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Destination:**Recovery**

Te Ūnga ki Uta: Te Oranga

Mental Health Advocacy Coalition

Destination:**Recovery**
Te Ūnga ki Uta: Te Oranga

Future responses to mental distress and loss of well-being
A discussion paper from the Mental Health Advocacy Coalition

Ko te pae tawhiti whāia ki a tata
Seek your aspirations on the horizons

Mental Health Foundation of New Zealand

Contents

Mental Health Advocacy Coalition

The Mental Health Advocacy Coalition had its origins in a meeting of community mental health organisations, known informally as the National Mental Health Alliance, convened by the Mental Health Foundation in 1986. The structure and function of the group were formalised in 1994 when it proposed, and secured a contract, to provide mental health sector perspectives and policy advice to the Ministry of Health. The Coalition first met and adopted its current name in November 1994. Membership of the Coalition reflects the broad range of groups with an interest and stake in mental health in New Zealand.

The current members of the Mental Health Advocacy Coalition are:

- Judi Clements (Chair), Chief Executive, Mental Health Foundation of New Zealand
- Robyn Byers, District Manager, Nelson Marlborough District Health Board, Mental Health Service; representing mental health service managers
- Vicki Burnett, Consumer Advisor, Northern Consumer Network; bringing a consumer perspective
- Dr David Codyre, Consultant Psychiatrist/Medical Director, ProCare Psychological Services; representing the New Zealand branch of the Royal Australian and New Zealand College of Psychiatrists
- Susie Crooks, Central Potential; bringing a consumer perspective
- Diane Foley, Consumer Advisor, Southern Consumer Network; bringing a consumer perspective
- Paul Ingle, Chief Executive, Pathways; bringing a community mental health service provider perspective and representing Platform (New Zealand association of support services and community development in mental health)
- Dr Jacquie Kidd, Senior Lecturer, University of Auckland; representing Te Ao Maramatanga, New Zealand College of Mental Health Nurses
- Florence Leota, Chief Executive, Schizophrenia Fellowship New Zealand Inc. (Supporting Families); bringing a family/whānau perspective
- Margaret Manuka-Sullivan, Māori Mental Health Advisor (Alcohol & Other Drug), Hawkes Bay District Health Board; bringing an addictions perspective
- Caroline (Moe) Milne: Māori Mental Health Advisor; bringing a Māori perspective
- Fuimaono Karl Pulotu-Endemann, Pacific Health Consultant; bringing a Pacific perspective

- Dr Helen Rodenburg, General Practitioner, Island Bay Medical Centre; representing the Royal New Zealand College of General Practitioners
- Ana Sokratov, Consumer Consultant, Waitemata District Health Board; bringing a Māori consumer perspective
- Char Turei, Chair, Midlands Regional Consumer Network; bringing a consumer perspective
- Rob Warriner, Director, WALSH Trust; bringing a perspective from the Association for Supported Employment in New Zealand (ASENZ)

Members of the Mental Health Advocacy Coalition: Standing from left: Robyn Byers, Vicki Burnett, Diane Foley, Fuimaono Karl Pulotu-Endemann, Judi Clements, Susie Crooks, Ana Sokratov, Caroline (Moe) Milne, Dr David Codyre, Dr Jacquie Kidd, Florence Leota; Seated from left: Rob Warriner, Margaret Manuka-Sullivan, Dr Helen Rodenburg, Char Turei, Paul Ingle.

Acknowledgements

A note about language

In this paper we refer to mental health as well-being and poor mental health as loss of well-being. Mental illnesses are referred to as mental distress.

Executive summary

"Vision is perhaps our greatest strength…it makes us peer into the future and lends shape to the unknown." – Li Ka Shing

The Mental Health Advocacy Coalition has a vision for society's well-being. We believe everyone should experience not only good mental health, but the benefits of being able to cope with life stressors and enjoy a productive working life and fulfilling relationships. We believe mental health services have a major role to play in bringing about well-being for all; but only if these services are transformed.

Maps

There are three underlying foundations to our vision:

- Te Tiriti o Waitangi and its principles of partnership, participation, and protection.
- The concept of well-being: the state in which people can realise their abilities, cope with stress, work productively, and contribute to society.
- The philosophy of recovery: achieving the life we want in the presence or absence of mental distress.

Signposts: Forces for transformation

The rise in human rights awareness, self-determination, the consumer society, multiculturalism and the Māori renaissance have all impacted on the mental health arena.

Deinstitutionalisation, awareness of the social determinants of distress, and the service-user movement are all drivers for mental health service transformation. Expectations are also changing – people with mental distress want the same from life as everyone else.

There is already change at mental health policy level in many countries, including New Zealand. Moreover, demographic changes in New Zealand – such as the increasing Māori population and New Zealand-born Pacific population, with increasing numbers of young people – will require services to respond.

Destination: Our vision for well-being

Values and people

In our vision:

- Madness is a fully human experience.
- The purpose of services is recovery.
- Self-determination is the foundation of service delivery.

Adopting these values changes the way people think. Everyone is encouraged to be informed, active and competent – this includes the workforce, people who use services, their families and the wider community.

The nature of mental health services

In our vision:

- Services are easily accessible for all, with primary health settings as their hub; many services are delivered in ordinary community settings such as schools, workplaces and marae.
- Services are not compulsory and no longer focus on risk reduction at the expense of recovery.
- Mental health workers promote autonomy over authority, and the language used by services reflects this change.
- Services adapt to the needs of people, rather than people having to adapt to the needs and priorities of services.

Individuals and populations

In our vision:

- The service user negotiates and navigates services themselves with support from professionals, and advocacy services are available to all.
- Talking therapies are available to everyone, and drug therapy is one of a range of options for treatment, which includes complementary therapies.
- Individuals are offered day-to-day and crisis support, and are routinely provided with support for housing, employment and education, as well as peer support.
- Well-being is promoted within at-risk populations and is the responsibility of all sectors, not the health sector alone.

- Anti-discrimination work is ongoing and focuses on behaviour change, not simply awareness-raising.

Sectors

In our vision:

- Primary services are the most common point of access, and offer service negotiation, navigation, drug and talking therapies and other forms of support.
- Niche mental health services include acute, forensic, and early intervention services, and services for specific client groups.
- Other sectors are structurally aligned and work closely with primary services and mental health services to promote well-being for all.
- All agencies are accountable to powerful and well-resourced district leadership groups.

Systems

In our vision:

- Policy is profoundly influenced by service users, families and those most affected by mental distress, and funding is planned and responsive.
- Measures of effectiveness of services are simple and focus on outcomes that are important to service users.
- Coordinated service development, workforce development and research lead to adaptive, responsive services for all.
- An independent national agency monitors services and provides information on quality and advocacy for service users and whānau.

Pathways: Our recommendations

The following recommendations regarding strategic actions to facilitate the required transformation are not comprehensive. The Mental Health Advocacy Coalition has chosen them because they are actions that are in line with *Te Tāhuhu: Improving mental health 2005-2015: The second New Zealand mental health and addiction plan* (Ministry of Health, 2005), and we believe that prioritising these actions will give the most leverage to create a domino effect of further change, while taking the least amount of resources. The recommendations, if implemented, will also challenge the underlying barriers to change described in this paper.

