Joining the Dots

A framework to inform system-level change
in the mental health and addiction sector in New Zealand.

Phillipa Gaines
Lattice Consulting Ltd
lattice.co.nz

Lattice

INTENDED AUDIENCE

This discussion document has been written by Phillipa Gaines in preparation for a presentation at the 7th *Australasian Mental Health Outcomes and Information Conference* (AMHOIC) in Auckland, New Zealand on 30 October 2019.

What pattern connects the crab to the lobster and the orchid to the primrose and all four of them to me? And me to you? There is no such thing as something that is separate from something else. Insight emerges when you connect the dots and recognise the underlying pattern.

Gregory Bateson - Mind and Nature

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1. Introduction

1.1 Background

In February 2018 the New Zealand government launched an inquiry into mental health and addiction services. The final report *He Ara Oranga* (NZ Government, 2018) highlighted deficiencies in the current system and proposed that various elements should be added, reconfigured and/or expanded.

The report also noted that there was a high degree of consensus from most parts of New Zealand society about the need for a new direction for mental health, with an emphasis on the following - wellbeing and community; health promotion, prevention and early intervention; expanded access to services; more treatment options; treatment delivered closer to home; whānau and community based-responses and cross-government action.

In May 2019, in response to the recommendations made in He Ara Oranga, the government announced $1.9b of funding for a number of new mental health and addiction initiatives - as part of the nation's first Wellbeing Budget (NZ Treasury). The centrepiece of the budget was a $455m primary care programme of activity that aimed to provide better access to MH&A services for approximately 325,000 more people by 2023/24.

Whilst this is a sizeable boost to an ailing mental health and addiction system, there are concerns about the ability of the current system to effectively and efficiently absorb the increased level of funding in ways that are in accordance with the paradigm shift that is outlined in He Ara Oranga and which will be sustained over time.

> *Our mental health system has become institutionally locked into a vicious cycle of 'assess – treat – repeat'. We disregard the social determinants of health and too often fail to take a holistic perspective of patients.* ***We do not connect the dots*** *across the different agencies and people fall through the cracks. However we cannot just pump more money into the existing system. Firstly, we do not have a ready-made workforce to hire to deliver more services. Secondly, our services are wrongly configured or fail to address the real needs of our targeted populations.*
>
> ***(Deloitte, 2019).***

The underlying premise of this paper is that a strong and effective mental health and addiction system is reliant on key stakeholders being able to more easily make the connections between different components of that system. This paper presents a conceptual framework that could be used to inform changes in one or more of the component parts of the mental health and addiction system in New Zealand - with a focus on the outcomes.

1.2 Limitations

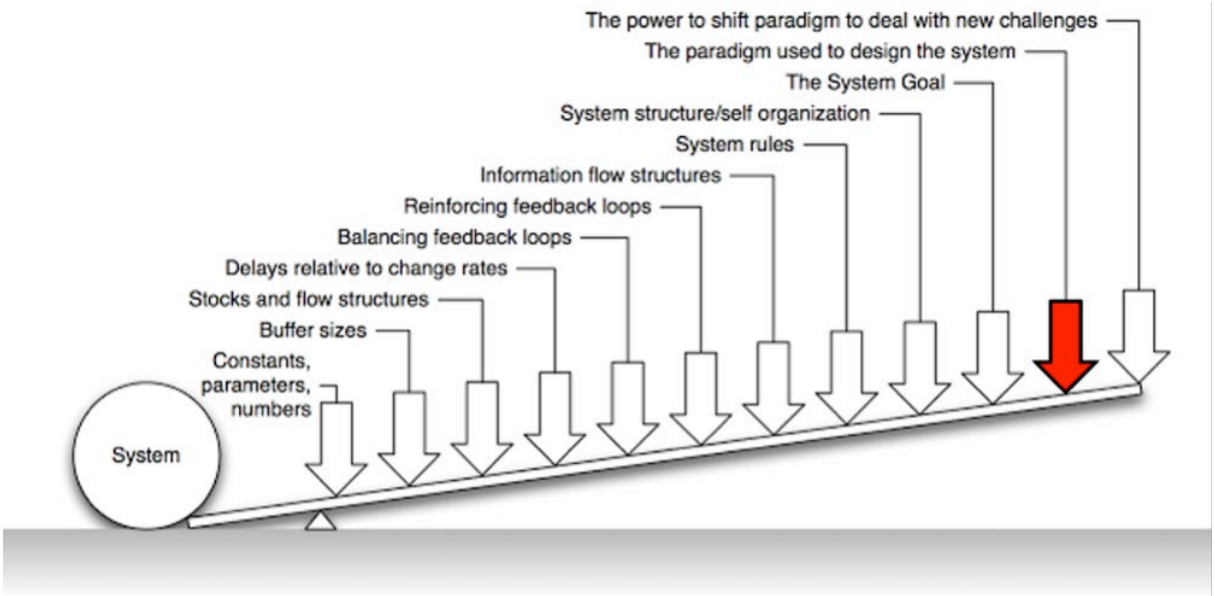
Inevitably, any attempt to simplify a complex construct such as the mental health and addiction system will be fraught with problems.

It is acknowledged that there are many things that are missing from this framework. For example, it does not take into consideration the underlying social and economic determinants of health, it does not elaborate on the inter-dependencies within the MH&A system and it does not include the touch points with other parts of health or the social sector.

However, what this framework does do is to make explicit the various components of the mental health and addiction system - with a particular focus on the building blocks of that system. This is because drilling down into each component to examine the dynamic linkages that exist between them as well as the interactions with other systems represents a significant amount of work that is beyond the scope of the author.

However, the fundamental question is not whether this framework is right or wrong, but whether or not it adequately captures the essential aspects of the mental health and addiction system in a way that enables people to influence it and/or to intervene in it to good effect. The purpose is to help stakeholders to intentionally apply their change efforts to the key leverage points in the system – as per figure 1.

Figure 1: Leverage points – places to intervene in the system



Source: Donella Meadows (2008). *Thinking in systems. A primer*.

1.3 A work in progress

Please note that this conceptual framework is still a work-in-progress. It has been developed to provide a systematic way of considering the critical components that might influence the transformation of the current mental health and addiction system. This is particularly relevant given how important it will be to be able to monitor and evaluate the impact of any policy and funding decisions that are being made in response to the recommendations in *He Ara Oranga* (2018).

