Introduction 1
Minister's perspective 2
Rod Bartling 3
The Service Development Plan
Workforce planning
Professor Mezzina: Key Issues in Mental Health 4
Citizenship, social control, danger and risk
Legal Context
Public Opinion
Institutionalisation and Citizenship
Voluntary and Compulsory Treatment
Focus on the Narrative
Responsibility for mental health of the community
System Integration
Values
Plenary session: What will transformational change look like? 7
Change in Systems
Ministry-led vision and systems development
Access – Low threshold, easy access and exit, and service integration
Shared responsibility and public 'good practice'
Change in Thinking
Truly citizen-centred systems
Clear vision for and knowledge of transformative change
Positive risk taking
Mental health is everyone's business
Change in Practice
Pilot projects
Workforce working at the top of their scope
Recent developments in Christchurch
Six months on: Transformational Change and the Service Development Plan 11

TRANSFORMATIONAL CHANGE IN MENTAL HEALTH: A LEADERSHIP SUMMIT

INTRODUCTION

In September 2012 the ARC Group coordinated a Mental Health Leadership Summit in Wellington which we invited leaders in New Zealand's mental health sector, along with Professor Roberto Mezzina from Trieste, Italy, to talk about transformational change in our mental health and addiction system – what is required of this change, what it may look like and what each of us can do to facilitate such a change. Professor Mezzina discussed his understanding of New Zealand's mental health system in the context of Blueprint II and the (then upcoming) Service Development Plan. His perspective allowed us to challenge our 'givens' – the things we regard as fundamentals – and to ask why we are hanging on to some of these 'fundamentals' when other parts of the world don't need them.

This document summarises the presentations and discussions held at the Leadership Summit and compares the outcomes of this discussion with the recently released Service Development Plan.

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MINISTER'S PERSPECTIVE[2]

Associate Minister of Health, Hon. Peter Dunne

The Minister provided an opening address to the Leadership Summit, stating that improving mental health is currently a high priority for the government and that it has wide ranging social and economic impacts. Progress in mental health service development over the past two decades has included:

- growth in the mental health and addiction sector capacity and infrastructure
- increased access rates to specialist services
- growth in the non-governmental (NGO) sector
- better partnerships between funders, planners, providers and service users
- reduced total acute inpatient bed days and length of acute inpatient stay
- capturing of outcomes data on the severity of mental health or addiction issues at admission and discharge of people using DHB specialist inpatient and community services
- the highly successful 'Like Minds' programme and the National Depression Initiative, and changes in public attitudes that has come from these
- increased number of primary mental health initiatives that have augmented standard GP consultations for people with less severe mental health and addiction issues, with a developing primary mental health workforce.

The Minister noted that currently about 30 percent of DHBs' funding of specialist services are allocated to NGO-provided services, and that the government wants to see the NGO sector increasingly recognised as the best fit for health services, the default provider, rather than as the backstop when government services decide they do not have the capacity.

The release of Blueprint II emphasises the need for earlier and more effective responses; improved equity of outcomes for different populations; increased access; and effective use of resources and improved partnerships across the whole of government. The Service Development Plan is a framework for implementing previously agreed government priorities, incorporating key themes from Blueprint II and providing a platform for further transformation of mental health and addiction services. Related government priorities that underpin this further transformation include: Better public services; The Prime Minister's Youth Mental Health Project; Identifying the Drivers of Crime; Welfare Reforms; and Implementing the Suicide Prevention Action Plan. These varied and diverse factors recognise that mental health is everyone's business and has its roots in many realities.

The minister stated that transformational change in mental health and addiction services will be achieved in years to come through more effective use of resources, the application of more consistent models of care, the collection of robust data that tells us what we need to know, and integrated systems not only across health but across whole of government.

