



# Blueprint II

*For the New Zealand Mental Health  
and Addiction sector*

## Supporting paper

Developing Blueprint II for the Mental Health and Addiction Sector  
Working draft

Mental Health Commission  
**February 2012**

# THE PURPOSE OF THIS SUPPORTING PAPER

The Mental Health Commission (MHC) is developing a new Blueprint (Blueprint II) for the Mental Health and Addiction (MH&A) Sector. This work will update the 1998 'Blueprint for Mental Health Services in New Zealand: "How Things Need to Be". Blueprint II proposes a bold vision for the MH&A sector which will require innovation and changes in how we meet the MH&A needs of New Zealanders over the next 10 years.

A high level overview of the proposed changes is described in the Blueprint II Consultation Document (1<sup>st</sup> February 2012). This document provides additional detail to support the consultation document and will be used to inform the more technical tasks of Blueprint II development over the period February – April 2012.

Many from the MH&A sector have already been involved in developing this document, taking part in interviews, workshops and discussions.

Some of the ideas and thoughts described in this document are less well formed than others. In the spirit of transparency and openness we are sharing this information so you can see the emerging thinking and where ideas are heading – albeit in places without much of the detail which will be required in the final Blueprint II document.

Please read with that caveat. We welcome your feedback on these ideas.

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## 2. BACKGROUND AND CONTEXT

Over the decades, progressive national strategies and policies together with the MH&A sector have been responding to the challenge of better meeting the needs of consumers and family/whānau.

The mid to late 1990s saw the combination of the National Mental Health Strategy, *Looking Forward*, (1994) together with its action plan, *Moving Forward* (1997) and the Mental Health Commission's *Blueprint* (1998). Collectively these made MH&A a priority for the Government and supported the sector to:

- Steadily grow access to specialist services and to grow sector capacity and infrastructure.
- Strengthen consumer voices and their say in how services are planned and developed.
- Shift the mix of care with far fewer consumers 'treated' in institutions and many more supported in their recovery within the community.
- Grow the non-governmental (NGO) sector together with Māori and Pasifika providers.
- Go from a level of relative underinvestment to increased investment.

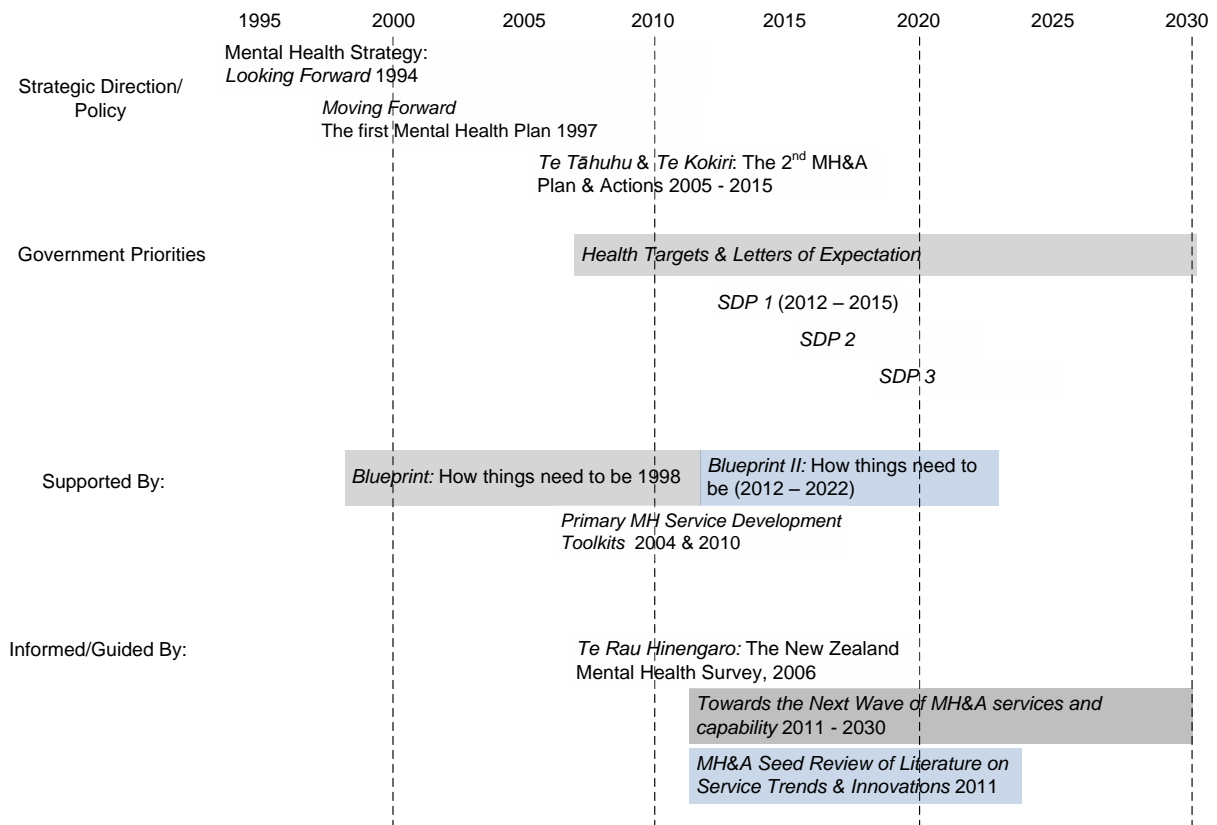
During this period from 1994 – 2005, the prioritised focus tended to be on those most severely affected by MH&A and their associated specialist services.

By 2005/06 there was a growing acknowledgement of mental health's significant impacts right across society, the needs of those with mild and moderate symptoms and the importance of early intervention, prevention and promotion of mental wellbeing. This was heavily influenced by the national *Mental Health Survey, Te Hinengaro* (2006) and the *MAGPIe study* (2003).

As a result, *Te Tahuu plan* (2005) and its associated actions, *Te Kokiri* (2006 - 2015), sought to significantly broaden the focus of both the MH&A sector to a population beyond the most severely affected as well as the responses across all government agencies.

Since 2005 there have been some significant achievements with various primary mental health pilots and mental health promotion (e.g. the destigmatisation) as well as ongoing increases in access rates to specialist services which now sit at a national average of 3.1%. In addition, some other government agencies have increased their focus on MH&A and launched their own initiatives (e.g. Children Youth and Family's recent investment in MH&A services for at-risk youth).

## New Zealand Mental Health Strategies, Plans and Priorities



### 2.1 BLUEPRINT II AND MINISTRY OF HEALTH SERVICE DEVELOPMENT PLAN

Blueprint II covers a 10 year time horizon and represents an independent, sector informed view of how the MH&A system needs to evolve to meet future challenges and what is needed to enable change. It takes a broad view of MH&A and provides structured guidance on how the sector should position itself over the next 10 years to support the next wave of sector innovation and change. This next wave includes intersectoral partners (i.e. health, social care, justice, education) along with communities and families/whānau.

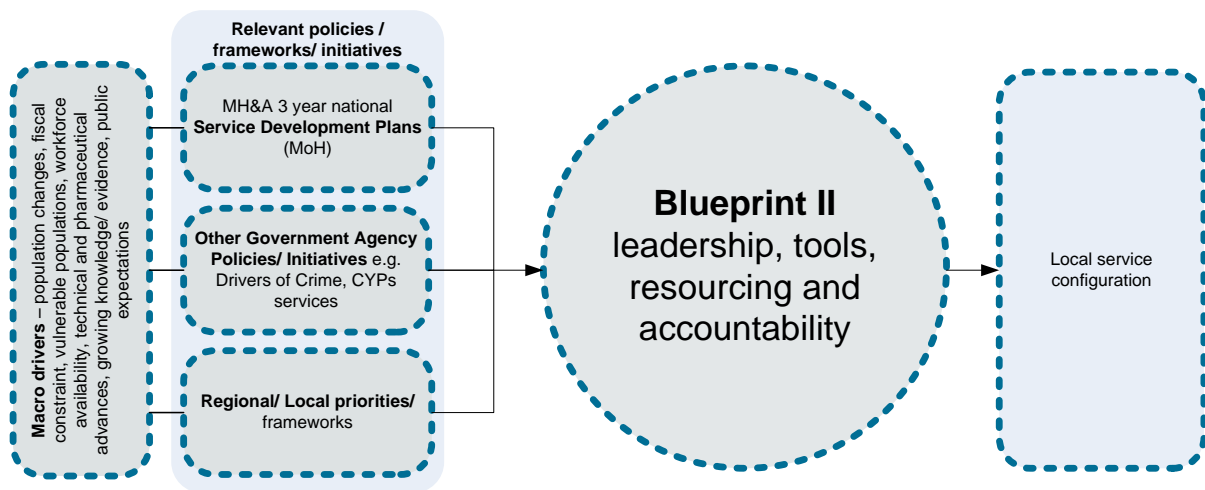
Blueprint II, will also help inform the Ministry of Health thinking on its Service Development Plan (SDP) that is in development and due for release later this year. The SDP will articulate how health-funded services (primary and general healthcare and specialist mental health and addiction services), will need to develop, over the next three to five years, in order to implement government policy imperatives.

Blueprint II and SDP serve different purposes, however they are both supporting sector change. It will be this combination of three yearly national *Service Development Plans*, together with the leadership, resourcing and change responsibilities articulated in *Blueprint II*, that will help the

sector build on its current strengths to address its future challenges, for example as articulated in *Towards the Next Wave*.

Blueprint II has been designed with a 10 year view so that it can include these iterative Service Development Plans as well as other relevant policies (e.g. Drivers of Crime) and government priorities (e.g. the Prime Minister’s focus on Vulnerable Children). It is designed to be a flexible framework that enables the policies and priorities of the day at a national and local level to be worked through to generate a service configuration that works for that population and associated outcomes (see the diagram below).

Figure 1: Blueprint II as the supportive infrastructure for national and local priorities, policies / frameworks



### 3. WHY WE NEED TO CHANGE

Mental wellbeing plays a critical role in creating a well-functioning society. With a greater understanding of its impacts, there is much more compelling evidence for us to increase and broaden our focus in our approach to improving mental health. By looking at all aspects of a person's wellbeing - mental, physical and social - we can do much more to aid the recovery of consumers and their family/whānau.

But we are working in a changing world. We have an increasingly ageing and ethnically diverse population, a greater expectation of personalised services and we are operating in a fiscally constrained environment. We need to build a Blueprint that is flexible enough to respond to these changes and challenges and mutually complements other initiatives in the sector.

For the past decade, the original Blueprint has guided MH&A resourcing and service development. Much has changed since 1998: our service capability and capacity has improved greatly for those with the most severe problems, our understanding of the nature of population need and the impact of mental health and addiction has deepened, and a wider range of interventions and innovative service responses are available. There is also an awareness of significant levels of unmet need for MH&A services and significant disparities in MH&A outcomes.

We are working in a changing world. MH&A has benefited from a decade of investment but we are now in an environment that combines constrained funding, challenges in building workforce capacity along with the demands of an increasingly ageing and ethnically diverse population. We need a step change in how we use existing resources, to harness the capability across the wider health sector and work alongside intersectoral partners where MH&A also matters. Our challenge is to use the current financial constraints as a source of creativity, stimulating the investment of commitment, time, energy and resources to make change happen.

#### 3.1 NO HEALTH WITHOUT MENTAL HEALTH

The argument for our society to invest in mental wellbeing is strong and growing. Resilient mental health and freedom from the adverse impacts of addiction play a critical role in the positive health of our population as well as the wellbeing and productivity of our society.

Our understanding of the drivers and impacts of mental ill health and addiction has been significantly strengthened since the publication of Blueprint I in 1998. The need for investment in improving mental health and addiction outcomes is compelling as demonstrated through:

- 1. Mental health and addiction being more common than typically recognised.**  
Globally, one in every four people (25%) will be affected by a mental health disorder at some stage in their life (World Health Organization 2001). In New Zealand, this is higher at 40%, or two in every five people. Youth, Māori, and more deprived populations experience higher rates of mental ill health (Oakley Browne, Wells and Scott 2006; OECD 2009).
- 2. Personal impacts are higher than any other group of diseases.** When both loss of life years due to premature death and disability impacts during life are considered, neuropsychiatric disorders have more impact than any other disease group. That is, they are responsible for the greatest number of disability adjusted life years (DALYs) for high income countries like New Zealand, 75% higher than cardiovascular diseases and 77% higher than cancers (World Health Organization 2008a).
- 3. Societal impacts go well beyond the individual and the health sector,** placing significant pressures and costs on carers, relatives, and society at large. In the UK the 'costs' borne by individuals and their carers are estimated to be 2.5 times that of public health costs. Costs to businesses and the country from lost productivity and welfare use are almost 1.5 times greater than the public investment in mental health services (Centre for Mental Health 2010). What's more, there are significant personal and justice system impacts of association with crime. Improved mental health is linked with better physical health, improved health behaviours (e.g. good nutrition), greater educational achievement, improved productivity, higher incomes, reduced absenteeism, less crime, more participation in community life, and reduced mortality (Department of Health 2011a).
- 4. Mental health and substance use disorders are often identifiable** with about half of mental health disorders beginning before the age of 14 and therefore able to be picked up early (World Health Organization 2001).
- 5. Many mental health and addiction issues go unrecognised and untreated** due to the high levels of stigma attached to mental health and poor or variable access to basic mental health care. In New Zealand "nearly half of all adults who had ever been diagnosed with depression or bipolar disorder reported not receiving any treatment," (Ministry of Health 2008a) and 42% of those with a serious disorder in the last 12 months had not had a mental health visit in the healthcare sector (Oakley Browne, Wells and Scott 2006).
- 6. Many physical and biomedical conditions have components of mental ill health which go unrecognised and untreated.** For example, the high number of diabetics with

depression (Ciechanowski 2011) and the poorer cardiology outcomes for those with underlying mental health conditions.

7. **When patients access services we can do more to aid their recovery** with a strong and growing evidence base of what works and what doesn't. We know much more about what works from a clinical perspective (e.g. psychological, physical, social and pharmaceutical management) but also the importance of a person's context, e.g. employment, housing and social connectedness for recovery and resiliency.

To capture the value in MH&A investment, the World Health Organisation points to the need to widen our view of MH&A services and describes a new 'wave' or philosophy that moves beyond deinstitutionalisation and focuses on the interaction between MH&A, physical health and a person's social context.

We are embracing this next wave of development, and yet our resourcing framework for MH&A is more than a decade old and is constraining service delivery and development. It is time to develop a new direction and framework. One which maintains our position at the forefront of MH&A services internationally, building from today's strengths while improving whole of system MH&A outcomes.

