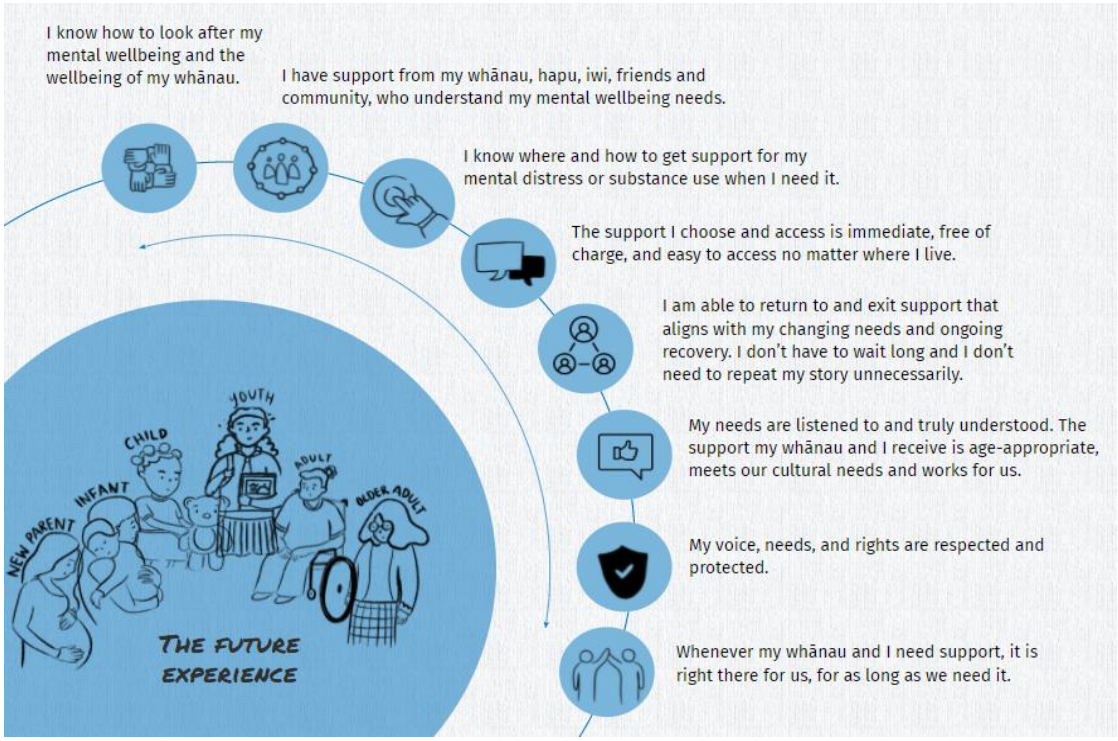
The Mental Health and Addiction System and Service Framework 2022–2032

Core Concepts



This draft document describes the future state of the mental health and addiction system and services in ten years' time: the next step in moving our health system toward the aspirational future experience of mental wellbeing for all. It includes guiding principles and values, sets out the critical shifts required and provides practical guidance about the core mental health and addiction services that should be available locally, regionally, and nationally. Finally, it describes what the health system will need to do to support the changes needed. It is a beginning only, intended to prompt discussion and will be refined in light of sector feedback.

Our Commitment to Te Tiriti o Waitangi:
The System and Service Framework (SSF) will require and support the principles of *tino rangatiratanga, equity, active protection, options, and partnership* to be woven through all elements of commissioning and service provision. This is discussed further below.

Why do we need the System and Service Framework?

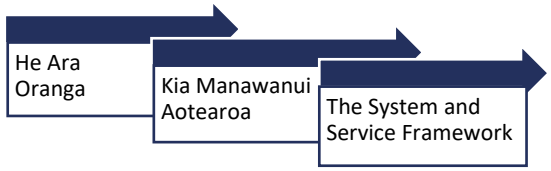
In recent decades, the mental health and addiction sector has faced both constrained resources and increasing demand. Transformation has begun and we have made positive progress. However, inequity persists and there is huge variation in services around the motu.

While there are tools and guidance to inform service planning, commissioning, and delivery, these are still based on the foundations set by *Blueprint for Mental Health Services* in 1998.

The SSF provides up-to-date guidance to the sector to support the mental wellbeing aspirations of our communities and promoting equitable access to core mental health and addiction services nationally.