[2] This is the author's summary of Minister Peter Dunne's opening address. The full address can be found at: http://www.beehive.govt.nz/speech/address-arc-group039s-conference-039transformational-change-mental-health-%E2%80%93-leadership-summit

ROD BARTLING

Group Manager, Mental Health Services, Ministry of Health

The Service Development Plan

Where the last ten years of mental health system development was focussed on deinstitutionalisation and increasing services to 3% of people living with severe mental illness, the Service Development Plan and the next five years will be about integration, earlier intervention, earlier access and increased access for all. Rod framed Blueprint II as advice from the sector through the Mental Health Commission to the ministry, and the Service Development Plan as government policy and the ministry's response to Blueprint II. The Service Development Plan is also now under ownership and responsibility of Cabinet, hence is not the responsibility of just one particular Minister.

The Service Development Plan holds the healthy tension between the Ministry driving national change, and the capability of regions and individual locations to tailor services for their particular needs. This will continue to require strong sector engagement and, once the plan is released, the Ministry will focus on how to roll the plan forward, in collaboration with the community sector.

The timing of the Service Development Plan is based on DHBs' annual planning processes to clearly articulate government policies and to drive those planning processes. The Ministry is asking DHBs and providing guidance to the DHBs as to how they will respond to the annual planning round, while recognising that different DHBs start at different points.

Workforce planning

The Service Development Plan will result in a large change in workforce planning, including the change management capability to implement the plan, and this will be a challenge for a number of organisations. The Ministry will focus on what the additional transformational capability is that organisations require, and how resources are freed up to manage this change effectively, efficiently, and safely.

John Crawshaw's statutory role as Director of Mental Health will look at New Zealand's model of mental healthcare, looking at each DHB, and come back with what needs to change; working towards a more integrated approach which will put more services in the community from secondary care. This model of mental healthcare, and the Ministry's funding levers, are the main levers of change the sector has; what will drive much of this change, however, is the common direction that everyone in the sector appears to be working towards.

PROFESSOR ROBERTO MEZZINA

"A movement from clinicalised, specialised, centralised, hospital based services, based on separate healthcare organisations [and] specific pathologies, versus integrated, comprehensive, decentralised, small scale, low-threshold services closely linked to social context and the local community. [This is] a clear movement that could occur in New Zealand."

Key Issues in Mental Healthcare

1. Citizenship, social control, danger, and risk

"The more you create special places for so called 'special' people the more you create and emphasise this sort of behaviour. You really create risk rather than reduce risk. This is something really related to the way we look at mental health."
"We can design a perfect system in theory, or try to do it in reality, but psychiatry is based historically on the concept of total institution – if we are not able to dismantle or deconstruct this point we cannot really move forward in the direction of community based care."

a. Legal Context

In Italy, "Law Basaglia" (Law 180) led to the total closure of all psychiatric institutions, stating that care should be provided in community settings. Voluntary treatment is linked only to decisions about the health of the client, and along with the Spanish law it is the only law in the world that ***disconnects the role of psychiatry from the role of social control*** related to behavioural problems, and instead links psychiatry to the health organisation, whose goal is to provide support for good mental health for all citizens in the community.

b. Public Opinion

The opinion of families and of professionals at the time of the law change was strongly against the change. Now this public opinion has changed so much so that the Trieste people ***do not recognise the link between mental illness and dangerousness***. This is in stark contrast to Australasia's emphasis on risk in our mental health systems, e.g. development of special rooms in acute units for high dependency, high security. Psychiatric colleagues in these places are saying things are getting worse rather than better in these institutions.

c. Institutionalisation and Citizenship

Throughout the process of deinstitutionalisation, one of the great changes has been to ***not reproduce the institutionalised mentality***; that of containing and providing procedures for people living with mental illness that are showing socially deviant behaviour. The role of social control should not fall to psychiatry alone, rather the person must be considered as much as possible within the law. In Trieste when a person's behaviour breaks the law, police come and set the limit of the law. We don't dismiss their behaviour by saying "this is just a symptom of the illness" – this is a person that is doing something not acceptable, not just according to our psychiatric knowledge but also using what are the normal rules of society. The person committing the behaviour is not wholly responsible, nor wholly not responsible, but somewhere in the middle that also recalls service responsibility; if you have a condition of illness that limits your capacity but you have committed this particular act, it will be taken into account in your trial that you have this particular condition, so provide a limited sentence. This means the Mental Health Department supports this person throughout the trial, provides alternatives to prison if possible, and provides support in prison, "through the normal door" rather than in a special place. There are still forensic units throughout Italy, though we are moving towards deinstitutionalisation of these places. In this institutionalised mentality, people living with mental illness are still considered dangerous and irresponsible; we think they are citizens who have a condition that limits their

ability but that they are still the actor of the crime so should be supported through normal pathways. Here the citizenship of the people living with mental illness is critical.