Governance of services

Establish district leadership groups with a majority of service users, families, Māori, Pacific and other communities most affected by mental distress to:

- Assess and report on the needs and strengths of their local communities.
- Participate with local service leaders in developing strategic directions for services.
- Negotiate changes with planners, funders and providers.
- Prioritise areas for investment of new funding/service development.
- Oversee local service development in all involved sectors.
- Lead and facilitate a cross sector and integrated /coordinated approach to service development and delivery.
- Lead development of local performance indicators that reflect recovery-based practice, and support ongoing quality improvement processes based on use of these measures.
- Monitor and report on outcomes of service use for people with mental distress, and progress in meeting performance indicators.
- Provide independent information on the availability and quality of local services.
- Lead and encourage perspectives which consider more the social determinants of mental health and well-being.

Provide all participants with the opportunity to develop governance skills.

Implementing this recommendation will require an explicitly agreed and documented level of devolved decision-making authority from and accountability to District Health Boards.

National oversight advocacy

Strengthen national-level systemic advocacy and influence on decision-making by service users, whānau and families to the point at which they have a profound influence on the development of policy, funding, planning and provision of mental health services. This will require:

- Access where required to training in effective advocacy, and participation in decision-making processes.
- Development/strengthening of dedicated service user, whānau and family positions in national policy, funding, planning and provision bodies.

Transformational leadership

Strengthen visionary leadership at all levels of the mental health service system, and support these leaders to drive the transformation to recovery-based services, systems and organisations. This will in particular require:

- Recruitment of people into leadership roles with the vision and passion to drive this change process.
- Support and access to ongoing training in the skills to manage effectively the required change processes in the sector.
- Access to mentorship and supervision (including peer support/supervision) in transformational leadership for sector leaders.

Resourcing

Evolve funding/resourcing models that support and facilitate recovery-based practices and whānau ora. In particular this will mean a focus on funding model(s) that:

- Allow for flexible and individualised approaches to meeting service user needs – individually tailored 'packages of care'.
- Require integrated collaborative approaches to service provision across both specialist clinical and support organisational boundaries, and secondary-primary organisational boundaries.
- Address barriers to evidence-based 'best practice' in promoting recovery.
- Require the establishment of collaborative, complementary and robust partnerships across sectors (e.g. social services, housing, employment, education, justice and local government).

Progress towards such a funding approach is likely to require, among other things, a substantive review of local and international funding models to facilitate recovery and whānau ora, and piloting of one or more approaches across the sector locally with a view to generating learning and generalising successes.

Introduction

"Reinvention is not changing what is, but creating what isn't. A butterfly is not an improved caterpillar; a butterfly is a different creature." – Tracy Goss

Imagine a world where most people experience optimal well-being, and the assets that go with it, such as better health, greater productivity, better relationships and greater resilience in the face of life's challenges. Imagine too, that most people diagnosed with mental distress experience optimal well-being and the assets that go with it, because they have what they need to enable their recovery.

We are not even close to this world, but most of us want to reach it.

Mental health leaders in a number of countries are saying that mental health systems require transformation (Compagni, Adams, & Daniels, 2006). Transformation is more than just change – it does not mean doing more of the same or even doing the same better – transformation is the death of one way and the birth of another. We know it's happening when people start to think that the risk of staying the same outweighs the risk of change.

Within any kind of service, transformation requires a whole new set of attitudes, values, relationships, explanatory theories, models of practice and organisational structures. Our mental health services transformation must be built upon the recovery philosophy, which focuses on hope, self-determination, active citizenship and a holistic range of services.

What are the forces promoting transformation, and what are the barriers to change? What will the transformed services look like? How can we ensure the transformation happens as it should?

This paper proposes some answers to these difficult questions. The answers are generic and do not attempt to describe the huge diversity of people with mental distress and loss of well-being, or the specific responses that different groups of people might need. We do not focus on alcohol and drug issues except where these intersect with mental distress.

We use a whole population approach to mental distress and well-being, in which the desired outcome is for everyone to flourish.

A nurse with mental distress

On my return to work [after experiencing mental illness] I felt this amazing vulnerability, like an onion that had been peeled. I was very emotional and unable to screen out any emotional stimulus. It actually felt great. I was more tuned in to things than I could ever remember.

It was a bit difficult at first with clients; gaining confidence that these new perceptions were OK, as long as I was aware of the usual boundaries. I was more able to sense vulnerability in others, and build a rapport with clients that I had not previously experienced.

Some of the outcomes for my clients during this initial time were exciting. My work since has been of a different quality. It is difficult to explain, but it has to do with the enhanced empathy I've experienced with clients, since my own experience of mental illness. I have learned to be confident with this and usually follow where it leads.

Maps

1. Maps

"When an organisation reinvents itself it must alter the underlying assumptions and invisible premises on which its decisions and actions are based…it must uncover its hidden context."
– Tracy Goss

To begin, we need to explain some of the fundamental points of view used to construct this paper. They are like the different maps we use to understand the territory we are in.

1.1 Te Tiriti o Waitangi

Kia mau ki te kura whero, kei mau koe ki te kura tawhiwhi, kei waiho koe hei whakamōmona, mo te whenua tangata.

Hold onto the precious treasures, to the ancestral treasures, leave alone what is harmful to the people enriching the land today.

Te Tiriti o Waitangi (the Treaty of Waitangi) governs the relationship between Māori and the Crown. It gives the Crown the right to govern, though the extent of this is disputed. It also gives Māori the right to self-determination and the same citizenship rights as non-indigenous New Zealanders. Today Te Tiriti is interpreted by Government as giving Māori the right to take part in determining policy, to equal access to health and social services, as well as the right to provide services for their own people.

Māori have a unique status as tangata whenua under Te Tiriti and these rights are not transferrable, but the principles of partnership, participation and protection enshrined in Te Tiriti provide a good framework for understanding and protecting the human rights of other groups who face disadvantage in our society, including people with mental distress.

These human rights and such principles are central to the recovery approach and underlie the messages in this paper.

1.2 Mental distress and well-being

"The language of psychiatry [has been] a monologue of reason about madness." – Michel Foucault

Mental health, or well-being as we call it, is defined as a state in which people can realise their abilities, cope with stress, work productively, and contribute to society (World Health Organization, 2007). Loss of well-being occurs when these assets cannot be realised.

Mental illnesses, or mental distress as we call it, are conditions of the mind, such as 'schizophrenia' or 'major affective disorder', that match the descriptions found in psychiatric diagnostic manuals.

People usually think of 'mental health' and 'mental illness' as two ends of the same continuum. They assume that as a person's mental illness decreases their mental health must increase and vice versa. Whole systems, organisational structures and professional groups have been built on the view that promotion and prevention are for people at the healthy end of the continuum, and treatments and services are for people at the illness end.

There is now evidence that mental distress and loss of well-being are best regarded as separate phenomena, because some people with diagnosable mental distress also experience well-being, and many people with a major loss of well-being do not have a diagnosable condition (Keyes, 2007; Tudor, 1996).

They are also intimately related phenomena, however. The origins of mental distress and loss of well-being are often similar; they both emerge from the complex interaction between genes and life experiences such as inequality, racism and trauma (Bentall, 2004; Read, Mosher, & Bentall, 2004; Wells, 2004; Wilkinson, 2005). The consequences of mental distress and loss of well-being are similar too – both lead to poorer outcomes in physical health, productivity, relationships and psychological resilience (Keyes, 2007). Therefore, the prevention of mental distress and loss of well-being, and responses to them, should overlap significantly.

Mental distress and loss of well-being are also conditions with vast ripple effects. They are experienced by individuals but their origins and consequences are not only personal, they are social and economic as well. They both require responses that go far beyond the health sector, and right to the heart of social and economic policy.

In this paper we use the terms 'mental distress' and 'well-being' to replace 'mental illness' and 'mental health' because they better represent our understanding of these two conditions.

