On Track

Knowing where we are going

Acknowledgements

This document has been developed with significant help from different parts of the mental health and addiction, and primary health care sectors. It also draws on national and international trends and practices.

In particular, we would like to acknowledge the following people: the authors of the vignettes (Michelle, Suzy, Val, Karl, Maria, Ngaromoana and Manu) and the peer reviewers (Anna Nelson (Matua Raki), Michelle Atkinson (Affinity Services), Luke Rowe (Te Taiwhenua o Heretaunga), Monique Faleafa and Denise Kingi-Uluave (Le Va)); Emma Wood (Te Pou) for her workforce-related expertise and Phillipa Gaines for putting it all together.

See Appendix One for further details of the individuals, groups and networks consulted during the development of this report.

ISBN:

Citation: Platform Trust & Te Pou o Te Whakaaro Nui. (2015). On Track: Knowing where we are going. Auckland: Te Pou o Te Whakaaro Nui.

Te Pou
o Te Whakaaro Nui

On Track

PLATFORM

Contents

TBC LAST

1 - INTRODUCTION

On Track to 2030

The changes proposed under *Rising to the Challenge* (Ministry of Health, 2012) and *Blueprint II* (Mental Health Commission, 2012a; 2012b) will be achieved by a fundamental transformation of the way that mental health and addiction (MH&A) services are currently being delivered to service users and their families/whānau. This includes working with other agencies on actions linked to other government priorities, such as the Prime Minister's Youth Mental Health Project[1], the Addressing Drivers of Crime initiative[2], the Children's Action Plan[3], welfare reforms[4] and the Suicide Prevention Action Plan[5].

However, this transformation is unlikely to be achieved by incremental service improvements alone, or by tinkering with aspects of the existing infrastructure, or by instituting minor policy changes. It will require every part of the system to rethink its approach, while at the same time preserving the gains that have already been made for those people with the most severe MH&A disorders.

This report is intended to serve as a road map for MH&A non-government organisation (NGO) providers as they work to achieve this transformation. It has been written from the perspective of NGOs, with the principal aim of helping providers to make changes in their models of service delivery.

The road map describes the different ways that MH&A NGO providers can accelerate system reform, by working both within and alongside the current system, with the ultimate goal of replacing it by 2030, if not earlier.

The report is structured as follows:

- Sections 2 and 3 provide the strategic context and offer a model of primary mental health and addiction service delivery, which has been modified to include community MH&A services operating with both a health and a social determinants lens.
- Section 4 outlines the current situation and sets out the case for change.
- Section 5 focuses on seven areas for action.
- Sections 6, 7 and 8 focus on the future. Section 8.1 provides an illustrative theory of change, which can also be used as a self-assessment tool by all organisations interested in participating in the change process. It clearly shows the direction of travel and describes what success looks like along the way. In addition, section 8.2 offers a road map that outlines some actions that key stakeholders can take at the following three levels in the system – frontline staff, individual organisation and the system itself.

[1] www.beehive.govt.nz/feature/prime-minister%E2%80%99s-youth-mental-health-project
[2] www.justice.govt.nz/justice-sector/drivers-of-crime
[3] www.childrensactionplan.govt.nz/
[4] www.msd.govt.nz/about-msd-and-our-work/work-programmes/welfare-reform/
[5] www.health.govt.nz/our-work/mental-health-and-addictions/suicide-prevention/suicide-prevention-strategy-and-action-plans

On Track is about a continuous stream of small transformative actions, undertaken by different people, in different places, all working in a consistent direction to address the wide range of challenges that are facing the MH&A system.

NGOs are in a good position to lead this movement for reform, based on their unique position in the community. Ideally, the road map will also be used by other partners, such as community services, primary health care services and district health board (DHB) specialist services, to inform the development of their own integrated service responses.

In addition, this road map aims to inform the work of those national organisations tasked with developing the MH&A NGO workforce, particularly with regard to evolving new roles, increasing the scope of practice (Te Pou o Te Whakaaro Nui, 2015), developing new competencies, and responding to existing and future NGO capacity and capability issues.

Given the complexity of the sector, the key actions in the road map are generic, unless otherwise stated. In some instances, service-specific issues have been mentioned in order to capture the fundamental differences in the ways that mental health services, addiction services (including problem gambling), culturally-specific services and age-specific services respond to their target populations.

Sponsors and contributors

The development of this road map has been jointly sponsored by Te Pou and Platform Trust. A steering group of sector representatives provided oversight for the project: see Appendix One. Input was also sought from the wider sector: see Appendix Two and Appendix Three.

2 - THE CONTEXT

Fast facts

MH&A NGO services involved in direct service delivery received **28 per cent** of the total funding **($1.2 billion)** for MH&A services in 2013/14.

The MH&A sector is diverse and forms part of an even broader spectrum of community services that support improved social outcomes.

MH&A NGO services saw over **50,000** service users in 2012/13.

New models of service delivery are emerging in response to government demands for high-quality, effective health and social services that are of lower cost.

Increased effectiveness of the social sector is a key aspiration of the current government (New Zealand Productivity Commission, 2014).

Promising initiatives that form part of the wider social sector's response to these demands include the whānau ora initiatives and social sector trials.

2.1 Policy environment

Rising to the Challenge: The mental health and addiction service development plan 2012–2017 (Ministry of Health, 2012) builds on previous national MH&A plans, and was informed by the Mental Health Commission's *Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be* (2012a) and *Blueprint II: Improving mental health and wellbeing for all New Zealanders: Making change happen* (2012b).

In the same year that the above documents were published, Health Workforce New Zealand commissioned a review of the MH&A workforce entitled *Towards the Next Wave of Mental Health and Addiction Services and Capability* (Health Workforce New Zealand, 2011). The review signalled that the health sector could expect a doubling of demand for MH&A services over a 10 year period, based on providing improved access for the 7 to 9 per cent of the population with the highest MH&A needs. However, the review also indicated that this increase in demand would need to be achieved with no more than a 30 to 40 per cent increase in total MH&A resources (Health Workforce New Zealand, 2011, p. 53).

With this challenge in mind, the working group for the review modelled the possible impact on current service activity and capacity, using eight consumer journeys. For each journey, estimates of the existing MH&A service response were made, and calibrated to actual data of service usage where this was possible.

The service responses were categorised using a relatively simple structure of seven layers of care. The layers were considered useful for estimating the impact of the increases in demand on the future workforce. They also represented aspects of the stepped care model (Health Workforce New Zealand, 2011, p. 26). The seven layers of care are:

- primary care
- social care
- self-care
- organised primary MH&A packages of care
- community-based MH&A support
- specialist MH&A support
- hospital inpatient and acute services support.

It is important to note that these layers are additive, as people are likely to be accessing more than just one layer of service at any one time.

It should also be noted that the review suggested that any future modelling could be extended to allow issues around the required cultural mix of the workforce to be explored.

The proposed shifts in service responses required for the seven layers of care are captured in Figure 1.

Figure 1: Relative changes in response by service level (2010 base = 100)

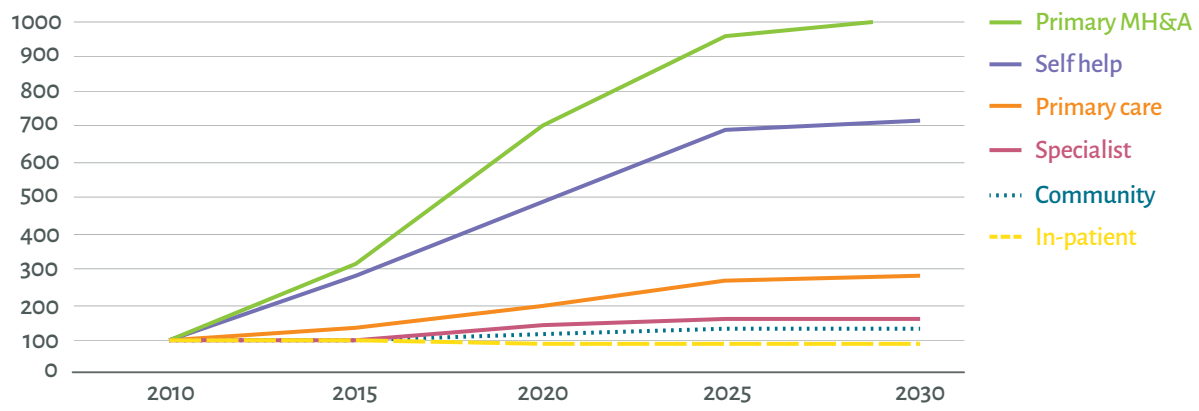


Figure 1. Relative changes in response by service level (2010 base = 100). From *Towards the next wave of mental health and addiction services and capability: Workforce service review report* (p. 27), by Health Workforce New Zealand, 2011, Wellington: Health Workforce New Zealand.

The most significant shifts are in the areas of self-help and the two layers of primary care. These are also the areas most amenable to receiving refocused support from existing MH&A NGOs.

Self-help responses include targeted health promotion and illness prevention, e-therapies, brief problem-solving interventions to support self-care, and more structured whānau and informal carer support, as well as various levels of peer support (Health Workforce New Zealand, 2011, p. 26).

For the purposes of this report, primary care is assumed to represent the full spectrum of community services that act as the first point of contact for people with MH&A needs. It is not restricted to services provided by general practitioners (GPs). While GPs, and their associated primary health care teams, are still recognised as a person's traditional medical home, the new approach extends the horizons of primary care to include some aspects of current specialist MH&A services (eg early intervention and rehabilitation services), current and evolving community MH&A NGO services (eg peer support services) and so is more accurately referred to as a health home rather than a medical home.

In addition, because the approaches described in this road map focus on improving the health of the population and not just those people currently accessing MH&A services, they will require the health sector to forge new alliances with some non-traditional community partners (eg community workers, youth workers, housing, welfare, education, social sector, etc). These partners and alliances are also included within the meaning of primary care.

2.2 Stepped care model of primary/community care

Figure 2 is a diagram of the model of primary MH&A service delivery that has been used to inform this road map.

The model reflects the prominence of the stepped care model in the service demand estimates used in *Towards the Next Wave* (Health Workforce New Zealand, 2011). It is based on a stepped care model for primary MH&A originally developed by Dowell, Morris, Dodds and Mcloughlin (2012), which has been modified to incorporate the following features.

- The main focus is on the needs of the population and not on services, hence the inverted pyramid with the majority of people situated at the top.
- The traditional primary care space has been expanded to include mental health and addiction NGO services.
- Mental health and addiction NGO services provide a wide range of community services across the continuum of care.
- Services intervene early to help avoid the need for more intensive services.
- The appropriate level of service intervention is constantly being matched to the diverse and changing needs of the person and their family/whānau.
- People have the ability to manage their own health and wellbeing at any stage. It is the role of MH&A services to coach people in how to grow this ability.
- Traditional health interventions are complemented by the social determinants of health (eg, housing, welfare, employment, etc.)
- The sustainability of health and social services is critical to the effectiveness of this model.

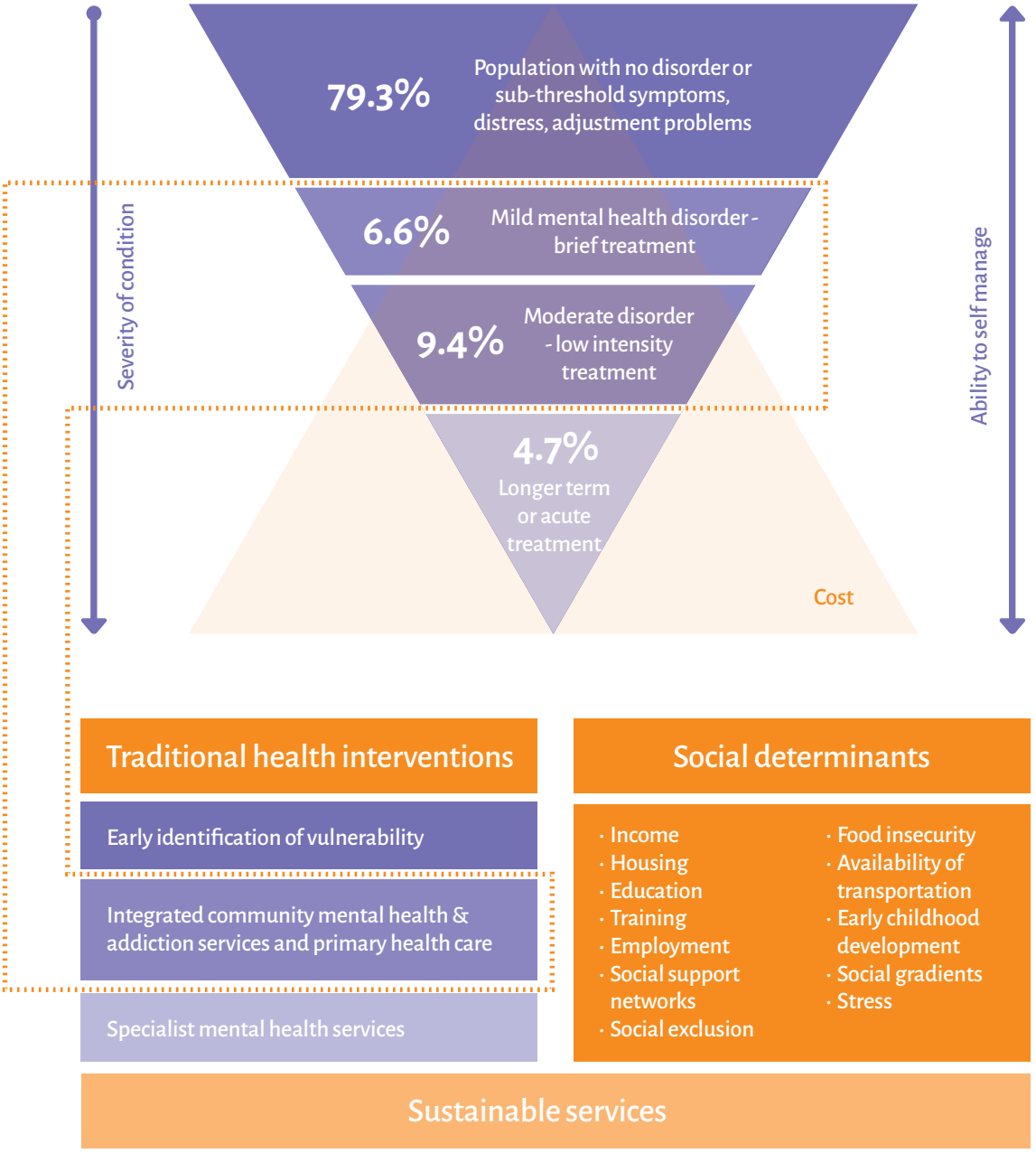


Figure 2. Stepped care model of primary MH&A service delivery

Adapted from Dowell, A. Morris, C. Dodds, T. Mcloughlin, H. Psychological interventions in primary care mental health. In *Companion to Primary Care Mental Health*. Ed. Ivibjaro, G. (2012) Radcliffe Publishing London.

Medibank Private Ltd & Nous Group (2013) *The Case for Mental Health Reform in Australia. A Review of Expenditure and System Design.*

NB: The percentages in the inverted triangle represent the 12-month prevalence figures for adult MH&A disorders, as reported in *Te Rau Hinengaro* (Oakley Browne, Wells, & Scott, 2006).These figures are for policy development and service planning purposes only and are not intended for categorising service users and their families/whānau, particularly if these categories are then used to determine whether or not someone receives a MH&A service.

2.3 An overview of the mental health and addiction sector

Table 1 provides an overview of the characteristics of the MH&A sector, with the NGO share of the totals shown in brackets. The information in the table draws from the NZ Census (2014 update), the Ministry of Health's contract management system (CMS), client claims processing system (CCPS) and price volume schedule, the Ministry of Health's programme for the integration of mental health data (PRIMHD), the Te Pou stocktake of the adult MH&A workforce (2014a) and the Werry Centre stocktake of child and youth MH&A services (2012).

Table 1. An overview of the MH&A sector (various data sources for 2012–2014)

	Child and youth (0–19 years)	Adult (20–64 years)	Older persons (65+)	Total
New Zealand population	*1,201,295*	*2,625,418*	*621,383*	*4,448,095*
Service type	Child and youth mental health services	Adult mental health services	Older persons mental health services	All mental health
Total funding in 2012/13	$139,891,435 (18% NGO funding)	$965,700,618 (30% NGO funding)	$45,228,517 (2% NGO funding)	$1,150,820,570
People seen in 2012/13	35,739 (21% of people are seen by NGOs, of which 54% are seen by both NGOs and DHBs)	72,521 (35% of people are seen by NGOs, of which 69% are seen by both NGOs and DHBs)	13,181 (13% of people are seen by NGOs, of which 72% are seen by both NGOs and DHBs)	121,441
Employed workforce (Vote Health FTEs)	1,430.56 (in 2012) (29% NGO FTEs)	7,243 (in 2014) (34% NGO FTEs)	Unknown	Unknown
Employed workforce (other funded FTEs)	This category was not reported separately for child and youth services	213 (in 2014) (97% NGO FTEs)	Unknown	Unknown
Vacancies (Vote Health and other FTEs)	93.8 (all FTEs in 2012) (4% NGO FTEs)	378 (in 2014) (26% NGO FTEs)	Unknown	Unknown

Service type	Child and youth addiction services	Adult addiction services	Older persons addiction services	All addiction
Total funding in 2012/13	$15,304,525 (80% NGO funding)	$100,932,264 (52% NGO funding)	$0	$116,236,789
People seen in 2012/13	8,349 (61% of people are seen by NGOs, of which 7% are seen by both NGOs and DHBs)	37,619 (42% of people are seen by NGOs, of which 22% are seen by both NGOs and DHBs)	673 (30% of people are seen by NGOs, of which 11% are seen by both NGO and DHBs)	46,641
Employed workforce (Vote Health FTEs)	Unknown	1,269 (in 2014) (52% NGO FTEs)	Unknown	Unknown
Employed workforce (other funded FTEs)	Unknown	183 (in 2014) (99% NGO FTEs)	Unknown	Unknown
Vacancies (Vote health and other FTEs)	Unknown	52 (in 2014) (51% NGO FTEs)	Unknown	

Notes:

- Population figures are based on Statistics NZ Census data (updated in November 2014).
- The funding figures are for direct service delivery only and exclude funding for the national workforce centres and for problem gambling services. The data has been extracted from CMS, CCPS and the Price Volume Schedules as at 28/04/14.
- The funding figures exclude any services that are not mental health or addiction services, but which are still coded to MH&A General Ledger codes.
- The NGO share of the total is shown as a percentage in brackets. Please note that the FTE total positions may differ from the national workforce stocktake reports due to rounding.
- Child and youth figures are taken from the infant, child and adolescent MH&A stocktake produced by the Werry Centre (2012), although the numbers of children and youth seen are based on PRIMHD data extracted on 19/11/14.
- The adult mental health FTEs include 559 FTE positions that were located in combined MH&A teams, which means that the addiction FTE total position is under-represented.
- Addiction services includes MH&A services and problem gambling services, but only one DHB reports to the CLIC database with information regarding people seen for problem gambling issues (n=6,074), so the total number of people seen with a problem gambling issue is unknown.
- MH&A services for older people are funded out of the MH&A budget in the northern and midland regions only. Equivalent services in the central and southern regions are funded by disability services. For this reason, not all of the relevant data for this service area can be reported at this time, as it is collected and stored in different places. All central and southern data for older people is excluded from this table.

