

National Mental Health Information Strategy

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Foreword

Significant achievements have been made in the area of mental health information development in New Zealand since the early 1990s. The World Health Organization (2001) reports that mental health reporting is not done by 27 percent of countries and data collection or epidemiological studies are absent in 44 percent of countries. In comparison New Zealand is well advanced, collecting information about consumer utilisation of mental health services in a standardised national data set that covers inpatient and community settings. This data set is soon to be enhanced with the addition of consumer outcome data, which will be used to inform clinical practice and provide high-level information about services' overall effectiveness. These advances in information development have been supported to some extent by parallel developments in electronic information systems, which have been associated with a broad range of infrastructure developments to support the collection, validation, reporting and analysis of mental health information.

A key feature of the National Mental Health Information Strategy is its focus on the use and application of information at all levels of the mental health sector. However, the sectors ability to use information effectively is constrained by several factors. While progress has been made on the development of mental health information, it has not been evenly matched by the development of electronic information systems and the development of the necessary infrastructure has not been uniform across the sector. These factors have combined to limit opportunities for some mental health stakeholders, including consumers, to be involved as active participants in emerging e-health initiatives.

With the launch of *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005) the time is right to consider the critical role of information in the development of a high-quality mental health sector. This document provides a strategic framework for mental health information and outlines priority areas to support current and future requirements for mental health information.

The Ministry of Health is committed to working with providers to develop a well-informed mental health sector where providers have easy access to the information they need to deliver high quality care to consumers and can provide evidence of an effective and efficient mental health sector.

We sincerely thank the members of the national advisory group (see Appendix A) who participated in the development of this strategy and those individuals and agencies who provided submissions as part of the public consultation process.



Dr Janice Wilson
Deputy Director-General, Mental Health

Contents

Foreword ...	iii
Executive summary.....	vii
Introduction	1
Background.....	1
National Mental Health Information Strategy	1
Stakeholders' information needs.....	2
Scope of the strategy.....	4
Principles.....	4
Drivers of change	5
From information collection to information use	5
Best use of limited resources.....	5
Consumer recovery	5
Primary mental health	6
Māori: whānau ora	6
System or sector development	7
Quality improvement.....	8
Research and development	8
Data quality	9
Information developments.....	10
Types of information required.....	10
Priority areas for action	14
Fix and renovate.....	14
Non-governmental organisations' development.....	14
Implementation plan.....	14
Conclusion	24
Appendix A: National advisory group	25
Appendix B: International context	26
United States	26
United Kingdom	26
Australia	27
Glossary ...	28
References	30

Figures

Figure 1: Link between health and information strategies.....	2
Figure 2: Stakeholder requirements for different types of information.....	3
Figure 3: Achieving whānau ora.....	7
Figure 4: Types of information required to support a comprehensive info system.....	11
Figure 5: Components of Decision Support 2000+.....	26

Tables

Table 1: Descriptive and evaluative information at mental health system level.....	12
Table 2: Fix – priority areas for targeted activity.....	16
Table 3: Renovate – priority areas for targeted activity.....	23

Executive Summary

International investment in improving mental health information (see Appendix B), as in other industries, continues to increase in response to the increasing demand for better information on which people can base decisions. The challenge is for the mental health sector in New Zealand to find innovative ways to build on the current foundation and at the same time maintain sufficient flexibility to accommodate the information requirements of the future.

The National Mental Health Information Strategy outlines the priorities guiding the development of national mental health information from 2005 to 2010. It signals a shift in emphasis from information collection towards the local and national use of mental health information. The key objective is to achieve better outcomes for mental health consumers and increase accountability for expenditure on mental health services.

The priorities describe an evolving process whereby the mental health sector develops information technology and collects relevant information to improve the quality of services for consumers.

With reference to the leading challenges outlined in *Te Tahuhu – Improving Mental Health* this information strategy has targeted nine priority areas for activity.

- 1 Shift the focus from information collection to information use.
- 2 Minimise the cost of collecting information.
- 3 Increase opportunities for consumer input into clinical records.
- 4 Extend the coverage of mental health data to primary health care.
- 5 Support Māori goals for whānau ora.
- 6 Support information sharing among providers (eg, District Health Boards, non-governmental organisations and primary health care providers).
- 7 Use information as a quality improvement tool.
- 8 Use information for research and development.
- 9 Fill data gaps and improve data quality.

The ability to make progress on these priorities depends on the necessary resources being available and assumes stakeholders will continue to work together to develop a coherent national approach to mental health information development. The group of stakeholders includes mental health providers as well as the Directorates within the Ministry of Health that are developing strategic plans for information development in areas of common interest to mental health (eg, primary health care).

Developing the implementation plan will include assessing the extent of work involved in each priority area and the interdependencies among the activities.

Introduction

Background

Despite the diverse range of users of mental health information and the different purposes to which information is put, no overarching information strategy exists for mental health services in New Zealand. Therefore, information technology (IT) projects and information initiatives have been developed in an ad hoc and uncoordinated way. This has resulted in IT projects and initiatives that are each important, but with no means for ensuring that effort is not duplicated, there are no information gaps, and the information gathered fulfils its original purpose. Even more importantly, no means exists to ensure the information being gathered by services actually improves consumer outcomes.

The need for good quality information to support the development of health services generally and mental health services specifically in New Zealand has been recognised in several documents. However, these documents also acknowledge that the use of information in the health sector in New Zealand is not ideal, and that ‘better means of organising health information need to be employed’ (Ministry of Health 2001).

This is the Ministry of Health’s first sector-wide mental health information strategy. It addresses the ongoing development of mental health information systems based on the requirements of a range of stakeholders. Mental health service providers have already invested substantially in the collection and use of current information, so the strategy suggests activities to enhance what has already been accomplished, using resources already in place and focusing on areas requiring further work.

To realise the mental health sector’s full potential to help the consumer recovery process, efforts need to be concentrated not only on the *collection* of data, but on building the necessary information infrastructure, so stakeholders can *use* the mental health information collected, at local and national levels, more effectively.

The Ministry of Health gained a better understanding of what the sector requires from a national mental health information strategy by developing and disseminating *Mental Health Information Strategy – Key directions: Discussion document* (Ministry of Health 2005a) and holding public meetings to discuss the issues. This document is the result of all the input the Ministry has received.

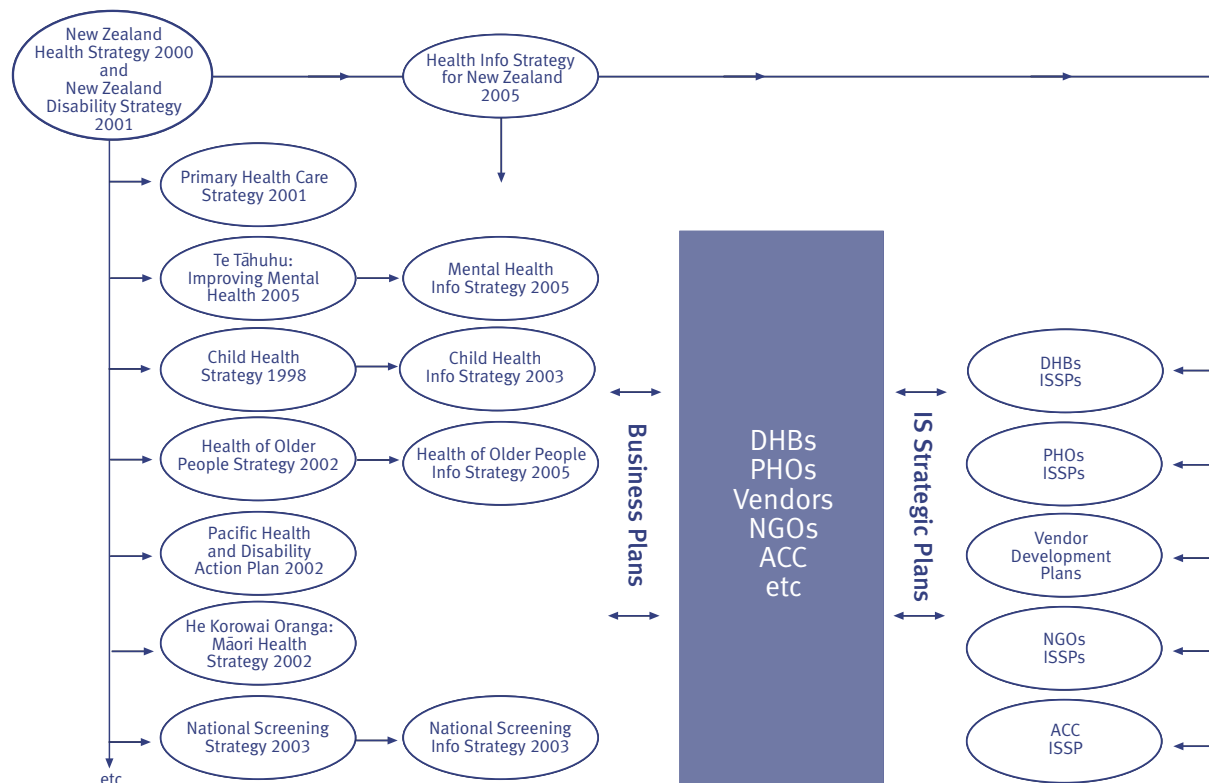
This strategy aims to move the mental health sector closer to the ideal of an integrated network of service providers, while recognising that this will take time and relies on the development of the necessary information infrastructure, especially in the NGO sector.