1.3 Recovery

"Those who do not have power over the stories that dominate their lives, power to retell them, rethink them, deconstruct them, joke about them, and change them…truly are powerless because they cannot think new thoughts." – Salman Rushdie

Recovery is the first genuinely post-institutional service philosophy. It has broad origins, but over the last 15 years it has been profoundly shaped by the service user movement.

We define recovery as achieving the life we want in the presence or absence of mental distress. The right conditions for recovery are the strength and interrelationships of our self-determination, personal resources, supports, therapies, and our social and economic opportunities.

The role of recovery-based practices and systems is to ensure all of these factors are maximised for both people with mental distress and those with loss of well-being.

Peer-run support service

We knew that some people needed more comprehensive resources and longer-term relationships than they were getting from existing mental health services. Our peer-run service negotiated individualised packages of care with the local District Health Board to support people to find their way back into the community.

We're non-clinical. We don't see a diagnosis as the problem. Instead, a person may need a house to live in or crisis respite, a hand with budgets, help with groceries or a lift to see a family friend. Or they might need assistance getting out of the psychiatric unit or advocacy with a doctor to change medications.

Our service does whatever it takes to solve a problem – with love and acceptance, with wisdom, with expert action and with time. Staff members listen to the client and then take action, always checking with the client whether the action is appropriate.

It's all about relationships – sustained, consistent and on time. It might take years, decades even. Staff members have to understand the relationship and know when to put out their hand and when to keep their hand at their side. Nothing else matters but the relationship with the client.

Signposts

2. Signposts

"One of the tests of leadership is the ability to recognize a problem before it becomes an emergency." – Arnold Glasgow

The signposts to the future provide us with some clues about the destination we are heading towards.

2.1 Forces for transformation

"Revolutions begin when people who are defined as problems achieve the power to redefine the problem." – John McKnight

The mental health arena, like everything else, reflects the dominant forces in contemporary society.

Within the last two or three generations, human rights have taken a more central place in the world, particularly in western democracies. At the same time the rise of individualism in western societies has contributed to the partial disintegration of communities as well as the moral imperative for individuals to take charge of their own lives.

Since the 1980s liberalisation of the New Zealand economy, private enterprise and public services have put more emphasis on consumer satisfaction. Consumers of all kinds tend to be better informed and have higher expectations of services.

Contemporary New Zealand has also been shaped by the Māori renaissance of the 1970s and 1980s, which helped to reverse the impacts of colonisation, leading to the return of stolen land, or compensation for it, and the revival of Māori culture, language and practices. Over the last two or three generations New Zealand has also become a far more multicultural society, with a greater diversity of communities and lifestyles.

These changes herald an unprecedented acceptance of diversity and respect for individual and collective self-determination, which have been mirrored in many of the changes in the mental health arena.

The last psychiatric hospital in New Zealand was closed in 1999, a change prompted in part by human rights concerns. Deinstitutionalisation will not be complete, however, until services fully embrace the recovery philosophy/whānau ora and people with mental distress are free to actively participate in society.

The recovery philosophy stresses hope, self-determination, full citizen participation and a broad range of services and resources for people with mental distress. Whānau ora – the foundation of Māori health policy – resonates with the recovery philosophy. It is defined as 'Māori families supported to achieve their maximum health and well-being' (Ministry of Health, 2002). Whānau ora accentuates collective well-being, whereas recovery, with its western roots, tends to be more individualistic (Mental Health Commission, 2001).

The last century has seen the proliferation of chronic lifestyle-related conditions such as depression, cardiovascular disease and diabetes. Unlike the simpler solutions to infectious diseases, these conditions require good self-management in their prevention and treatment. This approach aligns with the recovery philosophy.

Mental health services can no longer work in isolation if their purpose is inclusion rather than segregation. Other sectors are becoming more involved and anti-discrimination projects and other initiatives are communicating the right of people with mental distress to be fully participating citizens.

There is also a renewed awareness of the social determinants of mental distress such as trauma, racism and inequality, and of the complex interactions of nature and nurture. This knowledge is starting to become apparent in awareness of the need for whole-of-government approaches to prevention and a broad range of holistic services.

An important ingredient in many of these changes has been the service user movement, which, like other movements of our times, is seeking self-determination as well as more responsive services and an inclusive society. There has also been the parallel development of a family voice in the mental health arena.

These forces for change in wider society and within the mental health arena signal the kind of transformation described in this paper. In the future, responses to people with mental distress and loss of well-being need to:

• Reduce social determinants such as trauma, racism and inequality.
• Provide a broad range of responses for diverse needs and populations.
• Cooperate and integrate with other agencies, sectors and communities.
• Build the capacity of people and communities to create well-being.
• Respect the subjectivity of people with mental distress.
• Foster their self-determination.
• Develop the governance and leadership of service users in services.
• Advocate the right of people with mental distress to participate as citizens.

2.2 Barriers to transformation

"If your only tool is a hammer, all problems look like nails." – Mark Twain

Forces always have counter-forces, and there are considerable barriers to the transformation we seek. The underlying barriers, which are often implicit, are probably the hardest to shift. The institutional barriers, which are well known, are more tangible and appear easier to break down; however, the ultimate solution lies in also addressing the underlying barriers.

The first underlying barrier is that communities, mental health professionals and even people with mental distress themselves tend to believe that madness is entirely negative and has no value. This belief generates fear, pity, discrimination, exclusion and the coercion of mad people. Unlike other extreme experiences such as intense grief or surviving a war, society still does not legitimise madness or nurture a pathway through it towards growth or recovery.

Second, these views on madness have led to community assumptions that mad people are prone to violence and cannot take responsibility for their behaviour, so someone else needs to take control. Communities have abdicated all responsibility for people with severe mental distress to mental health experts and services. If something goes wrong mental health services are habitually blamed. These expectations are often based on flawed generalisations that mad people lose all personal responsibility on one hand, and that services have a superhuman ability to predict disasters on the other. Unfortunately, this leads to defensive practitioners, risk-averse practices, and services that focus on risk at the expense of recovery.

A third underlying barrier is that publicly funded health and social services have a number of often conflicting stakeholder interests to satisfy, owing to their complex ownership, accountabilities and funding arrangements. Mental health services also have the politically-charged role of containing and controlling some people. It's easy for these services to lose their focus on the needs and views of people who use them. Some people also argue that communities and individuals have become over-dependent on services. Although professionals and services can be of huge benefit, their tendency to focus on deficits and not strengths can prolong or even manufacture problems.

The institutional barriers tend to be symptomatic of the underlying barriers described above. They include the following:

- There are no comprehensive and coordinated policy frameworks, structures and practices for reducing the determinants and reversing the consequences of both mental distress and loss of well-being (Keyes, 2007).
- Guidance from the centre is outdated and often inflexible. For instance, the national service specifications framework (currently under review) under-emphasises humanistic responses such as talking therapies and peer support, and there is a focus on outputs such as staffing levels and beds, to the exclusion of outcomes such as service users' quality of life or income levels.
- The different agencies and sectors are not set up to collaborate as a result of current funding approaches, differing accountability mechanisms, and a lack of skills, resources and commitment.
- It is difficult to spread good practice, partly because there is no agency with responsibility for service development at a national level.
- The workforce is not well equipped for the future. The current workforce is ageing, small, and sometimes demoralised. New workforces such as peer-support specialists are not being developed rapidly enough.