2.4 Diversity of non-government organisation services

NGOs provide a broad range of mental health, addiction and wellbeing services, as well as some highly specialised programmes to specific populations, including Māori, Pasifika, Asian and refugees. These services are situated within an even broader spectrum of community agencies, all of which are striving to improve social outcomes for people in their local communities (see Figure 3).

Figure 3. Adapted from the diversity of services supporting social outcomes. From *More effective social services: Issues* paper (2014, p.16) by the New Zealand Productivity Commission.

In effect, many of these other agencies are responding to MH&A issues in their local communities, even if they are not funded by Vote Health to do so. The most cost-effective approach would involve each area of the social sector leveraging off the other areas' capacity and operating as a system of care, in order to make a difference to individuals, their families/whānau and local communities. In particular, an integrated approach would entail MH&A services working more closely with primary care and other community services, to help disrupt the trajectory of mental illness and addiction that is associated with disadvantage, social dislocation, neglect and abuse.

This integrated approach is consistent with a life-course approach, which emphasises the importance of identifying potential problems (eg, children of parents with mental illness or addictions), intervening early and offering the right supports to help people address any issues that are known to have a negative impact on mental health, particularly for infants, children and adolescents.

Vignette one

MH&A services in 2015

I've been feeling really down recently, grumpy, not enjoying things, can't sleep very well. I think I am depressed. My friends and family keep telling me to snap out of it. My GP doesn't know any free counsellors and I can't afford to pay for one. She offered me pills but I don't want to be taking medication for stuff that I just need to talk about. She said it's unlikely I'll be able to access mental health services because I'm not very unwell.

MH&A services in 2030

I've been feeling really down recently, grumpy, not enjoying things, can't sleep very well. I think I am depressed. Some of my friends tell me to snap out of it, but I know a couple of mates who have talked about their own depression – I had a chat to them and they said it's a tough thing that people go through, and things can get better. They took me along to a group at the local community centre, which they go to on a Tuesday, where people talk about this sort of stuff. It was a relief to feel like I'm not going crazy. People at this group were able to talk to me about what's going on, and whether I needed any help applying for money to cover costs if I'm off work. They talked to me about how I can explain what's going on to my other friends and family, and how to ask for support. They also helped me set up an appointment with my GP and one of them came with me. My GP had some ideas, but the guy with me knew what sort of support to ask for. Now I have some supportive mates around me, people to talk to, financial assistance, and a counsellor that I can see every week. It's all close to home with people I know, so it's not too scary.

Michelle

Comment:

Four service users were asked to develop a vignette that described service delivery in the present day and again in fifteen years' time. The purpose of the vignettes was to provide stakeholders with examples of some possible futures, no matter how unlikely or implausible they may appear to be.

What is significant about the above vignette is that it is neither unlikely nor implausible. In fact, you might ask why this level of support is not available to Michelle right now. Such low expectations of the future MH&A system should be a major cause for concern. This is the reason why this particular vignette appears first. It should be relatively easy to make this vision of MH&A services in 2030 happen right now.

3 - WHERE WE HAVE BEEN AND WHERE WE ARE GOING

Community organisations in New Zealand have a long tradition of providing support to people in situations where the state either doesn't have, or is struggling to fulfil, a role.

The last major period of growth in the MH&A NGO sector was in the 1990s as a result of the closure of the long-stay psychiatric hospitals. As hospitals closed, a number of new entities were created to help meet the demand for residential rehabilitation services. People moved out of the hospitals and into the community, but they were not necessarily part of those communities, nor were they entirely free of institutionalised care.

The sector is now entering into another period of reform that has been described by Professor Mason Durie as the 'fourth wave' (Health Workforce New Zealand, 2011).

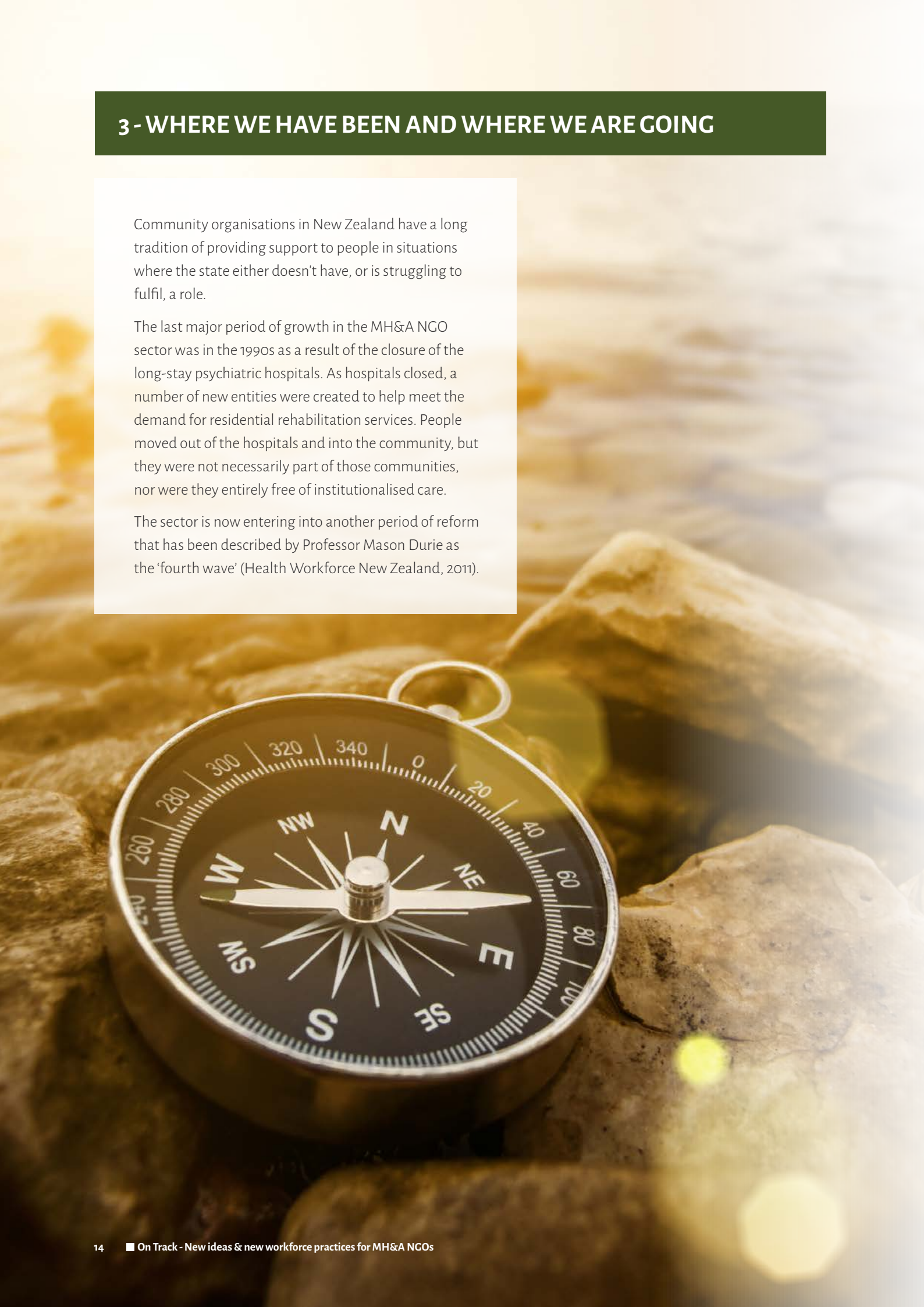


Table 2. The development of the MH&A sector over time

Past	Current	Future (fourth wave)
Disease focus	Illness	Wellbeing
Hospitals	Community-based care	Health and social systems
Volume	Outputs and outcomes	Value
Fragmented	Coordinated	Integrated
Singular responses	Joined-up actions	Collective impact
Command and control	Collaboration	Co-production
Simple	Complicated	Complex
Low adaptability	Innovative	Agile and adaptive
Patients	Service users	Citizens
Medical model	Recovery model	Social determinants model

3.1 Strengthening community care

The international evidence indicates that a combination of a strong primary care sector and a well-developed NGO sector will be critical to the breakthrough that is needed, both in terms of improved outcomes for people and increased system capability.

It has become apparent that hospital-based interventions perpetuate the dislocation of people from their home, family/whānau and communities, and that specialist clinical services are more costly. NGOs, on the other hand, are ideally placed to work with a range of partners to increase the number of viable, cost-effective supports and interventions that are available to people and their families/whānau in community settings.

It is also being increasingly acknowledged that complex social problems cannot be solved by a single organisation. This has seen the emergence in New Zealand of some collaborative community initiatives such as the whānau ora initiatives[6], the Social Sector Trials[7], the children's teams[8] and Strengthening Families[9] all of which aim to address complex social problems at a community level.

> New Zealand has a rich network of NGOs that are responding to the needs of people with mental health and addiction issues by collaborating with primary and secondary health services and a wide range of social, housing, education and justice agencies. (Platform Trust, 2014, p. 1)

However, in order for these collaborative initiatives to be effective, the evidence suggests that they need to be highly structured and possess the following five key preconditions: (a) common agenda (b) shared measurement systems (c) mutually reinforcing activities (d) continuous communication and (e) the presence of a backbone organisation (Hanleybrown, Kania & Kramer, 2012). It is the presence of all five preconditions that differentiates a 'collective impact' initiative from all other types of collaborative community initiatives.

[6] http://www.tpk.govt.nz/en/whakamahia/whanau-ora/
[7] https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/
[8] http://childrensactionplan.govt.nz/childrens-teams/
[9] http://www.strengtheningfamilies.govt.nz/about-strengthening-families/

3.2 Addressing inequities

The benefits of improved health are not shared equitably across all population groups. In New Zealand, Sheridan et al. (2011) reviewed chronic disease management in DHBs and primary health organisations, and described "wilful ignorance embedded in habitual, inequitable practices" (p.12).

Whether or not a new approach that gives equal weighting to the social determinants of health can be translated into health gains for vulnerable population groups, particularly for Māori, Pacific peoples and Asians is a question of considerable importance.

Actions that prevent MH&A disorders and promote wellbeing are seen as an essential part of efforts to improve the health of the population and to reduce inequities. However, despite all of the evidence linking a range of social and economic conditions to good health, the MH&A system has struggled to accommodate a social determinants approach (Durie, 2005).

The World Health Organization maintains that adopting a social determinants approach to MH&A would reduce health inequalities, through the prioritisation of health equity in all policies across multiple sectors and all levels (World Health Organization [WHO] & Calouste Gulbenkian Foundation, 2014). From this perspective, three principles stand out as being important for improved health outcomes, two of which are informed by the work of Professor Mason Durie.

The first principle is of indigeneity, which takes into account the determination of indigenous peoples to retain their distinctive cultural identity, avoid assimilation and exercise a degree of autonomy.

> This principle goes beyond cultural recognition to claim a special place for indigenous peoples in the life of the nation. The principle of indigeneity does not mean other cultures should not also be duly recognised in health care, but it does acknowledge a unique position for indigenous peoples. (Durie, 2005, p.8).

Clinical and cultural competence is the second principle. All New Zealanders expect that they will receive the best possible care, based on a combination of the evidence and professional judgement.

> They also expect that MH&A workers will be competent at the interface between their own culture and the culture of others. Language barriers, differing codes for social interaction, variable community expectations and a willingness to involve friends or families in assessment, treatment and rehabilitation make important differences to the way care is experienced. (Durie, 2005, p.8).

The third principle is that of proportionate universalism, whereby policies are universal yet calibrated proportionate to the level of disadvantage or need. This principle is important, because actions that focus solely on the most vulnerable groups in the population will fail to achieve the reduction in health inequalities that are needed to reduce the steepness of the social gradient in health (WHO & Calouste Gulbenkian Foundation, 2014).

Vignette two

MH&A services in 2015

Matiu is a 17 year old rangatahi sitting his final NCEA exams. He plans to go to Victoria University in Wellington next year. He is feeling stressed, is chain-smoking, and is not sleeping well or eating healthily. He has a history of suicidal ideation and behaviour, but was recently assessed by the CAT team and sent home with no sighting of mental illness. He is having problems with his girlfriend who is also stressing out over exams and is planning to study at Auckland University next year.

Matiu managed to get an appointment with his busy GP 10 days after his exams commenced. His GP prescribed him Fluoxitine to help with the stress and Zopiclone at night for sleep.

MH&A services in 2030

Matiu is a 17 year old rangatahi in his final secondary education year. He is feeling stressed, and is not sleeping well or eating healthily. He is not smoking (as a result of Smokefree 2025), but is considering a relapse and engaging in ultra-synthesised 'mind-alterants'. He has a history of suicidality and is having problems with his girlfriend who is considering changing her relationship status on Social Media.

Matiu's i-watch picks up on the physical and cognitive indicators of his stress (eg decreased physical activity and sleep, and inappropriate social media comments), and beeps this through to his local i-Health multi-disciplinary provider. The pre-risk assessment formula means that he is automatically allocated to the immediate home and marae-based response team who respond accordingly.

As DHBs are now extinct, Matiu is a member of the individualised funding programme (IFP). For ongoing care, he redeems his IFP credits by selecting and purchasing the specific health specialists and skill sets he needs from the wide array of options (eg mirimiri specialist, sleep consultant, relationship navigator and clinical psychologist). Matiu receives timely, effective and culturally appropriate support.

Matiu is given an incentive for redeeming his IFP health credits – a bonus of 10 IFP credits to use at his own discretion.

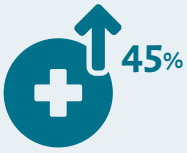
Val, Karl, Maria, Ngaromoana and Manu

4 - THE CASE FOR CHANGE

Fast facts

In 2006, mental disorders were the third leading condition group for health loss in New Zealand, accounting for **11.1 per cent** of total disability adjusted life years (DALYs). Within this group, the main conditions were **anxiety and depressive disorders (5.3 per cent), alcohol use disorders (2.1 per cent) and schizophrenia (1.3 per cent)** (Ministry of Health, 2013).

The societal impacts of mental illness and addiction are wide ranging and costly (Organisation for Economic Co-operation and Development [OECD], 2014).



The costs to the health care system are also significant. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least **45 per cent** for every person with a long-term condition and co-morbid mental health problems (Naylor et al., 2012).

Nearly all MH&A disorders are most common in the **16 to 24 years** age group, with prevalence subsequently declining across the older age groups (Oakley Browne et al., 2006).

Unadjusted prevalence rates, which show the burden of disorder, are generally highest for Māori, intermediate for Pasifika, and lowest for the 'other' composite ethnic group. Much of this burden appears to be because of the youthfulness of the Māori and Pacific populations, and their relative socioeconomic disadvantage (Oakley Browne et al., 2006).

The following section outlines the various change pressures that together build the case for change.

4.1 Population pressures

The first argument for change focuses on the changing needs for MH&A services as the demographic (age and sex structure), epidemiologic, cultural and social profile of the New Zealand population changes.

4.1.1 Prevalence rates

At an overall population level, there is little evidence that the prevalence of mental health disorders is substantially increasing outside the effects of the changing demographics, which will change the composition of the services needed over time (Levin, Hennessy, & Petrila, 2010). The situation is slightly different for substance use disorders, where there is some evidence to suggest that the prevalence rates are increasing.

Table 3 presents the prevalence rates for mental health and addiction use disorders.

Table 3. Twelve-month prevalence rates

Disorder	Twelve-month prevalence rates
Mental health	*Te Rau Hinengaro* (Oakley Browne et al., 2006) found that 20.7 per cent of the population had a mental disorder in the past 12 months. Anxiety disorders (14.8 per cent) were the most common disorder group, followed by mood disorders (8.0 per cent) and eating disorders (0.5 per cent). Comorbidity of mental disorders is common, with 37 per cent of those people experiencing a disorder in the past 12 months having two or more disorders. Mood disorders and anxiety disorders are most likely to co-occur.
Substance use	*Te Rau Hinengaro* (Oakley Browne et al., 2006) found that 3.5 per cent of the population had a substance use disorder in the previous 12 months (13.8 per cent reported a disorder at some point in their lifetime).
Co-existing substance use and mental health problems	Substance use and mental health problems have a negative impact on each other and worsen a range of health outcomes (Drake, 2007). Te Rau Hinengaro (Oakley Browne et al., 2006) found that of those people who reported a substance use disorder in the past 12 months, 29 per cent had also suffered a mood disorder and 40 per cent had suffered an anxiety disorder. Of those with a mood disorder in the past 12 months, 12.9 per cent also had a substance use disorder.
Mental-physical comorbidity	The key theme that emerges from *Te Rau Hinengaro* (Oakley Browne et al., 2006), and from the evidence review of the physical health of people with a serious mental illness and/or addiction (Te Pou, 2014b), is that people with MH&A disorders have a much higher prevalence of several disease risk factors and chronic conditions. People with chronic physical conditions are also more likely to experience mental disorders, compared with those without physical conditions. Mental disorders are at least as disabling as physical disorders, and the combination of the two is more disabling than either disorder on its own (Oakley Browne et al.2006, p88).
Gambling	The *New Zealand Health Survey* (Ministry of Health, 2009) found that 1.3 per cent of the general population experienced problem gambling. Those people who did have gambling problems also had significantly higher rates of tobacco use and problem drinking.