National Mental Health Information Strategy

The activities in this strategy are situated within the broader range of national health information initiatives outlined in the Health Information Strategy for New Zealand (HIS-NZ) (in press). HIS-NZ supports New Zealand health and disability strategies by encouraging the innovative use of information in ways that improves New Zealanders’ health and independence. The effectiveness of the National Mental Health Information Strategy depends on the timing of other information-related developments across the health sector, so cannot be implemented successfully in isolation.

The link between health strategies, in particular *Te Tāhuhu: Improving Mental Health* (Minister of Health 2005) and its priorities, to the relevant information strategies is illustrated in Figure 1.

Figure 1: Link between health and information strategies



Source: Health Information Strategy Steering Committee (in press)

Figure 1 also illustrates how health strategies inform the development of provider business plans and strategic information plans. It is important the business planning cycle drives the information system development, not the other way around. In New Zealand information systems have been developed without regard to the requirements of the frontline staff directly responsible for collecting the information. Many of these ‘developments’ have then used additional time and resources in modifications so everyone participating in the delivery, management and evaluation of mental health services can collect and use the information they need.

Stakeholders’ information needs

The development of systems for collecting and using information should be guided by the information requirements of the different groups of stakeholders (ie, consumers, caregivers, providers, managers, District Health Boards (DHBs), funders and planners, Māori, and national agencies).

In determining different stakeholders’ requirements for different information it has been important to distinguish between two main types of information.

- Information collected to support the delivery of care to individual consumers (commonly collected by patient management information systems).
- Information collected to support the management of mental health service systems (eg, for funding, planning, monitoring and policy development).

The first type of information is qualitative data (recorded alongside relevant sociodemographic data). It is information about the care service providers are providing to consumers. This information essentially involves only the participation of consumers, informal caregivers and care providers and increasingly relies on the development of electronic files for recording and sharing of clinical information.

The second type of information is used as a strategic management or accountability tool. It relies primarily on the aggregation of the sociodemographic data extracted from the patient management information system that is linked to data captured from other information sources (eg, finance systems). Local operational management relies on this information to describe the relationships among consumers, staff and costs. At the national level any assessment of provider performance to determine ‘value for money’ relies on linking information about inputs and outputs to outcomes.

It is important to note that if the information that is collected for management purposes does not help staff to deliver care to consumers on a daily basis then data quality will remain poor and negatively impact on the quality of decision making at both clinical and managerial levels. For this reason the strategy focuses on developments that support the production and quality of both types of information.

Figure 2 demonstrates the extent to which different stakeholders are involved in the production and use of both types of information and the general principle that the quantity of information needed at regional and national levels should be a by-product of the information collected locally. The richest and most detailed information about a consumer is held at the local level for the purposes of delivering care and treatment. Only specific items of individualised consumer data are of interest to regional and national agencies and this information is usually presented in an aggregated format for planning and monitoring purposes.

Figure 2: Stakeholder requirements for different types of information

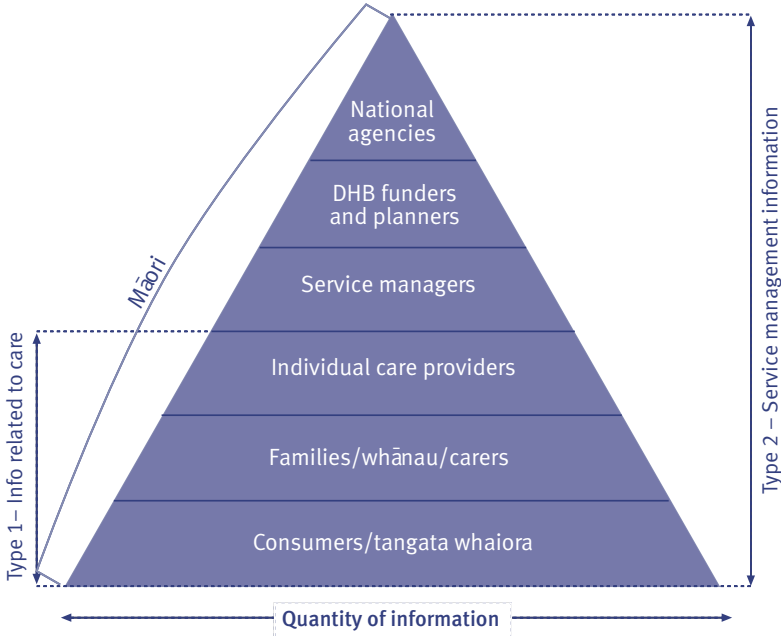


Figure 2 also shows that in this context Māori needs and aspirations should be considered across all stakeholder groups.

Consumers are the principle stakeholders, as they make up the base of the triangle and have the largest requirement for easy access to information as well as the largest requirement for active participation in information systems that support their care.

Scope of the strategy

The scope of this strategy is to improve the collection and use of the two types of mental health information.

- Information collected to support the delivery of care to individual consumers (commonly collected by patient management information systems).
- Information collected to support the management of mental health service systems (eg, for funding, planning, monitoring and policy development).

Consumers and informal caregivers also want improved access to general information about different mental health conditions and their associated treatments, and access to a directory of mental health service providers. While this information is not the focus of this strategy some suggestions have been made in section 4 about how national agencies might work together to facilitate progress in this area, as sources for this information exist, albeit in a number of different places.

Principles

The ongoing development of information systems offers stakeholders an opportunity to share information in such a way that consumers should be confident that they will receive the best care regardless of which provider that they see.

Three core principles are proposed to guide the ongoing development of mental health information systems:

- partnership (active engagement of consumers in the therapeutic relationship via greater access to areas such as records and recovery plans)
- protection (privacy and security of information)
- participation (connectivity between individuals and agencies).

This strategy represents more than a set of technical activities to support the collection of mental health information. Providers have already invested significant sums of money in the development of information systems to meet their own and national requirements. The task ahead is to reach a consensus on how to improve the systems already in place.

These principles support the development of an information base (monitoring, research, evaluation, resource allocation, outcome and performance information) that will contribute to the achievement of whānau ora.

Drivers of change

The health and disability sector, as have other sectors, continues to increase investment in information systems in response to an increasing demand for better information on which to base decisions. Investments such as the National Health Index to provide a unique consumer identifier, National Minimum Data Set for inpatient services, and National Mental Health Information Collection (MHINC) has significantly increased the sector's capacity to describe the services that are being delivered and to whom.

From information collection to information use

We cannot build on the sector's achievements over the last few decades without considering what needs to be done to improve the dissemination and use of information that forms the evidence base for planning, delivering and monitoring services for mental health consumers.