## 3.2 WE HAVE MADE PROGRESS BUT WE CAN DO MUCH BETTER

### 3.2.1 HISTORY OF MENTAL HEALTH AND ADDICTION DEVELOPMENT

Our response to mental ill health and addiction has changed through progressive waves of thinking about underlying philosophy, understanding and approach, which has been quite different to other areas of the health sector. This progression is summarised within WHO's Mental Health Policy and Service Guidance as four waves:

- In the 17<sup>th</sup> and early 18<sup>th</sup> century explanations of madness were often secular or the result of 'excess passion' and many were confined to public jails, workhouses, poorhouses, and private asylums
- The rise of humanitarian concerns during the 18<sup>th</sup> century led to the establishment of mental asylums as a way to manage and restrain those with madness while not subjecting them to imprisonment
- In the 1950s, mental asylums were increasingly discredited on humanitarian grounds and the community care movement took hold. This resulted in the downsizing and closure of many state mental hospitals, and the growth of community care commonly referred to as 'deinstitutionalisation'

- Over the last decade the principles of 'recovery' have guided service development for those severely affected by mental illness; to empower consumers, assure their rights, to get the best outcomes through increasing their control over their own mental health and wellbeing and enable them to fully participate in society.
- The next stage we think will be shaped by our deepening understanding of mental health from both a biomedical perspective and the sophisticated interaction with physical health, but also from the social sciences and how a person's context and history can shape their mental health (World Health Organization 2003a). This is increasingly being seen in developments like Whānau Ora.

It is this fourth wave that is driving a widening focus for mental health and addiction, driven by growing evidence of the complex interactions between mental health, physical health and a person's social context. Blueprint II should be influenced by the need for New Zealand to embrace this 'fourth wave' as the future path for our service and societal response to mental health and addiction need.

### 3.2.2 SYSTEMIC DRIVERS OF CHANGE FOR MENTAL HEALTH AND ADDICTION SERVICES

New Zealand's changing demography, health needs and public expectations within a fiscally and workforce constrained environment are driving technological and service changes within the health and mental health sector (National Health Board and Ministry of Health, 2010 and Mental Health Commission 2011). Underlying systemic drivers of change for the mental health sector are:

1. **An ageing and ethnically diverse population** with urban growth and rural stasis. This pattern is driving a growing demand within the older population and associated organic disorders as well as those with multiple complex co-morbidities (particularly long term conditions). There is also a growing need for greater cultural responsiveness and capacity within urban areas while finding more sustainable solutions for rural areas. Building on our knowledge of cultural models of care is critical here.
2. **A growing number of people with chronic conditions**, particularly those with multiple co-morbidities, of which mental health is a component, and the increasing need to integrate and co-ordinate across services and specialties.
3. **A fiscally constrained environment** and the need for better ways to prioritise and direct resources to need, and shift to more efficient and affordable service models, given the future resource context.
4. **An acceptance that certain vulnerable groups experience higher rates of mental ill health and addiction than others** which is driving greater integration across health, and wider public services as the social and economic drivers of these differences sit outside the traditional mental health and addiction responses.

5. **A changing workforce driven by** structural constraints within the overall population. These constraints are driving requirements to leverage existing resources better through streamlined models of care, technology, and use of new workforce roles as well as a greater reliance on supported self and whānau based care.
6. **A rapidly advancing technological landscape** with increasing communications options and access to information, enabling different forms of interaction (e.g. destigmatisation) and service to emerge. The rapidly developing, evidence-based field of e-therapy, combined with a growing capability in the population (particularly youth and adolescent) offers opportunities for very different models of care delivery.
7. **An evolving sophistication and knowledge base for interventions** that apply to health and well-being across psychological, psycho-education, social, physical and medical (pharmaceutical) treatments.
8. **Increasing public expectations and changing perceptions** including better informed health consumers who are able to challenge, and demand the support they expect, delivered in the way they need it, particularly given the consumer movement within mental health. It also includes a public with changing perceptions and a better understanding of poor mental health.

In summary, mental health and addiction service trends and innovations need to address the rapidly ageing population, urban growth and rural stasis, increasing cultural diversity, and public expectation while dealing with limited growth in funding and workforce shortages but expanding opportunities with technology.

### 3.2.3 RESULTANT TRENDS IN MENTAL HEALTH AND ADDICTION SERVICES

The evolution of the underlying philosophy for MH&A services and the current and future systemic drivers of change (outlined above) are reflected in emerging trends in mental health and addiction services.

1. **Consumer and family/whānau involvement as clinical partners** in design, development and improvements.
2. **Prevention and early intervention, based on the growing understanding of the biomedical, psychological and social origins of mental health disorders.** There is increasing realisation of the psychological, social and economic burdens if there is not effective early intervention and the “current limitations in effectiveness of treatment modalities” (World Health Organization 2004).
3. **The growing focus on recovery, resiliency and Whānau Ora models** which tend to focus on both the biomedical components of a person’s condition as well as their overall context, particularly in relation to their family/whānau situation, employment, housing and social connectedness.

4. **A continuum of acute services in responding to crisis and emergency mental health events/situations:** The MH&A sector offers a wide range of choices and levels of intensity in responding to acute events, including: intensive home based treatment, respite, 24/7 crisis assessment and intervention, community residential acute recovery, extended assessment in emergency departments, and hospital based inpatient care. As these responses develop they are driving improvements in the effectiveness of inpatient care, alongside improved consumer experience and shorter lengths of stay. Advances in trauma informed care, minimising the use of seclusion and restraint, sensory modulation strategies, inpatient peer support and better integration with community-based services helps support people with acute need and reduces lengths of stay.
5. **Community-based levels of support across clinical and NGO services,** including community mental health team interventions, early intervention in psychosis services, intensive community support and assertive outreach models, flexible packages of care and formal peer support. These services appear to work best when integrated with primary care, effective family/whānau support and informal community care.
6. **Development and expansion of primary mental health,** with an ability to address unmet need and the growing interplay between physical and mental health and addiction needs - particularly those with long term conditions. Examples of development include improved integration across primary and secondary care services, the shared development of clinical pathways, nurse liaison roles for early assessment and treatment, consultation and advice links across medical staff and brief psychological interventions. Growing supportive communities and peers together with community based self care, particularly consumer-led advocacy, formal and informal peer support and stigma reduction.
7. **Developments outside the health sector,** including initiatives by non-health agencies and businesses that look to address the impacts of mental health and addiction (e.g. Children and Young Persons' recent investment in mental health services for children and youth in their care) as well as the role of mental wellbeing generally (e.g. the increased use and availability of workplace counselling).

The implications of this history and future trends is that we will need to lift system performance so that people experience a strengthening of recovery and a return to resiliency. The focus of our responses will need to keep shifting outwards, towards community based sources of social inclusion and individual/whānau strengths. We will need to drive for faster and earlier responses to minimise loss of resiliency. We will need responses that are more effective in meeting a balance of needs, whether social, mental, behavioural or physical.

### 3.3 OUR ENVIRONMENT IS CHANGING

The MH&A sector has benefited from a decade of investment. Today however, we are in an environment that combines constrained funding, challenges in building workforce capacity with the demands of an increasingly ageing and ethnically diverse population.

The evidence for the costs of not addressing MH&A issues are increasingly clear; without lifting access to effective MH&A responses, we as a society, will bear the costs in terms of loss of employment, increased dependency on benefits and higher costs across the full spectrum of health, social and justice services.

Given the overall tight financial environment, we cannot count on new investment, or expect any new money unless we have both used our current resources most effectively and can show the clear whole of government benefits of doing more.

Achieving 'sustainability' is a challenge in today's environment of constrained funding alongside increasing awareness of need and broadening service options. Sustainability requires innovative support responses and service developments that focus on value across pressing population health priorities. It must be able to effectively respond to the trajectories and pathways people experience through mental health and addiction.

Sustainability is the product of an overall environment that positively influences the multitude of clinical practice, service development and resourcing decisions made by clinical leaders, funders and service managers across the sector as a whole.

In response, Blueprint II should aim to develop an outcomes-oriented service development and resourcing framework that facilitates sector based leadership to navigate the shifts in care and breakthroughs in productivity and performance that will be required across the system as a whole.

In its report *Towards the Next Wave of MH&A Services and Capability*, Health Workforce New Zealand looked ahead to 2030 to identify "service configurations, models of care and health workforce requirements of a situation of a doubling of service demand by 2020 with only a 30-40% increase in funding from 2010 levels", i.e. no more than the rate of expected of underlying population and GDP growth. The sector experts' whole of system life course based review suggested the sector needed a 250% increase in 'organised' MH&A responses by 2020 to significantly close the gaps in unmet need. It also recommended further shifts in focus "towards primary and integrated care and preventive interventions at both ends of the life-cycle, while preserving the gains we have achieved for those with high and complex needs."

Blueprint II is aiming to facilitate a breakthrough or step change in how effectively we can use existing resources, to harness the capability across the wider health sector and work alongside intersectoral partners where MH&A also matters. Many, if not most, of the innovations in practice or service delivery needed to achieve this breakthrough are already evident across the sector, but not yet developed, integrated or scaled to the point where the new level of system performance could be consistently achieved.

Our challenge is to use the current financial constraints as a source of creativity, stimulating the investment of commitment, time, energy and resources to make change happen.

## 4. FUTURE DIRECTIONS - HOW THINGS NEED TO BE

From our dialogue with the sector we believe there is an emerging shared world view on the future shape of MH&A services. This is founded on a common understanding that mental wellbeing plays a critical role in creating a well-functioning and productive society. To assist in realising this vision, Blueprint II proposes to support three interrelated developments in the way MH&A services work as a system, both in their own right and alongside wider health and intersectoral organisations and agencies.

- An outcomes oriented, whole of population, life course approach that responds more effectively to the developmental pathway of MH&A issues and the needs of vulnerable populations
- Development of systems of care that are people centred and delivering more timely, responsive and integrated approaches to recovery and building resiliency
- A drive for a step change in performance that maximises the results we achieve from our limited resources of energy, time, capability and money.

### 4.1 AN EMERGING SHARED VISION

From our dialogue with the sector we believe there is an emerging shared world view on the future shape of MH&A services. This is founded on a common understanding that mental wellbeing plays a critical role in creating a well-functioning and productive society. The emerging shared vision is of a future in which everyone plays their part in protecting and improving mental wellbeing:

- People, families and communities actively develop their own ability to weather adversity;
- Primary and other general healthcare services support resilience, recognise emerging issues early and enable people to recover rapidly;
- Focused MH&A treatment and support services<sup>1</sup> further support and enable recovery and full participation in community living by people who have MH&A issues;
- Publicly-funded agencies work together to make best use of funds to enable people involved with multiple sectors to achieve the best possible outcomes.

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<sup>1</sup> Within primary care and in specialist services working closely with primary and general healthcare, and in separate specialist community and inpatient settings

## PRINCIPLES

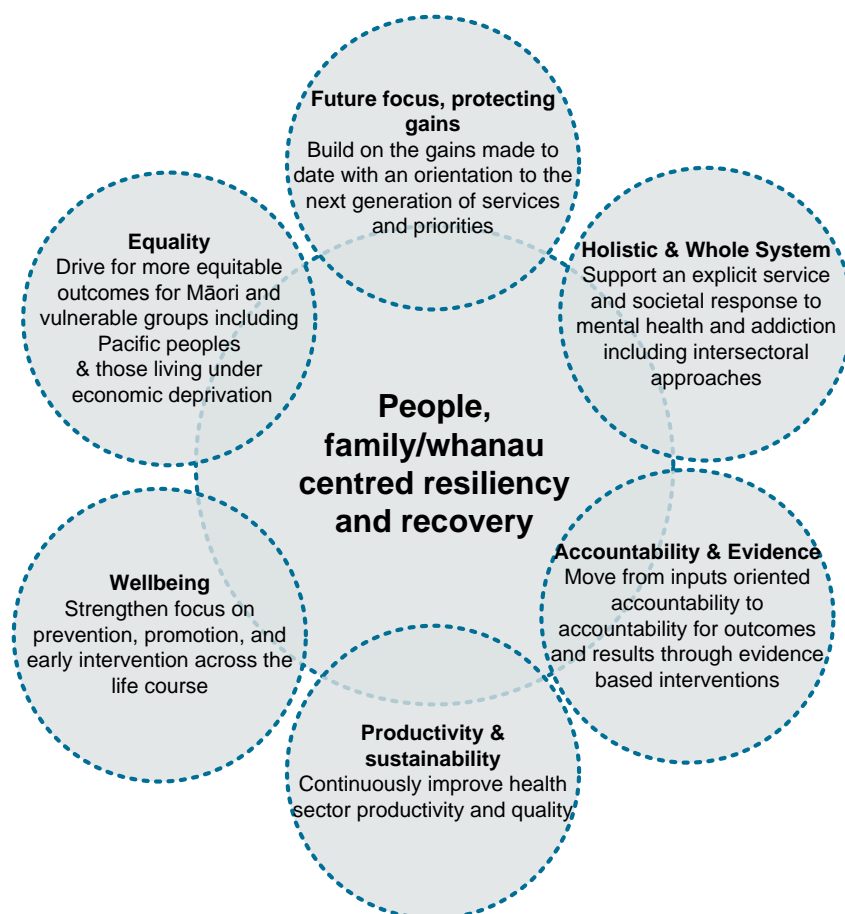
Over the last decade the principles of 'recovery' have guided service development for those severely affected by mental illness; to empower consumers, assure their rights, to get the best outcomes through increasing their control over their own mental health and wellbeing and enable them to fully participate in society.

Blueprint II should seek to strengthen the recovery approach while embedding this within the broader principle of resiliency; the ability of people and their family or whānau to adapt, gain strengths and prosper, despite the adversity of addiction or mental ill health.

Strengthening the focus on recovery means ensuring that outcomes, service pathways and performance monitoring are all focused on achieving steps toward recovery.

Resiliency takes us a step further towards 'no health without mental health' with a focus on those at high risk of poor health and living outcomes due to mental health or addiction issues. Resiliency promotes a service approach which strengthens social inclusion as a means to supporting self care, and facilitates capacity in families and community and primary based care. Resiliency makes the best use of the limited resources of the health and MH&A system by seeking the most effective support in the least intensive setting.

Figure 2: The core principles underpinning Blueprint II



The people centric principles of resiliency and recovery form the core that guides and structures the descriptions of 'how things need to be' found in the rest of this document.

To support this emerging vision and set of principles, while responding to the pressing drivers of change, we believe that Blueprint II needs to support three interrelated developments in the way MH&A services work as a system, both in their own right and alongside wider health and intersectoral organisations and agencies.