- Many people experience difficulty accessing services because they do not recognise their problems early enough, cannot afford to see their GP, or because mental health services don't take them on.
- Community expectations feed risk-averse practices such as the frequent use of compulsory treatment, locked wards and security guards. At a service level, a false sense of safety is often derived from sticking to known practice, even when there is evidence that it doesn't work well.
- Evidence about mental health services and treatments comes primarily from a narrow quantitative base, and ignores the subjective experience of people who use services.

2.3 Expectations

"The mental health business is the only business in the world where the customer is always wrong." – Doris Wells

Our Lives in 2014 (Mental Health Commission, 2004) describes the lives that people with major mental distress want to lead by 2014. They state that the purpose of services and other community responses is to support people to lead their own recovery, so they can regain personal power and a valued place in their whānau and communities. Put simply, people with mental distress want the same out of life as others.

Personal power is achieved when people experience hope, purpose, self-agency, a positive identity, a sense of achievement and satisfying relationships.

A valued place is reached when people are an integral part of safe, strong families, have equal access to education, employment, housing, transport, and goods and services, and are free to participate in the commercial, cultural, political, spiritual and recreational life of their communities.

Traditionally, mental health services have tended to focused on the minimisation of symptoms. With the advent of the recovery approach they need to focus on priorities expressed in *Our Lives in 2014*.

2.4 Emerging policy

"There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction." – John F Kennedy

A comparative analysis of the latest policy directions in seven countries (New Zealand, Australia, Canada, England, Scotland, the United States of America and Italy) notes considerable convergence in their priorities, including (Compagni et al., 2006):

- Making the promotion of well-being and anti-discrimination a public priority.
- Improving access and enhancing the range of services.
- Ensuring an adequate, competent and skilled mental health workforce.
- Focusing on service user participation, responsiveness and recovery.
- Integrating and linking health and social sectors.
- Promoting evidence-based, measurable and accountable responses.

These priorities are reflected in the ten challenges set out in the second New Zealand mental health and addiction plan, *Te Tāhuhu: Improving mental health 2005-2015* (Ministry of Health, 2005) (see Appendix 1).

2.5 Demographics

"If we do not learn from history, we shall be compelled to relive it. True. But if we do not change the future, we shall be compelled to endure it. And that could be worse." – Alvin Toffler

Young people, Māori, Pacific people and people in low socio-economic groups have the highest rates of mental distress in New Zealand (Oakley Brown, Wells, & Scott, 2006).

Population projections reveal (Statistics New Zealand, 2007):

- By 2026 people of European[1] origin will make up less of the population than today; the Asian population will almost match the Māori population; and Pacific peoples will make up slightly more of the population than today.
- Māori and Pacific populations will be younger than European or Asian populations.
- All ethnic groups will live longer than they do today.
- In the period 2006-2031, two thirds of all population growth will be in the Auckland region

Services and programmes need to plan for and respond to these forecasts.

[1] People who identify as 'European or other (including New Zealander)'

Māori rangatahi health promotion service

Our service is driven by the belief that young people can deliver health education to other young people and encourage them to lead a healthy lifestyle.

We provide peer education programmes to youth in a lot of community settings modelled on te whare tapa whā. It covers things like self-esteem, resilience, support systems, communication, conflict resolution, power and control, sexual health, sexual orientation, relationships, drugs and goal setting.

In the last ten years, our service has given many youth the opportunity to become more aware of their health and lifestyle choices. This has enabled them to become more self-determining – to reach their full potential, gain new qualities, and have more positive experiences. We've learned that if we can give rangatahi the right information they are able to make more informed choices.

Destination

3. Destination

"Change is the process by which the future invades our lives, and it is important to look at it closely, not merely from the grand perspectives of history, but also from the vantage point of the living, breathing individuals who experience it." – Alvin Toffler

The signposts to the future don't paint a full picture of what services will look like. We now attempt to do this based on a combination of knowledge of what works, an understanding of current trends and an informed vision. We paint this picture in the present tense, in recognition that some services are already part of the way there, and in anticipation that this vision is possible for all services in the future.

3.1 Values

"They called me mad, and I called them mad, and damn them, they outvoted me." – Nathaniel Lee

Madness is a fully human experience

People recognise the importance of social, economic, political, psychological and spiritual, as well as biological, contributors to mental distress and loss of well-being. Mental distress is seen primarily a way of being, with associated personal and social barriers to living well, as well as a fully human experience from which value and meaning can be derived (Roberts, 2000). It is not routinely referred to as illness.

The purpose of services is recovery

Services support people with mental distress and loss of well-being, as well as their families, to lead their own recoveries. For Māori this means whānau ora.

Self-determination is the foundation of service delivery

People working for the benefit of those with mental distress believe in their self-determination. They enhance self-determination by fostering hope, offering a choice of responses and ensuring a quick return to active citizenship. They foster the leadership of service users in their own recovery, and at a collective level through their advocacy and workforce roles.

3.2 People

"In a time of drastic change it is the learners who inherit the future. The learned usually find themselves equipped to live in a world that no longer exists." – Eric Hoffer

The new purpose and values of services change the way people feel, think and behave. Everyone is encouraged to be informed, active and competent in their role – not just the paid workforce, but people who use services, their families and the wider community.

People with mental distress

They don't struggle much with internalised stigma, gloomy predictions or loss of hope. Instead, they are supported to take responsibility for their own lives, negotiate the services they want, and make their own informed decisions. Collectively, people with experience of mental distress are a major force, demonstrating leadership in advocacy and in the workforce at all levels.

People with loss of well-being

They are educated and supported to improve their well-being, within their whānau, communities, schools and the workplace. Some of the funded responses available to people with mental distress, such as recovery education, peer support and talking therapies, are also available to them.

Families

Families and whānau retain hope for their family member. They are supported and educated to enhance the recovery of their family member, as well as the recovery of the family unit, from the stresses associated with mental distress. All families have access to family peer support and recovery education. Mental health workers welcome their involvement, knowing that they can be part of the recovery journey.

The workforce

People in the workforce feel valued by service users, their families and management. They are freer to take reasonable risks and manage them in partnership with the service user and their family. The wisdom gained from experiencing mental distress is highly valued and seen as a qualification for working with others. Māori, Pacific people, families and service users also have a much greater presence in the workforce.

Communities

People in the wider community understand that people with mental distress are not especially prone to violence and usually retain their competence, and that services cannot prevent all tragedies. They see major mental distress as a fully human experience and think discrimination against people with mental distress is wrong. Community members, without the blinkers of fear and discrimination, are valuable stakeholders in the planning, delivery and evaluation of responses.

Politicians

Politicians have a sense of urgency about the huge personal, health, social and economic costs of social inequality, racism and trauma. Governments are developing new policies, funding approaches and incentives to coordinate work across the spectrum to reduce the social determinants of mental distress and loss of well-being.

3.3 Key elements of services

"Language exerts hidden power, like the moon on the tides." – Rita Mae Brown

New language

The language people use reflects the purpose, values and assumptions that services are built on, especially the roles of service users as active agents in their recovery, the broad understandings of mental distress and the anticipation of recovery. The new language values both subjectivity and objectivity. It emphasises internal autonomy over external authority. In the context of respectful relationships with service users, workers feel uncomfortable describing them with terms like 'non-compliant', 'lacking insight', 'inappropriate', or 'manipulative'.

Easy access

Individuals and families know where to find independent information on the availability and quality of services. There are many doors into services – a lot of them open into primary health settings which act as the hubs of service delivery and referral. People are not denied access to help on the basis that their distress or loss of well-being are insufficiently severe; they are either provided for or immediately referred elsewhere. People in prison and forensic services have access to the same range and quality of mental health responses as other citizens.