In addition, it is hoped that it is a useful resource for anyone who has an interest in the design, development and delivery of high quality MH&A services to New Zealand citizens.

2. Overview of the conceptual framework

There are four revolutions currently underway that will transform health and health systems. These are the revolutions in (a) life sciences; (b) information and communications technology; (c) social justice and equity; and (d) systems thinking to transcend complexity.

Frenk, J. (2008)

2.1 Developing the framework

The multifaceted and complex nature of the mental health and addiction (MH&A) system poses significant challenges to the key stakeholder groups that are interested in making and monitoring transformative, sustainable changes to the system over time.

A number of researchers have created definitions, frameworks and models that attempt to explain the complexity of the health system with a view to improving it. However, most of these frameworks have focused on conceptualising functions, processes and outcomes and proposing some associated performance measurement approaches, with rather less of a focus on developing practical solutions to strengthen the operational 'building blocks' of the health system.

Over the last decade, health system strengthening has risen to the top of the health development agenda in a number of jurisdictions. There is now a growing body of knowledge and understanding about what constitutes an effective health system (WHO, 2009), even if there is a lack of agreement about how it might be measured. It is this evidential base that has informed the development of this framework.

2.2 The Theory of Change

A Theory of Change is essentially a mental model (Senge, 1990) or a working hypothesis about how and why a desired change is expected to happen in a particular context. It differs from a logic model in that it is focused on the bigger strategic picture, whilst the logic model zooms in on a specific pathway within the Theory of Change.

It is useful to use both approaches because the Theory of Change helps make explicit any assumptions that have been made about how the whole system might work in practice, while the logic model digs into some of the detail.

An important feature of this Theory of Change is that it situates the mental health and addiction system within a larger learning framework. Specifically it utilises the Triple Loop Learning Framework that was originally developed by Chris Argyis (1991) and subsequently modified by various consultants and researchers.

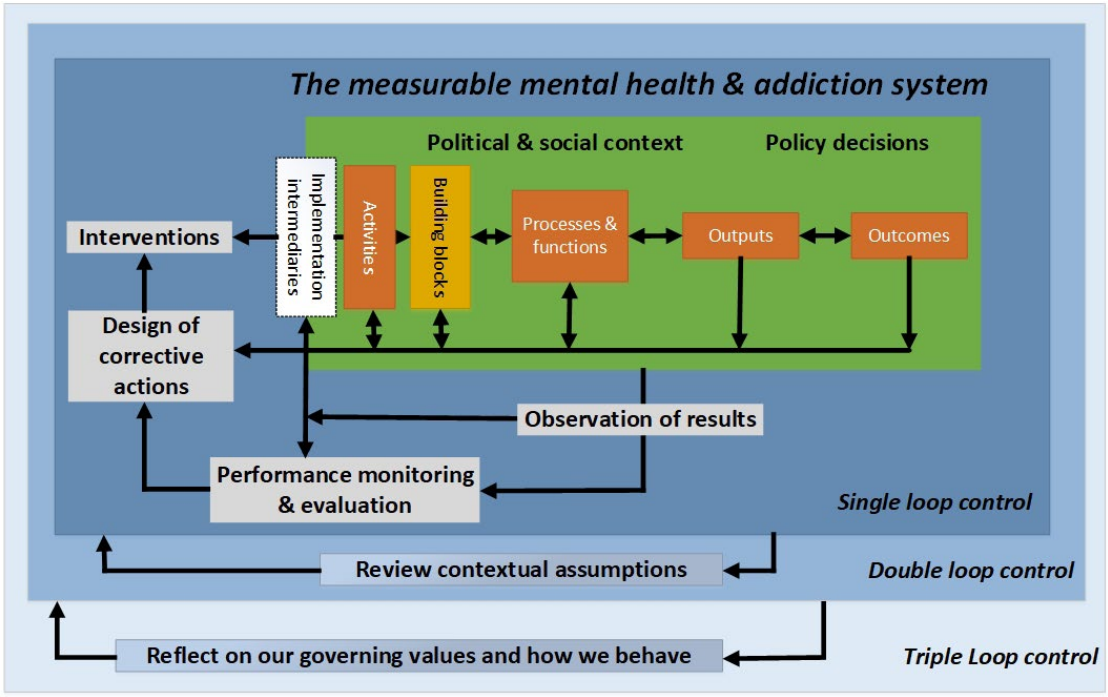
The Triple Loop recognises three types of learning - as described by Mark Cabaj (2019):

- Single loop – what are we learning about what we are doing?
- Double loop – what are we learning about our assumptions, understanding and thinking?
- Triple Loop – What are we learning about how we are being?

The theory is that the current DHB performance monitoring and evaluation framework (single loop control) is not sufficient on its own to detect transformative change. The observation of results in the mental health and addiction system, and the way that these are framed and measured, must also take into consideration the role of context (double loop control) and the changes in mind-set and behaviour that signal that a paradigm shift is truly happening (triple loop control).

The other important feature of this Theory of Change is that it is assumed that it is not possible to build a new mental health and addiction system on the same flawed foundations as the old system. For this reason, it is the foundation stones or the 'building blocks' of the system and the relationships between them that are the main focus of this paper.

Figure 2: Theory of change – transforming the mental health & addiction system



Adapted from Fred Kofman (1992). *Double Loop Accounting - A Language for the Learning Organisation.*