The SSF will be given effect by the interim New Zealand Health Plan (2023/24) and future NZ Health Plans. These plans will host the system-level accountability for the SSF.

The SSF whakapapa



What does the System and Service Framework deliver?

The SSF identifies the core components of a contemporary mental health and addiction system to support everyone to experience mental wellbeing and address mental health issues and substance related harm.

It will give direction to those responsible for publicly funded health system policy, design, service commissioning, and delivery.

It sets clear expectations for:

- **what** mental health and addiction services will be available to individuals and whānau
- **how** services should be organised locally, regionally and nationally
- the **principles** that should inform system and service design and service delivery
- the **critical shifts** required to get there within a 10-year horizon.

The SSF is not intended to determine *how* services are delivered at a regional or local level and does not provide detailed descriptions of services. Work to describe and quantify the services will follow finalisation of the SSF.

Who will use this framework?

The SSF sets out the critical shifts and the parameters of the future system and has a range of purposes and audiences.

- For the **Ministry of Health and the Māori Health Authority** it provides information to guide the development of policy, investment decisions and accountability mechanisms
- For **Health New Zealand and the Māori Health Authority** as commissioners, it sets expectations of the spectrum of services that should be available nationally, regionally and locally and signals the need to develop system enablers (such as funding models and workforce planning)
- For **mental health and addiction service providers** (Health New Zealand, NGO and primary care) the SSF sets out expectations for ways of working with Māori, tangata whaiora and their whānau, the local community, and other services
- For **tangata whaiora, whānau, communities, and other interested parties** the SSF provides information about how providers and government agencies should be working, and what they should be working towards.

He nui ngā kupu - Words are important

Although the concept of mental wellbeing is widely used and understood, ideas about mental wellbeing differ among different populations, groups, cultures, and individuals. In this document the term '*mental wellbeing*' is used to describe the experience of being resilient, enjoying positive relationships and having meaning and purpose in life. Everyone can enjoy good mental wellbeing whether or not they experience mental health issues or substance-related harm.

When we refer to '*mental health and addiction se*rvices', we refer to all publicly funded services that support New Zealanders to address mental health issues, substance-related harm and addiction and to alleviate distress and gain, sustain and improve mental wellbeing. We use these words to afford us a common understanding and language; however, we acknowledge that the words are dated and lacking.

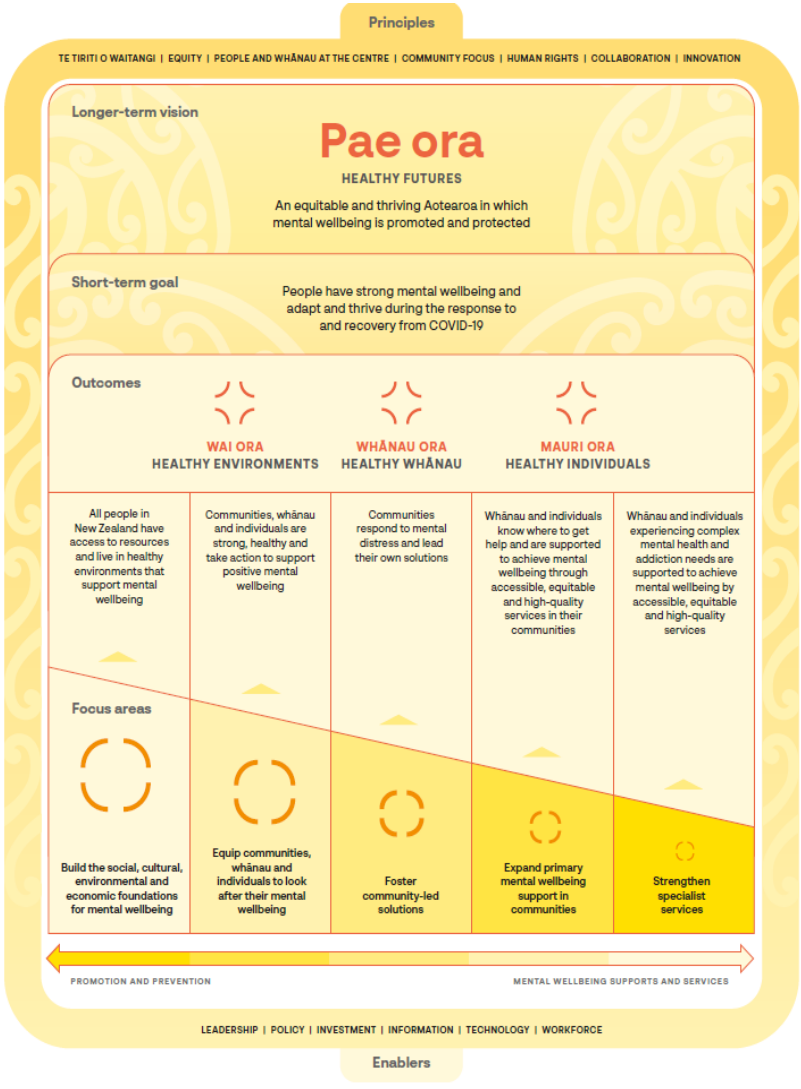
With time, we hope to find and adopt words for these services that more closely align with the concept of pae ora and the Government's visions for Māori health and for transforming New Zealand's approach to mental wellbeing, as outlined in *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing.*

Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing

Kia Manawanui is the whole-of-government strategy and action plan for transforming Aotearoa's approach to mental wellbeing. It recognises that mental wellbeing is not the sole responsibility of the health system. Our wellbeing largely results from the positive and negative experiences we have, which are influenced by factors including income, housing, employment and education.

Recognising this, *Kia Manawanui* sets out the actions needed across sectors to achieve pae ora. One of the key actions for the health sector is the development of this SSF.

The SSF translates the wider mental wellbeing system transformation into guidance for the mental health and addiction sector, so we play our part in enhancing mental wellbeing and addressing mental health issues and substance-related harm.



Commitment to Te Tiriti o Waitangi

All government agencies and publicly funded services are expected to uphold the principles of Te Tiriti, as articulated by the Courts including the Waitangi Tribunal. The Waitangi Tribunal's 2575 kaupapa inquiry into health services 2019 *Hauora* report[1] recommends a series of principles be applied to the primary health care system. These principles are *tino rangatiratanga*, *equity*, *active protection*, *options, and partnership*.

The SSF aspires to progress beyond obligations to proactively give effect to the principles of Te Tiriti in all elements of commissioning and service provision.

Tino rangatiratanga

Tino rangatiratanga means that Māori are guaranteed self-determination and mana motuhake (the right to be Māori and to live on Māori terms in accordance with Māori philosophies, values and practices) in the design, delivery and monitoring of health and disability services. Māori will lead the design of services that will be delivered by Māori through the Māori Health Authority, Iwi Māori Partnership Boards, service providers and hāpori Māori.

Equity

The current health system, including mental health and addiction, is delivering inequitable outcomes. All elements of the SSF reflect commitment to equity. The SSF affirms the mental wellbeing rights of Māori and provides guidance to planners, commissioners and providers to ensure that structural arrangements do not prevent Māori from attaining mental wellbeing and to ensure Māori have equitable rights and privileges alongside non-Māori. This includes expectations that all services have targets to improve equity of access and outcomes.

Active protection

Active protection means acting to the fullest extent practicable to achieve equitable health outcomes for Māori. Planners, commissioners and providers will be well-informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity. The SSF seeks to actively protect the rights, interests and knowledge systems of Māori, by ensuring that mātauranga Māori and the voices of whānau, hapu and iwi drive decision-making.

Options

The SSF provides guidance to planners, commissioners and providers to ensure that there are options, led by Māori, for whānau, hapū, iwi and hapori Māori at all levels of the new, contemporary system, that kaupapa Māori services are equitably resourced, and all services are provided in a culturally safe and appropriate way. This will include discontinuing the retrofitting of kaupapa Māori services into mainstream service design.

Partnership

The SSF will be implemented by the collective efforts of the Māori Health Authority, Health New Zealand, and all mental health and addiction service providers. The design and delivery of services will be shaped by the Iwi Māori Partnership Boards, service providers and communities. The concept of partnership implicitly includes power-sharing between representatives of the Crown, as tangata tiriti, and Māori, as tangata whenua. Partnership will therefore require all opportunities to devolve power to be identified and implemented.

[1] Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal 2019).

