



He Ara Oranga

Report of the Government Inquiry into
Mental Health and Addiction

He Ara Oranga translates as Pathways to Wellness

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Foreword

We are pleased to deliver *He Ara Oranga* – the report of the Government Inquiry into Mental Health and Addiction.

It has been an honour and privilege to undertake this Inquiry. We are grateful to all the people who shared their experiences and wisdom with us, in meetings and submissions.

We believe that the Inquiry process itself has been a catalyst for change.

We thank everyone who contributed to the Inquiry, particularly the members of the Inquiry Secretariat who have been so committed to our work and production of this report.

We know we carry the hopes of many people throughout Aotearoa, who believe in what this Inquiry can achieve. We are humbled by your encouragement and faith in us.

We hand our report to the Government, trusting that the ‘once in a generation’ opportunity of the Inquiry will be seized.



He mihi mahana ki a koutou

Professor Ron Paterson (Chair)

Sir Mason Durie

Dr Barbara Disley

Dean Rangihuna

Dr Jemaima Tiatia-Seath

Josiah Tualamali'i

Wellington, November 2018

Acknowledgements

In many ways this report is a collaborative effort. We especially thank all those people and organisations who gifted their time to meet with the Inquiry panel and made thoughtful, and often extensive, submissions.

We also acknowledge the organisations that responded to our request for information, including for our stocktake of services, issues and opportunities. We made many requests for information and advice over the course of the Inquiry, and we appreciate the patience and goodwill of those who had to respond, particularly the Ministry of Health.

We tasked some organisations and individuals with providing us with specific information, advice or review, often within short timeframes. They include the Government's social sector science advisors, Te Pou o te Whakaaro Nui and the University of Otago, Wellington. Helpful analysis and reports were provided by Allen + Clarke, Alison Mills, Dr Michelle Levy, Lisa Cherrington, Dr Karlo Mila and Tiaho Ltd and Fernhill Solutions.

We thank the individuals and organisations who helped with the logistics of engaging with their communities or hosted consultation meetings. They included Iwi, marae, advocacy and community groups, district health boards and service providers.

We are also grateful to our kaumātua Ron Baker and Koromiko Richards for cultural support during the Inquiry. Tēnā kōrua.

Finally, we would like to thank the Secretariat, Counsel Assisting the Inquiry Hanne Janes and the Department of Internal Affairs for their support.

Executive summary

Background

The Government Inquiry into Mental Health and Addiction was announced early in 2018. The catalyst for the inquiry was widespread concern about mental health services, within the mental health sector and the broader community, and calls for a wide-ranging inquiry from service users, their families and whānau, people affected by suicide, people working in health, media, Iwi and advocacy groups.

Purpose of Inquiry

The purpose of this Inquiry is to:

- hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction and what needs to change
- report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems
- recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

The full Terms of Reference are set out in Appendix A.

Inquiry panel members

The members of the Inquiry panel are:

Professor Ron Paterson (Chair)

Dr Barbara Disley

Dr Jemaima Tiatia-Seath

Sir Mason Durie

Dean Rangihuna

Josiah Tualamali'i

Inquiry process

The Inquiry commenced work in February 2018 and reported to the Minister of Health in November 2018. The Inquiry process involved widespread public consultation and high media interest. In April 2018, a consultation document was released in multiple languages and formats. The level of public and mental health and addiction sector engagement with the Inquiry was remarkable.

Over 2,000 people attended public meetings at 26 locations around the country. Over 5,200 submissions were made to the Inquiry. Over 400 meetings were held with tāngata whaiora,¹ their families and whānau, other members of the public, health and other service providers, Iwi and Kaupapa Māori providers, community organisations, researchers and other experts.

The Inquiry obtained information from a wide variety of sources, including a stocktake of government-funded services and programmes and perceived gaps and opportunities. A report was commissioned from the University of Otago, Wellington, on the determinants of mental health and wellbeing, specific populations' experiences of mental health and wellbeing, and opportunities for service improvements and a move to a wellbeing approach.

Approach to report

We recognised from the start that this Inquiry represented a 'once in a generation' opportunity for change. All over the country, people told us they wanted this report to lead to real and enduring change – a 'paradigm shift'.

There has been no shortage of mental health inquiries and reviews in the 22 years since the last national mental health inquiry in New Zealand, led by Judge Ken Mason in 1995–1996. It too was born out of heightened public concerns and calls for change. It came in the wake of deinstitutionalisation in the 1980s and 1990s, with patients being moved out of psychiatric hospitals and into the community.

We note two important differences about this Inquiry. One is the breadth of its Terms of Reference, including mental health problems across the full spectrum from mental distress to enduring psychiatric illness, and a mandate to look beyond the health sector to other sectors and social determinants that influence mental health outcomes. We are also asked to advise how to promote mental health and wellbeing for the whole community. The inclusion of addictions and harmful use of alcohol and other drugs is also different from past reviews.

The second main difference that emerged during this Inquiry is the striking degree of consensus, from most parts of New Zealand society, about the need for change and a new direction: an emphasis on wellbeing and community, with more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau- and community-based responses and cross-government action.

1 Literally translated, 'tāngata whaiora' means 'people seeking wellness', and is generally used in preference to 'service users' and 'consumers'. See also the explanation in Table 1.

Given the degree of consensus, why hasn't change occurred already? In many respects, we have the system we designed. The target set in the 1996 Mason Inquiry report, of having specialist services available for the 3% of people with the most severe mental health needs, has been achieved. But the subsequent goals of more prevention and early intervention, and more support in the community, have not been realised, despite worthy policies and strategies. Much time and effort has gone into planning, with lots of good work by hardworking people. Yet, apart from some pockets of success, little progress has been made. The fact that other countries are facing similar challenges and asking the same questions gives us no comfort.

So, we have taken a different approach. We have deliberately taken a 'people first' approach in writing this report, being guided by the needs of people and communities rather than the preferences of the various groups accustomed to the way the system is structured and services are delivered at present.

We have sought to be bold and bring some fresh thinking to old and complex problems. Rather than develop a strategy or lay out a 'shopping list' of new services to be funded, we have analysed the underlying reasons why New Zealand's mental health and addiction system has not really shifted over the past two decades.

Some facts and figures

Mental health and addiction problems touch the lives of many people in New Zealand. Each year around one in five of us experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition to the human costs, the annual cost of the burden of serious mental illness, including addiction, in New Zealand is an estimated \$12 billion or 5% of gross domestic product.

Any one of us can be affected: over 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. But some people are more at risk. A range of social determinants are risk factors for poor mental health: poverty, lack of affordable housing, unemployment and low-paid work, abuse and neglect, family violence and other trauma, loneliness and social isolation (especially in the elderly and rural populations) and, for Māori, deprivation and cultural alienation.

New Zealand has persistently high suicide rates. Annual suicide rates reported by the Office of the Chief Coroner have increased over the last four years, with the 2017/18 suicide rate the highest since 1999. Every year, 20,000 people attempt to take their own life. In 2015, 525 people died by suicide. Our suicide rate for young people is among the worst in the OECD. The greatest loss of life through suicide occurs among people older than 24, particularly males aged 25–44. Every suicide creates significant, far-reaching impacts on the person's friends, family and whānau, and the wider community.

Addiction to alcohol and other drugs is causing widespread harm in New Zealand communities. A heavy drinking culture harms health and wellbeing. Harmful use of alcohol and other drugs is significantly implicated in crime – around 60% of community-based offenders have an identified alcohol or other drug problem and 87% of prisoners have experienced an alcohol or other drug problem over their lifetime. Well over half of youth suicides involve alcohol or illicit drug exposure. Over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems.

Voices of the people

Early on in the Inquiry, we consulted Judge Ken Mason. “Listen to the people”, he said. “They will tell you what to do.” We did, and the voices of the people were powerful and compelling. We have reported them faithfully and they have guided our approach.

Strong themes emerged from the people we met and submitters. People shared deeply personal experiences, motivated by a desire to tell their stories and bring about change. We heard a lot of heartache and sorrow, but also stories of hope and recovery.

This report records the main themes from the voices of the people: a call for **wellbeing and community solutions** – for help through the storms of life, to be seen as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one’s sense of self.

For **Māori health and wellbeing**, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and iwi.

For Pacific peoples, the adoption of ‘Pacific ways’ to enable **Pacific health and wellbeing** – a holistic approach incorporating Pacific languages, identity, connectedness, spirituality, nutrition, physical activity and healthy relationships.

People said that unless New Zealand tackles the **social and economic determinants of health**, we will never stem the tide of mental health and addiction problems. There are clear links between poverty and poor mental health. People need safe and affordable houses, good education, jobs and income for mental wellbeing.

Addictions are recognised as a serious public health issue in New Zealand. Alcohol and other drugs are tearing families and communities apart. People and communities called for decisive action to limit the sale and promotion of alcohol, particularly around children and young people. As well as more treatment and rehabilitation services, people argued for a mature drug policy, with addiction treated as a health, not a criminal justice issue.

Families and whānau described patient privacy as a barrier used to exclude them from treatment and discharge planning, even though they are the ones there for the long haul. They asked for help for their family members, and more support for their own needs as carers. Families bereaved by suicide described a lack of support, and the delays and trauma of current suicide review processes.

Children and young people are exhibiting high levels of behavioural distress leading to deliberate self-harm, risk-taking, anxiety and other troubling behaviours. Parents are concerned about the harms of bullying and misuse of the internet and social media. School counsellors and teachers are overwhelmed by the number of students in distress. New Zealand’s high rates of youth suicide are a national shame. Students and teachers highlighted the importance of learning about mental health as part of the health curriculum and helping young children develop resilience and learn how to regulate their emotions.

People wanted **support in the community**, so they can stay connected and receive help for a variety of needs – crisis support and acute care, addiction recovery, long-term support, respite care, drop-in centres, social support, whānau wrap-around services and employment support. They sought access to an expanded range of therapies, and resources to shift from district health boards (DHBs) to non-governmental organisation (NGO) providers, which are closer to the community.

Problems of **access, wait times and quality** were reported all over the country – having to fight and beg for services, not meeting the threshold for treatment, and the cruelty of being encouraged to seek help from unavailable or severely rationed services. Gaps in services, limited therapies, a system that is hard to navigate, variable quality and shabby facilities added up to a gloomy picture of a system failing to meet the needs of many people.

Members of the **workforce** told us of their love of their jobs, but reported stress, burnout and exhaustion from overwork and an increasing risk of assaults. One manager warned, “All the dreams of the Inquiry will come to naught if we don’t have a workforce”. There were loud and clear calls for more peer-support workers; more staff trained in Māori culture and Pacific cultures; and more training in mental health and addiction within primary health care and other sectors (education, corrections, police and social work).

We heard that New Zealand needs a **human rights and mental health** approach to be recognised in law to honour our international treaty obligations. People called for repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) and an end to seclusion and restraint. Even in 2018, shame and stigma shape attitudes and act as barriers to seeking help. The Mental Health Act embeds archaic and risk-averse attitudes that cause clinicians to opt too readily for coercion and control.

Submissions described a lack of clear **leadership and oversight** at a national level. People talked about what can be achieved when mental health and addiction is a priority area for government and there is clear leadership and direction from a mental health commission with a powerful statutory mandate. They asked for local leadership and innovation to be supported. We saw and heard about many examples of grass-roots leadership by people with lived experience.

Our conclusions

New Zealand’s mental health and addiction problems cannot be fixed by government alone, nor solely by the health system. We can’t medicate or treat our way out of the epidemic of mental distress and addiction affecting all layers of our society. We need to ensure practical help and support in the community are available when people need it, and government has a key role to play here. But some solutions lie in our own hands. We can do more to help each other.

Wellbeing has been a theme during this Inquiry and in national conversation in recent years. It’s hard for people struggling with poverty, abuse and deprivation to take steps to become well – yet, every day, people recover from distress, overcome addictions and find strength in their lives. Sleep, nutrition, exercise and time outdoors help recovery. So too does strengthening one’s cultural identity and helping others.

We have a solid foundation to build on: New Zealand’s mental health and addiction system has valuable strengths. Many people in the system receive good care and we have a skilled and committed workforce. But the system is under pressure and unsustainable in its current form. Signs include escalating demand for specialist services, limited support for people in the community and difficulties recruiting and retaining staff.

Despite the current level of investment, we're not getting the outcomes we want for our people. The outcomes for Māori are worse than for the overall population, and Māori are subject to much greater use of compulsory treatment and seclusion. There are also unmet mental health needs for Pacific peoples, disabled people, Rainbow communities, the prison population, and refugees and migrants. The estimated reduction in life expectancy of people with severe mental health or addiction challenges is 25 years. Our persistently high suicide rates are of major concern.

Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed. Even when it responds to people with a mental illness, it does so through too narrow a lens. People may be offered medication, but not other appropriate support and therapies to recover. The quality of services and facilities is variable. Too many people are treated with a lack of dignity, respect and empathy.

We do not have a continuum of care – key components of the system are missing. The system does not respond adequately to people in serious distress, to prevent them from 'tipping over' into crisis situations. Many people with common, disabling problems such as stress, depression, anxiety, trauma and substance abuse have few options available through the public system. By failing to provide support early to people under the current threshold for specialist services, we're losing opportunities to improve outcomes for individuals, communities and the country.

We also fail to address people's wider social needs. Initial expansion of culturally appropriate services has stalled, and there has been little investment in respite and crisis support options, forensic step-down services in the community, and earlier access to a broader range of peer, cultural and talk therapies.

Despite a lot of consensus about the need for reform, we are yet to take a bold, health-oriented approach to the harmful use of alcohol and other drugs and to provide a wider range of community-based services to help people recover from addiction. Our approach to suicide prevention and the support available to people after a suicide is patchy and under-resourced. Tackling the social and economic determinants of mental health and wellbeing requires a coordinated, integrated approach from social services.

It's time to build a new mental health and addiction system on the existing foundations to provide a continuum of care and support. We will always have a special responsibility to those most in need. They must remain the priority. But we need to expand access so that people in serious distress – the 'missing middle' who currently miss out – can get the care and support they need to manage and recover.

The new system should have a vision of mental health and wellbeing for all at its heart: where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience, tools and support they need to regain their wellbeing.

We set out *Whakawātea te Ara*, clearing the pathways that will lead to improved Māori health and wellbeing. We outline *Vai Niu*, a vision of Pacific mental health and wellbeing. We believe that many dimensions of the aspirations of Māori and Pacific peoples, especially the call for a holistic approach, point the way for all New Zealanders.

We describe a vision for mental health and addiction services, with people at the centre; responsive to different ages, backgrounds and perspectives; centred on community-based support and local hubs, using a mix of peer, cultural, support and clinical workforces; providing support for people in crisis; a comprehensive harm-minimisation approach to alcohol and other drug use; more community-based addiction services to help people recover; and a broader range of therapies for people who are detained and support for their transition back to the community. Psychiatrists and appropriate medications will continue to be important – but they are only part of the picture.

Honouring the voices of the people who shared their stories with the Inquiry means there must now be decisive action. Our approach is to focus on a few critical changes to shift the system. In addition to the gains in health and wellbeing, a strong economic case exists for further investment in mental health and addiction. The key principles that underpin our recommendations are a commitment to equity and the Treaty of Waitangi; putting people with lived experience and consumers at the centre of the system; recognising a shared responsibility for improving mental health and wellbeing in our society; and building on the foundations already in place, with mental health and addiction services remaining part of the health system.

Rationale for recommendations

We propose major changes in current policies and laws, supported by significant increases in funding. Our recommendations cover 12 broad areas. They are summarised, with the supporting rationale, below.

Expand access and choice from the current target of 3% of the population being able to access specialist services to provide access to the ‘missing middle’ of people with mental illness or significant mental distress who cannot access the support and care they need. Given current prevalence data suggesting one in five people experience mental health and addiction challenges at any given time, an indicative access target may be 20% within the next five years. New Zealand has deliberately focused on services for people with the most serious needs, but this has resulted in an incomplete system with very few services for those with less severe needs, even when they are highly distressed.

An explicit new access target must be set, supported by funding for a wider range of therapies, especially talk therapies, alcohol and other drug services, and culturally aligned services. This expansion will transform mental health and addiction services. Making it happen requires the involvement of all key players in a co-design process and implementation support for the change process itself. It also requires workforce development, better information, a commitment to a clear funding path, new funding rules and expectations, and strong leadership. (Chapter 4, recommendations 1–12)

Transform primary health care so people can get skilled help in their local communities, to prevent and respond to mental health and addiction problems. Responding appropriately to people with these challenges should be part of the core role of any general practice or community health service. The capability of the primary care workforce needs to be enhanced, with additional mental health and addiction training for general practitioners, practice nurses and community health workers.

The transformation envisaged by the 2001 Primary Health Care Strategy is yet to happen. Affordability remains an issue, models of care have largely not evolved, and primary, community and secondary services are not well integrated. The Health and Disability Sector Review should focus on the wider transformation of primary health care as this will be a critical foundation for improved mental health and addiction care and support. (Chapter 5, recommendations 13 and 14.)

Strengthen the NGO sector to support the significant role NGOs (including Kaupapa Māori services) will play with the shift to more community-based mental health and addiction services. The NGO sector is an increasingly important contributor to the delivery of government-funded mental health, addiction and wider health and social services. But factors such as short-term contracts, high compliance costs and reporting requirements, multiple funders and contracts, and a power imbalance impact on the sustainability of NGO providers and the service they can provide. We recommend a clear stewardship role within central government to support NGO development and sustainability and improve commissioning of health and social services with NGOs. (Chapter 6, recommendation 15)

Take a whole-of-government approach to wellbeing to tackle social determinants and support prevention activities that impact on multiple outcomes, not only mental health and addiction. Despite the substantial benefits of focusing on prevention and promoting wellbeing, especially early in life, the balance of resources has not shifted to prevention and long-term investment in our future. Multiple agencies are engaged in fragmented and uncoordinated activities that target similar outcomes. A proposed social wellbeing agency would provide a clear locus of responsibility within central government for social wellbeing, with a focus on prevention and tackling major social determinants that underlie many inequitable outcomes in our society. (Chapter 7, recommendations 16 and 17)

Facilitate mental health promotion and prevention with leadership and oversight from a new commission, including an investment and quality assurance strategy for mental health promotion and prevention. Although there have been some excellent national campaigns, such as Like Minds, Like Mine, a plethora of different programmes are delivered by many organisations; some may not be sound. A more organised approach, with quality-assured programmes, would benefit schools, workplaces and local communities. (Chapter 7, recommendations 18 and 19)

Place people at the centre to strengthen consumer voice and experience in mental health and addiction services. People with lived experience are too often on the periphery; they should be included in mental health and addiction governance, planning, policy and service development. Consumer voice and role should be strengthened in DHBs, primary care and NGOs. Families and whānau should be supported to be active participants in the care and treatment of their family member, subject to the wishes of the individual patient. Too often they are excluded by service practices, based on misconceived privacy concerns. New, consolidated guidance should be developed on information-sharing and partnering with families. A review is needed of the wellbeing support provided to families and whānau, given the high emotional and financial costs of caring for family members. (Chapter 8, recommendations 20–25)

Take strong action on alcohol and other drugs by enacting a stricter regulatory approach to the sale and supply of alcohol; replace criminal sanctions for the possession for personal use of controlled drugs, with civil responses; support that law change with a full range of treatment and detox services; and establish clear cross-sector leadership within central government for alcohol and other drug policy. These steps are needed in response to the harmful use of alcohol and other drugs and the devastating impact on individuals, families and communities.

A much bolder approach to alcohol law reform is justified, given community concerns and evidence-based recommendations from the Law Commission and other agencies. The criminalisation of drug use has failed to reduce harm around the world. A shift towards treating personal drug use as a health and social issue is required to minimise the harms of drug use. Demand for addiction services is increasing and investment in more services is needed, from brief interventions in general practice and primary care settings to social and detox options and follow-up community-based services. Alcohol and other drug policy leadership and coordination also needs a clear home within government. (Chapter 9, recommendations 26–29)

Prevent suicide. Urgently complete and implement a national suicide prevention strategy, with a target of a 20% reduction in suicide rates by 2030. New Zealand's persistently high suicide rates were one of the catalysts for this Inquiry. Suicide affects people of all ages and from all walks of life, with thousands of New Zealanders touched by suicide every year. Suicide prevention has suffered from a lack of coordination and resources. Reducing suicide rates should be a cross-party and cross-sectoral national priority. Suicide prevention requires increased resources and leadership from a suicide prevention office. Suicide bereaved families and whānau, who are at increased risk of suicide, need more support, and the processes for investigation of deaths by suicide, which are often slow, traumatic and costly, need to be reviewed. (Chapter 10, recommendations 30–33)

Reform the Mental Health Act. Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992, to reflect a human rights approach, promote supported decision-making and align with a recovery and wellbeing model, and minimise compulsory or coercive treatment. The Mental Health Act is out of date, inconsistent with New Zealand's international treaty obligations and sometimes results in trauma and harm to compulsorily treated patients. The use of compulsory treatment orders varies around the country, and there is far too much use of seclusion and restraint, especially for Māori and Pacific peoples. Clinicians working under the Act have developed a culture of risk aversion and defensive practice. New Zealand needs a national level discussion, carefully crafted, to reconsider beliefs, evidence and attitudes about mental health and risk. (Chapter 11, recommendations 34 and 35)

Establish a new Mental Health and Wellbeing Commission to act as a watchdog and provide leadership and oversight of mental health and wellbeing in New Zealand. There has been a general lack of confidence in leadership of the mental health and addiction sector over many years, since disestablishment of the original Mental Health Commission. A new Commission is needed to provide system leadership and act as the institutional mechanism to hold decision-makers and successive governments to account. It should publicly report on progress in mental health and addiction, including on implementation of the Government response to this Inquiry's recommendations. (Chapter 12, recommendations 36–38)

Refer to the Health and Disability Sector Review for consideration, broader issues such as the future structures, roles and functions in the health and disability system, including the establishment of a Māori health commission or ministry. During the Inquiry, significant structural and system issues, including concerns about the current DHB model, and the transformation required in the primary health care sector, were raised. The Health and Disability Sector Review, announced part way through this Inquiry, has a wider scope and is better placed to consider those issues. (A final note, recommendation 39)

Establish a cross-party working group on mental health and wellbeing to reflect the shared commitment of different parties to improved mental health and wellbeing in New Zealand. Mental health is too important to be a political football. Similar initiatives are in place in the United Kingdom and Canada, and some support exists for a similar concept in New Zealand. A cross-party working group would provide an opportunity for members of the House of Representatives to collaborate and advocate for education, leadership and legislative progress on mental health and wellbeing. (A final note, recommendation 40)

Closing thoughts

This is not simply a report calling for more money for mental health and addiction services – though it is clear further investment is needed in Budget 2019 and in the future. It is a whole new approach to mental health and addiction in New Zealand. It sets out He Ara Oranga – Pathways to Wellness.

The changes we have recommended, in a comprehensive set of 40 recommendations, are intended to transform our approach to mental health and addiction – to prevent problems developing, respond earlier and more effectively and promote mental health and wellbeing. Implementation will require policy decisions and legislative change backed by a commitment to a long-term funding path. We are confident of the cost-effectiveness of greater investment in the targeted areas.

Change will take time. It must be sustained over a long period, but we need to start now. Some of the necessary changes can and must happen promptly. People have waited long enough.

Acting collectively, we can improve our mental health and wellbeing.²³

In unity there is strength
... he toa takitini²
So’o le fau i le fau³

2 The complete whakatauki is ‘Ehara taku toa i te toa takitahi, engari he toa takitini’ (My strength is not that of a single warrior, but that of many).

3 A well-known Samoan proverb that means to join the hibiscus fibre to hibiscus fibre. Metaphorically, it conveys that unity is strength.

Recommendations

Expand access and choice

Expand access

1. **Agree** to significantly increase access to publicly funded mental health and addiction services for people with mild to moderate and moderate to severe mental health and addiction needs.
 2. **Set** a new target for access to mental health and addiction services that covers the full spectrum of need.
 3. **Direct** the Ministry of Health, with input from the new Mental Health and Wellbeing Commission, to report back on a new target for mental health and addiction services.
 4. **Agree** that access to mental health and addiction services should be based on need so:
 - access to all services is broad-based and prioritised according to need, as occurs with other core health services
 - people with the highest needs continue to be the priority.
-

Increase choice of services

5. **Commit** to increased choice by broadening the types of mental health and addiction services available.
 6. **Direct** the Ministry of Health to urgently develop a proposal for Budget 2019 to make talk therapies, alcohol and other drug services and culturally aligned therapies much more widely available, informed by workforce modelling, the New Zealand context and approaches in other countries.
-

Facilitate co-design and implementation

7. **Direct** the Ministry of Health, in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body) to:
 - facilitate a national co-designed service transformation process with people with lived experience of mental health and addiction challenges, DHBs, primary care, NGOs, Kaupapa Māori services, Pacific health services, Whānau Ora services, other providers, advocacy and representative organisations, professional bodies, families and whānau, employers and key government agencies
 - produce a cross-government investment strategy for mental health and addiction services.
8. **Commit** to adequately fund the national co-design and ongoing change process, including funding for the new Mental Health and Wellbeing Commission to provide backbone support for national, regional and local implementation.

9. **Direct** the State Services Commission to work with the Ministry of Health to establish the most appropriate mechanisms for cross-government involvement and leadership to support the national co-design process for mental health and addiction services.

Enablers to support expanded access and choice

10. **Agree** that the work to support expanded access and choice will include reviewing and establishing:
- workforce development and worker wellbeing priorities
 - information, evaluation and monitoring priorities (including monitoring outcomes)
 - funding rules and expectations, including DHB and primary mental health service specifications and the mental health and addiction ring fence, to align them with and support the strategic direction of transforming mental health and addiction services.
11. **Agree** to undertake and regularly update a comprehensive mental health and addiction survey.
12. **Commit** to a staged funding path to give effect to the recommendations to improve access and choice, including:
- expanding access to services for significantly more people with mild to moderate and moderate to severe mental health and addiction needs
 - more options for talk therapies, alcohol and other drug services and culturally aligned services
 - designing and implementing improvements to create more people-centred and integrated services, with significantly increased access and choice.

Transform primary health care

13. **Note** that this Inquiry fully supports the focus on primary care in the Health and Disability Sector Review, seeing it as a critical foundation for the development of mental health and addiction responses and for more accessible and affordable health services.
14. **Agree** that future strategies for the primary health care sector have an explicit focus on addressing mental health and addiction needs in primary and community settings, in alignment with the vision and direction set out in this Inquiry.

Strengthen the NGO sector

15. **Identify** a lead agency to:
- provide a stewardship role in relation to the development and sustainability of the NGO sector, including those NGOs and Kaupapa Māori services working in mental health and addiction
 - take a lead role in improving commissioning of health and social services with NGOs.

Enhance wellbeing, promotion and prevention

Take a whole-of-government approach to wellbeing, prevention and social determinants

- 16. Establish** a clear locus of responsibility for social wellbeing within central government to provide strategic and policy advice and to oversee and coordinate cross-government responses to social wellbeing, including:
- tackling social determinants that impact on multiple outcomes and that lead to inequities within society
 - enhancing cross-government investment in prevention and resilience-building activities.
- 17. Direct** the State Services Commission to report back with options for a locus of responsibility for social wellbeing, including:
- its form and location (a new social wellbeing agency, a unit within an existing agency or reconfiguring an existing agency)
 - its functions (as proposed in Figure 3 in section 7.1.3).
-

Facilitate mental health promotion and prevention

- 18. Agree** that mental health promotion and prevention will be a key area of oversight of the new Mental Health and Wellbeing Commission, including working closely with key agencies and being responsive to community innovation.
- 19. Direct** the new Mental Health and Wellbeing Commission to develop an investment and quality assurance strategy for mental health promotion and prevention, working closely with key agencies.
-

Place people at the centre

Strengthen consumer voice and experience in mental health and addiction services

- 20. Direct** DHBs to report to the Ministry of Health on how they are including people with lived experience and consumer advisory groups in mental health and addiction governance, planning, policy and service development decisions.
- 21. Direct** the Ministry of Health to work with people with lived experience, the Health Quality and Safety Commission and DHBs on how the consumer voice and role can be strengthened in DHBs, primary care and NGOs, including through the development of national resources, guidance and support, and accountability requirements.
- 22. Direct** the Health and Disability Commissioner to undertake specific initiatives to promote respect for and observance of the Code of Health and Disability Services Consumers' Rights by providers, and awareness of their rights on the part of consumers, in relation to mental health and addiction services.

Support families and whānau to be active participants in the care and treatment of their family member

- 23. Direct** the Ministry of Health to lead the development and communication of consolidated and updated guidance on sharing information and partnering with families and whānau.
- 24. Direct** the Ministry of Health to ensure the updated information-sharing and partnering guidance is integrated into:
- training across the mental health and addiction workforce
 - all relevant contracts, standards, specifications, guidelines, quality improvement processes and accountability arrangements.
-

Support the wellbeing of families and whānau

- 25. Direct** the Ministry of Health, working with other agencies, including the Ministry of Education, Te Puni Kōkiri and the Ministry of Social Development, to:
- lead a review of the support provided to families and whānau of people with mental health and addiction needs and where gaps exist
 - report to the Government with firm proposals to fill any gaps identified in the review with supports that enhance access, affordability and options for families and whānau.
-

Take strong action on alcohol and other drugs

- 26. Take** a stricter regulatory approach to the sale and supply of alcohol, informed by the recommendations from the 2010 Law Commission review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship and the 2014 Ministry of Justice report on alcohol pricing.
- 27. Replace** criminal sanctions for the possession for personal use of controlled drugs with civil responses (for example, a fine, a referral to a drug awareness session run by a public health body or a referral to a drug treatment programme).
- 28. Support** the replacement of criminal sanctions for the possession for personal use of controlled drugs with a full range of treatment and detox services.
- 29. Establish** clear cross-sector leadership and coordination within central government for policy in relation to alcohol and other drugs.
-

Prevent suicide

- 30. Urgently complete** the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention.
- 31. Set** a target of 20% reduction in suicide rates by 2030.
- 32. Establish** a suicide prevention office to provide stronger and sustained leadership on action to prevent suicide.

- 33. Direct** the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.

Reform the Mental Health Act

- 34. Repeal and replace** the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights–based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.
- 35. Encourage** mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.

Establish a new Mental Health and Wellbeing Commission

- 36. Establish** an independent commission – the Mental Health and Wellbeing Commission (with the functions and powers set out in Figure 4 in section 12.2.2) – to provide leadership and oversight of mental health and addiction in New Zealand.
- 37. Establish** a ministerial advisory committee as an interim commission to undertake priority work in key areas (such as the national co-designed service transformation process).
- 38. Direct** the Mental Health and Wellbeing Commission (or interim commission) to regularly report publicly on implementation of the Government’s response to the Inquiry’s recommendations, with the first report released one year after the Government’s response.

Wider issues and collective commitment

- 39. Ensure** the Health and Disability Sector Review:
- assesses how any of its proposed system, structural or service commissioning changes will improve both mental health and addiction services and mental health and wellbeing
 - considers the possible establishment of a Māori health ministry or commission.
- 40. Establish** a cross-party working group on mental health and wellbeing in the House of Representatives, supported by a secretariat, as a tangible demonstration of collective and enduring political commitment to improved mental health and wellbeing in New Zealand.



Part 1

Where we are now

Introduction

This part describes the current situation – where we are now – for mental health and addiction in New Zealand.

Chapter 1 describes the context of this Inquiry. In chapter 2 we summarise what we heard from the people who use mental health and addiction services, their families and whānau, and the people at the front line of service delivery. In chapter 3 we outline what we think – our findings about what we’ve seen and heard and the other evidence we gathered during the Inquiry to inform our deliberations. We set out our vision and direction for a transformed mental health and addiction system.

Explanation of important terms

The most important terms used in this report are explained in Table 1.

Table 1: Meaning of important terms

Term	Explanation of term as used in this report
mental health and wellbeing	<p>Mental health and wellbeing form one component of broader wellbeing. Te Whare Tapa Whā is a model that uses the symbol of the wharenuī (meeting house) to illustrate the four cornerstones of wellbeing: taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health), and taha whānau (family health).</p> <p>For Pacific peoples, mental health and wellbeing encompasses a holistic approach of reciprocity, respect, belonging, genealogy, and relationships with all entities – <i>Atua</i>, the land and environment, ancestors, cultures, languages, family and others, collectivism – elements that protect and strengthen family and individual wellbeing.</p> <p>Mental health is “a state ... in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.^a</p>
addiction	<p>For the purposes of this report, we focus on addiction as it relates to alcohol and other drugs. This includes the full spectrum of severity from mild issues to more serious addiction.</p>
tāngata whaiora	<p>Tāngata whaiora, literally translated, means ‘people seeking wellness’. In this report, it refers to people from all ethnic backgrounds who experience mental health or addiction challenges and who are seeking wellness or recovery of self. It includes mental health and addiction service users and consumers of mental health and addiction services.</p>

Term	Explanation of term as used in this report
person with lived experience, service user or consumer	<p>A person with lived experience, a service user or a consumer is a person who accesses, or has accessed, services for mental health and/or addiction needs.</p> <p>The Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights uses 'consumer' to describe a person who accesses health services or disability services.</p>
family and whānau	<p>Family and whānau are not limited to blood ties, but may include partners, friends and others in a person's wider support network. It is up to each whānau and each individual to define for themselves who their whānau is.</p>
mental health and addiction services	<p>Mental health and addiction services are primary and secondary services (that is, services delivered for people with mild to moderate, moderate to severe, and severe needs) that are provided through primary care organisations (such as general practices), non-governmental organisations or district health boards (DHBs) in hospital inpatient, outpatient, forensic or community care settings.</p>
service provider	<p>A service provider is an individual or organisation providing support, care or treatment to people with mental health or addiction challenges.</p>
Kaupapa Māori services	<p>Kaupapa Māori services provide health and social services for Māori within a Māori cultural context across a broad range of conditions and ailments and within a whānau-centred framework.</p>
non-governmental organisation (NGO) sector	<p>The NGO sector comprises independent community, Iwi and Māori organisations operating on a not-for-profit basis.</p>
primary health care	<p>Primary health care comprises generalist health services designed for delivery to the general population. These services are partly funded by Vote Health, and include general practice, school-based services, midwifery, Well Child Tamariki Ora, and NGO primary health support.</p>
mental health and addiction specialist services	<p>Mental health and addiction specialist services are services designed specifically for people with complex and/or enduring mental health and/or addiction needs. These services are publicly funded through Vote Health, and include NGO- and DHB-delivered community and residential services and services delivered in a hospital setting.</p>
postvention	<p>Postvention refers to interventions in the aftermath of a suicide. It has a dual focus on bereavement support and suicide prevention among those who have lost a loved one to suicide.</p>
trauma-informed care	<p>Trauma-informed care uses a strengths-based framework "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment".^b</p>

a World Health Organization. 2014. Mental health: A state of well-being (web page) www.who.int/features/factfiles/mental_health/en.

b E Hopper, E Bassuk, and J Olivet. 2010. Shelter from the Storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal* 3, 80–100, p 82.

Hearing the
Voices of the People

5,200+
Submissions



Post



Video



Facebook



Freephone



Email



Website

400+
Meetings

26
Public
Community
Forums



Chapter 1:

The Inquiry

1.1 Purpose of this Inquiry

The purpose of this Inquiry is set out in the Terms of Reference (reproduced in Appendix A).

First, *to hear the voices* of the community, people with lived experience of mental health and addiction challenges, people affected by suicide, and people involved in preventing and responding to mental health and addiction challenges, on New Zealand's current approach to mental health and addiction and what needs to change.

Second, *to report* on how New Zealand is preventing mental health and addiction problems and responding to the needs of people experiencing those problems.

Finally, *to recommend specific changes* to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

1.2 How this Inquiry differs from earlier inquiries

This is the sixth general inquiry into mental health policy and services in New Zealand since 1858. Historian Warwick Brunton notes that setting up an inquiry is a generational phenomenon in this country,⁴ yet several features of this Inquiry mark it out as different from its predecessors.

This Inquiry is significantly different because it is *not incident driven*, although it was prompted by widespread concern about the toll of suicide on New Zealand families and communities and reports of difficulty accessing help for mental health and addiction challenges.⁵ It has a *wide scope*. It is not just about services for people with acute and semi-acute mental disorders, which was the focus of the 1996 Mason Inquiry report,⁶ but includes mental health problems across the full spectrum from mental distress to enduring psychiatric illness, and looks beyond the health sector to other sectors (including education, justice and social policy) that influence mental health outcomes. In addition, it covers addictions and harmful use of alcohol and other drugs, which past reviews generally treated as a separate policy area.

4 W Brunton. 2005. The place of public inquiries in shaping New Zealand's national mental health policy 1858–1996. *Australia and New Zealand Health Policy* 2(24). www.ncbi.nlm.nih.gov/pmc/articles/PMC1351184/.

5 A number of groups and petitions explicitly called on the Government to initiate an Inquiry.

6 Committee of Inquiry into Mental Health Services (K Mason, Chair). 1996. *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley*. Wellington: Ministry of Health. <https://tinyurl.com/y6w4nqr5>.

The Inquiry encompasses the *broader social determinants* of mental health and wellbeing, including how mental illness and addiction might be prevented or treated from outside as well as inside the health sector. It has a *specific focus on Māori*, the obligations of the Crown under Te Tiriti o Waitangi (the Treaty of Waitangi) and poorer mental health outcomes for Māori, and an explicit focus on other groups with special needs, including Pacific peoples, young people, disabled people, Rainbow communities,⁷ the prison population and refugees.

The Inquiry panel is diverse and multicultural and brings a wide variety of life and work experiences, including lived experience of mental health challenges. The Inquiry process was broad and far reaching, with panel members meeting with thousands of people from Kaitiāia to Invercargill, in urban and rural settings, on marae, in churches and in community halls. We met people with lived experience of mental health and addiction challenges, younger and older people, Māori, Pacific peoples, families, service providers, community and government organisations, members of Rainbow communities, refugees and others. We received submissions (written, online, by video and artwork) from thousands of individuals and organisations.

For all these reasons, many people, including the panel, see this Inquiry as a ‘once in a generation’ opportunity. Our report reflects the momentum for real change and makes recommendations for a new approach to achieve enduring improvements in an area that touches all our lives.

1.3 How we went about our work

As soon as the Inquiry was established, we met to discuss what we hoped to achieve as an Inquiry panel and how we would undertake our work. We agreed on a set of values to guide our engagement with people, our deliberations, and the development of our report and its recommendations. Our guiding values have been:

- **aroha** – love, compassion, empathy
- **whanaungatanga** – relationship, kinship, sense of connection
- **kotahitanga** – unity, togetherness, solidarity, collective action
- **whakamana** – respect for everyone’s dignity and connections
- **mahitahi** – collaboration, cooperation
- **tūmanako pai** – hope, positivity.

⁷ In this report we use the term ‘Rainbow’ as an umbrella term for people who are lesbian, gay, bisexual, trans, intersex, queer, asexual, and other diverse sexual orientations and gender identities. The term ‘LGBTIQA+’ is another term often used in this context.

The Government set us a challenging timeframe. As a panel, we sought to make it easy for people to have their say and we engaged as widely as possible.

In April 2018, we released a consultation document in multiple languages and formats. We offered people the opportunity to make submissions online or in writing by email or post, to provide audio or video submissions, to provide submissions in a variety of languages, or to call a toll-free 0800 number and speak with someone who could write down their views. People could also present their views at Meet the Panel meetings at 26 locations around the country. Over 2,000 people attended these meetings.

We used social and traditional media to promote the Inquiry, spark discussion and encourage participation in the Inquiry. Our Facebook posts were shown to nearly 497,000 people between 13 May and 9 June 2018.