Sophisticated 'electronic decision support systems' provide an example of what is currently available as a direct aid to clinical decision-making. The general aim is for consumers, carers and service providers to have access to information and to use that information to better understand the current situation in order to make decisions about the future.

There is some evidence to suggest that the mental health sectors reluctance to use the information that it already has available to it by electronic means will not be solved by the application of more technology (NICs:2002). The better use of information by all stakeholders relies much more on developing an environment that supports a change in individual and organisational behaviour.

Best use of limited resources

Given the diverse nature of mental health providers and the decentralisation of decision making, a national information strategy will help to align local level decision making with national policy. As a small nation, New Zealand does not have the financial resources to continue to approach information system development in an individualised way. As much as possible we need to coordinate our efforts to make sure that IT developments are not duplicated and that different IT systems support the easy exchange of mental health information across the sector.

The Ministry of Health is promoting a 'Leading for Outcomes' approach for all who are involved in the health system, whether in actual health care delivery or administration or policy, to help maintain focus on the overall results of the sector's collective actions – on outcomes. The mental health sector needs to be able to demonstrate that services operates efficiently and that the development of the information infrastructure is shaped by the outcomes that the sector seeks to achieve, namely that mental health services help reduce the impact of severe mental illness and promote consumer recovery.

Consumer recovery

The increasing emphasis on consumers' active participation in their care and treatment presents some challenges for the mental health sector. It means clinical information systems will need further technical development, so consumers and their nominated carers can provide direct input.

The Internet offers considerable opportunities in this regard, but access to consumer health records needs to be considered in the light of Privacy Act 1993 requirements as well as the development of technical standards. It is expected that Web-based access mechanisms will be developed under the Ministry of Health's Information Systems Strategic Plan.

Primary mental health

The Primary Health Care Strategy (Minister of Health 2001) and the establishment of Primary Health Organisations (PHOs) provide a unique opportunity to develop mental health services according to population needs. One study has offered some useful insights into the incidence, severity and patterns of treatment for mental health conditions at the level of primary care (MaGPIe Research Group 2003). Given the prevalence of mental health conditions in the general population and the pivotal role of primary health care as the first point of contact, we now need better information at a national level about the use and effectiveness of primary care services for mental health consumers.

Te Tāhuhu: Improving mental health 2005–2015 (Minister of Health 2005) emphasises the need for good links between primary health care and specialist mental health services for the provision of coordinated care for people with severe or enduring mental illness. This link involves expanding the level of electronic communication and coordination between primary and secondary care, particularly in the areas of referrals, discharges and the transfer of relevant clinical reports. Developments in this area will also be part of the work under the Ministry of Health's Information Systems Strategic Plan, which emphasises the importance of providers conforming to common standards where available.

Māori: whānau ora

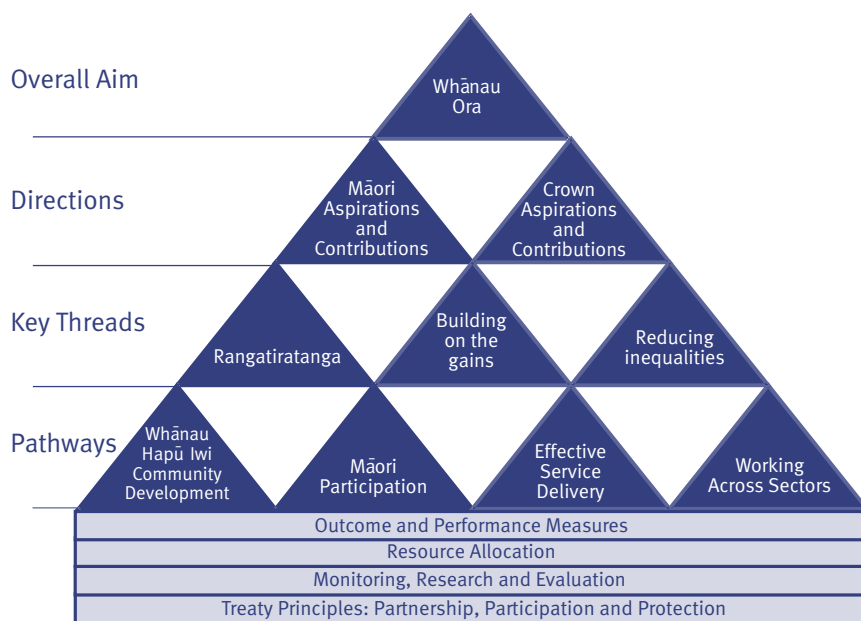
Perhaps the biggest challenge to developing a culturally competent mental health information system is the very nature of the mental health sector.

Who collects what information, in what way and how it is analysed are all key determinants of the cultural relevance of the eventual findings, especially to the population under consideration. For this reason the development of cultural competence at clinical and administrative levels continues to be important for achieving whānau ora as outlined in *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002).

Whānau ora is a dimension of wellbeing that is gaining acceptance in the mental health sector as it best encapsulates a Māori world view of total wellbeing and 'recovery'. More work is required to define 'whānau ora' within the context of a mental health information system. However, it is clear that this concept is broad in scope, focuses on recovery, and requires innovative and extensive approaches to data collection. The definition will be key in the development of outcomes for Māori and when monitoring whether desired outcomes have been achieved. This is not to say that existing systems will be unhelpful, but that measurement processes should reflect the desired outcomes of Māori.

Most importantly, from an information perspective, it will involve providing the information that enables effective Māori participation at all levels of the sector, including decision making, planning and development, and the delivery of health and disability services (Ministry of Health 2004).

Figure 3: Achieving whānau ora



Source: Minister of Health and Associate Minister of Health (2002, p4).

System or sector development

Sharing information in a safe and appropriate way across different care delivery settings is critical to the effective delivery of an integrated continuum of care for consumers. Innovation and excellence in isolation will not produce the benefits required across the sector. Mental health providers need to operate as part of an interactive sector with their sole focus being the seamless delivery of care to consumers to produce the best possible outcomes. This means developing IT systems that, at the very least, conform to national standards that permit the easy transfer of information.

In addition, the mental health sector also needs to consider its relationships to the wider health sector and other sectors, including the social (general health care, education and training, justice and rights), environmental (housing), economic (income and employment) and cultural (personal services) sectors. Given the significance of other sectors' contribution to improved health outcomes it is important mental health information systems can share appropriate information across sectors.

The importance of a systems approach is recognised in *Improving Quality* (Minister of Health 2003) and the consultation document for *Improving Mental Health* (Ministry of Health 2004), which suggested that DHBs be asked to report on how they integrate and co-ordinate the services they fund. DHBs have a key role (as part of their role in implementing the Primary Health Care Strategy (Minister of Health 2001) and *Te Tāhuhu: Improving mental health 2005–2015* (Minister of Health 2005)) in helping to improve how information systems interface between the primary and NGO providers. The roles and responsibilities of the Ministry of Health and mental health providers for information system development are covered in more detail in section 4.

Quality improvement

The quality dimensions described in *Improving Quality* provide a framework for measuring the mental health sector's overall performance (Minister of Health 2003). *Improving Quality* illustrates how several dimensions of quality are common to a range of key stakeholders, and how 'quality improvement needs to encapsulate all levels of the sector and the interactions between them' (Minister of Health 2003).

At the service provider level, frontline staff are interested in obtaining information about how to improve their practice on the basis of what is known to work best for consumers. While numerous references about 'best practice' exist, there is no single repository of information where staff can easily learn about the latest research and no single agency supporting providers in their attempts to incorporate research findings into routine practice. This is a gap in the mental health sector's current national workforce and service development infrastructure.

At the national level, key performance indicators are a central component of any health service quality improvement process as they provide a basis for accountability and monitoring. The Ministry of Health is proposing to expand the current dimensions of quality (access and equity, safety, effectiveness and efficiency) to form a framework for the development of national key performance indicators for the mental health sector to use at provider and national levels. It is proposed that this framework includes a further five domains (services that are appropriate, continuous, responsive, capable, and sustainable) as identified in the performance framework for Australian public mental health services (National Mental Health Information Strategy Committee 2004).