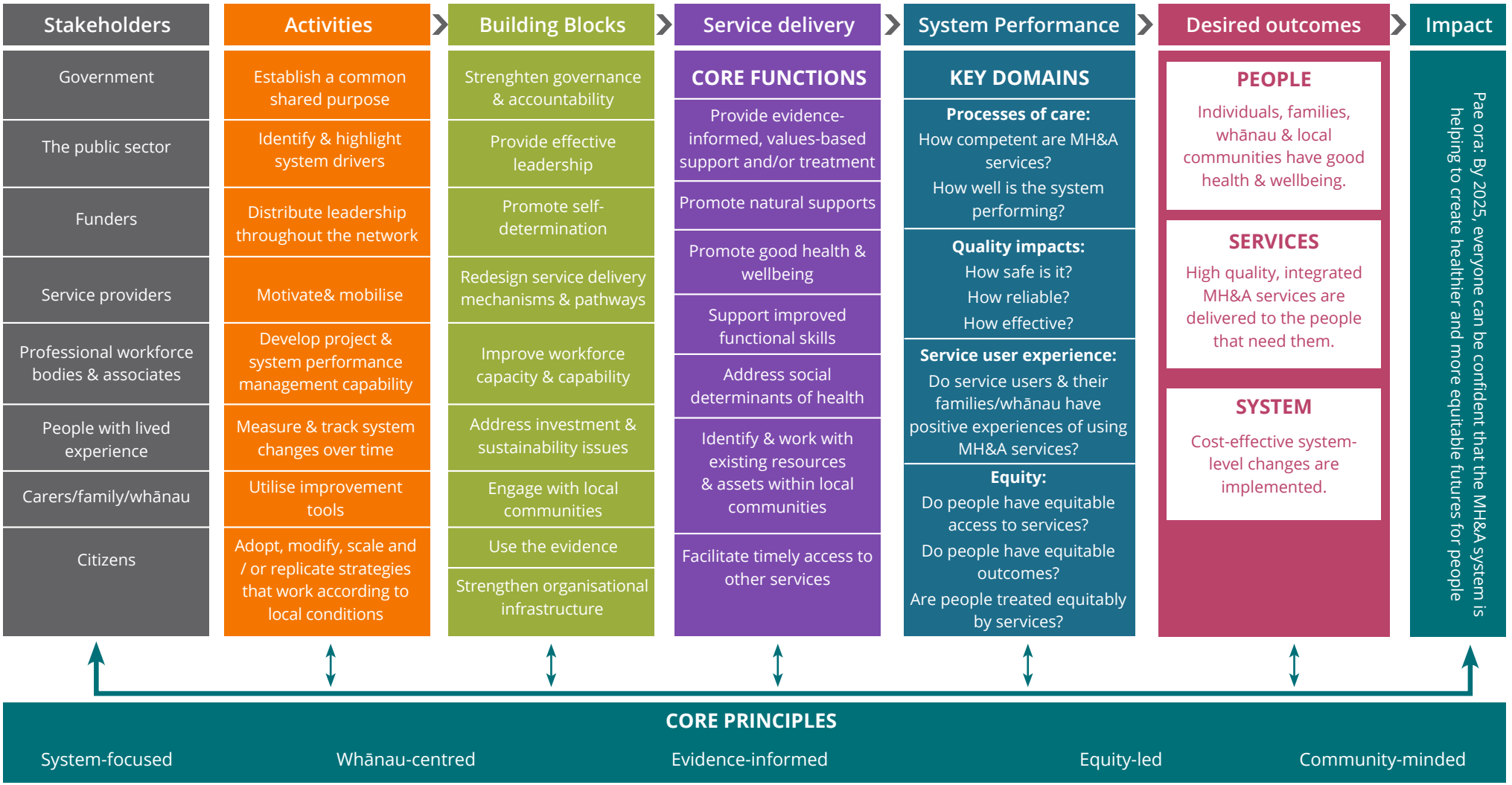
Please note that additional detail about the main assumptions that underpin this Theory of Change can be found in Appendix one.

2.3 The logic model

The logic model presented in figure 3 outlines the inputs, processes, outputs and outcomes of the mental health and addiction system in a 'logical', sequential way. Unlike the Theory of Change, it is linear, which means that there are no cyclical processes or feedback loops. The added value of this model is that it brings together information from across the results chain in its entirety – including the building blocks.

In using the framework it is important to recognise that the principles that underpin it are value driven and need to be seen in a social and political context.

Figure 3: The Mental Health & Addiction System - Logic Model Gaines, P. (2019)



3. The building blocks of the MH&A system

In order to generate better outcomes for people, families/whānau and communities we need to create the conditions for the development of a healthy mental health and addiction MH&A system.

3.1 The supporting evidence

An important contribution to the technical debates on health systems frameworks was the report from the World Health Organisation (2007) *Everybody's business - strengthening health systems to improve health outcomes*, which proposed practical ways to organise health systems. The report proposed six operational building blocks – service delivery, health workforce, health information systems, access to essential medical products and technologies, financing and leadership/ governance.

These six building blocks are thought to contribute to the strengthening of health systems in different ways. Some cross-cutting components such as leadership/governance and health information systems provide the basis of the overall policy and regulation of all the other blocks, and others are key inputs into the system such as financing and the health workforce.

It is acknowledged that the building blocks on their own do not constitute an effective mental health and addiction system, any more than bricks and mortar constitute a functional hospital. Leff et al (2014) suggest that the injection of targeted funding should support both infrastructure and service improvements - taking into account the existing evidence and the resources that are required to implement and monitor any changes. In many respects, these comments are captured in the results chain that is depicted in the logic model for this paper.

Whilst it is accepted that work needs to happen across the results chain in order to transform the system, the building blocks approach is still a useful means for locating, describing and classifying system constraints, identifying where and why investments are needed, what will happen as a result, and the means by which any changes can then be monitored.

3.2 Mapping the building blocks

For the purposes of this paper, the six building blocks described by the World Health Organisation have been mapped to the seven areas that stakeholders had identified as priorities in the development of *On Track* (Platform Trust & Te Pou o Te Whakaaro Nui, 2015). In the process of doing this, it became clear that On Track had a notable omission – namely leadership/governance. This building block is considered to be such a critical 'cornerstone' to the change process that it has been mapped across to the On Track list (see figure 4).

However, whilst governance and leadership have a symbiotic relationship with one another, in that good leadership can energise governance and good governance can serve to sustain leadership (Davila et al., 2012, p70), they are still two very different constructs. Given their individual importance, they have been included as two separate building blocks (see figure 5).