We received over 5,200 submissions through the various channels. We received 16 petitions with 339,217 signatures by 18 October 2018. Petitions were initiated by family members bereaved by suicide, parents searching for services to help their children, young service users calling for better community services, and organisations and individuals determined to make New Zealand a world leader in mental health care.

Over the course of the Inquiry, we held over 400 meetings with tāngata whaiora,⁸ their families and whānau, other members of the public, health and other service providers, Iwi and Kaupapa Māori providers, community organisations, researchers and other experts. These meetings traversed a range of issues affecting mental health and addiction services in communities as well as people's desire for a wider focus on promoting positive mental health and wellbeing across Aotearoa New Zealand.

We travelled the length of the country, and everywhere we went we heard stories of heartbreak and stories of hope. We listened to kōrero in community centres, in village halls, on marae, at Returned Services' Associations, at workers' and sports clubs, at youth centres, and in churches and prisons. We visited city missions, a rest home and a refugee centre.

At the Paraparaumu Bowling Club on a sunny winter's day we heard about issues facing elderly people. On a stormy June day at Te Mānuka Tūtahi Marae, Whakatane, we heard an Iwi perspective. At the Te Awamutu Rugby Club on a cold, wet July day we talked about mental health challenges for rural communities. One August night in Wellington, Rainbow leaders sang and shared with us, while historic pride quilts adorned the walls. People's concerns were real, the issues diverse, often emotional and sometimes tragic, but also hopeful and inspirational.

8 Literally translated, 'tāngata whaiora' means 'people seeking wellness'. See also the explanation in Table 1.

We were humbled by the willingness of people to share their personal stories and their hopes for the future.

We sought information from a wide variety of government agencies on the services and programmes they fund and where they thought the gaps and opportunities were. We commissioned a report from the University of Otago, Wellington, on the determinants of mental health and wellbeing, specific populations' experience of mental health and wellbeing, and opportunities for service improvements and a move to a wellbeing approach.⁹ We read widely and held numerous follow-up meetings with experts on particular topics. All this material was included in our deliberations, alongside the voices of the people.

1.4 Context

1.4.1 Mental health and addiction in New Zealand

Facts and figures

Mental health and addiction challenges are common in New Zealand, and anyone can experience them. Prevalence studies indicate that 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. Around one in five people will experience mental health and addiction challenges in any given year.¹⁰ There are some indications that prevalence appears to be increasing.¹¹ Disparities in outcomes also exist for groups such as Māori, Pacific peoples, and people in contact with the criminal justice system. In addition, New Zealand's rates of suicide remain stubbornly high and have been trending upward in recent years.

9 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

10 MA Oakley Browne, JE Wells and KM Scott (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health. www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey; JD Schaefer, A Caspi, DW Belsky, H Harrington, R Houts, LJ Horwood, A Hussong, S Ramrakha, R Poulton and TE Moffitt. 2017. Enduring mental health: Prevalence and prediction. *Journal of Abnormal Psychology* 126(2): 212–224. DOI: 10.1037/abn0000232.

11 Social Sector Science Advisors. 2018. *Towards an Evidence-Informed Plan of Action for Mental Health and Addiction in New Zealand: A response by the social sector science advisors to the request of the Government Inquiry into Mental Health and Addiction*. Wellington: Social Sector Science Advisors.

Quick statistics

- The annual cost of the burden of serious mental illness, including addiction, in New Zealand is an estimated \$12 billion or 5% of gross domestic product.¹²
- The estimated total annual cost across government agencies associated with the nearly 60,000 health and disability benefit recipients whose primary barrier to work is mental illness is \$1.5 billion.¹³
- The estimated lifetime housing liability associated with the 6,700 social housing tenants receiving benefits and whose primary barrier to work is mental health is \$1.2 billion.¹⁴
- The estimated reduction in life expectancy of people with severe mental health or addiction challenges is up to 25 years.¹⁵
- The number of prescriptions for mental health–related medications increased 50% in the last 10 years and continues to grow about 5% each year.¹⁶
- The number of people accessing mental health and addiction services has grown 73% over the past 10 years.¹⁷

12 Ministry of Health. 2017. *Briefing to the Incoming Minister of Health, 2017*. Wellington: Ministry of Health. www.health.govt.nz/publication/briefing-incoming-minister-health-2017-new-zealand-health-and-disability-system.

13 Ministry of Health. 2018. Appendix 1: Cross-government mental health strategy development. In *Submission to the Inquiry into Mental Health and Addiction*. Wellington: Ministry of Health. www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry/submission-government-inquiry-mental-health-and-addiction.

14 Ministry of Health. 2018. Appendix 1: Cross-government mental health strategy development. In *Submission to the Inquiry into Mental Health and Addiction*. Wellington: Ministry of Health. www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry/submission-government-inquiry-mental-health-and-addiction.

15 Te Pou o Te Whakaaro Nui. 2014. *The Physical Health of People with a Serious Mental Illness and/or Addiction: An evidence review*. Auckland: Te Pou o Te Whakaaro Nui. www.tepou.co.nz/resources/the-physical-health-of-people-with-a-serious-mental-illness-and-or-addiction-an-evidence-review/515.

16 HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

17 HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

Severity and prevalence of mental health and addiction need

In the mental health and addiction sector, level of mental health and addiction need is commonly classified as mild, moderate or severe. Estimates of prevalence for each category are used for a variety of policy, funding, service and workforce planning purposes. Two main sets of mental illness prevalence figures have been used over the last two decades: those in the 1997 National Mental Health Plan¹⁸ and those from Te Rau Hinengaro, the national mental health survey, published in 2006 and based on data collected in 2003 and 2004.¹⁹

Prevalence figures from each of these were similar, with the proportion of the adult population in each category in any given year expressed as follows:

- **severe need** – about 5% according to Te Rau Hinengaro (or 3% in the National Mental Health Plan)
- **mild to moderate and moderate to severe need** – about 16% in Te Rau Hinengaro (7% and 9% respectively) (or 17% in the National Mental Health Plan)
- **no need or low need** – about 79% in Te Rau Hinengaro (or 80% in the National Mental Health Plan).

It is important to note these categories do not describe individuals but rather refer to the mental illness prevalence in the population in a given year – an individual's needs shift over time and throughout their life. The severity of need can also fluctuate, even for people with long-term, serious mental health challenges such as persistent and severe depression, bipolar disorder or schizophrenia.

We have used these severity categories and prevalence rates throughout this report primarily because they are in common usage and because they underpin so many aspects of our current system. On this basis, they form an essential part of our discussion throughout this report.

We emphasise, however, that we do not find the terms mild, moderate and severe very useful, so at times we have simply referred to people with severe needs and people with less severe needs or, sometimes, to 'the spectrum of mental health and addiction needs'. In addition, prevalence survey methodology in the past has used definitions based on 'mental disorder', which is based on Diagnostic and Statistical Manual diagnostic criteria and does not capture the full range of challenges and distress we refer to in this report.

There are wider difficulties in much of the terminology used to describe mental health and addiction challenges, and no easy answers. Terms can be subjective, language can be stigmatising, and boundaries are blurred, for example, between mental distress due to mental illness and mental distress that is not diagnosable as an illness (for example, distress due to a behavioural need).

Mental health conditions do not necessarily mean the presence of mental illness, while mental distress, even when quite disabling, can often be understood and managed without a medical response. And there are many situations in which a person who has a diagnosable condition can be helped through non-medical approaches. We find distress a useful concept and have used it throughout this report. 'Distress' encompasses mental illness, people who are seriously upset, and people who are reacting normally to a stressful situation such as bereavement.

18 Ministry of Health. 1997. *Moving Forward: The National Mental Health Plan for More and Better Services*. Wellington: Ministry of Health. www.moh.govt.nz/notebook/nbbooks.nsf/c3c3fdfe9ab9c116cc256e3800747b1c/1afc12d0677638624c2565d700185b11.

19 MA Oakley Browne, JE Wells and KM Scott (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health. www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey.

An important point is that, regardless of what they are called, mental health and addiction challenges exist along a continuum, including severe and sometimes long-term conditions such as bipolar affective disorder, schizophrenia and other psychoses, as well as less severe but high prevalence conditions such as anxiety and depression. People may also have problematic alcohol or other drug use, which may develop into addiction.

Finally, people who experience mental distress or addiction have different needs, influenced not only by the severity of their symptoms, but also by the duration and complexity of their symptoms and the presence of other needs.

Given this very complex picture, rather than focus too heavily on definitions, our approach in this report is broad-based. We generally refer to the spectrum of mental health and addiction needs or challenges, including the concepts of mild, moderate and severe challenges when appropriate.

Organisations and people

New Zealand's mental health and addiction system comprises a complex network of organisations and people.

The Ministry of Health is the main government agency responsible for mental health and addiction strategy, policy and regulation. Commissioning, implementation and service delivery are the responsibility of different organisations, based primarily within the health sector, including the Ministry of Health, district health boards (DHBs), primary health organisations, private hospitals, non-governmental organisations (NGOs), Kaupapa Māori services and community groups.

Some mental health and addiction services and supports are also funded by sectors outside health. They include the justice, education, social development and defence sectors and the Accident Compensation Corporation.

A variety of arts, cultural and sporting programmes and initiatives are not typically considered 'mental health services'. They may, however, support mental health and wellbeing. Some specifically focus on providing opportunities for people with mental health and addiction challenges to participate in these everyday activities.

Finally, some services are not publicly funded at all. For example, some services, such as phone counselling, are delivered by NGOs or community groups that rely on fundraising or grants. Employers may also provide some support, such as counselling, for their employees. Private providers deliver other services for people who choose to pay directly.

The mental health and addiction workforce is diverse, comprising workers in both clinical and non-clinical roles (for example, psychiatrists, psychologists, general practitioners, mental health nurses, social workers, community support workers, cultural advisors, peer-support workers and youth workers) across a number of environments (from hospitals to schools to community-based services, marae, hubs and people's homes).

Mental health and addiction services

Since deinstitutionalisation in the 1980s and 1990s, most mental health and addiction services are delivered in a community setting, rather than in hospitals.

Most mental health and addiction services are funded by the public health sector. In 2016/17, around \$1.4 billion (or 9% of the total Vote Health budget) was spent on these services. The vast bulk of this funding, about \$1.35 billion, is ring-fenced for services focused on meeting the needs of people facing the most severe challenges (targeted to at least 3% of the population in a given year²⁰). Although these services are called ‘specialist services’, they are not provided exclusively by specialist clinicians, but include services such as community-based and respite care, as well as social support services (for example, vocational support, living skills and housing coordination services).

Outside the ring-fenced funding, about \$30 million of public health funding is provided for services for people with mild to moderate or moderate to severe needs. These services are usually referred to as ‘primary mental health services’ and include psychological therapies and extended general practitioner visits. Public funding for these services is tightly targeted towards young people, Māori, Pacific peoples and people on low incomes.

A further \$100 million of nationally purchased services and activities (for example, national health promotion campaigns, workforce development, adult inpatient and forensic services) are funded directly by the Ministry of Health. (See Appendix B for further information about mental health and addiction funding and services.)

1.4.2 How we approached our report

The Inquiry’s Terms of Reference are broad and we had a relatively short time to report – we began in February 2018 and were required to report by 31 October 2018.²¹ Our first priority was to give people an opportunity for their voices to be heard. What we heard confirmed that there are long-standing mental health and addiction challenges in New Zealand, increasing and unsustainable pressure on the current system, and an urgent need to tackle the problems we face.

Many people with lived experience, their families and whānau, workers, providers and funders and policy advisors argued for a radically different approach to mental health and addiction. But there was much less clarity about the best way forward.

We considered how best to approach this report, given the wide range of complex issues, our time constraints, and the risk of being overwhelmed by detail. We have not produced a strategy, a roadmap or a detailed implementation plan with comprehensive and fully costed actions. Our analysis convinced us that none of those well-trodden paths would achieve the fundamental change of direction required.

20 This 3% target dates from the 1996 Mason Inquiry, which recommended this target based on prevalence figures at the time: Committee of Inquiry into Mental Health Services (K Mason, Chair). 1996. *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley*. Wellington: Ministry of Health. <https://tinyurl.com/y6w4nqr5>.

21 A one-month extension was subsequently granted by the Minister of Health.

Instead, we have focused on the critical reforms necessary to create the right environment and support a significant shift in how we prevent and respond to issues of mental health and addiction. We have identified priority areas for action, many of which require decisive action by the Government and Parliament.

We have deliberately taken a ‘people first’ approach in writing this report, being guided by the needs of people and communities rather than the preferences of the various groups accustomed to the way the system is structured and services are delivered at present. We have not proposed major structural change, since we do not have any evidence to show that dismantling and rebuilding the current system is necessary or desirable. We have highlighted where roadblocks must be removed and how we can build a new system on the solid foundations already in place.

We are conscious of the need to be bold and make the most of this once in a generation opportunity. We want this report to lead to real and enduring change: the ‘paradigm shift’ that so many New Zealanders have called for.

Our report reflects the voices of the people, sets out our vision of a transformed mental health and addiction system, and identifies the key reforms needed to bring about major change.

1.4.3 Structure of this report

This report has two main parts.

Part 1 describes where we are now: the context of this Inquiry (chapter 1), what we heard (chapter 2),²² and what we think, including our vision and direction for a transformed mental health and addiction system (chapter 3).

Part 2 sets out our conclusions about what needs to happen. We detail the main areas where we recommend change:

- expand access and choice (chapter 4)
- transform primary health care (chapter 5)
- strengthen the NGO sector (chapter 6)
- enhance wellbeing, promotion and prevention (chapter 7)
- place people at the centre (chapter 8)
- take strong action on alcohol and other drugs (chapter 9)
- prevent suicide (chapter 10)
- reform the Mental Health Act (chapter 11)
- establish a new Mental Health and Wellbeing Commission (chapter 12).

A final note and two appendices complete the report.

²² A summary of submissions will be published separately.



“Go and see your neighbour, take their washing off the line, cook them a meal.”

Chapter 2

What we heard – the voices of the people

2.1 Introduction

Our first job was “to hear the voices of the community, people with lived experience of mental health and addiction challenges, people affected by suicide, and people involved in preventing and responding to mental health and addiction challenges, on Aotearoa New Zealand’s current approach to mental health and addiction, and what needs to change” (from the Terms of Reference, see Appendix A). We did this by inviting public submissions (in writing or other formats), holding public meetings around the country, and meeting with groups and individuals with personal or professional experience of New Zealand’s mental health and addiction services.

We heard from thousands of people through written and online submissions and in public meetings and discussions with individuals and organisations. The experiences, insights and views expressed together give an overall picture of mental health and addiction in New Zealand, which reflects both heartbreak and hope.

We heard from *tāngata whaiora*; literally, people seeking wellness. They talked about their struggle to access help for mental distress and addictions and evoked the image of being “up to their necks in deep water”.²³ People shared deeply personal experiences, motivated by a desire to tell their stories and bring about change.

We also heard from families, *whānau* and close friends²⁴ and from front-line staff in mental health and addiction services²⁵ – two groups strongly allied to *tāngata whaiora*, but with different perspectives.

We also had numerous submissions from professional and representative bodies, government agencies, district health boards (DHBs), non-governmental organisations (NGOs), Māori and Pacific providers of health and social services, and a wide range of advocacy and community organisations. In different ways they reiterated much of what we had heard from individuals but also added perspectives that addressed limited resources, limited reach and consequent limited impact of their own efforts.

We have sought to present the voices of the people as faithfully as possible, using headings that capture their main themes.

23 From the Tongan proverb *‘Fe’ofa’aki a kakau’* (‘the love of swimmers’).

24 Families may struggle to provide help when they too are up to their necks in water.

25 In the proverb mentioned in footnote 23, the *tufuga/tufunga* or specialists on the front line are the fishermen and navigators who seek to rescue the people in the water.

2.2 A new approach: wellbeing and community

The overarching kaupapa emerging from the collective voices is hope for universal, integrated, community-focused health promotion alongside a set of services accessible to those who need them, when and where required. (NGO provider representing voices of staff, service users and families)

We heard that our mental health and addiction system is not fit for purpose. We have a health system that focuses on *responding* to psychiatric illness, but people want a system that *prevents* mental distress and addiction, *intervenes early* when problems start to develop, and *promotes* wellbeing.

Repeatedly, people talked about the need for fences at the top of the cliff, rather than ambulances at the bottom. They called for policies to address the societal foundations of mental wellbeing as part of a strategy of promoting physical, social, cultural and spiritual wellbeing. We were reminded that “there is no health without mental health”.

People called for transformation in our approach to mental health and addiction, with a focus on wellbeing and community solutions.

- New Zealanders of diverse backgrounds asked for a more values-based and holistic approach to promoting the wellbeing of individuals, families and communities.
- The strong consensus among Māori was that Te Ao Māori, mātauranga Māori, whānau, and te reo me ona tikanga are essential aspects of wellbeing for Māori.
- Pacific peoples called for Pacific ways and world views of knowing and doing, where connection is paramount through relationships with family, community and the environment, to be honoured.

The Wellbeing Manifesto (Table 2),²⁶ with its call for a shift from ‘big psychiatry’ to ‘big community’, encapsulates several dimensions of the paradigm shift many submitters desire.

Table 2: Wellbeing Manifesto – from ‘big psychiatry’ to ‘big community’

Big psychiatry	Big community
Mental disorder is viewed primarily as a health deficit.	Mental distress is viewed as a recoverable social, psychological, spiritual or health disruption.
A mental health system with a health entry point led by medicine.	A wellbeing system with multiple entry points led by multiple sectors and communities.
Most resources are used for psychiatric treatments, clinics and hospitals.	Resources are used for a broad menu of comprehensive community-based responses.
Employs predominantly medical and allied professionals.	Employs a mix of peer, cultural and traditional professional workforces.

²⁶ Developed by Mary O’Hagan in consultation with tāngata whaiora, Māori, Pacific peoples, health promotion experts, mental health professionals and mental health system leaders: M O’Hagan. 2018. *Wellbeing Manifesto for Aotearoa New Zealand: A submission to the Government Inquiry into Mental Health and Addiction* (prepared for PeerZone and ActionStation). www.wellbeingmanifesto.nz/.

Big psychiatry	Big community
Has a legacy of paternalism and human rights breaches.	Has a commitment to partnerships at all levels and to human rights.
Focused on compliance, symptom reduction and short-term risk management.	Focused on equity of access, building strengths and improving long term life and health outcomes.
Responds to people at risk with coercion and locked environments.	Responds to people at risk with compassion and intensive support.
A colonising medical system that excludes other world views.	A bicultural system that embraces many world views.

All around the country, people advocated for Te Whare Tapa Whā,²⁷ the concept that health and wellbeing are underpinned by four cornerstones: taha tinana (physical health), taha hinengaro (mental health), taha wairua (spiritual health) and taha whānau (family health).

People emphasised the value of community hubs and networks of peers who have themselves ‘navigated the storm’. Families and communities wanted to support tāngata whaiora to return to wellness, with expert help when needed.

What’s working in the community? It’s community that’s working in the community. (Kaimahi Māori)

As part of the widespread call for a focus on wellbeing, people asked for prevention initiatives and services to be integrated across the system. Suicide prevention, in particular, was emphasised in a high number submissions given the rates of suicide and the devastating impact on families across Aotearoa New Zealand.

There was a strong call in submissions to embed prevention services into the education system and workplace. These services include evidence-based resiliency programmes, particularly in early childhood centres and schools, whānau-based programmes, emotion regulation training, properly funded counselling, and mindfulness training.

Prevention was seen as a societal response, not simply a health service issue.

Strengthening protective factors is not a role that is best led by health services alone, but by whānau, hapū and iwi, Pacific peoples, Rainbow and other communities, universities and tertiary providers, schools and early childhood education providers, workplaces, sports groups, faith centres, social services, organisations that support positive parenting, youth development, and positive ageing, and a range of other community sectors.²⁸

27 MH Durie. 1985. A Māori perspective of health. *Social Science and Medicine* 20(5): 483–486.

28 Le Va, Te Rau Matatini, Changing Minds, A Beautrais, Northland District Health Board, Clinical Advisory Services Aotearoa, Victim Support, Te Rūnanga o Ngāti Pikiao Trust, Skylight, and Mental Health Foundation of New Zealand. 2018. *Five Key Solutions for Suicide Prevention in New Zealand: A submission to the Government Inquiry into Mental Health and Addiction – Oranga Tāngata, Oranga Whānau*. www.mentalhealth.org.nz/assets/Our-Work/policy-advocacy/Five-key-solutions-for-suicide-prevention-in-New-Zealand-a-submission-to-the-Inquiry-on-Mental-Health-and-Addiction.pdf.

2.2.1 Help through the storms of life

People described grief, sadness and loss as challenging but ordinary parts of life. We were told that people need help through these ‘storms’ and that we should stop classifying them as ‘illnesses’. They said that defining mental distress as an ‘illness’ reinforces a deficit mindset and requires people to identify as sick in order to qualify for assistance. People want to be active participants in their recovery, not just passive recipients of services, and to be encouraged and supported to heal and restore their sense of self.

They said their desire to participate in decisions about their lives was often ignored by clinicians wielding power or seen as an obstacle to be ‘managed’ rather than an essential aspect of their pathway to wellbeing.

I think there are messages we are supposed to learn through this storm and medication is only a temporary fix, but most importantly is exercise, healthy eating, sleeping ... the spiritual side ... Feeding my mind with positives ie, reading my spiritual devotions, shopping, only connecting with positive friends/family. (Service user)

2.2.2 Seeing the whole person

People complained that the biomedical approach fails to see the whole person, so provides only part of the answer (and sometimes no answer at all) to restoring and maintaining wellbeing. They said that merely matching people to a diagnostic label such as depression, psychosis or schizophrenia and treating their distress as a problem of brain dysfunction or a problem that can be relieved by medication, does not address their overall life circumstances or their personal histories, traumas and challenges.

The ideal system would acknowledge and attend to the whole person in the one facility. An overall positive transformation would take place without compromising other aspects of health and wellbeing as a result of service delivery. (NGO provider of Kaupapa Māori services)

Workers at all levels of the system questioned the effectiveness of current clinical practice models. We were told that medical science is only part of the answer and that the health system alone cannot solve the crisis in mental health and addiction.

Although medication can often be necessary and life-saving, we also need comprehensive services that mean people’s mental health can be looked after fully – this would involve root causes of issues being explored. (Service user)

People noted that, although many service providers aspire to a more holistic model, it’s often not evident in their practices and 15-minute general practitioner (GP) consultations don’t allow it. The Wellbeing Manifesto listed 12 aspects of a holistic model, with psychiatric treatment being only one aspect alongside advocacy and navigation services, education and employment support, and whānau and parenting support.

In my experience, the patient is not treated as a whole, but a fragment of the area of expertise the particular doctor is trained in ... A band aid will eventually wear off, fix the wound and there will no longer be a need for the plaster. (Family member caring for service user)

People criticised current services for failing to acknowledge how much mental wellbeing is a function of meaningful work, healthy relationships with family, whānau and community, good physical health, and strong connection to land, culture and history.

Employment is a huge part of recovery. It is important for self-esteem, routine, social connectedness, physical health, and of course it helps to relieve the poverty that is very often part of the lives of someone with poor mental health. (Service provider)

A person's connection with their family, culture and identity can be a significant source of strength and recovery. (Advocacy group)

2.3 Māori health and wellbeing

When the whaiora falls over the whaiora is blamed and not the model. Why don't we match the client with the right service? (Kaupapa Māori service provider)

In hui with Māori, on marae and in community meetings, we heard from Kaupapa Māori providers and Iwi that they are achieving good outcomes for tāngata whaiora through initiatives like the project run by Te Taitimu Trust in Hawke's Bay, helping rangatahi at risk to develop resilience and wellbeing.

Overwhelmingly, submissions from Māori said that the health and wellbeing of Māori requires recognition of indigeneity and affirmation of indigenous rights. They argued that our approach to mental health needs to acknowledge the Tāngata Whenua status of Māori under Te Tiriti o Waitangi. In addition to more Kaupapa Māori services and a strong Māori mental health workforce, many Māori want to determine how services are commissioned, delivered and evaluated.

The responses and solutions reside in the realisation of Treaty guarantees and whānau, hapū, iwi rangatiratanga/self-determination. (Whānau group)

We were told that the Western model of mental health, enshrined in the health system and legislation, is based on beliefs that are not shared by all Māori and are not always helpful – for example, the separation of mental health from oranga (health and wellbeing) is contradictory to holistic understandings of health.

Māori identity is rooted in whakapapa, tikanga and kawa. (Māori leaders)

Māori organisations are surrounded on all sides by non-Māori perspectives. There is conflict between Western and Māori ideas of best practice. (Group of Kaupapa Māori providers and tāngata whaiora)

Many Māori pointed out that current mental health services, strategies and policies do not reflect a genuine partnership between the Crown and Māori. They argued that the way our health system approaches mental distress and illness reflects a colonising world view largely hostile to Māori understandings of wellbeing. They spoke of compulsory treatment as a threat to mana and to their ability to live as Māori.

We heard that recognition of the importance and significance of ties to whānau, hapū, iwi and family group, including the contribution those ties make to wellbeing, and proper respect for cultural and ethnic identity and language²⁹ rarely form part of psychiatric assessments. They are routinely not addressed by courts, tribunals or others when making decisions about compulsory assessment and treatment. We also heard that patients are denied their entitlement to be dealt with in a manner that accords with the spirit of proper respect for cultural identity.³⁰

Māori explained that their mental health has suffered as a direct result of a long-standing alienation from their land and the impact of colonisation and generational deprivation. They said that reclaiming mental wellbeing requires reconnection to land, culture, whakapapa and history, but many mental health and addiction services barely acknowledge the importance of this connection and thus reinforce trauma.

Those who cannot understand or connect to the lived experiences of intergenerational historical trauma, of resilience in the face of life threatening adversity, of dignity scorned and beaten out of us, simply have no business advising tāngata whaiora on how to live their lives. (Kaimahi Māori)

Māori hoped this Inquiry would prompt the Crown to re-engage with iwi, hapū and whānau on issues central to the future wellbeing of Māori and their right to live as Māori.

At the heart of current Māori ‘un-wellness’ is colonisation, institutionalised racism, unconscious bias and a western model of wellbeing, with systems that strengthen that model and perpetuate further inequity than those already experienced by Māori. (Māori NGO providers)

29 As required by the Mental Health (Compulsory Assessment and Treatment) Act 1992, section 5.

30 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 65.

2.4 Pacific health and wellbeing

We heard from Pacific peoples that the current system is not working for them – that the design of the system, the spirit of services and the dominance of mainstream models of practice have not enabled Pacific health and wellbeing.

Consistently, Pacific peoples spoke of a lack of quality and described services they found hostile, coercive, culturally incompetent, individualistic, cold and clinical. We heard many times of their experiences of pain, inequity, institutional racism and preventable loss.

The call from Pacific peoples was for transformation. They saw the solution to many existing problems as adoption of ‘Pacific ways’ of supporting people and their families. This was described as including a genuine, holistic approach, incorporating Pacific languages, identity, connectedness, spirituality, nutrition, physical activity and healthy relationships.

Relationships were seen as vital to Pacific health and wellbeing outcomes.

By Pacific, for Pacific services are more than just having Pacific peoples at the frontline to work with their own. By Pacific, for Pacific services means that the model of care reflects the values and philosophies of Pacific. (Pacific service provider)

What we heard was a need for an extended village of Pacific services working cooperatively and collaboratively, with complete cultural integrity to adequately meet the needs of Pacific peoples. This village of services would be governed and managed in a way that meaningfully demonstrates Pacific authority and autonomy with decision-making that best serves the interests of Pacific families, clients and staff – entrenched in Pacific ways of knowing, being and doing. There was a call for services to be funded by Pacific peoples who would determine the procurement process and scope of contracts. We were told that, for real change to occur, contracting and funding must promote – not hinder – the ability to deliver services that will facilitate recovery, healing and resilience for Pacific peoples and their families.

The diversity of Pacific peoples was an important theme – they are multilingual, multigenerational, and of diverse sexualities and genders, represent many ethnic-specific interests, and hold various clinical, community and cultural skills. Pacific culture in all its diversity cannot be compromised.

At every corner of the system, people wanted a strong Pacific presence – an interconnected network of Pacific providers, or one large service, serving the needs of Pacific peoples. We heard that a Pacific integrated approach would reflect a commitment to like-mindedness, working seamlessly in partnership at all ends of the service spectrum: from acute beds and respite services, to secondary and primary mental health and addiction services right through to health promotion. We were encouraged to learn from Pacific approaches to peer support, which work well even with few resources.

Rather than a mere re-branding of services or forcing services to work with one another, Pacific peoples wanted an opportunity to do things differently, with optimal quality care and culturally effective options.

You can service people without knowing who we [Pacific peoples] are — and do not consider the context ... It's not a one size [fits all] approach, instead [it] might be a Matrix. Mainstream is not serving us well, we could do it better. We are happy to fix ourselves, we just need opportunity. (Pacific health leader)

2.5 Social and economic determinants of health

People saw poor mental health and addiction as symptoms of poverty, social exclusion, trauma and disconnection. They talked about threats to basic needs such as affordable and safe housing, quality education, meaningful employment, adequate income, social connectedness, freedom from violence and reliable social support. They explained how this leads to chronic stress on families, whānau and individuals and compromises wellbeing.

Access to health care. Access to education. Access to decent housing. Access to sustainable income – a living wage ... access to proper social services. (Service user and provider)

Many people called for a mental health lens to be applied to all policies that shape society (for example, education, criminal justice, economics, care of the elderly and housing policies) and argued for prevention to reduce risk factors, such as alcohol and other drug abuse, homelessness and violence, that harm the wellbeing of individuals and communities.

By removing silos of thinking that compartmentalise where care is offered, we can begin to heal those whose life trajectories have been hampered by factors outside their control. (Māori professional organisation)

People placed particular emphasis on reducing economic deprivation among our children, mokopuna and young people, as child poverty paves the way for worse health outcomes in childhood, adolescence and adulthood. Young people identified insecure employment, spiralling housing costs and the burden of debt as major sources of anxiety. Similar social and economic issues were raised by under-served or marginalised groups such as the elderly, disabled people, homeless people, Rainbow communities, refugees, migrants and people living on long-term income support.

Poverty goes hand in hand with [poor] mental health. (Kaimahi Māori)

It is difficult to afford a healthy diet in New Zealand while earning the minimum wage where the majority of your income goes on rent. (Youth service user)

2.5.1 Local communities want more control

We repeatedly heard how poor mental health outcomes can become endemic within communities. We met leaders in communities devastated by the impact of easy access to alcohol and other drugs. People told us how whole communities, not just individuals, can become depressed or anxious, disconnect from each other, and lose the sense of trust and the ability to work together. They expressed dismay at their limited influence over important decisions that affect community wellbeing, such as the number and placement of liquor or gambling outlets and access to addiction detoxification (detox) facilities. They wanted access to national resources to create local solutions and sought wider powers to take charge of what they perceived to be the main drivers of poor mental health outcomes for their communities.

2.5.2 Discrimination remains a barrier

Numerous submissions described the impact of discrimination on the basis of mental health status – how it added to their mental distress and sense of alienation. Discrimination was reported to still be common in New Zealand society and within the mental health system. We also heard about the harmful effects of discrimination on the basis of ethnicity, culture, disability and gender identity. Rainbow youth and other marginalised groups reported not feeling safe accessing mainstream services and suffering harm from discrimination.

Sexual orientation, gender identity or expression and intersex status are not the cause of the elevated risk of mental health problems, addiction and suicidality among the rainbow population. Rather, the increased risk is due to stigma, discrimination, prejudice and exclusion. (Providers supporting Rainbow communities)

2.5.3 Loneliness and isolation

People talked about loneliness and isolation in our communities. They spoke of the need for stronger connections and manaakitanga, practical care and concern for the wellbeing of others.

Go and see your neighbour, take their washing off the line, cook them a meal. (Community member)

We were told that the pressure to be constantly available for work fosters anxiety, insecurity and isolation.

[We need] societal changes to reduce the pressure on people's lives. Get house and rent prices back under control, stop food prices going up far faster than wages, make public transport useable. Jobs that respect weekends and evenings should be the norm, not the exception. If people's lives are easier, mental health problems will be less frequent or more manageable. (Service user)

We were reminded of the forgotten patients in our system.



Photo: Karakia i te koroha, Prayer in the Wilderness, Chapel at Kenepuru Hospital, Porirua

2.5.4 Trauma is a key factor in mental distress and addiction

Many submissions highlighted trauma in childhood as the origin of mental distress and the trigger for counterproductive coping mechanisms such as addiction. People noted that steps to prevent or reduce the trauma of childhood abuse and neglect, sexual abuse and sexual violence, adult partner violence and bullying at school and work should be recognised as strategies for preventing future distress and investing in the wellbeing of future generations.

We were told that health services responding to mental distress need to get better at acknowledging and responding to the trauma that underpins 'symptoms', rather than merely offering ways to 'dull the pain'. People noted that state agencies such as Oranga Tamariki—Ministry for Children, schools, New Zealand Police, the Department of Corrections, Work and Income New Zealand and mental health services can cause or exacerbate trauma.

A repeated theme was that intergenerational trauma can affect families and whānau and that understanding mental health through the lens of trauma requires a change in mindset and different approaches to healing for individuals, families and whānau.

**Unless we provide trauma informed services the system will remain broken.
(Parent supporting service user)**

2.5.5 Alcohol and other drugs and addictions are tearing families and communities apart

People demanded action to reduce the harmful effects of drugs (especially methamphetamine or 'P') and alcohol, particularly among young people and during pregnancy. We heard from communities being torn apart by the P epidemic. Many people expressed concern about the ease of access to alcohol and gambling in our communities, noting their potential for social harm if not tightly controlled. They talked of our national 'love affair' with alcohol, how alcohol use fuelled their depression and suicidal thoughts or triggered violence and neglect of children. They called for decisive action limiting the sale and promotion of alcohol, particularly around children and young people (including sports sponsorship).

What a great way to induce suicide, depression and multiple episodes of interpersonal violence. What a wonderful way to traumatise children – just have their parents exposed to alcohol in their early teens so that their problems are well established by the time they have kids. (Service provider and advocate)

Gambling was also seen as harmful due to its addictive nature and the financial stress and anxiety it causes families, contributing to neglect of children and family violence.

2.6 Addictions

Many people identified addiction as a serious public health issue. People criticised the subtle normalisation of alcohol, other drugs and gambling within our society over past decades, with much easier access to all three. They pointed to the increasing number of liquor and gambling outlets, their placement near schools and in poorer communities, and the failure of 'tough on drugs' policies to restrict availability.

Many submitters called for more restrictive legislation and advertising rules for alcohol to enhance protective and preventative initiatives. They argued for a pragmatic 'what works' approach, pointing to successful public health policies, such as those used to treat nicotine addiction. People asked for a public health response to restrict supply, alongside increasing the range and availability of therapies to assist people recover from addiction.

We were told that addiction is the opposite of connection, a taniwha that isolates users and holds them in its grip. They spoke of the high social costs of not addressing addictions: harm to families, children and communities. People saw an urgent need to prevent harmful addictions and provide pathways to recovery.

2.6.1 More treatment and rehabilitation services

We heard that when people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options within their communities. People called for rehabilitation (rehab) services such as detox facilities and counselling to be much more widely available. They wanted residential and other services to keep people safe during drug withdrawal and to aid their recovery with professional help, peer-support programmes and strengths-based approaches to healing.

When a person is ready to change the treatment needs to be available then. Not one hundred placements down the line. (Self-identified service user and provider)

2.6.2 A mature drug policy

People wanted New Zealand to adopt a mature drug policy, with addiction treated as a health issue not a criminal justice issue. The threat of criminal sanctions was said to be ineffective in reducing drug use and a barrier to seeking help, especially for families enmeshed in the subculture of illegal drug manufacture and supply. People called for addiction to be destigmatised and recognised as a maladaptive response to stress, anxiety and trauma.

People spoke of the harmful perverse effects of ‘tough on drugs’ policies, such as encouraging gang control of drug supplies and pushing addicts and their families into the margins of society. We were told that our largely punitive criminal justice response to drug use fails to acknowledge the root causes of drug addiction (trauma, abuse, anxiety and isolation) or the frequent connection between intergenerational abuse, addiction, mental distress, unemployment, poverty and homelessness. We heard how addiction programmes begun inside prison are difficult to maintain as a prisoner transitions back to the community, and how programmes such as diversionary drug courts provide a person-centred, coordinated and effective approach.

It’s not a war on drugs it’s a war on very sick people and it needs to stop. Addicts need to be treated as addicts not criminals. (Family member of service user)

2.7. Families and whānau

We heard that mental health services often make it difficult for individuals to stay connected to their families and communities. They acknowledged that mental distress can put immense pressure on an individual’s relationships with family and other networks, sometimes to the point of breakdown, and that family can generate and exacerbate distress. But relationships with family, whānau and community give lives meaning and provide a potential path back to wholeness. Many people described how mental health services have severed or jeopardised these relationships.

The moment that mental health became involved in his treatment, we were isolated from him. ... As parents we were treated worse than criminals. (Family member of service user)

A significant number of submissions from families told of their being excluded, offered culturally inappropriate services or even treated with contempt or indifference.

Our experience is one of marginalisation, frustration, worry and never having a voice. (Family member of service user)

People praised Whānau Ora providers for valuing the role of family and whānau in keeping people well and supporting their recovery. They wanted service providers to share information in an environment of trust and to work with families to enable their support role.

When families and whānau are included in meetings with clinicians it makes a difference – families know what is happening for their family member and are given opportunities to ‘fill in the gaps’; so the clinician has the full picture of what is happening at home for the consumer and can make better informed decisions about subsequent treatment. (NGO-collated responses from family and whānau)

2.7.1 Privacy concerns

Families described being kept in the dark and excluded from treatment and discharge planning, even though they are the ones there for the long haul. Families and whānau reported struggling to support their loved one with complex needs or at risk of suicide while receiving little help from services, little education about what to do and limited respite. Families often felt excluded from care plans, treatment and follow-up, despite many times being primary supporters of their family member.

What families want is guidance on how to deal with situations, how best to reinforce the goals being worked on at that point, the opportunity to work as part of the [mental health] team. (Family support person)

Submissions from family members said that privacy was used inappropriately as a reason for withholding information from them (for example, in discharge planning). Families spoke of loved ones discharged without the family being notified and without appropriate support, and some described subsequent self-harm or suicides they believe could have been prevented with family intervention.

[My family member] went to hospital at 5pm that night after an attempt to kill [themselves]. Less than 5 hours later [they were] assessed and released with no way of getting home. (Family member of service user)

Some submissions noted that family members may be part of the problem or have agendas that conflict with the individual’s best interests. Others expressed concern about clinicians sharing information without the consent of tāngata whaiora.

2.7.2 Support for families

Families spoke of the difficulty of accessing advice, respite care or other forms of assistance to help them support their family member through mental distress and during recovery. They spoke of overloaded crisis services, a lack of integration and continuity of care, and having loved ones returned to their care with little information or support.

We are winging it. We are winging it. (Whānau Māori)

We heard from grandparents caring for their mokopuna while the parents were in residential programmes or in prison and from older people caring for adult children, concerned about what would happen once they were no longer able to provide or oversee care.

Some families said they were dealing with multiple intergenerational disadvantages, layers of trauma, limited skills and ongoing addiction. They asked for help to address their own wellbeing challenges.

2.7.3 Support for suicide bereaved families

Hundreds of submissions from families and whānau affected by suicide highlighted serious deficiencies in how they were supported through an extremely traumatic process. They spoke of lengthy police, coronial, DHB and Health and Disability Commissioner processes, feeling excluded from full involvement in DHB reviews, inadequate communication from services and professionals, a sense of being disregarded and excluded, a lack of affordable professional services, services that were not culturally appropriate for their grieving, and processes that were traumatising rather than healing.

