

*Moving
Forward*

The National Mental Health Plan
for
More and Better Services

July 1997

The Goals of Looking Forward

Goal 1:

To decrease the prevalence of mental illness and mental health problems within the community.

Goal 2:

To increase the health status of and to reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

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THE MINISTER'S FOREWORD

Mental health is a priority for me. I am determined to see more and better services for people affected by a mental disorder.

Part of leadership is setting direction and strategy. This National Mental Health Plan completes that process begun by my predecessor, Hon Jenny Shipley, when in 1994 she released *Looking Forward, Strategic Directions for Mental Health Services*.

Moving Forward provides national objectives for years 4–10 of the mental health strategy and gives steps along the way to achieve them. *Moving Forward's* objectives and targets will also assist the Mental Health Commission in evaluating how well the National Mental Health Strategy is being implemented.

We all know that there is still a lot to be done to improve mental health services in New Zealand. The Government is committed to fully funding the 1996 Mason Report recommendations to assist the mental health sector improve services. It is important that Government sets clear priorities for mental health so providers know where additional funding will be applied.

The regional plans of the funding/purchasing body will show how these national objectives and targets are translated into more and better services at regional level. I expect the many participants in the mental health sector to take the opportunity to be closely involved in the development of these plans. In particular, providers have the opportunity to put forward services which meet these objectives.

What we have to do now is stop refining objectives and strategies – and speed up action. I am committed to more and better mental health services. We all need to play our part in delivering on that commitment to people affected by mental disorder.

A handwritten signature in blue ink, appearing to read 'Bill English', is positioned below the text. The signature is fluid and cursive, with a large initial 'B' and 'E'.

Hon Bill English
Minister of Health

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TE TIRITI O WAITANGI

The development of *Moving Forward*, the National Mental Health Plan for New Zealand, has been consistent with the principles of Te Tiriti o Waitangi. The Plan is reflective of the special mental health needs of Māori and their unique needs as tāngata whenua. Te Tiriti o Waitangi is relevant for all New Zealanders in maintaining co-operative co-existence and harmony. It is appropriate that Te Tiriti o Waitangi underpin the provision and delivery of mental health services for all people of Aotearoa New Zealand.

INTRODUCTION

Moving Forward is the National Mental Health Plan for New Zealand. The Plan is based on the National Mental Health Strategy *Looking Forward*, which was released in 1994 and which outlined the goals and strategic directions for the development of mental health services over the next ten years.

Moving Forward has been devised to make sure that *Looking Forward* is implemented. Its aim is to build on the five strategic directions contained in *Looking Forward* and to deal with issues that have arisen since the release of the strategy.

Considerable progress has been made in providing mental health services but much more needs to be done. *Moving Forward* points to areas where we know we need *more* services – for instance, for children and young people. It also identifies areas where we need *better* service delivery. For example, we know that many services are more responsive to Māori than they used to be, but there is a lot further to go to achieve the National Mental Health Strategy's objectives for Māori. Similarly we need to keep looking for ways to make mental health services more responsive to the needs of consumers, caregivers, and people from other cultural backgrounds such as Pacific people.

The National Mental Health Plan is wide in its scope. It includes not just mental health services but also mental health promotion, prevention and primary healthcare activities. It is written at a national level and has measurable targets, most of which relate to policy development, funding and purchasing. The key finding of the Mental Health Strategy Group, which reported to the Minister of Health in 1996, was that progress towards the goals of *Looking Forward* needed to be measurable. The 1996 Mason Report (the *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services*) concurred with this. *Moving Forward* links the goals and strategic directions in *Looking Forward* to objectives and targets that can be used to measure progress.

The targets are directed at the Ministry of Health and at the funding/purchasing body that will replace the four separate regional health authorities (RHAs). The Plan also encompasses the National Mental Health Standards, which have been developed by the Ministry and which will act to improve the performance of providers of mental health services. The Plan is not a “blueprint” showing the future shape of service provision across New Zealand – this is a task that the Mental Health Commission is currently undertaking.

Moving Forward provides the sector with a detailed guide to the implementation of the National Mental Health Strategy. In short, it shows where mental health is heading and gives ways to measure our progress in getting there.

What Has Happened So Far

The development and release of *Looking Forward* was the Government's response to the need to address the inadequacy of mental health services. In 1994, public concerns about mental health services were not new. They had arisen in the main from changes in the delivery of services, where the focus was moving from large stand-alone psychiatric hospitals to mental health services that were integrated with other health services (predominantly based in the community and at general-hospital sites). Although these changes had been occurring for many years, it was generally acknowledged that there was not enough resource and support given to this major infrastructural and cultural change process.

More Services Have Been Funded ...

Since 1994, more mental health services have been purchased and provided. A stocktake undertaken late in 1995 showed a major increase in community mental health teams and community-based residential services for adults. There has also been a large increase in new community providers from the non-government sector.

Such increase in services has been made possible with additional funding for mental health services provided by the Government. In 1994, the Government allocated \$70 million of tagged funding over three financial years for improvements in community mental health, high-dependency residential services, Māori mental health, and young people's mental health. In 1996, the Government announced a further \$30 million for 1996/97, increasing annually to around \$140 million in the 2000/01 year. This funding is to be used to give priority to community services for adults and children and young people, access to new anti-psychotic drugs, workforce development, and better co-ordination of services.

The increases in mental health services since 1994 were above what had been expected to occur. But while there has definitely been an increase in quantity, it is not so clear that this has meant an increase in quality.

... But Services Are Not Necessarily Better

It has been difficult to measure quality except by anecdotal information and by surveying key informants. Repeat surveys have shown some small improvement in increasing consumer and carer participation in services, and in some areas there has also been an increase in Māori provision and in Māori participation in service delivery.

The main information available about the quality of services is from the *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services* (the 1996 Mason Report). This indicated in no uncertain terms that, although there may be more services around, "more" does not mean "better". The Ministry's own findings suggest there are significant problems with integration of services because of the rapid increase in the number of providers and the lack of co-ordination of care on an individual basis. There is also considerable work to be done in terms of consumer participation, Māori participation and partnership, and caregiver involvement. As well, workforce and skill development are issues of paramount concern, because the achievement of more and better services depends on having sufficient numbers of skilled staff.

Moving Forward sets out to remedy these defects – and, by doing so, to provide the direction that is necessary for the ongoing development of mental health services.

Responsibility for the Implementation of the Plan

We are now moving into an environment where there is an expectation of greater national consistency and direction. This will be assisted by the move towards one overall funding/purchasing body instead of the four separate RHAs. In addition, the Ministry of Health has developed this National Mental Health Plan; and the Mental Health Commission is developing a blueprint for services that will include elements of this Plan as well as service specifications and best practice methods. (The more detailed functions of each of these organisations can be found in Appendix 3.)

The National Mental Health Plan now needs to be translated into regional plans. This is a task that the funding/purchasing body is expected to complete, in consultation with consumers and providers.

The Mental Health Commission and the Ministry will make sure that four detailed regional implementation plans are developed within the next year, showing how each region will make progress against the national targets. These implementation plans will be within the funding path agreed to by the Government over the next five years for adult services and children's and young people's services, with an emphasis on Māori. Further policy development will occur for Pacific peoples, older adults, drug and alcohol services, and refugees.

What will Mental Health Services Offer in the Future?

The two key directions of the *Moving Forward* National Mental Health Plan are to continue the emphasis on more services and to focus increasingly on improving the quality of services.

The Plan is looking to achieve:

more and better mental health services
that *work together* and with other health and social services
so that the *right* people get services
and these services meet their *needs*.

It should also be noted that, in the context of *Moving Forward*, "mental health services" includes drug and alcohol services unless specifically stated otherwise.

We Still Need More Services

Figure 1 (opposite) illustrates the basis on which *Moving Forward* has been developed. It is based on epidemiological evidence that 20% of the population have a diagnosable mental illness (including a drug or alcohol disorder) at any one time. About 3% of adults – and about 5% of children and young people – have a severe mental health disorder. A further 5% of adults have a moderate to severe disorder, and 12% have mild to moderate disorders or problems.

The immediate intention of *Moving Forward* is to ensure that there are enough mental health services to meet the needs of the 3% of adults (and the 5% of children and young people) who have major mental health disorders. As well, it has a longer-term aim of ensuring that primary healthcare services are adequately equipped to recognise the severity of disorder and then refer people or manage their problem. (It is acknowledged that many people with mild disorders will never present to health services and will instead get support from their own informal networks.)

Moving Forward also allows for mental health promotion activities to be delivered to the general population – including the 80% who are not currently experiencing mental health disorders or problems.

We Also Need Better Services

There will be greater emphasis on *better* as well as more services.

More emphasis will now be placed on workforce development, with this being specifically identified and purchased by the funding/purchasing body. Greater partnership between and among health providers and education providers is critical if skill development is to be properly addressed in this area.

Providers must focus on delivering services in ways that are cost-effective, and at the same time must strive to meet international best practice at all levels of services. This will mean an integrated “team” approach to service delivery, including integration with other secondary health services and with primary healthcare services. There is no doubt that it will take time to achieve the shifts in thinking that lead to such changes in the local delivery of services.

Lastly, but not least, the stigma which is attached to mental illness in the community (and which is reinforced by well-publicised tragedies and incidents) must be addressed. Elimination of this stigma – and the discrimination against people with mental illness that results from it – is necessary for encouraging potential consumers to seek early intervention and treatment for their disorders. It is also necessary for making mental health services more attractive as a career.

Figure 1: Estimated prevalence of mental health problems amongst adult New Zealanders

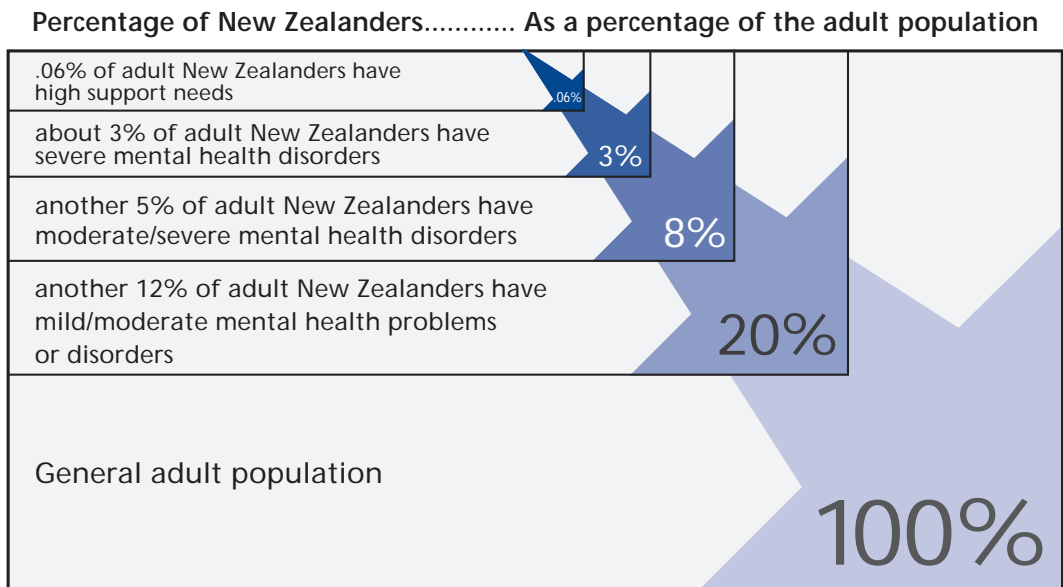
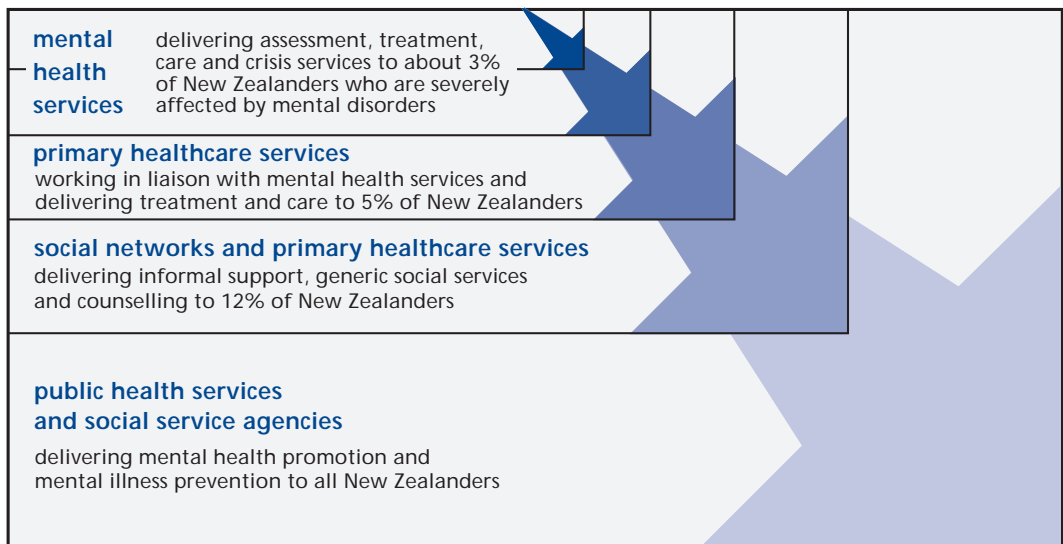


Figure 2: Delivering mental health care to New Zealanders – what we want to happen



What We Want to Achieve

A “building blocks” approach can be used to show the direction in which we want to move. We can use the building blocks to show in general terms where we are now and what will have changed by 2005.