1. An outcomes oriented, whole of population, life course approach that responds more effectively to the developmental pathway of MH&A issues and the needs of vulnerable populations.
2. Development of systems of care that are people centred and delivering more timely, responsive and integrated approaches to recovery and building resiliency.
3. A drive for a step change in performance that maximises the results we achieve from our limited resources of energy, time, capability and money.

#### 4.2 AN OUTCOMES ORIENTED, WHOLE OF POPULATION, LIFE COURSE APPROACH

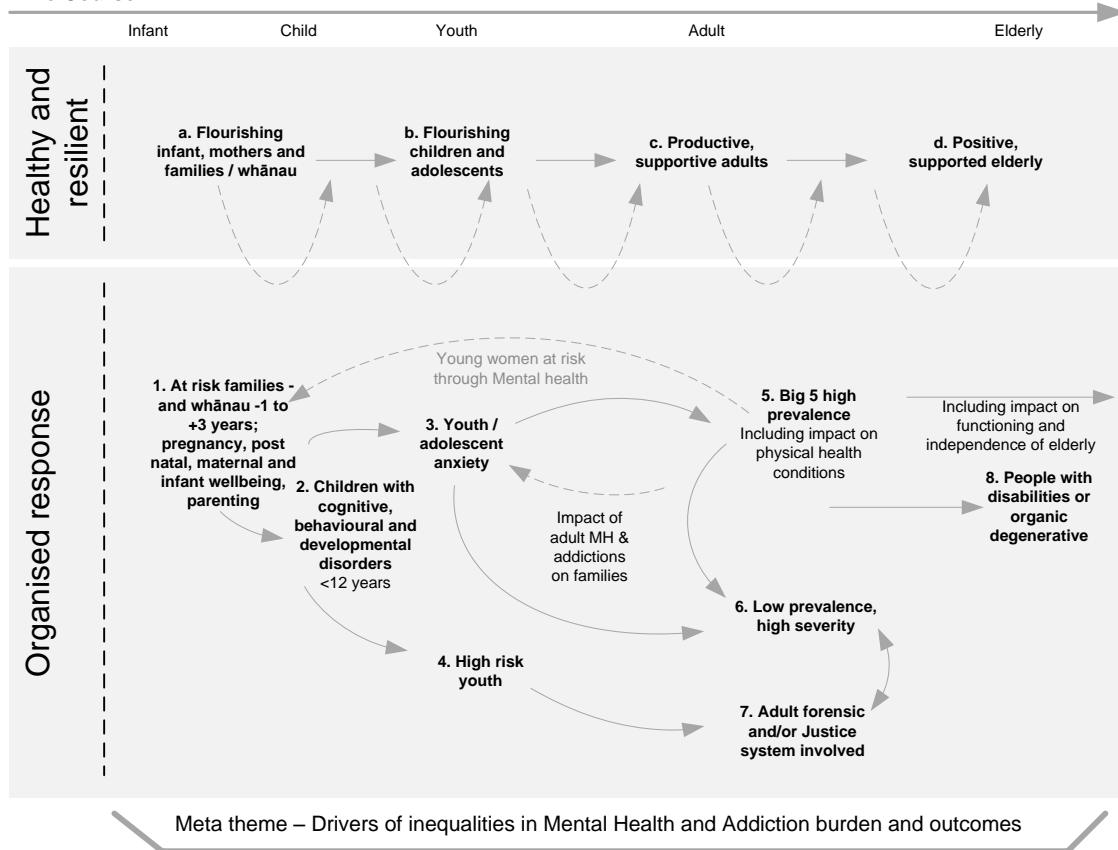
We believe we must move to a population based, life course understanding of the development and prevalence of MH&A issues.

Maintaining health and maximising wellbeing should be central to the life outcomes of all new Zealanders. The MH&A sector has a role to play in supporting people, to not only provide effective responses when people require support and use these to support and maximise recovery, but also maintain their health and wellbeing and build resiliency across the population. Using a population life course approach forces us to see the service and resource investments we make for different needs and populations as being connected within a service system and to look at how our responses impact on a consumer's journey through life.

To do this requires an innovative approach to understanding people and how peoples lives, needs and the responses from the MH&A sector change over the course of their lives. Peoples lives are not segmented into silos of child, adult and elderly but are connected and linked and what happens as a child impacts on people as adults. Our system and the responses we provide must reflect this reality.

To support this framing we propose using a variant of the life course view described within the '*Towards the Next Wave*' report as the basis for Blueprint II.

## Life Course



This variation on the *Towards the Next Wave* life course approach incorporates the critical requirement of maintaining the health and wellbeing of the population as well as an effective, efficient set of organised responses available to people when they require them.

The top layer depicts the state of resilient wellbeing that we believe Blueprint II should promote. In this domain we are concerned about the support the MH&A sector provides to people, families and communities to actively develop their own capacity to be resilient and weather adversity. This is the domain of health promotion, awareness, mental health first aid, destigmatisation and self/whānau care. This is not an area where the MH&A sector can take sole responsibility since it is a shared outcome and goal across people, families, communities, employers alongside health and the wider social sector.

Using a life course approach forces us to see our different populations as connected and changing over time. It forces us to see the service and resource investments we make for different populations as being connected and to look at our service system and how our responses impact on a consumer's journey through life. For example, more effective earlier action in 'upstream' journeys could potentially reduce the level and intensity of demand arising within subsequent journeys.

The eight population clusters are defined below:

- 1. At risk families and whānau - 1 to +3 years; pregnancy, post natal, maternal and infant wellbeing, parenting:** This cluster recognises the critical role of the peri-natal and infant years in developing a platform for subsequent success in life. The population group is mother, child and parenting focused, building on emerging evidence of successful interventions with the aim of working alongside sector partners to reduce the impact of family/whānau MH&A issues on this critical period of child development.
- 2. Children with cognitive, behavioural and developmental disorders:** This cluster focuses on pre-school to pre-pubescent (<12years) children and their families with developmental related mental health needs. It builds on stream 1 but with a strong focus on parenting support and early interventions for behavioural disorders, (including ADHD, oppositional defiance, conduct), with the aim of gaining substantial benefits for child educational participation and reduction in risk of subsequent trajectories towards youth and adult mental health, addiction and criminality.
- 3. Youth/adolescent anxiety and depressive disorders:** This cluster recognises the extremely rapid rise in prevalence of mixed anxiety/depression in youth which has significant impact on wellbeing for this group together with representing an opportunity to intervene earlier in the trajectories towards risk of subsequent adult mental health needs.
- 4. High risk youth:** This cluster describes the low prevalence/high severity mental health, alcohol and behavioural disorder related service demand, including self harm and conduct disorder. Substantial evidence exists for adverse flows from journeys 1, 2 and 3 above ending up in this pathway generating life-long risks of poor mental health, substance abuse and criminality.
- 5. Adult/older people 'big 5 high prevalence':** This cluster of overlapping situations characterised by anxiety, depression, drug and alcohol abuse, complex psycho/social stress and medically unexplained symptoms. The people within this pathway frequently have co-occurring medical conditions with high usage of health services, many/most have not accessed effective interventions. The aim is to increase the resiliency of this population and reduce the society wide burden of poor health, loss of employment and loss of independence.
- 6. Adult low prevalence, high severity:** This cluster encompasses multiple pathways for adults with severe MH&A conditions including those for early intervention, episodic acute needs, uncomplicated or complicated recovery as well as the small proportion with severe and enduring care needs. People in this population, particularly those with severe and enduring MH&A are at risk of substantially reduced life expectancies, higher morbidity and reduced social and employment participation. Strengthening recovery, reducing morbidity and improving social inclusion is the aim for this population.
- 7. Adult forensic and/or justice system involved:** This cluster is generated by the overlapping nature of some high severity MH&A and criminal behaviour. The aim is to support more comprehensive and integrated responses across Corrections, Mental Health and AoD services to gain society wide benefits with this population; better health, reduce reoffending, reduce benefit usage and increase employment.
- 8. People with disabilities and organic degenerative needs:** While this cluster is dominated by more elderly oriented 'psycho-geriatric' demand (mainly dementia) it recognises that the MH&A needs of those with disabilities and organic disorders also affect a wider age range (e.g. acquired brain injury). The aim is to integrate MH&A interventions with sector partner responses to maintain functioning and independence and slow decline, contributing through this to increasing our economic sustainability in the face of an aging population.

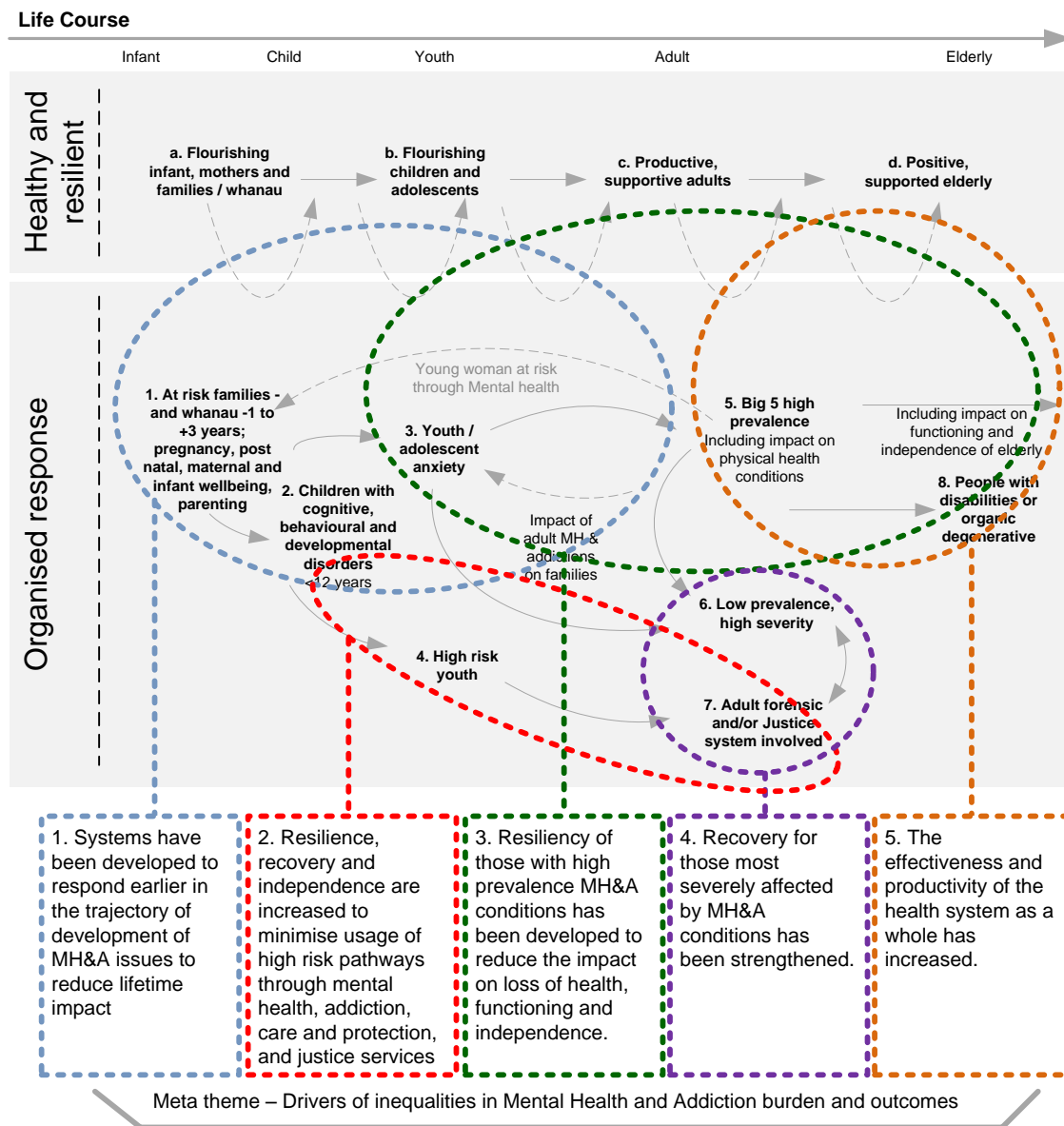
#### 4.2.1 OUTCOMES FOR THE NEXT DECADE

Taking this population view this working paper proposes five outcomes that, taken together, provide a shape and focus for how things need to be:

1. Systems have been developed to respond earlier in the trajectory of development of MH&A issues to reduce lifetime impact.
2. Resilience, recovery and independence have been increased to minimise usage of high risk pathways through mental health, addiction, care and protection, and justice services.
3. Resiliency of those with high prevalence MH&A conditions has been developed to reduce the impact on loss of health, functioning and independence.
4. Recovery for those most severely affected by MH&A conditions has been strengthened.
5. The effectiveness and productivity of the health system as a whole has increased.

Each of these outcomes is central to one or more of the populations that should be a focus for Blueprint II. The diagram below locates each outcome across all of the population and how, in some places, they overlap.

## Linking outcomes across the population life course



It is clear that the MH&A sector cannot achieve these outcomes on its own. It requires the support of partners, of people and their family/whānau, of communities and of services across health and social service and justice sectors. Without working in partnership, the MH&A sector will not drive the way things need to be.

Each outcome described in more detail:

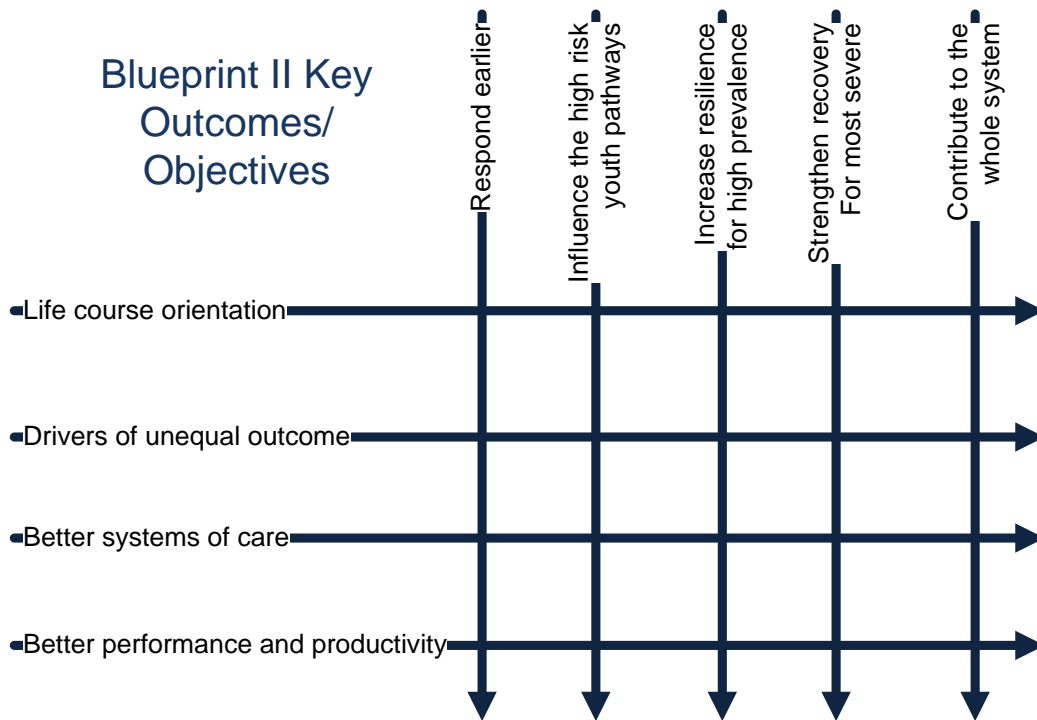
1. **Systems have been developed to respond earlier in the trajectory of development of MH&A issues to reduce lifetime impact:** Our better understanding of the trajectory of development of MH&A conditions demands that we recognise and respond earlier in the development pathway. We need to take concerted action to build resilience and avert future adverse outcomes for our infants, children and youth. This

requires that Blueprint II should guide development of a different mix of services, emphasising the impact of child and youth pathways as the precursor of most adult MH&A need and the value of early recognition and fast service responses across the continuum.