Figure 4: Mapping the building blocks of the mental health and addiction system

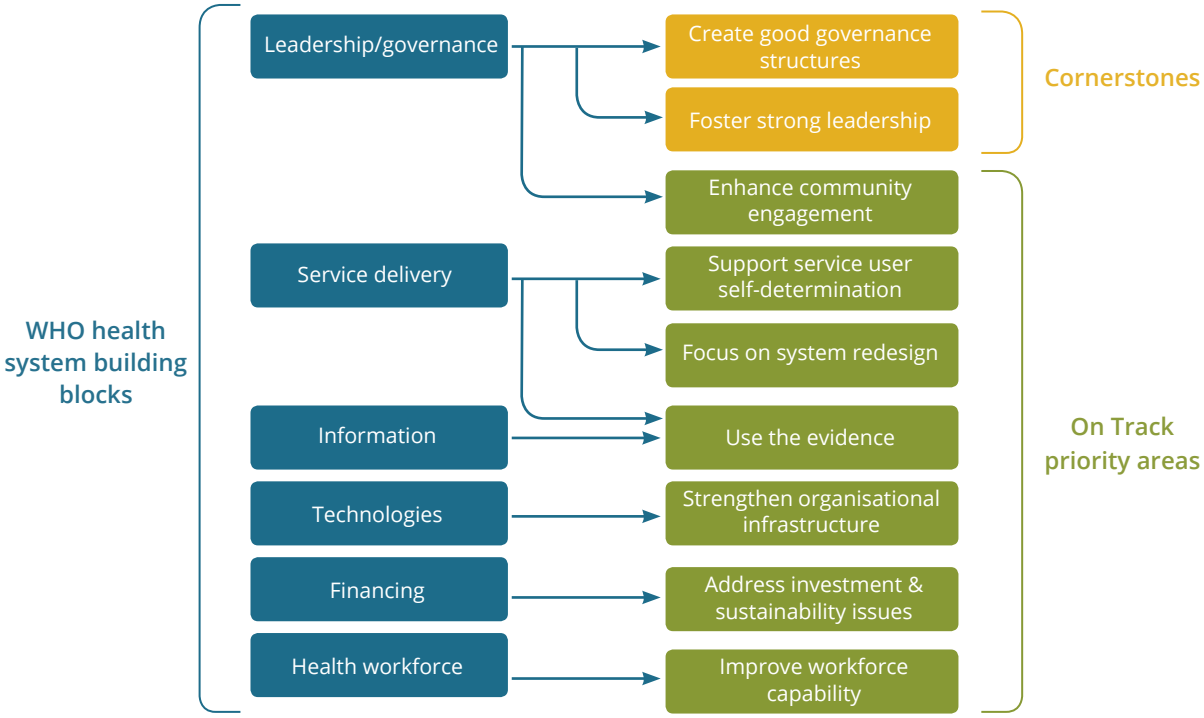


Figure 5: The nine building blocks of the mental health and addiction system

Adapted from *On Track: Knowing where we are going* (2015, p33).

4. The evaluative approach

You can't connect the dots looking forward; you can only connect them looking backwards. So you have to trust that the dots will somehow connect in your future.

Steve Jobs (2005)

4.1 The development of the evaluative approach

In order to support countries to undertake an assessment of the building blocks the Health Finance & Governance Project (2017) compiled a list of possible measurable indicators. However, many of these indicators are oriented towards the functioning of the wider health system and do not reflect areas that are of specific interest to the mental health and addiction sector in New Zealand.

This highlights one of the problems that pervades the health sector – namely, the plethora of measurement tools and performance indicators that have been designed to assess and monitor individual, organisational and system level outcomes. All of them differ based on purpose, context and perspective and, as a consequence, all of them are deficient in one way or another.

With this difficulty in mind, one of the objectives of this paper was to develop an evaluative approach that was grounded in the evidence, easy to use, and did not rely on a significant investment of time and resources into data development, collection and analysis.

4.2 The continuous improvement cycle

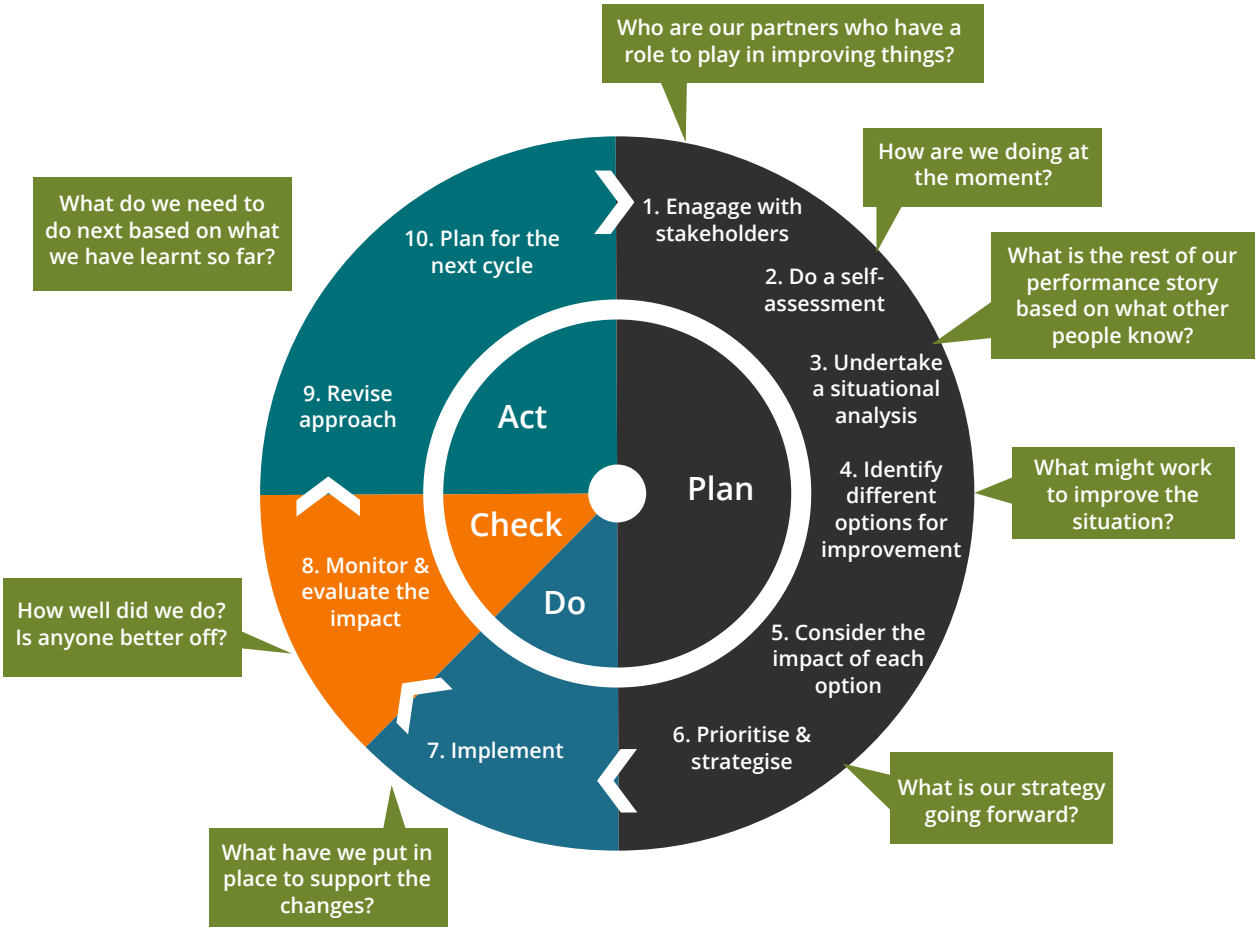
The evaluative approach is informed by the PDCA cycle (Deming, 1994) presented in figure six. It contains ten elements that are situated under the following four categories - plan, do, check, act. The self-assessment process outlined in section 4.3 of this paper covers the first six elements under the initial 'Planning' category.