The general activities currently being carried out by mental health services throughout the country are defined as:

- crisis response
- assessment and treatment
- recovery and extended support
- consultation and liaison
- risk management and safety.

(This list of activities is based on the Mental Health Services Specification/Common Base Definitions Project, which was completed in 1997.)

There are some areas where more specialised activities are also occurring, such as skilled interventions to meet the needs of people who are newly presenting with major mental disorders. But, generally speaking, the more specialised responses to particular needs are only fragmentary.

Figure 3 illustrates, in very general terms, the building blocks we have at present. Figure 4 shows where we would like to be by 2005.

The specialised activities shown for 1997, however, are inconsistent across the country. The “wall” of services built with the current blocks is neither as high nor as strong as it needs to be. The emphasis must be on strengthening the current basic blocks, adding kaupapa Māori services and consumer/carer support as basic blocks, and also building on the top layer of more specialised activities.

The top level of building blocks in Figure 4 represent additional or more specialised mental health activities. In essence, they take into account the development of new and improved therapies and the importance of matching service activities to specific mental health needs:

- people with high support needs will get assertive care management
- people who are newly presenting with major mental illness will get early intervention
- people affected by mental disorders will have access to appropriate psycho-social interventions
- people with dual diagnoses will get access to services that treat, for example, both their mental illness and their drug misuse/abuse
- people with particular disorders will have access to services that are better tailored to their needs
- people with particular cultural needs will have those needs recognised and provided for.

The increasing range of services requires specific co-ordination, to ensure that the services work together and that services given to each consumer are matched to their individual needs.

We are in the middle of complex change which will not occur overnight and will not be solved by the commitment of increased dollars alone. Improvement requires ongoing commitment at all levels. More money has been expended and this will continue to grow over the next three to five years. There are more services than three years ago, and these will also continue to develop. More emphasis must and will be placed on developing quality, with workforce development and best practice standards.

The rest of this document now addresses the steps to be taken in moving forward to 2005.

Figure 3: Mental Health Activities 1997

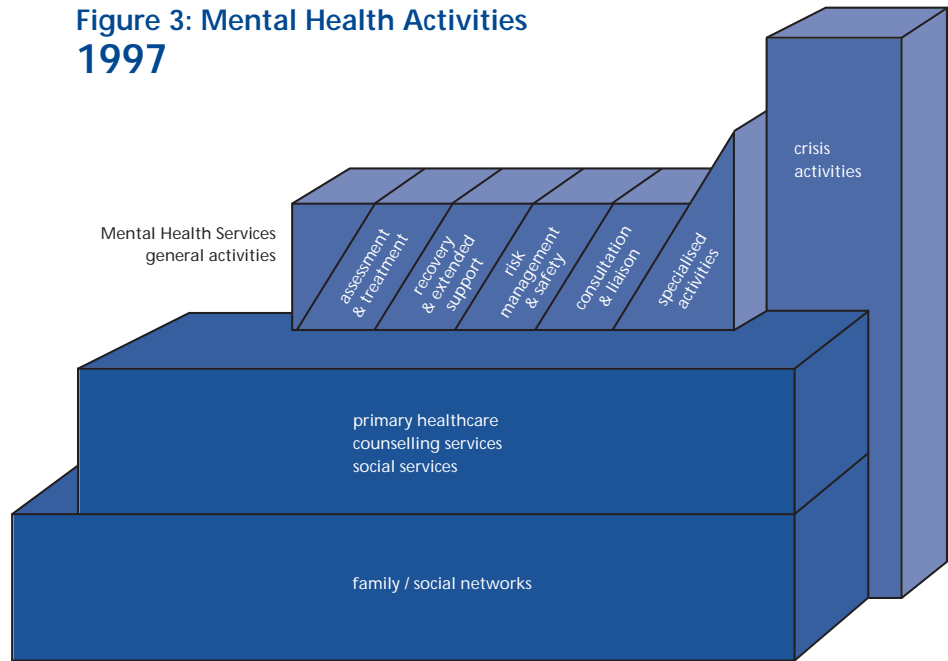
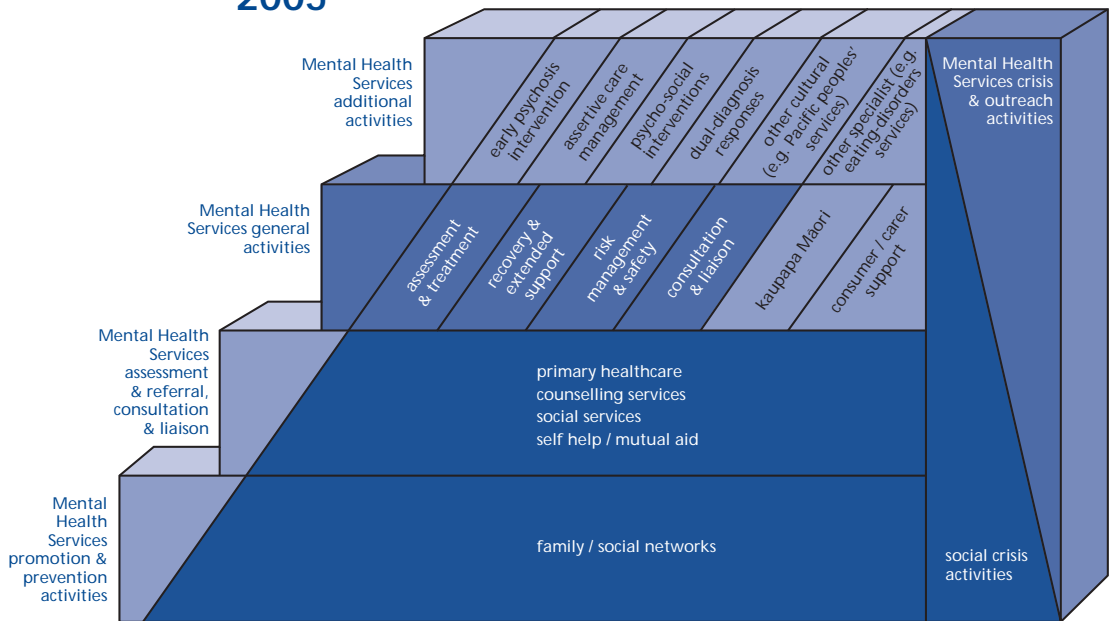


Figure 4: Mental Health Activities 2005



Note: Mental Health Services' activities apply to all client groups (adult, children and youth, older adults, Maori, Pacific people) and to all mental health settings (e.g. forensic, drug and alcohol services, hospital, home).

MOVING FORWARD: FIRST STEPS

The “first steps” in the National Mental Health Plan are high-priority national objectives which can be achieved within existing resources. The Government has recently provided additional funding to improve the ability of the sector to achieve these objectives.

The national objectives are organised under seven strategic directions. These strategic directions consist of the five in *Looking Forward*, plus two new strategic directions. The two new strategic directions reflect the importance of infrastructural development in supporting more and better services, and the need to start addressing promotion and prevention issues.

Targets have been set under these national objectives. These targets are national targets, and the regional plans that will be prepared by the funding/purchasing body in 1997/98 are expected to show the extent to which the targets can be achieved at a regional level within available resources.

These targets can be used by the Government in a number of ways to ensure accountability for achieving key priorities in mental health. The Government may select key targets to negotiate with the funding/purchasing body, and hold it accountable (through its annual statement of intent) for achieving these targets. The Government may also require the Ministry of Health to meet some of the targets via its work programme; and it may require other targets to be addressed through CHEs’ business plans. In addition, the targets may assist the Mental Health Commission as a means of evaluating how well the *Looking Forward* strategy is being implemented.

Some of the national objectives do not yet have targets – this is usually because the information which will be used to construct the targets is not yet available. But there are specific dates by which targets for the objective must be set, and these are indicated in the commentary.

Strategic Direction 1: **More Mental Health Services**

This is *Looking Forward's* Strategic Direction 1: "Implementing Community-Based and Comprehensive Mental Health Services".

There is one national objective in the "first steps" of this strategic direction.

National Objective 1.1:

To increase and maintain mental health services to benchmark levels for adults and children/young people – that is:

- **3% of the adult population have access to adult/general mental health services in any one month**
- **5% of children and young people have access to children's and young people's specialist mental health services in any one month.**

The Government is committed to a community-based model for mental health services, backed up with sufficient hospital services for acute and secure care.

Although there has been a significant increase in service provision in community settings in recent years, there are still gaps. The first priority of the National Mental Health Strategy has been to address these gaps for adult services and for children's and young people's services. Funding and purchasing decisions have been focused on increasing the level of services for these groups. The intention is to have adequate levels of adult services in place by the year 2001, with adequate levels of children's and young people's services by the year 2005. (A longer lead-time is needed to address the gap in children's and young people's services.)

In *Looking Forward* a national adult-population "benchmark" for mental health services coverage was set, at 3%. Input benchmarks (for hospital services, community residential services and community services) were also set. These input benchmarks have been used to establish the level of resources needed for delivering services to 3% of the adult population.

The 3% adult-population benchmark is being reviewed in 1997, and it will continue to be reviewed as part of the monitoring of the National Mental Health Strategy. The 1997 review involves both an update and a refinement of the benchmarking process. In particular, it will look at the resource implications of taking a needs-based approach to the delivery of mental health services. (A description of the needs "groups" and the types of services or activities that are appropriate for these groups can be found in Appendix 4.)

In 1996, a national benchmark of 5% was set for mental health services coverage of children and young people. The resourcing needed to meet this benchmark was also identified. Included in the resourcing is a specific consultation-liaison function with other agencies and providers such as the CYPFS (the Children, Young Persons and their Families Service), schools, general practitioners, and adult mental health services.

It should be remembered that who uses what services is not always clear-cut. Children and young people in crisis may need to access adult crisis services, which will have advice and backup from children's and young people's services. Young people may use adult mental health services or they may use children's and young people's services – it depends what is more appropriate to their needs. Likewise, older people may use psychogeriatric services.

TARGET 1.1.1

*By 30 September 1997, the funding/purchasing body will notify **the percentage of the adult population who accessed adult/general mental health services in any one month**, using agreed nationally consistent definitions. This percentage will become “the baseline” for future planning purposes.*

TARGET 1.1.2

*By 31 March 1998, the regional plans of the funding/purchasing body will demonstrate, for each of the three years from 1998/99 to 2000/01, **the amount of annual increase above the baseline that is planned for access to adult/general mental health services to achieve Objective 1.1.***

The national benchmarks mentioned in the Plan – such as the 3% for adults and the 5% for children and young people – are not necessarily valid for deciding local service configurations and resourcing. There are different needs and differences in access to mental health services around the country. This is why the funding/purchasing body is being asked to prepare regional plans which translate national targets into specific services that meet local and regional needs.

After the current baseline for access to adult general and children’s and young people’s specialists mental health services is more accurately known, milestones towards achieving the objective will be set.

TARGET 1.1.3

*By 30 September 1997, the funding/purchasing body will notify **the percentage of children and young people who accessed children’s and young people’s specialist mental health services in any one month**, using agreed nationally consistent definitions. This percentage will become “the baseline” for future planning purposes.*

TARGET 1.1.4

*By 31 March 1998, the regional plans of the funding/purchasing body will demonstrate, for each of the three years from 1998/99 to 2000/01, **the amount of annual increase above the baseline that is planned for access to children’s and young people’s specialist mental health services to achieve Objective 1.1.***

Historically, mental health services for children and young people have been under-resourced in comparison with adult services. This has happened despite the fact that this group accounts for approximately 30% of the population and has mental health problems that can have a major impact on the community.

Intensive adolescent programmes (such as day programmes) need to be provided, as an adjunct to community teams. The number of additional inpatient services, if any, also needs to be assessed.

Services provided will be expanded to ensure that the full range of children’s and young people’s mental health needs are catered for. This will include:

- consultation and liaison services with other agencies
- mental health assessment, diagnosis and treatment
- advice and backup to mental health crisis services on a 24-hour basis
- specialist treatment services (for example, for early psychosis and eating disorders)
- day programmes

- respite options for children and young people with severe mental health problems who are in crisis
- safe, age-appropriate inpatient services
- supported accommodation for young people who are unable to live with their parents.

Strategic Direction 2: **More and Better Services for Māori**

This is *Looking Forward's* Strategic Direction 2: "Encouraging Māori Involvement in Planning, Developing and Delivering Mental Health Services".

There are two national objectives in the "first steps" of this strategic direction. These are:

- To encourage Māori involvement in planning, developing and delivering mental health services. (National Objective 2.1).
- To increase the responsiveness of mainstream mental health services to the special needs of Māori. (National Objective 2.2).

(The issues of Māori provider and workforce development are addressed under Strategic Direction 6 of *Moving Forward* – see National Objective 6.1 on page 31 and National Objective 6.4 on page 46.)

National Objective 2.1:

To encourage Māori involvement in planning, developing and delivering mental health services.

It is essential that mental health services (which in the past have operated in a predominantly monocultural manner) have the ability to develop services that are sensitive to the cultural, physical and emotional needs of Māori. This can only be done by ensuring the active involvement of Māori in the first stages of service development and at all stages of service delivery.

TARGET 2.1.1

By July 1998, the planning processes of the funding/purchasing body will involve Māori, and the plans themselves will include specific undertakings to increase Māori involvement in the design and purchasing of services appropriate to Māori needs.

The funding/purchasing body will need to involve Māori in the development of its regional plans. It will also need to show, in those plans, how it will increase the number of programmes designed by Māori and the number of programmes delivered by Māori.