Notes:

- The 12-month prevalence of a disorder is the proportion of the population who have ever met criteria for a disorder and who have experienced symptoms or an episode in the past 12 months.
- The target population for Te Rau Hinengaro (Oakley Browne et al., 2006) was people aged 16 and over who were living in permanent private dwellings in New Zealand. The survey did not collect information about specific psychotic disorders such as schizophrenia or schizoaffective disorder.
- Half of all people who will develop any disorder have experienced disorder by age 18 and three quarters by age 34. Median age for onset is 13 years for anxiety disorders, 32 years for mood disorders, 18 years for substance use disorders and 17 years for eating disorders (Oakley Browne et al., 2006, p64).

4.1.2 Demographic changes

The workforce implications associated with the demographic changes are summarised in Table 4.

Table 4. Population-related change pressures

Change pressures	Workforce implications
There are different age structures within the different ethnic groups in the New Zealand population, which need to be factored into workforce planning	While the New Zealand population is rapidly ageing, population projections indicate that there will be ethnic-specific differences in the various age groups. For example, the 65+ year age group in 2026 will include 23 per cent of the European population, compared with 9 to 12 per cent of the Pacific (and Māori) population (Statistics New Zealand, 2014a). In contrast, the Māori, Pacific and Asian populations are much younger, providing a potential pool of young people who may be interested in working in the MH&A sector. For these reasons, it is important that the right mix of services is matched to the population needs of the local community. In addition to the right mix of services, providers need to take active steps to improve access to these services (eg by offering culturally appropriate models of service delivery), particularly for disadvantaged groups, and by more closely matching the workforce to the population.
Population growth will be concentrated in urban centres, particularly metropolitan Auckland	The population in New Zealand is projected to grow from 4.5 million in 2014 to 5.1 million in 2030 (Statistics New Zealand, 2014a). Between 2011 and 2031, all growth in 56 (84 per cent) of the territorial authority areas is projected to be in the 65+ year age group. All territorial authorities are projected to see an overall decline in the 0 to 64 year age group. Population growth will be concentrated in urban centres, particularly metropolitan Auckland (Jackson, 2014). Funding will be redistributed over time to support those urban DHBs that are experiencing the most population growth. This will result in increased pressure on service viability and quality in the rural and provincial DHB areas, which will not have the population to support highly specialised MH&A services. In addition, rural and provincial DHBs will also experience a decline in the supply for the MH&A workforce. Inevitably, smaller specialist MH&A services will need to partner more closely with primary care and community social services to support people with MH&A problems.
People are living longer, but they are not necessarily experiencing healthier lives	The likely impact on the overall demand for MH&A services as the population ages is unclear. The impact on workforce development is likely to involve enhancing the skill set of the existing workforce, so that staff are better able to help people deal with complexity. For example, the shift in the model of service delivery might involve upskilling the workforce to work with more people who have complex, long-term conditions, multiple morbidities (including a range of physical health conditions, and mental health or addiction issues and cognitive decline), as well as supporting them to address risk factors, such as social problems and poor living conditions. Staff will need to be upskilled in these areas and able to work across traditional professional boundaries in order to meet the needs of service users. *Scope it right* (Te Pou o Te Whakaaro Nui, 2015) identifies this skill as being essential for a fundamental change in the health sector. In addition, it is predicted that in 2031 over 602,000 people will be living in one-person households (Statistics New Zealand, 2014a). Given the demographic shift towards the 65+ age group, many of these people who will be living on their own are likely to be older. It is not known to what extent social isolation might then become an issue for this group; if it does, older people on their own might need help connecting with their local communities in ways that are very different to the other age groups.

Change pressures	Workforce implications
Ethnic diversity	Around 28 per cent of the population in 2012 were not born in New Zealand, up from 22 per cent in 2001 (Statistics New Zealand, 2014a). Hindi is now the fourth most commonly spoken language in New Zealand after English, Māori and Samoan. Migration brings with it the stresses of adjustment to an often very different culture. Consequently, there will be increased demand for a more culturally competent MH&A workforce, particularly in urban areas. > Cultural competence includes knowledge, skills and behaviours based on the understanding of how and why different belief systems, cultural biases, ethnic origins, family structures and other culturally determined factors influence health seeking behaviour. These differences are real, and impact on the way in which people experience illness, adhere to medical advice and respond to treatment. A culturally competent health workforce cannot be trained simply by reading textbooks or attending lectures, but must include encountering and interacting with individuals from a variety of racial and ethnic backgrounds.(Cohen, 2002). Given that the majority of people are seen in mainstream services, there will need to be an increase in the dual clinical and cultural competency of the workforce in these services. In order for cultural competency to work, it must be situated within an organisational culture that is also culturally responsive.
Variable geographic distribution of ethnic groups	Workforce planning in response to ethnic diversity in the population is not a one-size-fits-all approach in all parts of the country. For example, 97 per cent of the Pacific population live in the main urban areas of New Zealand, with the Auckland metropolitan region alone accounting for 71 per cent of Pacific people, where Pacific people make up 16 per cent of the total population. Most of these people are registered with one of three general practices that operate in the Counties Manukau DHB catchment area (Pacific Perspectives, 2013). This concentration makes it possible for a range of other community health and social agencies to come together to extend the services and activities offered by the GPs. The second largest group of Pacific people (12.4 per cent) lives in the Wellington area (Pacific Perspectives, 2013). This clustering means it is possible to deliver a range of targeted ethnic-specific services to people living in defined geographical areas. However, in other parts of New Zealand it is not feasible to establish an ethnic-specific service. In these instances, it is important that mainstream organisations work to top of scope and offer culturally responsive services.

4.2 The system

Fast facts

The future needs of the population will not be met by the current silo-like configuration of MH&A, primary care, health, disability and social services.

There is growing evidence about the complex interactions between a person's mental and physical health, and their social context (WHO & Calouste Gulbenkian Foundation, 2014).

Increasingly, the research shows us that more socially isolated people have poorer health and increased mortality, and that more socially cohesive societies are healthier and have lower mortality rates.

New models of care will need to be developed to help meet the demand for a wider range of MH&A services.

The second argument for change is that while the underlying demand for MH&A services is both predictable and stable, the volume of demand presenting to the system is increasing, mostly because of multiple failures in the current system, starting with the first point of contact between a service and the service user. Service users often report problems with obtaining a service at the first point of contact, mostly because the assessment process that has been adopted by almost all parts of the MH&A system is designed to refer the majority of people onto someone else. The net effect of multiple assessments and multiple referrals is poor outcomes for service users and an amplification of demand throughout the system (Locality & Vanguard, 2014, p15).

Other examples of common system failures include people representing multiple times with the same problem, re-work because of bureaucratic complications and mistakes, unnecessarily long waiting lists and time delays for referrals between different services. Such system failures all contribute to a growing sense of frustration by service users, their families/whānau and the MH&A workforce. The extent of these failures has been estimated to be enormous in terms of cost, quality and overall system performance with some estimates suggesting that it accounts for 80 percent of demand for health and social care services (Locality & Vanguard, 2014, p16).

This situation requires changes in workforce practices at three levels.

1. Placing greater emphasis on services partnering with individuals and their families/whānau, to help them identify their strengths and increase their capacity to manage their own health and wellbeing within a wider community context.
2. Changing the current configuration of services (eg introducing new models of care, shifting the emphasis from specialist services to community/primary care, making greater use of multi-disciplinary teamwork, integrating services, increasing collaboration between services, piloting innovative service delivery arrangements and eliminating the needless cycles of assessment and referral).
3. Giving equal weighting to the social determinants and cultural aspects of health, as well as the medical aspects.

In addition, there needs to be changes to the systems and structures that underpin the current service delivery model (eg, developing a new commissioning framework, streamlining contracting arrangements, using new contract reporting requirements and introducing new human resource practices that support different ways of working).

Table 5. System-related change pressures

Change pressures	Workforce implications
Increasing demand for MH&A services coupled with financial restraint	In an operating environment where there is no new money, the status quo will not meet the future demand for MH&A services. The only response is to rethink what the workforce is doing and how they are doing it, in conjunction with service users and their families/whānau. This will involve an examination of the roles and functions that are required to deliver high-quality MH&A services using different models of care, and an increased emphasis on the relational, rather than the transactional, nature of the partnership between the workforce and service users and their families/whānau.
Changes in human resource management practices	The changes in the workforce will need to be supported by equivalent changes in human resource management practices including different recruitment and retention strategies, the development of new roles, increased use of more flexible working arrangements and a proactive approach to the development of talent within the organisation.
Addressing increasing inequities	The benefits of improved health are not shared equitably across all population groups. In New Zealand, Sheridan et al. (2011, p.12) reviewed chronic disease management in DHBs and primary health organisations, and described "wilful ignorance embedded in habitual, inequitable practices". This situation can only be changed by increasing the cultural competency of the existing workforce and, at the same time, attracting new workers who are familiar with the traditions and customs of particular population groups. A social determinants approach to mental health would see a reduction in health inequalities being achieved through the prioritisation of health equity in all policies across all sectors (WHO & Calouste Gulbenkian Foundation, 2014). At a practical level, this means that the workforce from a number of different sectors will be required to share information with one another, and to work more collaboratively to affect change for identified population groups in ways that the health sector cannot do on its own. A more collaborative way of working together will raise issues to do with the information sharing and people's rights to privacy, but this is an organisational issue in terms of understanding how best to apply the legislation, as much as it is about the challenges associated with working across organisational boundaries. The Social Sector Trial in Porirua is an example of what can be achieved when agencies work together to reduce ambulatory sensitive hospitalisations and emergency department attendances amongst Porirua residents aged 0–74 years, with a particular focus on children under ten years of age.
Stigma and social exclusion continue to impede recovery	Even with the favourable changes that have been reported in New Zealander's attitudes to mental illness (ie as a result of the Like Minds Like Mine campaign), service users still report that they find themselves excluded from many aspects of life – from jobs, recreational opportunities, housing, proper health care and community life. Given that social exclusion is detrimental to good health outcomes, the workforce needs to be involved, to a greater or lesser extent, in delivering public health approaches to mental health. This could mean being involved in advocacy, building community capacity, or supporting education or contact strategies that are aimed at influencing the perceptions, attitudes and actions of others.
The role of the social determinants of mental health	There is growing evidence about the complex interactions between a person's mental and physical health and their social context (WHO & Calouste Gulbenkian Foundation, 2014). In countries around the world, a shift of emphasis is needed towards preventing common mental disorders, such as anxiety and depression, by acting on the social determinants of health, as well as improving the treatment of existing conditions. In the future, successful outcomes will be defined not only in terms of symptom reduction, but also in terms of good housing, education, employment and community participation (WHO & Calouste Gulbenkian Foundation, 2014). This does not mean that the specialist MH&A workforce becomes all things to everyone. The idea is that staff practise holistically, link people with the natural supports in their local communities, join-up the different cross-sector services and coach people on how to address any issues in their life that might be hindering their recovery.

Change pressures	Workforce implications
Life-course approach	Taking a life-course perspective recognises that the building blocks for good mental health are constructed at a very young age and then accumulate throughout life. The implication is that, depending on the life stage of the person and the extent of their exposure to trauma, different staff from different organisations may be best placed to deliver particular interventions in particular settings (eg, school health checks, employee assistance programmes, youth one-stop shops, marae-based programmes, aged care facilities, refugee services).
Family/whānau-orientated service delivery	Strong evidence shows that many mental and physical health conditions emerge later in life, but originate in early life (Shonkoff & Garner, 2012; Fryers & Brugha, 2013). Preventative, primary and secondary health care services will need to be more integrated to achieve a holistic people and family/whānau-centred health service delivery model (Pacific Perspectives, 2013).
Seamless service delivery	People want service providers to cooperate with one another and to deliver services to them in a seamless way. One of the major challenges to system integration is that each organisation does not want to integrate with another to the point that their particular expertise or philosophical approach is compromised or they lose their sense of autonomy. *Better Connected Services for Kiwis* (Institute of Policy Studies, 2008) and "Collective impact" (Kania & Kramer, 2011) are two resources that offer some useful suggestions for organisations that want to work together to increase their impact.
Māori MH&A service models based on whānau ora	Whānau-centred MH&A services are services that focus on the whānau as a whole, build on whānau strengths and increase its capacity. Examples can be found at www.whanauoraresearch.co.nz (Tangata Whenua, Community & Voluntary Sector Research Centre, 2012). While the desired results of an intervention will vary according to particular whānau circumstances, the outcome goals are the same: self-managing, living healthy lifestyles, participating fully in society, confidently participating in te ao Māori, being economically secure and successfully involved in wealth creation, and being cohesive, resilient and nurturing. A significant challenge for the future is evolving an approach to whānau development that bridges social, cultural and economic domains, so that full participation in society, the economy and education can be realised (Taskforce on Whānau-Centred Initiatives, 2010).

4.3 The workforce

The third argument for change is that the MH&A workforce is itself changing. It is experiencing the same socio-demographic shifts as observed in the general population (eg ageing). In addition, younger workers' expectations in terms of quality of life are different from those of previous generations. These changes will have an impact on labour market participation and on productivity (Price, Waterhouse & Coopers, 2011).

Recruitment in the NGO part of the MH&A sector faces stiff competition from DHBs and other sectors (eg, community services, disability, aged care), particularly because of lower wages, which reinforces a view that MH&A NGO services are of lower-value.

The price that funders are willing to pay for NGO services is important, because it influences workforce entry decisions, education and training decisions, the quality of labour, retention and productivity gains, and the overall sustainability of the organisation over time.

The quality of the NGO workforce is important for improved productivity, as a higher skill level means that staff are more able to work more effectively with service users and their families/whānau. It requires a reasonable level of skill to support individuals who are experiencing a severe mental health or addiction disorder, multiple morbidities, are socially and economically disadvantaged, and possibly living in a household that is also in crisis.

The workforce-related pressures are listed in Table 6. The competencies capabilities that will be required of the MH&A workforce to meet all of these change pressures are covered in more detail in Section 5.3.

Table 6. Workforce-related change pressures

Change pressures	Workforce implications
Ageing workforce	Labour force supply is not keeping pace with demand, and as the population ages, new labour force entrants will not replace existing exit rates. However, the proportion of older workers who are in the workforce is continuing to increase, and it may be that more attention to the quality of that participation and the effective utilisation of older workers could yield greater returns for the MH&A sector (Heathrose, 2011). The primary issues for employers in retaining and using older workers relate to health and wellbeing, employee desire for more flexibility, and ensuring employees are treated equitably (eg, in terms of access to training and development, career planning and opportunities, recruitment, performance management).
Different expectations of youth in the workforce	As the baby boomer generation starts to retire over the next ten years there will be increased competition for a smaller pool of younger workers, many of whom will come from the ranks of the millennial generation. Employers will need to modify their organisational culture and management style in order to attract and retain younger workers. The particular characteristics of millennials, such as their desire for workplace flexibility and their ambition to keep learning and move quickly upwards through an organisation, as well as their willingness to move on quickly if their expectations are not being met, will require a more focused response from employers (Price, Waterhouse & Coopers, 2011)
The roles of generalists and specialists	Rather than continuing to try and grow the specialist workforce, new models of care will need to be developed that involve, for example, MH&A specialists sharing tasks with general community workers who are already located in local communities, working with people who have MH&A issues, but are not funded by Vote Health. This approach will involve some careful consideration about how best to maintain professional standards and high-quality services using a mixture of generalist and specialist staff (refer to Scope it right, Te Pou o Te Whakaaro Nui, 2015)
Changes in stocks and flows	At any point, the workforce stock grows (or shrinks) depending on the inflows (eg recent graduates) and the outflows (eg retirees, those leaving for new careers, those taking a break from the labour force). Innovative approaches for increasing the workforce stock could include the creation of new pathways for workers from related sectors (eg, Education sector, Corrections, Ministry of Social Development, etc). These workers may be prepared to receive some additional training that will enable them to work in the MH&A sector, as long as they are able to easily enter and exit the MH&A workforce.
Provider competition for labour	NGOs have to compete for labour not only between themselves, but also with DHBs. While NGOs are able to compete for labour using more favourable terms and conditions for employment, the level of funding for NGOs precludes them from competing on wages, particularly for clinical staff. If the wage rate for some professional groups continues to rise relative to other staff who are employed by NGOs, providers may choose to reallocate some tasks to other staff in the workforce (eg, peer workforce, technical assistants).
Time lags between workforce demand and supply	It takes time to orient existing and new education and training providers to emerging skill requirements (eg, the development of the peer workforce). As the model of care changes, NGOs will need to find ways to influence decisions about the required competencies for working in the MH&A sector. NGOs will need to link with education agencies and national workforce development centres, so that the agencies continue to evolve their training programmes in the direction that NGOs want to go.