Person-centred principles

Principles that are person- and whānau-centred are critically important to designing the new system. The principles in *Kia Manawanui* and Te Tiriti principles of tino rangatiratanga, equity, active protection, options and partnership underpin the mental health and addiction system and practice principles outlined below.

System-wide principles

Person- and whānau-centred:	The system will keep people and their whānau at the centre of care so that they are co-producers of their care, with shared decision-making. This includes ensuring that personal, whānau, community, spiritual and cultural values are respected and integrated into the design and delivery of support, as well as ensuring that system-focussed policies such as unnecessary age restrictions or geographical boundaries are designed out (so people choose services rather than services choosing people).
Human rights:	The system will adhere to national and international conventions. Human rights entail values such as partnership, participation, protection, safety, dignity, decency, fairness, freedom, equality, respect, wellbeing, community and responsibility.
Holistic:	Substance-related harm, mental health issues and distress occur within a cultural, social, spiritual, environmental and economic context. The system will provide pathways for people to access holistic support for their needs, acknowledging most people will be able to cope without formal mental health and addiction services.
Equity-driven:	The system will take intentional action to achieve equity of outcomes, ensure equitable access to quality care for all and remove racism.
Accessible:	The system will ensure easy access to services for all New Zealanders. Services and supports will be accessible early, but also easy and timely to exit.
Community-focussed:	Strong communities provide a foundation of support and connection which is vital for mental wellbeing. Communities may be based around a particular locality (such as a suburb or town), a particular identity (such as ethnicity or sexual orientation) or common interests/purpose (such as a profession, sports club or school). The system will acknowledge the importance of fostering community-led solutions.
Anti-discriminatory:	The system will be inclusive and will actively seek to reduce discrimination and stigma associated with drug use and mental health issues.
Collaboration and innovation:	Strong, trusting relationships are at the heart of collaboration, which will be a major success factor in the new system. Collaboration will also be required to support and encourage innovative and original approaches to supporting mental wellbeing.

Practice principles for all services

Recovery-oriented:	Services and supports will uphold the right of people to build meaningful lives for themselves, including being valued in communities and relationships.
Harm reduction:	Services and supports will take a harm reduction approach by seeking to prevent and reduce avoidable harms from substance use.
Suicide prevention:	Services and supports will, at every encounter, be alert to opportunities for suicide prevention and provide timely and effective support.
Trauma-informed:	Services and supports will take a trauma-informed approach by acknowledging what has happened in the lives of individuals, whānau and families and helping them to reduce distress and find value and meaning.
Strengths-based:	Services and supports will honour people's own expertise and compulsory treatment will be rare and brief.

Critical shifts required

For the future experience to be realised, there are some critical shifts that need to occur within our mental health and addiction services and wider system to make an enduring difference to individual, whānau and community mental wellbeing.

These shifts will take sustained, collective effort and investment over the long-term. They will require sequencing over time and implementation in stages as New Zealand moves towards a transformed approach to mental wellbeing.

Critical shift 1: Actively deliver on Te Tiriti

What does this mean?
Actively delivering on Te Tiriti o Waitangi means that mental health and addiction systems and services deliver equity of access and outcome for Māori. This means aspiring to progress beyond obligations and proactively enact the principles of te Tiriti which include tino rangatiratanga, equity, active protection, options and partnership. Te Tiriti principles will underpin and be woven through all elements of commissioning and service provision.

What will change?
Across all levels of service, there will be more services designed by and for Māori, and Māori will play a central role in designing and delivering services for largely Māori populations or where the majority of people using services are Māori. As a result:

- There will be more services and supports planned, designed, funded and delivered for Māori, by Māori. These services will be grounded in te ao Māori, based in mātauranga Māori and informed by the knowledge systems of te ao Māori, iwi, hapū and whānau.
- All services that are predominantly accessed by Māori or serving a high Māori population will be radically re-designed (by and with Māori) to reflect te ao Māori values and practices and utilise mātauranga Māori and pūrakau to support oranga hinengaro.
- All core mental health and addiction services will be focused on achieving equity of access and outcome for Māori and supported to make the changes needed to this end. There will be service options that are informed by mātauranga Māori available at every part of the service landscape, with whaiora and whānau leadership to inform decision making.