National Objective 2.2:

To increase the responsiveness of mainstream mental health services to the special needs of Māori.

Evidence has shown that over the last 30 years, admission and re-admission rates for Māori have increased dramatically while rates for non-Māori have remained static or declined. As well, because of the severity of illness at the time of admission, Māori are more likely to be admitted at the instigation of a welfare or justice agency – and when this happens, the admission is to a mainstream service.

Although some mainstream services have tried to take the needs of Māori into consideration, many remain monocultural in their actions and in their ways of dealing

with Māori consumers. The difficulty that mainstream services have in responding to Māori is reflected in the short stay and high re-admission rates for Māori.

So to achieve National Objective 2.2, mainstream services need to respond to the needs of Māori in a proactive and positive way. They need to focus on providing services to Māori in a way which aims to reduce the re-admission rate as well as reducing the severity of illness. Approaches that could be encouraged include joint initiatives with Māori community providers, appropriate cultural assessments and follow-up processes, and appropriate staff-awareness training.

TARGET 2.2.1

*By July 1999, all mental health services will be using **cultural assessment procedures** for Māori consumers.*

The use of cultural assessment procedures allows consumers whose cultural background is different from that of the majority population to be adequately assessed. The use of such assessment procedures makes sure that cultural beliefs and practices that can have an impact upon diagnosis and treatment are not ignored.

Māori consumers must be given the option of being culturally assessed before any other assessment is undertaken. Cultural assessment also needs to occur at varying stages of treatment and therapy, as consumers' perceptions of themselves and their world adjust and change.

Both Lakeland Health's Māori mental health team and Auckland's Mason Clinic are successfully using cultural assessment procedures. As well, the Ministry is developing a set of agreed procedures for use by providers.

TARGET 2.2.2

*By July 2000, all mental health services will be operating under **cultural effectiveness protocols**.*

Outcome measures are one of the most significant means by which the effectiveness of a service to meet the cultural needs of consumers can be ascertained.

The Ministry of Health has commissioned Professor Mason Durie to develop a cultural effectiveness tool that will assist services to measure effectiveness by outcome.

Strategic Direction 3: **Better Mental Health Services**

This is Strategic Direction 3: “Improving the Quality of Care” in *Looking Forward*.

There are seven national objectives in the “first steps” of this strategic direction. These are:

- To improve the delivery of mental health services for children and young people with moderate and severe mental health problems. (National Objective 3.1)
- To improve responsiveness of mental health services to consumers. (National Objective 3.2)
- To improve responsiveness of mental health services to families and caregivers. (National Objective 3.3)
- To implement, throughout mental health services, best practice and continuous quality improvement that is consistent with the National Mental Health Standards. (National Objective 3.4)
- To have an identifiable individual or agency responsible for co-ordinating individualised care, with priority given to people with high support needs. (National Objective 3.5)
- To prescribe new anti-psychotic medications to people who are newly presenting or who can benefit most from changing from older-style anti-psychotic medications (including those who currently suffer intolerable side-effects). (National Objective 3.6)
- To improve responsiveness and effectiveness of services for people who have both a severe mental illness and a drug or alcohol disorder. (National Objective 3.7)

National Objective 3.1:

To improve the delivery of mental health services for children and young people with moderate and severe mental health problems.

Many severe mental health problems have their genesis in childhood or early adolescence – and so early identification and treatment may prevent chronic problems in adulthood.

Service delivery for children and young people differs from that for adults. Children and young people present different patterns and types of mental health problems and require consideration of their developmental needs and the family context in which they are being treated.

Services will be improved by:

- increased emphasis on mental health consultation and liaison services
- provision of youth specialist services for older adolescents
- the ability to respond in a timely way to young people who are presenting with psychotic illnesses, so that these illnesses can be treated appropriately as soon as possible
- services being provided in a culturally appropriate context

- increasing accessibility of services for young people by creating appropriate treatment environments for them
- increasing training for new and current staff, to improve the quality of service delivery.

The needs of children often embrace a number of sectors and services – and so “better” mental health services will also require major intersectoral collaboration. (This is dealt with under Strategic Direction 6 – see National Objective 6.3 on page 33.)

TARGET 3.1.1

*By July 1998, a blueprint defining the **parameters of specialist mental health service provision for children and young people** will be developed.*

This blueprint for children’s and young people’s services is being prepared by the Ministry of Health, in collaboration with the sector. It links closely with the blueprint being developed by the Mental Health Commission, and will focus on the provision of specialist mental health services within the overall context of children’s and young people’s mental health.

The blueprint for children’s and young people’s services will define the range of specialist services needed, specify the tasks of these services and their relationships both to one another and to non-specialist services, and identify their workforce needs.

National Objective 3.2:

To improve responsiveness of mental health services to consumers.

The main area where service responsiveness and quality improvements in mental health can be achieved is through increasing involvement of consumers in all aspects of the sector – planning, policy, purchasing and provision.

TARGET 3.2.1

*By July 1998, there will be specific **undertakings to actively involve consumers in regional planning and in the design and purchase of mental health services.***

TARGET 3.2.2

*By July 1998, all contracted providers will demonstrate **involvement and participation of consumers** including, for major providers, employment of consumers (or will have a process in place to achieve it by 1999).*

TARGET 3.2.3

*By July 1998, the Ministry of Health will demonstrate that **consumers are appropriately involved in national planning and policy development.***

Over the life of the National Mental Health Plan, groups of individual consumers are likely to consolidate their networks, become more representative of consumers overall, and further develop their skills and knowledge base. It is also expected that more consumers will gain employment in various capacities in the mental health sector. As well, implementation of the National Mental Health Standards will mean increased involvement by consumers. There needs to be more training, to better support consumers in all these activities.

The *Guide to Effective Consumer Participation in Mental Health Services*, produced by the Ministry of Health, needs to be more actively used by everyone involved in mental

health. (The *Guide* will be reviewed from time to time, to keep up to date with the needs of consumers and with modern approaches to mental health.)

An increase in consumer responsiveness also calls for the development and trialling of consumer outcome measures. Specific targets about improved quality of life or other outcome measures have not been included in the National Mental Health Plan at this stage, because it is not yet clear when such measures will be available in a form that can be used generally in mental health services.

National Objective 3.3:

To improve responsiveness of mental health services to families and caregivers.

TARGET 3.3.1

*By July 1998, the funding/purchasing body will be monitoring contracted providers to see that the providers have processes for **informing and involving caregivers.***

Families and caregivers ask principally that they be listened to, at an individual level. They are also seeking more influence over how mental health services develop. In particular they seek access to the information they need, to enable them to participate positively in treatment and support planning.

For caregivers, “better services” means services that use best practice methods (which involve the family), and better co-ordination of care. Where there is good co-ordination of care, caregivers are kept appropriately informed and involved, even when the type or location of services is changing for their relative or friend.

The implementation of the National Mental Health Standards will also be important in ensuring that caregivers and families are informed and involved.

National Objective 3.4:

To implement, throughout mental health services, best practice and continuous quality improvement that is consistent with the National Mental Health Standards.

Providers need to regularly assess their achievements and outcomes to improve performance. The National Mental Health Standards (which have been developed by the Ministry of Health during 1997, in consultation with the sector) provide a framework for this assessment, by focusing on how the processes of care are organised. The processes of care include access, entry, assessment, care planning, care implementation, care evaluation, discharge, and community support/followup. It is essential that each part of a service, clinical and non-clinical, considers its performance against all relevant standards and criteria. Each part of the service needs to consider:

- how it contributes to consumer care
- how well it is led and managed
- how safe its environment and practices are
- what it is doing to improve its performance and to rectify any difficulties being experienced.

The National Mental Health Standards will be introduced across the mental health sector in 1997. They will be monitored closely in selected sites during 1997/98, and will be further refined in response to that monitoring.

TARGET 3.4.1

By July 1999, the funding/purchasing body's contracts with providers will include the National Mental Health Standards; and, by July 2000, providers will be required to provide evidence of achieving these standards.

Since not all providers will be in a position to comply completely with the National Mental Health Standards from the time of their introduction, the timeframe for compliance will need to be negotiated on a case-by-case basis.

A self-assessment (completed by providers) will establish valuable baseline data that will be the starting point for further improvements in delivery of consumer care.

The National Mental Health Standards will be reviewed every five years to ensure they remain current and appropriate.

National Objective 3.5:

To have an identifiable individual or agency responsible for co-ordinating individualised care, with priority given to people with high support needs.

This national objective exists to ensure that consumers – particularly those with high support needs – have care, treatment and support that is characterised by:

- access to appropriate types of services, support, care and treatment
- provision of continuous and co-ordinated care by a range of service providers in a range of settings
- access to specialised mental health services that can meet their specific needs (including cultural needs) during the onset, acute, and recovery phases of their changed status
- care, support and treatment that is individualised and that meets the unique needs of the individual consumer.

TARGET 3.5.1

By July 1998, the funding/purchasing body will purchase from providers a process for identifying all individuals with high support needs.

TARGET 3.5.2

By July 2000, all care, treatment and support for people with high support needs will be co-ordinated by a designated case manager/care co-ordinator.

National Objective 3.6:

To prescribe new anti-psychotic medications to people who are newly presenting or who can benefit most from changing from older-style anti-psychotic medications (including those who currently suffer intolerable side-effects).

About 12,000 people in New Zealand are on anti-psychotic medications. Most are taking older-style drugs, which have unpleasant side-effects for all people and are ineffective for up to 30% of the people who take them. New products have become available in New Zealand (specifically clozapine and risperidone), and other products are likely to become available within the next few years.

Clozapine is an effective drug for up to 70% of people with schizophrenia whose condition is resistant to treatment with other drugs. Its benefits can be considerable, but there is a potentially fatal side-effect in about 1% of recipients which can be prevented by

careful monitoring. Prescription of clozapine therefore needs close supervision and monitoring, including blood monitoring, and must be carried out according to strict protocols.

Risperidone is considered by Pharmac as suitable for the following groups of people:

- patients with marked side-effects who have been trialled with an effective dose of one other anti-psychotic
- patients who are intolerant of other anti-psychotics and are unwilling to continue on anti-psychotic therapy
- patients presenting with marked and disabling negative symptoms of schizophrenia and newly presenting young males (under 25 years old)
- patients who have previously shown poor response to an effective dose of one other anti-psychotic
- all newly presenting cases of schizophrenia.

In 1996, resource needs for new anti-psychotic medications were calculated on the basis that, by the year 2001, new anti-psychotics such as risperidone will be prescribed throughout New Zealand as a first-line treatment.

TARGET 3.6.1

By July 2000, all those for whom clozapine is clinically indicated will be prescribed it and will be monitored according to protocols.

TARGET 3.6.2

By July 2001, all people meeting the criteria set out on Pharmac's priority list will be prescribed risperidone, or an equivalent new anti-psychotic medication, as a first-line treatment.

It is possible that the advent of new anti-psychotic medication may replace the expected total need for clozapine. If this happens, Target 3.6.1 will be revised accordingly.

National Objective 3.7:

To improve responsiveness and effectiveness of services for people with both a severe mental illness and a drug or alcohol disorder.

In many parts of New Zealand, drug and alcohol services have developed quite separately from other mental health services. The two types of services have often focused on the differences in their roles and their consumer groups, rather than on the similarities in the needs of their consumers. They have tended to focus rather narrowly on what they see as their areas of expertise, rather than sharing their knowledge and experience more widely.

As a result, a sizeable group of consumers who have both serious mental illnesses and drug or alcohol disorders have tended to “fall between the cracks” or have not received adequate treatment from the particular service to which they were admitted. Neither type of service has considered it their role to deal with all the needs of this consumer group, and so the skills to do so have not been developed. Since mental illness and drug and alcohol disorders have a compounding effect on each other, people with both have tended to be regarded as “difficult” or “problem” consumers.

More recently, there has been a move – internationally as well as in New Zealand – to utilise the skills and experience of both the mental health and the drug and alcohol workforces and so develop services specifically designed to meet the needs of people who have both a severe mental illness and a drug or alcohol disorder.

TARGET 3.7.1

By July 1999, specific services for people with both a severe mental illnesses and a drug or alcohol disorder will be available in each major centre.

TARGET 3.7.2

By July 1999, training in assessment and management of drug and alcohol disorders will be provided in each major centre for mental health service clinical staff.

TARGET 3.7.3

By July 2000, training in assessment and management of mental illness will be provided in each major centre for drug and alcohol service clinical staff.

TARGET 3.7.4

*By July 2000, the funding/purchasing body will include, in all contracts for mental health services and drug and alcohol services, specific provisions for a **comprehensive assessment of people in either service and for improving liaison and co-ordination between these services.***

Effective services for this group are starting to emerge. There is a great need to share experience and to adopt effective models of service provision and service co-ordination and liaison. Training programmes must be developed to upskill clinical staff in both types of service, so that they are equipped to meet the needs of their consumer group.

The guidelines for the assessment and management of people with both a severe mental illness and a drug or alcohol disorder are being revised during 1997. This revision is a joint initiative by the Mental Health Commission, the Alcohol Advisory Council, and the Ministry of Health.

Strategic Direction 4: **Balancing Personal Rights with Protection of the Public**

This is Strategic Direction 4: from *Looking Forward*.

There is one national objective in the “first steps” of this strategic direction.

National Objective 4.1:

To maintain a balance between:

- **mental health and criminal justice legislation which imposes compulsory treatment and restriction of normal liberties on mentally disordered individuals**
- **the usual rights and freedoms of the individual**
and
- **the public interest, in particular the safety of the public.**

The objective of balancing the personal rights of the mental health consumer with the protection of the public can be achieved in a number of ways.