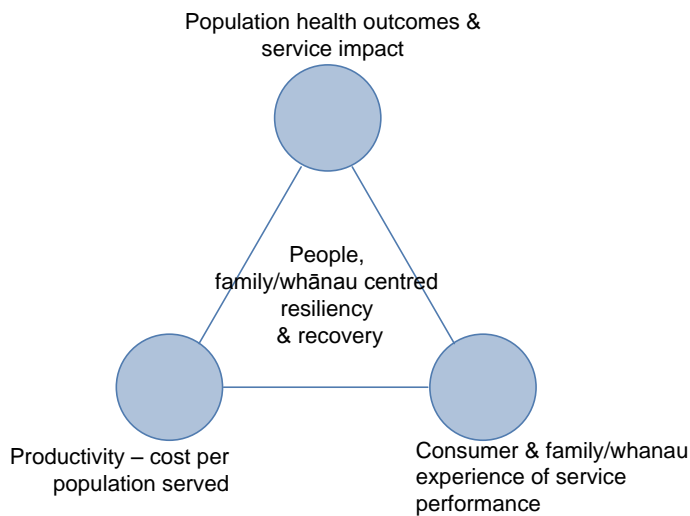
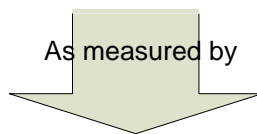
2. **Resilience, recovery and independence have been increased to minimise usage of high risk pathways through mental health, addiction, care and protection, and justice services.** The data around the conjunction of mental health and high risk of harm, behavioural issues and the impact and cost of these pathways is clear. The interdependencies between service responses requires that MH&A engages alongside sector partners in these areas to support reduction in harm and promote recovery and independence for people and whānau who find themselves on pathways through high risk mental health, addiction, care and protection, and justice services. The aim is to decrease presentations to these state sector services.
3. **Resiliency of those with high prevalence MH&A conditions has been developed to reduce the impact on loss of health, functioning and independence.** We have a better understanding of the wide prevalence of common MH&A conditions and their impact across both society as a whole, and on specific populations. This is seen in terms of health (both mental and physical aspects), employment, participation in education and risk of crime. This demands that Blueprint II supports the vision of 'No Health without Mental Health' and sets goals for effective responses across the various journeys through MH&A.
4. **Recovery for those most severely affected by MH&A conditions has been strengthened.** Our understanding of the adverse impact of MH&A across all aspects of health and wellbeing has deepened; reduced life expectancy, poor physical health, reduced social and economic participation emphasises the requirement to strengthen our response to those most severely affected by MH&A. Blueprint II must move beyond the original 3% access goal to be more explicit about the outcome needed - to reduce the 15 – 20 year life expectancy disparities for those diagnosed with severe MH&A conditions by aggressively targeting its drivers.
5. **The effectiveness and productivity of the health system as a whole has increased.** As MH&A has matured the relative separation from mainstream medical care becomes harder to justify. While a greater investment in MH&A is still required within our constrained funding environment this can only be justified in terms of MH&A's contribution to increasing the effectiveness and productivity of the health system as a whole. This demands both a focus on value from the resources within MH&A and commitment from MH&A to contribute to whole of system productivity issues; the impact of aging, long term conditions and medically unexplained symptoms where mental health can increase value and reduce cost.

These, together with cross population actions, are summarised in the following diagram.

## Blueprint II Key Outcomes/ Objectives



As measured by

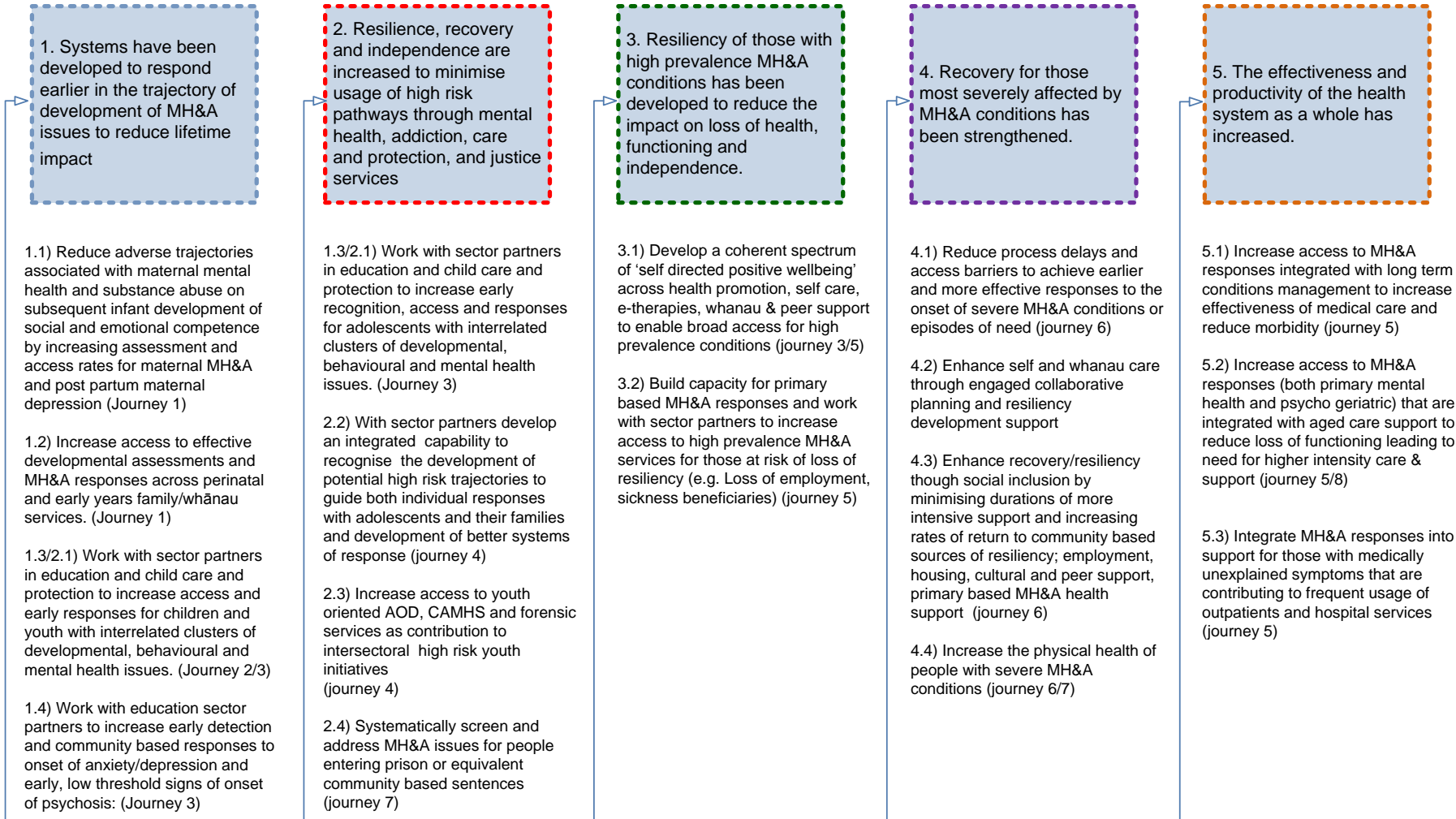


### 4.2.2 CALL TO ACTION

During the next phase of Blueprint II development a small set of specific areas of impact, (intermediate outcomes), will be developed under each outcome. These will sit alongside the priorities developing through the Service Development Plan.

The diagram below provides a starting point for these outcome linked impact areas.

Population Level Outcomes



### 4.3 ADDRESSING DRIVERS OF INEQUALITIES OF OUTCOME

Across each of these outcomes we will need to drive for more equitable outcomes for vulnerable groups, including those with high needs, Māori, Pacific people, refugees and asylum seekers and people living under economic deprivation.

There will be no single pathway for ensuring the best health outcomes are achieved for different population groups. With many of the determinants of health sitting outside of the health system, a whole-of-Government approach is required to attain the best health outcomes for many people. Within and across each of the populations and journeys through mental health and addiction it is important that we recognise that many different population groups have distinctive world views and unique ways of meeting their particular needs. This requires a balance between differentiated responses, to increase effectiveness, and integrated responses to ensure comprehensiveness and access to specialised support.

#### 4.3.1 OBTAINING EQUALITIES OF OUTCOMES FOR MĀORI

Across each of the eight populations Māori MH&A prevalence rates remain high. Māori are more likely to experience two or more coexisting health conditions with their mental or substance use disorder, such as chronic pain, cardiovascular and respiratory disease.

Māori mental health and wellbeing clearly warrants continued focus as a health issue. Sustained efforts are required to develop the pathways, care environments and workforce that are more effective for Māori mental health service users and their whānau.

Future pathways have to ensure that the diverse needs and expectations of Māori mental health service users are met as part of service delivery. For services to be effective to Māori, holistic models of care such as those provided by Māori mental health providers continue to be needed, as there is evidence of good outcomes being achieved.

It is recommended that any approach for Māori must be based on:

- Meeting the broader health and mental health needs of the service user in the context of their whānau.
- Recognition of a Māori world view in any service delivery.
- The importance of cultural imperatives in mental health service because of the need to be able to communicate effectively with the service user and whānau.
- A broad understanding of the circumstances of the service user's life and goals.

Emerging innovations in Whānau Ora show that significant differences can be made if there is a better understanding of a person and the needs of their whānau. In addition, if Whānau Ora support meets the core needs of whānau, then it will lead to many more Māori meeting their full potential through positive health outcomes, educational attainment and social development.

#### 4.3.2 OBTAINING EQUALITIES OF OUTCOMES FOR PACIFIC PEOPLES

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

Access rates are significantly low, with low service utilisation proportionate to need, particularly for Pacific children and adolescents. When Pacific people do access services, evidence shows it tends to be a later presentation, at the more severe end of the continuum, with longer and more costly hospital stays.

The Pacific profile in relation to mental health and addiction in New Zealand is complex, with compounding risk and protective factors different from other groups and influenced in part by the dynamics of:

- **Migration & acculturation/cultural change:** Rates of mental disorder for New Zealand-born Pacific people are double that of those who migrated after the age of 18. The psychological impact of adapting to a new culture has long been understood as a significant mental health issue for migrants, and for the children of Pacific migration.
- **Relative socio-economic deprivation:** Unemployment, low income, poor housing, low levels of education, breakdown of family networks and rising alcohol and drug problems are having an increasing impact on the mental health of Pacific people.
- **A high burden of non-communicable diseases:** Pacific people have disproportionately high rates of non-communicable 'lifestyle' diseases such as cardiovascular disease, diabetes, and stroke. The relationship between poor physical health and poor mental health is an area of concern for Pacific people.
- **A rapidly growing, changing and youthful pacific demographic that appears to be carrying the burden of mental disorder:** The Pacific population has the highest proportion of children (aged 0 to 14) of all of the major ethnic groups (37.7 per cent), and younger Pacific people are more likely to experience mental disorder and "more serious" mental disorder than older Pacific peoples, Pacific youth have also been found to have double the rate of depressive symptoms, suicide ideation and suicide attempts, compared to New Zealand European youth.

Traditional Pacific approaches to mental illness differ from Western medical approaches. Unlike western understandings of mental disorders, Pacific peoples may not view 'mental illness' to be a disorder that necessarily originates from within an individual. Instead experts purport that Pacific people traditionally view mental illness as spiritual possession caused by breach of sacred

covenant between people, such as punishment for past sins committed by the individual or their family. This is treated by 'spiritual healers' or traditional methods of healing.

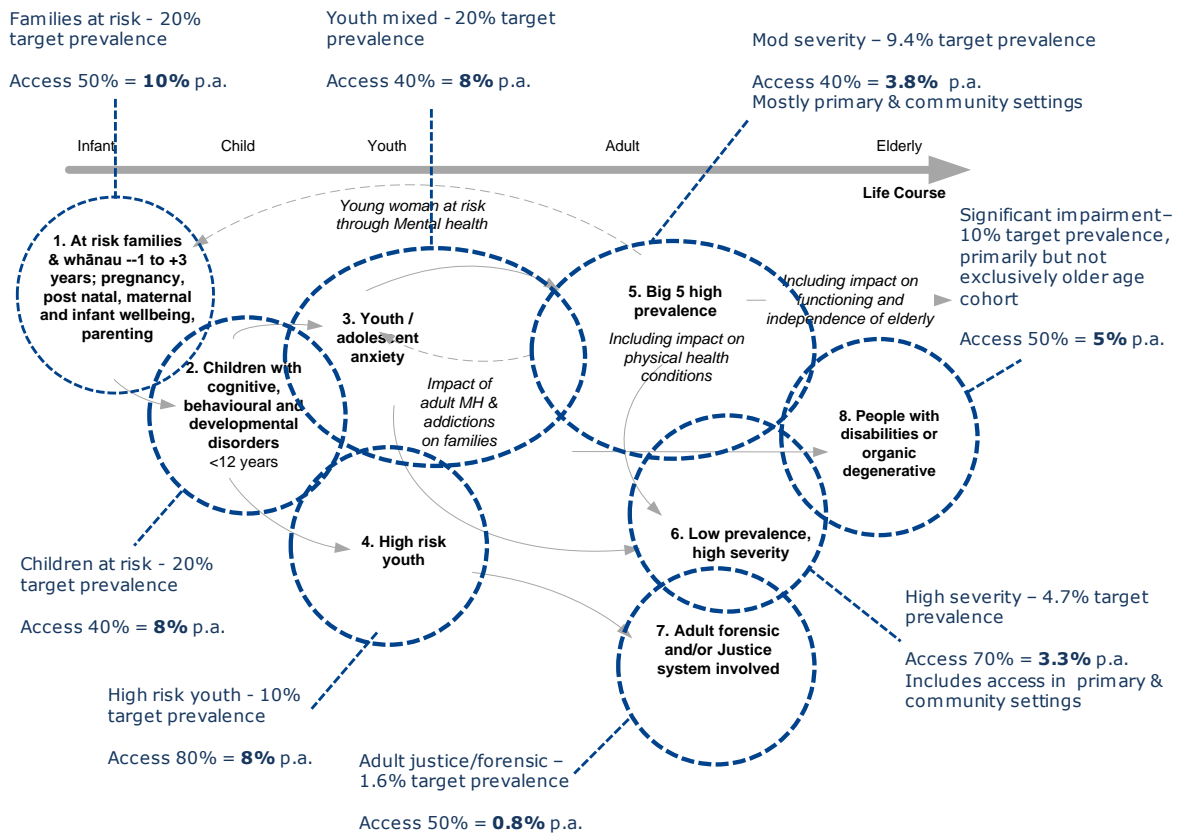
Pacific worldviews and identity are based on a collective approach, which is governed by a complex set of interrelationships between individuals, their families and their communities. Pacific health literature outlines three frameworks conceptualising Pacific mental health: The Samoan *Fonofale* model, the Tongan *Kakala* model and the Cook Islands *Tivaevae* model. These frameworks all emphasise the importance of understanding Pacific concepts such as use of language, family and spirituality as a key component in Pacific models of care that exists alongside the physical, mental and social aspects of a person's wellbeing.