The main modification to the PDCA diagram that was included in *On Track* (2015) is the addition of a step at the start of the cycle called 'stakeholder engagement'. Al Etmanski (2015) remarked that wise travellers know their boundaries and are welcoming of fellow travellers when trying to make social change. He was acutely aware that the success of any transformative efforts would rely upon the environment in which they emerged, including all of the 'players' in that environment. For that reason, he intentionally sought out 'fellow travellers' who he thought might be prepared to join him as part of a coalition that was focused on solving a shared problem. Sometimes he found these fellow travellers in the most unlikely of places.

NB: Those organisations that are interested in strengthening both their staff and organisational capacity for collaboration and partnership are referred to a literature review on the subject, which was commissioned and published by Te Pou o Te Whakaaro Nui and Platform Trust in 2018.

Whilst the broad direction of travel can be captured under one of the four PDCA categories, in reality a complex change process will mean that several different things will be happening all at once at different points in the improvement cycle. It is only when we look back at the false starts, dead ends and subsequent modifications to our action plans that the sense of 'controlled chaos' reveals some sort of pattern. It is much easier to 'join the dots' in retrospect.

Figure 6: A cyclical improvement process for the MH&A system



Adapted from *On Track* (Platform Trust & Te Pou o Te Whakaaro Nui, 2015, p53).

4.3 The self-assessment process

The aim of the self-assessment process is to help people to establish a 'baseline' for the improvement activities and to reach a common understanding amongst the stakeholders about the relative priorities. Ideally, the leadership will bring together a mixed group of stakeholders to go through this process so that a broad range of perspectives can be heard. It may be helpful to seek input from past or current critics. It may also be useful to bring in some 'outsiders' who know the issues but who haven't been closely associated with the MH&A system for one reason or another, as they might be able to offer some objective insights.

The objective is to gain as clear a picture as possible of the current situation before deciding on the priority actions, so it is important to undertake this process in a spirit of good will, co-operation and critical self-awareness.

Suggested Process

Step One - AVOID GROUP THINK

Issue each participant with a small stack of post-it notes and ask them to work on their own to assess the current state of the MH&A system using the key questions under each of the nine building blocks.

Stress that they should record their views on separate post-it notes and record the number of the question that it relates to. Suggest that they could add an asterix to any issues that they want to discuss in more detail.

Step Two – REVIEW INDIVIDUAL FEEDBACK

Gather in all the post-it notes and sort them out into groups of issues preferably on a wall, or perhaps on a table-top. The group can participate in the sorting process.

Get the group to spend a few minutes looking at the display of notes. As this is a way of encouraging participants to give their views, request that people do not comment on or critique People's feedback at this stage.

Step Three - SEEK TO UNDERSTAND WHAT IS GOING ON

The group as a whole can now evaluate the spread of opinions that have been expressed. Questions to pose are:

- Is there a consensus, or are there conflicting perceptions and attitudes within the group?
- Where are the key differences and similarities between the opinions expressed?
- Are these factors consistent or have things been getting better or worse lately?
- Have specific incidents or events contributed to the situation? Can the root causes be pinpointed?

If there are more than 8-10 participants, it will be preferable to discuss these questions in small groups first. Ask the participants whether they would prefer the small groups to be mixed-interest groups or single interest groups (ie, those representing cultural interests, service user interests, NGO interests, etc).

NB. The flow chart is an adaption of the process used by Engage East Midlands (Clark, 2001) to self-assess and improve community participation and partnership.

Suggested Process (continued)

Step Four – DISCUSS SMALL GROUP FEEDBACK

The next step is to get each small group to give feedback to the main group. At this stage, the direction the session takes will depend on the views of the group.

If there is a consensus of opinion, the participants can now move on to Step Six.

In other situations, there may be conflicting opinions and perspectives between participants. which will now need to be explored further in Step Five.

Step Five – EXPLORE DIFFERENCES

If there are differences of opinion within the group, it is essential to note that attempting to prove or disprove 'the facts' is unlikely to lead to any reconciliation: each participant will have their own perspective and though 'the facts' may change some views, people's experiences will be different.

It is more constructive to get participants to explore the differences and, if need be, to agree to disagree on certain points.

Step Six – DEVELOP A FOUNDATION

It could be helpful to progress at this point to generate two lists:

- Things we do not agree on
- Things we can agree on

It will be helpful to be as specific as possible on the issues in question, and care should be taken to avoid wide generalisations, particularly on those issues where there is not agreement.

The list of 'things we can agree on' provides a positive foundation for future discussions, no matter how many items are on it.

Step Seven – REACH A SHARED CONSENSUS

Reach a shared consensus about the current state of the system using a simple three point classification:

- not achieved;
- partially achieved;
- fully achieved.

This assessment provides a 'benchmark' for moving forward (see template in appendix two).