One of the proposed activities is to engage a group of providers in the development of key performance indicators using current data. Then to use those indicators as part of a benchmarking activity whereby providers can learn from each other about the practices and processes that best contribute to improved outcomes for consumers.

Research and development

Role of information in research and development

The role of information in research is critical to the sector's ability to respond in a focused and timely fashion to what is found to work best for consumers in terms of the most effective interventions and models of service delivery.

While this strategy focuses on the routine collection of information it is anticipated that a national approach to information development will also support the sector's capacity to conduct research into priority areas. A national approach to information development will not only increase the range, volume and quality of data to meet identified immediate clinical and planning requirements, but will provide the opportunity for additional evaluation of services in a research and development framework.

Role of Mental Health Research and Development Strategy

It is not cost-effective for a national data collection to include data that is useful only for research, especially when that data could otherwise be collected as part of a one-off study. For example, some large one-off research projects under the Mental Health Research and Development Strategy (MHRDS) have relied on the collection of data not currently collected by the mental health sector (for example, the Mental Health Epidemiology Survey and the Mental Health Classification and Outcomes Study (Gaines et al 2003).

The MHRDS was developed in 1997 to undertake research projects that would lead to improvements in the delivery of mental health services in New Zealand and to increase research expertise and develop a culture of inquiry and evidence-based practice within the mental health sector. To achieve these two aims three areas were identified as priorities for research:

- epidemiology
- outcomes
- sector development.

A review of the projects in these three areas showed that overall the MHRDS had met its original objectives and the time was right to establish its future priorities. Given the limited resources available to the MHRDS and the wide range of possible research projects it is recommended that projects that build on previous work should be the MHRDS's first priority. This does not preclude the MHRDS funding other areas of mental health service research but it aims to maximise the MHRDS's limited resources.

Given the increasing number of reports produced by MHRDS projects and that research evidence is derived from multiple sources it is recommended that the MHRDS takes a more active role in translating mental health research findings into practice. The Mental Health Standard Measures of Assessment and Recovery initiative (MH-SMART) provides an example where research into the area of outcome measurement is being linked to implementation in routine practice with the support of the MHRDS and the national Workforce Development Programme.

The first step in increasing the opportunities for the sector to access the findings of research involves the MHRDS disseminating up-to-date and reliable information about mental health programmes and practices that have been demonstrated to be effective in improving outcomes for consumers. Further investigation and planning will be required to identify mechanisms to help the workforce translate those research findings into routine practice.

Data quality

Poor quality data is a significant barrier to effective service delivery and limits the Government's ability to monitor service delivery and develop good policy. Providing high-quality information helps to provide efficient and cost-effective care, improve consumer health outcomes, safety and satisfaction. The Ministry of Health's Data Quality Improvement Programme (due for release in 2005) seeks to provide the health and disability sector with a common understanding and philosophy about data quality.

One of the programme's and this strategy's core requirements is that data quality is first and foremost the provider's responsibility. The Ministry of Health's role is to manage the data that is provided to it and to maintain its integrity. It does not have the capacity to check whether the data submitted to the NZHIS reflects actual practice.

For all stakeholders to be able to rely on the national Mental Health Information Collection (MHINC) as a reliable source of data, service providers and the Ministry of Health need to devote more effort towards improving data quality. Providers need to commit to having a data quality strategy, whereby action is taken as a result of the data staff submit and data quality is monitored as an integral part of a provider's quality improvement process.

Information Developments

Types of information required

Scope of the strategy (page 4) highlighted that this strategy's scope focuses on the developments required to support the collection of two main types of information.

- Information collected to support the delivery of care to individual consumers (commonly collected by patient management information systems).
- Information collected to support the management of mental health service systems (eg, funding, planning, monitoring and policy development).

Purpose of information collection

The United States Center for Mental Health Services (Henderson et al 2000) has classified the two types of information into four categories that allow us to think critically about the data being collected and for what purposes (see also Figure 3):

- descriptive information
- evaluative information
- prescriptive information
- corrective information.

Information from each category is required to support decisions at all levels of the mental health sector.

Descriptive information: What are we doing?

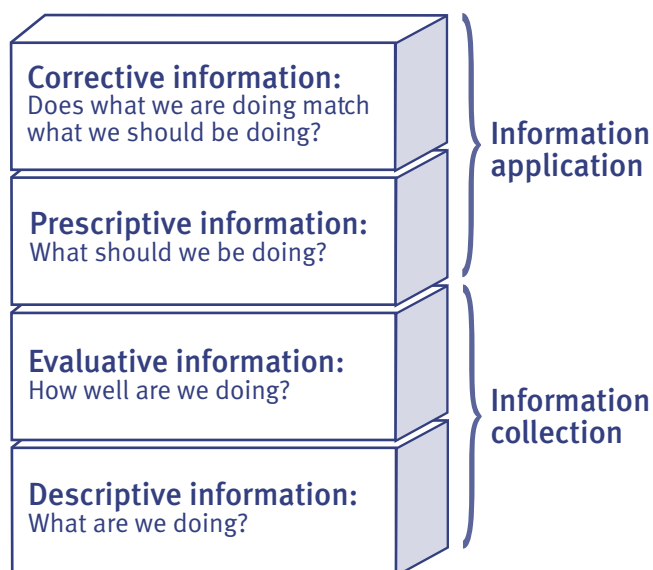
Basic, descriptive information answers the question, 'What are we doing?' Data in this category may describe, for example, the services provided, to whom services are provided, who provides the services, and how often and at what cost services are provided.

Evaluative information: How well are we doing?

Quality improvement tools such as consumer satisfaction surveys, consumer outcome measures (eg, MH-SMART) and key performance indicators can all be used to answer the question at individual consumer and organisational levels, 'How well are we doing?' The Knowing the People Planning approach uses a range of information to focus staff attention on the individual requirements of consumers who have been seen by services for more than two years.

When data is collected in uniform and standardised ways, quality tools also support comparisons across individuals, teams and organisations.

Figure 4: Types of information required to support a comprehensive info system



Source: Department of Health and Ageing (2005). Adapted from Henderson et al (2000) Decision Support 2000+ .

Prescriptive information: What should we be doing?

Clinical and administrative guidelines in the information system help staff by summarising the existing knowledge on a particular subject. This then informs staff decision-making. They offer a summary of what the literature or clinical or managerial experience indicates might work to produce the best results. This kind of information is fundamental to evidence-based practice but should not be applied in a simple ‘cookbook’ approach to the complex process of assessment, care and treatment.

Corrective information: Does what we are doing match what we should be doing?

Fidelity measures compare clinical and administrative practices with the practices recommended in guidelines. Sector performance measures such as performance indicators and report cards measure administrative and managerial performance, while consumer outcome measures provide an indirect assessment of provider input into an individual consumer’s care. When the desired effects are not achieved, the information obtained through these measures refocuses and redirects quality improvement activities.

Performance management is a new and evolving area in the mental health sector and for this reason a degree of experimentation will be required as part of the process of developing system performance indicators. In order for this development to be successful all parties will need to be able to participate in the process in the spirit of shared learning and without fear of any punitive repercussions.

Information developments

At the level of the individual consumer, the development of a recovery plan should involve all four categories of information (ie, descriptive, evaluative, prescriptive and corrective information).

At the level of the individual service, providers need answers to questions about which staff are seeing which consumers, how frequently, over what period and to what effect. They also need information about the processes and procedures being followed. Again, this relies on all four categories of information.

Initial national sector information development efforts in New Zealand have focused on gathering descriptive information under the MHINC, followed by more recent work to introduce consumer outcomes data into routine mental health collections under the MH-SMART initiative, thereby extending the national focus of information into the evaluative domain.

The Ministry of Health has used Leginski et al’s (1989) framework to consider ‘Who receives what, from whom, at what cost and with what effect?’ from the perspective of ‘value for money’ and using available descriptive and evaluative information.

In the light of the different dimensions that need to be considered when evaluating system performance the Ministry of Health is also proposing to modify Leginski et al’s framework by adding a sixth element about consumer need. By focusing on ‘who needs what’ the sector will be able to measure the difference between what is needed and what services are received, which will inform a process for identifying how the difference between the two might be addressed.