#### 4.4 MAKING DIFFERENCES THAT MATTER

To make the magnitude of difference on population level outcomes envisaged by Blueprint II, it is clear that we need a substantial lift in access rates, both in aggregate and for specific populations.

While 'no health without mental health' describes a broad and comprehensive role for MH&A across all of health promotion, primary care, social services and general medical care it is our proposition that Blueprint II should have a more specific focus on providing guidance for organised MH&A responses that will drive for pressing outcomes for those most in need.

Some preliminary steps to modelling the changes in access and response rates was undertaken by the clinical working group in the *Towards the Next Wave* report, shown in the diagram below:



In this analysis a range of data sources were used to generate a 'target prevalence' for each consumer journey, representing a sub-set of the overall mental health and addiction prevalence where a high impact could be achieved through organised service responses.

The target prevalence represents an approximate threshold boundary between health promotion, self care or general primary care responses and a level where more structured MH&A services would be applied. For example in *Journey 5: Adult high prevalence*, the target prevalence of 9.4% represents only those classified with moderate severity MH&A disorders as measured through *Te Rau Hinengaro: The New Zealand Mental Health Survey 2008*, assuming that the much larger group of mild MH&A conditions would be the domain of general primary care and supported self care responses.

Within each population not everyone seeks help, is recognised or needs support in any one year so the annual access rates are expressed as a percentage of target prevalence. For example in *Journey 5: Adult High Prevalence* it was expected that only 40% of the 9.4% of the population would access services in any one year.

**Aggregating across these journeys the implication is clear – we need a substantial lift in access rates if we are to have an impact on the proposed Blueprint II outcomes – based on this analysis an increase in access to at least 9% per annum.**

In the co-development phase of Blueprint II we are proposing that a more rigorous workup of these population level target prevalence, access and response goals should be undertaken.

#### 4.5 CREATING SYSTEMS OF CARE THAT ARE PEOPLE CENTRED, RESPONSIVE, TIMELY AND INTEGRATED, BUILDS RESILIENCY AND ARE RECOVERY FOCUSED

To achieve these outcomes we need to recreate our systems of care in order to deliver rapid and appropriate responses for people, family/whānau that build recovery and resiliency.

Our current system of care has evolved out of the first and second waves of deinstitutionalisation with a focus on specialist responses for the most serious mental health issues designed for either relatively short duration, early intervention or episodic acute care needs. It also included ongoing support for those with more complicated recovery pathways as well as the small proportion with severe and enduring care needs.

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

When needed, our system of care should provide fast access to a range of response using 'close to home' primary and community settings and brief focused interventions as much as is appropriate and possible.

The resiliency principle emphasises the value of strengthening the social context around people; family/whānau, activity with friends, the health benefits of workplaces and the role of peer support networks.

While episodic and intensive acute needs cannot always be anticipated, enhancing the planning and cross system continuity of care for relapse response is important for supporting recovery and minimising loss of resiliency.

Where longer durations of support are needed, our systems of care must retain the focus on pathways to recovery; minimising the risk of people becoming stuck and isolated by their engagement with ongoing MH&A care, ensuring good integration with medical care and supporting social inclusion, housing and employment where possible.

In essence, we need to turn our current system of care into one that is people-centric and resiliency focused and utilises tiers or layers of responses; from self care, primary and community through to more specialised and intensive services.

#### 4.5.1 CREATING SYSTEMS OF CARE THAT ADDRESS THE DRIVERS OF INEQUALITIES

In facilitating the evolution of new systems of care Blueprint II should seek to ensure that these contribute to addressing the drivers of inequalities for critical population groups.

##### **For Māori**

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

- **Primary Health Services:** In the area of early engagement or promoting early access to health services, consideration should be given to the involvement of Māori health providers. The rationale for this is that many of these services have excellent skills in connecting with 'hard to reach' whānau and encouraging them to access services.
- **Secondary Level Services:** The involvement of Māori community workers or social workers at this level of service delivery can be instrumental in ensuring that Māori are connected into the best range of health and social services.
- **Tertiary Level Services:** It is important that doctors and other health professionals continue to achieve greater awareness of the cultural diversity and the place of Māori in New Zealand, in order to meet the cultural competencies within their fields of expertise.
- **Whānau Ora:** Emerging innovations in Whānau Ora show that significant differences can be made if there is a better understanding of a person and the needs of their whānau. In addition, if Whānau Ora support meets the core needs of whānau, then it will lead to many more Māori meeting their full potential through positive health outcomes, educational attainment and social development.

##### **For Pacific peoples**

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

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

service workers, and understanding the importance of the spirit of a person to his/her mental health.

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

#### 4.5.2 CALL TO ACTION

The need for a more primary/community based tiered response is not new, however many of our current structures of delivery and funding do little to support the transition needed. In its next phase of development, Blueprint II will identify specific areas of high impact changes that will accelerate the transition to a tiered service system within our current constrained resource environment. The six areas below are proposed as leverage points for system of care change.

##### **1. Self care and resiliency support**

Increase support for consumers and families centred services to respond most appropriately, to build capacity for self care and promote resiliency and wellbeing. We need to turn our current system of care into one that is people-centric and resiliency focused, and utilises tiers or layers of responses; from self care, primary and community through to more specialised and intensive services.

##### **2. Develop a responsive 'no wait' system**

Early and timely responses matter in MH&A. Stigma can slow people from seeking help; delays in response leads to escalation of issues and increased risk to resiliency through factors such as loss of employment. Non responsive services with barriers to entry can lead to longer durations of service support that is both costly and ineffective. Fast responses support independence with the security and safety of fast access when needed. 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 tiered system of care.

##### **3. Develop 'closer to home' responses**

Our current community MH&A resources are a success story of the last decade. However our current system of care has oriented these towards support for specialist services with access requiring a pathway through specialist care, requiring time, coordination and use of scarce skills. Meeting the outcomes of Blueprint II will mean emphasis on increasing recognition, assessment and treatment 'closer to home' within primary and community settings in order to achieve early, timely and appropriate responses.

1. Reorienting community support to provide responses alongside, and accessible from, primary care would shorten the response pathway for people, increase access to services and create pressure on building capability across both areas.

2. Bringing specialist expertise closer to primary care (e.g. through liaison roles for assessment and 'see and treat' models of care) has demonstrated benefits of faster responses and reduced pressure on outpatient care.

#### **4. Develop integrated responses across addiction, mental health, and behavioural disorders**

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

#### **5. Strengthened focus on the flows along pathways to resilience and recovery**

To date our system of care has emphasised access rather than progress on a pathway towards recovery. Better understanding of the results we achieve is emerging through structured process of measurement, but compliance rates remain relatively low. Detailed review processes have highlighted that some people are inappropriately 'stuck' in the system while opportunities to reduce dependency and increase resiliency are available. Blueprint II needs to create an environment where the use of measurement to underpin pathway planning and action is universal. Monitoring results achieved together with duration of care will ensure we have a system of care that uses the right mix of responses and resources to accelerate recovery.

#### **6. Join up services across partners in general health and social sectors**

Each of the five outcomes described earlier require MH&A services to have an alignment of effort with partners in general health and across social and justice sectors. This partnership will require strengthening relationships to understand the mutual pressure points for effective development. It requires integrating service responses and clinical pathways, and in areas of high interdependency such as child/youth or addiction and justice, a step further towards common infrastructure, including aligned funding and information capability.

### **4.6 CREATING A STEP CHANGE IN PERFORMANCE THAT MAXIMISES THE RESULTS WE ACHIEVE FROM OUR LIMITED RESOURCES OF ENERGY, TIME, CAPABILITY AND MONEY**

To achieve the proposed outcomes within the constrained funding path of the foreseeable future will require a radical increase in overall system performance and effective use of resources. Minor changes to status quo system of care and modes of operation will not achieve the results needed.

This system performance lift is required across three interrelated levels:

1. Day to day care delivery – micro level.

2. Organisation of MH&A services – meso level.
3. Whole system (including other government agencies) – macro level.

### **Day to day care delivery - Micro scale system performance**

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

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

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

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

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

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

### **The organisation of services - Meso scale system performance**

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

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

- Effective integration of tiered services and pathways of care: We have made substantial progress in developing a range of peer based, community and specialist services but have yet to integrate these across low intensity self care, group interventions, primary care and social services. Both local and overseas experiences show that integration of tiered services and pathways of care can better utilise the resources in the system, enabling increased access and more effective response. While a fully fledged tiered service model will require investment in service models and workforce capability, fast progress towards this can be achieved by removing existing policy and operational barriers, e.g. the reorienting of community support to provide access from primary care.
- Management of episode of care service duration and 're-admission': MH&A pathways will always exhibit individual variation but actively managing support duration can benefit both individual recovery and system productivity. The proviso is that shorter durations of support are achieved through strengthening resiliency and connections to social support structures, otherwise readmission rates or frequent service needs will negate the productivity benefits.

### **Whole of sector/cross sector - Macro scale system performance**

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

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

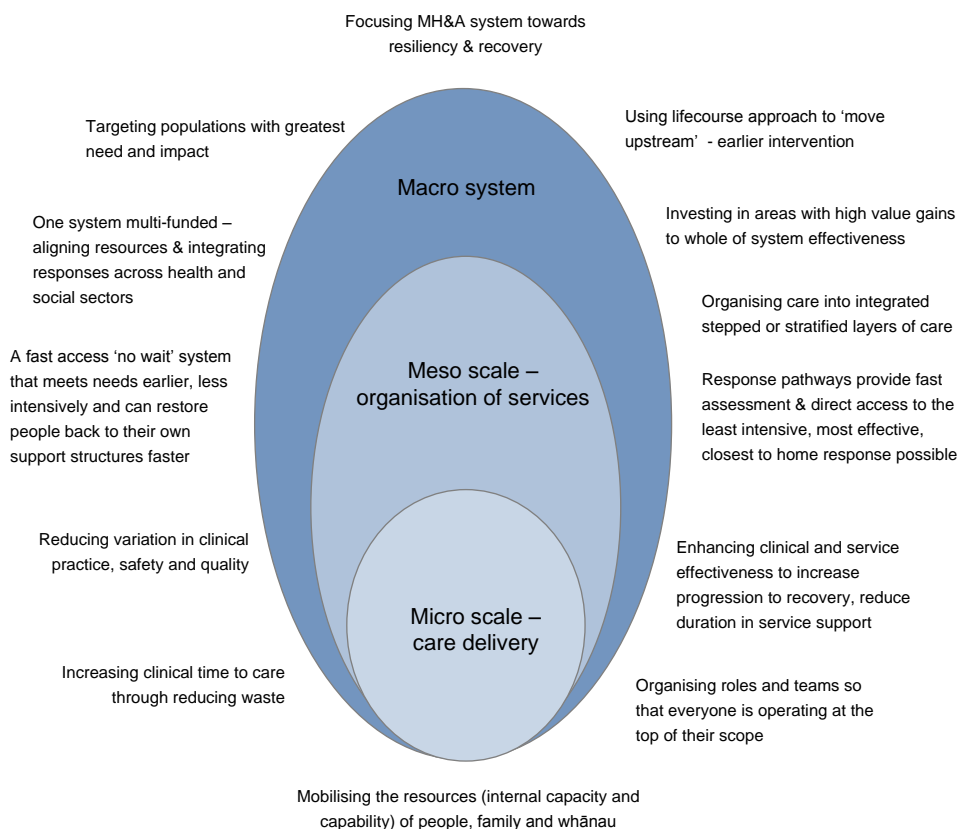
Making Blueprint II work will require people across the sector to engage creatively in the challenging task of weaving together the component parts a new value for money system in ways that are practical and effective. It will require a new form of distributed sector network leadership; one that embodies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

### **Supporting multi level system performance and effective use of resources**

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

- **One system multi-funded** – aligning resources and integrating responses across health and social sectors.

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



#### 4.6.1 CALL TO ACTION

Increasing system performance and effective use of resources is an urgent yet difficult task. What is clearly needed is a combination of whole of system leadership, operating at each level described above, and more clarity over the high value starting points that could initiate a self reinforcing breakthrough in performance.

For example, the establishment of clinically led system performance networks at district, regional and national levels charged with leading focused initiatives similar to those used in ED waiting time or Cardiac Services networks:

Day to day care delivery - at a micro scale:

- Use of stretch 'time to care' goals as a stimulant for high value quality and performance improvement in day to day service activities.
- Use of relative recovery improvement benchmarking, (e.g. as emerging through the primary mental health initiative, the national KPI project or within the Knowing the People Planning process), to stimulate changes in practice and model of care.

The organisation of services - at a meso scale:

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

The whole of sector - at a macro scale:

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

During the next phase of Blueprint II development these ideas will be the focus of co-development with sector stakeholders.

## 5. MAKING IT HAPPEN

The transformation envisaged in Blueprint II will not be achieved with the processes of leadership and change we have used to date.