For example, it is important to ensure that all mental health services are of high quality – which also includes having an appropriately skilled workforce. However carefully thresholds and systems are defined in legislation, their application depends entirely on the expertise of the clinicians responsible for assessment and treatment. So clinicians must be familiar with current legislation and its application, and must be able to accurately assess the risks arising from mental disorders.

Ongoing review of the legislation that imposes compulsory treatment on those who are mentally disordered and restricts their liberties is also necessary. Some mental disorders affect individuals’ perception or judgement – and so there are times when individuals may be ill and at risk of not being able to look after themselves, or of harming themselves or other people, without understanding the risk and being able to seek the help that is needed.

Mental health legislation already provides for compulsory assessment and treatment in such circumstances. It legally defines what “mental disorder” is; how severe this needs to be before there is a compulsory intervention; and who is empowered to make these decisions. It also sets up systems and processes so that compulsory assessment and treatment is used only when needed and is properly carried out. These ensure that the normal rights and freedoms of the individual are limited only to the extent that is absolutely necessary.

Setting the threshold for compulsory intervention is complex, and it must be constantly reviewed in the light of changes in clinical knowledge and in the social and ethical climate. The current Mental Health Act – which has been in force since 1992 – is generally considered to have achieved a reasonable balance between the rights of the individual and the requirement to impose compulsory treatment. Regular review of the Act ensures that such a reasonable balance continues. (Where appropriate, this review takes into account Part VII of the Criminal Justice Act 1985, which deals with mentally disordered offenders.)

A further step in achieving National Objective 4.1 is through maintaining a comprehensive national system of forensic psychiatric services. Forensic services provide assessment, treatment and secure care for those who offend as a result of mental disorder. They also provide expertise in assessing the risk of someone being likely to harm

themselves or other people. So an effective forensic service interacts closely with the courts and the corrections system, and has a key function in balancing personal rights and the protection of the public.

It must be remembered that the rights and freedoms of those mental health consumers who are not subject to compulsory assessment and treatment also need to be protected. This can be done by ensuring that they do not suffer discrimination in their everyday lives. Existing legal protection – notably under the Human Rights Act 1993, the Privacy Act 1993, and the Health and Disability Commissioner Act 1994 – provides legal means for affirming the rights of mental health consumers as members of the community.

TARGET 4.1.1

*By July 1999, the funding/purchasing body will specify, in its contracts with specialist mental health services, that all **individuals** assessed and treated by the service will have **risk assessment** and that all **providers** responsible for risk assessment will have **comprehensive risk-assessment protocols**.*

TARGET 4.1.2

*By July 1999, the funding/purchasing body will require that providers responsible for risk assessment can demonstrate that **staff have undertaken training in risk assessment and, where necessary, refresher programmes**.*

Strategic Direction 5: **Developing and Implementing the National Drug Policy**

This is Strategic Direction 5: “Developing a National Alcohol and Drugs Policy” in *Looking Forward*.

There is one national objective in the “first steps” of this strategic direction.

National Objective 5.1:

To minimise harm caused by tobacco, alcohol and other drug use to both individuals and the community.

Part 1 of the Government’s National Drug Policy – which covers tobacco and alcohol – was released in 1996. Part 2 deals with other types of drugs; it is expected to be released in 1997.

Overall, the National Drug Policy sets out the key directions for decreasing the prevalence of drug problems in New Zealand and for reducing the impact of these problems. Under Part 1 of the Policy, the priorities for action during the first five years are:

- to enable New Zealanders to increase control over and improve their health by limiting the harm and hazards of tobacco, alcohol and other drug use
- to reduce the prevalence of tobacco smoking and exposure to environmental tobacco smoke
- to reduce hazardous and excessive consumption of alcohol, and the associated injury, violence and other harm, particularly on roads, in the workplace, in and around drinking environments, and at home.

The expected priorities for Part 2 are:

- to reduce the prevalence of cannabis use and use of other illicit drugs
- to reduce the health risks, crime and social disruption associated with the use of illicit drugs and other drugs inappropriately used.

In focusing on the harm caused by tobacco, alcohol and other drug use (rather than simply on the quantities used) this policy firmly states the Government’s intention to direct its efforts where harm can be best prevented or reduced. In developing this policy, the Government has recognised that simply improving health services is likely to have a limited impact overall. A much wider range of strategies, incorporating the work of many different government and non-government agencies, is needed to achieve the levels of improvement desired. The policy is therefore an intersectoral policy which relies on the efforts of many different agencies.

The implementation of the National Drug Policy will be overseen by a Ministerial Committee. A monitoring group of officials will develop an intersectoral work programme and develop measurable outcomes against which the impact of strategies may be assessed. The responsibility for determining the best strategies for reducing harm and how they should be implemented lies with each government agency. The strategies will encompass the following:

- information, research and evaluation
- health promotion
- assessment, advice and treatment services
- law enforcement
- policy and legislative development.

The National Drug Policy sets an overall direction and provides a framework for resource allocation and co-ordination among government agencies. However, the successful development and implementation of best practice strategies will often involve non-government agencies. They will be encouraged to participate in the development and implementation of strategies, where it is appropriate. Much work has already been done by government agencies in establishing targets and identifying strategies. The National Drug Policy builds on this work by ensuring that the strategies are implemented and by developing targets and best practice strategies where needed.

TARGET 5.1.1

*By July 1998, an **intersectoral work programme** will have been agreed by all relevant government agencies. This intersectoral work programme will include strategies to advance the National Drug Policy's desired outcomes (including appropriate outcomes, targets and strategies for Māori).*

Strategic Direction 6:

Developing the Mental Health Services Infrastructure

This is an additional strategic direction. It covers the “infrastructure” necessary for delivering more and better services – elements such as workforce development, data collection and analysis, and co-ordination between services. In *Looking Forward*, these elements were seen as part of Strategic Direction 3 “Improving the Quality of Care”. In the three years since the release of *Looking Forward*, they have become recognised as important enough and complex enough to warrant a separate strategic direction of their own.

There are three national objectives in the “first steps” of this strategic direction. These are:

- To ensure all mental health services employ sufficient staff with the necessary knowledge and skills to deliver essential services to their identified target groups in the mental health sector. (National Objective 6.1)
- To improve the accuracy, timeliness and appropriateness of mental health data collection, in order to help monitor the achievement of a number of targets in the National Mental Health Plan. (National Objective 6.2)
- To promote co-ordination among all agencies associated with mental health services and to ensure that clear lines of accountability exist. (National Objective 6.3)

National Objective 6.1:

To ensure all mental health services employ sufficient staff with the necessary knowledge and skills to deliver essential services to their identified target groups in the mental health sector.

Workforce development has been neglected over many years in the development of mental health services, with major deficiencies in skills acknowledged in the mental health workforce. One particular priority is education and training for community mental health support workers. Ongoing skills development for traditionally trained workers such as nurses, occupational therapists, social workers, psychologists and psychiatrists is also necessary. Deficiencies have arisen from historical neglect in part, but also from the total reconfiguration of mental health services over the last 10 to 20 years.

Another priority is skills development for staff who work with children and young people. The diverse needs of Māori and Pacific consumers also necessitate specific skill development and training for staff who work with them.

There is an urgent need for upskilling, generally, in drug and alcohol services. As well, postgraduate specialist training in drug and alcohol treatment is required.

Providers of mental health services have a direct responsibility for the recruitment and retention of a workforce that has relevant knowledge and skills. Formal and informal supervision – a responsibility of all providers – should be evident in all mental health services.

TARGET 6.1.1

*By July 1999, the funding/purchasing body will have required, in its contracts with providers, **workforce development plans** that address recruitment, retention and training issues to ensure the mix of skills required for providers' services over a 5-year period and on a year-by-year basis.*

The funding/purchasing body will ensure that providers address the skill mix that the workforce requires for providing the core functions of the mental health services.

TARGET 6.1.2

*By July 2001, **education and training** for the mental health workforce will be **consistent across New Zealand**.*

Currently, education and training for the mental health workforce is not consistent across New Zealand. Geographic access and course content vary, and qualifications gained in one part of the country are not always recognised in other areas.

Education and training needs to be more nationally consistent – so that qualifications are transferable, access is more equitable, and content reflects identified and proven need. This can be achieved through the development of a three-way partnership between mental health service providers, education providers, and the funding/purchasing body.

TARGET 6.1.3

*By July 2001, **post-entry and postgraduate clinical needs** will be addressed through purchasing of training by the Clinical Training Agency.*

The Ministry of Health has agreed with the Clinical Training Agency on requirements for reprioritising and increasing mental health training programmes for various workforce groups – in particular, for staff working with children and young people and for staff working with people who have both a severe mental illness and a drug or alcohol disorder.

National Objective 6.2:

To improve the accuracy, timeliness and appropriateness of mental health data collection, in order to help monitor the achievement of a number of targets in the National Mental Health Plan.

Information currently being obtained is limited in terms of both accuracy and coverage, and is generally about three years out of date.

The aims of this national objective are: to collect national data on services in ways that are consumer-based, flexible, timely and accurate; and to allow access to the information derived from the data at agreed levels of security.

TARGET 6.2.1

*By July 2000, there will be a **national mental health data-collection process** which:*

- *provides accurate and timely information that can be used to help monitor a number of targets in the National Mental Health Plan*
- *includes mental health and drug and alcohol data collection.*

Pilot data collection projects are being set up in the 1996/97 year. These will demonstrate whether national mental health data collection is feasible. They will also provide accurate costs for the implementation of a such a data-collection system, and an estimate of costs for the ongoing collection of mental health data.

If the pilot projects show that the implementation is too costly, options for alternative ways of getting accurate information to inform the strategy will need to be explored.

National Objective 6.3:

To promote co-ordination among all agencies associated with mental health services and to ensure that clear lines of accountability exist.

This objective is concerned with the co-ordination of agencies within the mental health sector, and co-ordination outside the sector. Co-ordination of services at an individual consumer level is dealt with under National Objective 3.5 (see page 24).

TARGET 6.3.1

By July 1998, the funding/purchasing body will purchase specific mechanisms to address the interface between CHE mental health services and other mental health services, and will monitor their implementation.

Within the mental health sector, co-ordination can be promoted by improving relationships between agencies. National Objective 1.3 in “next steps” (see page 38) will go some way towards improving co-ordination between specialist mental health services and primary healthcare providers, by requiring consultation-liaison from the specialist service. But there need to be processes and/or forums for improving relationships overall at regional and subregional levels. There also need to be specific accountabilities, to ensure that such improvements happen.

TARGET 6.3.2

By July 1998, all Ministry of Health protocol development and review will reflect intersectoral consultation and co-ordination.

Initially, sector-to-sector co-ordination usually involves central protocol or guideline development (which is subject to regular review).

Guidelines and a Memorandum of Understanding have been developed to improve service co-ordination between the health, education and welfare sectors, for children and young people with mental health problems. A commitment to the implementation of these guidelines is being sought. This will require services to develop their own local protocols.

Memorandums of Understanding have also been agreed between the Ministry of Health and the Police, and the Ministry of Health and the Ministry of Justice.

(The National Drug Policy – which represents another type of intersectoral co-ordination – is outlined under Strategic Direction 5, in National Objective 5.1 on page 29.)

Strategic Direction 7: Strengthening Promotion and Prevention

This is an additional strategic direction.

The focus of *Looking Forward* was on having more and better services as part of making progress towards Goal 2 of the National Mental Health Strategy. More and better services continues to be the main focus of *Moving Forward*, but it also begins to place more emphasis on the strengthening of promotion and prevention, as part of making progress towards Goal 1 as well as Goal 2. (The goals are stated in full in Appendix 1.)

Secondary prevention programmes that focus on early detection, counselling, treatment, and support are essential for reducing the incidence and prevalence of mental disorders.

While there is as yet little evidence on the efficacy of population-based primary prevention for adults, there *is* evidence to support promotion and primary prevention programmes for children and young people and their families who may be at risk because of adverse conditions. There is also evidence to support targeted programmes for adults who may be at risk because of adverse conditions.

There are two national objectives in the “first steps” of this strategic direction. These are:

- To increase public knowledge and awareness of mental health issues in order to:
 - create a more supportive environment for people living with a mental illness
 - help remove the barrier of discrimination and stigma that stops people seeking early assistance and support. (National Objective 7.1)
- To improve the mental health of young people, including the prevention of suicide. (National Objective 7.2)

(Promotion and prevention strategies focusing on drug-related problems and disorders will be developed under the National Drug Policy, which can be found under Strategic Direction 5 on pages 29 to 30.)

National Objective 7.1:

To increase public knowledge and awareness of mental health issues in order to:

- **create a more supportive environment for people living with a mental illness**
- **help remove the barrier of discrimination and stigma that stops people seeking early assistance and support.**

New Zealand research into public knowledge and awareness of mental health issues has confirmed that there are many negative attitudes and misconceptions. The research reveals:

- low levels of knowledge about mental illness
- perceptions that people with mental illness are violent, dangerous, and unpredictable
- substantial concerns about people with a mental illness living nearby, with feelings of unease arising from lack of understanding rather than fear.

However, the research has also shown that the public is keen to know more about mental illness, and there is real potential for public education to change attitudes. In particular, there is potential to build on the less authoritarian views of younger people, and on the views of the 60% of the public who have had a mental illness themselves or know someone who has.

In order to create a more supportive environment for people who have or have had a mental illness, the funding/purchasing body will purchase community-based programmes that address negative attitudes, stigma and discrimination. These will include programmes for Māori and for Pacific people. Their focus will be on key groups and opinion leaders – social service agencies, the health workforce, employers, local media, councillors and community workers. This may be supported by a media campaign.