No one should be made to feel tortured on top of feeling their immeasurable loss and grief ... (Bereaved family member)

Those of us bereaved by suicide are the forgotten group, we're expected to get over it, get on with it and fall back into life as it used to be. Well we don't get over it, we try to manage it and where we are is our new 'normal' but we can't do this alone ... Postvention needs to sit alongside prevention and be resourced and supported ... (Peer-support group for suicide bereaved)

2.7.4 Cultural support

Māori and Pacific peoples pointed to evidence that treating the mental health of an individual in isolation from family and community is ineffective and inappropriate for cultures that value collectivism. They argued that cultural approaches are vital to recovery and get much better outcomes – so should be funded and supported. Many Pākehā and other ethnic communities voiced similar concerns about treatment models that do not sufficiently acknowledge family, whānau and social context.

People were dismayed that many clinicians working from a biomedical model were reluctant to recognise cultural evidence and failed to appreciate the value of staff and support people from the individual's own culture. Culturally appropriate services were described as rare and poorly resourced.

Communities need the opportunity to shape models of care so that they fit the needs (cultural and social) of the communities they serve. (Community advocate)

2.8 Children and young people

We heard that children and young people are exhibiting high levels of distress leading to deliberate self-harm, risk-taking, anxiety disorders and other troubling behaviours.

Parents spoke of their deep concerns about bullying and alcohol abuse, which link to youth suicide, about the misuse of the internet, including pornography and harmful sexual images, and about social media, also linked to bullying and poor social skills development. We heard about high levels of mental distress among children, resulting in cutting, other forms of self-harm and eating disorders, which can be devastating and life-threatening.

Students talked about young New Zealanders needing guidance on mental health – how to look after oneself and to look after friends. School counsellors and teachers told us they are overwhelmed by the number of students in distress, the complexity of their issues and the incidence of acting out via problem behaviours in class.

Children and young people who represented their peers in state care asked that there be deeper training for foster parents around mental health challenges.

We heard of a tidal wave of increased referrals to Child and Adolescent Mental Health Services and Behaviour Support Teams, which make it difficult to respond to the early signs of mental distress. Childhood trauma was reported to be a major issue.

We believe a society where the treasuring of our children’s well-being is paramount is the only way to ensure that children have what they need to grow and develop. Sadly in New Zealand childhood exposure to maltreatment and relational trauma is extremely common and along with poverty can most often be found in the narratives of children diagnose[d] with mental health conditions. As a nation it is imperative that we increase our awareness and understanding of childhood trauma and its bio-psycho-social impact as a critical factor in determining child and family functioning and dysfunction. (NGO provider)

Paediatricians and other professionals working with children and young people described a ‘patch-up’ mentality in state-funded services, with pressure to record ‘outcomes’ in terms of case closures. In their view, complex health, developmental and familial challenges meant that engagement throughout a child’s early life course, from the womb to early adulthood, is necessary. People said a short-term fix mentality is inappropriate and harmful, and that what is required is an opportunity to resource a long-term, consistent engagement and create a trusting and respectful relationship between a child or young person, their family, and a therapeutic team. Continuity of care is important, but it can be disrupted by setting a rigid age limit that requires moving to an adult service.

We also heard about high levels of concern about the impact of poverty, student debt³¹ and deprivation on children and young people and about their regular exposure to alcohol and other drug abuse, violence (against themselves or between adults in the household), not having enough food and a warm home, and family turmoil (for example, frequent changes of address leading to disrupted schooling and opportunities for socialisation).

31 S Nissen. 2018. *Student Debt and Political Participation* (chapters 3–4). London: Palgrave.

Helping families is helping children, and helping children is helping the future of this beautiful country. (Service provider)

A strong theme from submissions was that prevention must engage more fully with life-course theory and that child-centred, early intervention service delivery is insufficiently embedded into current mental health and addiction services. The role trauma plays in mental health and addiction challenges and the need for adequate and appropriate responses were emphasised.

Submitters highlighted the toxic environment in which many children and young people live, affected by multigenerational trauma, family violence, poverty, abuse and neglect. Reversing this situation – intervening to prevent adverse childhood experiences among today’s infants, children and young people and supporting whānau to nurture them – was described as the best medium- to long-term investment in mental wellbeing.

Prevention! Prevention! Prevention! We need to focus on early childhood. Attachment. Parenting. Love. Pregnancy. A system that enables parents. (Provider and researcher)

Maternal mental health is a major public health issue, not just because of the adverse impact on the mother, but also because mental health issues have been shown to compromise the health, emotional, cognitive and physical development of the child with serious long-term consequences. (NGO provider)

2.8.1 Youth suicide in New Zealand – a national shame

Many people described the high rate of youth suicide in New Zealand as a national shame and said that the number one priority is to prevent so many young people from taking their own lives. We heard heart-breaking accounts from family and whānau who had undergone the trauma of losing loved ones to suicide, sometimes several members of the extended family. Many people expressed anger at the inadequacy of mental health services to act on early indications of suicidality and despair at the ongoing ripple effects of such traumatic loss on families, whānau and friends.

Workers reinforced the message that our current responses are inadequate. They said that despite the complexity of the causes of suicidality, we can do better to prevent suicide and support family and friends through the aftermath of suicide, when they are at increased risk themselves. People spoke about some impressive multi-agency teams working through schools and youth programmes and a growing number of peer-support organisations.

Students and teachers highlighted the importance of learning about mental health as part of the health curriculum in schools and of helping young children develop resilience and learn how to regulate their emotions.

2.8.2 Young people facing stress and anxiety

A survey of 1,000 young people and rangatahi (run by Action Station and Ara Taiohi as an input to the Inquiry) highlighted multiple sources of stress and anxiety for youth, including:

- economic insecurity
- unaffordable housing
- student debt
- insecure, low paid work
- body image
- oppression of various kinds (racism, sexism, homophobia, transphobia, ableism)
- concern about damage to the natural environment
- concern that they lack the life skills and knowledge to flourish in the 21st century
- loss of community and communal spaces.

These findings align with what we heard from tertiary students across Aotearoa. A 2018 report by the New Zealand Union of Students' Associations identified adjusting to tertiary study, feelings of loneliness and academic anxiety as major triggering factors of depression, stress and anxiety amongst students.³² We heard that students find it hard to access adequate support and face lengthy wait times to see a counsellor. They described needing to work too many hours to make ends meet and a lack of campus community, leaving many struggling with their mental health challenges alone and considering dropping out of tertiary study because they felt overwhelmed and unable to cope.

2.8.3 Young people in prison

Young people in prison said youth development approaches and access to therapy and counselling are essential. It is vital to their mental health, wellbeing and rehabilitation to have greater access to their family, whānau, cultural and spiritual support. Young people commented that the social determinants of health are often the root cause of their offending.

Not being able to afford to live led to my offending. (Young person in prison)

They also shared about the impact of the stigma of their offending, which can affect the success of their transition to the community and diminish their mental wellbeing.

We only hear negative things about ourselves in the media. There are positive parts of our lives. (Young person in prison)

32 NZUSA. 2018. *Kei Te Pai? Report on students' mental health*. Wellington: New Zealand Union of Students' Associations. www.students.org.nz/mentalhealth.

2.9 Support in the community

Recovery

Kindness unlimited
They left him alone
A council flat
Wasn't that lucky

Another success
Now independent
Part of the community
All his needs fulfilled

A narrow bed
A narrow table
A wooden chair
1 knife
1 fork
1 pot
1 pan

And they left him alone

Not totally of course

They visited
They checked he took his meds
They helped him set goals for recovery
But for 23 hours a day
He sat there
On the wooden chair
Or lay on his bed
And the room filled up.

Poem provided by family member of service user

People wanted support in the community, so they are enabled to stay connected and receive help for a variety of needs – crisis support and acute care, addiction recovery, long-term support, respite care, drop-in centres, social support, whānau wrap-around services and employment support.

Examples of 'step-down' and other community-based services such as drop-in centres were highly praised. We heard that for people using inpatient facilities, the lack of such services made discharge planning fraught and, when combined with a risk-averse approach, the result was scarce inpatient beds being occupied by people who were ready and willing to return home, but could not leave because the required package of services could not be assured.

Very few submissions called for a return to institutions of old. A handful cited positive experiences or the ‘safety’ of being cared for in such an institution. Some people advocated for ‘places of sanctuary or asylum’, which could offer respite or long-term accommodation to people who needed a stable home and some sense of community. Many people, particularly family members such as parents growing older and looking after adult children, called for an increase in supported living.

We were told that some current accommodation options in the community leave people isolated.

2.9.1 People want access to an expanded range of therapies

Many people expressed frustration at the lack of a holistic response from mental health services. They wanted a choice of therapies, including more counselling, rongoā Māori, talk therapies and online therapies, Pacific healing, spiritual healing and mind–body practices such as mindfulness, “rather than a reliance on pharmacology” (provider). People also wanted services that address broader health and social problems such as chronic pain, physical conditions, addictions, age-related disabilities, trauma, violence, relationship issues and nutrition.

2.9.2 Support to return to work

People told us that mental distress or psychiatric illness can compromise a person’s ability to continue full-time work, leaving them socially isolated and lacking a sense of purpose. Meaningful work was described as essential for healing, and long-term dependence on sickness benefits was seen as impeding recovery. Work of any kind – paid or voluntary – was said to give a sense of purpose, a reason to get out of bed in the morning.

We were told that mental health services rarely extend to assisting people to maintain work or return to work. We heard about employers and colleagues who facilitated a return to work, but also of the need for workplace education about mental health.

2.9.3 Shift resources from DHBs to NGO providers in the community

We heard calls to shift resources from DHBs to NGO providers, which are closer to the community and better equipped to provide the services and supports that people need. People saw DHB-provided services as institutional and bureaucratic, driven by rules that reflect the priorities of the organisation such as fixed budgets, deficits and competing health services rather than the priorities of individuals and families in need. Many feared that mental health services have a permanent Cinderella status among other DHB services and that addiction services are Cinderella’s poor cousin.

People saw NGOs as embedded in communities – more responsive and innovative, more likely to use peer-support workers and volunteers, more oriented towards achieving outcomes instead of ‘ticking boxes’. They voiced a perception that DHBs, with their dual funder–provider roles, will often favour their own DHB-provided services rather than those delivered by NGOs.

2.10 Access, wait times and quality

Many people spoke of difficulty accessing services. People described a system under stress characterised by long delays, overworked staff, inadequate environments, a lack of clear information and gatekeeping rules that served as barriers.

People have to fight and beg their way into services, and wait far too long. In the meantime everything gets worse and permanent damage is done ... Most people find it incredibly hard to reach out for help. So why are we forced to prove that we're worthy. (Service user)

We heard of services stretched to breaking point, a lack of timely, responsive and culturally appropriate access, few options and a lack of 24/7 services, disjointed care, and limited wellbeing and preventative interventions and initiatives.

For many submitters, the current system was not providing the help, care, oversight or holistic response required to meet the full range of mental health challenges from short-term distress to long-term mental illness. The result was a revolving-door scenario, a preventable escalation of personal distress and, tragically for bereaved submitters, the death of their loved one.

2.10.1 Fighting for access

A consistent theme in submissions was having to fight for access to mental health care due to high thresholds of acuity, limited and non-existent services, or complex care requirements beyond current service provision. We heard that some people presenting with a high risk of suicide were deemed ineligible for help and were unable to find timely, responsive service.

I was treated like I wasn't 'bad enough'. I wasn't properly admitted and because I didn't have scars from cutting or anything that could fix on the outside, they discharged me quite quickly. (Youth service user)

My father committed suicide in 2015. ... If my father, an educated, intelligent, creative, powerful man, could not get access to the help he needed – even when he was persistent and explicit in seeking it – what hope does this system have of helping those even more vulnerable than he? (Family of service user)

People recounted being told their situation was not serious enough to meet the threshold for specialist services, a message they interpreted as 'go away and only come back if your condition becomes life-threatening'. Having summoned the courage to ask for help, they felt ignored, minimised and not heard – denied an appropriate service or left in limbo awaiting space in a detox programme or respite care. People spoke of the cruelty of encouraging individuals, family and friends to seek help from mental health services that are unavailable or severely rationed.

The awareness campaigns, as necessary as they are, now make me angry. "It's okay to ask for help." That is a cruel and dishonest message to send to the public if you're not going to provide the resources to provide that help. (Family member of service user)

Even when the need for services was acknowledged, people often had to wait a long time. Tāngata whaiora and families reported a constant struggle to gain access to specialist services or to cobble together packages of assistance that were incomplete, inadequate or subject to change. Submitters spoke of deficiency: of beds, staff, specialist care, timely assessments, quick intervention, rehab services, kindness, culturally appropriate care, communication, an integrated care continuum, funding, referral options, and crisis response. In regional New Zealand, people experienced added burdens of distance, limited specialist care and maintaining privacy.

In rural New Zealand, people find it difficult to find the services that they need with any sense of anonymity. (Service provider)

We heard about general difficulties accessing detox, rehab, and other alcohol and other drug services due to long waitlists, a lack of culturally appropriate options and limited service locations. This was exacerbated by complexities of addiction and mental health challenges, fear of accessing services due to repercussions, and under-resourcing. People talked of being told to ‘keep using’ while they sat on waiting lists.

2.10.2 Limited options

Many people referred to over-medicalisation or, simply, medicalisation of mental health responses as inappropriate, inconsistent with holistic world views (particularly Te Ao Māori and Pacific world views), and dismissive of the broad array of social determinants of mental distress. These social determinants include trauma, inequity, early life conditions, discrimination, education, employment, housing, financial stress, violence, social isolation, and bullying. Pacific and Māori submissions spoke of the need for culturally embedded solutions for their communities, given the inequitable distribution of social determinants and high rate of mental health challenges. People also sought early life-course intervention solutions that placed children and their whānau and extended whānau at the centre.

There was strong discontent across submissions about the ease with which help-seeking was often met with only a prescription, instead of a breadth of accessible, community-based, timely, holistic options. People sought options and choice: more talk-based therapies, peer-led services, trauma-informed therapy, addiction services that are not wait-listed, early intervention services, maternal mental health services, Kaupapa Māori services, Pacific-led solutions, wrap-around services, and an emergency bed for the night.

I stated that [my son] was not safe overnight and that I had real concerns unless someone intervened. The hospital called the Crisis team ... they were busy and unavailable to come ... the doctor told us ... that [my son] should be given a zopiclone sleeping pill by the hospital and that we should drive him over to [town] first thing in the morning ... My daughter and I took this advice as having full weight and medical authority. So we accepted. I wish more than anything that we had refused ... While we were all still asleep, in the early hours of the morning, [my son] went to the garage and hung himself. So now we have no options ... This was a preventable death. (Bereaved family member)

Services for those bereaved by suicide were also seen as critical to suicide prevention. Bereaved whānau, family and friends called for effective and culturally relevant postvention supports as a priority, with access, options and consistency across New Zealand. They also called for culturally relevant and age-appropriate postvention support to decrease the trauma and long-term consequences of the loss of their loved one.

Some people reported the added difficulties (and limited options) when presenting with complex, chronic or multifaceted needs such as mental health challenges and eating disorders, addiction challenges, dementia, learning disabilities or neurodiversity. Families searching for help with their children were often frustrated by limited access, services and availability.

As treatment options in [New Zealand] are severely lacking I have had to take my child overseas to try to save her life. If we didn't have the money to do that I am sure my daughter would have died. That is terrible ...
(Family member of service user with anorexia)

For many, obtaining a diagnosis was complicated due to not 'fitting neatly' into a diagnostic category.

If you do not have an easy, clear or specific diagnosis it is hard to find experienced professionals willing to work within your difficulties.
(Service user)

Submitters reported limited options for discharge back into the community, follow-up times, waitlists for further treatment and variability within current community services. For many people, exiting the system (or being exited from the system) was as distressing as having to fight for access.

2.10.3 Gaps in services

We heard of a large gap in mental health and addiction services for people with mild to moderate and moderate to severe needs. We were told there were insufficient services GPs could refer patients to for help such as health education, social support, respite care and employment support. DHB staff described a lack of 'step-down' services to help people recovering from being acutely unwell to re-establish a stable and meaningful life in the community. This need for a continuum of support and services was a constant concern among tāngata whaiora, families, members of the public, clinicians and NGOs.

The lack of available services, especially talk therapies, was blamed for much of the perceived ineffectiveness and inefficiency of the current system such as an over-reliance on medication, the exhausting struggle to meet criteria for specialist services and the difficulties of discharge planning. We also heard repeated concerns about the challenges for people in rural areas or smaller centres trying to access specialist services such as detox centres, respite care or treatment for eating disorders. Although people acknowledged that such services could not be available everywhere, they were concerned that DHBs do not appear to collaborate well on a regional or national basis to provide consistent coverage.

2.10.4 Navigating the system is hard

People spoke of the frustration of a mental health ‘system’ that is really multiple systems with complex boundaries to be negotiated between:

- mental health services and addiction services
- primary health care and secondary services
- medical treatment and social support
- mental health services and physical health services
- mental health services and disability services.

People reported difficulties with boundaries between services even within the same DHB. They described negotiating the system as time-consuming and a cause of anxiety and uncertainty – a problem echoed by GPs and paediatricians. Submitters felt disempowered by unexplained delays, confusing and sometimes contradictory criteria to access services, difficulty in sustaining and adjusting packages of support over time, and uncertainty in moving between different levels of service and service providers.

**Our mental health and addiction services are literally all over the place. So many times I have been confused by which service to contact, which service I am currently even engaged with and so many times when being referred somewhere I have heard “I’m not sure why they referred you to us”.
(Service user)**

We heard calls for much wider provision of navigator services, such as Whānau Ora, to assist in connecting with multiple agencies.

**Whānau have voiced that they get confused with the amount of different people involved in their care and the number of cars up their driveway.
(NGO provider of Kaupapa Māori services)**

People noted the disconnect between mental health services and other sectors, such as housing, special education, Oranga Tamariki and corrections. They reported all sorts of practical difficulties, from scheduling appointments to reviewing medication to trying to coordinate with attempts to hold down a job. For prisoners with mental health and addiction challenges and their families, reintegration back into the community was described as an area of enormous stress and uncertainty.

2.10.5 Inconsistent, fragmented services and variable quality

People described how moving between regions or between different service-providers often leads to ‘falling between the cracks’ as the 20 DHBs apply different criteria and have different models of care. They asked for continuity and consistency of provision across DHB boundaries and for much greater care in planning and resourcing the transition between DHB and NGO services. Due to funding models, workforce and privacy limitations, and disconnected communications, services at many levels were unable to provide an integrated, continuum of care for many service users.

The amount of time ... patience that is asked of parents in order to get through the mess of people to deal with is astounding ... If all these agencies that are supposed to work together actually get to know what they are doing better and REALLY do work together, share their notes and cases with each other in one system, and ideally are all under the same umbrella or roof, things would be a lot less complicated and hopefully speed support up ...
(Family member of service user)

NGO providers attributed the problem in part to a contracting system that forced them to compete rather than collaborate. In their view, this discouraged collaboration in areas where it is particularly important such as discharge planning, suicide prevention and wellbeing promotion.

Submissions highlighted the interplay between positive mental health outcomes and broader sector-level integration across employment, income support, housing, justice, and education. Integration of physical, social and spiritual health was integral to healing for many submitters; so too was a sense of belonging to their culture and community. Having cultural agency was critical to both Māori and Pacific submitters. A high number of submissions addressing addiction also called for a cross-sectoral approach. People said that when they eventually got help, the quality of care and support was often variable, choices were limited and services did not meet their needs. We were told that there are no clear national service standards, and that some people felt brushed off by staff too stressed and overworked to truly listen to them.

Psychiatrist number four was time pressured and we didn't click and he couldn't quite figure me out, so he sectioned me. Because if you're time pressured it's 'safer' to section someone with chronic suicidality than to actually spend some time getting a better handle on their situation.
(Service user)

A particular source of irritation was the lack of consistent record-keeping and information-sharing and having to repeat basic personal and clinical details to a series of providers, even within the same organisation.

My experience of visiting multiple service providers ... Having to relate the same painful story over and over; being asked slight variations of the same question multiple times is humiliating and unhelpful. (Service user)

2.10.6 Shabby and depressing facilities

Frequent complaints were made about inadequate environments, reflecting the 'poor cousin' status of mental health and addiction within DHBs. A particular concern was the state of seclusion rooms, but people also described depressing inpatient facilities that were not fit for purpose and were poorly maintained, which hindered rather than helped recovery. People also expressed concern that, due to a lack of resources, community facilities are often shabby and unhealthy, with insecure tenure.

There were particular concerns over the use of police and prison remand cells to house people with severe depression, psychosis or withdrawal symptoms. They were described as entirely inappropriate for people in distress and not places of healing.

For someone unwell in crisis a police cell shouldn't become a second-rate surrogate replacement for a hospital bed. (Family member)

2.10.7 Physical health problems are overlooked

Many people cited the fact that tāngata whaiora have much higher rates of a variety of conditions such as diabetes, cardiovascular disease, cancer and oral health problems and die prematurely. It was noted that the health system pays insufficient attention to the physical health of people presenting with mental health problems. People also raised ethical concerns about the use and management of anti-psychotic and anti-depressive medications with serious side-effects such as weight gain and the risk of premature death.

People asked for a concerted effort to monitor the physical health of people with mental health and addiction issues, so that their treatment enables them to be 'equally well'. They cited the need to address factors such as sedentary institutional lifestyles, poor nutrition, smoking and lack of regular exercise and to ensure regular health checks or screening for cancers.

Physical health is a massive thing for me; eating healthy has doubled the way I've felt. Nearly no medication but eating and exercising well. I had trouble sleeping so [respite service has] a sleep clinic. ... All about your wellbeing and holistic health. (Service user)

2.11 Workforce

We heard from mental health and addiction workers who love their jobs and are committed to helping people recover, even to the point of jeopardising their own health and wellbeing. They talked about overwork and burnout and the increasing risk of assaults.

We are under-staffed, burning out, told to just get on with it and suck it up. No breaks are allowed on an afternoon shift as they pay us for this time. Abuse towards staff is on the rise ... We are always over 100% capacity. We are asked to do double shifts every day, we feel under-valued and paid. (Staff voice)

There have been many times when my stress levels are so high I have been unable to think clearly and make decisions. I feel my clients have not had the optimum care from me as I fumble through the paperwork and the liaising between other health professionals who are often themselves pushed for time. I run out of time to see my young people which is the whole reason I do this job. (Staff voice)

We also heard of the need to attract more people to work in mental health and addiction services – and to retain current staff.

All the dreams of the Inquiry will come to naught if we don't have a workforce. (Staff voice)

Workers described a lack of career planning, limited training and limited professional development. We heard about a short-term focus on immediate staffing needs, the lack of a clear 'pipeline' of new skilled staff and inadequate facilities.

Mental health always feels like bottom of the hierarchy – we don't get amazing facilities like Elective Surgery – or state of the art teaching facilities, we get shoved into little offices with little resources – not enough cars, not enough space, not enough treatment rooms, poor technology and systems. Eventually this depletion, transcends down, our practitioners feel it – our clients feel it. (Staff voice)

We were told that a markedly different workforce is needed, with more peer-support workers, community-based workers, and Māori and Pacific support services.

2.11.1 More peer-support workers

Numerous submissions praised services led by people with lived experience of mental distress, psychiatric illness or addiction. We heard that peer-support workers give people a sense of hope that inspires and sustains the healing process and provides a counterbalance to the medical focus of clinical services.

However, peer-support workers described being undervalued, poorly paid and provided with limited training and career options. We heard that, despite some good examples, mainstream services have not fully embraced the concept of incorporating peer-support workers into all aspects of service provision, including design and planning. People wanted peer support to be acknowledged as a basic component of services and to receive better funding.

People who have gone through this journey understand the feelings, pitfalls, distorted thinking and challenges that addiction brings. (NGO provider)

My [family member] attends a support group run by people with mental health for people with mental health and this for him is one of the most important therapies that he attends. (Family member)

2.11.2 Cultural competence and cultural workforce

People were concerned at the lack of cultural competence among workers. They said mainstream health services (especially hospital services) can be alienating and culturally unsafe environments for Māori, Pacific peoples, ethnic minorities, Rainbow communities and the Deaf community. We heard calls for more staff who work entirely within a Kaupapa Māori or Pacific framework.

Professionals should also be aware that when they meet with a client, even one they might not immediately recognise as Māori, the person standing before them may be struggling with their cultural identity; asking about identity and making space for it as an area that clients might want to develop could help with building relationships and their recovery.

The potential healing that can happen as a result of being acknowledged as Māori could be an important factor in recovery, as well as in building a relationship with mental health services. (Researcher)

Having a staff member from one's own culture was described as crucial to feeling safe and building the trust needed to recover from distress and anxiety. Māori and Pacific staff spoke of regularly working double shifts so Māori and Pacific tāngata whaiora had someone from their culture available to provide help and assurance. The Deaf community submitted strongly about Deaf culture and the need for services to meet their needs.

We also believe it is essential to give Deaf people training and learning opportunities to be involved in this sector; to work alongside current professionals, in order to not only up-skill but also to ensure that the necessary Deaf cultural accommodations are being provided. The power of having trained Deaf people providing access to another Deaf person cannot be underestimated. (Group New Zealand Sign Language submission)

2.11.3 Understanding of mental health and addiction in other sectors

Some submissions noted that other workers in other sectors need to become competent in recognising and responding to mental distress and addiction in their workplace. Examples cited included teachers, prison staff, police and social workers. We heard that these staff and managers also need practical understanding of issues such as trauma and depression.

Several submitters, including some GPs, said that medical and general practice training in mental health is limited to a theoretical understanding of conventional diagnoses and psychopharmacology. They called for improvements in mainstream primary health care and medical education.

2.12 Human rights and mental health

We heard widespread criticism of laws that allow people to be denied their human rights after being diagnosed with a psychiatric condition. Compulsory treatment, seclusion and restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) was described as a breach of fundamental human rights, in contravention of New Zealand's obligations as a signatory to the United Nations Convention on the Rights of Persons with Disabilities and the Declaration on the Rights of Indigenous Peoples. People argued that the Mental Health Act embeds archaic and risk-averse attitudes that cause clinicians to opt too readily for coercion and control when other options are available. Many people saw forced treatment as inhumane, undermining self-determination and causing significant trauma.

People welcomed the Health Quality and Safety Commission's initiative to end seclusion by 2020 and expressed frustration that it is taking so long for all DHBs to implement practices that make seclusion unnecessary. Many submitters pointed to the persistently higher rates of compulsion and seclusion for Māori and Pacific peoples, saying that the legislation legitimises unconscious bias and institutional racism.

Removing freedom and forcing people against their will is distressing, disempowering, creates further trauma and is antithetical to a recovery approach. Forced treatment clearly breaches basic human rights. (Consumer advocate)

People asked for legislative reform that would guarantee human rights, minimise the use of compulsion and seclusion in inpatient units, and require an approach to mental health and addiction that lifts the spirit and restores dignity.

2.12.1 Laws and stigma are barriers

We heard that people facing mental health or addiction challenges are often reluctant to seek help for fear of encountering negative attitudes from health practitioners and being subject to restraint, seclusion, the removal of their children, separation from family, loss of employment and suspension of their human rights. We were told that often the result is a worsening of their condition until they eventually enter the system under a compulsory treatment order or enter the criminal justice system.

Whānau are fearful of our Ministries. Fearful of mental health. Fearful of Oranga Tamariki taking their children. Fearful of Police who take away their Dads. Whānau are on the back foot before anything that happened, just because they are Māori. (Kaimahi Māori)

We also heard that the legacy of shame and stigma that has surrounded mental health remains a barrier to seeking help. People agreed that awareness and understanding of mental health challenges has improved in recent years, thanks to promotional campaigns and the actions of thought leaders in many sectors, including sport, business and the arts. But they said shame and stigma continue to shape attitudes and are embedded in our laws and the way services are structured and delivered.

2.13 Leadership and oversight

A common perception existed of a lack of clear leadership and national directions in mental health and addiction. People pointed to the much-reduced role of the Mental Health Commissioner and were critical of the lack of leadership from the Ministry of Health and the uncoordinated and varying approaches of the DHBs. People talked about what can be achieved when mental health and addiction is a priority area for government and there is clear leadership and direction from a mental health commission with a powerful statutory mandate.

Submitters asked why we don't have a current national mental health and addiction strategy or a national suicide prevention strategy,³³ why the mental health workforce doesn't receive the same planning and attention as other parts of the health sector, why Kaupapa Māori and Pacific services continue to be under-resourced and why there is no clear direction to fund the sort of community support people are crying out for.

33 The draft national suicide prevention strategy prepared in 2017 has not been progressed.

Across the spectrum of promotion or prevention, early intervention, primary care, specialist services and addiction services, people were concerned that a lack of direction and leadership means positive change is not sustained and good ideas are not implemented beyond the pilot stage. They also spoke of a lack of leadership and coordination in government services outside the health system, such as in the housing, police and corrections sectors, which clearly impact on mental health and addiction.

Some organisations and thought leaders expressed support for a single national entity charged with guiding and implementing mental health policy, able to commission services at a regional or local level. There was support for a dedicated national Māori health agency and expansion of regional commissioning of the Whānau Ora model. But there was also concern that a separate Māori health agency would lead to fragmentation and marginalisation.

It was also commonly argued that DHBs are too invested in a healthcare model and that funding decisions should be made by a body with a broader, wellbeing focus. However, some worried that a separate mental health agency might suffer from a 'poor cousin' status and lack the levers and authority to influence the wider group of departments whose work impacts on wellbeing. More than simply structural change, people wanted to see effective leadership at national, regional and local levels across the variety of departments and services. There was specific concern that Māori leadership within the health sector has been eroded.

2.13.1 Local leadership and innovation

We heard about inspiring services set up by communities with seed funding and support from local authorities and charities and only occasionally with input from DHBs or primary health organisations. People described innovative local initiatives that highlighted the value of non-clinical and peer-support services. We saw and heard about many examples of grass-roots leadership by people with lived experience of mental health and addiction challenges.

Suicide-bereaved families and whānau, families of young people with eating disorders, and other groups described setting up charitable organisations and informal networks to support each other, fill a gap in service provision and reach out to the community.

I have been impressed by the amount of support that is provided by online communities, in particular the Life Matters Suicide Prevention Trust, the Suicide Bereaved Network and Suicide Awareness/Prevention. These online communities offer practical support and suggestions, and also a much needed shoulder to cry on. They are currently filling the void that exists for families, in the aftermath of a death by suicide, where there appears to be very little official postvention support. (Bereaved family member)

Submitters called for greater acknowledgment of grass-roots innovations and argued that a system focused on wellbeing should invest in these initiatives and support them to be evaluated and, potentially, replicated in other communities.



“We are happy to fix ourselves, we just need opportunity.”

Chapter 3

What we think

3.1 Introduction

This chapter builds on what we heard through the inquiry engagement process. Early on in the Inquiry, we consulted Judge Ken Mason who chaired the last major mental health inquiry (in 1995–1996). “Listen to the people”, he said. “They will tell you what to do.” It was sage advice.

Our thinking is informed by the wealth of submissions we received, and by a stocktake of evidence and information from a variety of government and non-government agencies, as well as previous investigations, reviews and reports. In some areas, we commissioned supplementary data analysis.

We did not investigate the details of funding, service delivery or contracting arrangements. Instead, we deliberately focused on the underlying problems and the strategies needed to fix them – as well as identifying what’s working well and can be built on. We are confident in our findings, which reflect the clear messages we heard and read.

3.2 Our conclusions

3.2.1 We can do more to help each other

New Zealand is experiencing a rising tide of mental distress and addiction. Our experience is mirrored in other countries, including Australia, Canada, England and the United States.³⁴ The fact we are not alone in this is hardly reassuring, but it suggests some of the shared problems reflect common features of life in contemporary Western countries:³⁵

If our treatments work shouldn’t we have fewer people presenting in crisis, [fewer] people on a disability benefit due to mental illness, a reduction in community measures of psychological distress and a decrease in the suicide rate? ...

... despite access to costly biomedical treatment, something central to recovery appears to be missing in the social fabric of developed countries.

The cost of poor mental wellbeing and addiction is high. It is a high cost to individuals, families and whānau, businesses and organisations, communities, government and the country as a whole.

Clear links exist between social deprivation, trauma, exclusion and increasing levels of mental distress. Our wellbeing is being further undermined by aspects of modern life, such as loss of community, isolation and loneliness.

34 AF Jorm, SB Patten, TS Brugha and R Mojtabai. 2017. Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry* 16(1): 90–99. DOI: 10.1002/wps.20388.

35 R Mulder, J Rucklidge and S Wilkinson. 2017. Why has increased provision of psychiatric treatment not reduced the prevalence of mental disorder? *Australian and New Zealand Journal of Psychiatry* 51(12): 1,176–1,177. DOI: 10.1177/0004867417727356.

Part of the answer must lie in addressing inequity in our society – income inequality, child poverty, homelessness, unemployment, family violence and abuse. Māori disadvantage on all those measures is incompatible with the promises in the Treaty of Waitangi. Government has a crucial role to play in fixing these long-term, widely acknowledged problems. We highlight areas for action later in this report (see Part 2, chapters 4–12). Similarly, in the face of enormous harm to our communities from alcohol and other drug abuse, we need to act on international evidence and our own experience of previous epidemics (notably HIV in the 1980s) and respond with effective public health and legislative interventions.

However, New Zealand’s mental health and alcohol and other drug problems cannot be fixed by government alone, nor solely by the health system. Many of the solutions lie with families, whānau and communities and with social services. Some of the answers lie in new ways of thinking about the problems besetting us.

The epidemic of mental distress and addiction is affecting all layers of our society. When heart disease was very high 30 or 40 years ago, we didn’t bring in more heart surgeons, we changed our lifestyles – and significantly reduced the prevalence of cardiovascular problems. We think we’re at that point with mental health and addictions in New Zealand.

We agree with the view that we can’t medicate or treat our way out of the current crisis.³⁶ We need to ensure practical help and support in the community are available when people need it, and government has a key role to play here. But some solutions lie in our own hands. We can do more to help each other.

The pressures of modern life are clearly impacting on people’s mental health and contributing to unhealthy behaviour and addictions. Social media is an important connector of people, but children and parents are spending hours on their devices, isolated from their immediate surroundings and from the outdoors.³⁷ We know there is increasing evidence of the importance of strong early bonding for growing a healthy brain and talking to babies and young people is critical to this. While scientists investigate whether excessive device use may be affecting brain development and sleep patterns, we think it would be sensible to encourage some time out from social media and devices – as well as taking steps to keep people safe from bullying and limit exposure to violent and pornographic material.

Although lots of vibrant community hubs exist throughout New Zealand – around schools, sports clubs, arts centres, marae and churches – many people are isolated from their neighbours and local communities. We have much to learn from cultures that value collectivism and emphasise family, spirituality and connection to each other and the natural environment.

We also need to rethink our approach to urban growth in response to population pressures. Our planning and development processes should enable community and connections, with provision for communal facilities and parks, and access to public transport in new housing developments.

36 Analysis of prescribing data for New Zealand adults for 2008–2015 shows that antidepressant prescribing rates continue to increase in New Zealand. The authors note, “Simply giving more people more antidepressants does not seem to be working”: S Wilkinson and R Mulder. 2018. Antidepressant prescribing in New Zealand between 2008 and 2015. *New Zealand Medical Journal* 131(1485).

37 The OECD found that tamariki and rangatahi use of the internet increased outside of school in Aotearoa from just under 100 minutes per day in 2012 to just over 150 minutes in 2015. OECD. 2018. *Children and Young People’s Mental Health in the Digital Age: Shaping the future*. Paris: OECD. www.oecd.org/health/health-systems/Children-and-Young-People-Mental-Health-in-the-Digital-Age.pdf.

We observe that consumerism and strongly materialistic and competitive values do not lead to improved mental health. Many people are buying more, but according to surveys we're less happy. Young children and elderly people remind us of the old truth that the simple things in life give the greatest pleasure.

We also think modern society places too much emphasis on the unrealistic idea that we can constantly be happy. We need to remind ourselves that life consists of peaks and valleys. Many people who experience deep lows or serious mental illness report that the slow process of healing their heart and spirit brought them great strength and enriched their life.³⁸

Everyone agrees that we should pay more attention to the wellbeing of our children. Some children experience great inequity through poverty, neglect, parental alcohol and other drug use and addiction, and parental mental distress. The wellbeing of these children is especially at risk. But parents and teachers report that all children and young people need to learn skills in regulating emotions, mindfulness, and coping with adversity – to be resilient.

Wellbeing has been a theme during this Inquiry and in national conversation in recent years. It can be especially hard for people who are struggling with poverty, abuse and deprivation or dealing with mental health and addiction challenges to take steps to become well – yet, every day, people recover from distress, overcome addictions and find strength in their lives. The people we heard from talked about the simple but powerful things they did to climb out of a dark hole.

Sleep, nutrition, exercise and time outdoors are important for recovery. So too is regaining one's cultural identity and participating in cultural activities. Many people begin to regain their own wellbeing by helping others:³⁹

The best way to increase our own wellbeing is to have more concern for the wellbeing of others. There's a saying I try to take on board – don't think less of yourself, just think of yourself less.

Work, including voluntary and part-time work, is vital to recovery – a reason to get out of bed in the morning. Healing can come from helping others facing similar challenges, and the social connections provided by work can form a natural bridge to fuller employment and moving off income support. During 2018, an OECD team undertook a review of how New Zealand addresses mental health and work policy challenges. Many of the challenges the OECD team has identified in its draft report, provided to us as we finalised our own report, are similar to those expressed by people we heard from.⁴⁰

Our views above do not detract from the importance of continuing to respond to the needs of people with more severe distress and prolonged episodes of mental illness. The special duty of care owed to this group was the focus of the Mason Inquiry, and the Government's response to that Inquiry, in the late 1990s, has given New Zealand a solid foundation to build on.

38 M O'Hagan. 2014. *Madness Made Me: A memoir*. OpenBox.

39 D Chisholm. 2014. The survivor gene. *North & South* (January): 32–39, p 38, quoting Hugh Norriss.

40 OECD. 2018. *Mental Health and Work: New Zealand*. Paris: OECD Publishing.

3.2.2 We have a solid foundation to build on

On the back of the closure of large institutions and the changes driven by the Mason Inquiry, the 1990s and early 2000s were times of excitement and energy within the mental health and addiction sector. The Blueprint developed by the Mental Health Commission, with extensive engagement from the sector, provided a clear pathway forward. New models and relationships emerged, often on the back of new investment and expanded innovative programmes, services and supports including Kaupapa Māori services. This was supported by a clear and explicit incremental funding pathway, 'the Blueprint funding'.

That surge of development created a sound base we can build from. We consider New Zealand's mental health and addiction system has valuable strengths, including:

- the availability of publicly funded services and support for those with the highest needs, including a significant network of experienced non-governmental organisations (NGOs) providing services and supports in the community
- a comprehensive range of services that support people within a forensic environment
- some services delivered in ways that meet the needs of particular groups, often in ways unique to Aotearoa, such as tikanga and Kaupapa Māori services and services designed around the needs and preferences of Pacific peoples, as well as approaches and models for other high-need groups such as young people
- a history of successful promotion, prevention and anti-stigma initiatives and strong advocacy
- laws and processes to promote quality improvement, human rights and consumers' rights
- an enviable infrastructure of mental health and addiction workforce development centres
- a small, but valued, peer workforce
- a wider workforce providing support in community settings
- a rapidly growing Māori health workforce within health-related professions and community agencies
- some primary and community support for people with mild to moderate needs
- pockets of innovation, the most promising of which are often designed and delivered by people wanting to change the way things are done, including people with lived experience and people focused on, and based in, communities
- an extensive data and evidence base.