The changes envisaged by Blueprint II will work best when change at individual, organisational and cross system levels are aligned.

Making it happen will require embracing sector-led leadership that can learn and navigate shifts in care and breakthroughs in productivity and performance across the system as a whole. This will require strong support of the formal structures of accountability and leadership - but these cannot dominate.

Sector leadership exists across a spectrum of clinicians, service leaders, community leaders, planners as well as those with more technical skills, whether in policy, analysis or service development.

Most importantly this leadership requires a partnership with consumers and their family/whānau.

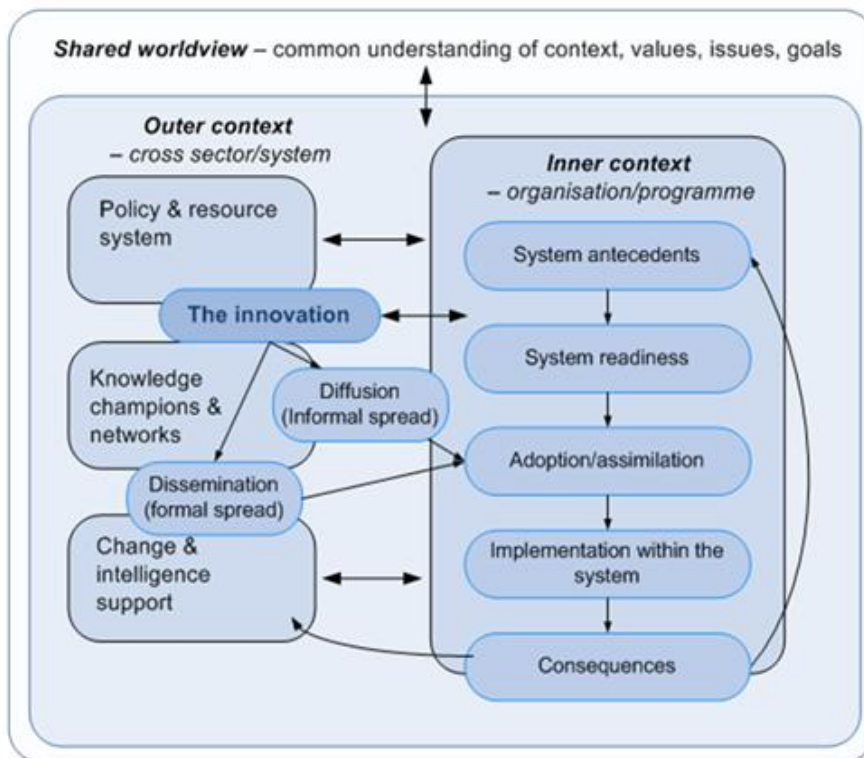
This section describes recommendations for Blueprint II about how we can collectively support the change leadership and processes required to make it happen.

### 5.1 BUILDING AN EVIDENCE INFORMED SYSTEM CHANGE CAPABILITY

Although there are outstanding examples of effective change across the sector we believe our current processes of system wide change are not up to the challenges of the future. We need to aim for a breakthrough in our change performance if we are to achieve what is needed.

For Blueprint II we propose a change strategy that is informed by evidence from literature and research on change, feedback from consumers and family/whānau, knowledge of clinical leaders and providers and learning from current innovations and exemplar services.

A review of contemporary approaches to change management and innovation in health systems provides pointers to the effective change strategy required to successfully implement Blueprint II. One framework shown below comes from an extensive review of health services innovation, adoption and assimilation.



Adapted from Greenhalgh et al 2004/2005: Conceptual model for considering determinants of diffusion of innovation in the organisation and delivery of health services:

The evidence supporting the framework above clearly points to the nature of the change alignment needed across:

- The formal policy system, (e.g. the Ministry SDP) and resource accountability structures (e.g. the monitoring and funding mechanisms).
- The informal or semi formal networks of knowledge champions and influence.
- A focused change intelligence support (e.g. as seen within existing benchmarking processes).
- The more internal processes established or emerging within services, districts and regions.

Alignment requires that each of these four aspects are to some level are embedded in a shared world view; a common or overlapping sense of values, issues and desirable goals and outcomes that define what matters.

Blueprint II seeks to assist the sector as a whole by contributing to articulating the values, issues and outcomes that matter in order to provide the ground for a common understanding for the next decade of MH&A development.

Government and the Ministry of Health both draw on and contribute to this articulation of what matters but have a particular role to help the sector through focusing on areas of priority (e.g. the Ministry of Health's Service Development Plan) and mobilising the resources of policy development, accountability structures, funding and infrastructure.

Knowledge champions and networks play a critical role in shaping and describing the critical innovations that will enable us to move forward, whether arising from practical experience or through more formalised research.

Change and intelligence support describes the capability needed to provide advocacy, develop change capability and help create the base of information and intelligence to support complex system change.

Fundamental to Blueprint II will be how the formal policy and resource system, the knowledge networks and the change and intelligence capabilities work together to support a focused but collaborative approach with the sector.

With limited resources we will need to create starting points that support self sustaining and self reinforcing change by rapidly and practically freeing up energy, time and resources to reinvest in the steps. Fortunately most of the needed innovations are already emerging; the task is to learn, spread, scale and integrate in a focused way rather than innovate from scratch.

We believe that as part of the next phase of Blueprint II development we need to:

1. Identify the small number of innovative system of care developments that can initiate the step-change in performance needed.
2. Using these as our focus, work with the sector to apply the evidence base for effective change to identify the system antecedents, system readiness and adoption/assimilation capabilities needed.
3. Again drawing on the evidence base, make recommendations to Government and central agencies on change support infrastructure required that will align the formal policy, monitoring and resourcing frameworks with sector led change networks and the change intelligence support needed.

## 5.2 SUPPORTING MINISTERIAL LEADERSHIP OF MH&A SECTOR

Ministerial leadership can help mobilise and focus sector effort by communicating through the formal channels that 'no health without mental health' matters and that lifting system performance is not optional. This leadership role needs to be supported by a deeply rooted commitment from the sector.

The future envisaged in Blueprint II needs focus. What gets measured gets done. Currently there are no Ministerial level targets for the Mental Health and Addiction sector. We believe this must change to support the effective leadership role that the Minister can play in the sector. We are proposing to develop a coherent set of performance indicators and targets that could be suitable for candidates for Ministerial adoption. These indicators and targets should be seen as an opportunity to enhance the profile of MH&A as an important contributor to the wider system of

government in areas such as employment, transition to adulthood and at-risk youth. Demonstrating this wider contribution will ensure the value of the MH&A sector is routinely seen and understood.

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

1. An overall access target.
2. A target that drives increased access and response to child and youth across MH&A.
3. A target that strengthens recovery and resiliency for adults through driving towards increased ability to gain or maintain employment.
4. A target that emphasises service responsiveness and encourages development of new systems of care, for example establishing strong expectations on waiting times.

### 5.3 STRONGER NATIONAL AND REGIONAL MENTAL HEALTH AND ADDICTION NETWORKS

We are proposing that Blueprint II supports the establishment of a sector-led change leadership capability in the form of stronger national and regional networks that enable and integrate leadership across a complex system with multiple organisations and groups. There are a range of existing networks that are well established. We are proposing that these are strengthened with a stronger role in shared governance and responsibility for achieving agreed local outcomes and performance goals. Networks involve leaders across clinical, policy, management, consumer, and families/whānau levels. The notion of distributed networks of leadership is not new and is used currently within the cancer networks.

It is important to note that some of this work has already begun.

The national KPI project has established the platform for service performance development using KPI information in a benchmarking and change intelligence role. The *Towards the Next Wave* process and this Blueprint II process have engaged leaders across clinical, service and consumer roles. Their advice is driving Blueprint II development and their leadership will be critical for the handover process and implementation. Other forms of sector led change are emerging during the Blueprint II development process that are extending and augmenting this leadership with their own energy and commitment; district led initiatives, practice groupings and through the existing change and development capabilities of sector organisations.

Essentially, the formation of the network mechanisms to support the leadership of Blueprint II have already begun.

- It is recommended that the existing mental health and addiction sector networks should be formally strengthened and in some cases extended into regional networks whose function and role is to support the ongoing operationalisation of Blueprint II.
- It is recommended that these networks have broad stakeholder involvement across DHB, NGOs, PHOs, NHB/MoH, consumers, families and whānau.
- It is recommended that these networks be given a clear purpose, mandate and resourcing to operate effectively in the way required to support 'the way things need to be'.

#### 5.4 WORKING WITH SECTOR PARTNERS

Working on its own the MH&A sector will not achieve the 'way things need to be' that this working paper envisages. The shifts require the MH&A sector to work with partners right across the system to achieve mutual outcomes and benefits. Three areas of current focus should provide a platform for development of effective 'whole of government' of mental health and addiction capability:

- Supporting social welfare reform and in particular the reduced use of social welfare support for people experiencing psychological distress.
- Supporting vulnerable children and adolescents in order to create positive transitions to adulthood.
- Understanding the drivers of crime and supporting the high levels of MH&A needs within this population.

In order to make a difference in these areas the MH&A sector must proactively demonstrate the associated value of supporting people with MH&A on the pathways to recovery and resiliency. Supporting people with MH&A issues is good in itself but more is required. The MH&A sector must position itself at the centre of the 'no health without mental health' agenda so that partners understand and see the practical contributions the sector makes. It is proposed that:

- Immediate focus be given to the three areas outlined above. These three areas require immediate attention and have a gravitas of whole of government buy-in to create traction and demonstrate immediate gains.
- In order to make progress in partnership on the three areas above, the MH&A sector investigate the use of alliance models (or similar) of partnership. These models focus on the achievement of shared outcomes in partnership which align closely to the outcomes specified by the way things need to be.
- This partnership work is owned and led by the, (to be established), mental health and addiction networks with extended involvement from sector partners. These networks will

have the reach and involvement of all the key partners to make progress on these shared outcomes – drawing on the premise of one system, multi-funded.

- Work be undertaken to develop a small set of integrated KPI and quality improvement practices. These KPIs would be owned by the MH&A networks and supported by continuous improvement resource to drive change forward.

## 5.5 PROPOSED ROLES AND RESPONSIBILITIES

### 5.5.1 OFFICE OF THE HEALTH AND DISABILITY COMMISSIONER

One of the reasons for the success of Blueprint I was the Mental Health Commission's advocacy and monitoring role to ensure it remained on the radar of the sector.

Blueprint II will require a similar host organisation. From July 2012 the functions of the Mental Health Commission will be integrated into the Office of the Health and Disability Commissioner (HDC).

From within the HDC the Mental Health Commissioner would be well placed to take on the role of supporting the implementation of service development as outlined in Blueprint II.

Detailed plans are currently being jointly developed for the transition of MHC functions and it is expected they will include supporting the transition of ongoing monitoring and advocacy projects for the next phase of developing services as outlined in Blueprint II.

The MHC has commenced discussions with the NHB to support the development of an implementation plan to enable regional and district plans and DHB contracts to reflect the key directions of Blueprint II.

### 5.5.2 MINISTRY OF HEALTH AND NATIONAL HEALTH BOARD

To support ongoing development and implementation of the key directions of Blueprint II HDC would require strong partnerships across the Sector. Key partnerships would be with the National Health Board and the Ministry of Health to support the changing relationships with DHBs, new policy settings and new guidelines for District Annual Plans.

Blueprint II will represent an opportunity for the MoH and NHB to take on a different form of sector leadership. Rather than operating in a traditional central agency role, the opportunity exists for the MoH and NHB to show leadership for MH&A across the sector and across government. This changing role must be tangibly shown in the frameworks such as monitoring and accountability and approaches to performance monitoring.

The NHB and MoH have a pivotal role in aligning investments in information architecture, information intelligence and service and clinical workforce required to ensure things are how they need to be.

### 5.5.3 DHB AND REGIONAL STRUCTURES

The owners and architects of the system that will move us towards how things need to be are the DHBs and regional planning structures. They provide the local governance and change leadership needed to energise the sector and act as the catalysts for change. They have the resources and local leverage to support the realisation of 'the way things need to be'.

To date, DHBs and regional structures have been influenced by having to meet Blueprint input targets. Blueprint II will signal a significant shift towards an outcomes-oriented view. To support this, a different orientation is needed to improve:

- Understanding of the populations they support (eight consumer journeys).
- Understanding and application of clinical evidence.
- Understanding of system performance.
- Use of workforce.
- Local level contracting mechanisms and performance monitoring structures.

Section 6 outlines the proposed development of nationally consistent 'intelligent tools' to help DHBs make these complex resource allocation and performance monitoring tasks.

## 6. GUIDING OUTCOMES ORIENTED DEVELOPMENT AND RESOURCING DECISIONS

This change will not happen without the right measures, tools and a supportive resource environment. In particular the sector needs:

- To evolve what we measure our achievements by, and how this is shared at all levels in the sector, particularly in relation to population outcomes, individual consumer experience and cost.
- Tools to aid decision making and assess trade-offs of different service models.
- To evolve the funding environment to drive the desired outcomes and support innovation and greater productivity. This will need a greater focus on outputs and less on inputs, a modified ring-fence and greater accuracy of the data that supports the PBFF calculations.

Navigating through the shifts in response and breakthroughs in productivity and performance required across the system to realise Blueprint II will require an intelligence capability that is able to guide outcomes oriented service development and resourcing decisions.

Over the last few years the sector has made a substantial investment in building a platform of measures and a culture of benchmarking that is starting to deliver results. Blueprint II will propose in 'how things need to be' our collective challenge in shifting to a next level of care for critical population groups using integrated service models to lift system performance and effective use of resources.

Feedback from the sector shows strong interest in creating a framework to guide performance that combines approaches such as 'The Triple Aim', with its explicit linkage of (1) population health, (2) user experience of care and (3) efficient use of resources inside a quality improvement framework and 'Results Based Accountability' with its clarity of purpose, structure and application for collaborative performance development. In the first part of this section we describe the initial steps towards creating this framework.

To realise Blueprint II will require a new form of collaborative planning and service development that supports exploration of the service options and alternatives by clinical leaders, service managers, service users and funders. A very preliminary start towards an integrated population, model of care and resource model was used in *Towards the Next Wave* to explore the feasibility of system wide reconfiguration of the sector to maximise the use of integrated resources across self

care, primary, community and specialist settings. This highlights the challenge for Blueprint II to create a planning tool that facilitates rapid system evolution within a disciplined environment that tests and refines critical ideas and assumptions quickly. The second part of this section describes progress towards achieving this aim and the pathway of co-development we see needed during the next phase of work.

## 6.1 EVOLVING HOW WE MEASURE AND GUIDE PERFORMANCE

The first step in achieving the outcomes outlined above is to evolve the way the sector measures its progress.