Table 1: Descriptive and evaluative information at mental health system level

Question	Answer	Information source
Who needs what?	Epidemiological information about the population with specific information about Māori and Pacific peoples.	National Mental Health Survey
Who receives?	Demographic and clinical characteristics of mental health consumers/tāngata whaiora.	Mental Health Information National Collection (MHINC)
What services?	Details of mental health services delivered (volume and type); consideration of aspects such as safety and cultural competency.	MHINC
From whom?	Service characteristics and details of the mental health workforce.	MHINC for service types and information on workforce by survey
At what cost?	Mental health service expenditure.	Costing systems National service framework
With what effect?	Consumer outcome data such as severity of symptoms and continuity of care;	Mental Health Standard Measures of Assessment and Recovery (MH-SMART) MHINC Knowing the People Planning Key performance indicator development

Source: Leginski W, Croze C, Driggers J, et al. (1989).

Feedback from the strategy’s public consultation indicated that not all the information in Table 1 is available to the satisfaction of all stakeholders in the mental health sector and some data currently collected is not seen to be useful. The next step is to investigate what changes or developments need to take place to upgrade the collection and dissemination of mental health information at the national level and, based on the feedback, to prioritise progressive steps to improve the situation over the next five years (see section 4).

Information development for *prescriptive* and *corrective* purposes (ie, to move from *collecting* information towards *using* information to support decision making) has not been a focus of national activity to date. This is one of the key challenges in information management that lies ahead for the sector.

Information infrastructure: the foundation

The Ministry of Health is not proposing that providers develop one physical information system to hold all their data. All service providers spend money on information systems that have been designed to meet their business requirements. What is now needed is a focus on the progressive development of these information systems so different components can be linked internally within organisations (intrinsic links) and externally (extrinsic links) across different organisations to achieve common objectives (Minden and Webman 2004).

There are problems with incompatible information systems (ie, where one system cannot ‘talk’ to another) and providers, for a variety of reasons, not having access to computers or broadband networks to facilitate the secure sharing of information with other providers. This is where a collaborative ‘system development’ perspective is critical if the sector wants to provide a more integrated response to mental health consumers’ needs.

In addressing the opportunities for information systems to contribute to improved health outcomes, different providers have different levels of information system capability, especially in the NGO sector. To realise any of the benefits of belonging to an integrated mental health sector, the implementation of this strategy’s key objectives depend on the solutions that are put in place to build information system capability in the wider health sector. The following building blocks identified in the Health Information Strategy for New Zealand (2005) are also critical to the successful development of mental health information systems:

- structural elements (eg, national connectivity, applications and national data collections)
- foundations (eg, standards, privacy and security)
- a governance framework (eg, capital investment framework, accountability frameworks and collaboration frameworks).

This document does not detail the activities that are already proposed in the HIS-NZ that are applicable across the broad spectrum of health. However, section 4 provides a detailed list of activities necessary for this strategy’s successful implementation and some of these activities relate to priority areas in the HIS-NZ that can be driven only by the mental health sector.

Workforce

Alongside building the necessary information infrastructure, providers must also develop their people, culture and business processes. The success of any information system depends on the way information is regarded and used by the mental health workforce. This includes frontline staff providing care and treatment, clinical leaders, managers, funders, planners, policy makers and researchers. The emphasis on developing an information-literate workforce at all levels of the mental health sector must be a priority if the sector is to make best use of the information and the available technology.

No organised national education strategy has helped to meet the mental health workforce’s ongoing information training and education needs. To increase awareness and expertise in information use to improve data quality requires a national educational strategy.

Just because we live in an age where rapid developments in technology have made possible that which was barely conceivable only a few years ago it cannot be assumed that the problems are all complicated technological ones. In some instances the problem is as simple and as basic as providing staff with access to a computer and then teaching them how to use it.

Priority areas for action

Fix and renovate

This section describes the different activities identified as being important to achieving whānau ora and to contribute towards developing a comprehensive information base for monitoring, research, evaluation, resource allocation, outcome and performance management.

Activities listed under the heading 'Fix' (Table 2) will occur from 1 July 2005 to 1 July 2007 and will occupy most (90 percent) of the work programme.

Activities listed under the heading 'Renovate' (Table 3) are likely to take longer (until 2010), because they depend on the completion of 'fix' activities or wider health information developments.

All activities have also been grouped into the following nine priority areas.

- 1 Shift the focus from information collection to information use.
- 2 Minimise the cost of collecting information.
- 3 Increase opportunities for consumer input into clinical records.
- 4 Extend the coverage of mental health data to primary health care.
- 5 Support Māori goals for whānau ora.
- 6 Support information sharing between providers (eg, District Health Boards, non-governmental organisations and primary health care providers).
- 7 Use information as a quality improvement tool.
- 8 Use information for research and development.
- 9 Fill data gaps and improve data quality.

Non-governmental organisations' development

Many of the activities listed are particularly relevant to the NGO sector, as most NGO providers have limited capability to connect and participate in a *local* information system let alone a *national* information system. Therefore, several activities target NGO-information development to facilitate NGO involvement in an integrated service delivery environment.

It is recommended that initial activity focuses on the priority areas that will have the most benefit for most NGO providers, rather than developing isolated points of excellence.

Implementation plan

Developing the implementation plan will include assessing the extent of work involved in each priority area and the interdependencies among the activities. This assessment will identify more detailed activities that are necessary for the strategy's successful implementation and will be included in the implementation plan.

The roles and responsibilities of the Ministry of Health and mental health service providers are summarised against each priority area and offer some direction for key stakeholders with regard to the Implementation Plan's development.

The ability to make progress on these priorities requires resources to be available and assumes the key stakeholders will continue to work together to develop a coherent national approach to mental health information development. This approach also includes other directorates within the Ministry of Health that are developing strategic plans for information development in areas of common interest to mental health (eg, primary care).

Priorities may change because of trade-offs between competing priorities, the costs of change outweighing the benefits, or other opportunities that may arise that offer even greater gain to multiple providers. For example, it is important for the Ministry to identify possible outcome measures for national collection by the NGO sector under the MH-SMART initiative. However, it may be more pressing to address the lack of information system development in the NGO sector for providers to capture and make sense of that data, especially when most NGOs cannot even report the current national mental health data set (MHINC).

Table 2: Fix – priority areas for targeted activity

Fix	Relative roles and responsibilities				
	Priority area	Focus	Barriers	Solutions	Ministry of Health
1. Shift the focus from information collection to information use	1.1 National data collection development	Limited analysis and reporting of descriptive (MHINC) and evaluative (MH-SMART) data.	Investigate the feasibility of merging MHINC and MH-SMART data items into one extract to reduce costs and increase opportunities for analysis of both data sets.	Undertake a feasibility study into merging both data sets into one extract.	Participate in the feasibility study to enable a cost-effective solution to be found.
	1.2 Workforce development	Full benefits of investing in information systems are not realised because the workforce is not equipped to use available information.	Provide training programmes to extend the skills of the current workforce so that staff at all levels are better equipped to interpret and apply information.	Scope the requirements for national information training initiatives via the Mental Health Workforce Development Programme.	Ensure staff has basic information management skills as a core competency for their work.
		Education providers do not see skills in information management as core competencies.	Develop training programmes to address the needs of people entering the mental health workforce.	Liaise with national training organisations, professional bodies and the Clinical Training Agency to determine how best to influence the education sector to meet requirements for information management in mental health services.	Ensure staff orientation programmes include an information management module.
		Staff training in information management is of variable quality and does not address priority areas.	Develop an accreditation system that offers the sector confidence in the standard and quality of training in information management.	Investigate developing an accreditation system for professional trainers.	Ensure staff access only those courses provided by accredited trainers and education providers.