d. Voluntary and Compulsory Treatment

"We are obliged to provide a treatment to a person that refuses, but this treatment is connected to their unwellness, rather than to the behaviour... this is one of the key issues, otherwise we are obsessed with controlling the behaviour of people... [also] when you have an open door more and more in the society the level of behavioural problems related to mental health problems tends to be very very low and decrease constantly. Now we have very few problems with people that are completely out of control."

In Trieste, ***psychiatric treatments are voluntary***. A compulsory treatment act can be used for those who are in a state of severe mental alteration and refuse treatments; this can only be used at the end of a process where all attempts to gain consensus to provide community alternatives to hospitalisation. If treatment is related to the management of an emergency, run under "state of necessity", then for a very short period of time you can oblige a person to take medication or stay in a place, but very quickly we have to ask for a compulsory treatment act. The purpose of the act talks about state of alteration, not behavioural problems, not about harm to self or others.

e. Focus on the Narrative

Services express their culture through the narrative; they are less focussed on symptoms, evaluations, checklists, etc., more about developing a common history between the service and the person, because the focus is on trusting relationships. Usually with the kind of everyday conversation around a client, we speak about "Who is this person?" "What is the story, their life circumstances?" "What are the 'knots' in their crisis, the elements, the conflicts, the problems, and how does this person express these?" This is ***not simply extracting the symptoms from the narrative; we are interested in the narrative itself***.

2. Responsibility for Mental Health of the Community

Each of the four catchment areas in Trieste (with populations of 50,000–60,000) are ***accountable and responsible for the mental health of that particular community*** – this seems a simple statement but in fact has a great impact on the way the service sees itself. Not only do they provide separate and discrete interventions, but they also have a wider vision for their community. This is because if you don't take care of that particular person, and you leave them socially adrift, you know that after a year or two you are likely to have a worsening problem and you will be required to take care of this person in a more difficult condition. Your position also has continuous feedback in a given catchment area – because you are the only reference for the population – and this obliges you to develop more intelligent and complex strategies to face the problem, to engage the person and to find new solutions; also face the failures that you have.

Having a clear mission to provide and accept all demands of mental healthcare in that particular area, to provide most of the responses or to relate with other services that can provide responses, there are no places to exclude people. There is nowhere to say "this is more severe or chronic than I can handle" and you develop a different position and perspective. The team is aware that you must increase the level of capacity, developed a range of competencies from crisis management to rehabilitation, in a continuum, not defining specialised functions.

3. System Integration

In Trieste legislation ***requires integration between social and health systems***, which obliges both services, and representatives of the community and welfare services, to sit around the table, identify priorities, identify a plan for each community area, and provide responses to issues like housing, work, income, social integration of people living with mental illness in mainstream services. This is a key issue in the community-based nature of a mental healthcare system.

NGOs in Italy do not have an autonomous role, so NGOs support daily life issues and not clinical intervention, which is provided by the mental health department. One of the main ways NGOs are engaged as a part of the system are when someone has such a high level of conflict or need, or low level of social function; here we have a wider discussion to set up an individualised plan of care with an allocated budget, and in order to do this we engage the NGOs that can propose the best programme for this person (for months or years); this person is followed all the way through, with a flexing budget depending on their need, rather than fixing on specific structures which are discrete in each area.