Accessing services through a group of GPs working together to provide health services, psychological services and health promotion

When I realised that my wellness was deteriorating I took immediate action, making an appointment to see my GP (with whom I have a long history). He confirmed that I was experiencing depression and arranged for me to see one of the group's psychologists.

Previously, when I needed help from community mental health services, I discovered that people who were not a danger to themselves or others had to wait a week or two to be seen. This didn't work well for me because I only have a small window of opportunity in which to seek help. If I miss that window I no longer believe I need help.

I saw the group's psychiatrist and psychologist for six sessions each. Their support enabled me to develop further coping skills and regain control of my life. The psychiatrist looked into different medicines and natural remedies as I react strongly to any medication. The psychologist provided cognitive behaviour therapy which helped me to change unhelpful thoughts. They listened to me, acknowledged my feelings, were supportive, encouraging, and empowering, and cared about my personal well-being. They treated me with dignity and respect, and gave me confidence in my ability to recognise and accept my symptoms. The experience has made me aware of the positive impact clinical services can have in the recovery process.

Voluntary use of services

Compulsory treatment is used rarely and briefly. There is no seclusion or compulsory electro-convulsive therapy (ECT). People working in mental health services strive to prevent compulsory interventions. Any use of compulsory powers is done humanely and their use is treated as a critical incident. This is matched by a changed emphasis on professional responsibility; providing the best possible advice and assistance is in the foreground, while containing clinical risk does not dominate.

Natural locations

Virtually all responses are delivered in an ordinary community location, such as a primary care setting, at marae, shopping malls, schools, workplaces, a person's home or online. Residential crisis services are small, home-like and rarely in a hospital setting. Environments are safe for everyone.

Trauma informed responses

There is widespread recognition of the role of trauma in the lives of many people with loss of well-being and mental distress which has led to the creation of safe and nurturing trauma-informed services. This approach places high value on service user leadership, recovery and strengths-based practice. Trauma-informed services always screen for trauma and provide specific responses for people who have experienced it (National Center for Trauma Informed Care, n.d.; Ohio Legal Rights Service, 2007).

Equalising relationships

Mental health workers strive to show people respect and treat them as whole human beings who have strengths and abilities as well as problems. They promote their autonomy. They are practiced at asking people what they need, listening with empathy and compassion, and giving hope and encouragement.

Services adapt to the needs of people, rather than people having to adapt to the needs and priorities of services.

Responding to diversity

The responses, and the workforces to deliver them, reflect our cultural diversity, ensuring that people of all cultures are well served.

Māori health inequalities are decreasing and Māori continue to develop their own services, workforce and kaupapa, as well as their influence over mainstream services. There is wide support for kaupapa Māori services, which are available to all Māori. These services are governed by Māori customs and protocols (tikanga), utilise a range of practices and therapies including traditional healing methods (rongoā), a holistic approach, and promote the development of strong families (whānau ora) (Mental Health Commission, 2007; Boulton, 2006). The Māori workforce includes many professionals and peer-support workers, some of whom are leaders in the wider mental health arena

Pacific peoples' health inequalities are decreasing. Like Māori, they continue to develop their services, workforce and leadership in the mental health arena.

Asian people are no longer the ethnic group that use services the least, now that the stigma of mental distress has been lifted, and they have the choice to use culturally relevant services.

People with English as a second language have quick access to trained interpreters.

People with physical, sensory and intellectual disabilities have good access to services and information. All buildings are accessible and information is immediately available in a variety of formats.

Bottom-up leadership

The workforce is able to work with people with mental distress, their families and affected communities to assess their capacities, develop their leadership, build empowering organisational structures and find the necessary resources for them to govern and lead in the design, delivery and evaluation of services (Laverack, 2001). They have the values and expertise to develop equalising relationships with stakeholders.

3.4 Responses to individuals

"Vision is perhaps our greatest strength…it makes us peer into the future and lends shape to the unknown." – Li Ka Shing

Services provide a broad range of core responses that address the full variety of contributors to, and consequences of, mental distress and loss of well-being. These core responses are better seen as functions rather than roles; a few of these functions could be performed by the same person.

Addictions responses are integrated with the other responses for people with mental distress and loss of well-being. All mental health teams, whether in the primary or specialist mental health setting, have day-to-day access to addictions expertise and vice versa.

Ensuring full access
Service negotiation
This is a process whereby the service user and the professional jointly identify the person's problems, strengths and aspirations, and negotiate how services could assist. This process uses the person's own expertise about their context and subjectivity, as well as the practitioner's expertise and willingness to accommodate various viewpoints. It culminates in a recovery plan that is regularly reviewed.

Service navigation

Service navigation ensures people with a number of needs have access to all the services, resources and opportunities they need in the primary, specialist mental health and social sectors, and in their communities. The evidence indicates that the service navigation function works best when combined with a support function in the same worker or team (Rapp, 1998; Rapp & Goscha, 2004).

Therapies

Talking therapies

Talking therapies are available to all who need them and are subsidised or free of charge in the specialist or primary setting. People affected by trauma have access to therapies that directly address the impact of their trauma and facilitate recovery from it (Harris & Fallot, 2001). Māori, Pacific and Asian people have good access to therapists from their own cultures.

Drug therapy

Drug therapy is offered as one of a range of options rather than the backbone of treatment and support. People enter into drug therapy in collaboration with the prescriber, with good knowledge of beneficial and adverse effects and with confidence that any adverse effects will be well managed. Choosing not to take drugs is a valid option that the prescriber is willing to advise on. The ultimate aim of taking psychiatric drugs is to enhance recovery, not to suppress symptoms.

Complementary therapies

The state funds some complementary therapies, especially as an adjunct to other therapies; for example, traditional Māori treatments, massage or acupuncture. There is funding for research regarding the benefits of these therapies, and funding and active promotion of those found to be beneficial.

Support

Day-to-day support

This is needed by some service users for tasks such as housekeeping, child-minding, planning routines or facilitating social contact. It is available to people in times of crisis as well as those who need ongoing support of this kind. Currently, most of this work is undertaken by community support workers.

Crisis support

When people are in crisis they have trained and empathetic people to care for them, listen to them, and attend to their spiritual, psychological and social needs. Staff members have the support, values and skills to ensure service users' safety without habitually using compulsary treatment or inadvertently re-traumatising people.

Education, employment and housing support

All people who are struggling in education, employment or housing receive support to choose and maintain their roles and responsibilities.

- Education support is available at primary, secondary and tertiary levels and may involve liaison with staff and teachers, study skills, a teacher aid, extensions on assignments or extra tuition.
- Employers are equipped to create mentally healthy workplaces and negotiate reasonable work conditions for diverse needs and talents. People with mental distress are offered flexible support to get and keep employment.
- There is very little staffed accommodation and most people are given support to find and keep their own homes.

The workforce in education, employment and housing support comes from a number of sectors, agencies and communities.

Peer support

Peer support, delivered by others who have been through similar experiences, is routinely offered to all people with mental distress or who are experiencing loss of well-being, as well as to families. Peer support includes peer mentoring, support networks, phone lines, befriending and peer crisis support.

Recovery education

This uses a health promotion approach that gives people tools to manage their whole lives – from dealing with internalised stigma, to finding meaning in their experience, getting the best out of services, finding friends, houses or jobs. Family recovery education gives families the tools to manage their own responses to their relative's mental distress as well as the tools to support their relative's recovery. Well-being education is similar to recovery education and is available to all people in schools as well as to adults with loss of well-being.