Step Eight – JOINTLY AGREE ON THE ACTIONS

- Having completed the assessment, stakeholders jointly agree on the possible actions.
- Consider both the likely impact and the feasibility of the action.
- Be as specific as possible about what it is that you want to do (and why).

Step Nine – CROSS-CHECK

- Cross-check the interdependencies of the possible actions (use the template in appendix 3).
- Prioritise actions accordingly.
- Develop SMART goals for each agreed action.
- Record the actions (use the template in appendix 2).

Other Considerations

- The change management aspect of the work should not be under-estimated. Given the amount of work involved it is recommended that any priority actions are limited to a realistic number.
- Start by acknowledging existing strengths and then build on areas of weakness.
- Does the group need to undertake further research or consult other agencies to help shed more light on any areas of concern or disagreement?

5. Drilling down into each of the building blocks

Each of the building blocks has been broken down into five key questions that are considered to target some of the more important elements of that building block. The key questions have been provided to assist stakeholders to assess each of the building blocks before reaching a consensus about what actions should be taken to intervene in the system.

It is suggested that an assessment of the building blocks is carried out jointly between commissioners and their local stakeholders as per the process outlined in the previous section of this paper. Please note that the evaluation of the building blocks relies on a qualitative approach (soft intelligence) and does not follow a scoring or a ranking system.

5.1 The supporting evidence

The selection of the five elements for each building block have been informed by the following sources: World Health Organisation (2015) Interim Report on an overview of the evidence for people-centred and integrated health services, the WHO (2016) report on a Framework for integrated, people-centred health services and the NZ National Health and Disability Services Standards Framework (2008). Other sources are noted against the relevant building block.

5.2 The self-assessment tool

1. Governance

Governance is defined by how collective decisions are made and then implemented. As yet, there is no standardised methodology to conceptualise and measure good governance and its influence on the performance of the health sector (Fryatt, 2017). However, it can be assessed through a process of reviewing the specific functions or principles of governance - as per the comments made in the interim findings of the *Health & Disability System Review* (2019).

#	Key questions - leadership	Yes/No
1.1	Does the governing group have a clear understanding of their roles and responsibilities with regard to the transformation of the MH&A system, including the issue of equity?	
1.2	Is there a clearly defined set of values and principles that guide the behaviours of the governing group and are these behaviours reflected at multiple layers throughout the entire MH&A system?	
1.3	Is the governance and operational relationship functional?	
1.4	Does the governing group mediate the views of different stakeholder groups to reach a broad consensus in on what is in the best interests of the whole community?	
1.5	Are a wide range of community and stakeholder voices identified and heard when planning, designing and developing MH&A services?	

2. Leadership

Good leadership can simply be defined as the successful integration of skill and soul (Cammock, 2003). The following capability descriptors are taken from the Leadership Success Profile that has been developed by the New Zealand State Services Commission (2016).

#	Key questions - leadership	Yes/No
2.1	*Envisioning* – has the leadership developed and articulated a clear strategic vision that is shared by all stakeholders?	
2.2	*Engaging* – has the leadership connected and engaged with others to work towards the delivery of high quality results - as per the shared vision?	
2.3	*Enacting* – does the leadership demonstrate optimism, a focus on making things happen and accountability?	
2.4	*Stewarding* – does the leadership work across boundaries to deliver sustainable and long-term improvements to the MH&A system and service user outcomes?	
2.5	*Character* – does the leadership work in a way that builds trust, inspires people to take action and fosters a collaborative culture?	

3. Community engagement

There is evidence to show that successful interventions to support people-centred and integrated MH&A services are those that the community ultimately has a stake in owning and directing for itself (Bloomfield & Cayton, 2009).

#	Key questions - leadership	Yes/No
3.1	Do the representatives of the MH&A system understand their local community and the various key stakeholders that operate within it?	
3.2	Do the representatives of the MH&A system understand the needs of the population based on a combination of the socio-demographic factors and current service utilisation (quantitative data) and community wisdom about people's needs and the impact of other factors, such as the social determinants of health (qualitative data)?	
3.3	Is the level and quality of community participation in the transformation process satisfactory? If not, why not?	
3.4	Do the key stakeholders have the skills to partner effectively with one another?	
3.5	Does the leadership engage effectively with Māori?	

4. Self-determination

People experience the full entitlements of citizenship.

#	Key questions - leadership	Yes/No
4.1	Do MH&A services support service users to increase their sense of 'agency' and to take control of their own health and wellbeing?	
4.2	Is Māori self-determination, know-how and whānau participation promoted and supported throughout the MH&A system?	
4.3	Does the MH&A workforce work with consumers and their family/whānau as equal partners in their care and treatment?	
4.4	Do MH&A services operate in ways that demonstrate their commitment to recovery- based principles and the notion of full citizenship for service users?	
4.5	Is there evidence of greater personalisation and choice of MH&A services?	

5. System redesign

Service providers are able to demonstrate shared accountability for improved outcomes for people and their families, whānau and their local communities.

#	Key questions - leadership	Yes/No
5.1	Is the process to commission MH&A services reflective of the new direction of travel?	
5.2	Is there a continuum of culturally appropriate MH&A services located throughout the local community?	
5.3	Are service users able to easily access high quality, trusted e-mental health options?	
5.4	Does the current configuration of MH&A services support the vision of a transformed MH&A system?	
5.5	Are service users routinely involved in the commissioning, design, delivery and evaluation of the MH&A system?	

6. Use of the evidence

The routine and proactive use of data and information is an important element in driving improvements in the MH&A system.

#	Key questions - leadership	Yes/No
6.1	Is the performance of the MH&A system routinely & proactively monitored to identify what is going well, what could be improved and whether or not targeted initiatives and interventions are having the desired effect?	
6.2	Are quality standards for MH&A service providers enforced throughout the MH&A system?	
6.3	Is the evidence used to learn and to inform decisions about commissioning MH&A services, models of care, policy directions and/or service delivery practices?	
6.4	Is the MH&A workforce routinely provided with the best available evidence about what works, for whom and in what settings?	
6.5	Is the MH&A workforce engaged in some sort of quality improvement activity at all levels of the MH&A system?	

7. Organisational infrastructure

MH&A service providers are fit-for-purpose and future-focused.