Critical shift 2: Design out inequities

What does this mean?
Equity recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes. Delivering on Te Tiriti will improve equity, however addressing equity of mental wellbeing for the whole population will require a proactive and sustained effort to design out inequity at every level.

What will change?
Availability of mental health and addiction services will be equitable across the country and services will be tailored for life-stages and population groups, reflecting the local population's characteristics and needs, to increase equity.

As a result:

- Health promotion activities will be tailored to population groups with highest risk or need.
- There will be a broader range of population-specific mental health and addiction services in those areas with sufficient population size and need (eg, for Pacific or Asian populations).
- For groups experiencing inequities who do not have access to local population-specific services, there will be national consultation liaison services to enhance and support delivery by other services (eg, for Pacific peoples, Asian people, the rainbow and takatāpui community, those who are deaf and hearing impaired, and refugees).
- People who have high and complex mental health and/or addiction needs will have ready access to effective general health services including comprehensive primary care teams.
- Information about equity of access and outcome will be routinely analysed and when inequity is uncovered, this will be acted on.

Critical shift 3: Build peer-led transformation

What does this mean?
People with lived experience of distress will form the heart of the future system of services – leading, delivering and partnering with colleagues to transform the way in which our services are delivered.

What will change?

- There will be peer support specialists in all specialist mental health and addiction services.
- There will be a greater range of peer-led services, in particular peer support, across the service landscape, including within the continuum of acute services.
- Lived experience and peer leadership will be strengthened across the board – in management, planning, commissioning, delivery and monitoring of the mental health and addiction system and services.
- The expanding primary mental health and addiction workforce will reflect the population they serve and will include people with common experiences of overcoming adversity.

Critical shift 4: Get in early to support whānau wellbeing

What does this mean?
This critical shift is about promoting mental wellbeing, supporting whānau, and intervening early – both early in the life course and early on when mental health issues, distress and substance-related harm first arise.

What will change?
The future system will prioritise investment in the early years, with a whole-of-whānau approach. There will be an increased emphasis on:

- Recognising that whānau wellbeing is essential to individual wellbeing: the future system will focus on enhancing whānau wellbeing and actively involve whānau.
- The first thousand days, with specialist infant and perinatal mental health services (either as stand-alone services or with specialist expertise integrated into other services such as specialist child and youth mental health services).
- Services for the young adult age range will be developed in line with recent evidence about human development which recognises that adulthood does not begin until the late 20s, so youth will not be required to transition to adult services until their 25th birthday.
- Equitable investment, relative to adult services, in services for infants, children, young people and their whānau, including parenting supports.

There will be a much greater emphasis on early intervention at onset of distress. This will mean increased focus on:

- Mental wellbeing promotion as part of the service landscape – in schools, workplaces and the community, and for the whole population following widespread traumatic events.
- Increasing mental health and alcohol and other drug literacy so people know what they can do to support each other.
- Telehealth and digital services that support self-management and provide widespread early access.
- Primary mental health and addiction services, which will be integrated into all comprehensive primary care teams.
- Population specific primary mental health and addiction services for Māori and for youth, which will be available in all areas, and for Pacific and/or Asian peoples where population size is sufficient.
- A strong continuum of community-based acute mental health and addiction responses in all parts of the country.

Critical shift 5: Create connected, locally driven networks

What does this mean?
This critical shift is about fostering integration in ways that work well for local communities. Opportunities for greater integration will focus on a whole-of-whānau approach across the lifespan, with vertical integration bringing primary and specialist services closer together and horizontal integration across sectors.

What will change?
Networked providers will be guided by locality plans, with shared accountability and seamless delivery. This will mean:

- Every locality will have integrated primary mental health and addiction services as part of their comprehensive primary care services. These services will forge strong links with:
    - cross-sector supports
    - kaupapa Māori, youth and Pacific primary mental health and addiction services
    - hospital and specialist mental health and addiction services.
- Specialist mental health and alcohol and other drug services will work seamlessly together, forge strong links with cross-sector supports and provide rapid access to consultation and advice for comprehensive primary care teams.
- The future system will be digitally enabled, with virtual access to advice and specialised expertise that is not available locally.
- Regionally delivered services will work together through national networks that support best practice.
- National networks will also support quality improvement for specific types of multi-locality services.
- Mental health services for older people will be closely networked with, or an integral part of, health services for older people.