Fix	Relative roles and responsibilities				
	Priority area	Focus	Barriers	Solutions	
2.0 Minimise the cost of collecting information	2.1 Aligning sector capital investment	Providers' individual approaches to information technology (IT) investment decrease opportunities to maximise investment and result in unnecessary duplication and fragmentation of information systems.	Adopt a more formal approach for coordinating investment in IT that includes DHB, NGO and primary health care providers.	Ministry of Health Develop guidelines for DHB capital investment.	District Health Boards (DHB providers and non-governmental organisations) Participate in formal forums to share ideas and collaborate on IT initiatives where common interests exist.
		Complex contract and monitoring frameworks are counterproductive to the development of an efficient and effective mental health sector.	Rationalise data for national contract and service-monitoring purposes to streamline reporting and reduce duplication.	Initiate a monitoring rationalisation project.	Participate in a monitoring and rationalisation project to streamline reporting requirements.
3.0 Increase opportunities for consumer input into clinical records	3.1 Collaboration	Providers have collected information about consumers that has not included consumer input.	Develop information systems that support active participation and collaboration between providers and consumers in the management of mental illness.	Upgrade information systems to enable consumers' active participation.	
4.0 Extend the coverage of mental health data to primary care	4.1 National data collection development	Lack of national primary mental health care information to support planning, research and policy development.	Develop a primary care minimum data set that is inclusive of mental health requirements.	Implement the Health Information Strategy for New Zealand (HIS-NZ).	Participate in developing a minimum data set for primary care inclusive of mental health requirements.

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Table 2: Continued from page 17

Fix	Priority area	Focus	Barriers	Solutions	Relative roles and responsibilities	
					Ministry of Health	District Health Boards (DHB providers and non-governmental organisations)
5.0 Support Māori goals for whānau ora	5.1 Workforce development	Māori are limited in their ability to participate in, and contribute to, strategies for mental health improvement because the workforce lacks analytical capability.	Enhance skill and expertise in the non-Māori and Māori mental health sector workforce to analyse Māori mental health information for the benefit of Māori.	Scope the requirements for national information training initiatives for the mental health workforce through the national Mental Health Workforce Development Programme.	Ensure staff have basic information management skills as a core competency for their work.	
		5.2 Cultural responsiveness	Inaccurate ethnicity data for Māori compromises service planning and monitoring activities.	Improve the recording and reporting of ethnicity to enable better decision making on appropriate service provision for Māori.	Continue to promote ethnicity and data protocols for the health and disability sector and support a train-the-trainer package to help providers implement the protocols.	
	5.3 National data collection development	National mental health information collection is of limited value to Māori because it lacks cultural relevance.	Ensure the national mental health information system can capture data on the cultural context of mental illness and recovery.	Review the cultural relevance of the MHINC to include modifications as part of the MHINC feasibility study.	Participate in the review and implement suggested changes.	
6.0 Support information sharing between providers	6.1 Applications	Current provider applications do not allow information to be shared with other mental health providers.	Develop applications to provide a standardised output that supports common business processes.	Implement the HIS-NZ.	Take up national applications to support common business processes.	
	6.2 Standards	Lack of data and business process standards limits providers' ability to share electronic information.	Develop and implement information management and technology standards for the sector.	Participate in developing and implementing the Health Information Standards Organisation (HISO) work programme.	Participate in developing and implementing the HISO work programme.	

Fix	Relative roles and responsibilities			
	Priority area	Focus	Barriers	Solutions
			Ministry of Health	District Health Boards (DHB providers and non-governmental organisations)
	6.3 Collaboration frameworks	Delivery of good quality, co-ordinated care to consumers is constrained by the lowest common denominator hardware and capacity to connect.	Providers work collaboratively on information system issues of common interest.	DHBs and NGO providers with more sophisticated information systems take a leadership role in developing capability in other parts of the sector.
7.0 Use information as a quality improvement tool	7.1 National connectivity	Providers lack access to an affordable, reliable and secure electronic network.	Develop a coherent strategy to maximise the benefits of broadband to the sector.	Implement the HIS-NZ.
	7.2 Quality improvement	Lack of national benchmark information hampers national quality improvement initiatives.	Develop a national set of key performance indicators for service benchmarking work.	Participate in a mental health sector working group to develop a national set of key performance indicators based on current provider capacity to produce the necessary data.
		Fragmented approach to using telepsychiatry limits its use for increasing access to services for consumers living in rural areas.	Develop a coordinated national approach to telepsychiatry to increase consumer access to services.	Implement the recommendations of the Telepsychiatry Project (Mental Health Workforce Development Programme).

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Table 2: Continued from page 19

Fix	Priority area	Focus	Relative roles and responsibilities			
			Barriers	Solutions	Ministry of Health	District Health Boards (DHB providers and non-governmental organisations)
8.0	Use information for research and development	8.1 Quality improvement	Multiple sources of information about what works leads to a fragmented approach to translating research findings into routine practice.	Create opportunities for all key stakeholders to have easy access to up-to-date information about effective programmes and practices.	Develop (by MHRDS) a mechanism to support the dissemination and uptake of information about effective programmes and practices.	Work with MHRDS and WDP to identify mechanisms to translate research findings into routine practice.
			Insufficient information exists for the sector to address service ineffectiveness.	Continue to invest in mental health outcome measurements.	Continue to support (through MHRDS) projects that build on previous work in outcome measurement.	Implement outcome tools and develop expertise in outcome management.
9.0	Fill data gaps and improve data quality	9.1 National data collection development	Key stakeholders regard some data collected under MHINC as being of dubious quality and/or surplus to requirements.	Review MHINC data items, business processes and provider reports as part of a five-yearly review.	Review MHINC data items as part of MHINC/MH-SMART feasibility study.	Participate in review and demonstrate a commitment to implementing changes and monitoring data quality at the local level.
			Lack of national information on mental health workforce limits planning and forecasting.	Develop a national mental health workforce information system to collect workforce information from several different providers.	Review options for collecting accurate mental health workforce information.	Support the collection of data on the mental health workforce.
			NGO sector's lack of apparent capacity severely limits providers' ability to contribute MHINC data towards the national information collection held by the NZHIS.	Survey NGO sector to assess information capacity and capability (as this is unknown).	Fund a full-time equivalent employee to survey the NGO sector. On the basis of the survey's findings develop a funding strategy to help providers unable to collect and report MHINC and MH-SMART data.	Support the rollout and ongoing maintenance of a NGO-information solution.

Fix	Relative roles and responsibilities					
	Priority area	Focus	Barriers	Solutions	Ministry of Health	District Health Boards (DHB providers and non-governmental organisations)
			Poor data quality limits the usefulness of MHINC.	Encourage sector to value data as a critical component of a quality improvement process and monitor data quality accordingly.	Release the Data Quality Strategy in mid-2005, setting out the strategic directions for ensuring the accuracy of all health information collections.	Commit to having a data quality strategy whereby data quality is monitored regularly as an integral part of quality improvement processes.
		Lack of understanding about how outcome ratings at the national level affect national planning and policy functions.	NZHS expands the roles and responsibilities associated with the maintenance of MHINC to encompass MH-SMART.	Support the development of NZHS to accommodate the additional requirements associated with the collection of outcome data.	No action required.	
		Data on problem gambling services is not integrated into the national mental health collection.	Develop the current data set for problem gambling services to align it with the recommendations of the MHINC feasibility study.	Review the data set currently collected for problem gambling services to establish what needs to be done to make it compatible with MHINC (after the feasibility study).	Participate in the review and modify their systems to report data in a standardised format.	
		Lack of accurate ethnicity data compromises service planning and monitoring activities.	Improve the recording and reporting of ethnicity to enable better decision-making.	Continue to implement the ethnicity and data protocols for the health and disability sector and support a train-the-trainer package to help providers implement the protocols.	Collect ethnicity data according to the data protocols.	
		Services are unable to evaluate the effects of interventions without access to consumer outcome data.	Implement consumer outcome data under MH-SMART.	Support provider capability development through the MH-SMART implementation team.	Participate in national train-the-trainer workshops and incorporate ongoing training on outcome measurement into routine in-house information management modules.	