#	Key questions - leadership	Yes/No
7.1	Are e-mental health options well integrated into primary, community and specialist MH&A services?	
7.2	Is information shared between service users and different service providers in ways that promote good continuity of care and treatment?	
7.3	Is the workforce mobile and predominately found working outside of a traditional office environment – ie, people's homes, marae, local communities, etc?	
7.4	Has there been an investment made in change management to support the transformation process?	
7.5	Is there evidence of significant improvements in practice, policy and culture throughout the MH&A system?	

8. Investment and sustainability

MH&A service providers are sustainable and offer value for money.

#	Key questions - leadership	Yes/No
8.1	Is there a financial framework that supports and sustains the transformation of the MH&A system?	
8.2	Are there financing and incentive arrangements that promote the provision of high quality MH&A services in a transformed MH&A system?	
8.3	Do the provider contract service specifications reflect the shift towards a high-trust, outcomes-orientated MH&A system?	
8.4	Does the DHB invest in innovative models of MH&A service delivery that could potentially produce more effective and efficient results?	
8.5	Has the balance of financial and human resources been re-orientated towards the delivery of MH&A services in primary and community settings?	

9. Workforce capability

The MH&A workforce has the capacity and the capability to deliver high quality MH&A services to the people who most need them.

#	Key questions - leadership	Yes/No
9.1	Does the MH&A workforce match the current and future needs of the local population?	
9.2	Is the MH&A workforce culturally competent?	
9.3	Does the MH&A system have an adequate workforce in terms of the numbers, competencies and skill mix to support the goals of a transformed MH&A system?	
9.4	Have workforce roles and responsibilities changed in response to changing requirements of the MH&A system (eg, increased numbers of peer workers)?	
9.5	Does the workforce work across professional, team, organisational & sectoral boundaries?	

6. Investing in change management activities

Designing a new system, even with all the right elements within and across sectors, will not be sufficient without also investing in supporting change itself. We need to use implementation science to bridge the gap between strategy and practice and to ensure supporting infrastructure is in place and aligned to deliver the desired outcomes.

He Ara Oranga (2018, p 116)

Once the high priority actions have been identified at the end of the assessment process, people and resources in the MH&A system need to be mobilised.

The King's Fund (Gilburt et al., 2014) noted that large-scale change and the employment of new approaches required a significant level of support for things like quality improvement, service design, staff training and new ways of working. It also noted that it would need to be supported with improvement methodologies at a national level.

Rather than try to list the wide range of resources that are available on the topic of change management this paper directs readers to look at the Change Model (see figure 7) that was developed by the NHS in England to support health and social care to adopt a shared approach to leading change and transformation.

Figure 7: The Change Model (NHS England, 2016)

The Change Model was co-produced with hundreds of health and care staff and is based on credible evidence and experience. It was developed for any project or programme that is seeking to achieve transformational, sustainable change.

The Model has eight components, all of which should be considered when implementing change. The components act as a guide to ensure all elements of change are considered and implemented effectively, creating an environment where change programmes deliver transformational, sustainable change. They have been captured under the list of 'activities' in the logic model that has been developed for this paper.

The aim of the Change Model is to add dimensions and emphasis to existing change strategies that can help to accelerate the pace of effective and sustainable change. The UK experience of change initiatives in health and care shows that they are most effective when teams take the essence of the approach and make it their own to fit with their context, their priorities, their service users and their communities.

For example, the Change Model includes 'improvement tools' because there is evidence that working systematically with evidence-based quality improvement tools increases the chances of successful change (Boaden et al, 2008). However, it does not recommend which tools should be used. This is because many teams across health and care have already adopted particular tools and will want to build on what they are already doing. In addition, different tools are appropriate for different problems in different contexts and can also be used in combination with one another.

6.1 The use of intermediaries

Bullock & Lavis (2019) define 'intermediaries' as individuals, organisations or programmes that work in-between existing system structures in order to facilitate communication or to achieve a particular goal. As the term suggests, intermediaries interface with a diverse array of organisations and coalitions that collectively comprise the implementation infrastructure and are sometimes referred to as backbone support in the collective impact literature (Hanleybrown et al. (2012).

There is one specific type of intermediary that is of particular relevance to the transformation of the MH&A system. This type is either people or organisations that help facilitate the effective implementation of evidence-informed policies into practice, primarily through the use of specific implementation strategies. The strategies include methods that are drawn from implementation science - such as an assessment of organisational readiness, identifying barriers and facilitators to implementation, coaching staff and leading rapid quality improvement cycles. The Theory of Change outlined in this paper situates this type of intermediary at the intersection between possible interventions and the operational part of the mental health and addiction system.

Whilst the role of the intermediary is not well utilised in the MH&A system at the moment, it is noted that there are resources that reside within the national MH&A workforce centres that could be more targeted towards those District Health Boards that want practical assistance to implement change.

That said, Bullock and Lavis (2019) noted that in order for an intermediary to be successful, the other actors in the system must also understand and accept the role. If the future function of the national MH&A workforce centres was to become more 'hands-on' at a local level, their role and responsibilities as 'intermediaries', especially with respect to the other key stakeholders, would need to be discussed before a revamped work programme could be introduced.

7. OUTCOMES AND IMPACT

Historically, health systems have not done enough to assess health care quality and outcomes from the perspective of those most concerned – patients themselves and their carers. Addressing this lack of patient-reported indicators of performance is an urgent need.

OECD (2017)

7.1 Desired outcomes

While the building blocks provide a useful way of clarifying the essential functions of the MH&A system, the challenges facing the mental health and addiction sector in New Zealand are not manifested in this way. They are more commonly represented by the voices of New Zealanders, some of whom took the time to make a submission to the Government's Inquiry into Mental Health Services (2018). Many of these people had lost a loved one to suicide or had experienced difficulty in accessing a specialist MH&A service when either they, or their family member, needed it. These people are not interested in the architecture of the MH&A system, they just want to know that it works, it is of high quality and that they can access a MH&A service when they need it. For that reason we cannot examine the building blocks without also paying attention to the resulting outcomes for people.

7.2 National indicator developments

New Zealand has a large number of indicators (including outcome measures) that are being used at multiple levels in the MH&A system to both monitor and improve services for people - sometimes with questionable results. Both the Ministry of Health and the Health & Disability Commissioner utilise different sets of indicators to monitor the performance of the mental health and addiction system as part of their formal accountability arrangements with government.