Rights

Advocacy

Individual advocacy is available to everyone using services to help people make complaints that are quickly responded to, and to ensure that the small number of people under compulsory treatment have reliable advocacy and information. Advocates, whether legal, peer or lay, act on their clients' instructions, showing a commitment to human rights.

Human rights redress

Human rights redress is easily accessible, effective and speedy for anyone who has experienced discrimination or human rights abuses on the grounds of mental distress.

3.5 Responses to populations

"In failed transformations you find plenty of plans and programs, but no vision." – John P Kotter

Prevention

The prevention of mental distress and loss of well-being is the responsibility of all sectors, not just health. Prevention addresses the social determinants of mental distress and loss of well-being, such as trauma, social inequality and racism.

Promotion

Well-being promotion takes a whole population approach and involves a range of responses and services. There is a focus on at-risk populations such as people with mental distress and loss of well-being, young people, Māori and socially disadvantaged people. Promotion activities dovetail with services for individuals with mental distress or loss of well-being. Well-being promotion for Māori is led by Māori and uses a wide range of approaches that facilitate cultural identity, environmental protection, safe and healthy lifestyles and full Māori participation in wider society (Durie, 1999, 2004).

Anti-discrimination and social inclusion

Increasingly people with mental distress are visible and valued members of their communities. There is an ongoing anti-discrimination campaign that uses social marketing, media monitoring and policy development to advocate the fully human status of mad people and zero tolerance of discrimination. The emphasis has shifted from awareness-raising to behaviour change. The

underlying message in all anti-discrimination work is the legitimisation of madness, and the rationale for action comes from human rights and recovery perspectives rather than a medical perspective (Sayce, 2000).

The media regard discriminatory coverage on the basis of mental distress as unacceptable.

The specialist and primary mental health workforces take responsibility for ensuring they and other agencies have a clear focus on social inclusion and responding to internalised stigma.

3.6 Sectors

"All fundamental political problems are problems of relationships; therefore, all fundamental solutions have to involve fundamental changes in relationships." – David Mathews

A broad range of responses requires a broad range of delivery and support agencies. The hub of service delivery could be an expanded primary health sector that works closely with a (potentially) reduced specialist mental health sector, with social services, iwi and hapū,

community resources, public health and human rights agencies (see Figure, page 46).

Integration (the formal merging of agencies or projects) and coordination (joint working between separate agencies or projects) are the norm both across the different services, sectors and communities, and through the system from policy to funding and delivery. Integration and coordination are achieved through joint planning and pooled funding; by moving workforces between teams, services and sectors; through information sharing, or shared use of communications technologies for online or distance service provision.

Primary mental health

Primary services are the most common point of access to services for people with mental distress and loss of well-being. They assist people to self-manage and provide access for people to use services in other sectors if needed.

Community mental health centres and many support services have merged into primary health settings, where most therapeutic and support services for people with mild, moderate or severe distress are provided. Service negotiation, navigation, most prescribing and talking therapies, day-to-day support, peer support, and recovery education, are part of an expanded primary health focus for all people with mental distress who need them, irrespective of whether their distress is severe or mild, long term or short term.

Mental health clinicians within the primary setting mainly work with people with more severe forms of mental distress, but they are also available to advise their primary health colleagues and to facilitate referral to specialist mental health services.

People with major mental distress also have enhanced access to physical health promotion and services to counter their alarming mortality rates.

Specialist mental health

Specialist niche mental health services include some, but not always all, acute services, forensic services, intensive early intervention services, child and youth services, older people's services, addictions services and psychotherapeutic services. They offer crisis support, as well as some therapies and support to people with severe distress, although many of these people are also using support services from primary mental health and other sectors.

Non-government services

Non-government organisations (NGOs) continue to be major service providers, especially those run by communities that are directly affected by mental distress, such as service user, family, Māori, Pacific and Asian organisations. It is a truly independent sector with sufficient funding and economies of scale to be sustainable and with more opportunities to access philanthropic funds. NGOs in a contractual relationship with primary health, mental health and social service government funders have more flexibility, but also more accountability when they do not deliver good quality recovery-oriented services. NGOs provide a wide array of responses, including clinical responses, often in collaboration with other agencies.

Other sectors

Social services

Supported employment, supported education and housing support are collaborative, using expertise in those sectors as well as mental health expertise from the primary or specialist mental health sectors.

Public health

The agencies that promote well-being including local authorities are structurally aligned and work closely with mental health, primary health, schools, workplaces and community organisations to coordinate their population based approaches with the individualised responses provided by services.

Community resources and agencies

Generic community resources are heavily utilised for the benefit of people with mental distress and loss of well-being.
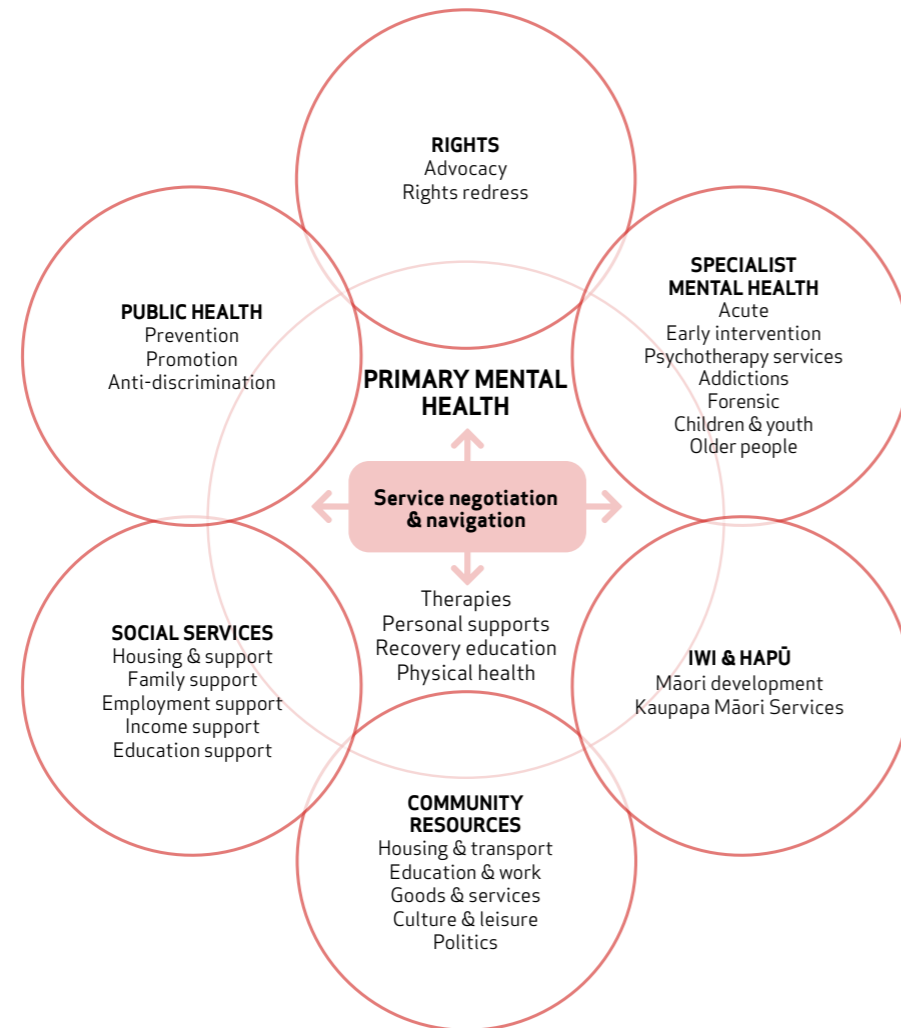
Iwi and hapū

Iwi and hapū have control over the development and delivery of kaupapa Māori services.