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Table 2: Continued from page 21

Fix	Relative roles and responsibilities					
	Priority area	Focus	Barriers	Solutions	Ministry of Health	District Health Boards (DHB providers and non-governmental organisations)
			Lack of suitable consumer outcome measures available for routine use nationally.	Develop outcome measures for routine use in mental health services under the MHRDS.	Provide funding and support for the development of national outcome measures under MHRDS.	Implement consumer outcome measures into routine practice.
	9.2	Privacy and security	Lack of consolidated information on privacy and security policies for providers to easily access.	Put in place privacy, security and authentication frameworks to provide a sound environment for information sharing.	Develop, with the ACC, the Privacy, Authentication and Security (PAS) guide that will bring existing documents together and specify a consistent level of security and privacy for the sector.	Implement and monitor information systems to ensure they comply with relevant legislation.
			Lack of understanding about the Health Information Privacy Code 1994 results in providers applying it inconsistently.	Improve availability of information about the application of the Health Information Privacy Code 1994.	Monitor provider compliance with legislation and standards.	Ensure all staff knows what consumer health information they are able to share and under what circumstances.
	9.3	Governance	Governance arrangements for the national collection of mental health data do not include the full range of stakeholders, so do not have buy-in from the whole sector.	Develop a stakeholder governance framework to ensure effective stakeholder management of all national mental health information.	Review the governance arrangements for MHINC as part of the Ministry's wider National Data Collection Framework Project.	Participate in developing a sector-wide framework for managing the national mental health data collection.

Table 3: Renovate – priority areas for targeted activity

Renovate Priority area	Relative roles and responsibilities			
	Focus	Barriers	Solutions	Ministry of Health District Health Boards
1.0 Support information sharing among providers	1.1 Standards	Electronic records cannot be shared between different providers	Standardise the format of the electronic record so information can be shared among providers.	Lead the development of national standards and formats for the electronic health record. Develop incrementally electronic consumer records to ensure alignment with national standards and formats.
		A single electronic record is too expensive and impractical to develop.	Spread information throughout several different physical information systems, but link and reference data electronically.	Lead the development of national standards and formats for the electronic health record. Develop incrementally electronic consumer records to ensure alignment with national standards and formats.
		Lack of consistent standards and systems prevents the analysis of cross-system service usage patterns.	Share information across sectors.	Lead the development of agreed data formats and establish protocols for what constitutes appropriate information sharing and monitor provider compliance. Comply with agreed data formats and protocols.
2.0 Shift the focus from information collection to information use	1.2 Quality improvement	Service development research	Focus research activities on service developments that are of high national priority and consistent with national policy directions.	Provide funding and support for the Mental Health Research and Development Steering Committee for service development related research consistent with national policy directions. Implement research and development findings into routine practice.
		Outcome measurement does not result in outcome management.	Develop an information-literate sector that uses evaluative data as part of its routine quality improvement activity.	Refine and implement the mental health Casemix classification to enable analysis of outcome data. Commit to incorporating outcome measurements into routine quality improvement activities within services.
		Cost benchmarking cannot be carried out on a fair and nationally consistent basis.	Develop an evaluative framework that includes cost-effectiveness.	Develop nationally agreed standards and formats to permit cost comparisons between services. Develop incrementally costing systems to ensure alignment with national standards and formats.

Conclusion

The objectives outlined in this strategy are to help move the mental health sector closer to the ideal state, while at the same time recognising the challenges are significant, and the strategies will take significant time to implement and rely on the development of an information infrastructure to sustain the changes.

The list of initiatives under each of the nine priority areas has been compiled from submissions from the sector. They represent a statement of common intent for the sector. Providers are at different stages of development, so this strategy proposes activities occur at different levels of the sector and are focused on the initiatives that will have the maximum benefit for groups of providers with similar problems.

The ability to make progress on each activity depends on resources being available and assumes key stakeholders want to continue working together to develop a coherent national approach to mental health information development that builds on the progress that has been achieved to date.

These activities do not preclude other activities being added later, as the strategy needs to be responsive to emerging policy directions and be sufficiently flexible that it can take advantage of opportunities as they arise.

The strategy will be subject to a process of ongoing review in accordance with timelines proposed for the review of the HIS-NZ (Ministry of Health 2005).

Appendix A: National Advisory Group

The following people participated as members of the national advisory group for the development of the National Mental Health Information Strategy.

- Chris Harris, General Manager, Mental Health Services, Waikato District Health Board
- Chris Windsor, Mental Health Directorate, Ministry of Health
- Debra Keylard, New Zealand Health Information Services, Ministry of Health
- Gabrielle Halstead, Mental Health Directorate, Ministry of Health
- Jennifer Chipps, National Project Manager, MH-SMART Initiative, Health Research Council of New Zealand
- Jim Burdett, independent consultant, consumer
- Marion Blake, Chief Executive Officer, Platform
- Matoroa Mar, independent consultant, Māori
- Phillipa Gaines, Mental Health Directorate, Ministry of Health
- Professor Graham Mellsop, School of Medicine, Auckland University
- Professor Peter Ellis, Wellington School of Medicine
- Steve Boyd, General Manager, Mental Health Services, South Canterbury District Health Board
- Te Paea Winiata, Mental Health Directorate, Ministry of Health

Appendix B: International context

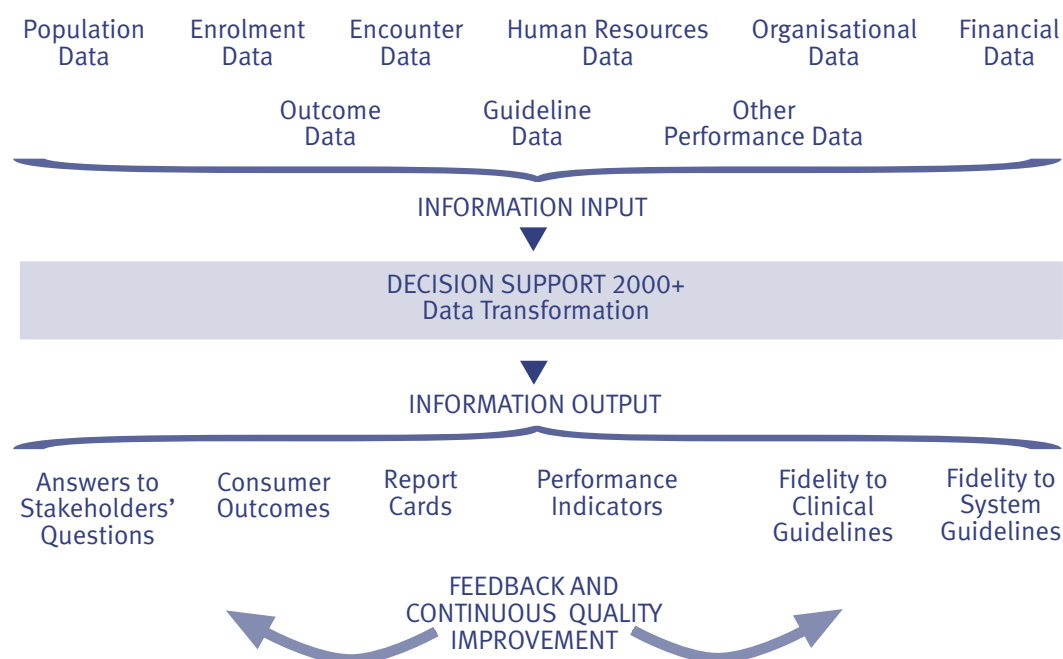
Mental health services internationally are dealing with the similar information problems New Zealand services are dealing with. Therefore, it is important to consider what other countries have done to develop information strategies to address strategic service development and policy issues.

United States

The United States Center for Mental Health Services has embarked on Decision Support 2000+ (Henderson et al 2000), which builds on Leginski et al’s (1989) work and raises the problems associated with there being no single medical record, a lack of investment and poor information infrastructure within mental health services. Decision Support 2000+ has four strands to information system development (see www.mhsip.org and Figure 5):

- protect privacy and confidentiality
- establish information standards
- use existing data
- link existing data sets.

Figure 5: Components of Decision Support 2000+



Source: Henderson et al (2000).

United Kingdom

The United Kingdom’s Mental Health Information Strategy addresses consumers’, and the general public’s, need for information on mental health services and deals with some of the same issues that have been identified with mental health information in New Zealand (eg, the integration of service user information and ensuring information supports effective clinical governance and management) (Department of Health 2001). One key expected outcome is the development of a mental health electronic record. The United Kingdom’s strategy recognises the need to develop a culture change programme and establish information-sharing protocols (Department of Health 2001).