Critical Shift 6: Do whatever it takes: Choice and control

What does this mean?
Services will 'meet people where they are at' and be flexible and re-oriented to respond to people's needs, rather than the delivering pre-determined care. The workforce will be empowered to listen to people's feedback and to provide options and tailor responses, so that people can exercise choice and self-determine what support they receive.

What will change?
Mental wellbeing network services will be adaptable, so they work well for everyone who uses them, prioritising both people with the highest needs and reaching people earlier on and responding rapidly when needed. As a result:

- There will be more service choices, including mātauranga Māori approaches, open dialogue, talking therapies and other approaches that are demonstrably effective, complemented by more traditional options where these prove helpful.
- All services will place people at the centre and adjust delivery to ensure the support they offer is relevant and useful for each person and every whānau they serve.
- Long-term inpatient mental health services for people with high needs will be replaced with individually tailored community-based and residential support services determined by the people themselves. This may include personally-determined use of funding to enable good lives and prevent harm.
- Community support options for people with addiction will be developed.

What will our future services look like?

The SSF supports commissioners and providers to have the autonomy and flexibility to support the mental wellbeing aspirations of their local communities, while also ensuring there is equitable access to core mental health and addiction services around the country. It can be used to not only identify the range of services that will be available nationally, regionally and locally, but also provides an opportunity to identify the amount of service required based on population need, which in turn will make it possible to quantify the gaps and plan both future investment and the workforce needed to deliver the future services.

The critical shifts have implications for the way in which services are delivered, the types of services delivered and future funding priorities. This section sets out the core mental health and addiction services that will be available to individuals and whānau, no matter where they live.

Service structure

All future mental health and addiction services will be organised nationally, regionally and locally, with networks providing support for excellence in implementing the framework and its principles.

National services are provided centrally or by a single provider for people regardless of where they live in Aotearoa. They include services for the whole population, like services promoting wellbeing or telehealth; nationwide services or consult liaison support for services for a particular population sub-group; and services with a level of demand that is so low that even a population of one million people would not have sufficient demand to justify a regional service.

Regional services include services for which the level of demand is so low that even a population of 500,000 people would not have sufficient demand to justify a sub-regional service, as well as services requiring technology and/or highly specialised knowledge and skills that would be difficult to source more locally. Some regional services require significant cross-agency involvement, so the provision of regional services simplifies the working relationships other agencies need to have with mental health and addiction services. In some instances, regional services may be made available in multiple locations within a region, so as to be more accessible. For each type of regional service, there will be national networks formed with participation from each of the four regions, to guide planning, best practice, models of care and quality improvement.

Local services may be delivered at a locality level or in many cases, across multiple localities. All parts of Aotearoa will be served by a comprehensive network of locally-driven mental health and addiction services, shaped by locality planning and inclusive of primary and specialist mental health and addiction services. Services will foster new connections, expand the available choices, and build a cohesive, seamless network of services across the life course and the continuum of need. Mental wellbeing networks will be a part of wider local health networks, and they will play a part in supporting communities to strengthen their collective mental wellbeing. Mental wellbeing networks will work with local communities and authorities and across agencies to address the broader social determinants of health.

SSF services landscape

MINISTRY OF HEALTH
MANATŪ HAUORA

National

National inpatient units
Youth forensic, SACAT residential

Consultation liaison services for populations
Pacific, Asian, takatāpui and rainbow, deaf and hearing impaired, refugees

Telehealth and digital tools

Telehealth and digital tools for Māori

Regional

National promotion and prevention

National promotion and prevention for Māori

Inpatient	Residential	Community
Adult forensic including court and prison liaison		
Maternal mental health		Youth forensic community
Managed inpatient withdrawal	Eating disorders	
MH child and youth inpatient	Trauma/ personality issues	
		MH / ID community
		Refugee community

Multi-locality

All ages

- Acute MH continuum: inpatient, residential (including peer-led inpatient alternatives), community
- General hospital liaison services
- Whānau support
- Primary mental wellbeing tertiary education-based services
- Pacific primary mental wellbeing and specialist MH and AOD services
- Asian primary mental wellbeing and specialist MH and AOD services
- Promotion/prevention including suicide prevention and mental health literacy

0–4 year olds

(and their parents)

- Specialist maternal MH
- AOD pregnancy and parenting
- Infant MH community services
- Parenting support