The current national KPI project offers an excellent start from two perspectives. Firstly, it has demonstrated the methodology required to develop a robust measurement framework and second, the mechanisms required to support ongoing clinical engagement, buy-in and ownership to such a framework. The KPI project offers the base on which we should build and expand the scope of indicators to cover the areas required to support the way things need to be.

### 6.1.1 EVOLUTION IS REQUIRED AT MULTIPLE LEVELS

How we measure and track progress will need to evolve at multiple levels. These are summarised in the table below.

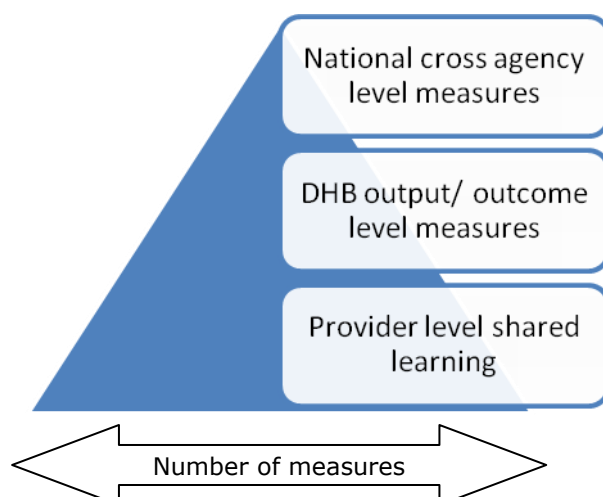
Level	From	To
<b>National cross agency</b>	Very few cross agency aligned outcomes.	A common set of combined outcomes across agencies in key areas (e.g. conduct disorder across Health, MSD and Justice).
<b>MoH – DHB</b>	MoH/DHB monitoring within mental health focused on 3% access, relapse prevention plans, client satisfaction and DHB expenditure levels (e.g. FTE and bed levels and % of expenditure against Blueprint Target).	Higher profile monitoring from the MoH and within DHBs with the possible use of a Health Target and Ministerial expectations focused on 9% aggregate access and the health sector’s role in broader societal outcomes (e.g. employment rates amongst those with mental health disorders).
<b>DHB funder – Provider (DHB provider arm and NGOs)</b>	A high proportion of NGO contracts and internal DHB provider monitoring that is input based (e.g. FTE based).	Provider orientation focused on outputs and outcomes (where possible) to leverage outcomes, incentivise outcomes oriented resourcing and models of care and therefore higher productivity.
<b>Cross provider</b>	Some functional shared learning with the national KPI project but	An extended shared learning environment building on the national KPI project with a

Level	From	To
	confined to specialist services.	broader whole-of-system view oriented to the outcomes outlined in section 4 above.

### 6.1.2 WHAT MEASURES AND WHERE?

The different levels described above will need different levels of detail. Very few measures will be needed at a national level whereas many more will be needed to inform service design and improvements at a provider level.

An initial set of measures will be developed over the co-production period but will also need to continually evolve as better access to information and data is achieved.



### 6.1.3 A FRAMEWORK FOR FOCUSING ACTION AND UNDERSTANDING RESULTS

The three areas of focus for 'how things need to be' fall into three categories of action – the 'Triple Aim'. The Triple Aim method, which has solid international acceptance, was developed by the Institute of Healthcare Improvement as a way in which to achieve simultaneous improvements across the core domains of quality and improvement.

- Population health outcomes and service impact - 'Life course population outcomes' and 'Addressing the drivers of inequalities in health outcomes'
- Consumer and family/whānau experience of service performance - 'Systems of care for people, family and whānau'
- Effective use of resources - 'Driving for system performance and effective use of resources'

Designing Blueprint II in this way will allow for the development of a performance indicator framework that aligns with international contemporary thinking on quality health system design and performance monitoring.

In order to ensure results across all three areas of the Triple Aim requires a robust framework. Results based accountability is a disciplined process where we start with the ends we want (results, targets and indicators) and works backward to the means to get there. It offers the practical focus required to structure a results oriented performance logic and framework in order to realise the outcomes we are aiming to achieve and/or influence.

Results based accountability insists that, *"programs and agencies identify the three or four most important measures; make sure these measures focus on customer results, not just amount of effort; create baselines for these measures, and hold agencies accountable for making progress against their baselines. These measures are then used to support a data-based decision making culture, and periodically produces what's needed for the budget."*

By linking the Triple Aim to results-based accountability we have the overall framework required to link populations, outcomes, consumer experience and effectiveness.

The way forward is to support the current national KPI development project to align with Blueprint II to create a system that is structured at all levels (see above) to continuously improve population health, consumer experience and system efficiency outcomes.

Further work on defining the KPI approach will be undertaken in the next phase of Blueprint II development.

An example of how Blueprint II proposes to link the Triple Aim, via a results-based accountability framework, to measure and performance is shown below.

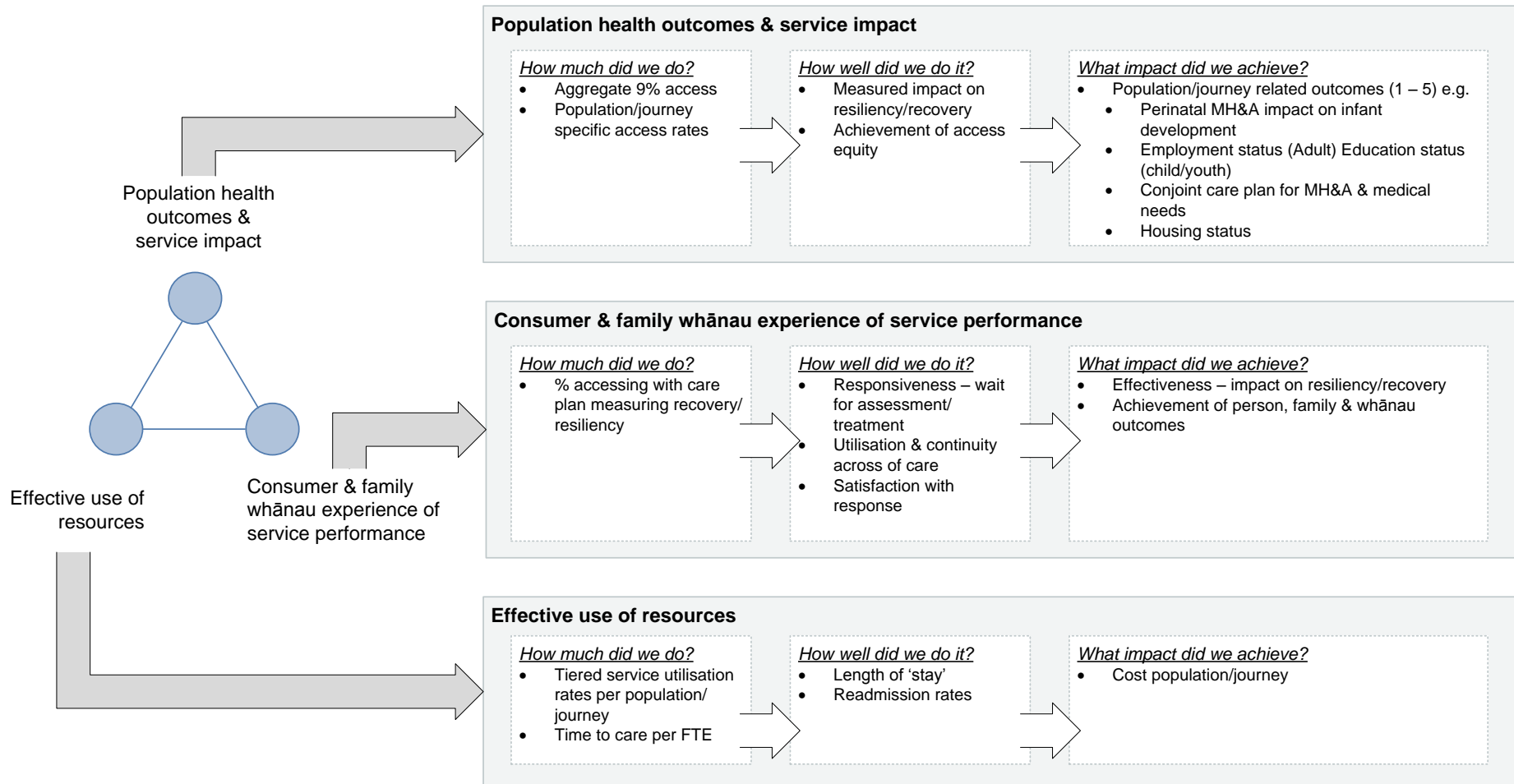
## **Aligning Triple Aim and Results Based Accountability**

The diagram below offers an initial outline of how the Triple Aim and Results Based Accountability approaches can be linked to create a powerful outcomes aligned performance framework that can clearly support resourcing and service development decisions.

The direction of travel needs to be towards a broader approach that both protects the gains in MH&A achieved to date and provides greater flexibility in the use of resources to enable innovation, efficiencies and collaboration across multiple services and sectors. To achieve the changes envisaged, we will need robust and accurate information that will be used to improve services delivered, guide investment decisions, and enhance accountability for use of public funding. This information will need to include information about people accessing services, the services they access (inputs and outputs) and the outcomes they achieve. This requires:

- **An evolution of existing KPIs:** Using the base of the existing national KPI programme develop and agreed set of nationally consistent KPIs with a stronger output and outcome focus using the Triple Aim/ Results Based Accountability approach that is aligned with broader sector based direction.
- **Providing an integrated, benchmarked, outcomes oriented approach to performance:** Develop the emerging benchmarking capability in the KPI programme into sector supported approach to whole of system development that supports change development and resourcing and contracting mechanisms.
- **Introduce nationally consistent resource allocation guidelines:** Develop a MH&A resource allocation decision support tool. This tool would provide a consistent systematic process for analysing need, performance and resourcing, to inform DHB MH&A resource allocation decisions (described in next section).
- **Annual process of review:** It is proposed that DHBs should be required to apply the decision support tool on at least an annual basis. The data from this process would inform a national database that would enable improved benchmarking, cross system learning and a national view of required forward investment levels in MH&A outcomes.

**Aligning Triple Aim and Results Based Accountability**



## 6.2 INFORMATION AND INTELLIGENCE

To realise the 'way things need to be' envisaged by Blueprint II requires a step change in the information architecture that supports the MH&A sector. Blueprint II will focus the sector on the need to have a strong population outcome and life course view of MH&A.

The result of this is that the sector needs to have the data, information and intelligence that support this view. A broad suite of data is required across traditional structures such as primary and secondary care, but also health promotion, consumer experience and social inclusion. The sector does not have the information collection and usage infrastructure to support these shifts. A number of current projects, initiatives and programmes are beginning to build this infrastructure, however these require ongoing investment and increasing integration across government. These projects include the national KPI project, PRIMHD and MAGPIe.

- It is recommended that the KPI project be extended to include the full suite of indicators required to support a population and life course view. This includes primary care, secondary care as well as community, consumer and linkages across government into areas such as social welfare.
- It is recommended that as a priority a subset KPIs be agreed at a national level around definitions of access and response that inform the core funding and performance relationships between MOH and DHBs.
- It is recommended that a Mental Health and Addiction Next Wave Information Strategy be developed by the Ministry of Health which outlines a Blueprint II aligned IT development pathway.

## 6.3 CONTINUOUS QUALITY IMPROVEMENT AND ACCOUNTABILITY

There is growing evidence that people and organisations are more accountable and honest to each other (as peers) through appropriate self assessment as an enabler for change. Emerging research is indicating that peer processes for accountability are a key performance influencer, often leading to greater levels of "stand out performance" than traditional top down approaches (J Grenny 2010).

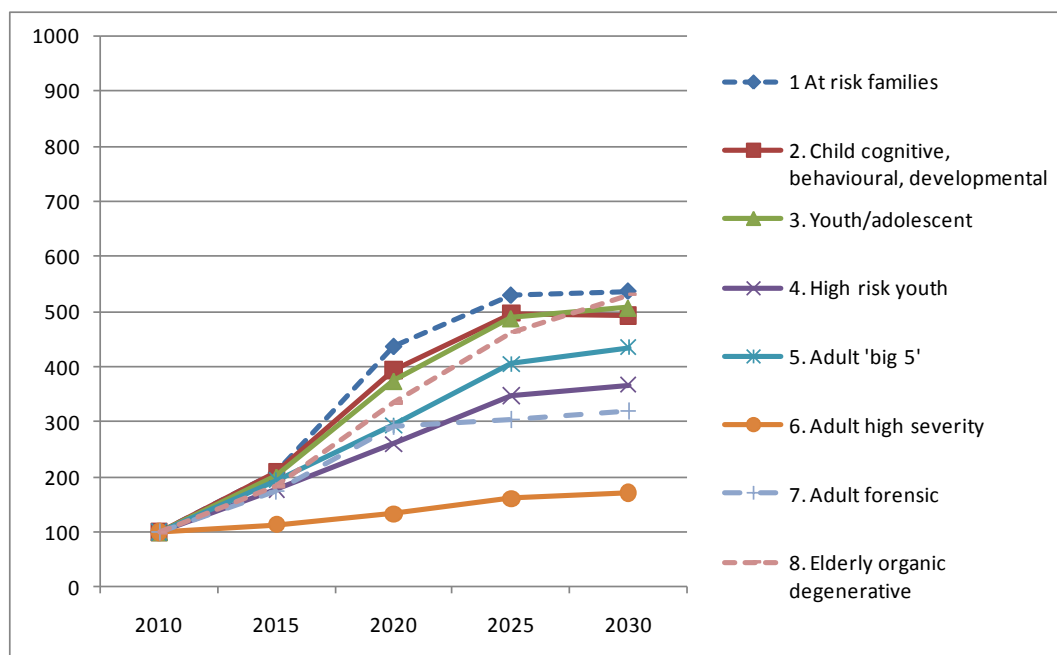
Complementing MoH, NHB and MHC monitoring and accountability mechanisms with the establishment of peer accountability will be required. There are opportunities to build on existing processes, for example MHC Sector Visits, National KPI Benchmarking processes, sector interest/stakeholder groups to provide the foundations for a nationwide, whole of sector Peer Monitoring and Accountability framework.

## 6.4 SUPPORTING OUTCOMES ORIENTED DECISION MAKING

Between 2011 and 2020 evidence is indicating that the health sector can expect a doubling of demand for services, with only a 30–40% increase in available resources. The doubling of demand is supported by modelling work by the NZIER (NZIER 2004) and the cost estimates based on health costs remaining at current levels (9.2% of GDP and 20% of Government spend) and in turn by an optimistic estimate of 3% annual growth of real GDP. (Gorman 2010)

This working paper describes a similar challenge for the future with increased access to services within a resource constrained environment. The graph below shows the magnitude of the relative changes required across the eight consumer journeys. The increases envisaged over the next 10 years are significant and will not be achieved unless we make some challenging decisions. If added together the journey level access changes shown below represent the aggregate increase in access outlined in section 4 above.