Change pressures	Workforce implications
Pressure to raise labour productivity	New Zealand has experienced a consistent gap in labour productivity since the 1970s, when compared with productivity internationally, and improving productivity remains a key area of improvement for the government. However, there is still considerable uncertainty about the key drivers of labour productivity, particularly in the MH&A sector, as many of the factors are interrelated and may act in synergy. For example, increases could reflect gains in multifactor productivity (such as innovation, managerial skill, business organisation, research and development), as well as changes in the characteristics, skills and the efforts of the labour force. MH&A services cannot continue to rely on increases in the number of people employed in order to meet the growth in demand for services. Future growth will increasingly need to be derived from increases in labour productivity. When providers are considering changes to the workforce, they might like to consider the key features from Scope it right (Te Pou, 2015).
Development of the peer support workforce	Continue to develop this part of the MH&A workforce, with a particular focus on recruiting staff from segments of the population which are currently under-represented in the MH&A workforce.

4.4 The work

The actual work that is done in the MH&A sector is also changing, in response to factors such as changing service users' expectations of services, technological innovations and changes in national policy directions. These change pressures are reflected in Table 7.

Table 7. The changing nature of the work and the implications for the workforce

Change pressures	Workforce implications
Changes in people's expectations of services	Service users will expect that the NGO workforce will be able to work with them in a true partnership model. This expectation will result in an increased focus on more relational ways of working with people (ie, co-production). The relevant values, knowledge, attitudes and skills of the workforce will need to be increased and reinforced at all levels in order to meet this expectation.
Recovery-focused MH&A services	Staff are involved in helping people to address their employment, housing, citizenship and social inclusion issues as well as helping them to manage their MH&A issues.
The use of evidence, coupled with increasing levels of accountability	Increase the capacity of the NGO workforce to deliver culturally appropriate, evidence-based interventions. Use other parts of the MH&A sector to provide supervision for the NGO workforce. Increase the evaluative capability of the NGO workforce, so that staff routinely review and reflect on the effectiveness of the services that they are offering.
Delivery of culturally appropriate interventions	The delivery of culturally appropriate interventions is seen as one of the main ways that services can help to reduce health disparities and promote equitable health outcomes for service users. The success of this approach is reliant on the availability of a culturally competent workforce.

Change pressures	Workforce implications
Collaborative care and working as part of a multi-disciplinary team or network	A major shift is required towards inter-professional education and practice, where health care staff from different backgrounds (including MH&A) learn with, from and about one another. This will improve collaborative team-based practice and the quality of care that is delivered to service users and their families/whānau (Thibault, 2013).
Family/whānau-centred service delivery	Humans are a communal species. People as not just individuals in isolation, but are members of families/whānau, communities and society, even if they feel alienated from a particular social network. As part of the life-course approach, staff need to be able to deal with families that are in crisis, irrespective of who the identified service user might be. Consequently, the family group (rather than just the identified service user) becomes the focus of service delivery. This presents a challenge for staff who have been trained to work with individuals only (Pacific Perspectives, 2013).
Technological innovations	The role of technology, digital transformation, big data and social networks will have a significant impact on how MH&A organisations will function in the future. In the future, people will be virtually connected to whoever they want, however they want (eg, skype, web-streaming, social media), whenever and wherever they want. As a consequence, the workforce will need to be comfortable with using the same technology, and become adept at working with people using various forms of digital contact and communication devices.
Some individualised care packages (based on individualised funding arrangements) are introduced into MH&A services	New mechanisms for delivering independent planning and navigation services to individuals and their families/ whānau will need to be tested in order to develop the best approaches and models for use in MH&A sector. Independent care planners and navigators may require MH&A specific training. Some New Zealand disability providers question what will happen to the employment market if individualised funding becomes more widespread in New Zealand (refer to section 5.22 on new models of care).
More services are delivered closer to where people live	Staff will be more mobile and will deliver services to people either in their homes or in community settings. The objective is to support people to stay in their own homes, and to ensure a smooth and effective transition of care between different settings when this is required.
Workplace flexibility	Flexibility is a key component in enhancing the length of employment, particularly for the older workforce. While evidence suggests that those workers over 65 years prefer flexible work arrangements (eg, part-time work, short-term contracts, unpaid leave options), there is also information that access to the type of flexibility required may be problematic (Heathrose, 2011).

4.5 Summary of change pressures

Figure 4 summarises the pressures behind the case for change.

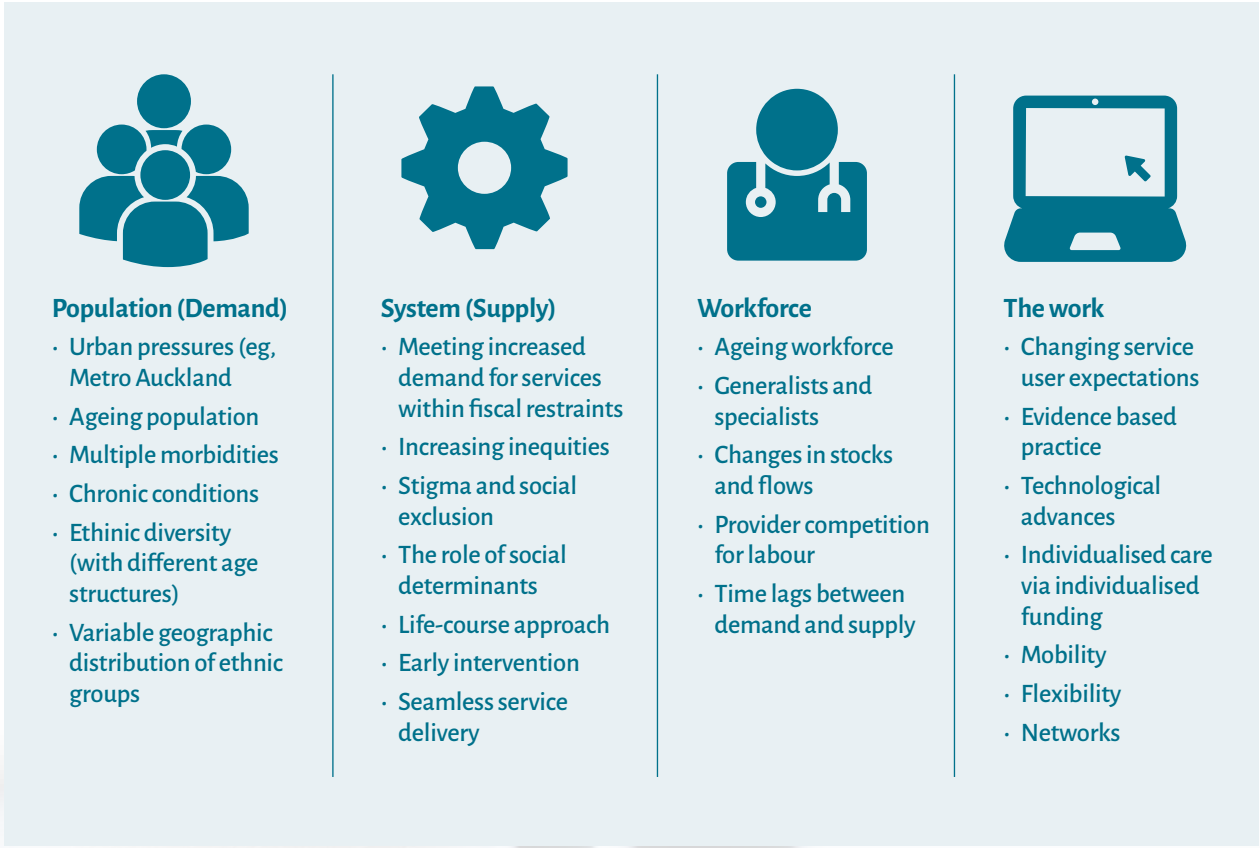


Figure 4. The case for change – summary of change pressures.

4.6 Force-field analysis – increased investment in mental health and addiction services

The World Health Organization (2013) suggests that there are a number of barriers that it is important for key stakeholders to consider when advocating for increased investment in MH&A services. For example, a level of sociocultural stigma continues to surround MH&A issues (which can negatively affect appropriate action being taken by governments), and the macroeconomic performance of the country often takes priority over broader measures of societal welfare (eg, social, cultural and environmental factors).

Figure 5 summarises a number of arguments that the World Health Organization considers support, and also potentially work against, greater investment in MH&A services from a number of different perspectives. This force-field analysis is useful when thinking about what might need to happen to reinforce the drivers for change, as well as what else might be done to weaken the restraining forces that continue to support the status quo.

For example, from a purely ecomonic perspective, the Organisation for Economic Co-operation and Development (OECD) has reported that the direct and indirect costs of mental ill-health are very high, and can amount to over 4 per cent of a country's gross domestic product (OECD, 2014). In 2013, the gross domestic product in New Zealand was worth 182.59 billion US dollars; when the OECD figure is applied to this amount, it is estimated that mental illness and addiciton issues cost the country about $7.3 billion US dollars in 2013.

While it is acknowledged that MH&A services will only go some way towards helping to prevent and mitigate the impact of mental illness or addiction on individuals and their families/whānau, there is increasing evidence about the cost-effectiveness of interventions that also deal with the social determinants of mental health. This adds weight to the economic argument favouring increased investment in health promotion and illness prevention activities, as well as in the treatment of mental health and addiction disorders.

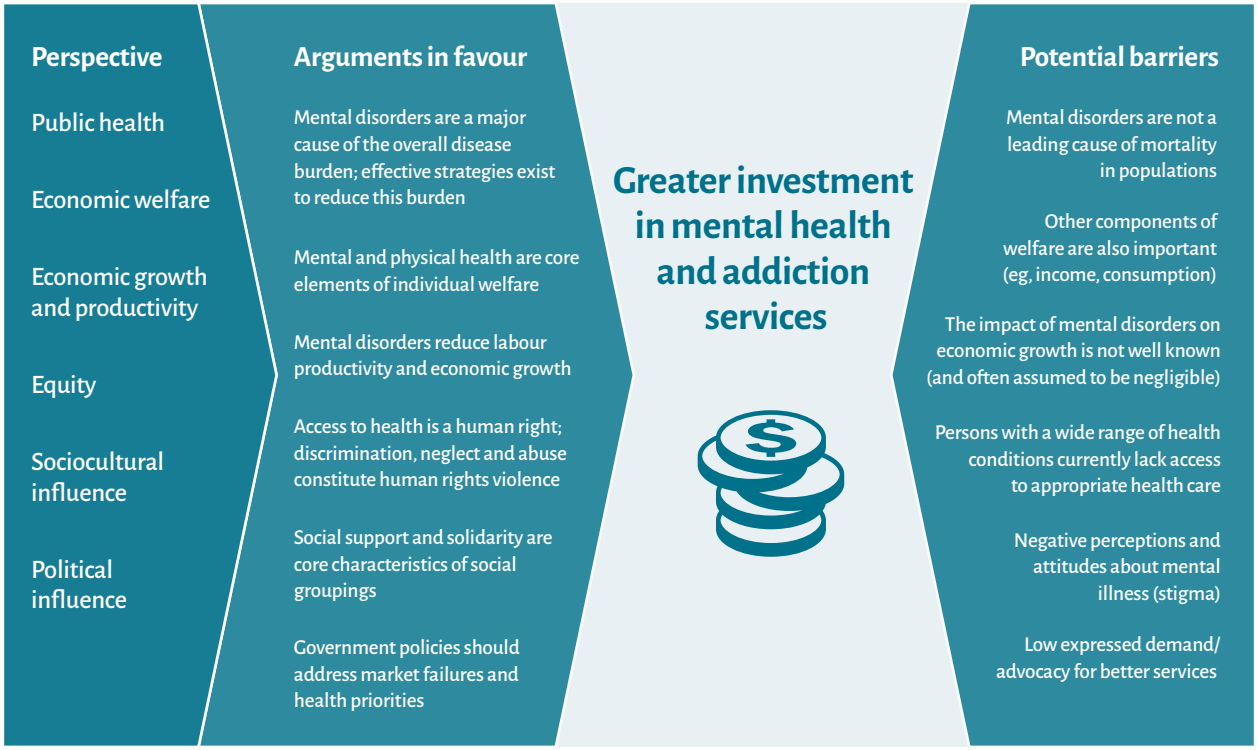


Figure 5. Force field analysis regarding greater investment in MH&A services. Adapted from *Investing in mental health: Evidence for action*, by World Health Organization, 2013, Geneva: World Health Organization.

Vignette three

MH&A services in 2015

My name is Max and I am 35 years old. My daughter Sara is 10 years old. We live together. I use methamphetamine and alcohol every day. I have done for years. I don't have a problem. I don't use as much as some of my friends. My parents think I have a problem. They told me last week that if I don't do something about my problem they will report me to CYFs and take custody of Sara. I don't want that to happen. I love her very much.

So I go to the local addiction service. I am assessed by one of the women who works there. I like her. She does not judge me. Anyway, she refers me to a weekly group. I don't want to go to a group. I want to be able to come back and see her. She gets me.

I do go to the group though, because I don't want Sara to be taken from me. And I realise I would probably be using more if she wasn't with me. Maybe my parents have a point?

I feel very anxious. What will they think of me? I am scared. The group is alright. Some of them have a similar story to mine and have not used for over three months and they seem okay. Maybe I can do that too? I miss some of them when I am not there, so I look forward to the weekly group. I feel lonely between times because I need to keep away from my using friends and I don't know anyone else besides my parents.

MH&A services in 2030

My name is Max and I am 35 years old. My daughter Sara is 10 years old. We live together. I use methamphetamine and alcohol every day. I have done for years. I don't have a problem. I don't use as much as some of my friends. My parents think I have a problem. They told me last week that if I don't do something about my problem they will report me to CYFs and take custody of Sara. I don't want that to happen. I love her very much.

So I go to the local addiction service. I am assessed by one of the women who works there. I like her. She asks about me and about Sara and what it is like being a mum on my own and using and that. It's not easy talking about Sara. I don't feel judged by her though. Anyway, she refers me to a weekly group. I don't want to go to a group. I want to be able to come back and see her. She gets me. I tell her this. She says, 'Okay how about we make a time to meet next week and we can talk about what is happening and you can tell me about Sara'?

I do agree to go to the group as well though, because I don't want Sara to be taken from me. And I realise I would probably be using more if she wasn't with me. Maybe my parents have a point?

I meet with the AOD worker before I go to the group. She reassures me that it is natural to be anxious. She says I can bring Sara to our next appointment and my parents are welcome to come too when I am ready. She also tells me that, if I want, I can have a peer support worker who can help me get connected to positive support in the community. And I sign up for a daily recovery-oriented text message. There is an online group of recovering people meeting every day and I can join that if I want some daily connection.

Suzy

5 - PRIORITY AREAS FOR ACTION

While the case for change discussed in Section 4 is very clear, it is not clear what actions should be prioritised over others, or if this assessment of the issues covers everything that people in the sector consider to be important. For this reason, the case for change was supplemented with sector feedback.

Figure 6 shows the seven priority areas for action that were identified as a result of this feedback. More information about the method used to identify the priority areas is included in Appendix Two.

Figure 6. Seven priority areas for action.

5.1 Support self-determination

5.1.1 Enhancing wellbeing

The new approach to the delivery of services requires MH&A providers to adopt a recovery philosophy that is based on self-determination and the maintenance of wellbeing.

According to Ryan and Deci's (2000) theory of self-determination, people have three core psychological needs – autonomy, competence and relatedness. They propose that people's sense of wellbeing is dependent on those conditions that foster or thwart these three needs. To the extent that these needs are satisfied, people are more likely to feel good on a day-to-day basis, but to the extent that they are thwarted, people are more likely to experience ill-health.

The dynamic model of wellbeing developed by Michaelson et al. (2012) connects these three core psychological needs to the internal resources and external conditions that act together to help generate positive experiences in people's lives (see figure 7).

In the case of those cultures that have strong familial and tribal ties, the relational aspects of a person's life (ie, connectedness) carries even more weight, with 70 per cent of Māori who were involved in the New Zealand General Social Survey reporting that involvement in different aspects of Māori culture was very important to them (Statistics New Zealand, 2014b).

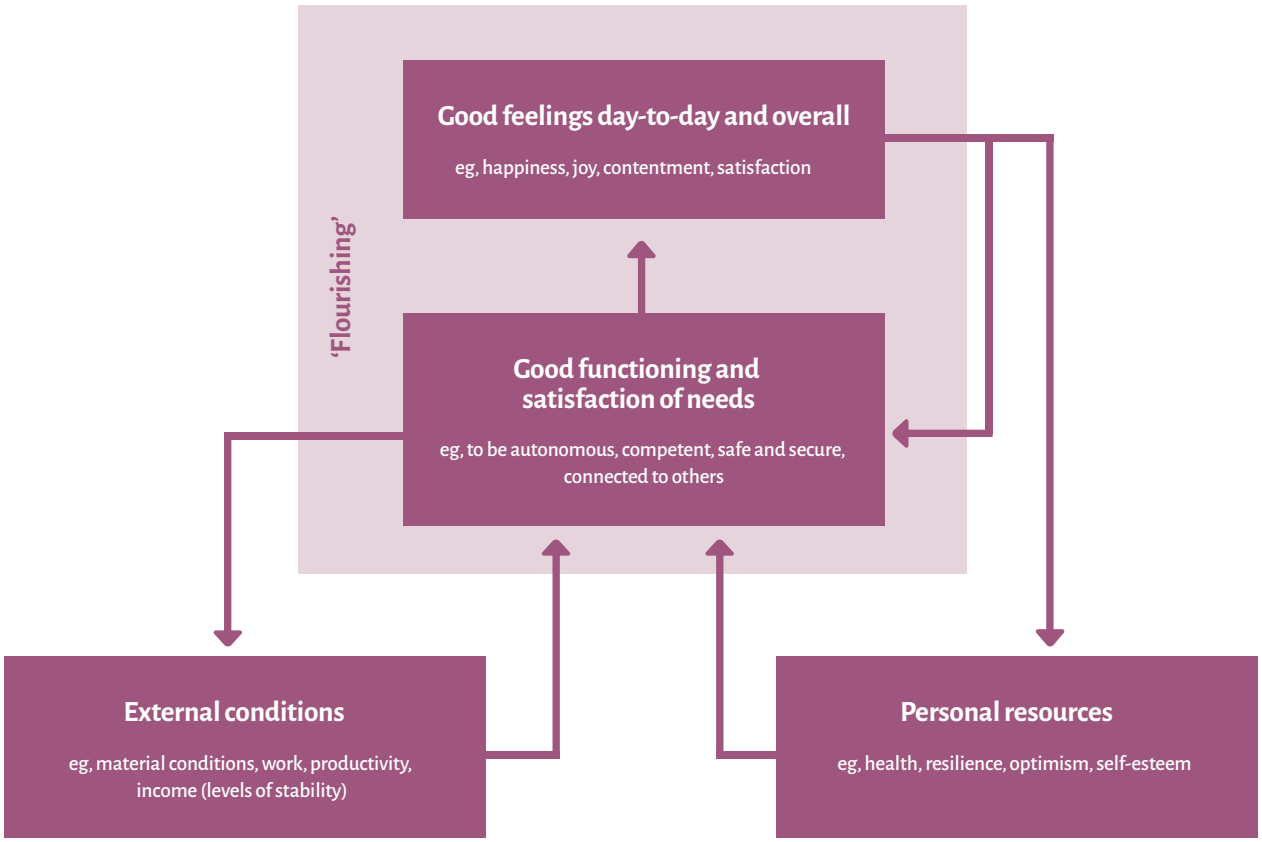


Figure 7. The dynamic model of wellbeing. From *measuring well-being: A guide for practitioners* (p. 7), by J. Michaelson, S. Mahony, & J. Schifferes, 2012, London: New Economics Foundation.