We also identified another vital strength within our system and society: a shared, widespread and strong desire to change our way of thinking about, and our collective approach to dealing with, mental health and addiction. Many people want to apply a wider perspective to prevention, and to respond more effectively and comprehensively when people experience mental health and addiction challenges.

3.2.3 But the system is under pressure

Some people told us that the mental health and addiction system had been responsive to their needs. This is backed up by data that shows:

- most adults have relatively timely access to specialist services
- higher needs groups tend to be higher users of specialist services
- most people's wellbeing improves when they are using services⁴¹
- most people are satisfied with the services they receive.⁴²

However, our existing approach to mental health and addiction challenges is under considerable pressure. Markers of this are:

- continually escalating demand for specialist services, across all age groups, especially in infant, child and adolescent services
- specialist services operating at capacity, applying restrictive criteria and being able to accept only the most distressed or unwell people
- limited or unavailable advice or support at times of crisis
- lack of forensic services to meet the needs of a growing number of prisoners with serious mental illness
- waiting times for young people (0–19 years) that are longer than for all other age groups and do not meet government targets or community expectations
- persistently high numbers of people presenting with suicidal thoughts and behaviours
- health and social service providers reporting increasingly complex individual and family situations
- New Zealand's extremely high rates of compulsion, including community treatment orders and seclusion, compared with rates in other countries
- limited access to funded mental health and addiction services for those with mild to moderate and moderate to severe needs
- increasing numbers of complaints about access.

41 Ministry of Health. 2017. *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health. www.health.govt.nz/publication/office-director-mental-health-annual-report-2016; HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018; S Gibb and R Cunningham. 2018. *Mental Health and Addiction in Aotearoa New Zealand: Recent trends in service use, unmet need, and information gaps*. Wellington: University of Otago.

42 Ministry of Health. 2017. *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health. www.health.govt.nz/publication/office-director-mental-health-annual-report-2016.

International data shows that in countries comparable to New Zealand, 35% to 50% of people with a mental illness receive no treatment.⁴³ Comprehensive and robust information to identify unmet need in New Zealand is lacking, but it is clear that many people are struggling to get access to appropriate, or even any, support, other than medication. Moreover, for many people, taking mental health problems to a general practitioner is not seen to be an appropriate or affordable response.

It is also clear that workers are often stressed and unable to work in the way that they want to and that would most benefit their clients. Recruiting staff to mental health and addiction roles and retaining existing staff are major problems. Workforce shortages, working conditions, increasing assaults on staff in inpatient units, negative perceptions about mental health, and a risk-averse culture are all contributing to a workforce crisis. These problems are putting pressure on existing staff. We are not preparing adequately for the workforce needed now and into the future.

Cumulative pressures are building at the intensive end of the system, where most services are located. Overall, the system is under severe pressure and is unsustainable in its current form.

3.2.4 We're not getting the outcomes we want for our people

Despite our current level of investment in mental health and addiction services, we don't appear to be achieving good outcomes, and the outcomes for specific populations are poor. The results highlight the complexity of the relationships between socioeconomic factors, housing, social exclusion, and mental wellbeing and addiction.

The poor outcomes for particular population groups (for example, Māori, Pacific peoples and Rainbow communities), the inequities in physical health of people with more serious mental health challenges, and our persistently high suicide rates are of particular concern. Mental health problems in schools and for children in state care, and the connections between employment, income and mental health, are also highlighted in the next sections.

Māori

Māori experience significantly higher rates of mental illness, higher rates of suicide and greater prevalence of addictions.

While the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are 30% more likely than other ethnic groups to have their mental illness undiagnosed.⁴⁴ The outcomes for Māori who access mental health services are poorer across a variety of measures and diagnoses.⁴⁵

43 World Health Organization. 2011. *Global Burden of Mental Disorders and the Need for a Comprehensive, Coordinated Response from Health and Social Sectors at the Country Level* (EB130/9). Geneva: World Health Organization. http://apps.who.int/gb/ebwha/pdf_files/eb130/b130_9-en.pdf.

44 Based on results from the New Zealand Health Survey between 2006/07 and 2016/17, cited in R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

45 Based on results from the New Zealand Health Survey between 2006/07 and 2016/17, cited in R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

In primary care, there is evidence that Māori present more often with mental health problems but their problems are underdiagnosed. In secondary care, Māori are more likely to be admitted to hospital, to be readmitted after discharge, to be secluded during admission, and to be compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and in forensic services.⁴⁶

Pacific peoples

Pacific peoples (including Samoan, Cook Islands Māori, Tongan, Niuean, Fijian, Tokelauan, Tuvaluan and a small number of other Pacific groups) make up 7% of the New Zealand population. A consistent pattern of high mental health need and low service use has persisted for Pacific peoples over time. While Pacific peoples are more likely to experience mental distress than the total population, they are much less likely to have received treatment.⁴⁷

Overall, Pacific peoples' suicide rates are lower than Māori and non-Māori rates, but suicide rates among Pacific youth (particularly young men) are high. Alcohol abuse and problem gambling are also significant challenges in Pacific communities, but the rates of addiction behaviours among Pacific youth appear to have reduced over time.⁴⁸

Refugees and migrants

Refugees and migrants form a significant and growing proportion of New Zealand's population and come from diverse backgrounds. According to the 2013 New Zealand Census of Population and Dwellings, the number of people living in New Zealand who were born overseas accounted for more than 1 million people, a quarter of the population.⁴⁹

Both refugees and migrants from different ethnicities report challenges accessing mental health and addiction services. In the case of refugees, many will have experienced trauma before coming to New Zealand to live, are more likely to be isolated from their family and their community, have experienced significant loss and grief, and may have pre-existing mental health and addiction challenges that require help. Barriers to access, over and above those that may be experienced by the general population, include language barriers, a lack of access to qualified interpreters, poverty, a lack of knowledge about entitlements and the healthcare system, and cultural beliefs about mental health that influence whether people seek help.⁵⁰

46 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

47 MA Oakley Browne, JE Wells and KM Scott (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health. www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey. Only 25% of Pacific people with severe mental health or addiction needs had received treatment from mental health services compared with 58% of the total population.

48 Based on results from the Youth Health Surveys between 2001 and 2012, cited in R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

49 Statistics New Zealand. 2014. 2013 Census QuickStats about culture and identity. <http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/ethnic-groups-NZ.aspx> (accessed 25 October 2018).

50 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

Rainbow communities

Rainbow communities are estimated to account for 6% to 15% of the total New Zealand population. A strong body of evidence shows that Rainbow communities have significantly poorer mental health and are at a much higher risk of distress, addiction and suicide. Poor mental wellbeing and substance use among Rainbow communities are often attributed to the cumulative effects of discrimination, bullying, prejudice and exclusion. Very limited access to gender reassignment services also has a negative effect on the mental health and wellbeing of people seeking to access them. Population-level data on the mental health of Rainbow communities in New Zealand, except for youth, is lacking. The Youth 2012 survey found that, compared with heterosexual youth, Rainbow youth were more than twice as likely to have deliberately self-harmed, and nearly one in five had attempted suicide during the previous year.⁵¹ Despite these high risks, few services specifically support the mental health of Rainbow communities. Many of the services available are in the NGO sector and are provided by minimally funded or volunteer organisations.⁵²

Rural communities

While the prevalence of mental health conditions is similar in urban and rural settings, people in rural settings are less likely to access mental health care.⁵³ In addition, while numbers are relatively small, data suggests that suicide rates are slightly higher for people in rural areas than in urban areas.⁵⁴ Young farm labourers are at highest risk of suicide among the rural population, with isolation, alcohol use and availability of firearms considered to be contributing factors.⁵⁵

Sparsely populated regions present challenges geographically as people may have to travel long distances to receive or deliver mental health and addiction services. Slow or no internet connection, limited cell phone coverage and poor roads can also make it difficult to access services and support. Recruiting staff to work in rural areas is also challenging. Often only crisis services are provided, with limited opportunity to undertake preventative work.

Disabled people

‘Disability’ is an umbrella term for a range of impairments. One-quarter of the New Zealand population reported a disability in the 2013 census. Disability is more common at older ages, with 59% of people aged over 65 reporting a disability, and more common among Māori and Pacific peoples.⁵⁶ The prevalence of different types of disabilities differs among the population. For example, autism spectrum disorder, which describes a range of conditions that includes autism and Asperger syndrome, is thought to affect one in 100 New Zealanders. For children, a learning difficulty is the most common type of impairment.

51 MFG Lucassen, TC Clark, E Moselen, EM Robinson and The Adolescent Health Research Group. 2014. *Youth’12 The Health and Wellbeing of Secondary School Students in New Zealand: Results for young people attracted to the same sex or both sexes*. University of Auckland. <http://oro.open.ac.uk/43995/>.

52 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

53 S Gibb and R Cunningham. 2018. *Mental Health and Addiction in Aotearoa New Zealand: Recent trends in service use, unmet need, and information gaps*. Wellington: University of Otago.

54 S Gibb and R Cunningham. 2018. *Mental Health and Addiction in Aotearoa New Zealand: Recent trends in service use, unmet need, and information gaps*. Wellington: University of Otago.

55 A Beautrais. 2018. Farm-related suicides in New Zealand, 2007–2015: A review of coroners’ records. *Australian and New Zealand Journal of Psychiatry* 52(1): 78–86.

56 Office for Disability Issues. No date. Key facts about disability in New Zealand (web page). www.odi.govt.nz/home/about-disability/key-facts-about-disability-in-new-zealand/ (accessed 23 October 2018).

The boundary between mental health and disability can be blurred, and mental health challenges can be both causes and consequences of disability. There is also some evidence of diagnostic overshadowing, whereby symptoms are attributed to a person's disability rather than to mental health needs (particularly for those with learning disabilities or autism spectrum disorders).⁵⁷ According to the 2013 Disability Survey, an estimated 242,000 people (or 5% of New Zealanders) are living with a disability caused by psychological and/or psychiatric conditions.⁵⁸ However, information is very limited about the mental health and wellbeing of disabled people, and disability support services and mental health and addiction services have remained relatively siloed.⁵⁹

Veterans

No information is routinely collected about the mental health of New Zealand veterans. However, the incidence of mental health issues and substance misuse among New Zealand veterans appears to be high. Nearly 36% of impairment compensation claims made by veterans since the Vietnam War have been for mental health and addiction challenges. Australian data suggests veterans are significantly more likely to experience post-traumatic stress disorder and affective disorder (especially depression) than the wider population.⁶⁰

The nature of contemporary conflict has shown a shift away from the post-traumatic stress injuries of earlier conventional conflicts to adjustment disorders and moral injuries.⁶¹ Many veterans with mental health and addiction needs require specialised care over an extended period, which is frequently not available in New Zealand.

Prisoners

New Zealand's prison population has increased markedly over the past 30 years. In 2016, the prison population exceeded 10,000 for the first time, and it has continued to grow.⁶²

The vast majority of prisoners experience significant challenges related to mental health and addiction, often in combination, and at rates much higher than in the general population. A study published in 2016 found that 91% of prisoners had a lifetime diagnosis of a mental health or substance use disorder and 62% had this diagnosis in the past 12 months.⁶³ As the Office of the Ombudsman has noted, prisoners (and people detained in other settings) often lack appropriate mental health support.⁶⁴

57 Ministry of Health. 2013. *Innovative Methods of Providing Health Services for People with Intellectual Disability: A review of the literature*. Wellington: Ministry of Health. www.health.govt.nz/publication/providing-health-services-people-intellectual-disability-new-zealand-literature-review-and-case.

58 Based on results from the 2013 Disability Survey, cited in R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

59 J Cumming. 2011. Integrated care in New Zealand. *International Journal of Integrated Care* 11(special 10th anniversary edition), e138. www.ncbi.nlm.nih.gov/pmc/articles/PMC3226018/.

60 AC McFarlane, SE Hodson, M Van Hooff and C Davies. 2011. *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study*. Canberra: Department of Defence. www.defence.gov.au/Health/DMH/Docs/MHPWSReport-FullReport.pdf.

61 'Moral injury' refers to an injury to an individual's moral conscience resulting from an act of perceived moral transgression that produces profound emotional shame – for example, witnessing an act in combat or peace-keeping that transgresses beliefs about what is right or wrong.

62 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

63 D Indig, C Gear and K Wilhelm. 2016. *Comorbid Substance Use Disorders and Mental Health Disorders among New Zealand Prisoners*. Wellington: Department of Corrections. www.corrections.govt.nz/resources/research_and_statistics/comorbid_substance_use_disorders_and_mental_health_disorders_among_new_zealand_prisoners.html.

64 Office of the Ombudsman. 2018. *Ombudsman Quarterly Review* (Issue 24). Wellington: Office of the Ombudsman. www.ombudsman.parliament.nz/ckeditor_assets/attachments/668/OQR_-_Sep18_-_Published.pdf.

Experiences of abuse and trauma can also contribute to an increased risk of mental distress and substance use. An overwhelming majority of prisoners have been victims of violence, with almost half of those in prison reporting experiences of family violence as a child, and 53% of women and 15% of men reporting experiences of sexual abuse.⁶⁵

Young people

New Zealand young people are more likely than older people to report symptoms of depression, anxiety and psychological distress, and New Zealand has one of the highest rates of adolescent suicide in the OECD.⁶⁶ The Youth2000 survey series has identified that suicidal ideation and attempts, self-harm and bullying are common experiences for secondary school students.⁶⁷ The Youth Wellbeing Survey estimates that up to half of young research participants (16- to 18-year-olds) have deliberately hurt themselves at least once.⁶⁸

While a range of targeted mental health services is available for young people, barriers to access include internal factors, such as privacy concerns, lack of knowledge about where to go and concerns about the attitudes of clinicians, and external factors, such as the cost and geographical location of services. Some groups are particularly at risk (including Māori, Pacific, and Rainbow young people and disabled young people) but are not seeking help or accessing services at the same rates as their peers. There are also reports of young people being inappropriately treated in adult services due to access problems.⁶⁹

Older people

Older people (65 years and over) are an important and growing segment of the New Zealand population. It is expected that by 2036 around two out of every nine New Zealanders, or 1,258,500 people, will be aged 65 and older, representing a 77% increase since 2016. This increasing proportion of older people in the population is expected to continue in the long term.⁷⁰

65 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

66 For the age group 15–19, the OECD reports that in 2015 the highest suicide rates among OECD countries were observed in Canada, Estonia, Latvia, Iceland and New Zealand, with New Zealand having the highest rate overall. OECD. 2017. *CO4.4: Teenage suicides (15–19 years old)*. OECD Family Database. www.oecd.org/els/family/CO_4_4_Teenage-Suicide.pdf.

67 TC Clark, T Fleming, P Bullen, S Denny, S Crengle, B Dyson, S Fortune, M Lucassen, R Peiris-John, E Robinson, F Rossen, J Sheridan, T Teevale and J Utter. 2013. *Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012*. University of Auckland.

68 M Wilson, J Garisch, R Langlands, A O'Connell, L Russell, L, E Brown, T Kingi, K Robinson, M Brocklesby and M Judge. 2015. Adolescent non-suicidal self-injury in Aotearoa New Zealand. *Psychology Aotearoa* 7(2): 130-133.

69 B Keogh. 2017. Children admitted to adult mental health wards. *NZ Herald*, 18 November. www.nzherald.co.nz/health/news/article.cfm?c_id=204&objectid=11944708, based on 18 requests to the Ministry of Health under the Official Information Act 1982 (accessed 29 October 2018).

70 Office of Seniors. No date. Key statistics (web page). www.superseniors.msd.govt.nz/about-superseniors/media/key-statistics.html (accessed 25 October 2018).

Mental distress in older people may arise from cognitive decline, grief and loss, role changes and loss of function, loneliness, isolation and stigma. They may be living with chronic anxiety, depression and dementia or may develop schizophrenia, psychosis or addictions late in life. These issues may be compounded by complexities relating to co-existing addiction, long-term disability and physical health issues. Data indicates that older people are less likely than people aged 25–64 to use primary mental health care services and are especially unlikely to use psychologist services.⁷¹

Children experiencing adverse childhood events

Children who have experienced adverse childhood events (ACEs) have higher rates of mental illness and addiction and worse health outcomes overall than others. To have multiple ACEs is a major risk factor for many health conditions. Research shows that the children of parents with multiple ACEs are also more likely to experience high levels of adverse outcomes due to the violence, mental illness and substance use they experience. Studies show that the greater the number of ACEs experienced as a child, the higher the risk of poor health outcomes. There is a moderate association for people with two or three ACEs for increased likelihood of smoking, heavy alcohol use, poor self-rated health, cancer, heart disease and respiratory disease and a strong link for sexual risk taking, mental ill health and problematic alcohol use. ACE links are strongest for problematic drug use and interpersonal and self-directed violence. The research provides support for a strong public health approach to preventing childhood exposure to adverse events, to building resilience in children to cope when they do occur and to ensuring all health and social services provide ACE-informed responses.⁷²

Children in state care

The incidence of mental health and addiction challenges is considerably higher among children in state care than among the overall population, reflecting the impact of wider social determinants and adverse childhood events. The mental wellbeing of parents is also associated with having children in state care. One review of children who came into Oranga Tamariki care before their second birthday showed 71% of their mothers had alcohol or other drug problems and 43% of their mothers had mental health problems.⁷³

Physical health

People with severe mental health or addiction challenges have higher rates of many health conditions and shorter life expectancy, and this gap has increased over time. New Zealanders accessing specialist mental health services have double the risk of premature mortality compared with the overall population and their life expectancy is shorter by up to 25 years.⁷⁴ The risk is greater for women and Māori.

71 S Gibb and R Cunningham. 2018. *Mental Health and Addiction in Aotearoa New Zealand: Recent trends in service use, unmet need, and information gaps*. Wellington: University of Otago.

72 K Hughes, MA Bellis, KA Hardcastle, D Sethi, A Butchart, C Mikton, L Jones and MP Dunne. 2017. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health* 2(8): e356–e366.

73 D Rankin. 2011. Upfront: Meeting the needs of children and young people in New Zealand who have been abused and neglected. *Best Practice Journal* (issue 37). <https://bpac.org.nz/BPJ/2011/August/upfront.aspx>.

74 Te Pou o Te Whakaaro Nui. 2014. *The Physical Health of People with a Serious Mental Illness and/or Addiction: An evidence review*. Auckland: Te Pou o Te Whakaaro Nui. www.tepou.co.nz/resources/the-physical-health-of-people-with-a-serious-mental-illness-and-or-addiction-an-evidence-review/515.

High mortality from physical health conditions is due to a higher risk of developing a disease, late diagnosis and poorer intervention levels as well as worse outcomes once a disease develops. While the risk of suicide is higher in this population, most premature deaths are due to cardiovascular disease, cancer and other chronic disease.⁷⁵ The estimated annual cost of premature deaths of people who have both physical and long-term mental health conditions, when the impact of addiction is factored in, is \$6.2 billion.⁷⁶

Equally Well – a collective initiative to reduce disparity

Equally Well is a sector-wide movement that has raised awareness of the poor health outcomes for people with mental challenges and engaged all parts of the sector in addressing this issue.

More than 100 organisations support Equally Well and are doing their part to work together for change. These supporters are cross-sectoral and include community organisations, mental health and addiction non-governmental organisations, primary care services including general practitioners, district health boards, medical colleges, and education providers. Mental health and addiction service users are important partners in all of Equally Well's work.

Hundreds of activities supporting Equally Well's goal are under way across the country, making promising steps towards improving the physical health of people facing mental health and addiction challenges. Change is occurring for individuals through increased awareness, improved service integration, and policy change. As a result of seeing the impact in New Zealand, there are now Equally Well collaboratives in Australia and the United Kingdom.

75 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

76 Victoria Institute of Strategic Economic Studies. 2016. *The Economic Cost of Serious Mental Illness and Comorbidities in Australia and New Zealand*. Melbourne: Royal Australian and New Zealand College of Psychiatrists. www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx.

Suicide

Rates of suicide were relatively stable in the decade to 2015 and down from a high in the mid-1990s. Rates of suicide are higher for males, Māori and people living in high-deprivation areas. Although New Zealand's suicide rates are highest for adults, especially middle-aged men, our youth suicide rates are among the highest in the OECD. Recent data from Coronial Services of New Zealand shows a concerning upward trend in suicides in recent years, signalling a need for a rethink of our current approach to suicide prevention and to the support available to suicide bereaved families, friends, whānau and communities. We discuss suicide prevention in chapter 10.

Education

Mental wellbeing affects the ability of young people to engage successfully in their academic learning and acquisition of social skills and as a contributing member of their school community. Young people with mental health challenges are less likely to complete their schooling.⁷⁷

The Ministry of Education advises that the education sector as a whole is seeing increased violent and uncontrolled behaviour at younger ages, high rates of youth suicide and deliberate self-harm among teenagers and young adults, and increased anxiety among young people about their educational performance and academic testing.

The Ministry of Education also advises that Māori and Pacific students and disabled students all report poorer wellbeing in student surveys compared with the overall student population, correlating with disparities in educational engagement and achievement and contributing to inequities in life outcomes. While intensive work is under way to address exposure to bullying, New Zealand has the second highest rate of bullying in the OECD.⁷⁸

Employment and income

Unemployment (and job loss) is associated with a greater risk of developing a mental illness. Jobseekers with mental health challenges have particularly poor outcomes. For over 40% of all recipients of health and disability income support, mental illness is the primary barrier to being able to work. This group has almost doubled since 2000, and is likely an underestimate of income support recipients with mental illness.⁷⁹

77 OECD. 2015. *Fit Mind, Fit Job: From evidence to practice in mental health and work*. Paris: Mental Health and Work, OECD Publishing. <http://dx.doi.org/10.1787/9789264228283-en>.

78 Based on students' reports of bullying across countries who took part in PISA 2015: Ministry of Education. 2017. *PISA 2015: New Zealand Students' Wellbeing Report*. Wellington: Ministry of Education. www.educationcounts.govt.nz/publications/schooling/pisa-2015-new-zealand-students-wellbeing-report.

79 Ministry of Health. 2018. Appendix 1: Cross-government mental health strategy development. In *Submission to the Inquiry into Mental Health and Addiction*. Wellington: Ministry of Health. www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry/submission-government-inquiry-mental-health-and-addiction.

While work can have positive impacts on mental health, work environments can also have negative impacts through overwork, bullying and other stressors. Data from WorkSafe New Zealand indicates that the experience of work-related stress or mental illness is increasing year on year (7% in 2014 to 11% in 2016).⁸⁰ The OECD has identified that many New Zealanders with mental health challenges are living in low-income households.⁸¹

3.2.5 Quality of services and facilities is variable

People reported, and we visited, facilities and service environments that are not conducive to recovery and wellbeing and are inappropriate for some groups, such as young people. We regularly fail to provide a system response or experience that meets people's needs. Some tāngata whaiora are not treated well or with kindness or given adequate time for their needs to be understood or met.

New Zealand does not have a mental health and addiction system that consistently works with people, wrapping around them to meet their needs. Although survey feedback suggests many people have positive experiences of accessing services and support, this is not always the case.⁸² Too many people are treated with a lack of dignity and respect and in a way that demeans their mana and their human rights. Frequently, tāngata whaiora are on the receiving end of poor communication and processes and services that do not meet their needs. Limited options are offered to people seeking help.

Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed. Even when it responds to people with a mental illness, it does so through a lens that is too narrow. For example, early intervention for psychosis works best when people are supported in their whānau or community, have access to talk therapies, education and training, and are helped to connect to others. This sort of comprehensive approach is uncommon.

At the moment, too many services are provider-oriented or have a solely individual focus, rather than considering people in the context of their family and whānau and the other things that are important in their life.

There are few suitable services for, and poor responses to, people with complex or multiple needs (for example, people with an intellectual disability and/or autism as well as a mental health need). Age and life stage transitions are not well supported. The lack of integration between and within the health and social sectors and for high-need population groups is a barrier to improving people's experience and outcomes.

80 Nielsen Co. 2017. *Health and Safety Attitudes and Behaviours in the New Zealand Workforce: A survey of workers and employers. 2016 cross-sector report*. Wellington: WorkSafe New Zealand. <https://worksafe.govt.nz/data-and-research/research/attitudes-and-behaviours-survey-2016/>.

81 OECD. 2015. *Fit Mind, Fit Job: From evidence to practice in mental health and work*. Paris: Mental Health and Work, OECD Publishing. <http://dx.doi.org/10.1787/9789264228283-en>.

82 The Health and Disability Commissioner collects the voices of consumers and their families through Mārama (real-time feedback from consumers of mental health and addiction services and their families). Of more than 14,000 consumers and family and whānau in three years to 30 June 2017, 81% reported being happy with the communication with the people they see. Of the 247 mental health and addiction complaints to the Health and Disability Commissioner in 2016/17, 13% were about the coordination of care: HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner, p 71. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

Current laws and practice result in unacceptable levels of compulsion and restrictive practices. Too often, lacking a full range of connected services that wrap around and care for people earlier (such as talk therapies and group support), we fall back on the use of compulsion and restriction.

3.2.6 Key components of the system are missing

Sector development has stalled and, in some areas, regressed. Important models, principles and directions are talked and written about, but are not implemented and followed. As a result, we have not made the system shift that has been signalled for several decades. This stall has resulted in an underdeveloped mental health and addiction system. Some services and supports do not exist in the system or are not provided in suitable and culturally appropriate ways. This is leading to lost opportunities and a lack of choice.

We do not have a continuum of care – few options are available to people who do not meet the threshold to access specialist mental health and addiction services. Of particular concern is the limited progress in developing services for people with mild to moderate and moderate to severe needs. Also, few initiatives aim to respond to serious distress and prevent people from ‘tipping over’ into crisis situations.

People experiencing psychological distress may be offered medication, but not appropriate support and therapies to manage and recover from their distress. We do not address people’s wider social needs, including housing, employment, isolation and income, which impact on people’s lives; nor do we provide the full range of evidence-informed interventions that we know are important in supporting recovery. While evidence exists that trauma is a major factor in the lives of many people with more serious mental distress or addictions, we do not provide comprehensive trauma-informed responses, nor do we offer appropriate psychological and talk therapies.

The initial expansion of culturally appropriate and population group–oriented models and services has not been maintained. In recent years, services that focus on high-need populations have received insufficient investment. Funding and contracting changes have negatively affected Kaupapa Māori and Pacific mental health and addiction services in particular.

Ample evidence exists that better respite and crisis support options, more forensic step-down services in the community, and earlier access to a broader range of peer, cultural and talk therapies would relieve pressure on inpatient and forensic units, yet growth in these areas has been limited, with little new investment. Pilot initiatives and partially constructed service models have not been properly evaluated, refined and rolled out.

Community forensic step-down services

Emerge Aotearoa provides four regional forensic mental health step-down services in Auckland (11 beds in two locations), Palmerston North (4 beds) and Wellington (4 beds).

Services provide a structured environment with 24-hour intensive support and a programme oriented towards recovery and rehabilitation of tāngata whaiora. People are supported to attain life skills, improve their quality of life and achieve independence in the community with reduced support. The services cater for people with a range of sophisticated needs who are moving from a forensic inpatient setting back into the community.

Intensive support is provided by a combination of onsite support staff and mental health professionals, with additional support from Forensic Community Mental Health teams to meet the unique needs of tāngata whaiora.

Services have seen many success stories and great outcomes, including tāngata whaiora:

- securing and maintaining employment
- gaining academic qualifications
- achieving pre-vocational goals
- reconnecting with their children and whānau
- moving towards independent living
- moving from Special Patient status.

We lack a strong, organised and long-term focus on promotion, prevention and early intervention – although it is questionable whether New Zealand is getting the maximum benefit from the many promotion, prevention and early intervention programmes and activities currently in place.

Despite a lot of consensus about the need for reform, we are yet to take a bold, health-oriented approach to the widely recognised problems of misuse of alcohol and other drugs in our community and to provide a wider range of community-based services to help people recover from addiction. Our approach to suicide prevention and the support available to people after a suicide is patchy and under-resourced. Raising awareness of suicide by itself is not enough; prevention initiatives should be monitored and evaluated for effectiveness, and there must be avenues for people to access early support for their distress.

As well as the big gaps in our mental health and addiction system, we lack a coordinated, integrated approach from social services to tackling the social and economic determinants of mental health and wellbeing. We need to target these underlying determinants to intervene early in the life course and at critical transition points in the lives of children and young people.

Leadership and oversight are important, given the impact of government agencies and policies on mental health and wellbeing and on all the factors that affect broader wellbeing in society. Key players will be a new commission – the Mental Health and Wellbeing Commission (discussed in Part 2) – and a reinvigorated Ministry of Health. A central locus of responsibility within government is needed for the wide range of wellbeing activities under way in the state sector to ensure coordination and integration and maximise impact.

But leadership from Wellington will not be enough to transform mental health and wellbeing in New Zealand. Everyone can help create an environment where mental health is promoted and distress responded to more effectively. Everyone includes individuals, families and whānau, Iwi, district health boards (DHBs), organisations and communities. We need to build our collective capability and capacity to prevent and respond to mental health and addiction challenges.

3.2.7 It's time to build a new system on the existing foundations

The foundations are in place for supporting those people with the highest mental health and addiction needs. We will always have a special responsibility to those most in need. We must continue to provide appropriate treatment and support and improve the quality of care. While some growth has occurred in community-based services over the years, it has been insufficient to respond to the needs of this group. Inpatient and DHB-provided services have remained at the centre of specialist services. More intensive community support options and pathways are required to support people so they don't need an inpatient admission or are helped to return to the community earlier.

Crucially, we need to build a continuum of care and support. We must expand the options available for people below the current eligibility threshold for specialist services. Many people with common, disabling problems such as stress, depression, anxiety, trauma and substance abuse have few options available through the public system. Often, they do not require medical interventions, but do need support to deal with the adverse events they may be experiencing and their distress. Within the health sector, the limited investment and lack of development in primary and community care has negatively affected the options available. This is despite strong evidence for focusing on primary and community care and early intervention and support, and the policy intent, expressed many times over the years, to target this area for growth. By failing to provide support early to people under the current threshold for specialist services, we're losing opportunities to improve outcomes for individuals, communities and the country.

We think New Zealand's future mental health and addiction system should build on the foundations in place, but should look and be very different. At its heart should be a vision of mental health and wellbeing for all.

3.3 Mental health and wellbeing for all

We aspire to a flourishing New Zealand, where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of our society, and people who experience mental distress have the resilience, tools and support they need to regain their wellbeing. This vision is consistent with what we heard across the country. Everyone should have the opportunity to 'live well', whether or not they have active symptoms of mental illness or a particular diagnosis. Our mental health services must have a strong focus on wellbeing, encompassing all aspects of people's lives and ensuring people have the support they need to live well.

A flourishing New Zealand will prioritise the wellbeing of children and young people. Every child will be nurtured from conception and protected throughout childhood from the impacts of violence, alcohol, tobacco and other drugs. Every child will be well nourished, live in a warm, safe environment where they are wanted, protected, loved and cared for, and where their parents are well supported to provide them with the necessities of life.

Mental wellbeing isn't just about the absence of mental distress or harmful substance use. So what is it? Ideas about wellbeing differ widely among different populations, groups and individuals. They also change throughout our lives and as our circumstances change. Overall, mental wellbeing is most likely when we are safe and secure and feel connected, valued, worthy, accepted for who we are, and hopeful for the future. For many of us this comes from growing up in loving families and whānau where we feel strongly connected and are nurtured and nourished; learning in great schools; having strong cultural, social and, for some, spiritual connections; being fit and healthy; having friends and family, a job, a home and a safe neighbourhood; being creative and having fun; contributing to our communities; having control over our lives; and mattering to other people.

Mental wellbeing is deeply connected to wider wellbeing in our society. We need to embed this understanding in everything we do – within our mental health and addiction system, our wider health and social system, and at every level of society.

Our system of the future will recognise the specific aspirations of Māori and Pacific peoples (discussed further in sections 3.4 and 3.5).

3.4 Whakawātea te Ara – Māori health and wellbeing

Whakawātea te Ara is about clearing pathways that will lead to improved health and wellbeing. While Māori health has made significant gains, evidence is mounting that the system is not working for Māori and fundamental changes are needed.

The paradigm shifts in sections 3.4.1 to 3.4.8 are the eight broad areas where, in our view, a change in direction is necessary. All areas require commitments from government, Iwi, Māori communities, whānau, clinicians, specialists, primary care providers, NGOs, DHBs, funders and sectors beyond health. Significant implications also exist for health and social services, Kaupapa Māori services, education, workforce capability, local and national policies, and Māori development generally.

3.4.1 Mauri ora (staying well) – from alleviating sickness and distress to fostering good health and wellbeing

A focus on Māori sickness and distress needs to be expanded to include a stronger emphasis on wellbeing – wairua, hinengaro, tinana and whānau (spirit, mind, body and family). Wellbeing, mauri

ora, is the right of tamariki, rangatahi, mātua and kaumātua (children, young people, parents and elders). A wellbeing paradigm requires a focus on positive aspirations with expanded treatment and care goals that go beyond the alleviation of symptoms to the attainment of wellness. Wellbeing aligns with tikanga Māori and Māori cultural norms; it demands cross-sectoral commitments. It also recognises the interdependence of mental health and physical health, the capacity of communities to generate opportunities for healthy living, and the strength and leadership of whānau so their people can live as Māori and participate fully in society.

Improving whānau wellbeing through teaching water safety skills

Te Taitimu Trust is a community initiative based in Flaxmere for Māori children, adults and families, many of whom have gang backgrounds, challenging home environments and compromised health. Since 2003, the Trust has brought groups together to learn vital water safety skills as well as basic living skills.

Awareness and changing attitudes towards the water are the main goals, but in the process, the importance of cultural values, whānau and whanaungatanga are emphasised within a marae context. Whānau are encouraged to join in.

Early indications among programme participants are of a gain in self-confidence, improved family relationships and a greater appreciation of tikanga Māori as well as the natural environment.⁸³

3.4.2 He tangata, he tangata (the person first) – from service and provider priorities to the priorities of each person

Recognition of mana, dignity and self-esteem is integral to mental wellbeing. The person – te tangata – should be the main focus. The person's concerns, hopes and priorities are more fundamental than the diagnosis, treatment plan or preconceived assumptions of clinicians or caregivers. Respecting human rights and integrity should underpin all treatment and care programmes. And kindness, empathy and rapport should epitomise the culture within mental health and addiction services.

3.4.3 Oranga whānau (whānau solutions) – from the individual to the active participation of whānau

We heard that whānau involvement is critical for successfully addressing mental health and addiction challenges: whānau should be co-participants in services, involved in decision-making and assisted to provide the support expected of families. Whānau span the human life cycle, and a life-course approach recognises the continuity between generations and the changing roles within whānau. Whānau also have the potential to prevent small problems from becoming major issues, to encourage early intervention, especially with tamariki and rangatahi, to care for older people and to promote lifestyles that lead to wellbeing.

83 R McClintock and V Martin-Smith. 2016. *Waka Hourua Community Initiative: Te Taitimu Trust*. Wellington: Te Kīwai Rangahau, Te Rau Matatini.

Whānau Ora has been able to balance an individual focus with the active involvement of whānau. By incorporating tikanga, kawa and whanaungatanga into practices, whānau self-management and wellbeing are encouraged. A healing process that converts crises for individuals into whānau resilience and capability is the aim. Whānau Ora commissioning agencies have prioritised services that help whānau realise their own aspirations and attain their own outcome goals rather than focusing only on goals chosen by services.

3.4.4 Ratonga whakahira (inspiring services) – from narrowly focused services to services that address Māori realities

Māori participation in conventional services has too often been hindered by the exclusion of whānau, a failed engagement process, offensive practices such as stigmatisation, seclusion, committal, over-reliance on medication, overt racism, and an inability of clinicians to understand Māori world views or te reo Māori. Obstacles to receiving timely help, especially during a crisis, or to meet the criteria required for help has further compromised Māori access to appropriate care and support. A serious shortage of acute inpatient beds and respite care adds to the lack of confidence in the system.

Kaupapa Māori health services offer alternate forms of service. They are grounded in te reo, tikanga and the use of rongoā, as well as a variety of clinical and social interventions. Typically, they address the whole person, the whānau and the socioeconomic environments that are contributing to the problem. They are guided by Māori models such as Te Whare Tapa Whā⁸⁴ and aim for outcomes that create a sense of manahau (exhilaration) and riaka (energy). Some also offer respite care and access to talk therapies.

3.4.5 Te piringa (integrated services) – from fragmentation to a joined-up mental health system

Fragmentation within the wider mental health system is a serious concern in many Māori communities – disconnection exists between primary and secondary care, prevention and treatment, NGOs and general practitioners, policy and practice, mental health services and general health services, tikanga Māori and Western approaches. Better connections between mental health services and addiction services are also needed. While the two services often overlap, addiction services are significantly different from mental health services.

Some communities have made substantial gains in reducing the fragmentation by forming community collectives that provide front-line mental health functions including mental health assessment, triage, early intervention, respite care and ongoing support. A preference exists for locating secondary specialist services in a community base and establishing a community mental health hub as a preferred alternative to emergency departments, hospital triage and a hospital psychiatric clinic.

Several Māori providers also emphasised the need for community workers to maintain contact with people who are receiving specialist care. Discharge plans made in consultation with whānau and community workers, and admission criteria that take into account the first-hand knowledge of community workers, could reduce the specialist-community disconnect. The employment of navigators has also been able to help whānau link up with key services, reduce confusion and improve continuity.

84 MH Durie. 1985. A Māori perspective of health. *Social Science and Medicine* 20(5): 483–486.

Further, instead of contractual agreements that are often short term and geared to the priorities of DHBs or other funders, Māori interest in establishing mental health commissioning arrangements with DHBs has been strong. The Whānau Ora commissioning agencies are options that are already operating, and arrangements with Iwi or Māori community organisations could also lead to commissioning agreements.

3.4.6 Ko te hāpai ō ki muri (a valued Māori workforce) – from a dispersed to a consolidated Māori workforce

The Māori mental health workforce has greatly expanded to include Māori psychiatrists, general practitioners, nurses, psychologists, social workers and counsellors, as well as cultural experts, consumers, people with lived experience of mental illness, kaumātua and rangatahi. But there have been concerns about those who work in isolation of other Māori staff members and who, as a consequence, can be overloaded with expectations that they should manage all Māori referrals or that they should use the same type of approach as their Pākehā colleagues.

A collaborative approach that enables Māori workers to extend their skills in both Te Ao Māori and Te Ao Whānui will be important for maximising the impact of the expanded Māori health workforce. Similarly, the application of a distinctive Kaupapa Māori approach will be more consistent and effective if opportunities exist for ongoing learning, research and collaborative models of care for the entire Māori health workforce.

Māori leadership at all levels of the mental health and addiction sector will be critical for the introduction of fresh approaches. Leadership in the future will require leaders who can be effective in cross-disciplinary and cross-sectoral settings, can straddle hospital and community divides, can link policy with practice, and are conversant in mātauranga Māori and global knowledge systems. To accelerate the process, Māori health leadership programmes should be available to clinicians, therapists, managers, directors, policy makers, community workers, consumers and people with lived experience.

3.4.7 Te tu ngātahi (collaboration for prevention) – from a focus on treatment and care to a united drive for wellbeing

Whānau experiencing social and economic disadvantage, struggling to meet the needs of children, living under the legacy of intergenerational trauma, locked into poverty, experiencing violence, let down by schools, or subjected to racism will have greatly reduced chances of realising wellness. The involvement of social and economic sectors in the promotion of health and wellbeing is critical. While government facilitation will be important, Māori community leadership has the potential to magnify the impact of local initiatives.