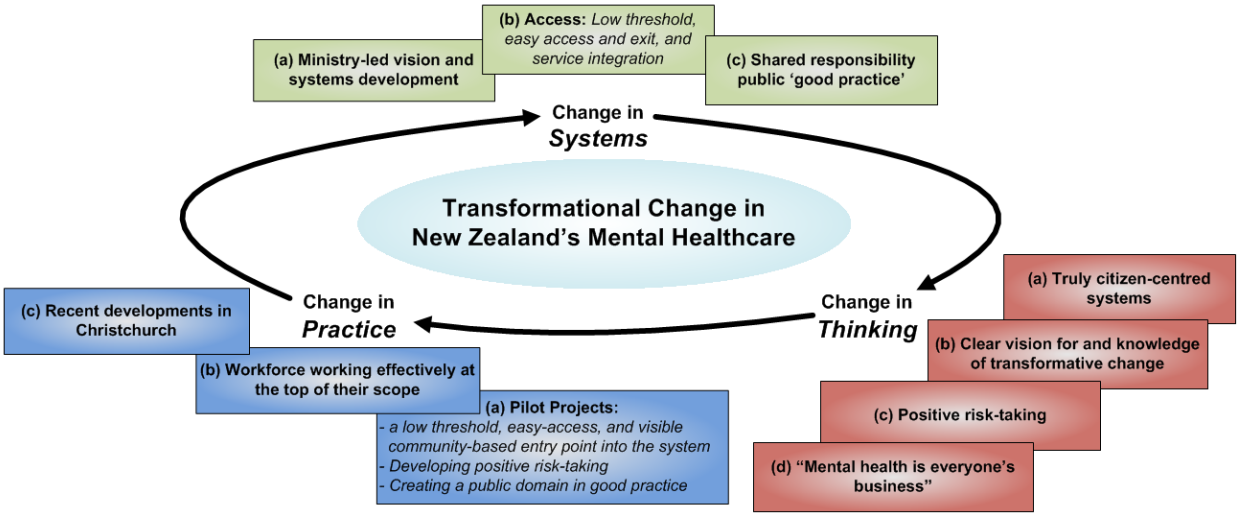
4. Values

"We are in front of a clear choice; on one hand having a system which has responses for the good client, and then having responses for the more difficult one and then increasing the level of checks and controls toward the seclusion; or we can accept the challenge of having an open system where the community mental health service can develop a total relative view in the sense of proving complex support and meeting complex needs but not having places where to put the failures. For me it's a primary issue, otherwise the system doesn't evolve."

Any change, particularly any systems-based change, will be values based. An important first step is making values explicit, such as the centrality of the person and their needs, protecting their social role, providing recovery pathways, and avoiding institutionalisation and seclusion. Blueprint II is fantastic for providing this values base. What is important from this values base is to strongly link these values to procedures/processes across the sector, and link these to intentional action that realises these values.

PLENARY SESSION: WHAT WILL TRANSFORMATIONAL CHANGE LOOK LIKE?

The plenary session focussed on the question "What will transformational change look like in our mental health and addiction system?" specifically around access, practice, location, and scope of practice. It was noted throughout the summit that we cannot simply compare systems and, while change of systems is important, we also need a change of practice and a change of thinking, and that each of these changes must be present to be successful; also that change in any one of these three will effect change in the others. Themes emerged around these three areas of change, as summarised and detailed below:



1. *Change in Systems*

a. *Ministry-led vision and systems development*

In Trieste the Mental Health Department declares a clear vision and direction, so each part of the system (public services, NGOs, and associated organisations) has a very clear role in the wider mental health system, and in turn the Mental Health Department is a part of the wider local health agency which gives the Mental Health Department a very clear place in the broader health system. Professor Mezzina challenged us as to whether we likewise had a clear, directive model of mental healthcare. It was noted earlier by Rod Bartling that John Crawshaw's statutory role of Director of Mental Health is in part to articulate a clear model of mental healthcare, but we are yet have the ability to 'articulate the system on a single page'.

Local area service planning and budget planning was noted as a key part of this clear model of mental healthcare, being clear how money is spent and where it comes from for all sources, and whether this is at the level of the organisation or of the system as a whole: "if we don't have a clear vision of where money comes and goes, we cannot control the investment of resources."