There are currently no targets developed for this objective. However, *by July 1998, the process and outcome targets for the increase of public knowledge and awareness of mental health issues will be set. These targets will be based on information from the baseline research and programme development in 1997.*

Baseline research into public attitudes was conducted in June 1997, and this will be used to set targets. Because there are other variables – such as negatively-publicised incidents – which influence attitudes in a small country like New Zealand, targets are likely to be framed in terms of improvement in attitudes over a five- to ten-year period rather than changes from year to year.

National Objective 7.2:

To improve the mental health of young people, including the prevention of suicide.

The mental health of young people has been described as being increasingly vulnerable. Suicide and suicidal behaviours are one indicator of the level of distress of young people, and the last two decades have seen the rate of youth suicide (15 to 24 years old) in New Zealand escalate greatly. Young men have a significantly higher rate of successful suicides than females, accounting for 80% of all suicides. (Young women have a higher rate of serious attempt at suicide, which result in harm but not death.) Given the complexity of factors which lead to suicidal behaviour, prevention strategies require a multi-sectoral and multi-dimensional approach.

Mental health problems (especially affective disorders, substance-use disorders and antisocial-behaviour disorders) are a key risk factor for suicide. So it is important that all levels of health services are equipped and committed to improving the mental health of young people. More attention needs to be given to reducing the prevalence of risk factors associated with youth suicide through promoting the well-being of young people, their families/whanau, and their communities. We also need to do more to identify and effectively assist young people (including young Māori people) who are exhibiting behaviours associated with suicide, and to provide effective support and treatment to those who have attempted suicide or who are suicidal.

Other sectors too have an important role to play in the identification, management, and referral of emotionally distressed young people, and in the prevention of suicide. The Ministry of Education and the Department of Social Welfare are two key agencies currently developing guidelines for suicide prevention for use in their respective sectors.

Provisional/interim targets for this objective are contained in the report *Youth Mental Health Promotion Including Suicide Prevention*, which was published by the Ministry of Health in 1996. These targets are being revised; and the revised targets will form part of the draft National Youth Suicide Prevention Strategy, which is due to be completed in 1997.

The National Youth Suicide Prevention Strategy is currently being developed by the Ministry of Youth Affairs with key input from the Ministry of Health, Te Puni Kōkiri and other government agencies. The strategy will provide guidance for the purchasing and provision of services (including mental health services) for the prevention of suicide. It will also provide a framework for the co-ordination of prevention activities across all relevant sectors at national, regional and local levels.

MOVING FORWARD: NEXT STEPS

The “next steps” in the National Mental Health Plan outline the future priorities for mental health, and the targets here are either actions for the Ministry or priorities for the funding/purchasing body.

To date, these “next steps” have not been explicitly funded. But the funding/purchasing body may still make progress towards achieving them within existing funding – by better utilisation of mental health expenditure, or by reprioritising funds from lower-priority areas of expenditure.

Like “first steps”, the “next steps” have been organised under seven strategic objectives.

Strategic Direction 1: **More Mental Health Services**

There are two “next steps” under this strategic direction. These are:

- To develop benchmarks for levels of service for other consumer groups. (National Objective 1.2)
- To improve access to methadone treatment for people who are opioid dependent. (National Objective 1.3)

National Objective 1.2:

To develop benchmarks for levels of service for other consumer groups.

TARGET 1.2.1

*By July 1998, benchmarks will be developed for **people with drug and alcohol disorders.***

TARGET 1.2.2

*By July 1998, benchmarks will be developed for **forensic service clients.***

TARGET 1.2.3

*By July 1998, benchmarks will be developed for **older people.***

These three groups of people are currently outside the benchmarks (for adults and for children/young people) which have already been established.

Information on epidemiological information and patterns of service use is needed to establish whether these groups need more services. Once the research into this has been completed, specific benchmarks will be set for each group.

National Objective 1.3:

To improve access to methadone treatment for people who are opioid dependent.

Currently, there is poor access to methadone treatment in many parts of New Zealand, with lengthy waiting times for both assessment and treatment. Methadone maintenance treatment is an effective treatment option for the majority of people with opioid dependence. Without treatment, opioid dependence results in considerable suffering and disruption to those affected, their families and the community. It is also associated with major public health risks, especially through the transmission of blood-borne viruses such as hepatitis and HIV.

TARGET 1.3.1

*By July 1999, 80% of **people assessed as requiring methadone treatment** for opioid dependence will be able to access this treatment within two weeks of assessment.*

TARGET 1.3.2

*By July 1999, 50% of **people receiving methadone treatment** will be receiving this treatment through general-practice providers.*

TARGET 1.3.3

*From July 1999, increases in **provision of methadone treatment** to meet demand will occur through the primary health sector.*

Demand for methadone treatment has been rising as this treatment has become more effective and more attractive to those with opioid dependence. To date, it has been provided mostly by specialist clinics, with a growing minority of people having their treatment provided by general practitioners. If most methadone treatment was provided through general practitioners, it would be more accessible to those assessed as requiring it. It would also make methadone treatment more integrated with the provision of other primary healthcare services.

Strategic Direction 2: **More and Better Services for Māori**

There is only one “next step” under this strategic direction.

National Objective 2.3:

To continue to increase responsiveness to the special needs of Māori, by providing access to both kaupapa Māori and mainstream services.

Currently, not all regions provide services at a level that would give Māori an adequate choice between mainstream or kaupapa Māori community mental health services. There is a need for significantly increased purchasing of community mental health services from Māori providers.

TARGET 2.3.1

By July 2005, 50% of Māori adults will have a choice of a mainstream or a kaupapa Māori community support mental health service.

The development of the Māori mental health workforce is included under Strategic Direction 6 of “next steps”, as National Objective 6.4.

Māori mental health promotion and mental illness prevention is included under Strategic Direction 7 of “next steps”, as National Objective 7.6.

Strategic Direction 3: **Better Mental Health Services**

There are three “next steps” under this strategic direction. These are:

- To improve the responsiveness of mental health services to Pacific peoples. (National Objective 3.8)
- To improve the responsiveness of mental health services to refugees. (National Objective 3.9)
- To improve the responsiveness of mental health services to people who are profoundly deaf. (National Objective 3.10)

National Objective 3.8:

To improve the responsiveness of mental health services to Pacific people.

Much needs to be done to improve the responsiveness of mental health services to Pacific people. While there are commonalities among Pacific nations, there is no one Pacific approach to mental health issues. In addition, there is a major shortage of Pacific mental health workers who are comfortable with both Western and traditional approaches, and there is a need for a framework that has the flexibility to deal with knowledge of Pacific people and training needs. Pacific peoples’ views on mental health (both the causes of mental illness and how they can best be addressed) can differ greatly from those of clinical staff. The resulting communication gap between the clinician and Pacific consumer can lead to difficulties in diagnosis and treatment.

The 1995 report *Strategic Directions for Mental Health Services for Pacific Islands People* advised two main strategies:

- changing mainstream services to ensure increasing acceptability, access, understanding, safety and sensitivity
- identifying and developing specific services provided by Pacific Island people for Pacific Island people.

The National Mental Health Standards, released this year, include a specific standard that relates to the cultural needs of Pacific people and sets out criteria for meeting that standard. The standard applies to both mainstream services and Pacific people’s services. The implementation of this standard will be a challenge for mainstream service providers. Mainstream providers who are serving areas of significant Pacific populations need to develop links with Pacific communities.

There are already a number of specific community-based mental health services (including drug and alcohol services) being provided by Pacific people, either as a team within a mainstream service or as an independent service provider.

The development of the Pacific mental health workforce is an important prerequisite for the further development of Pacific people’s services, as well as more responsive mainstream services.

TARGET 3.8.1

*By July 2000, the funding/purchasing body will have **purchased pilot community-based mental health services** for Pacific people in areas of concentrated Pacific populations. These services will be **provided by Pacific people**, either as independent service providers or as teams within mainstream services.*

TARGET 3.8.2

*By July 2000, the funding/purchasing body will have **commenced evaluating the responsiveness of mainstream mental health services to Pacific populations**. This evaluation will be done using the Pacific people component of the National Mental Health Standards or its equivalent.*

The development of the Pacific mental health workforce is included under Strategic Direction 6 of “next steps”, as National Objective 6.5.

Pacific people’s mental health promotion and mental illness prevention is included under Strategic Direction 7 of “next steps”, as National Objective 7.7.

National Objective 3.9:

To improve the responsiveness of mental health services to refugees.

While refugees are a small number within the population overall, there is evidence that their mental health needs are extensive. This is particularly true for refugees with past experience of torture and trauma. Many refugees will not present themselves for assessment and treatment because of uncertainties about authorities and how they will be viewed by their fellow refugees.

Currently, there are mental health services for refugees in Auckland and Wellington. In other areas, general mental health services may need to be used by refugees and their families. While public health nurses are often the link between refugee families and the mental health system, it is difficult to provide effective treatment and support where there is little understanding of the cultural beliefs and practices of the consumer.

Expertise is needed within services to deal with the mental health of refugees in culturally appropriate ways. This can be achieved through the development of guidelines for specific and culturally appropriate mental health services for refugees, which build on the expertise that is already available in the Auckland and Wellington services.

The aim is to develop guidelines nationally, so that all mental health services used by refugees operate under cultural assessment and treatment guidelines.

There are currently no targets developed for this objective.

National Objective 3.10

To improve the responsiveness of mental health services to people who are profoundly deaf.

The proportion of the community who have profound hearing-loss is small. The community of people who are profoundly deaf use sign language as their first language and their main source of communication. They see themselves as a distinct culture, and as experiencing unique pressures that affect their mental health.

A service for profoundly deaf people is being developed in Wellington, to serve people in the central region. There need to be similar services in other regions.

People who are profoundly deaf need access to interpreters, advocates, and staff who are trained to be aware of their needs. Ideally, they should have access to services provided by mental health professionals who can communicate fluently in New Zealand Sign Language.

There are currently no targets developed for this objective.

Strategic Direction 4:

Balancing Personal Rights with Protection of the Public

This strategic direction has no specific objectives and targets within “next steps”. The ongoing review of mental health legislation that provides for compulsory assessment and treatment acts as the “next steps” for this strategic direction. For example, a major review of the Alcoholism and Drug Addiction Act 1966 – which allows for the compulsory assessment and treatment of drug or alcohol disorders – will be undertaken in 1997/98.

(The development of benchmarks for forensic services – which could be seen as a “next step” for this direction – is included under Strategic Direction 1 of “next steps”, as National Objective 1.2 on page 38.)

Strategic Direction 5:

Developing and Implementing the National Drug Policy

This strategic direction has no specific objectives and targets within “next steps” because the intersectoral work programme, outcomes, targets and strategies are still being developed. The “next steps” in this area involve the implementation of the work programme and strategies, and measuring progress towards the targets.

Strategic Direction 6:

Developing the Mental Health Services Infrastructure

There are four “next steps” under this strategic direction. These are:

- To increase the Māori mental health workforce. (National Objective 6.4)
- To increase the Pacific mental health workforce. (National Objective 6.5)
- To improve the skills and competence of the drug and alcohol workforce. (National Objective 6.6)
- To improve the health status of New Zealanders and to enhance the quality of mental health decision-making by providing up-to-date knowledge based on research information. (National Objective 6.7)

National Objective 6.4:

To increase the Māori mental health workforce.

Before culturally appropriate services can be provided by both mainstream and kaupapa Māori mental health services, there must be an increase in the number of trained Māori mental health workers. There also needs to be a better partnership between the education and health sectors, so that training can be specifically targeted to Māori.

TARGET 6.4.1

By July 2005, the Māori mental health workforce (including clinicians) will have increased by 50% from the baseline in 1997/98.

To achieve this, the funding/purchasing body will ensure that providers specifically address workforce development for Māori.

National Objective 6.5:

To increase the Pacific mental health workforce.

Greater attention will need to be given to training Pacific mental health workers – and particularly Pacific mental health community workers – as a means of making mental health services more responsive to the diverse needs of Pacific peoples. To achieve this, the funding/purchasing body will ensure that providers specifically focus on workforce development of Pacific peoples. As well, there needs to be a better partnership between education and health, to improve training and to make it specific to the needs of Pacific peoples.

TARGET 6.5.1

By July 1999, the funding/purchasing body will require, in its contracts with providers, workforce development plans which demonstrate workforce development in services for Pacific peoples.

National Objective 6.6:

To improve the skills and competence of the drug and alcohol workforce.

Until 1996, no specialist postgraduate training in drug and alcohol treatment has been available in New Zealand for clinicians wanting to specialise in this area. Consequently, the skills and knowledge in the drug and alcohol workforce have been under-developed in comparison with other specialist areas. Provision of training opportunities, along with requirements for services to employ staff trained in these areas, are expected to result in the professional development of both those undertaking the training and those who work with them.

TARGET 6.6.1

By July 1999, postgraduate specialty training in drug and alcohol treatment for health professionals will be available in at least two centres, and by distance learning for most parts of New Zealand.

TARGET 6.6.2

By July 2002, 50% of contracted drug and alcohol services which employ clinical staff will include staff members with postgraduate specialty training in drug and alcohol treatment.

National Objective 6.7:

To improve the health status of New Zealanders and to enhance the quality of mental health decision-making by providing up-to-date knowledge based on research information.

The need for more research and development in the mental health sector is being acknowledged by all parts of the sector – by the Mental Health Commission, the funding/purchasing body, the Health Research Council, the Ministry of Health, and a number of CHEs.