Human rights

Human rights agencies provide accessible information, advocacy and rights redress.

Relationships and connections

Circle labels:

RIGHTS
Advocacy
Rights redress

SPECIALIST MENTAL HEALTH
Acute
Early intervention
Psychotherapy services
Addictions
Forensic
Children & youth
Older people

PUBLIC HEALTH
Prevention
Promotion
Anti-discrimination

PRIMARY MENTAL HEALTH

Service negotiation & navigation

Therapies
Personal supports
Recovery education
Physical health

SOCIAL SERVICES
Housing & support
Family support
Employment support
Income support
Education support

IWI & HAPŪ
Māori development
Kaupapa Māori Services

COMMUNITY RESOURCES
Housing & transport
Education & work
Goods & services
Culture & leisure
Politics

Overlaps between the circles illustrate cooperation and integration. The primary mental health setting is the hub of service delivery for all. Service negotiation and navigation provide access to the other sectors when needed. Non-government organisations feature across a number of the sectors. District leadership groups oversee the whole system.

District leadership groups

All agencies are accountable to a powerful, well-resourced district leadership group made up of all stakeholder groups, with strong service user, family, Māori, Pacific and other local community membership. They investigate the needs and strengths of their local communities, as well as the outcomes for people using services. They use this information to advise funders and providers from the various sectors, who are genuinely accountable to them. The district leadership groups also direct the provision of independent information to communities on the availability and quality of local services.

3.7 Systems

"The very essence of leadership is that you have to have vision. You can't blow an uncertain trumpet." – Theodore Hesburgh

Policy

Policy is aspirational, achievable and aligned with other sectors. It is profoundly influenced by service users, families, and population groups that are most affected by mental distress and loss of well-being, such as young people, Māori and Pacific people.

Measures

Government measures the well-being of the population and uses the results in the formulation of social and economic policy. Measures that indicate how a service is performing are simple and selective with a focus on outcomes that are important to service users. Services are evaluated on behalf of local leadership groups, and the results of the evaluations are explicitly connected to ongoing improvement processes and accountabilities.

Funding

Funders have the appropriate conditions and incentives to fund responses in a planned and future-driven way, ensuring there is equitable provision of services for people in the populations they serve. They have the resources and flexibility to tailor funding for people with unusual sets of needs, to make direct payments, to fund jointly with other agencies, and to phase out traditional services while they introduce new ones.

Development

Coordinated service development, workforce development and research help drive responses into the future. Existing services and workforces have been reoriented. New services and workforces are being developed.

Workforce development

This focuses on new workforces such as the service user, family and Asian workforces, as well as reorienting existing workforces. Education emphasises emotional competence (Kidd, 2007), reflective practice and self-care, as much as theoretical and practical competence. Large sections of the workforce learn and practice new occupational skills. There are also education programs for people working outside the health sector who deliver services to people with mental distress and loss of well-being.

Service development

This dovetails with workforce development. The development of peer support services, recovery education services, supported housing, employment and education, advocacy services, and new home- and community-based acute services are well coordinated in the different districts and with other development activities.

Research development

Research both reflects and tests the values and assumptions services are based on. Research and evaluation informs and shapes workforce and service development efforts. Service users, families, Māori, Pacific people and other traditionally excluded groups are getting equitable access to research money. Quantitative research and evidence continues but qualitative research has equal credibility (Faulkner & Thomas, 2002). The newer qualitative research approaches look at evidence from the ground up, emphasising client-based evidence, practice- and community-based evidence as well as formal research-based evidence (Naquin, 2007).

Independent oversight

A national agency or agencies, funded through the health sector but independent of the health line of accountability:

• Monitors the systems of services and responses.

• Ensures information provision to communities on the availability and quality of services.

• Provides national systemic advocacy by and for people with mental distress, as well as by and for families and whānau.

3.8 Comparing the old with the new

Traditional services and recovery-based services are best seen as two ends of a continuum. Most services in 2008 sit somewhere between the two.

		Traditional Services	Recovery-based Services
		← CONTINUUM →	
BELIEFS	Views of madness	Pathology No meaning	Crisis of being Fully human experience
	Philosophy	Treatment Paternalism	Recovery Self-determination
	Language	Medical Objective 'They'	Personal Subjective 'We'
PEOPLE	Service users	Passive recipients	Active agents and leaders
	Families	Unsupported and grieving	Supported and supportive
	Workforce	Mainly medical/clinical Expert authorities	Diverse backgrounds Collaborators
	Communities	Fearful and discriminatory	Accepting and inclusive
SERVICES	Service types	Drugs and hospitals	Broad range of therapies; supports; recovery education; and advocacy
	Service cultures	Authoritarian Segregation from society	Participatory Inclusion in society
	Service settings	Hospitals and clinics	Community and home based crisis and other services Online services
OUTCOMES	Social networks	Service community	Natural community
	Housing	Hospitals Residential services	Own home
	Employment	Pre-vocational services Sheltered workshops Unemployment	Real work for real pay A valued contribution to society

New-style clinic

A general practitioner (GP) approached a primary health organisation and proposed a 'hassle-free' clinic in a peer-run community centre. The idea was that mental health service users could drop in and see a GP for free, in an environment where they felt comfortable.

Many people had no access to GP care. Some had built up debts with GPs and were unable to make appointments until their debts were paid. Others had not seen a GP for many years.

The hassle-free clinic has been a great success and many serious health problems were uncovered. One person who was on psychiatric drugs had developed a physical health problem, because their combination of drugs was toxic. Others had not had their weight checked nor received advice on side-effects and diet, and people with diabetes were not having regular check-ups.

Now many of the people are much better physically, which in turn is helping their mental well-being.

Pathways

4. Pathways

"In truth, we are on a journey with no final destination and no resting points." – Norman R Augustine

4.1 The evidence and wisdom on change

"Management is helping to make happen what is supposed to happen anyway; leadership is making happen what isn't going to happen anyway." – R Pascale

Showing the destination is relatively easy but getting there is hard. Fortunately, there is some evidence and wisdom about what is successful with regard to organisational change or transformation. (Some key references are provided in the Appendix 2). Key points are outlined below.

Create a rationale, vision and strategies

Generally people are not motivated to cooperate with change unless there are compelling reasons supported by an ongoing sense of urgency. The vision, and any deficiencies it addresses, provides the rationale for the change. The vision then needs to be translated into sets of values, strategies, processes and outcome expectations, with measurable short-term goals that create quick wins.

Focus on the internal as well as the external

Individual thoughts or feelings and organisational culture are often hidden and hard to quantify. In this way they are unlike behaviour, organisational structures, policies and rules. Many change processes fail because they focus on the tangible externals at the expense of internal experience and culture – both require attention.

Get leadership support

Sustained and highly visible governance and management support is essential for organisational change to succeed. Leaders need to both champion and role-model the changes they are working towards. They need to ensure reliable funding streams, including funds for the additional costs of implementing change.

Use dedicated change management staff

It is unrealistic to expect staff with other responsibilities to manage significant organisational change. Success is much more likely if there is a dedicated change management team to address both task and process issues, made up of change management experts and key stakeholders.

Get the best out of the workforce

Recruit for values as well as skills. Find staff members who have the self-efficacy and resilience to easily accept change. Training on its own does not improve performance. It must be combined and coordinated with coaching and performance appraisal.