It was noted that funding needs to *direct* changes in the system according to the model of healthcare, rather than following the current provision of services. There was interest in meaningful discourse on what to *stop* funding in respect to services or models of care that are not effective (e.g. "if you can't show you're making a difference, you need to stop doing it").

It was also noted that any fundamental change will require increased change management capability, and that relationships within the sector will be the foundation and driver of this change; that the culture and values are as important as the structures.

Lastly it was noted that, as recognised in Trieste's system, the needs of people with addiction are often quite different from those people with mental illness.

b. *Access – Low threshold, easy access and exit, and service integration*

Much discussion was held around system change towards a low-threshold, easy access system. The caseload model is seen as needing to change, as currently people are afraid to leave the system because they can't get back in; being in the system provides a lot of resources and there is a need to free up these resources for people who need them. In Christchurch, opening up entry and not worrying so much about discharge has made a huge positive difference to services in the region.

The primary/secondary mental health distinction was seen as highly problematic ("trying to impose a public health-funded service on a private health-funded service") and the prohibitive cost associated with GP visits was seen as a significant barrier.

More consistency with how different DHBs operationalise the primary pathways into mental health services is needed, as this is creating fragmentation within the mental health sector (let alone across the wider health and social services). One example given was the devolution of NASC services in Christchurch and the creation of a large NASC service in Bay of Plenty. Use of sanctioned best practices, clarifying what works and what doesn't, was seen as being useful. A single mandated pathway into support was suggested, using a 'prioritising' model of triaging rather than being based on emergency services.

c. *Shared responsibility and public 'good practice'*

There was a lot of energy for collective accountability of how a person's needs are met, the concept of shared responsibility on all levels, from the client personally, through to the services, through to the social support system as a whole. Mixed in with this was the notion of greater visibility around performance, higher expectations of ourselves and sharing these expectations – this not just being population access targets but being clear what we're doing and who we are providing access to ("just sharing information about productivity will change productivity itself"). Also actively creating a 'public domain' around good practice; this will go towards breaking down boundaries between services that are caused by lack of confidence in or knowledge of other services in the sector.

2. *Change in Thinking*

a. *Truly citizen-centred systems*

Much of the discussion focussed on upholding the citizenship of people using the mental health services, re-orienting services (assessments, referrals, triaging, etc.) to people, not to organisation-centric services, to shift focus from 'gate-keeping' and criteria checking to focussing more on person's need and their narrative. Most importantly to uncouple the social control function of psychiatry and the broader mental health system from the provision of client-centred support services – this includes devolving social control function to normal rules and laws in society as discussed in Professor Mezzina's section. It was commented that a focus on citizenship immediately challenges practice to have people living well in their communities, rather than focus on illness and what is wrong (e.g. employment being noted upon entry as a part of the whole person).

b. *Clear vision for and knowledge of transformative change*

Professor Mezzina: *"From my point of view I'm really impressed that there's a separation of the vision, so the vision provided by [NGOs] and by the client movement in Australia and New Zealand is very different from what is psychiatry today in many places, so probably try to contaminate more the way psychiatry is."*

It was noted that NGOs provide a positive way of looking at things, as reflected in Blueprint II; that change in structure and systems of psychiatric services is an important issue.

Professor Mezzina also suggested that we develop our knowledge of transformation as a whole: how we can adapt a philosophy that is more open to a paradigm shift? Is it possible or feasible, for instance, to contaminate the social role and the clinical role with each other, to create a 'social psychiatry', in this country? Also how do we measure the shift from old institutions to new community-based services; the levels of freedom that people can experience, what are the targets for the freedoms, targets for the rights (shift from formal rights to social rights).

c. Positive risk taking

Change in thinking and practice towards positive risk taking was included in the discussion – to foster practices of therapeutic risk-taking rather than focus on a defensive position of risk and risk management (seclusion, restraint etc.). It was noted that everybody seems to agree this is important, but how to implement this is the problem: how to provide a safe umbrella with 'social tact'; suggesting that we experiment with not being focussed on these issues.

d. Mental health is everyone's business

There was several discussions around a required attitudinal change towards mental health services; a need to change philosophical attitudes around "Mental health is different, special (you wouldn't understand), that we need to leave it up to the experts". There is a need to normalise services themselves, demystifying mental health services. This will allow us to integrate services and to recognise "mental health is everyone's business". It was suggested the mental health system also focuses on mentally healthy workplaces, modelling workplaces that promote the health that we are supporting others to achieve.