A well-being approach to the concept of recovery is important because it enables service providers to do the following:

- Move beyond a narrow focus on what is going wrong in people's lives, to look also at what makes people's lives go well.
- Move beyond looking only at what service users lack or need, and look at the positive things people bring to situations and communities – their assets. This in turn can help service providers think about the different ways that they can partner with people who are involved in the task of shaping their own future.
- Promote a deeper understanding of the person situated within their wider context- family/whānau, friends, neighbourhood and community.

A study by Schrank et al. (2015) found that whilst mental health professionals might hold similar conceptualisations of wellbeing for themselves and for service users, in practice they applied a strengths-based model to themselves and a deficit-based model to service users. The study suggested that some staff might need support to work in a strengths-based way with service users and their families/whānau. For example, through specific types of interventions and/or the involvement of peer support workers.

Key points

Self-care and self-determination

The shift towards greater self-determination will be evidenced by service users being in control of their own health, including their recovery (competence), exercising choice about what interventions work best for them (autonomy), and being supported by a network of people who care about them (relatedness).

Workforce implication

MH&A services will have a greater or lesser role in supporting the process of recovery at various points in time, according to the individual's and their family/whānau's needs and preferences.

5.1.2 Co-production

Co-production is central to the delivery of the new MH&A NGO service model.

> Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change. (Boyle, Coote, Sherwood & Slay, 2010, p. 3)

In this context, co-production is broadly about equal partnership and transformation. Specifically, it is about changing the way MH&A services are conceptualised, designed and delivered as an integrated system of care.

Boyle et al. (2010) maintain that it is possible to recognise co-production, because it exhibits most or all of the following features.

- Recognising people as assets.
- Building on people's existing capabilities.
- Involving mutuality and reciprocity.
- Engaging peer support networks as the best way of transferring knowledge and supporting change.
- Blurring distinctions between professionals and recipients.
- Providers are facilitating change rather than delivering solutions.

These defining features move far beyond giving service users a voice or seeking their involvement in governance arrangements. Co-production is characterised by people who are active agents and equal partners in the design and delivery of services.

Vignette four

MH&A services in 2015

I'm 21 years old and have just started working. I've had a lot of hard stuff happen in my life and used to see my local community mental health team for help with that. They discharged me when I was stable, but I'm still on medication for depression and anxiety.

My life has been falling apart recently. I scraped together some money to see a GP, but she couldn't really help. I attempted suicide a couple of weeks ago and am still feeling very suicidal, but am trying really, really hard to stay safe, even though I don't have much support. I called my crisis team and explained everything to them. As I'm holding it together right now, there's nothing they can do. I told them it's likely that at some point I will lose it and be at high risk of suicide, and they said to call back if that happens. It's pretty unlikely I'll manage that, as it was nearly impossible to call the first time.

MH&A services in 2030

I'm 21 years old and have just started working. I've had a lot of hard stuff happen in my life and used to see my local community mental health team for help with that. When I was feeling stable, we made a plan for me to be supported without them, knowing that I can come back at any time. I now see a student psychotherapist every week – the community mental health team helped me set that up. They also chatted to my GP, helped me set up regular appointments with her, and helped me apply for WINZ support to cover the cost of that and the psychotherapy.

My life has been falling apart recently. My psychotherapist has been pretty concerned, so she talked to my GP and the community mental health team. Even though they can't see me straight away, they talked to my psychotherapist and GP and gave them some advice so that we can make a plan to help me stay safe. This includes letting some of my friends know what's going on – this was really awkward, as I don't usually talk about stuff, but my psychotherapist and GP helped me figure out what to say and strongly encouraged me to say it. Now it's not just me trying to keep myself safe. I have a bit of a safety net until I can sort things out.

Michelle

5.2 Focus on system redesign

The majority of sector feedback was in relation to system redesign. Given the large number of comments relating to this area, the feedback was grouped under four sub-headings: whole-of-system, service integration, service delivery and early intervention.

5.2.1 Whole-of-system

A whole-of-system approach recognises that health and social systems are inextricably interrelated, and that it is not possible to make a change in one part of the wider system without inevitably having an impact on another.

Two current examples of whole-of-system approaches, which have been introduced by the government and involve the MH&A sector, are the Addressing Drivers of Crime initiative and the Prime Minister's Youth Mental Health Project.

Addressing the Drivers of Crime

The aim of the Addressing the Drivers of Crime initiative is to reduce offending and victimisation, with a particular focus on improving outcomes for Māori.[10]

The alcohol work stream was one of four work streams that attracted funding in the government's 2012 budget. Alcohol-related crime imposes high costs on the criminal justice and health sectors, and on its victims. Two recent estimates put the cost to government alone at between $409 and $562 million per annum (Crampton & Burgess, 2009).

This particular work stream included two initiatives that focused on the general population, and three that focused on offenders. The two initiatives that had a general community focus were alcohol brief interventions in primary care and improving access to alcohol and other drug treatment services for youth. The three that had an offender focus were the AOD treatment court pilot in Auckland; improving access to AOD treatment for community-based offenders and improving access to treatment for repeat drink drivers

All of the above initiatives have been implemented in the last three years. Other programmes under the Drivers of Crime programme of activity are ongoing or are continuing to emerge.

Key point

The implication of this initiative for workforce development is that staff need to be equipped to train and work across professional and organisational boundaries, particularly in those circumstances where health, justice, corrections, children's services and the police are involved.

[10] See http://www.justice.govt.nz/justice-sector/drivers-of-crime/working-together

[11] http://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project/youth-mental-health-project-initiatives

Prime Minister's Youth Mental Health Project

In 2012 the government invested more than $12.2 million over four years in the Prime Minister's Youth Mental Health Project package of initiatives. The following list summarises the 26 initiatives.[11]

Prime Minister's youth mental health initiatives
School based health services
HEEADSSS Wellness Check
Expanded primary mental health services
E-Therapy
Primary care responsiveness to youth
CAMHS and AOD follow-up
CAMHS and youth AOD access
Positive behaviour school-wide
Check and connect
Friends youth programme in secondary schools
Education Review Office review of wellbeing and engagement in school
Improving the school guidance system
Review of alcohol and other drug education services
Youth workers in low decile secondary schools
Social media innovation fund
Improving the youth-friendliness of mental health resources
Information for parents, families and friends
Social support for One Stop Shops
Youth referrals pathways review
Youth engagement
Youth re-engagement and school attendance
Whānau ora for youth mental health
Referral pathway supports for young people
Developing integrated funding models and connected service delivery
Co-locating additional social services in schools
Addressing the emerging youth mental health issues in Canterbury

Key point

The youth mental health initiatives offer innovative examples of how the general community is starting to become involved in identifying and dealing with youth MH&A issues, which might otherwise have gone untreated. The implication for workforce development is the need to train generalists who work in community settings to respond to MH&A issues, as well as equipping both generalists and specialist MH&A staff to work more closely together.

5.2.2 Service integration

One of the biggest problems impacting on the system's capacity to respond to people's needs is the issue of fragmentation. This issue is the cause of frustration for services users, their families/whānau, funders, providers and policy-makers alike.

However, in practice service integration can be difficult, not least because of the many different models of integrated service delivery there are to choose from (World Health Organization, 2008). Attitudinal problems between staff from different teams and agencies is also an issue.

Whilst New Zealand has a history of attempting to integrate health services it is clear from a review of Canterbury DHB that the critical factors that support effective integration are more to do with how the vision is translated into practice rather than the model of integration that is selected (Timmins & Ham, 2013; Ham & Walsh, 2013).

Perhaps the best approach to service integration is the mantra that has been adopted by Canterbury DHB, and which was often repeated by various stakeholders throughout the development of the road map – one system, multi-funded, operating with one budget.

Models of care

Similar to the concept of service integration, the term models of care has many different meanings. For the purposes of this report, models of care has been defined as those NGO service configuration and workforce arrangements that might help to address the challenges, including demographic changes, facing the MH&A system in New Zealand.

The models outlined in Table 8 are not the only possible responses to the change pressures, nor are they mutually exclusive. They are put forward simply for further consideration by the MH&A sector.

Table 8. Models of care

Model	Benefits	Considerations
Improvements to the current model	Better integration of current MH&A services with primary care, as well as with other health, disability and social services, has the potential to improve outcomes for people at lower cost.	To some extent this could be achieved via the use of agreed integrated care pathways. However, its success will continue to be limited by organisational resources, contractual requirements and current operating policies.
Formalised stepped care	In stepped care, a person can start anywhere on the care pathway, but the idea is that they receive the least intensive intervention that is appropriate for their situation. Service users can step up or down the care pathway according to their changing needs.	Timely access, clearly integrated care pathways and good referral practices are features of this model. A study of psychological intervention services in the UK showed that those services that provided stepped care, and complied with the National Institute for Health and Care Excellence guidance on good practice, had better service-user outcomes and improved recovery rates than other services (National Institute for Health and Care Excellence, 2014).
Family-centred models of service delivery	The family group (rather than the individual) is the focus of planning and service delivery in this model of care. Preventative, primary and secondary health care service design and implementation are integrated, to achieve a holistic people and family-centred health service delivery model.	This model is used by the whānau ora initiatives and has been recommended for use with Pacific people (Pacific Perspectives, 2013). Service delivery organisations will need to undertake workforce development, so that staff are able to deliver family-focused care. Staff will also need skills development to help facilitate coordinated, effective responses at a family, community, social services and health system level.
Customised packages of care for people who have high and complex needs	People with high and complex needs receive a customised package of services. This approach is very similar to the current MH&A packages of care model, apart from the fact that some response options could address more than just mental health or addiction issues.	The Enabling Good Lives pilot is an example of what might be possible using pooled funding. Enabling Good Lives is a three-year pilot project focused on disabled people in Christchurch. It aims to show how a cross-government approach can be used to reconfigure supports and services for disabled people.
Task sharing with generalist community workers	This option relies on upskilling the pool of general community workers, so that they are more able to offer high-volume support services or brief interventions for people in generic community settings (eg, schools, work places, social services).	The risks associated with this approach are mostly to do with providing the necessary level of evidence based training, the maintenance of professional standards and ensuring people's equitable access to high-quality care.
Hub and spoke model	The tiered hub and spoke model is essentially a form of stepped care. The model requires formal links to be established between the providers of lower-level capability services (spokes) and the providers of higher-level capability services (hubs). As part of a service network, the services that act as hubs are, in turn, supported by larger or higher-level regional and specialist services.	This model works well in rural settings where economic, population and geographical challenges mean that the complete range of health care services is not provided in each local community. It also works well in cases where low-prevalence conditions are combined with high specialisation (eg, forensics).

Model	Benefits	Considerations
Individualised funding	Individualised funding is an expression of a people-centred approach to service delivery that is already available to some people who are using disability services in New Zealand. This approach enables service users (or their representatives) to use devolved funding to make their own purchasing decisions about the mix and type of services that they think are right for them.	Te Pou (2014a) has recently released a discussion paper about this approach. It recommends that new mechanisms for delivering independent planning and navigation services to individuals and their families/whānau would need to be tested in order to develop the best approaches and models for MH&A. Independent planners and navigators may require MH&A specific training. Matthews (2012) predicts that the introduction of individualised funding could mean that more staff will have to be employed on a temporary or a casual basis, in response to fluidity of demand. Other issues include provider competition for market share, at the expense of cooperation and collaboration.

5.2.3 Service delivery

Many workshop participants talked about the need to improve access to MH&A services. People liked the idea that 'any door was the right door' for someone with a MH&A problem, but expressed concern that the adoption of this approach relied on a well-integrated, functioning system that focused on people's real, contextual problems, and not just their presenting problem.

Other issues included multiple assessment and referral pathways with assessment processes being the key mechanism that providers use to help ration access to services.

In general, people expressed a desire for flexible, high-quality MH&A services that are more relational, more joined-up and more focused on responding to the unique needs of each service user and their family/whānau.

In addition, they wanted staff to focus more on people's strengths and to help service users to recover by identifying ways to build their own sense of self-determination. The ongoing development of the peer support workforce represents a sector-wide commitment to place people's recovery at the heart of the mental health system (Scott, Doughty, & Kahi, 2011).

5.2.4. Early intervention

The evidence suggests that investment in effective earlier interventions may have a significant and long-lasting positive impact on employment, education, health and other outcomes, particularly for disadvantaged groups of people in the population (Silva & Stanton, 1996; Gluckman, 2011; Boston & Chapple, 2014).

Towards the Next Wave (Health Workforce New Zealand, 2012) suggested a rebalanced mix of responses across the life-course continuum, with a focus on intervening earlier in the life-course where there is strong evidence for effective interventions that reduce the burden and cost of MH&A.

The recent emergence of programmes to increase the capability of health professionals to identify and attend to the needs of children whose parents experience a mental health and/or disorder (COPMIA) is an example of an associated service response.

The New Zealand National Centre for Lifecourse Research's (2014) perspective on the life course is summarised in Table 9. It focuses both on mitigating the impact of harmful factors and outcomes (vulnerabilities), and on promoting the protective effects of strengths and positive outcomes (capabilities), throughout the life-course. Particular emphasis is placed on intervention in the early years and during the transition to adulthood.

Table 9. The National Centre for Lifecourse Research way of understanding life-course development

Vulnerabilities	Mechanisms/Link	Capabilities
Poverty	Environments that mitigate vulnerability or promote capability and contribution	Self-control and efficacy
Social isolation		Healthy body and mind
Child maltreatment		Educational achievement
Violence and conflict		Family/whānau/community development
Structural inequalities	Life-course pathways that minimise vulnerability or enhance capabilities	Institutional capability (steps on the ladders to equity and access)
Intergenerational transmission of risk		

Note:
From *The NCLR way of understanding lifecourse development*, by National Centre for Lifecourse Research, 2014, retrieved from http://www.nclr.org.nz/what-are-you-up-to

Key point

More cross-agency resources need to be focused on promoting wellbeing, identifying problems early and delivering an integrated service response, particularly for those at risk infants, children, adolescents and families who are experiencing harmful factors and outcomes (ie, vulnerabilities).

5.3 Improve workforce capability

A large number of suggestions (n=90) from workshop participants related to improvements in the capabilities of the NGO workforce.

The two most frequent suggestions were to:

- amplify the core values and attitudes required to work in MH&A services
- improve the cultural and linguistic competencies of the workforce.

Most of the other comments that related to the workforce fell into the following categories:

- improve the capability of the workforce to deliver evidence-based programmes
- provide easy access to appropriate levels of supervision for NGO staff
- invest in NGO leadership at all levels and develop some succession planning
- review the horizontal and vertical career paths of a number of related workforce programmes to make it easier for people to enter the MH&A workforce based on prior learning and existing competencies
- build knowledge and skills in data collection and information use
- continue to develop the peer support workforce.

5.3.1 Improve workforce capability planning

There is a degree of frustration at the slow rate of progress in system-wide workforce innovation and reform, especially in the development and implementation of new roles for the MH&A NGO workforce.

Over the past six years, the sector has made a lot of progress in implementing the *Let's get real* (2008) workforce development framework and the related frameworks (eg, Real Skills Plus CAMHS, Te Whare o Tiki, and Real Skills Sei-Tapu). *Let's get real* (2008) takes a service-user-centred approach to the development of the essential knowledge, skills and attitudes required to deliver MH&A services. It complements existing professional competencies and the requirements of the Health Practitioners Competence Assurance Act 2003.

Given the increasing complexity of the sector, the time is right to focus on developing the practitioner and leadership levels of the *Let's get real* framework, so that it can be used to influence the direction of future workforce development programmes for both practitioners and leaders. Some targeted activity in this area will also help to increase the credibility and accountability of MH&A NGOs.

With this development area in mind, Platform Trust has developed an evidence-informed capability planning tool for the MH&A NGO workforce (see Figure 8). The tool takes into account the wide range of MH&A service-user characteristics that are known to affect outcomes for people. It is based on the work by Segal, May, Leach and Turnbull (2013) who developed a workforce planning tool to support best-practice diabetic care by primary care teams in Australia.

This planning tool has more than one million possible combinations of attributes or sub-populations, and reflects a holistic approach to MH&A issues. When applying the tool, it becomes obvious that a higher level of competency is required by those staff who are working with people who are very unwell, have multiple morbidities or multiple disadvantages, and are experiencing high levels of distress. It also becomes obvious that good practice would involve input from a number of different staff, possibly from different agencies and different sectors, who had the right skill mix to help service users address the many factors that are impacting on their mental and physical wellbeing.