To restore stability and confidence for whānau, Kaupapa Māori services spend considerable time working with schools, housing agencies, the Ministry of Justice, Oranga Tamariki—Ministry for Children and employment agencies. Too often that work is not recognised in contracts, yet it is key to creating environments that are conducive to health and wellbeing. Prevention and positive health promotion should be incorporated into the goals of all NGOs and both primary and secondary care services.

Some communities have established collective capacity to address the wider impacts of social and economic inequities. They have found that the prevention of poor health and the promotion of good health can be advanced through the involvement of schools, universities and tertiary providers, churches, state agencies, marae, NGOs, DHBs and the voluntary sector.

3.4.8 Te kawenata o Waitangi (Treaty of Waitangi and health) – from inconsistent Māori participation to giving effect to the Treaty

The 1988 Royal Commission on Social Policy⁸⁵ concluded that Te Tiriti o Waitangi was relevant to all social policies and recommended the adoption of three principles: partnership, participation and protection. The relevance of the Treaty to mental health is also evident in a claim before the Waitangi Tribunal.⁸⁶ Our Inquiry has not been party to the claim but is aware of strong interest from Māori working in the sector.

Options for reducing inequities and giving effect to the Treaty of Waitangi include ensuring Iwi are involved in strategic planning at district and regional levels and replacing short-term contracts shaped around DHB priorities with commissioning arrangements built around Māori and Iwi priorities. The establishment of a Māori health ministry or Māori health commission to address Māori participation in the wider health sector, including mental health and addictions, has also been suggested. A whole-of-health approach makes sense given the links between mind, body, spirit and family and the consequences that all too often follow a forced separation of mental health from the broader parameters of health. The establishment of a ministry or commission with that overarching function deserves further consideration by the Health and Disability Sector Review.

Meanwhile, to reduce inequities, give recognition to the Treaty and focus Māori mental health leadership, a Treaty partnership relevant to the new Mental Health and Wellbeing Commission (see chapter 12), will be important. The Commission could recognise Treaty obligations in several ways including Māori participation in governance arrangements, a partnership between the Commission and Iwi or Māori, or a Māori workstream within the Commission.

3.5 Vai Niu – Pacific health and wellbeing

The aspirations of Pacific peoples, who journeyed from the shores of their homelands to a land that held out the promise of prosperity, are reflected in *Vai Niu*,⁸⁷ which symbolises fresh Pacific beginnings and a vision of Pacific mental health and wellbeing.

85 Royal Commission on Social Policy. 1987. *A Fair and Just Society*. Wellington: Royal Commission on Social Policy.

86 The Waitangi Tribunal Health Services and Outcomes Inquiry was initiated in November 2016 to hear all claims concerning grievances relating to health services and outcomes of national significance.

87 Most Pacific peoples commonly recognise the use of the word *niu* to denote a coconut, and *vai* means water, so *vai niu* is translated as ‘coconut water’. Here, this expression encapsulates fresh Pacific beginnings: fluidity, indigeneity, nourishment, sustenance, resilience and innovation. In addition, the husk of the coconut, when woven tightly, binds all things; where there is strength in unity – *so’o le fau i le fau*.

Vai Niu is centred on the following world view:⁸⁸

I am not an individual; I am an integral part of the cosmos.
 I share a divinity with my ancestors, the land, the seas and the skies.
 I am not an individual, because I share a *tofi* (an inheritance)
 with my family, my village and my nation.
 I belong to my family and my family belongs to me.
 I belong to my village and my village belongs to me.
 I belong to my nation and my nation belongs to me.
 This is the essence of my sense of belonging.

Vai Niu represents a paradigm shift driven by Pacific solutions and aspirations and with a focus on promotion, prevention and early intervention, including in early childhood. It requires a reconfiguration of attitudes, behaviours and beliefs, while acknowledging the distinct values Pacific peoples place on their own definitions of wellbeing.

The shift envisioned needs to address current power imbalances – ‘cultural humility’⁸⁹ to generate thriving and empowering environments of self-determination for Pacific peoples. *Aiga/kopu tangata/kāinga/magafaoa/matavuvale/kāiga* (family)⁹⁰ is central to Pacific mental health and wellbeing, including family support and inclusion in decision-making. The paradigm shift will be an integrated approach and strengthen Pacific leadership, accountability, innovation, integrity and sustainability.

3.5.1 Empower Pacific ways of knowing and doing

Vai Niu is based on Pacific ways of knowing and doing, recognising the diversity of Pacific realities, world views and philosophies. Rather than solely medicalised and individualised approaches, Pacific ways of knowing and doing place relationships at the fore – relationships with all entities, *Atua*, the environment, ancestors, cultures, languages, family and others – and nurtures the sacred *va*.⁹¹ This approach is strengths-based, recognises Pacific peoples’ dignity and guardianship of relationships, the land and environment, culture, languages and traditional healing, and values compassion, love, reciprocity, ethics and human rights.

Vai Niu observes the special relationship Pacific peoples have with Māori as *Te Moana Nui a Kiwa*, while celebrating Pacific ethnic identities, languages, spirituality, values, beliefs and cultures.

88 Tui Atua Tupua Tamasese Ta’isi Efi, Head of State of Samoa. 2009. *O le e lave i tiga, ole ivi, le toto, ma le aano*: He who rallies in my hour of need is my kin. Paper presented at the New Zealand Families Commission Pasifika Families’ Fono, Auckland, New Zealand, November 2009, p 80. [www.head-of-state-samoa.ws/speeches_pdf/Tupua%20Family%20Commission%20FINAL4%20\(2\).pdf](http://www.head-of-state-samoa.ws/speeches_pdf/Tupua%20Family%20Commission%20FINAL4%20(2).pdf).

89 An overt connection between people, institutions and systemic power imbalances that is confronted rather than merely acknowledged: M Fisher-Borne, JM Cain and SL Martin. 2015. From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education* 34(2): 165–181. <https://doi.org/10.1080/02615479.2014.977244>.

90 *Aiga* (Samoan), *kopu tangata* (Cook Islands), *kāinga* (Tongan), *magafaoa* (Niuean), *matavuvale* (Fijian) and *kāiga* (Tokelau, Tuvalu).

91 *Va* is the sacred space that connects separate entities together in unity.

3.5.2 Achieve equity

To achieve equity for Pacific peoples, barriers of stigma, discrimination, institutional racism and unconscious bias must be eliminated and access to services improved. All people, including Pacific Rainbow communities, will be embraced for who they are.

A cultural approach must come first, before a clinical approach, with the provision of culturally appropriate, relevant, safe and effective options (including traditional healing and treatment) in Pacific settings (such as churches, homes, Pacific services and ‘character’ schools⁹²).

Greater recognition of the peoples of the Cook Islands, Niue and Tokelau and those nations’ constitutional agreements with New Zealand is essential.⁹³

Achieving equity requires growing Pacific leadership and governance at all levels of the mental health and addiction system and having a dedicated Pacific workstream operating under the Whānau Ora commissioning structure. Employment opportunities, entrepreneurialism, adequate housing and equitable income are essential to address inequities for Pacific peoples in New Zealand.

3.5.3 Invest in the Pacific workforce

To attain the highest attainable standard of *Vai Niu* for Pacific peoples, *fa’aaoloalo/’akangateitei/faka’apa’apa/fakalilifu/vakarokoroko/fakaaloalo*⁹⁴ (respect) as a core value must be acknowledged.⁹⁵ A continued investment in the Pacific workforce and Pacific cultural competence is required. A Pacific culturally competent workforce will include *tufuga/taunga/tufunga/kenadau*⁹⁶ (cultural knowledge holders), community support workers, *matua* (elders), youth and peer support and will be equitably remunerated. Continued investment in Pacific-centred research, monitoring and evaluation is also needed.

Dedicated Pacific wellbeing modules in schools and curriculum development in training establishments will ensure a well-prepared workforce. The workforce will enable Pacific peoples and their families, equipping them with skills, information and culturally appropriate therapies. Most of the Pacific population in New Zealand is born in this country, and there is a steadily increasing Pacific multi-ethnic population. Thus, more than ever, language familiarity, cultural identity and belonging, connectedness, communalism and resilience will be important to adequately serve these populations.

92 “Under the Education Act [1989], a designated character school has a particular character which sets it apart from ordinary state schools and kura kaupapa Māori”: I Stewart. 2018. Pasifika students excel at ‘aunty’ and ‘uncle’ school in NZ. *Radio New Zealand* (2 August) www.radionz.co.nz/international/pacific-news/363173/pasifika-students-excel-at-aunty-and-uncle-school-in-nz.

93 “Pacific peoples with ancestral ties to Pacific Islands that have constitutional agreements with [New Zealand] (Cook Islands Māori, Niueans and Tokelauans) hold the same rights as NZ citizens. This means they can move more freely between the Pacific Islands and NZ and, in effect, are more likely to be exposed to the NZ environment”: J Ataera-Minster and H Trowland. 2018. *Te Kaveinga: Pacific peoples: Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey*. Wellington: Health Promotion Agency, p 45. www.hpa.org.nz/research-library/research-publications/te-kaveinga-mental-health-and-wellbeing-of-pacific-peoples-report.

94 Respectively, Samoan, Cook Islands, Tongan, Niuean, Fijian, and Tokelauan and Tuvaluan.

95 J Tiatia-Seath. 2018. The importance of Pacific cultural competency in healthcare. *Pacific Health Dialog* 21 (1): 8–9. DOI 10.26635/phd.2018.909.

96 Respectively, Samoan, Niuean, Tokelauan, and Tuvaluan; Cook Islands; Tongan; and Fijian.

3.5.4 Foster future Pacific momentum

New Zealand's Pacific population is vibrant, young and fast-growing. It is reported that 60% of Pacific peoples are New Zealand-born, and Pacific children and young people are increasingly identifying with more than one ethnicity. By 2038, 20% of all children in New Zealand will be of Pacific heritage. The Pacific mental health and wellbeing sector needs to be ready to serve these Pacific futures, including use of nanotechnology, artificial intelligence, and digital mental health and social media platforms. Further, the sector must be well positioned to effectively care for Pacific climate migrants whose mental health and wellbeing may be significantly and adversely affected by the challenges of displacement from homelands because of rising sea levels.

Pacific services

Vaka Tautua

Vaka Tautua is a national 'by Pacific for Pacific' health and social service provider with offices in Auckland (West and South), Wellington and Christchurch, providing different levels of service. It is a Pacific-led and -driven integrated service to improve the health and wellbeing of Pacific peoples in New Zealand. It offers Pacific solutions through an elder abuse response service, disability advice and support, and mental health peer support as well as financial literacy coaching. Services are also delivered in Pacific languages.

K'aute Pasifika

K'aute Pasifika is a Pacific health provider based in Hamilton, with reach across the Waikato region. It uses a one-stop shop integrated service model so Pacific families can easily connect with other supports all under the one roof. For example, the hub offers a general practice, early childhood education, a family violence education programme, and a Whānau Ora provider, delivers the Ministry of Education's Pasifika PowerUP programme, and administers some New Zealand Qualifications Authority standards.

3.6 A vision for mental health and addiction services

3.6.1 People at the centre

A mental health and addiction system with a central vision of mental health and wellbeing, which recognises the aspirations of Māori and Pacific peoples, will offer services that look and feel different. Responding early and preventing further distress for people at all points will be an underlying principle across all services. Psychiatrists and appropriate medications will continue to be important – but they are only part of the picture.

We believe that many dimensions of the aspirations of Māori and Pacific peoples, especially the call for a holistic approach,⁹⁷ point the way for all New Zealanders.

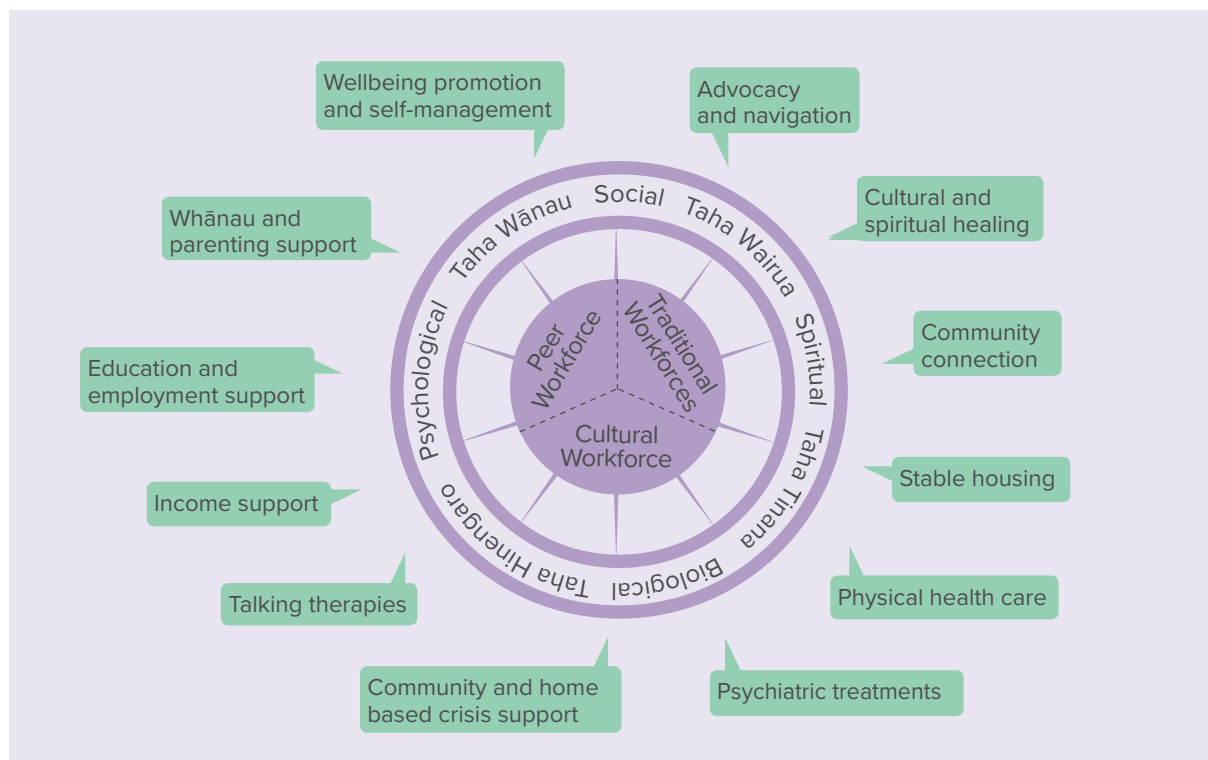
⁹⁷ New Zealand's Code of Health and Disability Services Consumers' Rights entitles consumers to be provided with services in a manner consistent with their needs and that 'optimises the quality of life' – defined to mean 'to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances' (rights 4(3), 4(4) and clause 4).

Our services of the future will be centred on the people seeking help and will ensure they:

- are treated with respect and empathy
- have a voice, and their voice has weight
- are seen and treated as a whole person, with their cultural practices and knowledge recognised, rather than as a diagnosis or set of symptoms
- are partners in their own care
- can access the support and services they need and transfer easily between different types of support
- can access culturally appropriate Kaupapa Māori and Pacific services
- have their family and whānau actively encouraged to support their recovery
- do not have to repeat their story over and over again
- experience services that are coordinated, trauma informed and high-quality.

A system with people at its centre will be flexible and connected, caring, underpinned by trauma-informed responses and focused on long-term outcomes for each individual and their whānau. It will protect and promote human rights, and will respond to people at risk with compassion and intensive support. Figure 1 from the Wellbeing Manifesto⁹⁸ illustrates the range of responses and workforces in a transformed mental health and addiction system.

Figure 1: Big Community wheel of responses and workforces



98 M O'Hagan. 2018. *Wellbeing Manifesto for Aotearoa New Zealand: A submission to the Government Inquiry into Mental Health and Addiction* (prepared for PeerZone and ActionStation). www.wellbeingmanifesto.nz/.

3.6.2 Responsive to age, background and perspectives

Services will meet the needs of people at various stages of their life. However, given the importance of intervening as early as possible, priority will be given to developing more and effective services for babies, children and young people. Access to mother and baby services will be widely available so that there is the maximum opportunity to support mothers with mental health and addiction challenges early to minimise the harm to their child. Support will be wrapped around mothers and their children and provided in a way that maximises their ongoing engagement.

Services for young people will be available in friendly settings including schools where young people can access them easily. There will be good coordination between early childhood centres, schools, universities and other tertiary providers, child health and mental health services to maximise the support available to children and their families. Early childhood centres and schools will promote resilience in young people through specific education programmes and by creating centre- and school-wide mentally healthy environments.

Families and whānau will have good information and support options to help them support their young family member when issues are first identified. Early intervention wrap-around services will be available to young people who are identified with more serious mental illnesses, self-harming behaviours or substance abuse concerns. Young people who have experienced abuse or trauma or are in care will have access to a full range of immediate and comprehensive support and interventions, seeking to avert long-term adverse impacts. Trauma-informed responses will underpin all interventions and services.

Services across the life cycle will be provided more flexibly so that consideration can be given to developmental needs. The transitions between youth services and adult services will not be driven by strict age criteria and will be smooth. Likewise, for older adults, transition to older people's services will not occur automatically when someone reaches 65. Services that best meet the needs of the individual will be provided from the most appropriate service base.

Services will be responsive to people from different cultural backgrounds, life experiences and perspectives, for example, rural dwellers, Rainbow communities, migrants and refugees, and people in the criminal justice system. All services will respect the cultural, gender and sexual orientation needs of the people being supported. For disabled people, people with autism and neurodiverse conditions, and the Deaf community, the system will support their access and use of services, and not further stigmatise or marginalise them.

3.6.3 Community-based support

Hospital and inpatient units will not be the centre of the system. Instead, the community will be central, with a full raft of intervention and respite options designed to intervene early, keep people safe and avoid inpatient treatment where possible. Mental health and addiction services will be an important component of a broader range of support options available to people.

Housing, employment, income support, financial management and ongoing learning and education programmes will be available. Support agencies will be well connected to their wider communities and well placed to connect people into existing social support, self-help, and recreational and community activities and programmes. The whole system will be focused on building strengths and resilience to improve long-term life and health outcomes. Health promotion and prevention strategies will be embedded across all services, including services for people with complex and persistent challenges.

Support will be available as close to home as possible in local hubs. These will offer people a range of immediate health and social support options. The focus will be working with the person and their whānau to sort out what is causing their distress and help them to relieve it. These hubs will be the first points of contact for people (and their families and whānau) to access immediate support, assessments, brief interventions, talk therapies, peer support, alcohol and other drug services, and self-help, individualised and group therapies. Psychiatric and clinical assessment, advice and support will be more widely available through primary health care, Whānau Ora and community providers that will link strongly to, provide or be part of local hubs.⁹⁹ A full spectrum of early interventions and support opportunities will be easy to enter and exit.

Local hubs will support people with differing needs, be well integrated into their local communities and have strong links with other services that help people with their physical health (including dental health), housing, employment, financial, education, recreational and general community support needs.

Support and service agencies will comprise a mix of peer, cultural, support and clinical workforces. Peers, cultural workers and specialists will offer a range of evidence-informed therapies, including talk therapies, family- and whānau-based practices, and clinical interventions. For Māori, interventions will be grounded in te reo, tikanga and the use of rongoā and other healing practices. For Pacific peoples, services will be grounded in their languages, core values and cultural and healing practices.

⁹⁹ A model used in Trieste, Italy, that treats mental illness and crises in community hubs has resulted in low levels of compulsory treatment, absence of restraint and seclusion, high levels of re-engagement in community life, and an overall reduction in the costs of mental health services.

3.6.4 Support for people in crisis

Mental distress, at all points, will be viewed as a recoverable social, psychological, traumatic, spiritual or health disruption. Underpinning all services will be early, easily accessible support for people in crisis, maintaining their connections to family and whānau, homes, schools, workplaces, friends and communities.

When people are seriously distressed and need immediate support, they will receive an immediate response from services led by caring, competent and skilled health, peer and cultural workers. All emergency departments will have access to skilled mental health workers who can provide immediate support and advice. Appropriate physical spaces will mean people can have their immediate needs addressed safely and privately.

The immediate response service will be able to effectively de-escalate situations and support people into appropriate assessment and respite services, community hubs or inpatient services. Community hubs, assessment and immediate support centres that provide calming and safe environments will provide an alternative to police cells. Peers will be present in these services. Where people come to the attention of police and are in custody, they will have access to trained mental health workers who can assess their immediate needs and make referrals as appropriate.¹⁰⁰ Police will be well trained and supported to provide trauma-informed backup and support to mental health immediate response teams.¹⁰¹

3.6.5 Alcohol and other drug services

Our new system will take a comprehensive harm-minimisation approach to alcohol and other drug use (and to gambling and other addictions) and seek to avoid criminalising people with drug abuse problems. This approach will underpin our health, justice and corrections services.

All services will be oriented to enabling people who want to address their addictions to do so and supporting them to engage with services that match their individual needs. People whose addictions are trauma-based will have access to trauma-informed services. We will review the wider issues impacting on an individual's life. Primary health care services and community providers will provide brief intervention options for people with alcohol and other drug challenges. Community-based detox facilities will be supported by comprehensive residential, community and peer-support services.

We will respond more assertively to the growing alcohol and other drug and mental health needs of people who come to the attention of the courts or are in prisons. Alcohol and other drug programmes will be readily available to the courts and to people in prisons. People moving back into the community will be supported with a warm handover process to continue their recovery journey.

¹⁰⁰ We note that Counties Manukau and Canterbury DHBs provide watch-house nurses at a central police station in the district. For information about the original pilot started in 2008, see J Paulin and S Carswell. 2010. *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative*. Wellington: New Zealand Police.

¹⁰¹ Many collaborative interventions have been developed and piloted around the world. Interventions tend to fall into one of three categories: increased training on mental health and distress for police officers; mental health staff working with police to triage, give advice or support over the phone or face to face if necessary; and 'ride along' models where police and health practitioners work together in response to mental health emergencies. Various forms of these interventions are in place in parts of New Zealand, but a collaborative national response, led by the Ministry of Health and New Zealand Police, could go a long way to supporting working partnerships and effective responses on the ground at a DHB level.

3.6.6 Services for people who are detained

People who are detained (such as within hospitals, secure care, prisons or aged care facilities) will have access to more comprehensive support through tailored primary mental health care and alcohol and other drug programmes that include access to cognitive behaviour and talk therapies. They will have access to an increasing range of therapeutic interventions that are trauma informed and designed to respond to their mental health and alcohol and other drug needs early, while they are detained. A broad range of e-therapy and over-the-phone (telehealth) options will be available to support people across the full spectrum of needs. Peer-support options will also be greatly enhanced along with trauma-informed approaches and self-help options.

There will also be stronger connections and capability within forensic services for specialist psychiatric liaison into prisons for people who are incarcerated, and the capacity to more easily transfer people who are very unwell into a health-focused environment. There will be an increased range of community-based residential step-down services and supported housing options available to people who are in forensic services, offering culturally responsive, intensive therapeutic community environments for them to transition back to the community. When released from prison, people will be supported through a warm handover process to access ongoing support close to where they live.

3.6.7 Making it happen

We need radical changes in services, policies and laws to achieve mental health and wellbeing for all, recognise the aspirations of Māori and Pacific peoples, and realise our vision of mental health and addiction services in the future. These changes are the focus of Part 2 of this report – what needs to happen.

A large, stylized green leaf graphic with prominent veins, curving across the page from the top left towards the bottom right. The leaf is rendered in various shades of green, creating a sense of depth and movement.

Part 2

What needs to happen

Introduction

Honouring the voices of the people means decisive action is needed

Part 2 sets out what we think needs to happen from here. It is striking that so much of what this inquiry has heard has been said before. Many people have been raising the issues set out in Part 1 of this report for a long time and many of the experiences people described echo those described in previous inquiries and reports. The desired direction – an emphasis on prevention and early intervention, expanded access to services, more treatment options, support closer to home, whānau- and community-based responses and cross-government action – has also been well articulated. Areas for action are outlined in multiple reports and strategies. Widespread agreement exists about the need for change and, in many respects, what change should look like.

Yet, despite so much consensus, the system has not substantially shifted. While many new and innovative approaches are being trialled in different parts of the country and dedicated people are working to bring about change, over and over again we were told that more of the same without fundamental change will not lead to widely desired improvements.

All of this adds to our sense of urgency. We cannot afford to have another report that repeats the same messages but does not result in real change. Honouring the voices of the people who shared their stories with the Inquiry means there must now be decisive action.

Our approach is to focus on a few critical changes to shift the system

It is clear to us that many people in all parts of our communities, including in our mental health and addiction workforce, know what needs to be done and are working hard to move the system in the desired direction. There are many pockets of success but overall progress has been slow and inconsistent. As we said in Part 1, we believe that roadblocks need to be removed, missing foundations put in place, and a government commitment to action made.

There has been too much ad hoc and fragmented investment over a number of years, often on a short-term basis and without coordination. Promising initiatives have developed without any clear plans for evaluation and scaling up. This has contributed further to the fragmentation in the system and led to frustration at the lack of sustained traction. We do not want to perpetuate that.

Therefore, we have explicitly avoided developing another strategy or a 'shopping list' of activities, or short-term investments. We do not want to dilute attention from the most important things necessary to create the right environment to support a significant shift over time in how we prevent and respond to mental health and addiction challenges.

Instead, our approach to the question ‘what needs to happen?’ is to focus on a few critical measures that together will shift the whole system. Important policy decisions and legislative change backed by a commitment to a long-term funding path are needed. These changes are intended to enable a transformation in our approach to mental health and addiction, with a focus on wellbeing and community solutions. They will underpin the shift from ‘big psychiatry’ to ‘big community’ that the Wellbeing Manifesto calls for.¹⁰²

A strong economic case exists for further investment in mental health and addiction

The economic costs of mental illness are substantial. Recent estimates for OECD countries are that mental illness reduces gross domestic product (GDP) by approximately 5%, through disability leading to unemployment, work absenteeism and reduced productivity, and the additional costs of physical health care among people with mental health problems.

However, cost-effective treatments are available for common mental disorders for which the savings through restored employment and productivity outweigh the costs. For example, for every \$1 spent treating depression, \$2.50 of productivity is restored and \$1 of physical health care cost is saved. In high income countries it has been estimated that increasing coverage (particularly of psychological treatments) to an additional one quarter of people experiencing mental health problems by 2030 would cost an additional 0.1% of GDP.¹⁰³

Key principles that underpin our recommendations

Commitment to equity and the Treaty of Waitangi

We recognise and support the need for a real government commitment to the Treaty of Waitangi, with policies and services that ensure current inequities are addressed and disparities between the health of Māori and non-Māori are eliminated. This commitment to equity and the Treaty of Waitangi underpins all our proposals. It is a commitment that should be evident in all the actions that follow. We also emphasise the need for active Māori participation in the design, commissioning, management and delivery of mental health and addiction services, health promotion programmes and strategies for prevention. Investment in Kaupapa Māori services will provide more choices for Māori seeking support, and a skilled cultural workforce will be able to deliver appropriate and effective services. A Treaty-based approach that involves Iwi and Māori community leaders will also be highly pertinent to tackling the wider social determinants that underlie intergenerational trauma and inequity in our society.

102 M O’Hagan. 2018. *Wellbeing Manifesto for Aotearoa New Zealand: A submission to the Government Inquiry into Mental Health and Addiction* (prepared for PeerZone and ActionStation). www.wellbeingmanifesto.nz/.

103 R Layard. 2018. Mental illness destroys happiness and is costless to treat. In Global Happiness Council. *Global Happiness: Policy report 2018* (chapter 3). New York: Sustainable Development Solutions Network. www.happinesscouncil.org.

People first

Our vision in Part 1 puts people with lived experience and consumers at the centre in the system. Our proposals reflect this by affirming human rights and the rights of consumers of mental health and addiction services under the Code of Health and Disability Services Consumers' Rights. We recognise the importance of treating people with empathy, dignity and respect and wish to see a greater role for people with lived experience in decisions about the design and delivery of services. Our proposals acknowledge the central place of families and whānau and the roles they play in supporting, nurturing and caring for family members.

A shared responsibility

Improving the mental health and wellbeing of people in our society is everyone's responsibility. The health system is one important player but, to make genuine progress, we must look further afield to solutions outside the health system and outside government. This has long been known but has been difficult to action. For example, the 1998 Blueprint (which gave effect to the 1994 National Mental Health Strategy¹⁰⁴) was necessarily restricted in its focus, noting that achieving a broad goal of decreasing prevalence of mental illness and mental health problems would require "a much wider approach involving other sectors".¹⁰⁵ It, therefore, focused only on a goal of addressing the impact of mental disorders on consumers, families, caregivers and the community.

Since that time, however, there has been increasing recognition of the need for cross-sectoral action on a whole range of complex social issues. Mechanisms to support cross-agency approaches have evolved significantly. This Inquiry builds on these developments. We now have a real opportunity to make sure all relevant sectors are fully involved in preventing and responding to mental health and addiction challenges and promoting wellbeing. This includes joined-up approaches within government and beyond. For example, we see models such as Whānau Ora commissioning and service provision as pointing the way, tackling the social determinants of health and providing wrap-around support earlier, in the community and closer to home.

104 Ministry of Health. 1994. *Looking Forward: Strategic directions for the mental health services*. Wellington: Ministry of Health. [www.moh.govt.nz/notebook/nbbooks.nsf/0/DAA659934A069A234C2565D70018A75A/\\$file/looking-forward.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/DAA659934A069A234C2565D70018A75A/$file/looking-forward.pdf).

105 Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission, p 3. [www.moh.govt.nz/notebook/nbbooks.nsf/0/0E6493ACAC236A394C25678D000BEC3C/\\$file/Blueprint_for_mental_health_services.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/0E6493ACAC236A394C25678D000BEC3C/$file/Blueprint_for_mental_health_services.pdf).

Build on the foundations already in place

In Part 1, we concluded that we should build on the foundations already in place. We have not proposed major structural change to the health system, since we do not have any evidence to show this is necessary or desirable, and we think it could lead to widespread disruption and delay progress. We also consider that mental health and addiction services should remain part of the wider health and disability system and not be separated into a stand-alone system. The goal should be greater integration of services, not further separation.¹⁰⁶ Our overall approach is, as far as possible, to build on the structures and systems in place now.

However, given the force of some submissions, we gave a lot of consideration to whether to recommend changes in how mental health, addiction and other social services are commissioned and by whom. Many non-governmental organisation (NGO), Māori and Pacific providers voiced concern to us about the current district health board (DHB) model, with DHBs having dual roles as funders and providers. Iwi asked for direct control of resources, while some NGOs called for a new wellbeing agency to commission services. We also note the complexity of having 20 independent DHBs, a Ministry of Health with significant commissioning responsibilities, and a range of other government agencies that also commission a variety of health and social services.

We acknowledge these issues and share some of the concerns, particularly about some aspects of commissioning with NGOs (which we discuss below). We expect that the Health and Disability Sector Review will consider broader issues about roles and functions of DHBs and, as noted earlier, the establishment of a Māori health ministry or commission with broad functions also deserves further consideration.¹⁰⁷

In the meantime, we see it as essential that commissioning approaches are improved to support a focus on wellbeing and services in the community. Necessary changes include better contracting practices and greater partnerships with Iwi and Māori, Pacific peoples, people with lived experience of mental health and addiction challenges, and NGO and other providers.

¹⁰⁶ We note that Lord Darzi's 10-point plan for reforming the United Kingdom's National Health System – albeit in the context of a much larger population, with separate commissioning of social and mental health services – recommended radically simplifying structural arrangements, including explicitly reducing and streamlining the number of commissioners in the National Health System, stating that “no other system in the world has chosen to fragment rather than consolidate”. A Darzi. 2018. *Better Health and Care for All: A 10-point plan for the 2020s*. London: Institute for Public Policy Research. www.ippr.org/research/publications/better-health-and-care-for-all.

¹⁰⁷ We have taken account of other Inquiries and reviews launched by the Government that touch on issues considered in this Inquiry, including the Royal Commission into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry (Wai 2575), Review of Tomorrow's Schools, Whānau Ora Review, and reviews by the Welfare Expert Advisory Group and the Safe and Effective Justice Advisory Group.

Overview of recommendations

The remainder of Part 2 sets out in detail what needs to happen. We recommend major changes in current laws and policy, supported by significant increases in funding. Nine topic chapters work together as a package. The chapters are listed in Figure 2, and each chapter is summarised below.

Figure 2: Chapters in Part 2



Chapter 4 begins by setting out the case for a significant increase in **access and choice** to mental health and addiction services. This includes an explicit change to current policy settings that focus funding and services on people with the most severe needs, with a current target of 3% of the population being able to access services each year. We argue that coverage of services needs to expand significantly from the current 3.7% of the population who access specialist services, given figures suggesting around one in five people experience mental health and addiction challenges in any given year. We make the case for a greater range of services and therapies, particularly more talk therapies, alcohol and other drug services and culturally aligned services. This will need to be supported by a national service co-design process with support for national, regional and local implementation, and key enablers such as workforce, funding, information and evaluation and changes to funding and accountability rules.

Another main area for change is the **primary health care** sector to overcome barriers that have inhibited the innovation originally envisaged by the Primary Health Care Strategy (**chapter 5**). New models of care, including to address mental health and addiction issues, have been slow to develop. Accessing services in general practices continues to be unaffordable for too many people. We endorse the focus on primary health care by the Health and Disability Sector Review.

Supporting a sustainable **NGO sector** is another area of focus, given the significant role NGOs already play in mental health and addiction services (**chapter 6**). This role will only increase with the shifts towards more community-based services that we propose. This sector is facing challenges and a clear stewardship role is needed in central government to support NGO development and sustainability.

In **chapter 7**, we call for a **whole-of-government approach to wellbeing** to tackle social determinants and support prevention activities that impact on multiple outcomes, not just mental health and addiction. The current approach is fragmented, without clear leadership for coordinating cross-government strategy and investment. A locus of responsibility is needed, for example a social wellbeing agency, to take on this important role. This agency could also take a lead role in issues such as NGO stewardship (chapter 6) and alcohol and other drugs (chapter 9). In addition, an investment and quality assurance strategy for **mental health promotion and prevention** must be developed. This could be led by the new Mental Health and Wellbeing Commission (chapter 12) in partnership with a social wellbeing agency to ensure a cross-sector focus.

Chapter 8 highlights specific measures to put **people at the centre** (although this is also a principle that underpins all our proposals). This includes measures to support **consumers and people with lived experience** to play a greater role in policy, governance, service planning and delivery and to enhance consumers' knowledge about their rights. Partnering with **families and whānau** in supporting people experiencing mental health and addiction issues is a priority, as is providing more support for families and whānau themselves.

We recommend strong action on **alcohol and other drugs** in **chapter 9**. This includes regulatory reform on both alcohol and other drugs and significantly increased availability of treatment and detox services. Clear cross-sector leadership is needed, possibly located in a social wellbeing agency (chapter 7).

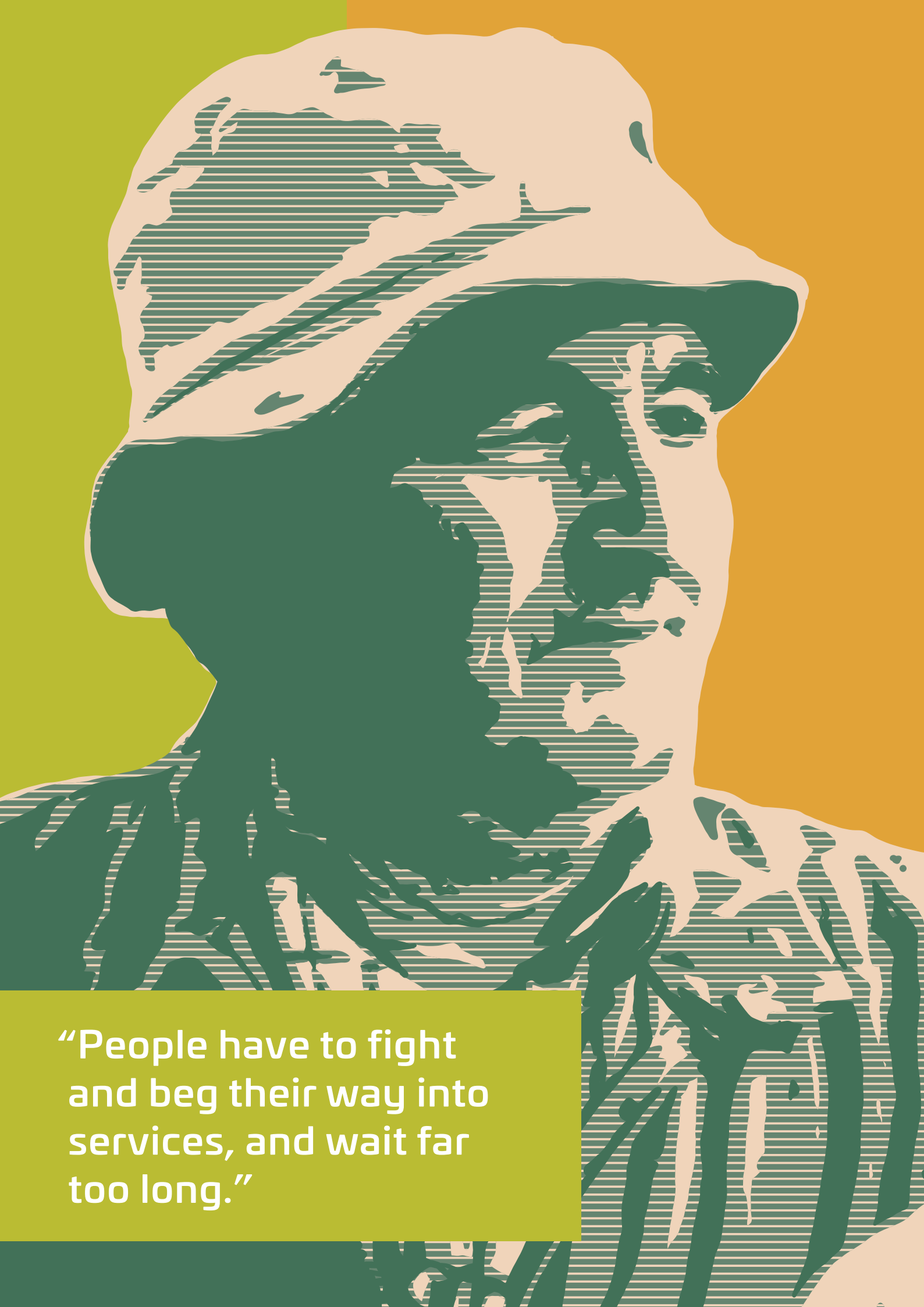
There is an urgent need to complete and implement the national **suicide prevention** strategy and implementation plan (**chapter 10**). We recommend a new suicide reduction target to drive action. Leadership and increased resources for suicide prevention and postvention are needed, along with a review of processes for investigation of deaths by suicide.

A key piece of legislation, the **Mental Health (Compulsory Assessment and Treatment) Act 1992**, is outdated and must be repealed and replaced (**chapter 11**). The Act does not reflect a human rights approach, promote supported decision-making or align with a recovery and wellbeing model. It must more strongly support the goal of minimising compulsory or coercive treatment. We also think New Zealand needs a national-level discussion, carefully crafted, to reconsider beliefs, evidence and attitudes about mental health and risk.

Leadership is essential. A new **Mental Health and Wellbeing Commission (chapter 12)** will play a critical role in enhancing leadership and oversight of the mental health and addiction system, partnering with both government and non-government agencies (including any social wellbeing agency), and acting as a much-needed change agent to bring resource and expertise to support the proposed co-design and implementation process in chapter 4.

We refer **broader structural and system issues** relating to primary care, the DHB model and the proposal for a Māori health ministry or commission to the Health and Disability Sector Review for further consideration.