Australia

The priorities included in the Australian National Mental Health Information Strategy (1999) are very much linked to achieving the goals of the Australian Second Mental Health Plan (2003) and are concerned with information in the sense of ‘management intelligence’. That strategy identified four priorities:

- strengthen the focus on consumer outcomes
- support improvements in service quality
- shift the focus of concern from the cost of services to value for money
- improve understanding of population needs.

Once again, the integrated medical record was seen as a primary goal for the strategy, as was the need to develop an information infrastructure. The second edition of a national framework for mental health information development has been developed (Dept of Health and Ageing 2005) to support the key directions of the Australian Second National Mental Health Plan 2003-08 (2003).

The issues in Australia are similar to those in mental health services in New Zealand, so the priorities identified in the New Zealand strategy reflect that similarity. However, significant differences also exist between the two countries, including issues of cultural identity and incremental funding that has been applied by successive New Zealand governments to progress the development of mental health services against *Blueprint* targets (Mental Health Commission 1998).

It is anticipated the Australian Second Mental Health Information Strategy will focus on consolidating work already under way under the first strategy as well as extending into new areas of activity driven by the requirements of the National Mental Health Plan 2003–2008.

Glossary

access	A potential consumer's ability to obtain a service when they need it and within an appropriate time.
assessment	A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs. A clinical assessment forms the basis for developing a diagnosis and an individualised treatment and support plan with the consumer, their family/whānau and significant others.
Blueprint (for mental health services)	The document the Mental Health Commission developed that defines the levels of specialist mental health services as well as the changes required to implement the Government's National Mental Health Strategy (Mental Health Commission 1998).
care provider	All professionals who provide consumers with clinical and/or social support.
carer	A family/whānau member or friend who cares for or supports a consumer either voluntarily or for a nominal payment.
consumer	A person with experience of mental illness. This term is often used interchangeably with 'service user' and/or 'tangata whai ora'.
evidence-based practice	An approach to decision making in which the clinician uses the best evidence available, in consultation with the consumer, to decide upon a course of action that suits the consumer best.
family	The consumer's whānau, extended family, partners, friends or other people that the consumer has nominated.
Health Information Strategy for New Zealand (HIS-NZ)	The broad range of national health information initiatives (HIS-NZ Development Steering Group 2005). In press.
health outcome	A change in an individual's or group's health attributable to one or more interventions.
HIS-NZ	See 'Health Information Strategy for New Zealand (HIS-NZ)'. In press.
information systems	In its broadest sense 'information systems' is the term used to cover all processes, information, communication and technology.
intervention	Action taken to improve a situation.
mental illness	Any clinically significant behavioural or psychological syndrome characterised by distressing symptoms or significant impairment affecting a person's ability to function.
mental health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001a).
Mental Health Information National Collection (MHINC)	The national database of mental health information held by the New Zealand Health Information Service (NZHIS) to support policy formation, monitoring and research.
mental health sector	The organisations and individuals involved in mental health to any degree and at any level.

mental health service provider	An organisation providing as its core activity assessment, treatment or support to consumers with mental illness and/or alcohol and drug problems.
Mental Health Standard Measures of Assessment and Recovery (MH-SMART)	<p>The Mental Health Standard Measures of Assessment and Recovery Initiative, referred to as ‘MH-SMART’, has been established to assist DHBs in outcome collection processes.</p> <p>MH-SMART will implement a suite of standard tools or measures to measure changes in the health status of mental health service users. These tools will assist consumers, clinicians, service providers and funders to identify the possible contribution mental health services have made to the recovery journey.</p>
MHINC	See ‘Mental Health Information National Collection (MHINC)’.
Pacific peoples	A diverse group of people from the Pacific region including Tongan, Samoan, Fijian, Cook Island, Tokelauan and Niuean peoples.
policy	A written statement that reflects an organisation’s or service’s position and values on a given subject. These may also be called protocols, standards or codes of practice.
recovery	Living well in the presence or absence of mental illness and the losses that can be associated with mental illness.
standard	An identified level of performance, made up of specific criteria, against which performance is measured.
strategic plan	An organisation-wide plan that establishes an organisation’s overall objectives and positions the organisation in respect of its environment.
tangata whaiora	A person with experience of mental illness. This term is often used interchangeably with ‘service user’ and/or ‘consumer’ The translation of the term from Māori means ‘a person seeking wellbeing’.
whānau	The family and extended family or group of people who are important to the consumer.
whānau ora	Families supported to achieve their maximum health and wellbeing, individually and collectively.

References

- Australian Health Ministers. 2003. *National Mental Health Plan 2003–2008*. Canberra: Australian Government.
- Department of Health. 2001. *Mental Health Information Strategy*. London: Department of Health, United Kingdom.
- Department of Health and Ageing. 1999. *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998–2003*. Canberra. Commonwealth of Australia.
- Department of Health and Ageing. 2005. *National Mental Health Information Priorities* (2nd Ed.). Canberra. Commonwealth of Australia.
- Gaines P, Bower A, Buckingham W et al. 2003. *New Zealand Mental Health Classification and Outcomes Study: Final Report*. Health Research Council of New Zealand: Auckland.
- Health Information Strategy Steering Committee. (in press) *Health Information Strategy for New Zealand*. Wellington: Health Information Strategy Steering Committee.
- Henderson MJ, Minden SL, Manderscheid RW. 2000. *Decision Support 2000+ (DS2000+)*. United States Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. URL: <http://www.mhsip.org/library/pdfFiles/ds2000sumdoc401.pdf>
- Leginski W, Croze C, Driggers J, et al. 1989. *Data Standards for Mental Health Decision Support Systems: A report of the Task Force to Revise the Data Content and System Guidelines of the Mental Health Statistics Improvement Program*. Washington, DC: National Institute of Mental Health, Department of Health and Human Services. URL: <http://www.mhsip.org/library/pdfFiles/fn-10.pdf>
- Knowing the People Planning. URL: <http://www.kpp.org.nz/>
- MaGPIe Research Group. 2003. The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe) *New Zealand Medical Journal* 116(1171). URL: <http://www.nzma.org.nz/journal/116-1171/379/>
- Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission.
- Minden S, Webman D. 2004. Introduction to the draft requirements analysis for Decision Support 2000+. In: SL Minden, S Davis, V Ganju et al. *Draft Requirements Analysis for Decision Support 2000+*. United States Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Pages I-1–I-29. URL: <http://www.mhsip.org/ds2000/sect1.pdf>
- Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health. Available from <http://www.moh.govt.nz>
- Minister of Health. 2003. *Improving Quality (IQ): A systems approach for the New Zealand health and disability sector*. Wellington: Ministry of Health. Available from <http://www.moh.govt.nz>
- Minister of Health, Associate Minister of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. 2004. *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005–2015: Consultation document*. Wellington: Ministry of Health.

Minister of Health. 2005. *Te Tāhuhu – Improving Mental Health 2005–2015: Second National and Mental Health and Addiction Plan*. Wellington: Ministry of Health.

Ministry of Health. 2005. *Mental Health Information Strategy – Key directions: Discussion document*. Wellington: Ministry of Health.

National Institute of Clinical Studies. 2002. *Electronic Decision Support for Australia’s Health Sector*. Report to Health Ministers by the National Electronic Decision Support Taskforce.

National Mental Health Information Strategy Committee. 2004. *Key Performance Indicators for Australian Public Mental Health Services*. Commonwealth of Australia.

Privacy Commissioner. 2000. *Health Information Privacy Code 1994* (revised edition). Wellington: Office of the Privacy Commissioner.

WAVE Advisory Board to the Director-General of Health. 2001. *From Strategy to Reality: The WAVE Project: Kia hopu te ngaru*. Wellington: Ministry of Health.

WHO. 2001. *Atlas: Mental Health Resources in the World*. Geneva: World Health Organization.

WHO. 2001a. *Strengthening mental health promotion*. Geneva: World Health Organization.