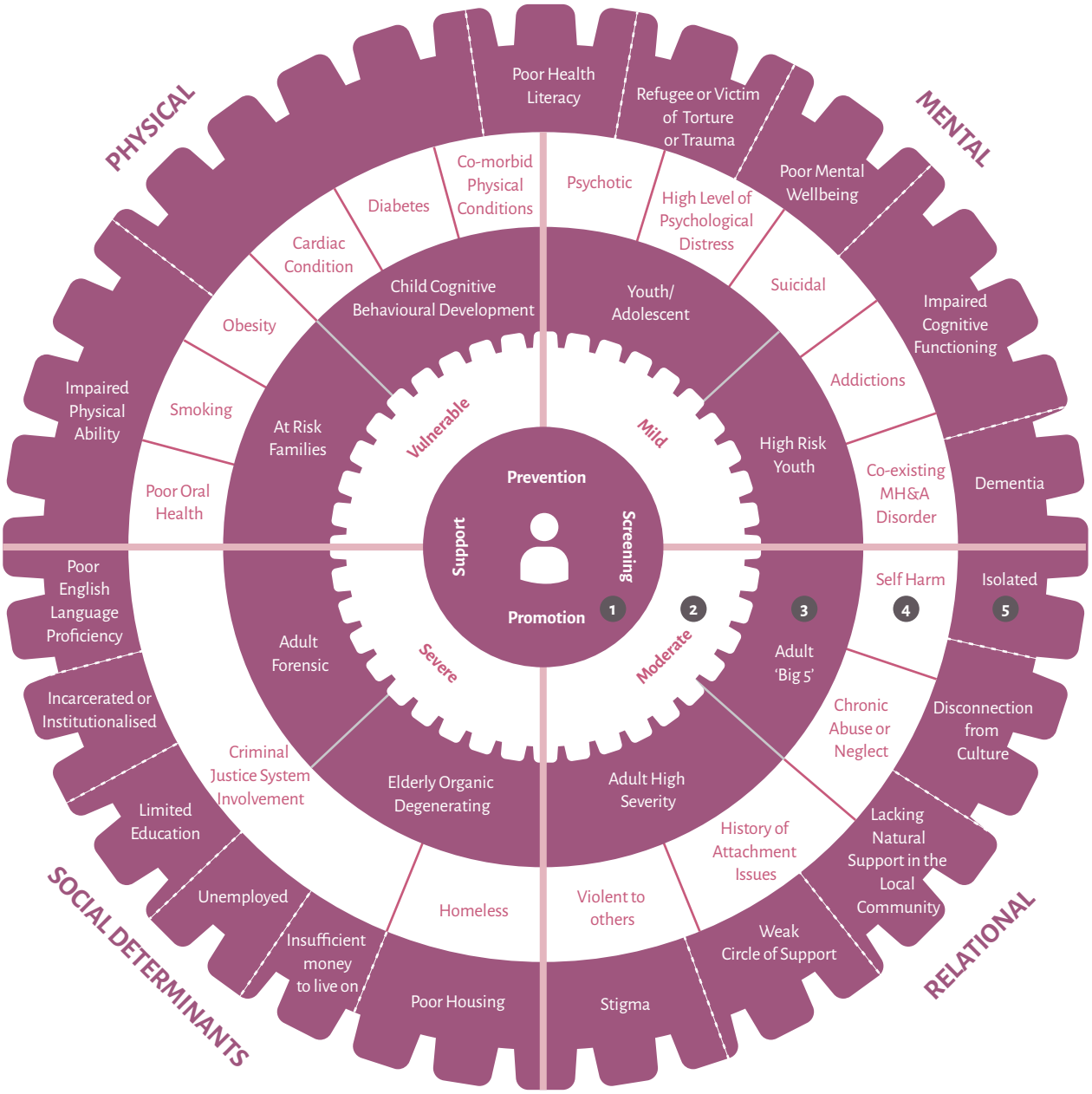


Figure 8. Capability planning tool for the MH&A workforce. Gaines (2014). Adapted from "Regional primary care team to deliver best-practice diabetes care: A needs-driven health workforce model reflecting a biopsychosocial construct of health" by L. Segal, E. May, M. J. Leach, & C. Turnbull, 2013, *Diabetes Care*, 36(7), p. 1899.

If this capability planning tool was to be developed further, some best-practice MH&A care objectives could be described against the 44 attributes that are captured in levels 2 to 5 of the tool. These care objectives could then be used to generate an associated list of competencies (rather than focusing on professional occupations), which could in turn, help to stimulate discussion about what the future MH&A services look like, recruitment and retention issues, service delivery models and the range of roles that will be required in the future to deliver services, particularly by MH&A NGOs.

To help avoid unnecessary confusion around the terms competency and capability as they are applied to this model, 'competence' is another word for an individual staff members knowledge and skill and 'capability' describes the features of the organisation or system which make it possible for staff to deliver MH&A services in new and innovative ways.

A key competency and capability of the future will be the ability to be adaptive and flexible, particularly as the pace of change increases over time.

Given the complexity of the emerging future, this capability planning tool also highlights the need for increased investment in the rapid development of the MH&A NGO workforce. It is not feasible to expect that the current level of investment in NGO workforce development will deliver the level of change that is required to transform the entire MH&A system. However, given current financial restraints, some thought will need to be given to achieving a balance between (a) developing a responsive NGO workforce at a reasonable cost and (b) ensuring that the NGO workforce is well-trained to deliver evidence informed practices.

Key points

1. Amplify the values and attitudes of the workforce, with a focus on partnering with individuals and their families/whānau to shape their own future.
2. Foster the development of adaptive leadership skills throughout organisations.
3. Establish a clear line of sight between NGO workforce development needs (eg core competencies) and the training and education curricula, particularly with regard to the emergence of new and expanded roles in non-traditional community settings.

5.4 Address investment and sustainability issues

While MH&A NGO service providers are doing their best within limited resources and a largely inflexible system, the reality is that funding for MH&A NGOs has not kept pace with increases in the cost of living. This situation has been compounded year on year, resulting in a decrease in funding in real terms for many NGOs throughout the country (Platform Trust, 2015).

The use of contracts has also led to increased compliance costs, increased inter-agency competition for resources, and, for many NGOs, greater insecurity of funding (Tennant, Sanders, O'Brien, & Castle, 2006).

Despite considerable rhetoric about the development of streamlined contracts and the routine application of good funding practices (ie, the New Zealand Treasury's (2009) *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown and Good Practice*), very little progress has been made in this area.

As the work of NGOs broadens and becomes more complex, concerns about the capacity, capability and sustainability of NGOs will become more of an issue for both funders and providers. These issues will need to be addressed in a systematic way in order for the sector to grow, evolve and move forward.

Key points

1. Funders and providers work together to build the capacity and capability of NGOs, so that these organisations are better equipped to deliver high-quality community MH&A services.
2. Relevant government organisations work together to build the capability of funders and to improve the commissioning of MH&A NGO services.
3. Funders establish an equitable and sustainable funding path for MH&A NGOs.

5.5 Enhance community engagement

Internationally there is a trend towards governments supporting local communities to develop bottom-up solutions to apparently intractable economic and social problems. The trend has emerged in response to the growing amount of evidence that the application of prescribed top-down policies and initiatives is not working and, in some instances, has actually hindered progress.

This trend represents a paradigm shift in thinking about the role of the state and its relationship with citizens, and hints at a very different future built on social networks and the capacity that exists within everyone to improve their own wellbeing. In the UK, this approach has been described by Locality & Vanguard Consulting (2014, p. 9) as being local by default: "A 'local by default' approach would build person-centred relationships, help people to help themselves, provide better integrated support, and reduce failure demand."

Key points

1. NGOs adopt community development principles.
2. Staff facilitate more 'everyday democracy', by partnering with individuals and their families/whānau to exercise the power that they have to shape their own lives.
3. NGOs get connected and build the capability of their organisations and the MH&A workforce to engage with the local community.

Note: The above key points are informed by the guiding principles outlined in Crowther (2014).

5.6 Use the evidence

There is now a great deal of research about the best evidence-based practices and programmes that MH&A services should be implementing, in order to achieve good outcomes for services users and their families/whānau. However, the most effective interventions will not produce positive outcomes if they are not implemented properly.

The sector also needs to invest in on-going research and evaluation of new and emerging practices for particular sub-populations in order to ensure there is a sound knowledge base that is supported by the appropriate level of training and supervision

There is general agreement that successful implementation of evidence-based practices and programmes is a reasonably complex endeavour, and that the science relating to successful implementation lags far behind the research on the actual interventions themselves.

It appears that certain implementation factors and processes are common across domains (eg mental health, juvenile justice, education and child welfare). If this is the case, then nationally-directed efforts to improve the science and practice of implementation have the potential for positive broad-scale impacts across a range of service systems (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005, p. vi). As Felner (1997, p. 521) puts it: "The community both defines the problem to be solved and tests the adequacy of the answer."

Key points

1. Training, coaching and peer review processes support the uptake and successful implementation of evidence-based practices and programmes.
2. Organisations collect fidelity measures as well as outcome measures.
3. National workforce development organisations work together to improve the science and practice of implementation.

5.7 Strengthen organisational infrastructure

The performance of the MH&A NGO sector has increasingly come under the spotlight in the past decade. In the context of a financially restrictive environment and greater competition for resources, questions about the effectiveness and productivity of the social sector, including MH&A NGOs, are being raised by funders (New Zealand Productivity Commission, 2014).

Central government and its funding agencies have expressed a view that New Zealand has too many small NGO providers, and that too many frontline resources are being diverted towards supporting unsustainable operations. The popular solution to this problem has been for funders to encourage NGO providers to either share their administrative functions, or to merge services so that there are fewer, but larger and stronger organisations.

In the absence of some credible evidence to help offset this view, it is very difficult for the MH&A NGO sector to argue that it is not the size of an organisation that matters, but its capability to deliver value to service users and to maximise its use of limited resources.

The New Zealand Treasury (2014) maintains that the specific elements that support 'smart investment' by funders are: clarity about the key outcomes; better use of data and cohort information to help target those people who most need services; clear institutional incentives; accountability to help drive performance and innovation; and organisational flexibility and evaluation loops with which to test, learn and adapt.

Irrespective of whether or not these key elements are present in the current funding and contracting framework, NGO providers need to continue making progress on incorporating these elements into their own organisations, so that they are able to monitor both their organisational performance and the quality of the services that they are delivering to people.

5.7.1 Invest in technological developments

The current reform of the health system is being accelerated by a number of technological advances, which are in themselves transforming the delivery and the management of health services. However, surprisingly few comments were made in the workshops about the possible impact of technology on service delivery. This gap may reflect the smaller numbers of service managers who participated in the workshops. It may also reflect the fact that people did not consider that technology was one of the three most important things that needed to be addressed as a matter of urgency.

Service delivery

Around 83.7 per cent of New Zealand households have access to a mobile phone. The proportion of these phones that are smartphones is rapidly increasing, representing 60 per cent of all mobile phones in 2013 (Statistics New Zealand, 2014a). This means that at any time of day, regardless of location, many people have a personal, portable, connected computer on them. This also means that they have unprecedented access to health information (including their electronic health record), and close to 100,000 health and wellness applications (Whittaker, 2014).

These types of changes in technology will enable some service users (and their families/whānau) to more easily access the information that they need, whenever and wherever they need it, in order to inform and take care of themselves, and each other.

It is likely that extensive use of the internet, text messaging services, mobile health applications and e-therapies will change the optimal configuration of the MH&A workforce over time, with navigational roles replacing some traditional case management roles, and the more specialist roles being utilised by people who have high and complex needs.

Management of services

The landscape of health management is also changing dramatically, with the introduction of innovations such as predictive modelling, analysis of big data, decision-support tools and inter-operable patient management systems. These rapid changes require NGO managers to have the capability to use technology and analyse information effectively to inform decisions, develop strategic plans and improve services.

Relational ways of working

While MH&A workforce roles will change and technological developments will enable people to have easier access to information, none of these changes will alter the importance of the relational aspect of MH&A service delivery. MH&A interventions that do not recognise the importance of human interaction, human values and the different world views that lie at the heart of high-quality care might be more efficient in the short-term, but it will be much less effective in the longer term. This is demonstrated, with respect to human values, in Figure 9.

> There is a human factor that cannot be simply reduced to technological opportunities or the mass application of scientific breakthroughs. While technology and science have a critical place in modern health care and offer fresh hope for the future, human feelings and beliefs are equally important to the healing process and need to be factored into the health care equation. (Durie, 2005, p. 2)

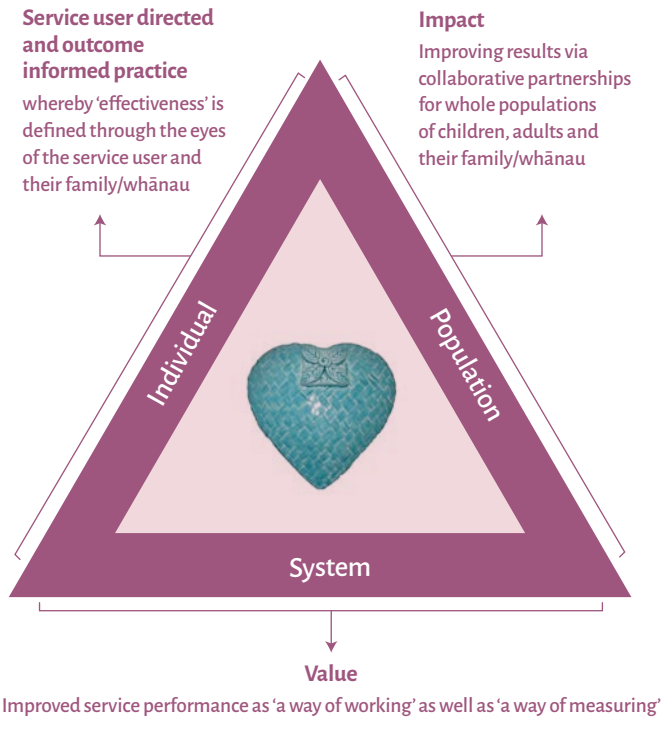


Figure 9. Placing human values at the heart of quality MH&A service delivery. Adapted from "The Triple Aim: Care, health and cost", by D. M. Berwick, T. W. Nolan, & J. Whittington, 2008, *Health Affairs*, 27(3), p.760.

6 - EMERGING MODELS OF HEALTH AND SOCIAL SERVICE DELIVERY IN NEW ZEALAND

Figure 10 highlights some of the models of service delivery, already operating in New Zealand, that are indicative of the paradigm shift that is needed for MH&A services. Although there are many international examples of innovative practice, this report has selected a few local practice examples to highlight what is working well within New Zealand.

Figure 10. Locations of emerging models of service delivery in New Zealand

7 - THE FUTURE

A purpose of this road map has been to share ideas and aspirations for the MH&A sector, and to stimulate discussion among NGOs and other stakeholders about the evolution of MH&A services in what is a rapidly emerging future.

The realisation of the vision requires a deep commitment to the transformation of the MH&A sector over a long period of time, led by sector leaders and thinkers. These are the people who can see the bigger picture, foster more reflective and generative conversations, and help shift the collective focus from problems that are 'out there' to solutions that are 'in here' (Senge, Hamilton, & Kania, 2015).

The MH&A workforce is being presented with issues that appear to be intractable and which do not easily fit within existing professional paradigms or current service models. Our vision for the future is that everyone is actively engaged in co-creating it. This means co-creation at every point in the system, starting with the relationship between the workforce, service users and their families/whānau.

To help support this transformation, On Track includes an illustrative theory of change (Figure 12) which can be used as a self-assessment tool by all organisations interested in participating in the change process. It clearly shows the direction of travel and describes what success looks like along the way. In addition, an associated road map (table10) outlines some actions that key stakeholders can take at three levels in the system – frontline staff, organisation and the system itself.

It is important to emphasise that progress needs to be made across all seven action areas in order for system transformation to occur. Partial successes at different levels of the system will result in some improvement in the quality of services but they will not add up to transformative change.

7.1 Change process

The idea is that all MH&A NGOs will use the illustrative theory of change to self-assess their starting position (ie, identify which horizon matches their current state). On the basis of this self-assessment each organisations is encouraged to review the actions that are outlined in the associated road map, identify their priorities and then develop their own action plan. The road map has not been pre-populated with any key performance measures, so it is recommended that providers develop some measures of their own to help them monitor their progress over time.

This change process is based on the plan, do, check, act (PDCA) cycle for service improvement (Deming, 1994) and incorporates the last five steps in Te Pou's workforce planning approach (Te Pou o Te Whakaaro Nui, 2014). The proposed cycle of service improvement activity is captured in figure 11 on the following page.

It is acknowledged that each point in the cycle is complex and presents its own set of challenges. Ideally every organisation within each locality would agree to undertake their own self-assessment and then share their findings, along with their action plan, with other key stakeholders for the purposes of shared learning and mutual accountability. A more collaborative approach to the change process will help to strengthen the natural support network, promote opportunities for learning about what is working well and enable a more efficient utilisation of available resources and expertise, including input from the national MH&A workforce development centres.

To some extent, the development of some local collaborative communities of practice could be viewed as a natural extension of the alliance approach that is now required across all PHO and DHB relationships. It is acknowledged that in some parts of the country these alliances are working well and already include MH&A NGOs as active partners in a whole-of-system approach to high quality health care. It is anticipated that the ideas that are presented in this report may find fertile ground amongst existing provider networks and formal alliances, so it will be important for NGOs to consider how best to grow and utilise these existing groups when developing strategies to support the change process.

Figure 11: Implementing the road map – a cycle of service and workforce development improvements

We encourage you to acquire your own copy of *On Track* as it contains something for everyone within it. Indeed, the only way that system change will succeed is if everyone, in their different settings, all works in a consistent direction to address the wide range of challenges that are currently facing the MH&A system.