Relative change in response by consumer journey (Year 2010 = base 100)



Source: *Towards the Next Wave* 2011

To realise the 'way things need to be' will require stakeholders to make challenging and important decisions over the coming years. Decisions will be required across all areas of the system, but in particular with regards to where effort, expertise and financial resources should be focussed. Overall it will not be possible to do more, we will not have the resources, we need to do things differently and we need tools to help us think differently and to make decisions.

Blueprint I supported decision makers by providing an inputs oriented 'service recipe', (appendix 4 in Blueprint I), that indicated the service areas and levels of resources required in each of these areas. In essence this recipe enabled stakeholders to make decisions with confidence that as long as the decisions being made supported the achievement of these inputs guidelines then they were appropriate.

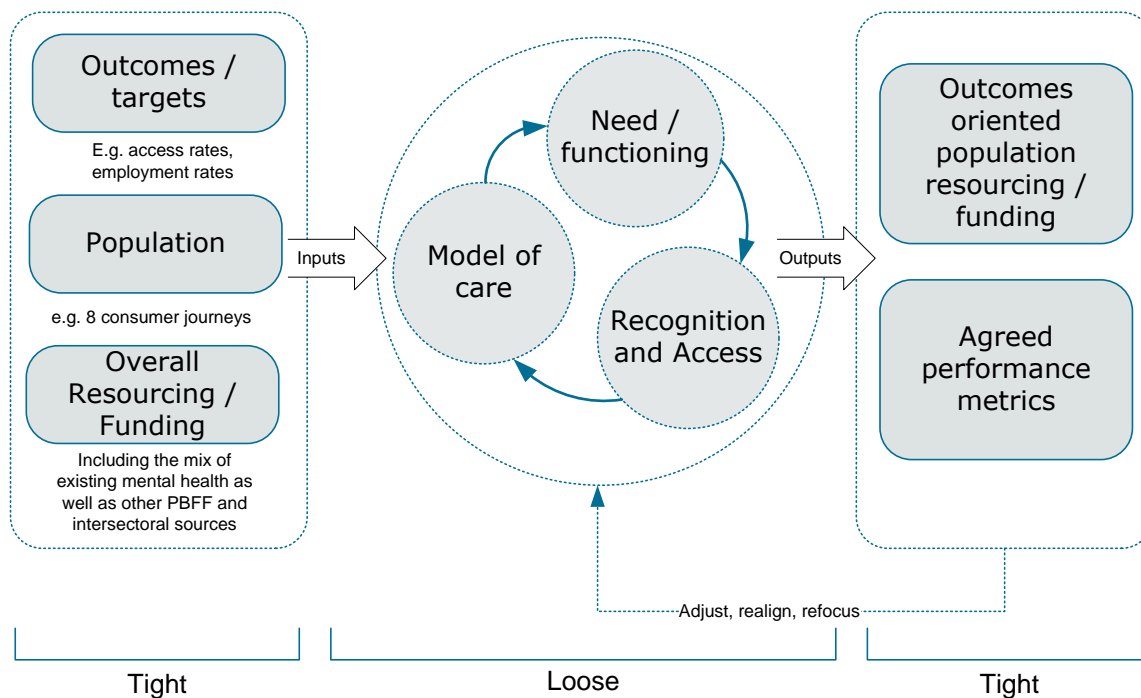
During the co-development phase of Blueprint II, stakeholders clearly signalled the need for the sector to move away from this inputs or 'service recipe' model towards a performance and outcomes oriented approach that enables flexibility and supports innovation at all levels of the system. Stakeholders described the unique challenges of responding to their local populations, local political environment, priorities, workforce, evidence and service model ideas. Clearly each region, district and/or locality is unique and Blueprint II should offer a consistent framework to support stakeholders to make decisions.

In order to support outcomes oriented resourcing decisions, local populations, priorities and innovation requires a new approach. It requires an environment where analysis is supported, tradeoffs are understood and decision makers supported with tools that help.

The diagram below represents the core elements of the decision support framework being proposed for Blueprint II. With further development this framework would be supported with modelling tools and other resources.

The intention is that this framework and tools will enable stakeholders to make informed data-driven decisions with regard to where to focus resources, to understand the model of care tradeoffs and how to set performance criteria for the key indicators required to support the way things need to be. The intention is that this framework is used to set the requirements for system performance and enable these to be tracked, understood and continuously improved over time.

The tools and the outputs from the framework will be used as part of the monitoring and accountability framework being proposed to support Blueprint II.



The framework is based on a 'tight, loose, tight' concept. The first 'tight' represents the elements that are either being created by Blueprint II (i.e. outcomes/target) or those set by central government agencies (i.e. overall resourcing / funding) or are a given (i.e. population and demographics). That is to say that a locality or region has little influence over this first 'tight' and must use these as inputs.

The second 'tight', represents the outputs of the framework. There are two key output areas: the resourcing funding pathway and the performance metrics. These 'tight's' are driven by the 'loose' component of the framework, and as such, can only be modified by altering the loose elements of the framework.

In the middle of the two 'tight's' is the 'loose'. The 'loose' represents the zone where adaptive flexibility is needed by districts or regions to make decisions about the need/functioning of their population, determine local recognition and access rates and progressively develop the capability and capacity of their local model of care. The model of care element is critically important in this framework. It is where decision makers must assess the real world tradeoffs at an operational service design level while at the same time achieving the first and second 'tight's'. For example, if the focus is on early intervention for a particular population, what model of care will work best? Where will effort need to be reduced to support efforts in another area? In a resource constrained environment these tradeoffs become harder to make.

These three elements (tight, loose, tight) would come together to form the decision support framework to support Blueprint II.

- It is proposed that this should form a key part of monitoring and accountability frameworks. Localities could be required to use the tool set to make submissions to the

HDC, MOH or NHB on their 12 month view of performance metric and associated funding profiles. This submission process would then be supported with discussion, dialogue, sector visits and the sharing of intelligence.

- The tools should also be used to support benchmarking of key service design and delivery elements and the use of a standardised tool would enable easier sharing of innovation across the system.
- It is intended that this framework would be usable to support performance and contracting relationships at many levels; from MoH/DHB performance expectations, possible network alliance agreements or DHB/provider contract agreements.

## 7. EVOLVING HOW WE ORGANISE FUNDING

MH&A funding is currently organised by a complex structure of Population Based Funding Formula (PBFF), annual Blueprint funding increments and a ring-fence for specialist MH&A services. These funding arrangements were put in place to support the implementation of the 1998 Blueprint.

These arrangements helped:

1. Increase access to specialist services for the top 3% of the population with severe conditions through a recovery-based model of care oriented to that 3%.
2. Increase investment to the mental health sector from a position of relative under investment.

The funding and performance mechanisms included the Mental Health ring-fence, annual Blueprint funding, tracking DHB funding and resources against the Blueprint resource guidelines and tracking DHB progress against access targets.

These objectives have largely been met for the majority of DHBs in New Zealand. That is, 14 out of 20 DHBs are at or above the 3% access target (Ministry of Health 2011) and there is a sense that both nationally and internationally the investment in mental health is reaching investment levels similar to other health services, particularly when relative to New Zealand's income (GDP).

The structure of the MH&A ring-fence and associated annual Blueprint funds reinforced an ever increasing investment in mental health by only allowing increases in funding year on year, which could not be used by any other services. The approach worked well while mental health and addiction funding was 'catching up' to personal health. However, this growth strategy is increasingly generating funding and resource conflicts for some DHBs in terms of:

- **Living within their overall funding envelope** as defined by the population based funding formula (PBFF). Some DHBs are finding it difficult to maintain a sustainable funding path with annual Blueprint funding but without the guarantee it will be covered within their overall PBFF. As a result the MH&A ring fence funding for some DHBs is now well in excess of the mental health component of their population based funding, whereas for some it is well under.
- **Driving innovation, efficiencies and reducing waste** when being monitored against a fixed input model (e.g. inpatient beds and FTEs per 100,000), particularly with the increasing need and opportunities through collaborative efforts with other services and agencies.
- **Being monitored against an input model** based on 3% access levels when these access targets, for many, have been reached.

The unaligned approach between PBFF funding, annual Blueprint funding increments and input based monitoring is creating funding and resource conflict, despite access targets increasingly being met.

We propose that Blueprint II should signal a broader approach, where greater flexibility in funding and monitoring will be needed. Mental health services will increasingly be multi-funded with common outcomes, particularly for those beyond what have traditionally been captured within the 3% of highest need.

Therefore, a modified approach to mental health and addiction funding is needed:

- Protect the gains in investment made to date, while allowing greater flexibility to promote innovation, efficiencies and collaboration across multiple services and sectors.
- Drive an increased outputs and outcomes focus to maintain appropriate investment within the whole system view of mental health and addiction.

Based on feedback to date, the proposed way forward would include:

1. **Protecting the investment gains made to date by having a modified ring-fence.**  
This could be linked to a relative portion of PBFF and/or outcomes (such as the 3% access) but not tied to year on year increases and/or solely input based monitoring.
2. **Improving the accuracy and reliability of future PBFF funding** through greater accuracy of utilisation data (e.g. PRIMHD and NGO data) and estimation of unmet need. This will allow greater equity across DHBs and improve links between needs and funding.
3. **Developing a more future oriented DHB performance accountability framework with a managed phase-out of the old:**
  - **Tune the National Service Framework to** reflect and track against nationally consistent output and outcome KPIs. Orient resources toward the outputs and outcomes detailed in 'the way things need to be'.
  - **Supplement input monitoring** (e.g. FTEs and beds), **with more balance between performance and outcomes oriented guides and targets**, particularly for those DHBs who have reached the 3% access target. Move towards an environment where DHBs have greater flexibility over funding in order to achieve required access and response rates.
4. **Improve resource allocation and accountability** as described previously in section 6.1.

### 7.1.1 TRANSITION AND CRITICAL DEPENDENCIES

The proposed changes would need time for transition. Some critical building blocks would need to be in place to support successful implementation. During the transition, the work programme would need to include:

- **Significant improvements and a broader scope for PRIMHD, the KPI project and other data sources** to confidently track outputs and outcomes.
- **Reinforcement from the centre regarding the importance of Mental Health** and Addictions, and the need for DHB Boards to maintain it as an outcome priority e.g. a Health Target and/or inclusion in the Minister's Letter of Expectation.
- **Developing receptive partners** to allow fertile ground for cross sector activity and access to cross sector outcomes e.g. employment rates and benefit use for those with mental health and addiction issues.
- **Agreed national KPIs** - Negotiating with DHBs a transition from the current 3% access performance requirements and '1998 Blueprint' input levels, to new nationally-agreed access and response KPIs (likely to include a mix of old and new indicators as new KPIs are introduced and old input based indicators are phased out).
- **An agreed approach to the modified ring-fence.**

These transition arrangements will be part of the co-development period over February to March 2012.

## 8. WHAT DOES THIS MEANS FOR ME?

Realising the outcomes discussed in this paper will require all of us to do our bit. This can't be achieved through a single organisation or group of individuals. The table below summarises the key actions and roles that various people in the sector could play. These are key to relieving the burden of those with MH&A and to helping people to be the best they can be.

Stakeholder	Key Actions
<b>People, families/whānau and communities</b>	<p>Consumers and families could expect services to work in partnership with them to promote positive recovery outcomes.</p> <p>Consumers and families would be supported by services to lead their recovery.</p> <p>Service responses for consumers would be accessible and timely.</p> <p>Actively develop the ability to protect and improve mental wellbeing for people, families/whānau and communities.</p>
<b>Government</b>	<p>Champion the cross sector, whole of government approach to mental health development that would be needed to support Blueprint II (e.g. as already underway with Youth Mental Health Initiatives).</p>
<b>Minister of Health</b>	<p>Champion mental health development and use the Ministerial role and relationships to help mobilise effective change.</p> <p>Choose a mental health related Health Target and drive DHB performance around that target.</p> <p>Link with other Ministers and government agencies to champion cross sector outcomes and agree joint KPIs.</p>
<b>Ministry of Health/ National Health Board</b>	<p>Develop and transition to a new accountability framework that is less inputs focused and more outputs and outcomes focused. These would need to be incorporated into DAPs, Regional Plans, and feedback to the sector.</p> <p>Work with the sector to develop and manage the transition to a modified ring-fence and mental health share of PBFF.</p>

Stakeholder	Key Actions
	<p>Continue to support the national KPIs project.</p> <p>Support a national MH&amp;A leaders' network to champion the implementation of the SDPs and Blueprint II.</p> <p>Add outcome measures to the National Services Framework for Mental Health.</p>
<b>Office of the Health and Disability Commissioner</b>	<p>Champion the implementation of Blueprint II through advocacy facilitation and monitoring of progress on achieving the system changes envisaged.</p>
<b>DHB Funders</b>	<p>Incorporate the SDPs and Blueprint II's life course and population approach into planning using the decision support tools made available.</p> <p>Transition NGO and other provider contracts to have less input based measures and more output and outcomes based indicators.</p> <p>Maintain and further develop local, district and regional networks.</p> <p>Implement initiatives to further engage primary mental health and youth.</p>
<b>DHB Provider Arms</b>	<p>Provide active leadership in innovative models of clinical service delivery and connected partnerships across the sector (clinical leadership, managers, professional leaders).</p> <p>Connected clinical partnerships with consumers, family/whānau, primary care, NGOs and cultural leadership.</p> <p>Actively engage in service, performance and productivity development and implementation initiatives.</p> <p>Support whole of system, cross service and organisation development.</p> <p>Actively look to support and lift the capabilities and competency of primary care and community NGO providers.</p> <p>Promote and actively support strengthening of non clinical/regulated workforce in particular peer support.</p>

Stakeholder	Key Actions
<b>NGO Providers</b>	<p>Actively engage in service, performance and productivity development and implementation initiatives.</p> <p>Actively look to support and lift the capabilities and competency of primary care and community providers.</p> <p>Engage in whole of system, cross service and organisation development.</p> <p>Promote and actively support strengthening of non clinical/non-regulated workforce in particular peer support.</p>
<b>Primary Care Leaders</b>	<p>Actively engage in service, performance and productivity development and implementation initiatives.</p> <p>Active leadership in exploring with DHB provider clinicians and NGO innovative models of connected, integrated and collaborative clinical service delivery.</p> <p>Build capability in primary care workforce.</p>