Finally, **collective and enduring political commitment** is needed to improve mental health and wellbeing in New Zealand. We recommend the formation of a cross-party working group in the House of Representatives (**a final note**).



“People have to fight and beg their way into services, and wait far too long.”

Chapter 4

Access and choice

Main points

- New Zealand's mental health and addiction system should be able to offer support to all those who need it.
- New Zealand has deliberately focused on expanding and funding services for people with the most serious needs. This has placed intense pressure on specialist services and resulted in very few services for those with less severe needs, even when they are highly distressed. Regardless of whether people can access services, the options available to them are limited.
- Access to (and funding for) mental health and addiction services needs to be significantly increased, from the 3.7% of the population who currently access specialist services to the 20% who experience mental health and addiction issues each year. An explicit decision must be made to do this, supported by funding a wider spectrum of suitable and culturally acceptable service options (particularly talk therapies, alcohol and other drug services, and culturally aligned services).
- This expansion will transform current mental health and addiction services. Making it happen requires the involvement of all key players in a co-design process and implementation support for the change process itself. It will also involve workforce development, better information, commitment to a clear funding path, new rules and expectations and strong leadership.

4.1 Introduction

One of this Inquiry's conclusions is that an urgent need exists to expand access and choice in mental health and addiction services.

Gaps in services, difficulties accessing services and a threshold for mental health and addiction services that seems increasingly hard to reach were key themes in what we heard. While some attributed these themes to a general underfunding of mental health and addiction services, others questioned where funding is being directed and how well it is being spent.

The system is unbalanced in focusing almost entirely on specialist services targeted at those people with the most severe mental health and addiction needs. Beyond this group, a significant gap exists in what is commonly referred to as the 'missing middle' or 'middle ground': people with mild to moderate and moderate to severe mental health and addiction needs. This gap is the result of deliberate policy choices that have shaped our mental health and addiction system over many

years. We believe it sits behind much of what we heard about people's inability to access services and contributes to the growing pressure on specialist services. We emphasise that this gap must be addressed, but not by diverting funding away from services for people with the most severe needs. Maintaining access for this group must remain a priority.

Even for people with severe needs who are able to access services, those services are spread thin. Oversight by psychiatrists and the use of prescription medicines play a necessary and important role, although debate about the balance of harms and benefits of some psychiatric medications is growing.¹⁰⁸ However, patients often do not get access to wider talk therapies or have their broader social and wellbeing needs met. For those in the middle ground who do not meet the criteria for access to specialist services, often the only option is to obtain a prescription for medication from a general practitioner (GP). There is only limited and highly targeted funding for other interventions such as talk therapies or peer and cultural support options that would more effectively address the root cause of their distress. More choices are, therefore, needed about the types of services and treatments available.

Finally, a broader range of service models and ways of delivering services that allows people to access services in different ways and in different contexts is required, whether that be more options for Kaupapa Māori or Whānau Ora services, Pacific models, youth one-stop shops, or primary and community hubs with teams of practitioners working together to support a range of needs. As outlined in chapter 3, greater integration of services is required to provide a more seamless and joined-up experience, including between primary and secondary mental health and addiction services, between services addressing mental and physical health, and between health and other social services.

The objective of expanding access and choice will need to be supported by several enablers such as future service design, commissioning approaches, including funding and accountability rules, workforce development, information and research, and joined-up leadership.

In this section, we discuss four areas:

- expand access and eligibility to mental health and addiction services beyond people with the most severe mental health and addiction needs (section 4.2)
- provide a wider menu of service options, especially additions to medication such as talk therapies, alcohol and other drug services and culturally aligned therapies (section 4.3)
- transform services by a national co-design process, with support for implementation (section 4.4)
- enablers to support expanded access and choice (section 4.5).

108 See, for example, Letter to the Royal Australian and New Zealand College of Psychiatrists. 2018. *Mad in America*. www.madinamerica.com/2018/03/letter-royal-australian-new-zealand-college-psychiatrists/.

4.2 Expand access to mental health and addiction services

4.2.1 Issues

Services are missing for people with less severe mental health and addiction needs

One of the most striking features of our current system of mental health and addiction services, is that it focuses almost entirely on those people with the most severe needs. New Zealand has relatively few publicly funded services for people with less severe mental health and addiction challenges. This includes high prevalence conditions such as anxiety and depression, and conditions related to alcohol and other drugs.

While we have succeeded in our deliberate policy goal of expanding services and support for people with the most serious needs, the almost exclusive focus on this group means opportunities for early intervention are lost. We fail to respond adequately to many people who are experiencing high levels of personal distress, often with a significant impact on their lives, but who do not meet the eligibility criteria for specialist services.

The lack of access to a broader range of options outside of specialist mental health services means that people remain in those services far longer than they need through fear of being discharged and then not being able to access support if and when they need it. Services are hard to get into, making people and clinicians reluctant to discharge. This provides an incentive to stay in the specialist system just to get ongoing support even when a general practice could provide clinical support. The fact specialist services are free, unlike most primary care services, creates another perverse incentive.

Finally, specialist services themselves are under intense pressure. At least some of this pressure is due to gaps in earlier intervention, resulting in distress escalating to the point where needs become severe and specialist services are needed. Sometimes though, people seek access to specialist services that are not necessarily the most appropriate for their needs, simply because there is nowhere else to go. All of this puts even more pressure on these services and creates a vicious cycle with negative impacts on access and quality.

Why mental health and addiction services focus on people with the most severe needs

The current system is designed quite explicitly to prioritise people with the most severe needs. To understand this more, we looked closely at mental health strategies, plans, rules for mental health and addiction funding in Vote Health, district health board (DHB) service specifications and policy settings. We describe these below.

As outlined in chapter 1, most publicly funded mental health and addiction services are funded through Vote Health, with about \$1.4 billion being spent on mental health and addiction services annually, of which \$1.35 billion is devolved to DHBs (in 2016/17). This funding is ring-fenced so it is protected within the DHB bulk-funding environment, and tight rules determine how the ring-fenced funding is to be managed and spent. These rules are also reflected in DHB mental health and addiction service specifications that set out the services DHBs are required to fund. These rules are not the *reason* the system is oriented the way that it is – they merely reflect and reinforce the policy decisions that have led to this situation.

In summary, the rules¹⁰⁹ around mental health and addiction funding are that:

- DHBs must maintain or increase mental health and addiction expenditure by applying at least demographic and cost-pressure adjustments each year
- funding must be used for services for people with the most severe mental health and addiction needs
- DHBs must fund ‘specialist services’¹¹⁰ for at least 3% of their population; once that target is reached, DHBs may use any remaining funding for other mental health and addiction services.¹¹¹

In comparison, about \$30 million is allocated specifically for primary mental health services for those with less severe needs. (See Appendix B for further detail about mental health and addiction funding and services.)

In some respects, the orientation of the system towards high-end, acute and specialist services and the challenge of investing more earlier is not unique to the mental health and addiction system. All health systems, including New Zealand’s, are grappling with this issue. This is reflected in New Zealand’s 2016 Health Strategy¹¹² and as far back as the 2001 Primary Health Care Strategy.¹¹³

Mental health and addiction services have additional dynamics. The policy of deinstitutionalisation in the 1980s and 1990s saw the widespread closure of psychiatric hospitals with most services shifted out of residential institutions and into community settings. Building on the 1994 strategy for mental health services¹¹⁴ and the 1996 Mason Inquiry report, the first Blueprint in 1998¹¹⁵ set in place a plan so services would be available, and prioritised, to people with the most severe mental health and addiction needs.

This group of people – those who had very severe needs – was estimated to be around 3% of the population in any given year, but in the late 1990s only about 1.5% of the population were receiving services. Therefore, coverage of 3% became the target.

This priority was supported by the introduction of mental health ring-fenced funding and associated rules that protected mental health money for its intended use on mental health services that were prioritised towards people with the most severe mental health and addiction needs.

109 Ring-fence rules are set out in Ministry of Health. 2016. *Operational Policy Framework 2018/19* (version 28 August 2018). <https://nsfl.health.govt.nz/accountability/operational-policy-framework-0/operational-policy-framework-201819>.

110 Details of the types of services that DHBs must provide are set out in Ministry of Health. 2017. *Mental Health and Addiction Services: Tier one service specification* (last updated 1 April 2017). <https://nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-and-addiction-services>. Note that ‘specialist services’ is the term used to describe a variety of services, including inpatient, forensic, and community-based mental health and addiction services and other social support services.

111 National coverage was about 4% in 2016/17 with some DHBs at 5–6% coverage (data supplied by the Ministry of Health).

112 Minister of Health. 2016. *New Zealand Health Strategy: Future direction*. Wellington: Ministry of Health. www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf.

113 Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health, p 21. www.health.govt.nz/system/files/documents/publications/phcstrat.pdf.

114 Minister of Health. 1994. *Looking Forward: Strategic direction for the mental health services*. Wellington: Ministry of Health. [www.moh.govt.nz/NoteBook/nbbooks.nsf/0/DAA659934A069A234C2565D70018A75A/\\$file/looking-forward.pdf](http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/DAA659934A069A234C2565D70018A75A/$file/looking-forward.pdf).

115 Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission. [www.moh.govt.nz/NoteBook/nbbooks.nsf/0/0E6493ACAC236A394C25678D000BEC3C/\\$file/Blueprint_for_mental_health_services.pdf](http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/0E6493ACAC236A394C25678D000BEC3C/$file/Blueprint_for_mental_health_services.pdf).

Previous attempts to expand the focus of the system

Concerns about focusing the system on people with the most severe needs, without a parallel focus on prevention, promotion and early intervention, have been raised over many years, including by the National Health Committee during the Mason Inquiry.¹¹⁶ The issue has always been that when resources are constrained, any change in priority might result in a reduction of access to services for people with severe needs.

Several strategic documents have sought to expand the focus of mental health and addiction services so services would be delivered across the spectrum of need. For example, Blueprint II for improving mental health and wellbeing for all New Zealanders stated:¹¹⁷

The first Blueprint successfully championed the recovery approach and the drive to provide access to services for the 3% of people most seriously affected by mental health and addiction issues.

We are now increasingly aware of the needs of those who have a lower level of need but whose mental health and addiction issues impact significantly on their overall health and their ability to function at home or at work. We are also more aware of the significant benefits of early recognition and response, as well as the importance of working across the whole health sector and other government agencies to achieve the best outcomes for people and society.

The new direction signalled by Blueprint II, and adopted as policy,¹¹⁸ is entirely consistent with the many calls we heard for a system with a continuum of services to address the spectrum of mental health and addiction needs, but did not seem to result in a significant shift.

Given this supposed change in policy, we were surprised to find that the current rules about what mental health ring-fenced funds can be spent on and the requirements on DHBs for the types of mental health and addiction services they must fund, still reinforce the priority of delivering services for people with the most severe mental health needs and are virtually silent on what services should be available for those with mild to moderate and moderate to severe needs.¹¹⁹

We conclude that a fundamental disconnect exists between stated strategic direction, funding and operational policy and ultimately service delivery.

116 Committee of Inquiry into Mental Health Services (K Mason, Chair). 1996. *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley*. Wellington: Ministry of Health. <https://tinyurl.com/y6w4nqr5>.

117 Mental Health Commission. 2012. *Blueprint II: How things need to be*. Wellington: Mental Health Commission, p 6. www.hdc.org.nz/media/1075/blueprint-ii-how-things-need-to-be.pdf.

118 Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health. www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017.

119 Rule 12.21.2 (a) of the rules for mental health funding: Ministry of Health. 2016. *Operational Policy Framework 2018/19* (version 28 August 2018). <https://nsfl.health.govt.nz/accountability/operational-policy-framework-0/operational-policy-framework-201819>.

Current response to people with mild to moderate and moderate to severe needs

Although the main focus has been on services for people with the most severe needs, some ability to respond to less severe needs exists, mostly through Vote Health funding, but also from other sources. This response, however, has been limited.

Some specific funding for primary mental health services is available (about \$30 million in 2016/17), which DHBs have used to support initiatives in primary mental health, including counselling sessions and extended GP visits. This funding is tightly targeted to young people, Māori, Pacific peoples and people on low incomes. Under the Fit for the Future programme, \$5 million was also made available for three time-limited primary mental health initiatives in 2016.

DHBs can use ring-fenced funding for primary mental health services if they meet the target of 3% of the population accessing specialist services during any year. We are aware that some DHBs have attempted to do more in primary mental health, working with primary health organisations and non-governmental organisations (NGOs), although the rules they operate within do not support this particularly well. As one former DHB mental health service planner said in relation to trying to develop services for people outside the 3% target group:¹²⁰

Unfortunately the primary mental health funding was small and in no way sufficient to tackle the full spectrum of need in the 17%. Investing upstream became a focus for us in the latter years and we invested in the first three years of life targeting the full spectrum of need (from prevention through to those most in need). We were really constrained because funding was still targeted at the 3% but we were able to be creative particularly with underspend from late start of services.

Primary health care services are another critical part of the response to mental health and addiction needs. Although not funded specifically for these services other than by the funding identified above, primary health organisations (PHOs) and general practices are funded through general capitation funding to respond to the health needs of their enrolled populations. Capitation funding is, thus, intended to respond to the mental health and addiction needs of enrolled patients whose needs are not dealt with through DHB specialist services. It was always anticipated in the Primary Health Care Strategy that there would be a focus on mental health, including liaising with specialist services to support people with chronic conditions. PHOs were also expected to consider how they could contribute to reducing the “incidence and impact of mental health problems ... specifically education, prevention and early intervention activities”.¹²¹

120 Communication to the Inquiry from Dr Sue Hallwright.

121 Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health, p 21. www.health.govt.nz/system/files/documents/publications/phcstrat.pdf.

We note also that the service specifications for DHBs for specialist mental health and addiction services state:¹²²

primary mental health services provide a general primary care response to the needs of people of any age with mild or moderate illness. The national expectations are outlined in the primary health strategy and are excluded from this suite of service expectations.

The implication of all of this is that primary health care services were expected to play a significant role in responding to less severe mental health and addiction needs. This was to be achieved through a significantly transformed primary health care sector, as envisaged by the Primary Health Care Strategy. That did not happen. We discuss the unfulfilled expectation of primary health care transformation separately in chapter 5.

Other options for people with less severe needs include accessing services funded through other agencies (for example, the Accident Compensation Corporation, Oranga Tamariki—Ministry for Children, the Department of Corrections and the New Zealand Defence Force) or accessing education-based health services. Many workplaces also fund a limited number of free counselling sessions for staff. Those who can pay for private care do so, although submitters noted that these services are often out of reach even for middle-income people as, even where they are available, they are expensive to access.

In summary, despite the rhetoric of various strategic documents, our system has not shifted significantly nor has there been explicit funding and direction to support a broader spectrum of services. This helps explain why so many people report unmet need, gaps in services and pressure on current services.

Attempts to fill the gap in services for people with mild to moderate and moderate to severe needs have been either ineffective or piecemeal. The Primary Health Care Strategy has not delivered a transformed primary care sector, and the relatively small amounts of tightly targeted primary mental health funding (or, more recently, time-limited pilots or demonstration projects) are not sufficient to fill the gaps in services. Allowing DHBs to use ‘left over’ ring-fenced funding is not a sustainable way to plan and build services to meet the needs of people with less severe mental health and addiction needs. A new approach is needed.

4.2.2 What needs to happen

New Zealand needs to stop *talking* about the need for a continuum of services to address mental health and addiction needs across the spectrum and make *action* a priority. A clear policy decision is needed to do this, and it needs to be backed up with a commitment to a funding path, funding rules and expectations that align with the desired direction, and an appropriate workforce.

We were struck when looking at other countries’ approaches that several already fund broad-based access to mental health and addiction services for people in the middle ground (especially talk therapies, such as 6–10 sessions of free counselling), including the United Kingdom, the Netherlands, Australia and the United States. Of course, differences exist between the health systems of these countries and New Zealand’s, and services need to be appropriate for our population, including our indigenous population. But, overall, they demonstrate much greater commitment and investment in providing access to mental health and addiction services to address a wider range of needs than is evident in New Zealand.

¹²² Ministry of Health. 2017. *Mental Health and Addiction Services: Tier one service specification* (last updated 1 April 2017), p 2. <https://nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-and-addiction-services>.

The United Kingdom's programme was introduced following analysis presented in 2005 that clearly set out the human and economic costs of failing to invest outside of, what was at that time, the 1% of the United Kingdom population who had the most severe needs.¹²³ Similar arguments can, and should, be made here.

A clear policy objective and access target

We recommend an explicit policy decision to expand access to mental health and addiction services beyond the group identified with severe needs requiring specialist services to include those with mild to moderate and moderate to severe needs. While this does not mean that everyone with mental health and addiction challenges needs or will seek to access a specific service intervention, over time, more people should be able to access support.

The last mental health Inquiry in 1995–1996 recommended an access target of 3%. This has been in place ever since and access rates have now reached 3.7% nationally. We propose setting a new target for significantly increased access to mental health and addiction services. Given current prevalence data suggesting one in five people experience mental health and addiction challenges at any given time, an indicative access target may be 20% within the next five years.

We recognise that further work will be required to identify a specific coverage target (since not everyone will need or want to access a service), definitions of services and access, how access might be expanded over time, and a cost-effective way to achieve the objective. Our point, however, is that a more concerted, widespread and ambitious approach is needed to expanding access to services than the piecemeal and limited approaches to date.

We recommend that the Ministry of Health undertake further work, with advice from the new Mental Health and Wellbeing Commission (chapter 12), to develop the specific target, bearing in mind that it will also be necessary to consider what mix of interventions will be both effective and cost-effective (for example, e-therapies may be a cost-effective and more easily accessible option for some people). Any target should also consider timeliness and quality.

Finally, priority for access to services should continue to be based on need. Access to services should be broad-based and related to the level of mental health and addiction need, rather than targeted on the basis of age, ethnicity or income (as current primary mental health services are). This is consistent with the approach to funding other core health services. We see no reason why mental health and addiction services should be treated differently. It is imperative that access for people with the most severe needs is not reduced in any way.

A funding path, workforce, and new funding and accountability settings

Additional investment in services for people with less severe mental health and addiction needs is required. We cannot simply stretch resources currently allocated to services for severe mental health and addiction needs to also cover services for less severe needs. We expect demand for specialist services will reduce as issues are dealt with earlier, before they escalate, but shifting resources to the middle ground would pose unacceptable risks for people with the most severe needs.

¹²³ DM Clark. 2018. Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology* 14: 159–183; R Layard. 2005. Mental health: Britain's biggest social problem? Strategy Unit seminar on mental health, 20 January. http://eprints.lse.ac.uk/47428/1/_Libfile_repository_Content_Layard_Mental%20health%20Britain%E2%80%99s%20biggest%20social%20problem%28Isero%29_Mental%20health%28Isero%29.pdf.

To achieve the objective of significantly increased access within five years, a commitment to a clear funding path is needed (see section 4.5.3). Significant investment will also be required to build a workforce able to deliver the range of services needed to support people across the spectrum of mental health and addiction needs. This investment should start as soon as possible, as it will take time to train the workforce. Workforce issues are discussed further in section 4.5.1.

Expanded access and eligibility will also require alignment between formal policies, funding rules and expectations on key actors, such as DHBs and primary health care providers, to reinforce and support the desired direction. Strategy documents over the years have envisaged a continuum of mental health and addiction services across the spectrum of need, but they have not been translated into operational policy or funding and accountability requirements. These enablers are discussed further in section 4.5.4.

Recommendations

Expand access

1. **Agree** to significantly increase access to publicly funded mental health and addiction services for people with mild to moderate and moderate to severe mental health and addiction needs.
2. **Set** a new target for access to mental health and addiction services that covers the full spectrum of need.
3. **Direct** the Ministry of Health, with input from the new Mental Health and Wellbeing Commission, to report back on a new target for mental health and addiction services.
4. **Agree** that access to mental health and addiction services should be based on need so:
 - access to all services is broad-based and prioritised according to need, as occurs with other core health services
 - people with the highest needs continue to be the priority.

4.3 Provide a wider menu of service options

4.3.1 Issues

As well as greater access to services, people have called for more choice in the *types* of services available. Māori want Kaupapa Māori options and Pacific peoples want access to services that align with their cultural values. Likewise, other groups such as the Deaf, Rainbow, and refugee and migrant communities want services that are culturally responsive and capable of meeting their specific and diverse needs.

People want a choice of therapies. A key thing many people asked for was ‘someone to talk to’ rather than only medication. Obviously, medication will remain an important treatment option, but our current system does not provide sufficient access to other evidence-based options such as talk therapies, alcohol and other drug services and culturally aligned therapies. Choice applies to people across the spectrum of need, not just in the middle ground.

Evidence of the cost-effectiveness of talk therapies and potential savings for health systems and other parts of government, provides support for making these therapies more widely available. For example, in the United Kingdom it has been estimated that providing free access to psychological therapies produces health service and Treasury savings (through increased tax revenues and reduced income support payments) that well exceed the cost of providing the therapies.¹²⁴ Similarly, it has been estimated that the societal benefits for New Zealand of providing cognitive behavioural therapy far outweigh the associated costs.¹²⁵ Making these therapies more widely available with suitable adaptations to different cultural and delivery contexts should be a priority.

While all countries are grappling with demands on mental health and addiction services, as noted above, some countries have decided to publicly fund services to provide access for a much broader range of their citizens. These programmes typically include broad-based access to a certain number of counselling sessions or other talk therapies. Examples include the Improving Access to Psychological Therapies programme in the United Kingdom¹²⁶ and the Medicare-funded scheme for Better Access to Mental Health Care in Australia.¹²⁷ The experience of these countries is that demand for these services stabilises, which provides a level of cost certainty each year.

A critical element to build and improve our mental health and addiction services is to develop a broader range of services to provide more choice for people seeking help. We believe one of the priorities must be to broaden access to evidence-based talk therapies. These services can be delivered in a variety of settings, such as DHB community mental health services, primary health care services, youth one-stop shops, Kaupapa Māori and Pacific services. However, regardless of the setting, a critical need is to build workforce capacity and capability to meet current and future demand, with the capability to provide new and innovative support and intervention options.

These therapies can also be delivered by different types of practitioners. While some self-help and e-mental health programmes do not depend on an expanded workforce, many talk therapies and culturally aligned models need to be delivered by skilled workers. A wide range of practitioners can deliver psychological therapy if suitably trained. They include the non-registered workforce, GPs and practice nurses, mental health professionals, peers and cultural practitioners. Higher intensity talk therapies can be delivered by people who have a qualification recognised under the Health Practitioners Competence Assurance Act 2003 and who have specialist training in talk therapies. The disciplines that currently incorporate specialist training in their professional qualifications include psychology, psychiatry, psychotherapy and counselling.

124 DM Clark. 2018. Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology* 14: 159–183.

125 Te Pou o Te Whakaaro Nui. 2012. *Exploring the Economic Value of Talking Therapies in New Zealand: Utilising cognitive behavioural therapy as an example*. Auckland: Te Pou o Te Whakaaro Nui. www.tepou.co.nz/uploads/files/resource-assets/exploring-the-economic-value-of-talking-therapies-in-New-Zealand-utilising-cognitive-behavioural-therapy-as-an-example.pdf.

126 DM Clark. 2018. Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology* 14: 159–183.

127 Australian Psychological Society. No date. Better access to mental health care: Medicare funded services (web page). www.psychology.org.au/for-the-public/Medicare-rebates-psychological-services/Medicare-FAQs-for-the-public# www.psychology.org.au/for-the-public/Medicare-rebates-psychological-services/Medicare-FAQs-for-the-public (accessed 16 October 2018).

4.3.2 What needs to happen

New Zealand needs to broaden the types of services available to address mental health and addiction needs, with a priority being to ensure we have the capacity and capability to provide far greater access to evidence-based talk therapies for people across the entire spectrum from mild to moderate through to severe needs that can be delivered in a range of settings including within different cultural service models. We propose that specific priority also be given to funding more alcohol and other drug services, since service options appear particularly limited for people seeking to recover from addictions.

While psychologists are not the only practitioners who can deliver these therapies, an immediate priority is to begin building this part of the workforce, given the likely lead in time to build capacity. Modelling by Health Workforce New Zealand suggests that, while the number of psychologists will increase over the next 10 years, this will not keep up with expected population growth.¹²⁸ This is without the impact of the proposal we make to significantly expand service access to up to one in five of the population, which will require a large increase in the publicly funded provision of talk therapies and culturally aligned therapies that are especially relevant to Māori and Pacific peoples. Broadening the range of people who have the skills to provide more intensive interventions is critical.

We understand that psychologists generally support the concept of other practitioners delivering psychological therapies. However, the success of these approaches depends on factors such as access to high-quality training, supervision and delivering enough therapy to maintain quality. Psychologists and skilled nurse specialists may need to directly provide therapies for people with more severe and complex needs and will play an important role as members of multi-skilled and multicultural intervention teams. They may also provide advice and oversight for others delivering psychological therapies with less training and experience.

Apart from psychologists, we also see the need for psychiatrists to have an extended range of interventions that include psychotherapy, talk therapy and family therapy. We recognise that those skills have long been an essential part of psychiatric training, but all too often they are subsumed by an over-emphasis on medication. When they are combined, the dual approaches – medication and psychotherapy – provide clinicians and tāngata whaiora with a more relevant and integrated approach to mental health.

We agree with submitters who said the focus needs to be on three areas to increase access to these therapies: increased access to psychologists, psychological therapies delivered by non-psychologists and e-therapies. There also needs to be investment in supporting the development of culturally responsive therapeutic interventions and a broader range of more intensive peer-provided options. This will require investment in a suitable workforce. A further area of focus will be to consider delivery mechanisms that would expand access, such as group therapies and brief interventions for people with mild to moderate needs.

¹²⁸ Health Workforce New Zealand, from demonstration of its modelling tool, July 2018.

We propose that the Ministry of Health builds on existing workforce modelling, including that presented to us by the Psychologist Workforce Taskforce, and examine approaches from other countries to providing broad-based access to evidence-based talk therapies (for example, Australia, the Netherlands, the United Kingdom and the United States, including indigenous models from Alaska¹²⁹). The intention should be to develop a range of approaches that are appropriate for New Zealand, ensuring ready access to talk therapies, culturally aligned therapies and a menu of alcohol and other drug services.

Recommendations

Increase choice of services

5. **Commit** to increased choice by broadening the types of mental health and addiction services available.
6. **Direct** the Ministry of Health to urgently develop a proposal for Budget 2019 to make talk therapies, alcohol and other drug services and culturally aligned therapies much more widely available, informed by workforce modelling, the New Zealand context and approaches in other countries.

4.4 Transform services through a national co-design process, with support for implementation

4.4.1 Issues

We need to focus on how services are delivered

We have proposed extending access to services and broadening the types of services available to provide more choice to people, with a particular focus on talk therapies that can be delivered in different settings and by a variety of providers. However, to deliver on the vision for services outlined in section 3.6, fundamental changes are needed in how services are delivered.

These changes need to be planned, developed, implemented and monitored in a more structured and coordinated way than the present approach of ad hoc funding, 'letting a thousand flowers bloom', and encouraging innovation without clear pathways to evaluate and scale up. We propose a national co-design process followed by implementation at national, regional and local levels, with an appropriate level of support to manage a complex change process.

A broader range of types of services and service models is needed

We need a broader range of mental health and addiction services for more people that are easily accessible, more options to access health and social services in different ways and in different contexts, easier ways for people to get support for multiple needs when required, a more diverse workforce, and to use our workforce in different ways. We have not specified the exact features of a new set of services, but Table 3 sets out a variety of approaches raised during the Inquiry.

129 J Derksen. 2009. Primary care psychologists in the Netherlands: 30 years of experience. *Professional Psychology: Research and practice* 4: 493–501; S Huhndorf. 2017. Native wisdom is revolutionizing health care. *Stanford Social Innovation Review* Summer: 18–23.

Table 3: Services and service models mentioned during the Inquiry

Examples of different types of services and service models
<ul style="list-style-type: none"> • More tools, support and guidance for self-help and self-care to maintain wellbeing; for example, e-therapy, e-navigation and e-mental health programmes • Expanded access to psychological therapies, alcohol and other drug services and culturally aligned therapies across the spectrum of mental health and addiction needs • Co-located multidisciplinary teams or hubs including general practitioners (GPs), practice nurses, nurse practitioners, social workers, health coaches, mental health workers, cultural support, peer-support workers and youth workers • A greater variety of options for individuals or groups who prefer not to use general practice as their first point of contact or ongoing relationship; for example, youth, Māori, Pacific peoples and Rainbow services • GPs, practice nurses and other health sector workers with more training and ability to identify and respond to mental health and addiction needs, without just resorting to medication • Extending the capability of those already working in primary and community settings to provide a greater range and depth of support (such as talk therapies and traditional therapies) • Robust relationships and referral pathways between non-governmental organisation and Iwi social services, Whānau Ora providers, general practices, specialist mental health and addiction services, and other government agencies • Using the specialist workforce differently to support primary and community-based services; for example, psychiatrists available for real-time telephone consults to GPs, and psychiatrists as part of multidisciplinary teams • A coordination and oversight role by community providers including general practice, other social services, NGOs and Whānau Ora providers, as appropriate • Seamless services for people with both chronic physical conditions and mental health needs and a workforce that is equipped to manage the interface • Upskilling of other parts of the wider workforce especially for front-line workers who come into contact with people with mental health and addiction needs • Alternative crisis response models such as a co-response model where police, DHB mental health services and paramedics jointly attend mental health callouts • Peer-led and peer-delivered services, including community-based alternatives to hospitalisation, for people with acute mental distress; for example, Piri Pono • Services for prisoners that meet the needs of specific population groups, such as youth, mothers and babies and children of prisoners.

Piri Pono: A peer-led, community-based alternative to hospitalisation

Several relatively new community-based acute alternatives to hospitalisation are showing great results for people who would otherwise be admitted to inpatient acute units. One of these is Piri Pono.

Piri Pono is a five-bed residential, acute alternative to hospitalisation provided by ConnectSR through a contract with Waitemata DHB. The service is peer-led and staffed with nurses and support workers. Piri Pono is available to those experiencing extreme mental distress, and guests can stay for up to 10 days in a home-like, personalised environment with a holistic approach to wellness.

Evaluations of Piri Pono have been positive, and tāngata whaiora and their families and whānau view it favourably.

Integrate services and support change

Achieving a set of services like those listed in Table 3 will require much more integrated service planning and delivery, an expanded workforce with different types of roles, including Kaupapa Māori and Pacific workers, and more effective use of our existing workforce. An integrated set of services also has to be connected across sectors, not just within the health sector. This means ensuring appropriate linkages between mental health and addiction and other social services (for example, housing, budgeting advice, employment services, relationship and anger management, and Whānau Ora services) for people who require other types of support. It also means considering how to most effectively plan and deliver mental health and addiction services in different settings, such as schools and prisons, or for people in contact with Oranga Tamariki.

This implies any process to plan and deliver mental health and addiction services, and associated social supports, must involve a variety of agencies across sectors, including outside government, that are appropriately resourced and mandated to deliver. This would represent a very different type of process from past practice.

We appreciate that many talented and highly motivated people are doing their best in a difficult environment and excellent pockets of innovation exist. But inspiring people are not always well supported and few mechanisms exist to evaluate and scale up or cease initiatives as appropriate. 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.

4.4.2 What needs to happen

In summary, we need:

- a national co-design process to build more people-centred and integrated services
- support for the change process itself, including at a national, regional or local level.

National co-design process

A shift of the magnitude envisaged will require a significant service transformation and design process. We think a robust co-design process should begin with a nationally led process for a high-level design, then work to identify priorities and develop the implementation framework for these, followed by regional or local adaptation, planning and implementation. Designing the 'how to' for implementation and evaluation at a national level will be essential to achieve traction locally and have a consistent evaluation framework to support shared learning and refinement. The service framework developed from this process should then inform the development of local services to meet the specific needs of the communities they will service. It should include Kaupapa Māori service frameworks.

This process should aim to develop a range of services that can address a spectrum of mental health and addiction needs, are integrated with a range of other support services, and have a significant emphasis on primary and community-based care. Five principles should underpin the development process.

- **Involve all the right people and agencies in designing the new system** (with appropriate mandates as required): people with lived experience of mental health and addiction challenges, DHBs, primary care, NGOs, Kaupapa Māori services, Pacific health services, Whānau Ora services, other providers, advocacy and representative organisations, professional bodies, families and whānau, employers and key government agencies.
- **Build a system and responses based around the people who use it** rather than around service providers and funders. This requires a real understanding of the people who will require those services and the variety of their circumstances and needs.¹³⁰ We should also move away from some of the language we heard around 'the 3%' and 'the 17%'. While useful for service and workforce planning purposes, it is not a helpful or accurate way to talk about people with mental health and addiction challenges.
- **Build a system that is integrated across services** for mild, moderate and severe mental health and addiction needs, recognising that these are not fixed categories of people, and that is a joined-up and seamless system for the people who access it, between mental and physical health and between health and other government and social services, when needed. New language to replace 'mild, moderate and severe' would also be helpful.
- **Maintain a focus on improving outcomes for people with the most severe mental health and addiction needs** and not shift resources from specialist services ahead of changes in demand.
- **Give effect to the specific aspirations of Māori and Pacific peoples**, including the shifts of direction identified in Whakawātea te Ara and *Vai Niu* (sections 3.4 and 3.5, respectively) to clear the pathways for improved Māori and Pacific health and wellbeing.

¹³⁰ As an example, see D King and B Welsh. 2006. *Knowing the People Planning (KPP): A new practical method to assess the needs of people with enduring mental illness and measure the results*. London: Nuffield Trust.

The high-level service design needs to be done well, but it also needs to proceed rapidly. This work can be accelerated by building on the foundations and consensus provided by the 2016 Ministry of Health-led Fit for the Future programme and other interagency work undertaken in recent years, but needs to extend further. It can also draw on lessons from the current transformation of disability support, but must result in progressive change across the whole country, not just at prototype sites. We expect that, in line with international experience, it is likely to take three to four years to implement 80% of the desired change, even without the challenge of workforce shortages and the need for a co-design process at the outset.

The co-design process should be facilitated by the Ministry of Health in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body). This is because the Ministry of Health is currently the clear lead, within government, for mental health and addiction services.

However, many other agencies and groups will need to be involved and provide leadership in the co-design process. They include government agencies such as the Department of Corrections (around meeting the mental health and addiction needs of people entering, in or leaving the corrections system), the Ministry of Education (around the provision of mental health and addiction and wellbeing services and support in educational environments, including programmes that build resilience and wellbeing), Te Puni Kōkiri (around the funding and goals of Whānau Ora) and the Ministry of Social Development (in relation to income support and employment support). We note there are already several models to bring agencies together to tackle complex, cross-cutting problems¹³¹ and that the proposed reform of the State Sector Act 1988¹³² may provide additional avenues for integrated leadership on issues relevant to mental health and addiction; for example, to support coordinated service planning that requires input and commitment from multiple government departments.

We suggest the State Services Commission advises on the most appropriate models and levers to bring together agencies across government to collaborate in the national co-design process for mental health and addiction services.

The co-design process should inform many of the investment decisions in the mental health and addiction area over the medium term. We suggest strategic investment in priority developments is needed rather than 'shopping lists', action plans with dozens of discrete items, and multiple pilots and demonstration projects. The focus should be on making good traction on a limited number of strategic priorities. As outlined in the previous section, a good case exists for immediate investment to fill critical gaps in services. This investment will be needed regardless and can proceed ahead of the co-design process.

131 See, for example, State Services Commission. 2018. Machinery of government: Toolkit for shared problems (web page). www.ssc.govt.nz/mog-shared-problems (accessed 16 October 2018).

132 State Services Commission. 2018. Consultation on State Sector Act reform opens (web page). www.ssc.govt.nz/node/10690 (accessed 24 October 2018).

Support for the change process

Investing in change itself is important. The speed and consistency of uptake of innovation or change is greatly improved by having implementation support. For example, it has been estimated that implementation support enables an 80% uptake of the intended change within three years,¹³³ whereas without implementation support only 14% of healthcare research is adopted into day-to-day clinical practice within 17 years.¹³⁴

We acknowledge those agencies that are already investing in and supporting change. The Health Quality and Safety Commission is leading prioritised quality improvements in existing services. Similarly, the mental health and addiction workforce development centres have been leaders in building workforce capability. However, there is no similar investment to support new service developments or substantive system change.

People with the passion, leadership skill, change know-how and experience in implementing system transformation will play a key role. We need to make the most of existing talent and build capability and relationships across the sector and communities to get traction in implementing the new system design. Peer and cultural leaders will play important roles.

The transformation we envisage needs to be supported by robust change methodologies, implementation science (to ensure the uptake of approaches that have proven effective into routine practice in ways that are locally relevant) and investment to support the change process itself. We have looked at examples where implementation support was provided for mental health and addiction system change to see what we could learn. Examples include a Canadian provincial support programme, a New Zealand mental health and addiction change team in a DHB, and collective impact approaches.

Ontario provincial support programme (Canada)

The Ontario provincial government commissions mental health and addiction implementation support from a central team, which helps clarify the intent of a change initiative and to define the outcomes and measures. It then designs how the change or new service will be implemented in such a way that it can be picked up locally and, with local stakeholder participation, adapted for local implementation.

Within the Canadian model, local teams also work with key local stakeholders to ensure the intended change is adopted, implemented with fidelity to a set of core features and sustained over time (but with flexibility). This arrangement also provides for knowledge exchange between local implementation sites and the centre, which helps build the body of evidence about what works.

The Ontario model is intended to address many of the problems we have identified in New Zealand and potential exists to build something similar that is adapted for our context. The new Mental Health and Wellbeing Commission (discussed in chapter 12) would be well positioned to be the hub for such a facilitative function.

133 D Fixsen, K Blasé, G Timbers and M Wolf. 2001. In search of program implementation: 792 replications of the teaching–family model. In G Bernfield, DP Farrington and AW Leschied (eds). *Offender Rehabilitation in Practice: Implementing and evaluating effective programs* (chapter 7). London: Wiley.

134 EA Balas. 1998. From appropriate care to evidence-based medicine. *Pediatric Annals*. 27:581–4.

DHB mental health and addiction change team

Several years ago, Counties Manukau DHB invested \$1 million per year (from its underspend in new funding) in a change team to:

- identify the evidence and promising practice internationally
- work collaboratively with stakeholders, including PHOs, NGOs, and DHB providers, Māori, tāngata whaiora and their families and whānau, and others, to design new services or service change and to define the desired impacts
- establish evaluation frameworks
- support the managers and staff responsible for implementing the changes
- enable shared learning between participating sites.

This investment enabled the DHB to improve the acceptability of services to the people who used them and increase staff satisfaction, without having to increase inpatient services in the face of population growth. This was at a time when the DHB's mental health and addiction system was experiencing significant demand pressures.

Collective impact approaches

Some of the pockets of success in New Zealand seem to build on collective impact approaches either explicitly or implicitly (for example, Equally Well and Waka Hourua). Collective impact has been described as “the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem”.¹³⁵ Critical success factors in collective impact approaches include:

- an influential champion – trusted and neutral, highly skilled in relationships and engagement
- adequate financial resources
- consensus on urgency for change around an issue
- building on successful initiatives under way, rather than building new initiatives from scratch
- a backbone organisation that supports the partners in the collaborative effort.

Collective impact initiatives are, by definition, community-led. There are lessons in this for how we might approach change on national issues (and local solutions).

135 J Kania and M Kramer. 2011. Collective impact. *Stanford Social Innovations Review* 9(1): 36–41. https://ssir.org/articles/entry/collective_impact#.

Adequate resources (including funding, people and the commitment of key stakeholders) will be needed for a national co-design process. Implementation support will also need to be provided at national, regional and local levels, to support change on the ground.