Involve stakeholders

Leaders need to ensure the involvement of stakeholders from the start as co-creators of the change. Frontline and middle managers can make or break the change process and are important to bring on side. Service users, followed by families need to be viewed as the primary stakeholders in the mental health arena.

Continuously communicate

The leaders and change management staff must continuously communicate and share information, targeting their approach for different stakeholders. Engagement with stakeholders needs to allow for open dialogue and disagreement. This is the best way to ensure ongoing buy-in and cooperation.

Build on successes and embed change

Use short-term wins to maintain momentum to move on to new stages of change, and reinforce the connections between the new practices and success. Don't let up until the change is fully embedded.

4.2 The next steps

"When you're trying to create things that are new, you have to be prepared to be on the edge of risk." – Michael Eisner

Visionary leadership, stakeholder involvement, open communication, dedicated resources and sustainable results are all essential for successful change. With this in mind we have identified four critical pathways that will take us to our destination.

The following recommendations regarding strategic actions to facilitate the required transformation are not comprehensive. The Mental Health Advocacy Coalition has chosen them because they are actions that are in line with *Te Tāhuhu: Improving mental health 2005-2015: The second New Zealand mental health and addiction plan* (Ministry of Health, 2005), and we believe that prioritising these actions will give the most leverage to create a domino effect of further change, while taking the least amount of resources. The recommendations, if implemented, will also challenge the underlying barriers to change described in this paper.

Governance of services

Establish district leadership groups with a majority of service users, families, Māori, Pacific and other communities most affected by mental distress, to:

- Assess and report on the needs and strengths of their local communities.
- Participate with local service leaders in developing strategic directions for services.
- Negotiate changes with planners, funders and providers.
- Prioritise areas for investment of new funding/service development.
- Oversee local service development in all involved sectors.
- Lead and facilitate a cross sector and integrated/coordinated approach to service development and delivery.
- Lead development of local performance indicators that reflect recovery-based practice, and support ongoing quality improvement processes based on use of these measures.
- Monitor and report on outcomes of service use for people with mental distress, and progress in meeting performance indicators.
- Provide independent information on the availability and quality of local services.
- Lead and encourage perspectives which consider more the social determinants of mental health and well-being.

Provide all participants with the opportunity to develop governance skills.

Implementing this recommendation will require an explicitly agreed and documented level of devolved decision-making authority from and accountability to District Health Boards.

National oversight advocacy

Strengthen national-level systemic advocacy and influence on decision-making by service users and families to the point at which they have a profound influence on the development of policy, funding, planning and provision of mental health services. Note that this will require:

- Access where required to training in effective advocacy, and participation in decision-making processes.
- Development/strengthening of dedicated service user and family positions in national policy, funding, planning and provision bodies.

Transformational leadership

Strengthen visionary leadership at all levels of the mental health service system, and support these leaders to drive the transformation to recovery-based services, systems and organisations. This will in particular require:

- Recruitment of people into leadership roles with the vision and passion to drive this change process.
- Access and support for ongoing training in the skills to manage effectively the required change processes in the sector.
- Access to mentorship and supervision (including peer support/supervision) in transformational leadership for sector leaders.

Resourcing

Evolve funding/resourcing models that support and facilitate recovery-based practices. In particular this will mean a focus on funding model(s) that:

- Allow for flexible and individualised approaches to meeting service user needs – individually tailored 'packages of care'.
- Require integrated collaborative approaches to care provision across both specialist clinical and support organisational boundaries, and secondary-primary organisational boundaries.
- Address barriers to evidence-based 'best practice' in promoting recovery.
- Require the establishment of collaborative, complementary and robust partnerships across sectors (e.g. social services, housing, employment, education, justice and local government).

Progress towards such a funding approach is likely to require, among other things, a substantive review of local and international funding models to facilitate recovery, and piloting of one or more approaches across the sector locally with a view to generating learning and generalising successes.

Conclusion

5. Conclusion

"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has." – Margaret Mead

At the start of this discussion paper we asked you to imagine a world where most people have optimal well-being, including those who experience mental distress.

We have imagined such a world in this paper. It is the Mental Health Advocacy Coalition's vision for transformation. We understand many of the forces driving this transformation, and the forces that could prevent it. We also know something about what can work when managing systemic and organisational transformation.

What we need now is action – action that will create the greatest leverage to start the change process, while utilising the least amount of resources.

We need action because the world we have imagined would improve people's lives, and if we can imagine a better world, the only morally defensible thing to do is to help create it.

Appendix 1: Ten leading challenges in mental health and addiction

Below are the ten leading challenges or action priorities for the mental health and addiction sector in New Zealand for the next 10 years, as identified in *Te Tāhuhu: Improving mental health 2005-2015: The second New Zealand mental health and addiction plan* (Ministry of Health, 2005).

Promotion and prevention: Promote mental health and well-being, and prevent mental illness and addiction.

Building mental health services: Build and broaden the range and choice of services and supports, which are funded for people who are severely affected by mental illness.

Responsiveness: Build responsive services for people who are severely affected by mental illness and/or addiction.

Workforce and culture for recovery: Build a mental health and addiction workforce – and foster a culture amongst providers – that supports recovery, is person centered, is culturally capable and delivers an ongoing commitment to assure and improve the quality of services for people.

Māori mental health: Continue to broaden the range, quality and choice of mental health and addiction services for Māori.

Primary health care: Build and strengthen the capability of the primary health care sector to promote mental health and well-being and to respond to the needs of people with mental illness and addiction.

Addiction: Improve the availability of and access to quality addiction services and strengthen the alignment between addiction services and services for people with mental illness.

Funding mechanisms for recovery: Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration.

Transparency and trust: Strengthen trust.

Working together: Strengthen cross-agency working together.

Appendix 2: Change management resources

Websites

Change Management Toolbook

http://www.change-management-toolbook.com
A free collection of more than 120 tools, methods and strategies you can apply during different stages of personal, team and organisational development, in training, facilitation and consulting.

Change Management Learning Center

http://www.change-management.com
Toolkit, tutorials, books, reports and articles on change management for CEOs, project leaders, coaches, supervisors and others.

Value Based Management

http://www.valuebasedmanagement.net
A large collection of summaries on management methods, models and theories, including change management

CommunityNet Aotearoa

http://www.community.net.nz
An information sharing resource for New Zealand community and voluntary groups, with guides, news, and tools for and by clubs, groups, charities, trusts, hapū and iwi.

Books and Papers

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Glossary

Hapū	sub-tribe
Iwi	tribe
Kaupapa	subject, topic, purpose
Kaupapa Māori	Māori philosophy; in the context of mental health services this refers to the culturally-derived philosophy that underlies and is woven into all aspects of service delivery, with wellness for Māori being the desired outcome
Marae	meeting place for iwi/hapū
Mental distress	the term used in this document to describe mental illness
Paternalism	treating or governing people in a fatherly or parental manner, in particular by providing for them without giving them rights or responsibilities
Pathology	manifestations of a disease
Pre-vocational	prior to entering work
Rangatahi	younger generation, or youth
Recovery	a philosophy and approach to services focusing on hope, self-determination, active citizenship and a holistic range of services
Rongoā	traditional Māori healing; rongoā Māori is informed by a body of knowledge that has as its core the enhancement of Māori wellbeing.
Te whare tapa whā	a model describing the four cornerstones of Māori health: whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health)
Tikanga	Māori customs and protocols
Well-being	the term used in this document to describe mental health
Whānau	extended family; recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the well-being of Māori individually and collectively
Whānau ora	Māori families supported to achieve their maximum health and well-being

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