TARGET 6.7.1

By July 1998, a mental health research and development strategy will be agreed on by the Ministry of Health and the funding/purchasing body (in consultation with the Health Research Council, the Mental Health Commission and the mental health sector).

This national mental health research and development strategy is currently being developed.

TARGET 6.7.2

By July 2000, there will be a clear process of ongoing research and development in the mental health area, the results of which will be accessible to all levels of the mental health sector.

TARGET 6.7.3

By July 2000, information generated by the research and development programme will be used to inform the National Mental Health Strategy and enhance clinical decision-making at the consumer level.

The Ministry of Health and the funding/purchasing body have already identified particular areas of research and development as high priority. These include research on outcome measures and their appropriateness, validity and reliability (which could lead on to research on best practice in specific areas), and research on “case mix” – grouping the range and types of consumers according to their resource use. Another high priority is the collection of epidemiological information on Māori mental health. Similar studies of Pacific people’s mental health would be done in subsequent years.

Strategic Direction 7: **Strengthening Promotion and Prevention**

There are five “next steps” under this strategic direction. These are:

- To improve access to primary healthcare providers for those with or at risk of developing mental disorders (including drug and alcohol disorders). (National Objective 7.3)
- To improve the quality of primary healthcare services for people with or at risk of developing mental health disorders (including drug and alcohol disorders). (National Objective 7.4)
- To develop and strengthen mental health promotion programmes. (National Objective 7.5)
- To reduce the rate of mental illness for Māori so that it is no higher than that of non-Māori. (National Objective 7.6)
- To put in place effective mental health promotion strategies for Pacific peoples. (National Objective 7.7).

National Objective 7.3:

To improve access to primary healthcare providers for those with or at risk of developing mental health disorders (including drug and alcohol disorders).

The following mental health services are provided within primary healthcare:

- prevention
- initial screening, early detection, assessment and referral
- ongoing treatment, including review of medication and prevention of relapse
- referral to support agencies, including counselling and social support.

It is important to improve access to these services for three broad groups of people.

One group is the estimated 12% of the general population who, at any one time, are experiencing mild or moderate mental health problems. Many of these people find that although their mental health problems are relatively mild, these can still limit their functioning and quality of life. Usually, the mental health problems of these individuals can be fully assessed and managed within primary care services.

The second group is the estimated 5% of the general population who are experiencing moderate to severe mental health disorders. With liaison/support from specialist mental health services, general practitioners can provide ongoing services to these individuals.

The third group is people with psychiatric disabilities. For these people, ongoing support from primary healthcare services is an alternative to using specialist mental health services. There are already some promising initiatives underway. One is a pilot programme in Napier where 10 general practitioners, working closely with specialist mental health services, are contracted by the funding/purchasing agency to provide care to about 200 long-term mental health consumers.

In 1996, the Mental Health Strategy Advisory Group recommended that the regional health authorities:

- pilot a range of strategies that encourage primary healthcare providers to deliver clinical services and support to people with mental illness, using specialist back-up as necessary

- purchase consultation-liaison from specialist mental health services (this will require the specialist service to consult/liaise with primary healthcare providers)
- explore options for purchase of primary healthcare that will facilitate early identification and treatment of mental health conditions in at-risk populations and the general population
- encourage links between primary healthcare providers and other groups such as victim support services, counselling services and self-help groups.

In addition, the Mental Health Strategy Advisory Group has recommended that there should be an increase in primary healthcare services, with an emphasis on early intervention, for those people who may be at risk of mental illness and who, on a population basis, under-utilise primary healthcare services. These include young people, Māori, and Pacific people.

TARGET 7.3.1

*By July 2000, the funding/purchasing body will have implemented, in each region, models of service which **improve access to general practitioners** for people with or at risk of developing mental health disorders (including drug and alcohol disorders).*

TARGET 7.3.2

*By July 1999, the funder/purchasing agency will specifically purchase, from adult clinical mental health services, **a consultation-liaison function with general practitioners.***

National Objective 7.4:

To improve the quality of primary healthcare services for people with or at risk of developing mental health disorders (including drug and alcohol disorders).

Depression, anxiety, and drug and alcohol disorders are common. On average, a general practitioner can expect to see two or more people each surgery session with one of these three disorders. These types of disorders are also the ones most commonly seen by community-based health services.

While research strongly suggests that these disorders are not usually detected by primary care practitioners, even the most severe disorder can be managed in primary care if the consumer has already been appropriately assessed. The primary care practitioner can refer the consumer to specialist services for further assessment and management during specific periods, if this becomes necessary. Practitioners – and general practitioners in particular – need to be supported by further training so that they can play an enhanced role in early detection and management of mental health problems, including drug and alcohol disorders.

In September 1996, the National Health Committee issued guidelines for the treatment and management of depression by primary healthcare professionals. It is now developing guidelines for anxiety and substance-abuse disorders. Together, these three sets of guidelines cover the detection, treatment and management of the majority of mental health disorders encountered in primary healthcare.

TARGET 7.4.1

*By July 2003, all contracts between the funding/purchasing body and general practitioners will specify requirements relating to the **treatment and support of the estimated 5% of the population with moderate/severe mental illness.***

TARGET 7.4.2

*By July 2005, all contracts between the funding/purchasing body and general practitioners will specify the use of **guidelines or other agreed processes for early detection and treatment of depression, anxiety, and drug and alcohol disorders.***

National Objective 7.5:

To develop and strengthen mental health promotion programmes.

The Ministry of Health has published two papers identifying issues concerning mental health promotion: *Youth Mental Health Promotion Including Suicide Prevention* (see National Objective 7.2 "To improve the mental health of young people, including the prevention of suicide", on page 35) and *Mental Health Promotion – The Public Health Issues for Young and Older Adults*. These papers identified activities that could be implemented to improve the mental health and well-being of New Zealanders and, in particular, those at higher risk of poor mental health. Some of the possible types of mental health promotion activities included:

- extending the coverage and effectiveness of targeted youth-depression awareness programmes
- fostering community-based initiatives for socially isolated individuals and communities, and for individuals experiencing high stress because of adverse personal circumstances or poor health
- strengthening and developing well-co-ordinated local programmes based on a community-development model.

Some of the targets for this objective have been developed; others are yet to be developed.

Provisional/interim targets for youth are contained in the report *Youth Mental Health Promotion Including Suicide Prevention*, which was published by the Ministry of Health in 1996. These targets are being revised as part of the draft National Youth Suicide Prevention Strategy, which is due to be completed in 1997.

Targets for adults will be developed in 1998, based on data collected from the 1996/97 New Zealand Health Survey.

National Objective 7.6:

To reduce the rate of mental illness for Māori so that it is no higher than that of non-Māori.

The majority of Māori consumers being admitted to mental health services are admitted at a severe stage of their illness. Māori consumers are also more likely to use intensive residential services for drug and alcohol disorders. The illness or disorder is therefore more difficult to treat than it would have been earlier, and it is far more devastating to the consumer and their whanau.

Early intervention and health promotion programmes that are of relevance to Māori are two ways by which Māori can be encouraged to seek assistance well before their illness has moved into a crisis stage.

There are currently no targets developed for this objective. However, *by July 1999, targets for improving the mental health of Māori will be set, using the proposed baseline epidemiological study of Māori mental health.*

To date, the mental health needs of Māori have been assessed solely on rates of admission and re-admission to hospital-based mental health services. This is inadequate, and the establishment of an accurate baseline assessment of mental health status of Māori is essential.

The baseline epidemiological study of Māori mental health has been identified as a priority for the research and development programme and is scheduled to be undertaken in 1997/98. (Data collected from the 1996/97 New Zealand Health Survey, which relies on self-reporting of health status, is a useful supplement to epidemiological studies.)

National Objective 7.7:

To strengthen promotion and prevention for Pacific peoples.

Sustaining the mental health of Pacific people has considerable cultural, social and economic benefits. The maintenance and development of Pacific cultures in New Zealand provides the basis for mental wellness and for educational and employment success.

In January 1997, the Ministry of Health released *Making a Difference – Strategic Initiatives for the Health of Pacific People* for consultation. This report suggested a number of strategies for maintaining and improving Pacific people's mental health. These included the use of both traditional Pacific and New Zealand structures for mental health promotion work, and the circulation of Pacific-language descriptions of key Western mental illnesses and support and treatment systems. A range of resource materials for mental health promotion work among Pacific peoples also needs to be developed – including material targeted at younger English-speaking Pacific people.

There are currently no targets developed for this objective. However, *by July 2000, targets relating to effective mental health promotion for Pacific peoples will be set.* These targets will be based on information from the proposed baseline epidemiological study on Pacific people's mental health.

The proposed baseline epidemiological study on Pacific people's mental health has been identified as a priority for the research and development programme and tentatively scheduled for 1998/99.

Glossary

Where applicable, the source for each of the definitions in this glossary is given in brackets at the end of the definition.

Access The ability of a potential consumer to obtain a service when needed within an appropriate time. (New Zealand Council of Healthcare Standards, 1997 [NZCHS])

Adults For the purposes of the targets, aged 20 years and older. In practice, the distinction between children/young people and adults is not so clear cut. It is not unusual for a person under 20 years to use adult mental health services and some people over 20 years continue to use children's and young people's services when appropriate. The World Health Organisation extends the definition of adolescents to the age of 24 years.

Assessment The systematic and ongoing collection of information about a consumer to form an understanding of how they think, behave, and feel, and to identify their needs. Assessment forms the basis for the development of a diagnosis and an individualised care plan, in collaboration with the consumer, their family, carers and significant others.

Blueprint (for mental health services) An agreed document that defines the parameters of comprehensive mental health services provision, with a focus on specialist mental health services.

Carer A family member or friend who provides care or support on a voluntary basis or for a nominal payment.

Children and young people For the purposes of the targets, aged less than 20 years. In practice, the distinction between children/young people and adults is not so clear cut. It is not unusual for people under 20 years to use adult mental health services. The World Health Organisation extends the definition of adolescents to the age of 24 years.

Consumer The person who uses a mental health service. It includes the terms patient, consumer, client, resident, and turoro. In providing services to a consumer, the organisation must also consider people supporting the consumer – family, carers, whanau, and friends. (NZCHS)

Consultation-liaison function Significant contact with/between mental health professionals (employed in a mental health service) and other agencies/persons providing a service to consumers where mental health services are not the lead agency.

Drug and alcohol service A comprehensive consumer-focused service providing assessment, treatment, information and referral for people who need assistance in changing their substance use patterns. (Mental Health Services Specification/Common Base Definitions Project, 1997)

Dual-diagnosis responses Responses for people who have both a severe mental illness and a drug or alcohol disorder.

Family For the purposes of *Moving Forward*, "family" includes a consumer's whanau or extended family, their partner, friends, or others nominated by the consumer. (NZCHS)

Forensic services Mental health services delivered by a multidisciplinary team to mentally ill offenders, alleged offenders, or those who pose a high risk of offending. These people require varying levels of care. The care is based on a comprehensive assessment and provided across a range of facilities/settings.

Funding/purchasing body A generic term used in this document to apply to the four existing regional health authorities, the Transitional Health Authority (the national funding agency for the 1997/98 transition year), and the national funding agency which will supersede the Transitional Health Authority.

Goal A general aim to strive towards.

Health outcome A change in the health of an individual or group of individuals which is attributable to an intervention or series of interventions. (Australian Health Ministers Advisory Council, 1994)

Health promotion The process of enabling people to increase control over, and to improve their health. Applying a health promotion approach to mental health and well-being goes beyond consideration of factors associated with mental disorders, to a consideration of factors associated with psychological health of communities. The strategies to achieve this are described in the Ottawa Charter. (WHO, 1986)

Incidence The number of new cases of the illness or disorder.

Independent practitioner associations (IPAs) A group of professionals (usually general practitioners) that provides its members with management services such as contract negotiation and information.

Iwi The Māori nation or people of the local area. (NZCHS)

Kaupapa Māori services Services provided by Māori for Māori.

Mental disorder or illness A significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder. (Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Services, 1991)

Mental health Mental health is the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice. (Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Services, 1991)

Mental health problem A mental health problem is a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health.

Mental health services An organisation that provides, as its core business, treatment or support to people with mental illness or mental health problems. For the

purposes of *Moving Forward*, “mental health services” includes drug and alcohol services unless otherwise stated.

Mental health workforce For the purposes of *Moving Forward*, the mental health workforce includes the drug and alcohol workforce unless otherwise stated.

Milestone A step towards achieving the target.

Objective The end result that a programme or set of activities seeks to achieve.

Pacific peoples Diverse consumer group including Tongan, Samoan, Fijian, Cook Island, Tokelau, and Niue peoples.

Pacific people’s services Services provided by Pacific people for Pacific people. Those providing the service may be independent service providers, or teams within mainstream services.

Prevention This focuses on reducing the prevalence and incidence of mental disorders.

Prevalence Total number of people with the illness or disorder.

Primary prevention Aims at reducing incidence of the illness or disorder and other departures from good health. It can be defined as the protection of health by personal and community-wide efforts.

Regional mental health plan A mental health plan (which may include more localised plans) for the geographical region covered by each of the four existing regional health authorities, prepared by the funder/purchasing body in consultation with providers and affected communities.

Secondary prevention Aims to reduce prevalence by shortening the duration of the illness or disorder. It can be defined as the measures available to individuals and populations for early detection and promotion and effective intervention.

Service provider Organisation or individual practitioner who provides a direct health or support service to consumers, their families, and their carers.

