time.
Integration	Coordination of services resulting in support that is seamless smooth and easy to navigate.
Interventions	An effort/activity to promote good health behaviour and/or prevent/ improve or stabilize a medical condition.
IT	Information technology such as computers.
Kaupapa Māori	Māori-centred services that are offered within a Māori cultural context.
Kessler 10 item scale	The Kessler measure is a 10 item self-report questionnaire intended to obtain a global measure of psychological distress.
Let's Get Real	This is a workforce development framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.
Life course	All stages of life from prenatal to old age.
Long term conditions	Health problems that require ongoing management over a period of years; such as, diabetes, cardiovascular disease, cancer, some mental health conditions.
Mental health and addiction ringfence	Government mechanism to ensure that funding intended for specialist mental health and addiction services is used solely for those purposes.
Ministry of Health	Government agency whose functions are to provide strategic policy advice and ministerial services to the Minister of Health, monitor DHB performance and administer legislation and regulations.
Modelling	The process of generating abstract, conceptual, graphical or mathematical models.
Morbidity	The incidence of ill health in a population.
Mortality	The incidence of death in a population.

Motivational interventions	Motivational interventions are a counselling approach for eliciting behaviour change developed by clinical psychologists with a semi-directive, client centred counselling style.
Neurodevelopment disorders	These include autism, attention deficit hyperactivity disorder, learning disabilities, developmental delays and intellectual retardation.
New Zealand Triple Aim	An approach designed to simultaneously achieve improved quality, safety and experience of care, improved health and equity for all populations and best value from public health system resources.
NGO	Non-government organisations. Independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both government and the market.
Organised responses	Recovery and resilience focused responses provided by the health and other sectors and covering self care, primary, community and specialist settings. To be counted as an organised response it must be planned, reviewed and measured.
Peer support services	Services that enable wellbeing, delivered by people who themselves have experienced mental health or addiction issues, and that are based on principles of respect, shared responsibility and mutual agreement/choice.
Perinatal	Of or relating to the time, usually a number of weeks, immediately before or after birth.
Prevalence	The total number of cases of a disease in a given population at a specific time.
Primary care	Essential health care that is universally accessible to people in their communities; the first level of contact with the health system.
PRIMHD	The Ministry of Health collection of mental health and addition activity and outcome data.
Psychological therapies	A group of therapies designed to improve mental health through talk and other means of communication.
Recovery	Living well in the community with natural supports.
Relapse prevention plan	A plan that identifies early relapse warning signs of clients. The plan identifies what the client can do for themselves and what the service will do to support the client. Ideally, each plan will be developed with involvement of clinicians, service users and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each service user will know, and ideally have a copy of, their plan.
Resilience	The capacity of individuals to cope well under adversity.
Ringfence	See 'mental health and addiction ringfence'.
Service user	A person who uses mental health or addiction services. This term is often used interchangeably with consumer and/or tangata whaiora.

Social inclusion	The absence of barriers to full participation within a chosen community by a person or group.
Specialist services	Those mental health and alcohol and other drug services described in the National Service Framework and funded through the mental health ring-fence. This includes both DHB and NGO services.
Stepped care	An approach which uses the least intrusive care to meet presenting needs and enables people to move to a different level of care as their needs change.
Talking therapies	Various forms of psychotherapy that emphasise the importance of the client or patient speaking to the therapist as the main means of expressing and resolving issues.
Tangata whenua	Indigenous people of Aotearoa/New Zealand.
Targets	A set of national performance measures specifically designed to improve performance and to provide a focus for action.
Triple Aim	See 'New Zealand Triple Aim'.
Value for money	A term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it.
Whānau	Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term whānau in this document is not limited to traditional definitions but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and each individual to define for themselves who their whānau is.
Whānau Ora	In this document Whānau Ora is used to describe government funded services or initiatives designed to place whānau at the centre and build on the strengths and capabilities already present within the whānau.
Whole of person	An approach which looks at all the needs of a person, including mental health and addiction needs, physical health, housing, employment, social supports, and so on. It can also be called a holistic approach.