In addition, the MH&A sector has developed its own set of national indicators for quality improvement purposes under the National Mental Health KPI Programme. The conceptual Framework is able to accommodate this activity under the component in the Framework called 'system performance', which precedes the 'desired outcomes' and the overall 'impact' of the system.

One of the issues moving forward is not so much about the development of yet more indicators, but rather selecting the right ones that will enable key stakeholders to have confidence that the MH&A system is 'on track' and that it is continuing to evolve in the desired direction.

7.3 Equity

The data tells us that the differences in mental health outcomes in New Zealand are not only avoidable, but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches in order to obtain equitable outcomes. It is not possible for the MH&A system to address inequities without access to good data. For this reason, the national indicators should be selected with system equity goals in mind and routinely stratified by ethnicity and age as a matter of priority.

7.4 Possible national indicators for the future

There is a key opportunity to reduce waste in the MH&A system by ensuring that national measures of system performance are meaningful and improve care, while also minimising the undue administrative burden of data collection on service providers.

With this issue in mind, the following composite set of potential indicators is proposed as a way of monitoring the transformation of the mental health and addiction system over time. The indicators should not be seen as definitive, but rather treated as possible options when reviewing the current MH&A measurement and reporting requirements. Importantly, some of the indicators could be built using information from current data sources that exist outside the MH&A system.

Figure 8: Composite set of potential national indicators

Personal outcomes for people (PROMs) (eg, percentage of people who report that they have an improved quality of life).

Consumer experience of services (PREMs) (eg, percentage of people who report that MH&A services helped them to achieve their personal goals).

Service proxies for improved mental health outcomes (eg, reduced % of people presenting to acute/crisis MH&A services, reduced % of known clients to ED, reductions in number of adverse events, reduced 28-day readmission rate).

Organisational processes (eg, easy access to services, more support for self-care, better care transitions, safer care).

System level measures of community well-being and population health (eg, measures of family wellbeing across the life-course (Superu, 2016)).

Measures that demonstrate the reorientation of activities towards primary and community care (eg, relative distribtion of financial and human resources, percentage of people seen in primary, community and specialist MH&A settings).

7.5 Assessing impact – Pae ora

Pae ora has been selected as the ultimate aim of the transformational process for the MH&A system, primarily because it is a holistic concept with an emphasis on health and wellbeing.

Pae ora is described in the Māori Health Strategy (Ministry of Health, 2014) as including three interconnected elements: *mauri ora* – healthy individuals; *whānau ora* – healthy families; and *wai ora* – healthy environments. All three of these elements are mutually reinforcing and underpin improved health and wellbeing. Pae ora offers an aspirational vision for all New Zealanders and, consequently, is considered to be a good place to end this paper.

We will be successful when we have a system that delivers the same high-quality health outcomes for all people to reach their full potential, no matter where they live, what they have or who they are.

Ministry of Health, 2019

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APPENDIX 1 – Critical assumptions underpinning the theory of change

The main assumptions that underpin the theory of change are as follows:

Component	Critical assumptions
Single loop control	As previously mentioned, the learning framework that is incorporated into the Theory of Change recognises three types of learning - as described below by Mark Cabaj (2019): **Single loop** – what are we learning about what we are doing in the mental health and addiction system and how effective are our interventions in the system? The performance monitoring and evaluation functions are situated at multiple levels in the measurable mental health and addiction system – namely service provider, DHB and Ministry of Health. • The DHB reports on its performance to the Ministry of Health as per the Crown Funding Agreement. • At a local level the DHB monitors the performance of MH&A service providers and commissions MH&A services in ways that align with national policy directions.
Double loop control	**Double loop** – what are we learning about our assumptions, understanding and thinking? What is the impact of the factors in the wider operating environment (including policies, political and social context) on different parts of the MH&A system and what adjustments do we need to make in order to be successful?
Triple loop control	**Triple Loop** – What are we learning about our values, attitudes and behaviours? • To what extent are we changing the drivers that shape the systems behaviour? • To what extent are the changed drivers leading to changes in the behaviours of different system actors? • Have the actions of individual actors in the system been sufficient to tip the system into new behaviours? • How deep and durable are these behaviour changes? • What (if any) are the unanticipated changes?
The role of context	The observation of results that are generated, in part, by whatever interventions or initiatives are introduced into the MH&A system need to be evaluated with regard to the surrounding context. For example, it is well known that organisational culture eats strategy for breakfast (Drucker, 2011). Even when organisations have a supportive culture, variations in local priorities and local politics, coupled with resourcing issues, will make direct comparisons between organisations and localities difficult.
Implementation intermediaries	Bullock & Lavis (2019) define 'intermediaries' as individuals, organisations or programmes that work in-between existing system structures in order to facilitate communication or to achieve a particular goal. These are the people that provide practical support to MH&A service providers that want to implement change.

APPENDIX 2 – Output from the self-assessment process

This template should be completed by the local MH&A collaborative (ie, commissioners, service providers, service users, carer groups, etc.) following the process outlined in section 4.2 of this paper. Once the issues have been identified, assess the inter-dependencies amongst them using the template in appendix 3 before deciding on the priority actions.

#	Building Block	Not achieved	Partially achieved	Fully achieved	Priority actions
		Tick one			
1	Create good governance structures				
2	Foster strong leadership				
3	Enhance community engagement				
4	Support service users self-determination				
5	Focus on system redesign				
6	Use the evidence				
7	Strengthen organisational Infrastructure				
8	Address investment & sustainability issues				
9	Improve workforce capability				

*Template adapted from Shepherd, Boardman & Burns (2010). *Implementing Recovery*.

APPENDIX 3 –
Consider each building block in relation to all of the others

Source of issues by building block	Note key issues affecting each of the other building blocks								
	Governance	Leadership	Community engagement	Self-determination	System redesign	Use the evidence	Organisational infrastructure	Investment & sustainability	Workforce capability
Create good governance structures									
Foster strong leadership									
Enhance community engagement									
Support service users self-determination									
Focus on system redesign									
Use the evidence									
Strengthen organisational Infrastructure									
Address investment & sustainability issues									
Improve workforce capability									