Target An intermediate result towards the objective that a programme or set of activities seeks to achieve.

Tertiary prevention Aimed at reducing complications. It consists of measures available to reduce or eliminate long-term impairments and disabilities, minimise suffering, and promote the patient’s adjustment to irremediable conditions. It extends the concept of prevention into the field of recovery.

Treatment Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.

Whanau A consumer’s family or an extended family/group of people who are important to the consumer. (NZCHS)

Appendix 1:

The Goals and Strategic Directions from *Looking Forward*

The National Mental Health Strategy *Looking Forward*, which was released in 1994, has two goals and five strategic directions:

Goal 1:

To decrease the prevalence of mental illness and mental health problems within the community.

Goal 2:

To increase the health status of and to reduce the impact of mental disorders on consumers, their families, caregivers and the general community.

Strategic Direction 1

Implementing community-based and comprehensive mental health services.

Strategic Direction 2

Encouraging Māori involvement in planning, developing and delivery of mental health services.

Strategic Direction 3

Improving the quality of care.

Strategic Direction 4

Balancing personal rights with protection of the public.

Strategic Direction 5

Developing a national alcohol and drug policy.

Appendix 2:

The Development of the Benchmarks for Adult Services

In 1993, “benchmarking” of adequate services for adults was carried out for the purposes of future planning.

This benchmarking was based on international work available at that time – Professor Gavin Andrews’ paper “The Tolkein Report, a description of a Model Mental Health Service”, information from epidemiological studies, and work undertaken in England.

Benchmarks were set in two ways. Firstly, a benchmark of 3% of the adult population was developed for “specialty” mental health services – those that service people with a severe mental disorder or high support needs. This means that in any one-month period “specialty” mental health services (excluding drug and alcohol services) are intended to service 3% of the adult population. This 3% was based on international epidemiology data and some service-utilisation studies. Some adjustments were made for differences within the New Zealand population (particularly for Māori), and for the different way forensic services are delivered.

Secondly, benchmarks were set for inpatient and residential beds per 200,000 population, and for full-time-equivalent staff in community teams per 200,000 population. This was based predominantly on Gavin Andrews’ work, with some minor adjustments for the different population groups in New Zealand and in particular Māori needs.

The resulting benchmarks were developed for the New Zealand population:

	New Zealand overall	Per 200,000
inpatient beds (acute 525; medium/long stay 424)	949	56 (31, 25)
community residential services (level I 654; level II and III 1,780)	2,434	144 (39, 105)
community mental health services (psychiatrists 203; nurses 678; other clinical 678; non-clinical 311)	1,870	110 (12, 40, 40, 18)

These benchmarks formed the basis for Government funding allocation and underpinned the move to adequate mental health services over ten years. However, it must be noted that they were not developed as benchmarks for purchasing in particular regions, nor for configurations of provision of services which must reflect particular regional and community needs.

Appendix 3:

The National Mental Health Strategy: Who Does What

There is a need to clarify who does what in relation to the National Mental Health Strategy. In this Appendix we outline the actions of three key agencies: the Ministry of Health, the funding/purchasing body (formerly the regional health authorities and most likely to be the National Funding Agency), and the Mental Health Commission.

Ministry of Health

The Ministry of Health works in the following areas to underpin the National Mental Health Strategy:

- **Policy development.** Policy development work is often undertaken as projects. These involve basic research, fact-finding and consultation (including consultation with other government departments and agencies). Some of the targets in the National Mental Health Plan are derived from the Ministry's projects. Policy development work may lead to advice to the Government on its mental health priorities; it may also lead to advice to the sector – for example, on best practice.
- **Advice to the Government.** Policy development work can lead to advice being given to the Minister of Health and other Ministers, such as the Minister of Finance, and, in some cases, Cabinet committees and the Cabinet. Sometimes the Government will seek advice on broader intersectoral issues to which the Ministry of Health and the Mental Health Services section are contributors. A current example of this is the “Families at Risk” initiative.
- **Assisting the Government in setting expectations on the funding/purchasing body.** There is now a new relationship between the Ministry of Health (as agent for the Minister) and the funding/purchasing body. Two key features of the new relationship are:
 - Key Performance Expectations (KPEs)* These set out the new policies and processes that the funding/purchasing body must adopt. Mental health has its own specific KPE – and this is an indication of the special status or priority that is given to achieving improvements in mental health.
 - Evergreen Funding Agreement (EFA)* This relates to all the unchanging policies, processes and services that the funding/purchasing body is expected to continue to purchase.
- **Monitoring the funding/purchasing body.** Information is regularly collected from the funding/purchasing body and its performance is assessed against its Statement of Intent. (The Statement of Intent is negotiated each year between the Ministry and the funding/purchasing body. It sets out what the funding/purchasing body will purchase and how it will conduct its business.)
- **Reviewing the National Mental Health Strategy.** Any strategy needs to evolve. There will be regular 3-yearly reviews of the National Mental Health Strategy, to update it in line with new knowledge both here and overseas and to undertake a measure of international comparison of progress. A great deal of work is currently underway in mental health overseas, in particular in Australia and the United Kingdom, where the issues being faced are similar to our own.
- **Setting national targets.** This is an integral part of the National Mental Health Strategy's development and implementation. National targets would ideally be set in terms of health status but, in the absence of effective measures of outcome, the targets

are expressed in terms of access and service-capacity measures such as the numbers of people seen, beds available, and full-time-equivalent staffing. The development of outcome measures for mental health has been identified as a priority for the research and development programme in 1997/98.

The Funding/Purchasing Body

The regional health authorities have carried out the following functions to underpin the National Mental Health Strategy – and it is assumed that the funding/purchasing body that replaces them will also perform these functions:

- **Regional planning.** Each of New Zealand's four health regions will develop a strategic plan that shows the year-by-year intentions for mental health service development and purchasing. The regional plans are developed taking into consideration the services that are currently purchased within the region, the gaps in service that have been identified as a result of needs assessment and consultation, and a working-out of the national targets that are contained in the National Mental Health Plan.
- **Translating national targets into specific services.** The targets in the National Mental Health Plan need to be reflected in regional plans in terms of actual services. This means that some indication needs to be made about what the services will actually focus on and where they will be located. In the past, planning and purchasing intentions across the four regions have been difficult to compare, because each region has used different terminology to describe services. A common method of describing services has been developed, for use both by the funding/purchasing body and by providers.
- **Funding services and monitoring contracts with providers.** The funding/purchasing body is responsible for contracting with providers to supply mental health services, with the funding for these services being allocated by the Government. The funding/purchasing body is also responsible for monitoring these contracts, to ensure that services are provided to the required quantity and quality standards.
- **Reviewing and updating the regional mental health plans each year.** The review of plans is an important mechanism for keeping the National Mental Health Strategy relevant and meaningful at a regional level. Feedback from these reviews is also needed to regularly update the regional plans, and also the national Plan. The reviews should have input from the users of services and from the community.

Mental Health Commission

The Mental Health Commission was established in 1996 for a term of five years, to help lead the development of mental health services in New Zealand.

The Commission is required to evaluate the implementation of the National Mental Health Strategy and to report on this to the Minister of Health. In particular, it evaluates:

- The extent to which the Ministry of Health has exercised leadership in ensuring delivery of the National Mental Health Strategy throughout the sector. (Key dimensions here include progress in establishing and negotiating the specific targets for all five strategic directions in the strategy; and monitoring progress made by the funding/purchasing body in implementing the strategy and clearly communicating the changes needed to providers, consumers and communities.)
- The degree to which the Ministries of Health and Education, the Department of Social Welfare, Housing New Zealand, the Department for Courts, the Department of Corrections, the Police, and any other government agency with responsibilities that


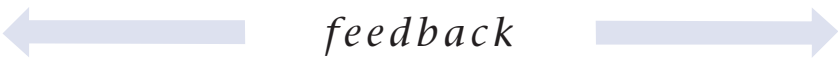
affect mental health are fulfilling the Government's expectations through their delivery of service.

- The robustness of the accountability systems that are put in place by the Ministry of Health and by regional health authorities or the funding/purchasing body. (These systems are put in place to ensure that mental health funding is not diverted for other purposes and to ensure that the effects of government expenditure on mental health can be clearly demonstrated.)

The Commission is also required to look into any matter (agreed to between the Minister of Health and the Commission) which requires particular attention in order for the National Mental Health Strategy to be implemented.

The Government has signalled that there may be changes in the Commission's role in the future.

Who Does What: An Overview

Ministry of Health	Funding/Purchasing Body	Mental Health Commission
		
Develops policy Advises the Government on priorities Assists the Government in setting expectations on the funding/purchasing body Monitors the funding/purchasing body Reviews the national strategy Sets national targets	Prepares regional plans Translates the national targets into specific services that meet regional needs Funds services and monitors contracts with service providers Reviews and updates regional plans	Evaluates the extent to which the Ministry has exercised leadership Evaluates the degree to which other government agencies are fulfilling their role in respect of mental health Evaluates the robustness of accountability systems for mental health funding Looks into any other matter that the Commission and the Minister agree needs particular attention
		

Appendix 4:

Needs Groups and Their Services

What follows is an indicative list of the types of services to be provided within the 3% benchmark for adult services.

It should be noted, however, that the groups are not mutually exclusive. People may belong to more than one group at any one time – for example, a person with ongoing support needs may on occasion be acutely unwell. So the types of services they need will span more than one group of services.

People who are acutely unwell or in crisis

These people are experiencing severe acute symptoms of mental illness. Some of them may present a risk to themselves or others and may be subject to a compulsory assessment or treatment order.

Assessment and treatment services for these people include:

- crisis teams – 24-hour mobile response
- assertive outreach
- crisis respite
- day hospital
- acute inpatient
- intensive care inpatient.

People with severe ongoing or recurring mental illness

This group includes:

- people with severe mental illness that is recently diagnosed
- people with an ongoing mental illness which manifests in periodic complex presentation
- people with an ongoing, complex, severe, recurring mental illness.

What these groups have in common is that their needs are best met by multidisciplinary teams, working from a range of settings and using a key worker or care co-ordination approach that enhances access and continuity of services for the consumer and accountability of the service provider.

Assessment and treatment services for people with severe mental illness include:

- community treatment teams
- early psychosis intervention
- care co-ordination
- general treatment/therapeutic intervention
- specialised services for some disorders, such as eating disorders or post-natal depression
- consultation-liaison.

People with short-term but significant mental health problems

These are people who may contact mental health services for a mental health problem that is readily treatable.

Services for people with short-term but significant mental health problems may include:

- assessment
- general treatment/therapeutic intervention
- referral
- consultation-liaison (with other health or other social service agencies).

People with ongoing housing, vocational and support needs

These people – some of whom are or have been in long-stay hospital care – have longer-term needs which relate to their living circumstances and functioning and which can be met in a variety of ways.

For most people in this group, the focus will be on recovery or return to optimal functioning. For others, it will be on improved quality of life.

The Disability Support Services framework of support-needs assessment, service co-ordination and service provision applies here. So services for people with ongoing housing, vocational and support needs include:

- support needs assessment
- service co-ordination
- community teams
- peer support
- skill development
- community residential services
- extended hospital care.

People with the highest support needs

These are a small group of people whose support needs are most intense and complex. When their support systems break down or can no longer manage, these people are frequent users of crisis and hospital services.

This group of people have been the most often neglected in the past. It is imperative that priority is given to meeting their support needs. Doing so will also free up crisis services and allow other users to get earlier and more comprehensive crisis response.

Services and responses that are appropriate to people with the highest support needs include:

- support needs assessment
- service co-ordination
- assertive follow-up
- peer support/consumer involvement
- intensive skills development
- behaviour management programmes
- modern drug therapy.

This list was based on the framework of consumer-focused services that was developed as part of the Mental Health Services Specification/Common Base Definitions Project (which was completed in 1997).

Appendix 5:

Summary of *Moving Forward's* Objectives and Targets

First Steps

Objective 1.1:

To increase and maintain mental health services to benchmark levels for adults and children/young people – that is:

- 3% of the adult population have access to adult/general mental health services in any one month
- 5% of children and young people have access to children's and young people's specialist mental health services in any one month.

TARGET 1.1.1

By 30 September 1997, the funding/purchasing body will notify the percentage of the adult population who accessed adult/general mental health services in any one month, using agreed nationally consistent definitions. This percentage will become "the baseline" for future planning purposes.

TARGET 1.1.2

By 31 March 1998, the regional plans of the funding/purchasing body will demonstrate, for each of the three years from 1998/99 to 2000/01, the amount of annual increase above the baseline that is planned for access to adult/general mental health services to achieve Objective 1.1.

TARGET 1.1.3

By 30 September 1997, the funding/purchasing body will notify the percentage of children and young people who accessed children's and young people's specialist mental health services in any one month, using agreed nationally consistent definitions. This percentage will become "the baseline" for future planning purposes.

TARGET 1.1.4

By 31 March 1998, the regional plans of the funding/purchasing body will demonstrate, for each of the three years from 1998/99 to 2000/01, the amount of annual increase above the baseline that is planned for access to children's and young people's specialist mental health services to achieve Objective 1.1.

Objective 2.1:

To encourage Māori involvement in planning, developing and delivering mental health services.

TARGET 2.1.1

By July 1998, the planning processes of the funding/purchasing body will involve Māori, and the plans themselves will include specific undertakings to increase Māori involvement in the design and purchasing of services appropriate to Māori needs.

Objective 2.2:

To increase the responsiveness of mainstream mental health services to the special needs of Māori.