8 - BUILDING COLLECTIVE IMPACT

8.1 Illustrative theory of change

	Emerging	Evolving	Partnering		
Action areas	Horizon 1	Horizon 2	Horizon 3	System level outcomes	
Challenge 1: Support self-determination	Service providers recognise and build on the strengths of service users and their families/whānau.	Service providers share power and responsibility with service users as active partners in defining agendas and making decisions.	People are supported to monitor and improve their own health and wellbeing.	People have the information that they need to take care of their own health and wellbeing.	Healthy individuals, healthy families/whānau and healthy communities
Challenge 2: Focus on system redesign	All service providers promote equitable, timely access to services (ie; A no waiting system where any door is the right door.	The MH&A system operates as one system of care for the benefit of service users, their families and whānau.	The health and social system operate as one system of care for the benefit of service users, their families and whānau.	Providers are able to demonstrate shared accountability for improved outcomes for people and their families/whānau.	
Challenge 3: Improve Workforce capability	Frontline roles are refocused on the values and skills of co-production and making reciprocal relationships work well.	The workforce acts as partners, mentors, facilitators and catalysts in helping people to shape the lives that they value.	Co-production becomes the default model of service delivery for the workforce.	People and their families/whānau have a positive experience of service provision.	
Challenge 4: Address investment and sustainability issues	The barriers to sustainable and productive community MH&A service provision are recognised and addressed.	Community organisations are able to demonstrate value for money.	Co-production is build into a new MH&A commissioning framework.	Community organisations are sustainable and offer value for money.	
Challenge 5: Enhance community engagement	Effective local alliances between service providers and their community partners are established and fostered.	Service providers and community partners allocate and align each of their resources in order to improve population level outcomes.	Service providers and community partners effectively mobilise the collective resources of the community to improve population level outcomes.	Provider and community resources are aligned with what is known to improve population health and community wellbeing.	
Challenge 6: Use the evidence	Treatment and support decisions are made on the basis of people's personal preferences, the evidence about what works and professional judgement.	All service providers are engaged in applying the evidence and evaluating the outcomes.	Service providers benchmark their performance against some agreed national performace measures.	The implementation of the evidence results in improved outcomes for service users and their families/whānau.	
Challenge 7: Strengthen organisational infrastructure	Providers upgrade and share infrastructure (where this is possible) and standardise IT systems across multiple providers locally and regionally.	Providers acceslerate the uptake of technologies that enhance workforce practices and increase productivity.	Service providers are equipped to operate as equal partners in the system of care.	Community organisations are fit-for-purpose and are sustainable over time.	

Leads to system level transformation

Figure 12. Illustrative theory of change

8.2 The road map: translating theory into action

Table 10. The road map

	STRATEGIES		
	Staff	Organisation	System
Key action area			
 **1. Support self-determination**	The shift towards greater self-determination and wellbeing is evidenced by service users being in control of their own health, including their mental health (recovery), exercising choice about what interventions work best for them (autonomy), and being supported by a network of people that care about them (relatedness).	NGOs introduce new incentives for frontline staff and include new criteria for performance management that reinforces co-production.	Funders build co-production into the commissioning framework. NGOs promote the principle of co-production in the wider system.
	Staff demonstrate the essential knowledge, values, skills and attitudes required to deliver effective MH&A services.	NGOs recruit and develop staff who are responsive to the needs and personal preferences of services users and their families/whānau.	National workforce development organisations further strengthen the Real Skills of Let's get real (Te Pou o Te Whakaaro Nui, 2008) and related frameworks, particularly with regard to 'values & attitudes'.
	Staff operate as partners, facilitators, mentors, coaches and catalysts for service users and their families/whānau.	NGOs create a culture of co-production.	National workforce development organisations reinforce the values and skills of co-production in all training programmes, education curricula and professional qualifications.
 **2. Focus on system redesign**	Staff operate as part of a cross-agency network (ie, system of care) that is focused on delivering positive outcomes to individuals, families/whānau and the local population, particularly the under-served communities.	NGOs engage in the delivery of collective impact as part of their core business.	Funders continue to develop the additional capability that is needed to contribute to the necessary system changes.
	Staff engage with the peer support workforce and networks as the best way of transferring knowledge and supporting service changes.	NGOs help to build the capability of the peer support workforce.	System leaders enable all current professional groups working in MH&A NGOs to work to their full or extended scope of practice, including options to better use the peer support workforce.
	Staff engage with people at the first point of contact and work in a way that eliminates the multiple cycles of assessment, screening and referral that currently exist in the system.	NGOs deliver flexible models of service delivery whereby the service response is continually being matched to the diverse and changing needs of service users and their family/whānau.	Funders give higher priority to the commissioning of flexible and innovative services that support people to deal with their problems, achieve their goals and stay well.

	STRATEGIES		
	Staff	Organisation	System
Key action area			
 **3. Improve workforce capability**	Amplify the values and attitudes of the MH&A workforce, with a focus on partnering with individuals and their families/whānau in ways that help people to shape their own future.	NGOs evaluate their current service provision and workforce skill mix, with a view to better matching the needs of under-served populations through staff who are able to work with people as partners, mentors, facilitators and catalysts, particularly in non-traditional work settings (refer to top-of-scope literature review).	National workforce development organisations establish a clear line of sight between NGO workforce development needs and the training and education curricula, particularly with regard to MH&A practitioner and leadership roles, as well as emerging and expanded roles in non-traditional work settings.
	Staff work across professional and organisational boundaries with a focus on improving both individual and population level outcomes.	NGOs support, promote and sustain inter-professional and inter-agency practice and workplace learning.	National workforce development organisations review the horizontal and vertical career pathways of a number of related programmes to make it easier for people to enter the MH&A workforce based on their prior learning and existing competencies.
	Staff demonstrate a broad range of cultural and linguistic competencies.	NGOs support the workforce to deliver culturally appropriate and safe MH&A services in all settings.	All workforce development and training, and clinical placements in MH&A-related fields, place greater priority on people achieving and improving their competencies to work effectively with a broad range of ethnic groups, particularly Māori, Pacific and Asian people.
 **4. Address investment and sustainability issues**	Staff are active participants in the process of building a capable organisation, including the use of organisational self-assessment tools and service improvement activities.	NGOs widen their organisational horizons and invest in tomorrow through the use of organisational self-assessment processes, new information, extended workforce capabilities, new tools and a range of strategic alliances/partnerships.	Relevant government organisations work together to build the capability of funders and to improve the commissioning of MH&A NGO services.
	Staff work in effective and efficient ways. For example, innovative use of mobile information technology can help reduce time spent on travel and administrative tasks.	Funders and providers work together to build the capacity and capability of NGOs, so that NGOs are better equipped to deliver a wide range of high-quality community MH&A services. For example, the success of a collective impact initiative relies on five key conditions, all of which require organisations to work together in new ways. These five key conditions will need an associated investment in staff skills and organisational infrastructure, particularly in the area of shared outcome measurement and backbone support.	Funders establish an equitable and sustainable funding path for MH&A NGOs.

	STRATEGIES		
	Staff	Organisation	System
Key action area			
	Staff are focused on delivering value to service users and their families/whānau.	NGOs support the ongoing development of system leadership amongst NGOs and develop organisational succession plans.	National workforce development organisations enhance national NGO leadership competencies and capacity-building mechanisms to support reform and to improve workforce productivity.
5. Enhance community engagement	Staff facilitate more 'everyday democracy' by partnering with individuals and their families/whānau to help them exercise the power that they have to shape their own future.	NGOs adopt community development principles.	System leaders adopt a systemic approach and foster collective leadership.
	Staff create opportunities to build strong inter-agency relationships.	NGOs build the capability of the MH&A workforce to engage with the local community.	System leaders encourage collaborative working based on community development principles.
	Staff identify and work with other community agencies, especially in those instances where two or more services are delivering support to the same group of service users and families/whānau.	Organisations shift some of their focus, from reacting to their own immediate issues to working alongside other like-minded organisations towards a shared vision for their local community.	System leaders support the development of a shared vision and a shared interest in good community outcomes and joint accountabilities.
6. Use the evidence	Staff implement programmes based on the evidence about what is known to work well for different groups of people in different settings.	NGOs support staff training, coaching and peer review processes that support the development, uptake and successful implementation of evidence-based practices and programmes in ways that respect the personal values and preferences of service users and their families/whanau.	National workforce development organisations work together to improve the science and the practice of implementing the evidence. In addition, organisations are coached in how to further develop and add to the existing evidence-base about what works.
	Staff use organisational support and resources to reflect and to learn from doing.	NGOs develop their leadership capacity to support and lead organisational innovation and reform.	System leaders cultivate the conditions that gradually bring about new ways of thinking and working.
	In situations where the evidence suggests that existing practices are no longer the most effective, staff redesign and refocus service activities.	NGOs benchmark their performance against agreed national performance measures and take action to make improvements in areas of weakness.	System leaders support NGOs to actively participate in national benchmarking and service improvement activities.

	STRATEGIES		
	Staff	Organisation	System
Key action area			
7. Strengthen organisational infrastructure	All staff throughout the organisation exercise their 'decision-power' and take responsibility to improve the experience and the outcomes for service users and their families/ whānau at all points of contact with the service.	NGOs foster the development of adaptive leadership skills throughout the organisation.	National workforce development organisations incorporate adaptive leadership competencies into all training and education curricula nationally.
	Staff are proficient in the use of technology.	NGOs facilitate the uptake of technologies that enhance workforce practice and productivity.	System leaders provide incentives for individual organisations to work collectively at the local and regional level on the uptake and implementation of various technological advancements.
	Staff are active participants in any organisational self-assessment and improvement process.	NGOs routinely self-assess their organisational infrastructure and make improvements in those areas where this is indicated.	System leaders provide incentives for organisations to routinely self-assess and improve their organisational infrastructure.

APPENDICES

Appendix One: Contributors

This document has been developed with significant engagement from different parts of the MH&A NGO sector, as well as the wider health and social sector.

Special thanks go to the following individuals, groups and networks, which have supplied ideas, information, support material and feedback, all of which have contributed to the development of this road map.

Name	Position	Areas of input
Ainslie Gee	Manager, Changing Minds, Auckland	· Service user perspective
David Todd	Director, Synergia	· Response-level estimates and associated workforce modelling for *Towards the Next Wave of Mental Health and Addiction Services and Capability* (Health Workforce New Zealand, 2012) · Stepped care model
Doug Alderson	Community support worker, Southland DHB	· The community support role within the DHB provider arm
Dr Bronwyn Dunnachie	Senior advisor, The Werry Centre	· Child and youth perspective
Dr Lynne Lane	Mental Health Commissioner, Health and Disability Commission	· Service-response estimates in *Blueprint II* (Mental Health Commission, 2012a; 2012b) · Early intervention and life-course model · Sustainability issues
Heather McDonald	Managing director, Heathrose Research	· Retention of the older workforce
Helen Lockett	Strategic policy advisor, Wise Group	· Peer reviewer · Alignment with work on *Equally Well*
Ian McKenzie	Manager, Regional forensic psychiatry services, Waitemata DHB	· Strategic commissioning of services · Risk analysis
Jayne Milburn	Senior advisor, Health Workforce New Zealand, National Health Board	· Current status of *Towards the Next Wave of Mental Health and Addiction Services and Capability* (Health Workforce New Zealand, 2012) – estimated changes in activity by consumer journey and by service levels
Jeff Bennett	Group manager, MH&A service, Waikato DHB	· DHB perspective
Jim Crowe	Supporting Families in Mental Illness	· Future vision of MH&A service provision · Individualised support to meet the needs of services users and their families/whānau
Karen Moses	MH&A workforce planning lead, Central Region	· Conceptual model – stepped care · Current and future MH&A workforce trends
Kathryn Leafe	CEO, Care NZ	· Alcohol and other drug service provision · Future alcohol and other drug workforce challenges
Kieran Moorehead	Changing Minds, Auckland	· Youth perspective
Kitty Ko	Asian service development coordinator, Counties Manukau Health	· Asian mental health needs · Cultural competency

Name	Position	Areas of input
Laura Lambie	Contractor, Te Pou	· Primary mental health care developments
Luke Rowe	General manager, Te Taiwhenua o Heretaunga	· Kaupapa Māori MH&A integrated service delivery
Martin Hefford	CEO, Compass Health	· Primary MH&A models of care
Michelle Wilde	Clinical project manager, ProCare	· Primary MH&A models of care
Monique Faleafa and Denise Kingi- Uluave	Le Va	· Pacific perspective
Peter Kennerley	Manager, Addiction treatment services, Ministry of Health	· Addiction outcome measurement · Results-based accountability · Alcohol and other drug workforce development
Professor Tony Dowell	Professor of primary health care, Otago University	· Primary MH&A service delivery model
Ranei Wineera	Project manager, Porirua social sector trial	· Outcome frameworks · MH&A input into Porirua social sector trial
Ruth Gerzon	General manager, Inclusion Aotearoa	· Disability workforce developments · Personalised funding options · Enabling Good Lives initiative
Shane Collett	Principal advisor, addiction treatment services, Ministry of Health	· Alcohol and other drug workforce
Sonya Russell	Senior project manager, Mental health service improvement team, Ministry of Health	· Primary mental health framework · Funding framework for mental health
Sue Lim	Operations manager, Asian health support services, Waitemata DHB	· Cultural competencies
Tania Anstiss	Senior advisor, parenting portfolio, The Werry Centre	· Child and youth perspective · Child and youth workforce development
Vanessa Caldwell	National manager, Matua Raki	· Alcohol and other drug workforce development
Veronica Bennett	National manager, business development, Stand Children's Services, Tu Maia Whanau	· Child and youth service provider perspective · Integrated care and integrated contracts · Interface with Ministry of Social Development

Sector groups and networks

Contributions were also sought through established sector networks, as shown below.

Date	Sector groups and networks
2 July 2014	Regional MH&A workforce leads
12 August	Midland Mental Health Network
14 August	Navigate (mental health NGOs in the northern region)
18 August	Whanganui service users and family representatives
18 August	Whanganui primary health organisation and primary care representatives
25 August	Family Whānau North (includes family advisors, family workers and family representatives from across the northern region)
2 September	Wairarapa MH&A leadership group
9 September	Waikato DHB local advisory group
11 September	DHB planners and funders national forum
15 September	Voices forum (Christchurch)
15 September	Alcohol and other drug hui, hosted by He Waka Tapu, Christchurch
16 September	Hutt Valley NGO providers forum
18 September	Midland region portfolio managers network
19 September	Youth focused forum, Affinity Services, Auckland

Steering group

Advice was also received from the members of a steering group that was specifically established to oversee the work. The individual members of the steering group are listed below.

Steering group member	Organisation
Marion Blake (chairperson of Steering group)	Platform Trust
Robyn Shearer	Te Pou
Paul Ingle	Chairperson of Platform Trust board
Kathryn Leafe	Care NZ
Derek Wright	Recovery Solutions
Frank Bristol	Balance NZ Whanganui

Appendix Two: Summary of Sector Feedback

In addition to individual meetings with key stakeholders, the project manager attended 14 sector forums to present some ideas about the project and to hear people's ideas and feedback. If time permitted, forum participants were also asked to identify the top three things that they thought would improve MH&A NGO service delivery in New Zealand. Participants wrote their three suggestions down onto a piece of paper and these ideas were then analysed.

This process resulted in 168 people providing 422 ideas. All of these ideas were categorised into 11 main themes, with 138 of the ideas then further categorised into a number of sub-themes.

The 11 main themes are illustrated in Figure 13, in terms of the number of times that they were mentioned by forum participants.

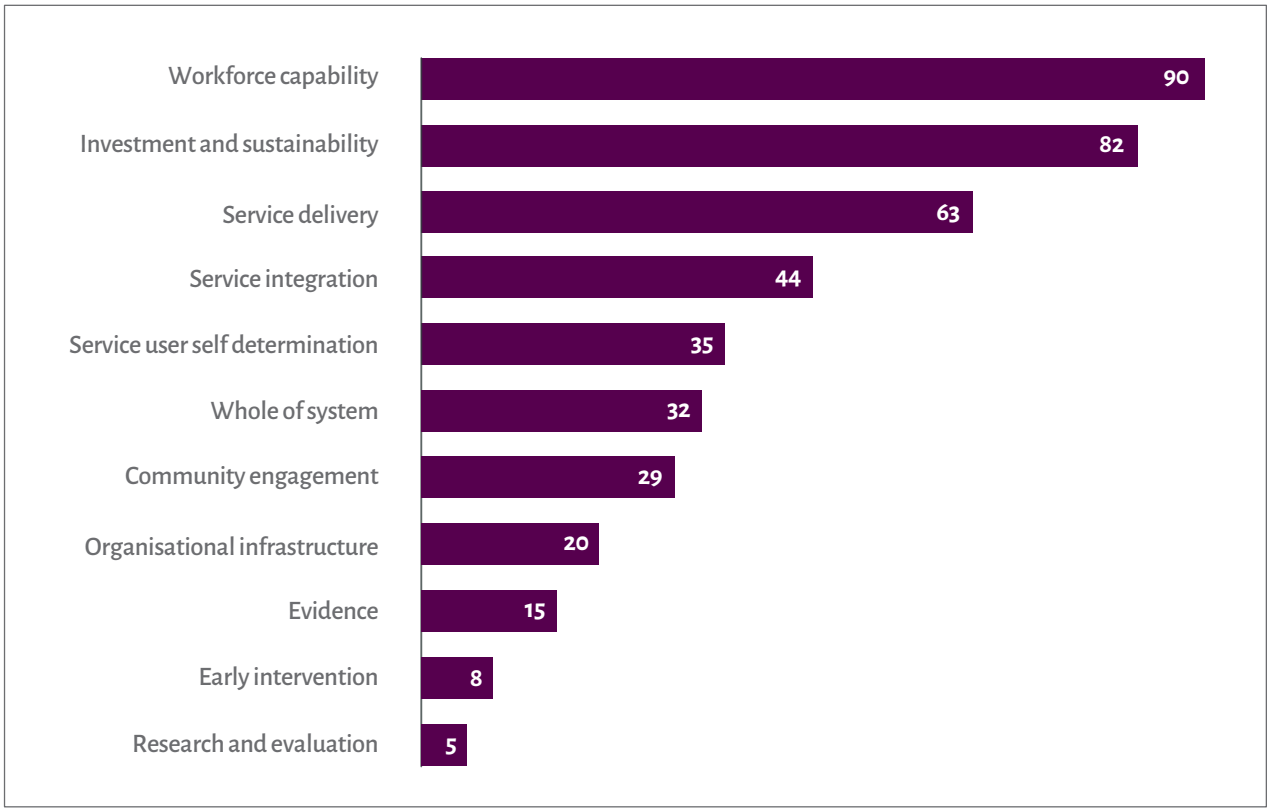


Figure 13. Main themes to emerge from the sector engagement process

While many of the ideas could have been categorised under more than one theme, each idea was allocated to the theme that represented the closest fit.