3. Change in Practice

a. Pilot projects

Suggestions for specific changes in practice include specific pilots that instantiate some of the above changes in systems and changes in systems and thinking. These included:

- an NGO/government partnership to pilot ***a low-threshold, easy-access (24 hours a day 7 days a week), visible, community-based entry point into the mental health system*** (possibly co-locating with Integrated Family Health Centres), to provide the first step to get people to the help they need, referring into community and clinical mental health services, or the wider public health system, as necessary; for this to be alternative to emergency services and as a first port of call to get people away from further severity, "which will compose of a number of different alternatives, even with clinical care, entering more and more into management of hard core issues including management of crisis [in the community], for example.
- Developing a pilot for ***creating a public domain in good practice*** (through benchmarking etc.), maybe supported by Blueprint II.
- A pilot programme for ***developing positive risk taking***, as described above in Change of Thinking, 2c.

Professor Mezzina stated that the World Health Organisation Collaborating Centre, Mental Health Research and Training, is interested in giving formal support (e.g. exchange of staff etc.) to these pilots and any others developing innovation in this area.

b. Workforce working effectively at the top of their scope

There were also many comments about changing the way our workforce works to work at the top of their scope, e.g. clinicians or mental health nurses to focus on what their role does best, rather than other tasks they get pulled into doing that someone else (e.g. support workers) can do when they are working at the top of their scope. Also indicated was that trained peer support was an important part of the workforce and of the system, for example as an alternative to acute care. There was also a challenge, citing recent Christchurch

developments, to bring common sense into everything we do; instead of workforce specialisation that excludes people, recognising specialists for their expertise, but that this is not exclusive knowledge.

c. Recent developments in Christchurch

The changes that Christchurch services have recently undergone featured as an example of how change can be quickly and easily implemented. They had to break down barriers to service very rapidly, and became a lot more responsive to peoples' needs. They cut out NASCs and multiple triages "almost overnight", and what developed very quickly was a collective responsibility to meet individuals' needs. For that to happen there needed to be a sense of urgency, a pooling of resources, cutting out inefficient services, and strong leadership within the sector. It was suggested that, as with Christchurch, we bring common sense into everything we do. With this there was a sense of impatience in leading and pushing these changes ("a 5-year plan; why can't we do it next week?") and a desire for the Service Development Plan to 'have some teeth' as far as key deliverables that funders and providers need to work towards, which enables accountability.

Toni Gushlag, General Manager Mental Health, Canterbury DHB, made the following comment:
"We [New Zealand as a country] do have the same kind of circumstances [as in the Christchurch earthquake; the financial constraints create exactly the same kind of circumstance, the only difference is the sense of urgency... The changes to community mental health and access to services that have transformed our system were based on a problem that we could have a huge increase in demand in the next week. We had to reorganise ourselves so that we could cope with that. We had to change our model of care so we do better with what we've got and do it fast... We came up with something we never thought possible but it was because we were aware of the constraints. We [New Zealand] have got a growing population; we're going to have to do more with what we've got and we've got no more money. So we're in the same situation across all DHBs."