4–14 year olds

- Specialist MH services for children and whānau
- Primary mental wellbeing school-based services

12–24 year olds

Youth focused:

- Specialist (early intervention) services: MH and AOD
- AOD residential treatment
- MH crisis respite
- Supported living: AOD and MH
- Peer support
- Primary mental wellbeing

20+ year olds

- Specialist AOD community services
- Managed withdrawal (community)
- Opioid substitution treatment
- AOD residential treatment
- Specialist MH community services including intensive community treatment
- Community and residential supports: MH and AOD
- AOD harm reduction services
- Specialist peer support (stand alone and within other services): MH and AOD

65+ year olds

- Inpatient assessment/ treatment/rehab
- Specialist community services

Kaupapa Māori

- Specialist AOD services
- Specialist MH services
- Primary mental wellbeing services, hapū and iwi wellbeing promotion/ prevention

Locality

Community wellbeing initiatives | **Local promotion/prevention** | **Primary mental health and addiction services within general practice** | **Locally based promotion/prevention and wellbeing initiatives for Māori**

Key features of the service landscape

Services for Māori

There will be kaupapa Māori services funded, designed and delivered by Māori to deliver promotion, prevention and primary mental wellbeing supports. There will be equitably-funded specialist mental health and addiction services specifically for Māori delivered by kaupapa Māori providers, reflecting te ao Māori and utilising mātauranga Māori and incorporating other effective services and supports.

General mental health and addiction services will be radically re-oriented to meet the needs of Māori where the majority of people served are Māori and all other services will have a focus on equity of access and outcome for Māori.

Prevention/Promotion

An increased emphasis on promoting mental wellbeing and preventing distress from occurring or escalating, both nationally and locally, will enable whānau and communities to support positive mental wellbeing, respond to mental distress, and lead their own solutions. Kaupapa Māori approaches will be essential to strengthening this area of the mental health and addiction system.

Support will take a range of forms including national health promotion and harm prevention and public health approaches to building wellbeing and resilience in communities and preventing suicide. In addition to tailored approaches to promotion and prevention, all services will have a role to play in promoting wellbeing and prevent distress.

Locality-based services

At a locality level, primary mental health and alcohol and other drug services will be integrated within comprehensive primary care services and provide support for local community-led wellbeing promotion and suicide prevention. There will be resource earmarked to support community-developed and prioritised initiatives to promote wellbeing, prevent suicide, prevent mental health and alcohol and other drug issues and/or provide “grass roots” peer support and mutual aid options.

Multi-locality services

Although multi-locality services will not be in every small locality, they will be readily accessible for all New Zealanders. They will look different in different areas.

Areas with larger populations are likely to have separate services (eg, for adults, youth or children or for mental health and for alcohol and other drug issues). Rural and remote areas with small, dispersed populations will require approaches tailored to local circumstances and workforce availability, for example they may have multi-purpose teams and multi-skilled staff to ensure access to all of the necessary expertise.

To support improved seamless service delivery, local services will form networks and create pathways for ease of movement between services. There will be overlaps between eligible age ranges for age-specific services so that people can choose to access the most appropriate service for their life stage rather than their chronological age. There will be alignment in age ranges

between primary and specialist services, and alcohol and other drug and mental health services (eg, youth-specific services).

Acute mental health continuum

The acute continuum will serve all ages, although there will be specific respite services for youth, and child and youth expertise will be available to provide assessment and advice to community acute teams when requested. The emphasis will be on providing rapid access to effective treatment and support within the community.

Pacific services

In all areas where there is a sufficiently large Pacific population to warrant separate service provision, there will be Pacific services shaped by Pacific peoples' values and experiences, utilising Pacific cultural frameworks and contexts and delivered by Pacific providers, including primary mental wellbeing services and specialist mental health and addiction services.

Asian services

In all areas where there is a sufficiently large Asian population to warrant separate service provision, there will be services designed with and for Asian populations. These may include primary mental wellbeing services and specialist mental health and addiction services.

National consultation liaison services

For populations that are without critical mass to justify population-specific services there will be national consultation liaison services supporting local service providers to deliver effective, culturally appropriate support, including offering virtual assessments and advice where appropriate. Populations with national consultation liaison services are likely to include:

- Pacific people
- Asian people
- Takatāpui and rainbow communities
- Deaf and hearing impaired people
- Refugees and ethnic communities.