The smaller number of comments (n=35) under the theme of 'service user self-determination' possibly reflects the way that the original question was framed, rather than its relative importance to participants. Despite the smaller number of comments, it has been given the highest priority in the road map, in accordance with the core principles of partnership, co-design and person-focused care.

The four themes that relate to service design (ie, service delivery, whole-of-system, early intervention and service integration) collectively attracted the largest number of comments (n=147), closely followed by the themes of 'workforce capability' (n=90) and 'investment and sustainability' (n=82), with 'fair funding' being mentioned 31 times.

Figure 14 summarises the critical themes and sub-themes that participants identified as being important. This diagram is not intended to be a complete record of people's ideas. It is more of a high-level summary that highlights the main areas that are covered in more detail in the body of this report.

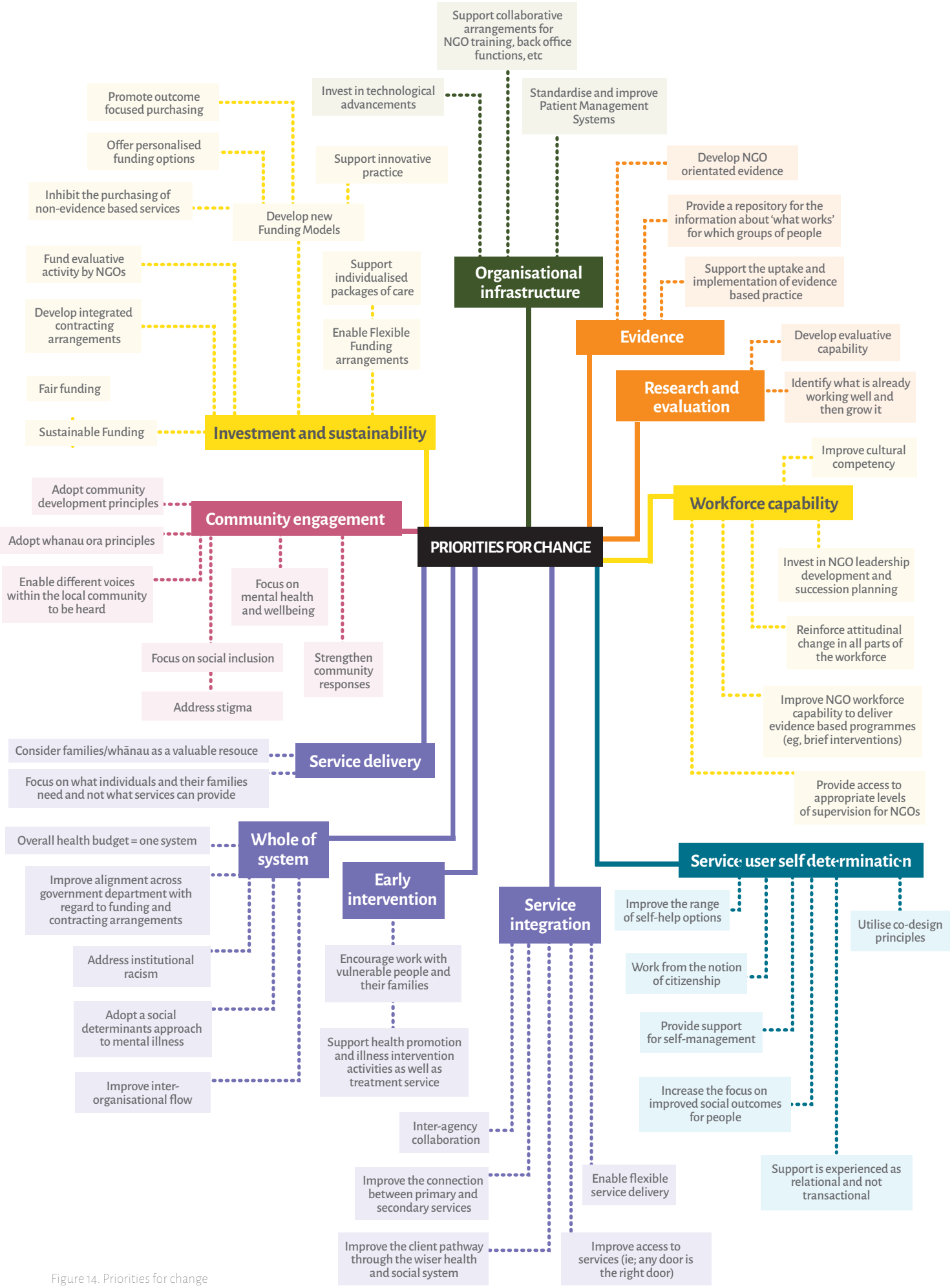


Figure 14. Priorities for change

The results of this thematic analysis formed the backbone of the road map, with a focus on the following seven priority areas for action:

- service user self-determination
- system design
- workforce capability
- investment and sustainability
- community engagement
- evidence
- organisational infrastructure.

This sector feedback was not the only source of information used in the compilation of this report. Key areas of interest were also informed by the national and international literature (particularly in describing the case for change), as well as advice received from subject matter experts.

Appendix Three: Youth Forum Feedback

Particular thanks go to the young people who attended the youth forum held at Affinity Services. Their views about positioning mental health and wellbeing in a broader context, which was focused on promoting the wellbeing of people in their local communities, was both refreshing and challenging.

A couple of members of this group subsequently submitted a number of questions about the future shape of MH&A services, which have been included here.

Questions

- How can we disperse the work of caring for mental health back into the communities?
- What steps need to be taken to educate us all about mental health so we can all support each other's mental wellbeing?
- What can we do to reduce the social stigma around mental illness and change the way it is framed within society?
- How will we empower us all to care about mental health? How do we educate everyone that mental health is all of our concern and act on it?
- How can we reduce the barriers between clinicians and members of the public so it's not 'you' (clinicians who diagnose mental health and supposedly have no mental health issues of their own) and 'them' (people with mental health 'problems'), but 'us' (everyone working on maintaining their mental wellness)?
- How can we improve the mental health of individuals who slip under the radar? Why do these people slip under the radar?
- Could we improve the way people are referred to clinics? As young people spend most of their time at school, should we collaborate with educational institutes to a greater extent?
- How can we utilise technology (eg social media, applications) to treat mental health more effectively for everyone?

Submitted by Thomas, Alice, Georgia, Aldrich, Melissa and Vidya

References

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health and cost. *Health Affairs, 27*(3), 759-769.

Boston, J., & Chapple, S. (2014). *Child poverty in New Zealand.* Wellington: Bridget Williams Books Ltd.

Boyle, D., Coote, A., Sherwood, C., & Slay, J. (2010). Right here, right now: Taking co-production into the mainstream. http://www.neweconomics.org/publications/entry/right-here-right-now

Cohen, J. J., Gabriel, B. A., & Terrell, C. (2002). The case for diversity in the health care workforce. *Health Affairs, 21*(5), 90-102.

Crampton, E., & Burgess, M. (2009). The price of everything, the value of nothing: A (truly) external review of BERL's study of harmful alcohol and drug use *Working paper no. 10/2009.* Christchurch: University of Canterbury.

Crowther, N. (2014). A call to action for the common good. Dunfermline: Carnegie UK Trust.

Deming, W. E. (1994). *The New Economics for Industry, Government, Education* (2nd ed.). Cambridge, Massachusetts: MIT.

Dowell, A., Morris, C., Dodds, T., & Mcloughlin, H. (2012). Psychological interventions in primary care mental health. In G. Ivibjaro (Ed.), *Companion to primary care mental health.* London: Radcliffe Publishing.

Drake, R. E. (2007). Dual diagnosis. *Psychiatry, 6*(90), 381-384.

Durie, M. (2005). *Indigenous health reforms: Best health outcomes for Maori in New Zealand.* Paper presented at the Unleashing Innovation in Health Care: Alberta's Symposium on Health, Calgary, Canada. http://www.massey.ac.nz/massey/learning/departments/centres-research/te-mata-o-te-tau/publications/publications_home.cfm

Felner, R. D. (1997). The project on high performance learning communities: Applying the land-grant model to school reform. *Phi Delta Kappan, 78*(7), 520-528.

Finney, A. (2004). Alcohol and intimate partner violence: Key findings from the research. London: Home Office Findings.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Fryers, T., & Brugha, T. (2013). Childhood determinants of adult psychiatric disorder. *Clinical Practice & Epidemiology in Mental Health*(9), 1-50. doi: 10.2174/1745017901309010001

Gluckman, P. D. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence.* Wellington: New Zealand Government - Office of the Prime Minister's Science Advisory Committee.

Ham, C., & Walsh, N. (2013). Making integrated care happen at scale and pace. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

Hanleybrown, F., Kania, J., & Kramer, M. (2012). Channeling Change: Making Collective Impact Work. *Stanford Social Innovation Review*: SSIR.

Health Workforce New Zealand. (2011). Towards the next wave of mental health and addiction services and capability: Workforce service review report. Wellington: Health Workforce New Zealand.

Heathrose. (2011). Attracting, retaining and utilising older workers project: Report prepared for Department of Labour. Wellington: Heathrose.

Institute of Policy Studies. (2008). Better connected services for kiwis: A discussion document for managers and front-line staff on better joining up the horizontal and the vertical. Wellington: School of Government, Victoria University of Wellington.

Jackson, N. O. (2014). *Thinking recreation - thinking demographic trends.* Thinking Recreation Conference 2014. National Institute of Demographic and Economic Analysis (NIDEA) Hamilton, New Zealand.

Kania, J., & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review,* (Winter). http://www.ssireview.org/articles/entry/collective_impact

Levin, B., Hennessy, K., & Petrila, J. (Eds.). (2010). *Mental health services: A public health perspective* (Third ed.). New York: Oxford University Press.

Locality & Vanguard Consulting. (2014). Saving money by doing the right thing: Why 'local by default' must replace diseconomies of scale. http://locality.org.uk/resources/saving-money-local-default-replace-diseconomies-scale/

Matthews, D. (2013). David Matthews' address to the NZDSN AGM Forum. Retrieved Nov 2014, from http://www.ccsdisabilityaction.org.nz/news/665-david-matthews-address-to-the-nzdsn-agm-forum

Mental Health Commission. (2012a). Blueprint II - Improving mental health and wellbeing for all New Zealanders: How things need to be. Wellington: Mental Health Commission.

Mental Health Commission. (2012b). Blueprint II - Improving mental health and wellbeing for all New Zealanders: Making change happen. Wellington: Mental Health Commission.

Michaelson, J., Mahony, S., & Schifferes, J. (2012). Measuring Well-being: A guide for practitioners. London: New Economics Foundation.

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

Ministry of Health. (2009). A focus on problem gambling: Results from the 2006/07 New Zealand Health Survey. Wellington: Ministry of Health.

Ministry of Health. (2012). Rising to the challenge: The mental health and addiction service development plan 2012 - 2017. Wellington: Ministry of Health.

Ministry of Health. (2013). Health loss in New Zealand: A report from the New Zealand burden of diseases, injuries and risk factors study, 2006–2016. Wellington: Ministry of Health.

National Centre for Lifecourse Research. (2014). The NCLR way of understanding lifecourse development. from http://www.nclr.org.nz/what-are-you-up-to

National Institute for Health and Care Excellence. (2015). Commissioning stepped care for people with common

mental health disorders: Guide for commissioners. Retrieved 15 January 2015, from http://www.nice.org.uk/guidance/cmg41/chapter/3-a-stepped-care-approach-to-commissioning-high-quality-integrated-care-for-people-with-common

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). Long-term conditions and mental health: The cost of co-morbidities. London: Kings Fund & Centre for Mental Health.

New Zealand Productivity Commission. (2014). More effective social services: Issues paper. Wellington: New Zealand Productivity Commission.

New Zealand Treasury. (2009). Guidelines for contracting with non-government organisations for services sought by the Crown and good practice. Version 2.2. Wellington: New Zealand Treasury.

New Zealand Treasury. (2014). Holding on and letting go: Opportunities and challenges for New Zealand's economic performance. A perspective from the Treasury. Wellington: New Zealand Treasury.

Oakley Brown, M. A., Wells, E., & Scott, K. M. (Eds.). (2006). *Te rau hinengaro - The New Zealand mental health survey*. Wellington: Ministry of Health.

Organisation for Economic Co-operation and Development. (2014). Making mental health count: The social and economic costs of neglecting mental health care. Paris: OECD Publishing.

Pacific Perspectives. (2013). Pacific health workforce service forecast: Report to Health Workforce New Zealand and the Ministry of Health. Wellington: Pacific Perspectives.

Platform Trust. (2014). Platform's statement for change. from http://www.platform.org.nz/uploads/files/Platform%20Statement%20of%20Change.pdf

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68-78.

Scharmer, O., & Kaufer, K. (2013). *Leading from the emerging future: From ego-system to eco-system economics*. San Francisco: Berrett-Koehler Publishers Inc.

Schrank, B., Brownell, T., Riches, S., Chevalier, A., Zivile, J., Larkin, C., . . . Slade, M. (2015). Staff views of wellbeing for themselves and for service users. *Journal of Mental Health*, *24*(1), 48-53. doi: 10.3109/09638237.2014.998804

Scott, A., Doughty, C., & Kahi, H. (2011). Peer support practice in Aotearoa New Zealand. Christchurch: University of Canterbury. .

Segal, L., May, E., Leach, M. J., & Turnbull, C. (2013). Regional primary care team to deliver best-practice diabetes care: A needs-driven health workforce model reflecting a biopsychosocial construct of health. *Diabetes Care*, *36*(7), 1898-1907.

Senge, P., Hamilton, H., & Kania, J. (2015). The dawn of system leadership. *Stanford Social Innovation Review*. http://www.ssireview.org/articles/entry/the_dawn_of_system_leadership

Sheridan, N. F. e. a. (2011). Health equity in the New Zealand health care system: A national survey. *International Journal for Equity in Health*, *10*(45). http://www.equityhealthj.com/content/10/1/45

Shonkoff, J. P., & Garner, A. S. (2012). The lifelong effects of early childhood adversity and toxic stress. *American Journal of Pediatrics*, *129*(1), e232-e246.

Silva, P. A., & Stanton, W. (Eds.). (1996). *From child to adult: The Dunedin multidisciplinary health and development study*. Auckland: Oxford University Press.

Statistics New Zealand. (2014a). 2013 Census. from http://www.stats.govt.nz/Census/2013-census.aspx

Statistics New Zealand. (2014b). Te kupenga: Maori well-being in 2013. from http://www.stats.govt.nz/tekupenga

Tangata Whenua Communty & Voluntary Sector Research Centre. (2012). Whānau ora research. from http://whanauoraresearch.co.nz/

Taskforce on Whānau-Centred Initiatives. (2010). Whānau ora: Report of the Taskforce on Whānau-Centred Initiatives Taskforce.

Te Pou o Te Whakaaro Nui. (2014a). Getting it right - a workforce planning approach. from from http://www.tepou.co.nz/library/tepou/getting-it-right-a-workforce-planning-approach

Te Pou o Te Whakaaro Nui. (2014b). Individualised funding for New Zealand mental health services: A discussion paper. Auckland: Te Pou o Te Whakaaro Nui.

Te Pou o Te Whakaaro Nui. (2014c). The physical health of people with a serious mental illness and/or addiciton: An evidence review. Auckland: Te Pou o Te Whakaaro Nui.

Te Pou o Te Whakaaro Nui. (2014d). *Stocktake of the adult mental health and addicitons workforce*. In print.

Te Pou o Te Whakaaro Nui. (2015). Scope it right: Working to top of scope literature review. Mental health and addiction workforce.

Tennant, M., Sanders, J., O'Brien, M., & Castle, C. (2006). Defining the nonprofit sector: New Zealand: Working papers of the John Hopkins comparative nonprofit sector project, No 45. Baltimore. The John Hopkins Centre for Civil Society Studies.

The Werry Centre. (2013). 2012 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand. Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development, The University of Auckland.

Thibault, G. E. (2013). Reforming health professions education will require culture change and closer ties between classroom and practice. *Health Affairs*, *32*(11), 1928-1932.

Timmins, N., & Ham, C. (2013). The quest for integrated health and social care: A case study in Canterbury, New Zealand. London: The Kings Fund.

Todd, F. C. (2010). Te ariari o te oranga: The assessment and management of people with co-existing mental health and substance use problems. Wellington: Ministry of Health.

Whittaker, R. (2014). The future of health is mobile. *Pulse+IT Magazine*, (November 2014). http://www.pulseitmagazine.com.au/index.php?option=com_content&view=article&id=2138:opinion-the-future-of-health-is-mobile&catid=49:new-zealand-ehealth&Itemid=329

World Health Organization. (2008). Integrated health services - What and why? *Technical brief no.1*. Geneva: World Health Organization.

World Health Organization. (2013). Investing in mental health: evidence for action. Geneva: World Health Organization.

World Health Organization, & Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva: World Health Organization.

On Track