SIX MONTHS ON: TRANSFORMATIONAL CHANGE AND THE SERVICE DEVELOPMENT PLAN

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 provides a strong vision to guide the mental health and addiction sector, as well as clear direction to planners, funders and providers of mental health and addiction services on Government priority areas for service development over the next five years

The Plan focuses on four key areas:

- *making better use of resources*
- *improving integration between primary and secondary services*
- *cementing and building on gains for people with high needs*
- *delivering increased access for all age groups (with a focus on infants, children and youth, older people and adults with common mental health and addiction disorders such as anxiety and depression.*[3]

For each of these key areas or goals, the Service Development Plan (SDP) outlines the rationale behind focusing on the goal, how progress is planned to be measured (pending development of an agreed set of outcomes measures and KPIs), and priority actions for the next five years to achieve the goal. The priority actions are attributed to the different parts of the sector within mental health service development (Ministry of health, DHBs, NGOs, primary care providers, and other specialist service providers), and the roles and responsibilities for each part of the sector that will influence the delivery of the plan.

With acknowledgement that the sector will continue to operate within a constrained financial environment, the SDP describes where funding for each service and programme identified to achieve the prioritised actions will come from; whether they can be implemented by making changes to existing services (i.e. no change in funding) or whether they will use "reprioritised existing funding or new demographic funding" or whether there is previously approved, targeted Government funding for specific services. Below, for each overarching goal of the plan and its expected result, there is a response articulating similarities to and differences from the plenary session themes and challenges above.

Goal A: Actively using current resources more effectively.
Expected result: Increased value for money in ring-fenced, publicly funded mental health and addiction services.
Summary: The first goal articulates Ministry-led change through a variety of mechanisms including enhanced accountability targets, developing a nationally consistent set of performance indicators, sharing information about performance, innovation and effective practice, and developing and implementing a planning and funding framework (providing guidance about service configuration, planning methods and results-based funding). Service deliverers' (DHBs and NGOs) roles are to improve efficiency and effectiveness using these indicators, accountability targets and the framework (see SDP, pp. 12-16).
Response: These priority activities strongly align with the above *Ministry-led vision and systems development* (1a, p. 7) and *Shared responsibility and public 'good practice'* (1b, p. 8). The challenge from the plenary discussion remains whether we will have a clear, directive model of mental healthcare delivered by a system that we can 'articulate on a single page', and how effectively the Ministry can shift funding and direct services towards this model of care. As stated in the summary above, there is clear indication in the plan that funding will be moved away from inefficient and ineffective services towards those that are aligned with the plan's goals.

[3] From http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

Goal B: Building infrastructure for integration between primary and specialist services.
Expected result: Enhanced coordination and integration between primary and specialist services through developing infrastructure.
Summary: The second goal focuses on building infrastructure between primary and specialist services, enhancing coordination and integration of the system, and addressing barriers to doing this. Priority actions include supporting "fit-for-purpose" service configurations, integrating IT systems, and enhancing information collection and workforce capability within the primary sector (see SDP, pp. 19-20).
Response: These actions may go some way towards the vision of *Access – Low threshold, easy access and exit, and service integration* (1b, p. 8), specifically with greater consistency in how different DHBs operationalise primary pathways into mental health services; there is no comment in the plan, however, about opening up access into and out of the system to engender low-threshold, easy access services. The Christchurch experience (p. 10 above) shows that "opening up entry and not worrying so much about discharge has made a huge positive difference to services in the region" (1b, p. 8). Professor Mezzina's comments on *System Integration* (p. 6) refer to the integration required between social and health systems, as well as the need for clear roles for each part of the system, to ensure that *Responsibility for the Mental Health of the Community* (p. 5) is taken by the system as a whole. Also, once this responsibility is taken – either reactively due to service disruption such as the Christchurch earthquakes, or in a planned manner such as Trieste's deinstitutionalisation process – then barriers to services are broken down and integration occurs (through "a sense of urgency, a pooling of resources, cutting out inefficient services, and strong leadership within the sector... bring[ing] common sense into everything we do", p. 10 above). This goal also does not appear to address the public/private funding conundrum and the prohibitive cost associated with GP visits as a barrier to accessing services. The priority action of "fit for purpose" service configurations, e.g. on-site delivery of specialist services within integrated family health centres, could develop a pilot based upon the suggested *Pilot Project*: *developing a low-threshold, easy access, visible community based entry into the system* (3a, p. 9), however the challenges articulated in this paragraph would need to be overcome to instantiate such a project in the way intended here.