A new Mental Health and Wellbeing Commission (chapter 12) should be funded to provide 'backbone support' to the sector.¹³⁶ It would support those responsible for implementing change with the tools they need and provide shared infrastructure for knowledge exchange.

The Commission's relevant functions could be to:

- identify the evidence and promising practice both nationally and internationally
- work collaboratively with stakeholders to co-design new services or service change and to define the desired impacts
- establish evaluation frameworks
- identify the stages of implementation – the 'how to' that will guide regional and local action to implement change
- provide support to the people and organisations responsible for funding and implementing the changes, to enable national, regional or local collaboration, implementation and evaluation
- enable shared problem-solving and learning between participating sites.

The Commission might also meet some implementation costs such as initial design and evaluation and participation in hui to share experiences and findings.

Close, face-to-face, high trust relationships that respect others' strengths and local ownership are central to this function working well. It will require significant investment in Kaupapa Māori and Pacific capability and capacity.

The Mental Health and Wellbeing Commission should work closely with the Ministry of Health, bringing the strength of its links to local communities and explicit mission to build implementation capacity across the system.

Filling the gap in support for the change process has the potential to enable the major system shifts proposed. Implementation support will enable progress to be monitored, provide missing system oversight of innovation, and allow learning and scaling opportunities. It will also provide an avenue to feed back the shared learning to the Ministry of Health to inform future policy refinement.

¹³⁶ 'Backbone support' is one of the critical elements in collective impact approaches and refers to an organisation or unit that supports the partners involved in a collaborative change effort.

Recommendations

Facilitate co-design and implementation

7. **Direct** the Ministry of Health, in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body) to:
 - facilitate a national co-designed service transformation process with people with lived experience of mental health and addiction challenges, DHBs, primary care, NGOs, Kaupapa Māori services, Pacific health services, Whānau Ora services, other providers, advocacy and representative organisations, professional bodies, families and whānau, employers and key government agencies
 - produce a cross-government investment strategy for mental health and addiction services.
8. **Commit** to adequately fund the national co-design and ongoing change process, including funding for the new Mental Health and Wellbeing Commission to provide backbone support for national, regional and local implementation.
9. **Direct** the State Services Commission to work with the Ministry of Health to establish the most appropriate mechanisms for cross-government involvement and leadership to support the national co-design process for mental health and addiction services.

4.5 Enablers to support expanded access and choice

Each element of our proposals to support expanded access and choice – more people able to access services, more choice of services (especially talk therapies, alcohol and other drug services and culturally aligned services) and a national co-design process and implementation – will need to be supported by core enablers. We discuss these in this section.

4.5.1 The right workforce

Earlier in this report we acknowledged the strengths of the mental health and addiction workforce and the pressures workers face. The right workforce will be fundamental to achieving a significant and successful system shift. It will need clinical, peer and cultural staff.

Workforce planning and development

We heard that current workforce planning and investment is not strategic or coordinated and that long-term workforce investment is not assured.

We agree that mental health and addiction workforce planning needs to take a long-term focus and not simply be based on service response in the past. We don't appear to be ready for the ageing of the workforce or emerging workforce shortages. Nor has there been sufficient recognition of the needs of a different service paradigm, which equally values peers, cultural knowledge, community support and clinical competence.

The Mental Health and Addiction Workforce Action Plan 2017–2021 was developed to respond to the existing system of provision and needs. It extends past the mental health and addictions workforce to the overall health workforce and explicitly focuses on growing the primary and community care workforce. However, this plan has been developed in isolation from a forward-looking service strategy or service design process. The sector has also indicated that more resource is required to properly implement the plan.

Workforce development tends to be isolated from other strategy development and service design. We need to take an integrated approach and design our workforce as part of a broader process of assessing our population needs and desired service response. The future workforce and those responsible for its training and development should be a fundamental part of the national co-design process we have proposed. It also needs to be integrated into regional and local planning.

This approach will lead us to build a workforce that is more representative of the people it serves. Peer leadership needs to increase across the board, in governance and management of both peer-led and mainstream organisations. A substantial increase in the peer workforce is needed across all services, including within specific peer-support services, and providing peer support as a part of all other services including alcohol and other drug services, crisis services, multidisciplinary mental health teams, and support services and in health coaching roles in primary care. Much larger proportions of Māori and Pacific workers are needed at all levels, and cultural supervision should be available. We see building the peer, Māori and Pacific workforces as priorities.

If we are to take a broader lens to people's wellbeing, we must orient the workforce towards understanding the impact of trauma and the socioeconomic determinants of health, including enabling staff to focus on 'prevention as intervention'. Many workers will need to know about, and be connected with, other local services and supports. The wider health and social services workforce (including NGO navigators, Kaupapa Māori providers, Whānau Ora navigators and Pacific providers) will need to bring their expertise in these areas.

We must invest in building a workforce that can deliver on our goal of providing more talk therapies and a broader range of interventions and supports. As noted above, a variety of different practitioners can be trained to deliver these therapies at different levels of intensity. For some of these workforces, a long lead in time is required to build capacity and capability, and urgent attention is needed to fill critical gaps. We note that efforts to build the psychiatrist workforce, which began some years ago, are starting to yield results. Health Workforce New Zealand told us that there has been a large jump in the number of registered psychiatrists in 2018, which is probably a result of changes to training five years ago. However, we need to grow our psychologist workforce, including retaining those already in the system to meet demand. Increasing a skilled and trained peer workforce, a strong and varied cultural workforce, and further developing the skills of nurses, support workers and allied health practitioners will be necessary. We will need a strong and sustained focus on creating the workforce for the future, including to extend support to the ‘middle ground’. This is likely to include:

- an increase in the number of support workers (including peer, cultural and youth workers)
- curriculum development and upskilling of workers to meet their communities’ diverse needs (for example, training in cultural responsiveness and in the needs and preferences of higher-need population groups)
- a trauma-informed approach that underpins all support and interventions
- more comprehensive and continuing training for generalists (for example, GPs and nurses) in mental health and addiction
- extending the capability of those already working in primary and community settings to provide a greater range and depth of support (for example, talk therapies, culturally based approaches, trauma-informed care, and support for co-existing conditions)
- creating or expanding new roles (such as health or lifestyle coaches, employment specialists and people with expertise in psychological therapies)
- ensuring specialist clinical support and advice is easily and quickly accessible to primary and community services
- building all of the above across Māori and Pacific providers.

Workforce planning and development should take account of the important contribution of specialist roles. We heard that challenges in workforce recruitment and retention differ between specialties and between subspecialties (for example, infant and maternal mental health, aged care and addiction). New Zealand relies heavily on overseas-trained doctors and nurses.¹³⁷

137 Te Pou o Te Whakaaro Nui. 2012. *Exploring the Economic Value of Talking Therapies in New Zealand: Utilising cognitive behavioural therapy as an example*. Auckland: Te Pou o Te Whakaaro Nui. www.tepou.co.nz/uploads/files/resource-assets/exploring-the-economic-value-of-talking-therapies-in-New-Zealand-utilising-cognitive-behavioural-therapy-as-an-example.pdf.

Sophisticated data modelling and research are beginning to be used to better understand the determinants of professional career pathways and to develop effective strategies to grow the workforce and incentivise people to work in traditionally less popular fields and geographical locations.

We will have to grow our own specialist workforce and make more use of new ways of delivering services, such as telehealth and consult–liaison and outreach roles, to ensure the same timely and high-quality specialist expertise is available irrespective of where people live or receive services. The clinical skills of psychiatrists will continue to be important, but psychiatrists may shift to working more in and with the community, supporting and liaising with GPs and primary health care providers, and using a broader range of therapeutic responses, including family therapies.

Psychiatrists are increasingly expected to respond to complex social problems they may not be well equipped to deal with. This reinforces the need for a shift within psychiatry, where psychiatrists bring their clinical expertise in assessment, diagnosis and treatment, working in partnership with patients, families and whānau, multi-skilled team members and other providers.

We also need to develop some other important skills if we are to comprehensively shift our system – collective leadership, collaboration, commissioning and implementation expertise.

Worker wellbeing

We have described a workforce under pressure. Workers and their representative organisations explained this as the consequence of increasing demand for mental health and addiction services, under sometimes difficult conditions. This view is backed up by data that show demand for mental health and addiction services is increasing significantly relative to the workforce, which means that workers are supporting more people.¹³⁸

Workers and their representatives asked that workforce shortages be addressed, safe staffing levels and practices be implemented, a strong focus be placed on workforce health and safety, and that meaningful engagement occurs with staff. There were also calls for increased access to learning and development, professional support and supervision (including cultural supervision, particularly in DHBs where there are significant Māori or Pacific populations).

Workforce wellbeing issues should be explicitly considered during the recommended co-design process.

138 Te Pou o Te Whakaaro Nui. 2018. *Mental Health and Addiction Inquiry Submission*. www.tepou.co.nz/initiatives/mental-health-and-addiction-inquiry/229.

4.5.2 Data, information, research and ongoing monitoring and evaluation

Good decision-making requires good quality information, including about the population, services, funding, consumer experience and the workforce. Analysis of data helps us understand whether support is making a difference and informs service delivery and planning at all levels of the system.

A rich array of information is available about mental health and addiction in New Zealand, particularly around publicly funded secondary care. However, there are some notable gaps.

For services to be responsive to population health needs, there needs to be an understanding of mental health and addiction challenges and how they are changing over time. The results from the last population health prevalence survey, Te Rau Hinengaro, were published in 2006, but based on data collected in 2003 and 2004. It missed some key groups, including children aged under 16, and is out of date. Widespread support exists for a new and improved prevalence survey that captures those groups missed in Te Rau Hinengaro and measures wider wellbeing of people with mental health and addiction challenges. Initial planning for a new survey was undertaken in 2017.

Other gaps we have identified through the course of the Inquiry are the lack of:

- outcomes data in some areas – several people noted that we collect a lot of input data and some output data, but often we can't identify the outcomes we're getting
- information about what is happening in the private sector (for example, privately funded mental health services or mental health in workplaces) and devolved environments (for example, the effectiveness of some education-based interventions)
- comparable, representative data on consumers' experiences of services and support
- primary care data, resulting in incomplete information about what services and support are being provided to people with mental health and addiction challenges.

Our view is that we should undertake a new and more comprehensive mental health and addiction survey. This information is essential for health care planning. How else will we know if the percentage of the population in need is increasing over time (as it has elsewhere in the world) or is growing in some parts of the population faster than others? If affordability and logistics are an issue, the components of the survey may need to be staggered over time. We should also plan to regularly repeat the survey.

Overarching data and information needs should also be considered as part of the wider national co-design process we have recommended. Initial priority may need to be given to the lack of information about what is happening in primary care.

New Zealand's unique population and characteristics mean we cannot solely rely on research conducted in other countries to meet our needs. Many submitters considered that mental health and addiction research is lacking, mainly due to under-funding. Areas where more research was seen to be needed included self-harm and suicide and research on ethnic-specific population groups and other groups including young people, Rainbow communities, disabled people, refugees and migrants. Research on what works for Māori, Pacific peoples and other groups was also seen as a priority for addressing inequitable health and social outcomes.

Some submitters were concerned that our current approach to research impeded addressing long-standing inequitable outcomes for some populations. We heard, for example, that it is difficult to implement practices emerging from international indigenous research because decision-makers do not consider it robust.

Some submitters recommended a separate mental health research fund. Designated funding for Māori mental health and addiction research, informed by mātauranga Māori, was also proposed.

New Zealand has some strengths in mental health and addiction research. The Government's social sector science advisors, the University of Otago, Wellington, and Te Pou o te Whakaaro Nui, for example, drew on a wide body of local and international evidence to assist the Inquiry. Organisations such as the Health Quality and Safety Commission and the Health Promotion Agency were identified as making good use of research and evaluation to inform service improvement and innovation.

The Health Research Council receives funding to allocate to health research. The Council advised us that, between 2006 and 2017, approximately \$83 million was allocated towards research, mainly clinical, related to mental health or alcohol and other drug dependence. We must continue investment in mental health and addiction research.

New Zealand's performance on evaluation is mixed. There are examples of programmes that have been well designed with robust evaluation built in from the outset and repeated at intervals to ensure the programme continues to be effective and a good investment, identify opportunities for improvement, and learn lessons from other countries. The world-leading web-based therapy programme *The Journal*, fronted by Sir John Kirwan, is a prime example of a successful innovation that is subject to ongoing evaluation.

We also heard that trials of some significant initiatives have been implemented without appropriate evaluation. There is a risk that in the haste to 'do something', decision-makers prioritise action over review of the evidence of effectiveness of proposed interventions. No new initiatives should be undertaken without good evaluation that builds in a continuous learning approach and draws on national, international and indigenous evidence.

Many innovations and service improvements are community-led, by groups that may lack research and evaluation skills. It is important they can access this expertise and funding to meet the costs of appropriate evaluation activity. Building the research and evaluation capacity of community and NGO providers is also highly desirable.

Many submissions emphasised the importance of building our knowledge of what works, for whom, and under what conditions, especially for groups experiencing inequitable outcomes. Evaluation is critical to achieving this. National oversight of the implementation and evaluation of new and existing initiatives is important, so we avoid duplication, build a robust knowledge base and disseminate learning. We have built this national oversight role into the new Mental Health and Wellbeing Commission.

4.5.3 Commitment to a funding path

We have already signalled the need for funding to support the co-design and implementation processes. In addition, commitment to a clear funding path to support expanded access to a broader range of services and new ways of delivering services is needed.

This path should be informed by a multi-year, cross-government investment strategy, costed and phased appropriately. Additional investment in some areas should start in Budget 2019. The priority is services for people with mild to moderate and moderate to severe needs, including more talk therapies, alcohol and other drug services and culturally aligned services. This will require increased workforce capacity and capability.

Other aspects of the investment strategy will need to be delivered over time, informed by the wider co-design process. Any investment strategy should be informed by robust cost–benefit analysis, agreement on outcomes sought, including for priority populations, and advice on the appropriate mix of services.

As the national co-design process could take some time (with regional and local implementation over a longer timeframe), a commitment to an indicative funding path is needed now to provide certainty for the sector with some interim supporting frameworks to quickly begin the change and development process. We note that this will need a cross-government approach, rather than being restricted to Vote Health. The Ministry of Health and other relevant agencies should advise on an indicative funding path, based on access rates and a broader mix of services.

While we have emphasised that funding needs to be increased rather than shifted from specialist services, we expect any analysis will consider how to make best use of existing funding to achieve value for money.

4.5.4 Funding rules and expectations that reinforce the new direction

Funding and accountability arrangements within Vote Health are still oriented overwhelmingly towards services for those with the most severe mental health and addiction needs. Current arrangements should be reviewed to ensure they properly reflect and reinforce the desired strategic direction, and make expectations of funders and providers clear. New national service specifications will be required, including service specifications for primary mental health services, which we have been unable to find.

This will require the Ministry of Health to review the DHB service specifications and any rules related to mental health and addiction funding, including ring-fence rules and primary mental health funding. Critically, funding and service specifications must enable more integrated planning and funding across the spectrum of primary, community and secondary services, rather than support the current siloed approach.

It may also be timely to review the ring fence itself. It appears the ring fence has been a reasonably effective mechanism to protect funding for mental health and addiction services from being diverted into other health services. But potential downsides also exist; for example, the ring fence can create a sense of separation of mental health from the rest of the health system or reinforce the false notion that mental health and addiction are somehow different or not core business.

We acknowledge that the ring fence is unique in health funding and recognise that, ideally, it should not be needed because mental health and addiction services should be seen as a priority by DHBs and funded appropriately. We are not prepared to recommend doing away with the ring fence without a proper review and suggest the Ministry of Health undertake this review in conjunction with the wider transformation process.

4.5.5 Enhanced primary health care and a sustainable NGO sector

Greater access and choice in responses to mental health and addiction will rely heavily on primary and community services to succeed. This will require a primary health care sector that looks very different from now, as well as a sustainable NGO sector to deliver key services. This, in turn, will require consideration of the wider primary care transformation agenda as well as broader issues of NGO sector sustainability and development. These wider issues are not unique to mental health and addiction and are discussed more fully in chapters 5 and 6.

Recommendations

Enablers to support expanded access and choice

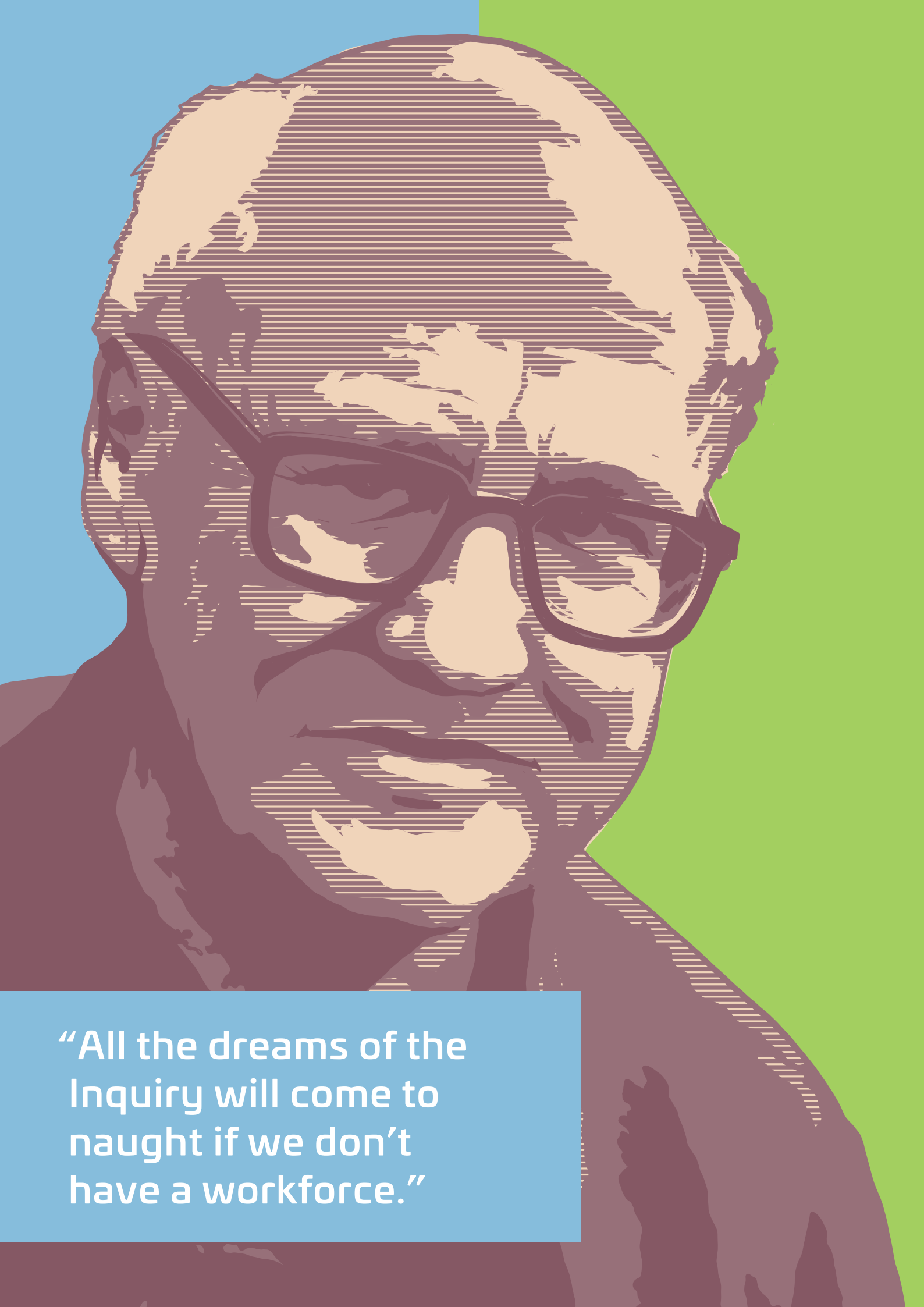
10. Agree that the work to support expanded access and choice will include reviewing and establishing:

- workforce development and worker wellbeing priorities
- information, evaluation and monitoring priorities (including monitoring outcomes)
- funding rules and expectations, including DHB and primary mental health service specifications and the mental health and addiction ring fence, to align them with and support the strategic direction of transforming mental health and addiction services.

11. Agree to undertake and regularly update a comprehensive mental health and addiction survey.

12. Commit to a staged funding path to give effect to the recommendations to improve access and choice, including:

- expanding access to services for significantly more people with mild to moderate and moderate to severe mental health and addiction needs
- more options for talk therapies, alcohol and other drug services and culturally aligned services
- designing and implementing improvements to create more people-centred and integrated services, with significantly increased access and choice.



“All the dreams of the Inquiry will come to naught if we don’t have a workforce.”

Chapter 5

Primary health care

Main points

- Skilled, accessible and integrated primary and community health care is essential for preventing and responding to mental health and addiction problems. Little progress has been made in addressing mental health and addiction in primary care.
- This will require a transformed primary health care sector but progress towards the vision of the Primary Health Care Strategy (2001) has been slow and inconsistent.
- The Government's Health and Disability Sector Review should focus on primary health care which is a critical foundation for improved mental health and addiction care and support. Mental health and addiction should be explicitly included as a priority in any future primary health care strategies.

5.1 Introduction

Building a broader spectrum of mental health and addiction services will require a significant focus on supporting primary and community providers to deliver more and different services in community settings for people with mental health and addiction needs, particularly in the 'middle ground' (people with mild to moderate and moderate to severe mental health and addiction needs).

One critical component, though not the only one, is the role of primary health care in preventing and responding to mental health and addiction needs.¹³⁹ We note that 'primary health care' is very broadly defined. Primary health care in this report refers to general practice, non-governmental organisations (NGOs), Kaupapa Māori, Pacific and other community agencies that offer front-line services. It also includes pharmacies, midwives, school-based services, Well Child Tamariki Ora, Whānau Ora, telehealth services and others. Our vision of what 'primary health care' needs to look like is consistent with the type of system outlined in chapter 3 (section 3.6) – that is, many different providers working together in a joined-up way with people at the centre, in a range of primary and community settings, with strong linkages between social and other support services across sectors.

139 N Kates, B Arroll, E Currie, C Hanlon, L Gask, H Klasen, G Meadows, G Rukundo, N Sunderji, T Ruud and M Williams. 2018. Improving collaboration between primary care and mental health services. *World Journal of Biological Psychiatry*. <https://doi.org/10.1080/15622975.2018.1471218>.

A transformed primary health care sector will be needed to properly support a comprehensive continuum of integrated services to address mental health and addiction needs. In this chapter, we focus on primary health care services, particularly general practice. Some of the issues relating to the wider NGO sector are outlined in chapter 6.

5.2 What needs to happen

5.2.1 Issues

Importance of primary health care for people with mental health and addiction challenges

General practices are the main way many people first seek support for mental health and addiction challenges.¹⁴⁰ They are a critical entry point to services, either in general practice itself or for referral elsewhere (for example, to counselling, psychological or community support services or to specialist services delivered through hospitals and community mental health teams). They should provide early intervention that is built on ongoing relationships and review of an individual's mental and physical health. The linkages between physical and mental health, and the disparities in health outcomes for people with mental health and addiction issues, make the role of primary health care critically important.

In our view, general practices should provide first-level services and may also take a coordinating role where people are accessing other care. Furthermore, general practitioners (GPs) should continue to provide ongoing support, including medication management, to those who are discharged from specialist services.

Currently, responses from general practice to mental health and addiction problems are variable. Some people report valuable relationships with their GP, supportive responses and efforts to access specialist services on their behalf. Others do not have their concerns addressed and are 'fobbed off' with medication. Costs associated with general practice create barriers to access and result in some people with mental health and addiction challenges remaining attached to specialist mental health and addiction services, which are free, rather than being discharged to primary care services. This creates additional pressures on specialist services and bottle necks.

What GPs can do in 15-minute consultations is limited. Some GPs have gaps in their knowledge and training about mental health and addiction and have poor linkages with other social services (both NGO and government services such as housing and income support services). These factors contribute to an over-reliance on prescribing medication, rather than utilising a broader range of approaches, such as talk therapies, and broader social and cultural supports. GPs experience difficulty accessing specialist services for their patients, excessive time spent on referral processes, and long delays in receiving discharge documents from specialist services.

140 K Allan. 2018. Broadening access and ongoing support for people with mental health and addiction need: Rethinking the role of primary and community care. *New Zealand Doctor* (28 March).

While, for most people, general practice is likely to be the first place they turn to when seeking professional help with mental health and addiction, it is not the only entry point for support. Many people will look elsewhere, because of cost or because general practices in their current form do not meet their needs and preferences. The role of other health care and social service providers, including NGOs, Whānau Ora providers, specialist youth services, and health services provided in school and tertiary education institutions, is critical to meet diverse needs. Again, this emphasises the need for services that are well connected so people can get the support they need through more than one ‘doorway’.

Nonetheless, responding appropriately to people’s mental health and addiction needs should be part of a core role of any general practice. GPs should be able to offer appropriate advice, interventions and support, and should know where and how to direct patients to other ongoing support.

As noted previously, some primary mental health initiatives are funded through specific and fairly minimal funding streams (for example, Youth Mental Health, Fit for the Future, and targeted funding for Māori, Pacific peoples and people on low incomes, such as extended GP visits and counselling sessions). Closing the Loop is a model the four largest primary health organisations developed to provide stepped care in primary and community settings.¹⁴¹ The model is being piloted in five Auckland practices, and preliminary independent evaluation shows early promise.¹⁴²

Overall, however, little progress has been made in addressing mental health and addiction issues in primary health care in a meaningful way.

General slowness of transformation in the primary care model

The lack of progress in addressing mental health and addiction issues in primary care needs to be seen in the broader context of overall primary care transformation.

The 2001 Primary Health Care Strategy (PHCS)¹⁴³ set out a vision for a transformed primary health care sector that emphasised keeping people well, accessible services and coordinated ongoing care. It also had a strong focus on population health and reducing health inequalities between groups. The strategy was guided by the 2000 New Zealand Health Strategy,¹⁴⁴ which included population health objectives directly relevant to mental health and addiction.¹⁴⁵ Coordination between primary care and mental health services was mentioned explicitly in the PHCS as an area of focus for primary health organisations.

141 The four primary health organisations are Procure, Compass, Midlands and Pegasus: Network Four. 2016. *Closing the Loop: A person-centred approach to primary mental health and addictions support*. www.closingtheloop.net.nz/#closing-the-loop.

142 S Appleton-Dyer and S Andrews. 2018. *Fit for the Future: An evaluation overview for the enhanced integrated practice teams and Our Health in Mind Strategy (Business Case One)* (report for the Ministry of Health). Sydney: Synergia. <http://synergia.co.nz/news/fit-for-the-future-evaluation/>.

143 Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health. www.health.govt.nz/system/files/documents/publications/phcstrat.pdf.

144 Minister of Health. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health. www.health.govt.nz/publication/new-zealand-health-strategy-2000.

145 For example, objectives included suicide reduction, minimising harm caused by alcohol and other drugs, and improving the health status of people with severe mental illness, as well as addressing social determinants (such as family violence) and general wellbeing (such as child and family health, nutrition and physical activity).

The overall vision for primary care in 2001 was transformative, but the goals of the strategy have not been delivered anywhere near the extent originally envisaged even 17 years on from the introduction of the strategy.¹⁴⁶ There are likely to be initiatives we could all learn from, but a lack of research in primary care makes it difficult to know how services are developing and which ones could be encouraged to spread.¹⁴⁷

Recent promising initiatives include Health Care Home, although this appears modest in its reach and ambition and adoption by general practices of the Health Care Home model seems to be voluntary. Overall, change has been slow and inconsistent.

A 2018 report found several factors supported and inhibited innovation in primary care such as Health Care Home. The funding model for primary care, in particular the ongoing reliance on co-payments by many practices, was identified as a barrier to innovation.¹⁴⁸ As well as creating barriers to developing new models of care, co-payments and other charges create affordability barriers for many people¹⁴⁹ – something we heard about during our consultation. This requires urgent attention so people can access primary care when they need it.

5.2.2 What needs to happen

Building a mental health and addiction system with more supports in primary and community settings for people with needs across the full spectrum, requires a very different model than is still widely found. Innovation has been slow to take off with strong disincentives to change, especially in the current funding model.

The impetus to transform the primary care sector, including addressing affordability and cultural responsiveness, is not unique to mental health and addiction. Primary care is, appropriately, a focus of the recently announced Health and Disability Sector Review. In addition, an urgent priority must be a significant increase in the capacity and capability of the primary care sector to respond to mental health and addiction needs.

We assume that the primary care funding model will be a focus for the Health and Disability Sector Review, alongside broader consideration of commissioning of health and disability services, including the roles of district health boards (DHBs), primary health organisations and others. Our current arrangements seem to provide little mandate to DHBs in relation to primary care.¹⁵⁰ This is likely to have had impacts for integration across primary, community and secondary services. Whatever the future structure of the health system, attention must be paid to the commissioning arrangements for primary care.

146 A Raymont and J Cumming. 2013. *Evaluation of the Primary Health Care Strategy: Final report*. Wellington: Health Services Research Centre. www.victoria.ac.nz/health/centres/health-services-research-centre/our-publications/reports/final-full-report.pdf; J Smith. 2009. *Critical Analysis of the Implementation of the Primary Health Care Strategy Implementation and Framing of Issues for the Next Phase* (prepared for the Ministry of Health). www.health.govt.nz/publication/critical-analysis-implementation-primary-health-care-strategy-implementation-and-framing-issues-next.

147 A Downs. 2017. *From Theory to Practice: The promise of primary care in New Zealand*. Wellington: Fulbright New Zealand. www.fulbright.org.nz/news/from-theory-to-practice-the-promise-of-primary-care-in-new-zealand/.

148 L Middleton, P Dunn, C O'Loughlin and J Cumming. 2018. *Taking Stock: Primary care innovation* (report for the New Zealand Productivity Commission). Victoria University of Wellington. www.victoria.ac.nz/health/about/news/1664649-taking-stock-report-looks-at-the-state-of-innovation-in-the-primary-care-sector.

149 The New Zealand Health Survey reports that 14% of New Zealanders each year are unable to see their GP because of cost: https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/_w_da2f5c23/#!/explore-topics.

150 J Cumming. 2018. *Brief of Evidence of Jacqueline Margaret Cumming in the Matter of the Treaty of Waitangi Act 1975 and the Health Services and Outcomes Kaupapa Inquiry*, Waitangi Tribunal (Wai 2575, #A60), 7 September 2018. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_142252651/Wai%202575%2C%20A060.pdf.

We emphasise, however, that New Zealand cannot wait for the wider transformation of primary care: a continuum of mental health and addiction services, including extended access to services to people in the middle ground, is urgent. The challenge is to start designing, funding and implementing these services without waiting for primary care transformation to be complete, but not to resort to ad hoc or short-term mental health and addiction initiatives and funding streams in the meantime. We recommended an approach to investment in chapter 4.

Attention should also be given to building the capability of the generalist primary care workforce, with additional mental health and addiction training for GPs, practice nurses, community health workers and others.

Recommendations

Transform primary health care

- 13. Note** that this Inquiry fully supports the focus on primary care in the Health and Disability Sector Review, seeing it as a critical foundation for the development of mental health and addiction responses and for more accessible and affordable health services.
- 14. Agree** that future strategies for the primary health care sector have an explicit focus on addressing mental health and addiction needs in primary and community settings, in alignment with the vision and direction set out in this Inquiry.



“What’s working in the community? It’s community that’s working in the community.”

Chapter 6

Non-governmental organisation sector

Main points

- The non-governmental organisation (NGO) sector is an increasingly important contributor to the delivery of government-funded mental health, addiction and wider health and social services.
- Factors such as the lack of a genuine partnership with government, funding insecurity and high compliance costs impact on the sustainability of NGO providers and the service they can provide.
- Solving these long-standing issues requires a committed focus from government and clear responsibility for strategic stewardship of the NGO sector.

6.1 Introduction

Giving effect to our vision (described in section 3.6) will require a significant focus on primary and community care, with an important role for the NGO sector.¹⁵¹ We already rely heavily on the NGO sector to deliver many mental health and addiction services as well as other social supports, and we expect this reliance will increase. The NGO sector initially grew out of charitable organisations and strong community-spirited people responding to unmet needs. In the 1980s and 1990s, there was a shift from primarily grants-based funding to NGOs and charities to deliver services that supplemented those provided by government. Over time, the government sector contracted with the NGO sector for particular services on the basis of partial funding. Today, the NGO sector is much more highly developed, often delivering core services supported by government via competitive and formal contracting processes.¹⁵²

The broader picture is one of increased contracting out of services by government over the last few decades. This was part of a deliberate policy to separate the purchase (funding) and the provision of services, based on the belief that making providers compete for resources would encourage greater efficiency, responsiveness and innovation.

¹⁵¹ We note that we have included Kaupapa Māori and Pacific services within our definition of NGOs where they are recipients of government funding.

¹⁵² For example, see Productivity Commission. 2015. *More Effective Social Services*. Wellington: New Zealand Productivity Commission. www.productivity.govt.nz/inquiry-report/more-effective-social-services-final-report and H Stace and J Cumming. 2006. Contracting between government and the voluntary sector: Where to from here? *Policy Quarterly* 2(4): 13–20. <https://ojs.victoria.ac.nz/pq/issue/view/501>.

NGOs, including Whānau Ora and Pacific providers, are widely seen to be closer to the communities they serve than government agencies or the private sector and are able to deliver a more holistic response to people who access their services. NGOs can often respond more effectively to diversity and provide services that are better aligned to the needs of Māori, Pacific and diverse communities than are government-provided services.

The net result is that the NGO sector is an increasingly important contributor in the delivery of government-funded social services, including those relevant to mental health and addiction. However, we heard from NGOs about the challenges many of them face. We need a sound platform for the NGO sector's development and sustainability.

6.2 What needs to happen

6.2.1 Issues

Among the main issues NGOs raised were concerns about how services are commissioned. These concerns are not new, mirroring the findings of a 2009 report into DHB contracting arrangements.¹⁵³ However, they also apply more generally to all commissioning across the social sector,¹⁵⁴ and many of the NGOs we heard from are contracting with government agencies in multiple sectors, not just the health sector. These concerns also reflect issues raised by NGOs in other countries, such as Australia.¹⁵⁵

The types of issues raised in this inquiry and in other reports include:

- short-term contracts, insecurity of funding and funding levels that are not always commensurate with contract expectations, thus undermining sustainability and capacity to plan for workforce stability and service continuity
- disproportionately onerous compliance and reporting requirements, often for no obvious purpose
- multiple funders and multiple contracts to manage with no, or fragmented, strategies to guide commissioning decisions
- an insufficient focus on outcomes, with contracts too focused on inputs and outputs
- a master–servant relationship that does not foster collaboration and innovation.

Several people also spoke of a power imbalance between government funders and NGO providers, including a lack of genuine partnerships in commissioning processes and the lack of a 'level playing field', with district health boards (DHBs) tending to favour their provider arms when deciding how to deliver services.

153 Platform Trust. 2009. *2008 NGO–DHB Contracting Environment* (NgOIT series). Wellington: Platform Charitable Trust. www.platform.org.nz/uploads/files/ngoit-2008-ngo-dhb-contracting-environment.pdf.

154 Productivity Commission. 2015. *More Effective Social Services*. Wellington: New Zealand Productivity Commission. www.productivity.govt.nz/inquiry-report/more-effective-social-services-final-report.

155 J Schwartzkoff and G L Sturgess. 2015. *Commissioning and Contracting for Better Mental Health Outcomes* (research report by Rooftop Social for Mental Health Australia). <https://mhaustralia.org/report/commissioning-and-contracting-better-mental-health-outcomes-report>.

The Social Investment Agency is consulting on its Investing in Social Wellbeing approach. Initial findings from that consultation identify similar dissatisfaction about the relationship between NGOs and commissioning agencies. Common frustrations include a lack of partnership between NGOs and central government and the lack of flexibility to allow for local solutions within a context of national goals.¹⁵⁶

Given the importance of the NGO sector to the delivery of social services, getting contracting and commissioning right is essential because of the potential impact on the sustainability of providers and the need to make best use of resources. It is widely recognised that the dynamics around contracting for social services and with the NGO sector are different from other types of services.

As a result, many government agencies are working to improve commissioning and contracting for social services. For example, the Ministry of Business, Innovation and Employment has a lead role in building contracting capability within government agencies and developing markets.¹⁵⁷ The Social Investment Agency produces tools and guidance to promote best practice commissioning in the social sector.¹⁵⁸ The Ministry of Health's Commissioning Framework for Mental Health and Addiction aims to ensure a consistent, outcomes-based approach across commissioners of services,¹⁵⁹ but we have heard it has not yet been implemented.

We were told some agencies, including some DHBs, have significantly improved their approach to contracting by offering longer contracts, providing opportunities for partnering in the design and specification of services, and increasing the focus on outcomes. However, this improvement is not universal, so further improvement is needed.

Some of the issues raised, however, represent more fundamental, strategic issues that cannot be addressed simply through better contracting practices, and these have been the subject of much commentary over many years. Areas of discussion have included different partnerships between the government and non-government sectors, long-term development and sustainability, the shape of the NGO sector and the number of small organisations competing for discrete contracts being an inefficient use of resources, suggestions for amalgamation to improve long-term sustainability,¹⁶⁰ and joined-up commissioning across agencies and sectors to address complex needs.

The guidance from multiple agencies about commissioning practices provides a strong basis to start from, but these more strategic issues require a different kind of approach. The issues are universal across social services and not unique to mental health and addiction services. Thus, some form of central government leadership, including a clear stewardship role with responsibility for advising on these issues, seems essential.¹⁶¹

156 Social Investment Agency. 2018. *Open Engagement Update Dashboard*. <https://sia.govt.nz/our-work/yoursay/latest-updates/>.

157 For example, see Ministry of Business, Innovation and Employment. No date. Social services procurement (web pages on the New Zealand Government website). www.procurement.govt.nz/procurement/specialised-procurement/social-services-procurement/.

158 Social Investment Agency. 2018. Commissioning and partnerships (web page). <https://sia.govt.nz/our-work/commissioning/>.

159 Ministry of Health. 2016. *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*. Wellington: Ministry of Health. www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide.

160 See, for example, Platform Trust and Te Pou o Te Whakaaro Nui. 2015. *On Track: Knowing where we are going*. Auckland: Te Pou o te Whakaaro Nui. www.tepou.co.nz/resources/on-track-knowing-where-we-are-going/597 and Productivity Commission. 2015. *More Effective Social Services*. Wellington: New Zealand Productivity Commission. www.productivity.govt.nz/inquiry-report/more-effective-social-services-final-report.

161 See, for example, J Schwartzkoff and G L Sturgess. 2015. *Commissioning and Contracting for Better Mental Health Outcomes* (research report by Rooftop Social for Mental Health Australia). <https://mhaustralia.org/report/commissioning-and-contracting-better-mental-health-outcomes-report>.

Earlier this century, the focus was on building stronger partnerships between government and NGOs. Within government, there was an appreciation of the need to build capacity and capability in the NGO sector. One example was the establishment in 2003 of the Office for the Community and Voluntary Sector within the Ministry of Social Development. A core function of that office was to act as a central point of contact at a national level to address cross-agency issues affecting the sector when dealing with government.¹⁶² The office was transferred to the Department of Internal Affairs in 2011 and disestablished in 2013.

So far as we have been able to establish, no central agency has stewardship responsibility for the NGO sector.

6.2.2 What needs to happen

We see a need for re-establishing an NGO stewardship role to advise on and respond to long-standing issues relating to the development and sustainability of the NGO sector. We suggest that a single government agency be identified to assume this role. If a social wellbeing agency were established (as discussed in chapter 7), it could take on this role.