National networks

All regional services will be nationally networked to develop consistent protocols and pathways where appropriate and create opportunities for shared learning and quality improvement. Some specialised types of multi-locality services may also establish national networks for this purpose. Under the reforms some regional services may consider whether a single national service would enhance delivery for example Regional Forensic Mental Health Services.

System enablers

In order to be high quality, accessible and effective, services need to be supported by system enablers that work together to build the environment in which services can operate. *Kia Manawanui* sets out key enablers of an effective mental wellbeing system including: *leadership; investment; workforce; information; and technology*.

Leadership

- shared governance accountable for implementation and quality, encompassing the responsible health entities and including clinical, cultural and lived experience leadership
- strong, well-informed national health system leadership collaborating across government to enhance mental wellbeing and address mental health issues and substance-related harm
- Māori leadership and decision-making in relation to service design and delivery of kaupapa Māori services and in shaping other services accessed predominantly by Māori
- Crown-Māori partnerships ensuring all services and supports are responsive to Māori aspirations and priorities
- the voice of lived experience being strongly represented among leadership at all levels, leading local and community-driven change and holding the system to account
- local networks with iwi, community, lived experience and whānau to shape and improve local services
- national networks for specialty/regional services to ensure evidence-informed and high-quality services across the country

Investment

- progressively increasing and prioritising investment in the system of services described and the enablers that will support it
- using a consistent funding approach to equitably allocate investment based on Te Tiriti, epidemiology / needs, population characteristics and gaps in existing services and investment
- having local plans developed with communities and Iwi Māori Partnership Boards to close service gaps and promote equity in service access through investment and disinvestment, prioritising services reflecting the critical shifts
- new commissioning approaches that foster collaboration, outcome achievement, people at the centre, flexibility to address emerging challenges, value for investment and accountability, with a contemporary national service framework

Workforce

- a coherent national workforce plan that takes into account cross-sector workforce demands; is regularly updated in light of planned service changes; and builds a diversified

workforce that includes new roles and qualifications[2] that complement those that already exist

- expanded Māori and peer workforces playing an essential role in transforming the mental health and addiction system, with recognition and active support for their roles
- active and ongoing promotion of careers in mental health and addiction and support for people working in this field to progress in their chosen career
- effective support for the workforce to put the principles for this framework into practice and participate in innovation and improvement
- strong partnerships with unions to safely maintain service delivery and respond to workforce realities

Information

- drawing together information derived from data, researched evidence, mātauranga Māori and lived experience
- robust data collection and regular, meaningful reporting about the service landscape, service use, people's experience and outcomes and about workforce with a specific set of reports to assess equity for Māori
- ensuring people who use mental health and addiction services, their whānau and communities are well-informed about how information is being used, what is being learned from the information and how services are being improved
- accurate information from around the country about expenditure on services, access, service levels, outcomes and equity around the country
- ongoing investment in a "hub" to support innovation, improvement, shared learning and implementation of successful approaches and models of care

Technology

- a suite of digital tools to support wellbeing, assessed against a standard to provide people with information about the tools' strengths and limitations
- options to access virtual service delivery online and via telehealth consultations
- access to, and control over, health information for people using services so they can better manage their health and wellbeing
- a digital health ecosystem that enables seamless service delivery across providers, eliminating the need to re-tell stories when people do not wish to
- technology that simplifies data capture by providers, provision of feedback by people and whānau, and widespread access to reports generated from this data and feedback

[2] Informed by the experience of areas where increasing workforce diversity has proven highly successful in enhancing engagement, improving outcomes and enabling rapid service expansion.

Finalising the SSF

Our questions for you

1. Are there any **system or practice principles** missing or that you disagree with (please explain)?
2. The initial **critical shifts** aim to prioritise the most pressing changes required over the coming years and will be refreshed over time. Is there any critical shift missing that you would include (and why), and if so, which lower priority critical shift would you drop?
3. The framework lists the key **types of service** that need to be available locally, regionally and nationally. Are there any key types of service missing, any included but should not be, or any that you believe are in the wrong category (and if so, what is your reasoning)?
4. Are there any **enablers** for implementing the framework that are missing or that you think should not be included?
5. Is there anything else you think we should know to inform further development of the SSF?