Goal C: Cementing and building on gains in resilience and recovery for: (i) people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions); (ii) (a) Māori, (b) Pacific peoples, refugees, people with disabilities and other groups.
Expected result: (i) Measurable improvements in mental health and wellbeing, physical health and social inclusion among people with low-prevalence conditions and/or high needs; (ii) Consistent mental health and addiction outcomes for all.
Summary: The actions in this section "aim to improve outcomes for those who are most adversely impacted by mental health and addiction issues... specifically on implementing effective services for people whose needs have not been consistently well addressed by previous service developments" (SDP, p. 22). The priority actions include items such as, for example, enhancing social inclusion opportunities, reducing and eliminating the use of seclusion and restraint, respectful engagement and partnerships with service users, and identifying and addressing disparities, as well as more specific actions such as supporting service users in their role as parents and enhancing interventions for opioid dependence (SDP, pp. 23-27, 34-37).
Response: The priority actions most closely align with the changes in thinking articulated above (2a-d, pp. 8-9), and are most closely linked to the key issues in mental healthcare of citizenship, social control, danger, and risk, as articulated in Professor Mezzina's address summarised above (pp. 4-5). Whether the changes in thinking will occur, or whether the key issues will be addressed, will depend on the development of the model of mental healthcare by the Ministry, and the realisation of this model within services by the wider sector. Creating *Truly citizen-centred systems* and *Positive risk taking* (2a and 2b, pp. 8-9) will require a much stronger shift in thinking and practice *within* the specialist mental health and addiction part of the sector (e.g. shifting focus from criteria-checking to the person's need and their narrative; uncoupling the social control function from the provision of client-centred support services; experimenting with practices of therapeutic risk-taking) as well as between parts of the sector and whole of government.

Goal D: Delivering increased access for: (i) infants, children and youth; (ii) adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms); (iii) our growing older population.
Expected results: Improved outcomes each of the three groupings with high-prevalence conditions through expanded access to integrated, effective mental health and addiction responses and decreased waiting times.
Summary: Progress with this goal is to be measured by monitoring access to services, waiting time to service deliver and access to primary (mental health and general) services for each group. The priority actions include the Ministry developing and implementing a primary mental health and addiction service delivery framework (which details the range and mix of primary care service types and interventions), and service providers enhancing the delivery and integration of mental health and addiction services within the wider context of these three service user groups (e.g. specialist infant, child and youth mental health and AOD services, primary care, health of older people services; SDP, pp. 41-43, 48-51, 55-56).
Response: As with Goal A, the Ministry's development of the service delivery framework strongly aligns with the above *Ministry-led vision and systems development* (1a, p. 7), and as with Goal B, may go some way towards the vision of *Access – Low threshold, easy access and exit, and service integration* (1b, p. 8), and will require a responsive and capable primary workforce, alongside a committed and highly integrated specialist workforce.

Workforce Goal: Supporting and strengthening our workforce.
Expected results: A mental health and addiction workforce with the capabilities and motivation to implement this Plan.
Summary: A workforce plan will be developed by Health Workforce New Zealand to identify workforce skills and competencies needed to deliver the Service Development Plan; to identify education, training and development required; and to identify recruitment and retention strategies for the workforce. Required competencies and development priorities for the workforce are indentified, including developing consultation liaison skills from specialist services to general health, and improving capability of the workforce in a variety of areas (e.g. co-existing conditions, physical needs, reducing seclusion and restraint).
Response: *Workforce working effectively at the top of their scope* (3b, pp. 9-10) is the summary of the plenary session's discussion directly on workforce utilisation, however much of the change of thinking discussed (*Truly citizen-centred systems*, *Clear vision for and knowledge of transformative change*, *Positive risk taking*, and the attitude that *Mental health is everyone's business*, 2a-d, pp. 8-9) will require the current and future workforce to lead these changes. This will require strong leadership 'positively contaminating' all levels of the sector, developing an inspired and confident workforce working at the top of their scope, while bringing common sense to everything that is done.