TARGET 2.2.1

*By July 1999, all mental health services will be using **cultural assessment procedures** for Māori consumers.*

TARGET 2.2.2

*By July 2000, all mental health services will be operating under **cultural effectiveness protocols**.*

Objective 3.1:

To improve the delivery of mental health services for children and young people with moderate and severe mental health problems.

TARGET 3.1.1

*By July 1998, a blueprint defining the **parameters of specialist mental health service provision for children and young people** will be developed.*

Objective 3.2:

To improve responsiveness of mental health services to consumers.

TARGET 3.2.1

*By July 1998, there will be specific **undertakings to actively involve consumers** in regional planning and in the design and purchase of mental health services.*

TARGET 3.2.2

*By July 1998, all contracted providers will demonstrate **involvement and participation of consumers** including, for major providers, employment of consumers (or will have a process in place to achieve it by 1999).*

TARGET 3.2.3

*By July 1998, the Ministry of Health will demonstrate that **consumers are appropriately involved** in national planning and policy development.*

Objective 3.3:

To improve responsiveness of mental health services to families and caregivers.

TARGET 3.3.1

*By July 1998, the funding/purchasing body will be monitoring contracted providers to see that the providers have processes for **informing and involving caregivers**.*

Objective 3.4:

To implement, throughout mental health services, best practice and continuous quality improvement that is consistent with the National Mental Health Standards.

TARGET 3.4.1

By July 1999, the funding/purchasing body's contracts with providers will include the National Mental Health Standards; and, by July 2000, providers will be required to provide evidence of achieving these standards.

Objective 3.5:

To have an identifiable individual or agency responsible for co-ordinating individualised care, with priority given to people with high support needs.

TARGET 3.5.1

By July 1998, the funding/purchasing body will purchase from providers a process for identifying all individuals with high support needs.

TARGET 3.5.2

By July 2000, all care, treatment and support for people with high support needs will be co-ordinated by a designated case manager/care co-ordinator.

Objective 3.6:

To prescribe new anti-psychotic medications to people who are newly presenting or who can benefit most from changing from older-style anti-psychotic medications (including those who currently suffer intolerable side-effects).

TARGET 3.6.1

By July 2000, all those for whom clozapine is clinically indicated will be prescribed it and will be monitored according to protocols.

TARGET 3.6.2

By July 2001, all people meeting the criteria set out on Pharmac's priority list will be prescribed risperidone, or an equivalent new anti-psychotic medication, as a first-line treatment.

Objective 3.7:

To improve responsiveness and effectiveness of services for people with both a severe mental illness and a drug or alcohol disorder.

TARGET 3.7.1

By July 1999, specific services for people with both a severe mental illness and a drug or alcohol disorder will be available in each major centre.

TARGET 3.7.2

By July 1999, training in assessment and management of drug and alcohol disorders will be provided in each major centre for mental health service clinical staff.

TARGET 3.7.3

By July 2000, training in assessment and management of mental illness will be provided in each major centre for drug and alcohol service clinical staff.

TARGET 3.7.4

*By July 2000, the funding/purchasing body will include, in all contracts for mental health services and drug and alcohol services, specific provisions for a **comprehensive assessment of people in either service and for improving liaison and co-ordination between these services.***

Objective 4.1:

To maintain a balance between:

- **mental health and criminal justice legislation which imposes compulsory treatment and restriction of normal liberties on mentally disordered individuals**
 - **the usual rights and freedoms of the individual**
- and**
- **the public interest, in particular the safety of the public.**

TARGET 4.1.1

*By July 1999, the funding/purchasing body will specify, in its contracts with specialist mental health services, that all **individuals** assessed and treated by the service will have **risk assessment** and that all **providers** responsible for risk assessment will have **comprehensive risk-assessment protocols.***

TARGET 4.1.2

*By July 1999, the funding/purchasing body will require that providers responsible for risk assessment can demonstrate that **staff have undertaken training in risk assessment and, where necessary, refresher programmes.***

Objective 5.1:

To minimise harm caused by tobacco, alcohol and other drug use to both individuals and the community.

TARGET 5.1.1

*By July 1998, an **intersectoral work programme** will have been agreed by all relevant government agencies. This intersectoral work programme will include strategies to advance the National Drug Policy's desired outcomes (including appropriate outcomes, targets and strategies for Māori).*

Objective 6.1:

To ensure all mental health services employ sufficient staff with the necessary knowledge and skills to deliver essential services to their identified target groups in the mental health sector.

TARGET 6.1.1

*By July 1999, the funding/purchasing body will have required, in its contracts with providers, **workforce development plans** that address recruitment, retention and training issues to ensure the mix of skills required for providers' services over a 5-year period and on a year-by-year basis.*

TARGET 6.1.2

*By July 2001, **education and training** for the mental health workforce will be **consistent across New Zealand**.*

TARGET 6.1.3

*By July 2001, **post-entry and postgraduate clinical needs** will be addressed through purchasing of training by the Clinical Training Agency.*

Objective 6.2:

To improve the accuracy, timeliness and appropriateness of mental health data collection, in order to help monitor the achievement of a number of targets in the National Mental Health Plan.

TARGET 6.2.1

*By July 2000, there will be a **national mental health data-collection process** which:*

- provides accurate and timely information that can be used to help monitor a number of targets in the National Mental Health Plan*
- includes mental health and drug and alcohol data collection.*

Objective 6.3:

To promote co-ordination among all agencies associated with mental health services and to ensure that clear lines of accountability exist.

TARGET 6.3.1

*By July 1998, the funding/purchasing body will purchase specific mechanisms to address the **interface between CHE mental health services and other mental health services**, and will monitor their implementation.*

TARGET 6.3.2

*By July 1998, all Ministry of Health protocol development and review will reflect **intersectoral consultation and co-ordination**.*

Objective 7.1:

To increase public knowledge and awareness of mental health issues in order to:

- create a more supportive environment for people living with a mental illness
- help remove the barrier of discrimination and stigma that stops people seeking early assistance and support.

There are currently no targets developed for this objective. However, by July 1998, the process and outcome targets for the increase of public knowledge and awareness of mental health issues will be set. These targets will be based on information from the baseline research and programme development in 1997.

Objective 7.2:

To improve the mental health of young people, including the prevention of suicide.

Provisional/interim targets for this objective are contained in the report *Youth Mental Health Promotion Including Suicide Prevention*, which was published by the Ministry of Health in 1996. These targets are being revised; and the revised targets will form part of the draft National Youth Suicide Prevention Strategy, which is due to be completed in 1997.

Next Steps

National Objective 1.2:

To develop benchmarks for levels of service for other consumer groups.

TARGET 1.2.1

By July 1998, benchmarks will be developed for **people with drug and alcohol disorders**.

TARGET 1.2.2

By July 1998, benchmarks will be developed for **forensic service clients**.

TARGET 1.2.3

By July 1998, benchmarks will be developed for **older people**.

National Objective 1.3:

To improve access to methadone treatment for people who are opioid dependent.

TARGET 1.3.1

By July 1999, 80% of **people assessed as requiring methadone treatment for opioid dependence** will be able to access this treatment within two weeks of assessment.

TARGET 1.3.2

By July 1999, 50% of **people receiving methadone treatment** will be receiving this treatment through general-practice providers.

TARGET 1.3.3

*From July 1999, increases in **provision of methadone treatment** to meet demand will occur through the primary health sector.*

National Objective 2.3:

To continue to increase responsiveness to the special needs of Māori, by providing access to both kaupapa Māori and mainstream services.

TARGET 2.3.1

*By July 2005, 50% of Māori adults will have a **choice of a mainstream or a kaupapa Māori community support mental health service.***

National Objective 3.8:

To improve the responsiveness of mental health services to Pacific people.

TARGET 3.8.1

*By July 2000, the funding/purchasing body will have **purchased pilot community-based mental health services** for Pacific people in areas of concentrated Pacific populations. These services will be **provided by Pacific people**, either as independent service providers or as teams within mainstream services.*

TARGET 3.8.2

*By July 2000, the funding/purchasing body will have **commenced evaluating the responsiveness of mainstream mental health services to Pacific populations.** This evaluation will be done using the Pacific people component of the National Mental Health Standards or its equivalent.*

National Objective 3.9:

To improve the responsiveness of mental health services to refugees.

There are currently no targets developed for this objective.

National Objective 3.10

To improve the responsiveness of mental health services to people who are profoundly deaf.

There are currently no targets developed for this objective.

At this stage, there are no objectives or targets for the “next steps” of Strategic Direction 4 and Strategic Direction 5.

National Objective 6.4:

To increase the Māori mental health workforce.

TARGET 6.4.1

By July 2005, the Māori mental health workforce (including clinicians) will have increased by 50% from the baseline in 1997/98.

National Objective 6.5:

To increase the Pacific mental health workforce.

TARGET 6.5.1

By July 1999, the funding/purchasing body will require, in its contracts with providers, workforce development plans which demonstrate workforce development in services for Pacific peoples.

National Objective 6.6:

To improve the skills and competence of the drug and alcohol workforce.

TARGET 6.6.1

By July 1999, postgraduate specialty training in drug and alcohol treatment for health professionals will be available in at least two centres, and by distance learning for most parts of New Zealand.

TARGET 6.6.2

By July 2002, 50% of contracted drug and alcohol services which employ clinical staff will include staff members with postgraduate specialty training in drug and alcohol treatment.

National Objective 6.7:

To improve the health status of New Zealanders and to enhance the quality of mental health decision-making by providing up-to-date knowledge based on research information.

TARGET 6.7.1

By July 1998, a mental health research and development strategy will be agreed on by the Ministry of Health and the funding/purchasing body (in consultation with the Health Research Council, the Mental Health Commission and the mental health sector).

TARGET 6.7.2

By July 2000, there will be a clear process of ongoing research and development in the mental health area, the results of which will be accessible to all levels of the mental health sector.

TARGET 6.7.3

By July 2000, information generated by the research and development programme will be used to inform the National Mental Health Strategy and enhance clinical decision-making at the consumer level.

National Objective 7.3:

To improve access to primary healthcare providers for those with or at risk of developing mental health disorders (including drug and alcohol disorders).

TARGET 7.3.1

*By July 2000, the funding/purchasing body will have implemented, in each region, models of service which **improve access to general practitioners** for people with or at risk of developing mental health disorders (including drug and alcohol disorders).*

TARGET 7.3.2

*By July 1999, the funder/purchasing agency will specifically purchase, from adult clinical mental health services, a **consultation-liaison function with general practitioners**.*

National Objective 7.4:

To improve the quality of primary healthcare services for people with or at risk of developing mental health disorders (including drug and alcohol disorders).

TARGET 7.4.1

*By July 2003, all contracts between the funding/purchasing body and general practitioners will specify requirements relating to the **treatment and support of the estimated 5% of the population with moderate/severe mental illness**.*

TARGET 7.4.2

*By July 2005, all contracts between the funding/purchasing body and general practitioners will specify the use of **guidelines or other agreed processes for early detection and treatment of depression, anxiety, and drug and alcohol disorders**.*

National Objective 7.5:

To develop and strengthen mental health promotion programmes.

Some of the targets for this objective have been developed; others are yet to be developed.

Provisional/interim targets for youth are contained in the report *Youth Mental Health Promotion Including Suicide Prevention*, which was published by the Ministry of Health in 1996. These targets are being revised as part of the draft National Youth Suicide Prevention Strategy, which is due to be completed in 1997.

Targets for adults will be developed in 1998, based on data collected from the 1996/97 New Zealand Health Survey.

National Objective 7.6:

To reduce the rate of mental illness for Māori so that it is no higher than that of non-Māori.

There are currently no targets developed for this objective. However, by July 1999, targets for improving the mental health of Māori will be set, using the proposed baseline epidemiological study of Māori mental health.

National Objective 7.7:

To strengthen promotion and prevention for Pacific peoples.

There are currently no targets developed for this objective. However, by July 2000, targets relating to effective mental health promotion for Pacific peoples will be set.

Appendix 6:

The Underlying Principles of *Moving Forward*

Moving Forward is underpinned by the fourteen principles of *Looking Forward*, and also by three additional principles.

The principles from *Looking Forward* are:

- encouraging services that **empower** individual consumers and their families/whanau and caregivers
- encouraging services that enable people of any age, culture, gender or individual interest to **fully participate** in society
- encouraging the development of **better specifications** for services purchased and provided to meet the needs of different groups of consumers and their families/whanau and caregivers
- ensuring **Māori involvement** in the planning of mental health services for Māori and in designing services appropriate to Māori needs
- ensuring **consistent safety standards** to protect the health of consumers and the public
- improving the **cultural safety** of services and ensuring that services accommodate cultural differences, especially Māori
- improving people's **access** to appropriate services of acceptable quality
- encouraging services to contribute to the **best possible outcomes** for consumers and their families
- respecting **personal dignity** and privacy
- encouraging services to be delivered in a way that **minimises disruption** to the lives of people with mental health problems and disabilities
- increasing the **sensitivity** of services and support systems to the changing needs and preferences of people
- giving priority to **cost-effective** services that provide the best value in terms of health gains
- encouraging services to be **integrated** at all levels and to be focused on achieving maximum wellness and independence for all consumers
- assuring the **rights of people** with mental disorders and disabilities within the context of overall community needs and rights.

The three additional principles are:

- encouraging programmes and services that enable individuals, families and communities to **increase control** over and improve their mental health and well-being
- improving community understanding and acceptance of mental illness and helping to **create supportive social environments** for those who have a mental illness
- **working intersectorally** to encourage the development and implementation of policies and programmes that will help maintain and improve the mental health and well-being of communities.

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