Functions suggested in previous reports that could be part of this stewardship role include:

- promoting partnership, alignment and trust between NGOs and service commissioners
- advising government on how best to support the sustainability of the NGO sector (including how contracts are funded and capability is developed)
- coordinating NGO capacity and looking at how the NGO sector can help to meet wider government goals (including how to align the sector with the agreed direction and strategies for mental health and addiction to deliver results for all New Zealanders)
- promoting collaboration, information sharing and best practice between and within NGOs and between government and NGOs.¹⁶³

Several agencies can play a role in supporting and guiding improvements in the commissioning of social services. Potential exists for greater coordination of this activity, possibly as part of the overall stewardship role. Further work will be required to determine the exact scope and function of this stewardship role.

¹⁶² OCVS. 2008. *Briefing to Incoming Minister*. Wellington: Office for the Community and Voluntary Sector, p 22.

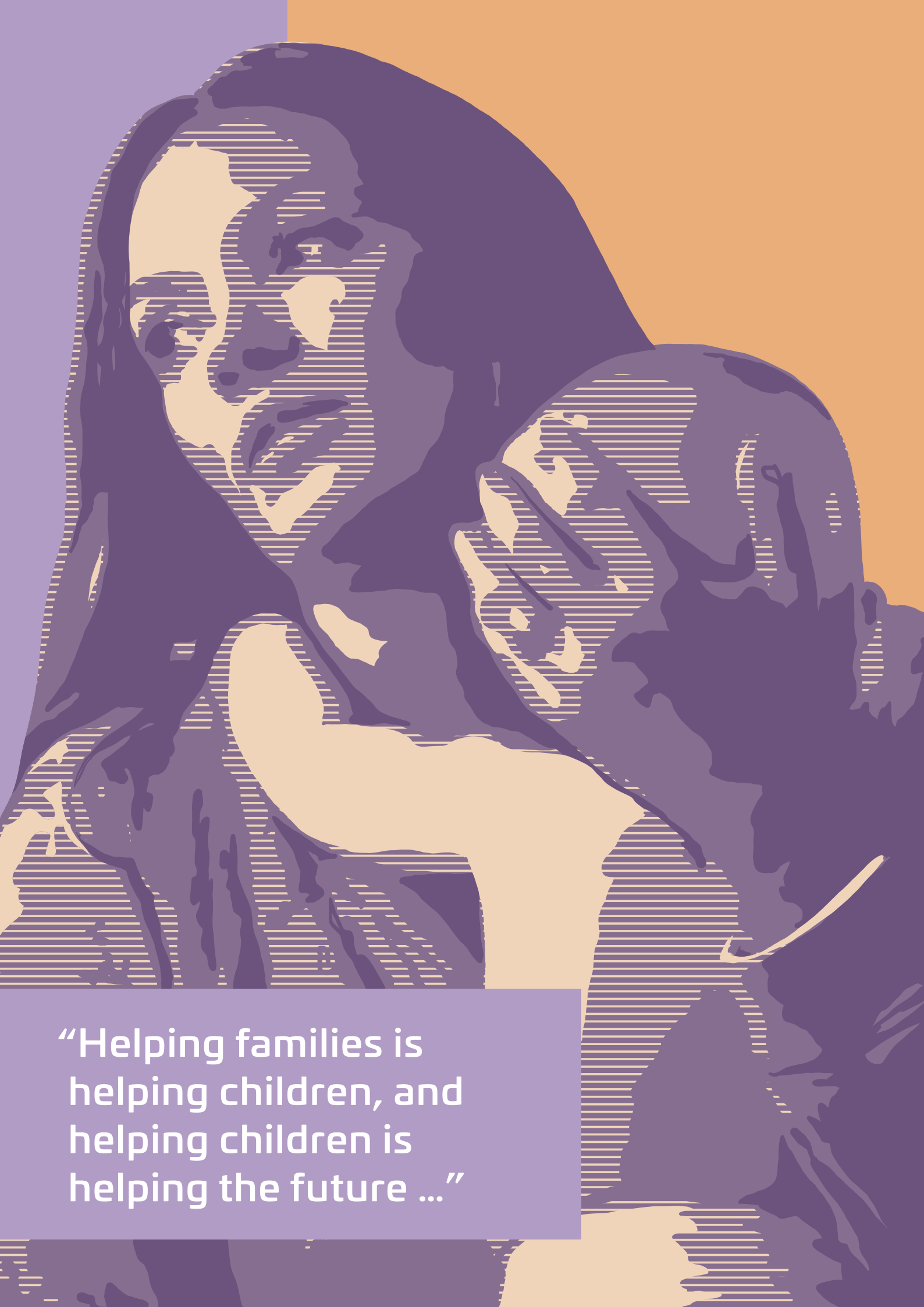
¹⁶³ For example, see H Stace and J Cumming. 2006. 'Contracting between government and the voluntary sector: Where to from here?', *Policy Quarterly* 2(4): 13–20. <https://ojs.victoria.ac.nz/pq/issue/view/501> and J Cribb. 2006. 'Agents or stewards? Contracting with voluntary organisations', *Policy Quarterly* 2(2): 11–17. <https://ojs.victoria.ac.nz/pq/issue/view/499>.

Recommendation

Strengthen the NGO sector

15. Identify a lead agency to:

- provide a stewardship role in relation to the development and sustainability of the NGO sector, including those NGOs and Kaupapa Māori services working in mental health and addiction
- take a lead role in improving commissioning of health and social services with NGOs.



“Helping families is helping children, and helping children is helping the future ...”

Chapter 7

Wellbeing, promotion and prevention

Main points

- To improve mental health and addiction outcomes, we must address the wider social determinants that influence not just mental health, but wider social wellbeing. This is a long-term project but must start now.
- Despite the substantial benefits of focusing on prevention and promoting wellbeing, it has been difficult to shift resources to those activities. Multiple agencies are engaged in activities that target similar outcomes.
- We need a more concerted and organised approach to our investment in social wellbeing, promotion and prevention. A clear locus of responsibility for social wellbeing should be established within government.
- As with social wellbeing, mental health and addiction promotion and prevention activities are dispersed and delivered by many organisations. Some programmes may not be sound and fit for purpose. The new Mental Health and Wellbeing Commission should develop an investment and quality assurance strategy for mental health promotion and prevention.

7.1 Whole-of-government approach to wellbeing, prevention and social determinants

7.1.1 Introduction

One of the overwhelming themes of this Inquiry has been the need to put significantly more effort into helping people be well and stay well. Wellbeing is more than simply the absence of distress or illness. Wellbeing encompasses many domains of a person's life, of which mental wellbeing forms one part.

People are unlikely to experience wellbeing if their basic needs – adequate food, safe environments free from abuse and violence, warm and secure homes, jobs and income – are not met. The stress and trauma that people experience from lack of appropriate housing, poverty, cultural alienation, family violence, racism and the impact of colonisation cannot, and should not, be addressed by mental health and addiction interventions alone. While we need to intensify interventions that target mental wellbeing, such as measures to counter stigma or promote resilience, mindfulness and self-care, these interventions are not sufficient on their own.

Critically, if we wish to make significant inroads into improving mental health and addiction outcomes, we need to address the wider social determinants that influence not just mental health, but overall wellbeing. These social determinants also underlie and perpetuate inequitable outcomes for many Māori and other groups in New Zealand society. We need to invest in broader prevention and promotion initiatives. Increasing evidence supports the efficacy of universal and selective preventive interventions to promote mental wellbeing and prevent mental health challenges throughout development.¹⁶⁴ This includes taking action in early childhood to build strong foundations for wellbeing and resilience and looking for opportunities through the life course to support and maintain wellbeing.

As noted earlier, improving the wellbeing of people in our society is everyone's business, and communities and families and whānau have critical roles to play, as do central and local government. In this section, we discuss the need for a more coordinated, whole-of-government approach to addressing these broader, cross-cutting issues related to wellbeing.

7.1.2 Issues

Earlier in this report, we noted that social determinants such as education, employment, family violence and poverty are underlying factors that contribute to overall wellbeing. The impacts of social determinants are complex, interactive and cumulative, and the same social determinants often influence a whole range of social outcomes.

In focusing on the social determinants of mental health and addiction and opportunities for prevention and promotion, it quickly becomes apparent that the same factors and responses have a role across multiple aspects of wellbeing and poor social outcomes, such as child abuse and neglect, offending and reoffending, family violence, educational underachievement, unemployment and homelessness.

The interventions needed to prevent poor outcomes and promote wellbeing are often similar across many social problems and sectors. For example, access to affordable, secure and stable housing contributes to child development and learning outcomes, improved management of chronic medical conditions, increased worker productivity and better mental health. Similarly, the kinds of issues typically addressed through health promotion activity, such as a healthy diet, getting enough sleep and responsible use of alcohol, contribute to better physical health, but they are also important for mental health, healthy child development, stable and loving homes and relationships, concentration and productivity in schools and workplaces, and reduction in behaviours that lead to poor decision-making, trauma, violence and crime.

164 C Arango, C Diaz-Caneja, P McGorry, J Rapoport et al. 2018. Preventive strategies for mental health. *Lancet Psychiatry* 5: 591–604.

Addressing homelessness using the Housing First approach

Many people spoke highly of Housing First, a programme that places people who are chronically homeless into stable housing before providing them with wrap-around services. Housing First leads to better clinical outcomes for people with severe mental illness and substance abuse issues.¹⁶⁵

Housing First is based on a set of core principles, including immediate access to housing with no housing-readiness conditions (for example, sobriety), choice and self-determination, and social and community integration. In New Zealand, providers have evolved these principles within a Kaupapa Māori framework.

The People's Project (a cross-agency collective led by NGO provider Wise Group and funded by the Ministry of Social Development) piloted the Housing First approach in Hamilton in 2014. The approach has since been rolled out in Auckland and Christchurch and is being rolled out in Tauranga and Wellington. It is expected to be expanded to Rotorua, Whangarei–Northland, Napier–Hastings, and Nelson–Marlborough later in 2018 and 2019.

Promoting wellbeing is also about getting ahead of problems before they arise. As noted by the Government's social sector science advisors, developmental neuroscience has established the critical role that prenatal and early brain development plays in good mental (and physical) health over a person's life, as well as in educational achievement, employment, friendships and relationships, and parenting. Early childhood is, therefore, a 'critical window of opportunity' for interventions that can be delivered through universal and targeted services. Supporting parents to better understand and be in a position to nurture, talk to and engage with their babies and young children is essential to the wellbeing of the next generation.¹⁶⁶ Universal services, especially health and education, provide a critical foundation for wellbeing throughout life.

In addition, high-quality early childhood education such as Kōhanga Reo can promote resilience and cultural enrichment, and provide the basis of key skills such as empathy, collaboration, self-control, language and literacy. If designed and delivered effectively, early childhood education services can also promote mental health in a coordinated way. Moreover, they can provide opportunities for teachers, parents and whānau to identify and intervene in early behavioural, emotional and cognitive challenges.

165 DK Padgett, L Gulcur and S Tsemberis. 2006. Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice* 16(1): 74–83; V Stergiopoulos, A Gozdzik, V Misir, A Skosireva, A Sarang, J Connelly, A Whisler and K McKenzie. 2016. The effectiveness of a Housing First adaptation for ethnic minority groups: Findings of a pragmatic randomized controlled trial. *BMC Public Health* 16(1): 1 110. <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-016-3768-4>; JR Woodhall-Melnik, and JR Dunn. 2016. A systematic review of outcomes associated with participation in Housing First programs. *Housing Studies* 31(3): 287–304.

166 Social Sector Science Advisors. 2018. *Towards an Evidence-Informed Plan of Action for Mental Health and Addiction in New Zealand: A response by the social sector science advisors to the request of the Government Inquiry into Mental Health and Addiction*. Wellington: Social Sector Science Advisors.

Other services include parenting programmes and Well Child Tamariki Ora initiatives, as well as more intensive support such as Family Start for families with known risk factors such as a history of family violence or alcohol or other drug issues.

While the early years are a critical period of intervention, opportunities also exist for preventative and resilience-building activity throughout life. Importantly, promotion of wellbeing is not just about promoting individual wellbeing, but also the connected wellbeing of families, whānau and communities. Initiatives may take the form of community programmes, school-based activities, family therapy or relationship counselling.

Iron Māori

Iron Māori is a community initiative supported by Ngāti Kahungunu Iwi. It is an annual half-ironman event that was first held in 2009 with 300 participants, and by 2011 had more than 1,550 participants. Apart from the overwhelming response from Māori, the significance of Iron Māori is its ability to change lifestyles by fostering keenness for change, encouraging at least a six-month period of dedicated fitness training, eating well, avoiding alcohol, and building supportive relationships with peers in a whānau-like setting. The success of Iron Māori can also be attributed to the Māori cultural context.

Results so far include anecdotal evidence of major weight loss, reduction of blood pressure, lowered blood sugars, and a renewed sense of purpose. The Iron Māori focus on physical fitness has increasingly come to include a focus on cultural strengths, mental toughness and whānau cohesion.

Despite substantial benefits of proactive investment in these areas, governments face universal challenges in shifting the balance of resources towards prevention, even when evidence about return on investment is strong.¹⁶⁷ Much of this relates to the timeframe involved. Outcomes, by definition, are usually not expected in the short to medium term, thus providing a disincentive for investment. Other issues include the difficulty of measuring outcomes and quantifying returns, challenges in targeting on the basis of risk factors rather than actual needs, and prevention and early intervention activity being ‘crowded out’ by more urgent needs, especially in agencies or sectors with large operational delivery roles.

167 See Productivity Commission. 2015. *More Effective Social Services*. Wellington: New Zealand Productivity Commission. www.productivity.govt.nz/inquiry-report/more-effective-social-services-final-report; P Burstow, K Newbigging, J Tew and B Costello. 2018. *Investing in a Resilient Generation: Keys to a mentally prosperous nation*. University of Birmingham.

These issues have been recognised for some time. Over the last 20 years, addressing the social determinants of wellbeing and investing in prevention in a deliberate and integrated way has become a focus internationally. For example, the United Nations Sustainable Development Goals 2015 have a strong focus on social determinants such as poverty, housing, and child and maternal health. Wales has introduced the Wellbeing of Future Generations Act 2015, with a focus on taking preventative action for the longer term. Sweden has progressively implemented many world-leading children's policies and now ranks as one of the world's best performers in children's wellbeing across a variety of health and social indicators, such as adolescent risk behaviours, teenage births and child maltreatment. Earlier this year, the Mental Health Policy Commission at the University of Birmingham recommended embedding prevention in all policies and practices that affect young people.¹⁶⁸

Wellbeing has also been high on the New Zealand policy agenda over this period. We note that successive governments have made efforts to invest more heavily in this area. However, despite this focus, in our view, clear strategic leadership is lacking in central government on wellbeing, prevention and tackling social determinants that impact on multiple outcomes. Historically, the Ministry of Social Development (and previously the Ministry of Social Policy) filled this leadership role. We understand that the Ministry's former cross-sector strategy role has been transferred to the Social Investment Agency, although it is not clear how or if it is intended that this role will evolve to fill the gap in leadership.

Multiple agencies take a role in leading aspects of wellbeing, but better coordination of effort and investment is needed, with clear alignment between the multiple frameworks, approaches and measurement regimes. During our stocktake, we collected information about programmes from government agencies, but we could not get a clear picture of current investment and saw gaps and duplication. Our impression was of fragmentation and a lack of coordination. While people called for more investment, we question whether we're getting the best value from current expenditure. Government agencies we talked to said opportunities existed for agencies to be more joined up with clearer leadership and coordination around prevention. Non-governmental organisations (NGOs) also talked about the lack of a clear, overarching investment strategy within which they can operate.

168 P Burstow, K Newbigging, J Tew and B Costello. 2018. *Investing in a Resilient Generation: Keys to a mentally prosperous nation*. University of Birmingham.

Some solid building blocks are in place to improve our approach to addressing social determinants and taking preventative action. We have some enviable universal services in place, such as through our health and education systems, that we can leverage to deliver key interventions. We have made significant strides recently in building our evidence base about what works and where the opportunities for a greater return on investment are; for example, through the establishment in government of the chief science advisor and departmental science advisor roles, the Social Investment Agency and the Integrated Data Infrastructure.¹⁶⁹ We note the recent steps to establish the Child Wellbeing Unit within the Department of the Prime Minister and Cabinet and to consult on a child and youth wellbeing strategy. Nevertheless, we see opportunities for greater coordination across agencies so that the same things everyone needs are in place to provide a good start to and throughout life.

Wellbeing initiatives in schools, such as Kāhui Ako

We were impressed by the variety of high-quality wellbeing initiatives and resources designed for implementation in schools and relating to areas such as bullying prevention, positive behaviours, healthy relationships, wellbeing and resilience – mostly by promoting ‘pro-social’ behaviour across the school environment.

However, some excellent initiatives have not been widely implemented. For example, we were disappointed to learn during a meeting with the Ministry of Education that even though the evidence-based Wellbeing at Schools survey (and related tools) has been fully funded by the Accident Compensation Corporation and the Ministry of Education to remove the cost barrier for schools, only 277 out of 2,500 schools took this up in 2018.

Several providers observed that it is extremely difficult negotiating school by school to implement wellbeing programmes. Kāhui Ako – Communities of Learning – appear to be providing new opportunities to implement initiatives at a scale that might not be possible in a single school. We were privileged to see, for example, school-based mental health practitioners in action in the Bay of Plenty. Schools belonging to the Otumoetai and Whakatane Communities of Learning noticed their students seemed to be lacking resilience. After discussions with the local district health board, two staff from the Child and Adolescent Mental Health Service are based at one of the schools as part of a three-year pilot.

¹⁶⁹ The Integrated Data Infrastructure (IDI) is a large research database. It holds microdata about people and households. The data is about life events such as education, income, state income support, migration, justice and health. It comes from government agencies, Statistics New Zealand surveys, and NGOs. The data is linked together, or integrated, to form the IDI. More information is available at Statistics New Zealand. 2018. Integrated Data Infrastructure (web page). www.stats.govt.nz/integrated-data/integrated-data-infrastructure/ (accessed 17 October 2018).

7.1.3 What needs to happen

We believe a clear locus of responsibility for social wellbeing with a focus on prevention, building general resilience and tackling major social determinants that lead to inequities within society, needs to be established within central government. The goal is to support a more strategic approach to investment across multiple, interconnected outcome areas; for example, by:

- providing leadership and strategic policy advice to the Government on investing in prevention, building resilience and tackling social determinants, including strategic investment across portfolios
- facilitating a robust programme of research and evaluation, building our knowledge of what works, so effective approaches can be scaled up
- working with other agencies, particularly the Treasury, to address systemic barriers to investment in prevention.

We consider a wellbeing entity of some kind should be created to provide this leadership. It could be a new agency, a unit in an existing agency or a reconstituted existing agency. For example, we note that the Government is consulting on the future role of the Social Investment Agency, so one option would be to reconfigure the Social Investment Agency as a social wellbeing agency to provide the necessary cross-cutting social sector leadership. This would be a significantly enhanced role for the Social Investment Agency, well beyond its focus of improving the evidence base to support investment decisions, and would require appropriate capability across a range of functions (see Figure 3).

Figure 3: Potential purpose and functions of a new social wellbeing agency

Overarching purpose	<ul style="list-style-type: none"> To provide cross-government leadership on social wellbeing and support a more strategic approach to investment across multiple interconnected outcome areas
Core functions	<ul style="list-style-type: none"> Provide strategic policy advice to the Government on investing in prevention, building resilience and tackling social determinants, including strategic investment across portfolios Facilitate a robust programme of research and evaluation Work with other government agencies, particularly the Treasury, to address systemic barriers to investment in prevention Support the new Mental Health and Wellbeing Commission, including to develop an investment and quality assurance strategy for mental health promotion and prevention (see section 7.2)
Other possible functions	<ul style="list-style-type: none"> Advise the Government on issues relating to the development and sustainability of the non-governmental organisation sector (see chapter 6) Provide leadership on alcohol and other drug policy (see chapter 9) Host the suicide prevention office (see chapter 10)

We suggest the State Services Commission be tasked with reporting back on how best to establish such an entity.

It is important that the function is not co-located in an agency where service delivery or operational demand pressures would compete with the whole-of-government strategy and policy focus needed, and that a long-term focus on social determinants and investment in prevention is protected.

We do not consider that the new Mental Health and Wellbeing Commission (chapter 12) should undertake the proposed functions of the social wellbeing agency. This is because an independent commission should act as a leader and watchdog of the mental health and addiction system. Keeping the roles of a social wellbeing agency and the Mental Health and Wellbeing Commission separate will prevent the Commission being ‘swamped’ by having to address every domain of wellbeing and all social determinants and will enable it to focus more directly on its core roles.

However, we would expect any social wellbeing agency and the new Commission to work closely together on their respective work programmes and identify opportunities to build on universal programmes to improve mental health and addiction outcomes – including promoting new ways of commissioning for flexible, innovative wrap-around services to meet people’s needs. The social wellbeing agency could also provide a stewardship and development function in relation to the NGO and community sector (chapter 6), be the lead coordination agency for broader alcohol and other drug issues (chapter 9), and host the suicide prevention office (chapter 10).

Another issue to consider is whether New Zealand should introduce a ‘Health in All Policies’ (or a ‘Mental Health in All Policies’) approach as has been done in other countries¹⁷⁰ and use health impact assessment tools to assess the impact of government policies and programmes on the wellbeing of the population. This has already gained some traction at local government level (particularly in Canterbury), although these approaches have not been sustained at national level. We suggest consideration be given to adopting a Health in All Policies approach. This could include the development and roll-out of health impact assessment tools to assess the impact of government policies on health, particularly mental health.

Recommendations

Take a whole-of-government approach to wellbeing, prevention and social determinants

- 16. Establish** a clear locus of responsibility for social wellbeing within central government to provide strategic and policy advice and to oversee and coordinate cross-government responses to social wellbeing, including:
- tackling social determinants that impact on multiple outcomes and that lead to inequities within society
 - enhancing cross-government investment in prevention and resilience-building activities.
- 17. Direct** the State Services Commission to report back with options for a locus of responsibility for social wellbeing, including:
- its form and location (a new social wellbeing agency, a unit within an existing agency or reconfiguring an existing agency)
 - its functions (as proposed in Figure 3 in section 7.1.3).

170 A Health in All Policies approach emphasises the consequences of public policies on health determinants and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making. A review of Health in All Policies initiatives around the world in 2010 found examples in 16 countries or subnational areas, including Finland, Norway, Sweden and South Australia: K Leppo, E Ollila, S Peña, M Wismar and S Cook (eds). 2013. *Health in All Policies: Seizing opportunities, implementing policies*. Finland: Ministry of Social Affairs and Health. www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf.

Mental Health in All Policies is a coordinated European Union public mental health programme to implement large-scale promotion and prevention activities, together with investment in mental health services. The approach reflects that many determinants of mental health lie in ‘non-health’ policy domains such as education, employment and community design: European Union. 2016. *European Framework for Action on Mental Health and Wellbeing: EU Joint Action on Mental Health and Wellbeing*, cited in R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

7.2 Mental health promotion and prevention

7.2.1 Introduction

Earlier in this chapter, we noted that many of the social determinants of mental health and addiction challenges (such as family violence, housing and employment) are not unique to the mental health and addiction system. Key interventions support the achievement of a broad range of wellbeing objectives across the social sector.

While we identified a need for a more coordinated, whole-of-government approach to addressing the complex, underlying drivers of wider wellbeing, we also stressed the need to look to solutions and support outside government – to families and whānau, communities and wider society.

However, some interventions target mental health and wellbeing specifically. These interventions include measures to counter mental health and addiction stigma and discrimination, reduce bullying in schools, foster (mentally) healthy workplaces, promote mindfulness and self-care, and build resilience in individuals and communities, especially in children and young people (both at school and in the home environment). Such interventions are important because for many people in our communities, the stigma of mental health acts as a barrier to seeking help. We also heard calls for more resources to help individuals and communities recognise or respond to mental distress or substance abuse in themselves or others.

Mental health promotion in schools

24–7 YouthWork

24–7 YouthWork started with one school in Christchurch in the early 1990s and now covers 71 local schools nationally. 24–7 YouthWork is a secular programme that encourages local churches to partner with local schools to fund 180 youth workers to support students across Aotearoa. The youth workers, who are often close in age to the students and outside the authority structure of the school, run activities to help students bond and feel a sense of belonging. They also offer a more informal way for young people to raise concerns and seek help. When it comes to mental health challenges, youth workers are able to do warm handovers for students to school counsellors and other supporters. There are several stories where students might not have been picked up by other methods. Youth workers typically serve for three to five years and also connect in regional clusters so can do handovers for students to new schools in the area, helping to make young people more comfortable with their new environments.

St John's College and Whatever It Takes Trust

St John's College and Whatever It Takes Trust (WIT) are based in Napier. Students and staff of St John's College have used their business enterprise class as a vehicle to connect with WIT clients. In their class, students designed an early warning tool to detect flooding and donated all profits from the products sold to WIT. Nine students and school staff regularly visit clients at WIT. The regular contact has enabled some of the young men to open up about the challenges they face. St John's shows the opportunity schools and other organisations have to form relationships with people who face mental health and addiction challenges. It also illustrates practical ways to be connected in the community and what a future of community care could be – the community providing care and support for people in distress and facing challenges.



Photo: Panel members listening to students at St John's College, Hastings, June 2018
Photo courtesy of Duncan Brown, Hawke's Bay Today

In the next section we discuss issues around mental health promotion and the prevention of mental distress.

7.2.2 Issues

As with general wellbeing, promotion and prevention activities for mental health and wellbeing are dispersed across and delivered by multiple central government organisations. A broad range of community and NGO initiatives are also available. We have highlighted some of these initiatives below.

The Health Promotion Agency undertakes research and health promotion activities. This includes two major national mental health campaigns (Like Minds, Like Mine and the National Depression Initiative), as well as responsible alcohol use campaigns (for example, ‘Say Yeah, Nah’ and ‘Don’t Know? Don’t Drink’). Like Minds, Like Mine aims to counter the stigma and discrimination associated with mental illness or distress. It combines community action, a national media campaign, and research and evaluation to bring about social change. Surveys of public attitudes demonstrate that, as a result of the campaign, attitudes towards people with mental illness in the target group of 15- to 44-year-olds have improved significantly, especially among Māori, Pacific peoples and young people.¹⁷¹

The All Right? campaign was established in 2013 by the Mental Health Foundation, Canterbury District Health Board and Healthy Christchurch after the Canterbury earthquakes in 2010 and 2011. All Right? provides basic positive psychological interventions and communications focused on emotional literacy and intelligence, empathy, character strengths and self-care.

WorkSafe’s GoodYarn programme aims to help rural people recognise and respond to stress and mental illness. This programme has been expanded into an award-winning national initiative for dairy farmers led by DairyNZ, with workshops conducted across the country. Another rural initiative is Farmstrong, a web-based, prevention-focused initiative founded by FMG Insurance and the Mental Health Foundation. Farmstrong’s emphasis is on building resilience and healthy thinking skills to handle stress. Its website (www.farmstrong.co.nz) contains practical tips and evidence-based strategies to improve mental health and wellbeing.

SPARX is an award-winning computerised, interactive fantasy game based on cognitive behavioural training that the University of Auckland developed. SPARX teaches young people the skills they need to help combat depression and anxiety. It is supported by trial evidence for use with many ethnic groups, has been adapted for use by Rainbow young people, and is effective in reducing depressive symptoms and emotional distress.¹⁷²

The growing amount of activity in this space is heartening, and it is encouraging to see mental health and wellbeing acknowledged and fostered beyond the health sector. However, as with initiatives to improve wider social wellbeing, strategic leadership and coordination for mental health promotion and prevention are absent. As a country, we have ended up with an approach of ‘letting a thousand flowers bloom’ and relying on enthusiastic and committed individuals and organisations. This approach is not sustainable or effective in the long run – and is not adequate to get ahead of the rising tide of mental health and addiction problems New Zealand is facing.

171 Ministry of Health and Health Promotion Agency. 2014. *Like Minds, Like Mine National Plan 2014–2019: Programme to increase social inclusion and reduce stigma and discrimination for people with experience of mental illness*. Wellington: Ministry of Health. www.likeminds.org.nz/assets/National-Plans/like-minds-like-mine-national-plan-2014-2019-may14.pdf.

172 Quigley and Watts Ltd. 2015. *Youth Mental Health Project: Research review*. Wellington: Superu. <http://superu.govt.nz/ymh>.

In addition, despite a proliferation of resources from government, academic institutions, mental health organisations and community groups, people do not know where to look for resources or how to determine what resources are most appropriate for their needs. Some organisations have resources to implement programmes, but struggle to identify which programmes are the most effective or are evidence-informed.

This issue has been highlighted in schools, where governance is devolved to local boards of trustees. A plethora of different programmes cover topics such as resilience, wellbeing, deliberate self-harm, anxiety and depression, bullying and suicide. Many providers fund and deliver these programmes to schools (including commercial entities, government and NGOs, charities and interest groups). In spite of this large volume of activity, resourcing and delivery varies across schools. Information is lacking about whether the programmes offered are sound and fit for purpose (particularly with regards to suicide prevention) and whether they are having a positive impact.

There are also significant gaps and untapped opportunities for mental health promotion and prevention, all of which would benefit from more funding and investment. For example, while many submitters praised national campaigns such as Like Minds, Like Mine for shifting thinking about mental health, more targeted destigmatisation and mental health promotion programmes are needed for marginalised groups.

Opportunities also exist for greater integration of promotion and prevention activities in people's day-to-day lives. For example, data from WorkSafe New Zealand indicates that experience of work-related stress or mental illness is increasing year on year.¹⁷³ Thus, workplaces have a critical role to play in promoting mental health and wellbeing. Workplaces can help develop core standards for mental health and wellbeing in the workplace or prevention programmes to reduce workplace bullying or stress among employees.¹⁷⁴ Families and whānau also play a vital role in promoting wellbeing (as discussed in chapter 8).

Finally, the potential of emerging digital technologies (for example, e-coaching, e-screening, e-therapy, e-navigation and other e-mental health programmes) is yet to be fully realised, despite a growing body of evidence suggesting their effectiveness. The Government's social sector science advisors have advised that, in an environment where funding is tight but with massive unmet need, e-mental health presents a potentially major and cost-effective tool. If effectively delivered, e-mental health can help people before their mental health needs escalate, improve the reach and accessibility of mental health supports and services (particularly in rural or isolated areas), and alleviate pressures in workforce capacity.¹⁷⁵

173 Nielsen Co. 2017. *Health and Safety Attitudes and Behaviours in the New Zealand Workforce: A survey of workers and employers. 2016 cross-sector report*. Wellington: WorkSafe New Zealand. <https://worksafe.govt.nz/data-and-research/research/attitudes-and-behaviours-survey-2016/>.

174 Work-related health, including mental health, is a priority in the Government's Health and Safety at Work Strategy 2018–2028. Other jurisdictions, such as Canada, have recognised the benefit of developing a voluntary national code of practice for work-related mental health aspects – a cohesive framework of voluntary guidelines, tools and resources – to raise awareness and support workplace stakeholders to adopt good practices for work-related mental health. WorkSafe, New Zealand's health and safety regulator, is well placed to lead or support this cross-sectoral and cross-regulatory work.

175 Social Sector Science Advisors. 2018. *Towards an Evidence-Informed Plan of Action for Mental Health and Addiction in New Zealand: A response by the social sector science advisors to the request of the Government Inquiry into Mental Health and Addiction*. Wellington: Social Sector Science Advisors.

7.2.3 What needs to happen

We consider that greater central leadership, including oversight of quality, is needed for mental health promotion and prevention activity. With this infrastructure in place, we would support significantly more investment in this area, including customised responses at a local level.

Clear leadership and increased oversight would prevent clusters of disparate, fragmented initiatives. It would also facilitate a national roll out of initiatives with a strong evidence base that can be effectively scaled up. As we note in chapter 12, the new Mental Health and Wellbeing Commission has a critical role in setting direction and driving action and investment. This includes for mental health promotion and prevention, in close liaison with a range of sectors and the proposed social wellbeing agency.

Other proposed functions of the Commission include spreading information, innovation and best practice and promoting collaboration, communication and understanding about mental wellbeing. The Commission could do this by facilitating the development of a central information hub or online gateway (similar to the approach taken in Finland¹⁷⁶), which provides a single electronic 'door' to online mental health resources. This hub could contain tools, resources and guidance about evidence-informed programmes and initiatives and guidance on design and evaluation, motivating engagement by celebrating and showcasing the diversity of approaches that have been successful. It could also provide links to resources hosted by other organisations, disseminate information and facilitate networking among those with common interests (for example, through events and seminars), and direct people to funding sources, supports and services that may help their initiative succeed.

We also see considerable benefits in developing regional hubs or mechanisms for sharing resources and ideas and empowering communities to lead the development of their own mental health promotion initiatives and customise national resources and tools to their local contexts. Schools and other community organisations stand to benefit from being connected to people who have similar interests and objectives, so they can exchange ideas, information and lessons.

It is a global challenge for learning environments, communities, whānau and workplaces to have the time and all the skills required to be able to determine what programmes, resources and interventions are safe and effective. In the United Kingdom, the mental health campaign Heads Together funded a website called Mentally Healthy Schools and coordinated a team to assess over 3,000 resources going into schools to support principals, teachers and boards to know what resources work and are safe. In New Zealand, we have a range of programmes including Health Promoting Schools, Mentally Healthy Schools and the Rethink programme. However, implementation is variable and resourcing issues and a lack of consolidation across education and health agencies have impacted on the ability of early childhood centres and schools to implement wellbeing and resilience programmes.

176 The Finnish mental health hub provides links to a wide range of resources on various mental health topics: www.mentalhub.fi.

It is important to build a strong evidence base of safe and effective mental health promotion and prevention interventions and fund accordingly. Particular consideration needs to be given to areas where greater investment should be provided and which are the most appropriate delivery agencies, including at national, regional or local levels. We see mental health promotion and prevention as a key area of oversight of the new Mental Health and Wellbeing Commission and recommend that it develops a targeted investment and quality assurance strategy for activity in this area.

Recommendations

Facilitate mental health promotion and prevention

18. **Agree** that mental health promotion and prevention will be a key area of oversight of the new Mental Health and Wellbeing Commission, including working closely with key agencies and being responsive to community innovation.
19. **Direct** the new Mental Health and Wellbeing Commission to develop an investment and quality assurance strategy for mental health promotion and prevention, working closely with key agencies.



“... the patient is not treated as a whole, but a fragment of the area of expertise the particular doctor is trained in ...”

Chapter 8

People at the centre

Main points

- People accessing services must be at the centre of the mental health and addiction system.
- Instead, many people receive treatment that does not meet their needs and find it hard to navigate the system. People with lived experience are on the periphery of service design and delivery – rather than at its centre.
- Consumer voice needs to be supported, strengthened and included in all aspects of the system, from governance to service delivery.
- Families and whānau want to be treated as a crucial part of the support network for their family members with mental health and addiction challenges.
- Instead, the mental health and addiction system focuses on the treatment of individuals, without seeing their family and social context. Family and whānau are often excluded from communication and decisions.
- Services need updated guidance on how to share information and partner with families and whānau. Families and whānau need better support, so they can maintain their own wellbeing.

8.1 Put people accessing services at the centre

8.1.1 Introduction

In chapter 3, we described the reality for people facing mental health and addiction challenges in New Zealand and how the future should look. There is widespread acknowledgement of the need for people to be at the centre of everything we do, but the rhetoric often does not match the reality.

We have a system based on the directions of governments and funders and dominated by providers, rather than the needs and preferences of the people using it. Even though mental health was the first part of the New Zealand health sector to legislate for patients' rights (albeit in the context of compulsory assessment and treatment), people have not been placed at the centre of mental health and addiction services.

In this chapter, we affirm the overarching principle that people accessing services must be at the centre of the mental health and addiction system.

8.1.2 Issues

We know how hard building a consumer-centred system is, but during this Inquiry far too many people told us they were not treated with kindness, dignity and respect. These types of stories are not restricted to the health system – people dealing with other government agencies and social services (such as Work and Income) often feel belittled and unsupported. For many people trying to access services, communication is poor and information, choice and consent are lacking. A consumer-centred system would prioritise the least intrusive care and support, provided in the community and close to home.

Thirty years ago, Judge Silvia Cartwright noted in the *Report of the Cervical Cancer Inquiry* that “the focus of attention must shift from the doctor to the patient” and recommended an amendment in New Zealand law to provide for a statement of patients’ rights.¹⁷⁷ However, despite the introduction of the Code of Health and Disability Services Consumers’ Rights and its strong framework for high-quality, consumer-centred care and support, we still have some way to go to fulfil Cartwright’s vision.

From the perspective of the people seeking to access the system, it too often feels fragmented, confusing and difficult to navigate. Many services are not provided in a holistic way that is consistent with an individual’s needs and preferences. Different services often do not talk to each other (even within the same organisation) and do not coordinate their responses across sectors.

Seclusion, restraint and compulsory treatment are overused, especially for Māori and Pacific peoples, within our mental health system. We note that the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) has been criticised for its lack of consistency with the United Nations Convention on the Rights of Persons with Disabilities.

While good examples exist of effective co-design, people with lived experience of mental health and addiction challenges, including Māori and Pacific peoples, are often on the periphery of the planning, design and delivery of services – relegated to an advisory group with little influence or represented by a single person appointed to a board or committee to provide ‘the consumer voice’ with little support or guidance. How well district health boards (DHBs) include the voices of consumers in their governance, policy, planning and service development varies around the country. There are differing levels of engagement with services at local, regional and national levels. The use of people with lived experience as trained peer-support workers and of consumer advisory groups is inconsistent. Variation also exists in how well DHBs resource their consumer advisors to provide support and link with consumer networks.

¹⁷⁷ Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women’s Hospital and into Other Related Matters (S Cartwright, Chair). 1988. *Report of the Cervical Cancer Inquiry*. Auckland: Committee of Inquiry, p 176. [www.moh.govt.nz/notebook/nbbooks.nsf/0/64D0EE19BA628E4FCC256E450001CC21/\\$file/The%20Cartwright%20Inquiry%201988.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/64D0EE19BA628E4FCC256E450001CC21/$file/The%20Cartwright%20Inquiry%201988.pdf).

8.1.3 What needs to happen

Putting people accessing services at the centre of mental health and addiction services should permeate all service planning and delivery, and not just be an action point to be ticked off.

We want to see renewed prominence given to the rights of consumers under the Code of Health and Disability Services Consumers' Rights, including the right to be treated with respect, the right to dignity and independence, and the right to be fully informed. It is concerning that some people do not know their rights and how to exercise them. They need more information about how the Code relates to mental health and addiction services, and providers need more training about how to embed the Code in service provision. The Health and Disability Commissioner should play a lead role in this area, particularly in the delivery of specific initiatives to promote respect for and observance of Code rights by providers and awareness of their rights on the part of consumers.

As noted in chapter 11, the Mental Health Act needs to be urgently repealed and replaced to affirm and strengthen the rights of people who need intensive mental health support, including their right to effective treatment and care. This includes supporting people and their whānau to access support early, make decisions about their care, have choices, access respite options easily and be subject to the least restrictive interventions, in a manner that seeks to protect and enhance their mana, dignity and wellbeing.

Mental health and addiction is not the only area in New Zealand's health or social services where we need to shift from a provider-centred system. The State Services Commission is proposing significant reforms to the New Zealand public service. As part of reforms to the State Sector Act 1988 under consideration, we suggest the introduction of a principle that consumers of *all* public services should be treated with fairness, dignity and respect.¹⁷⁸ This could be incorporated as one of the proposed set of principles and values being consulted on. It would be consistent with the concept of consumers being at the centre of all public services.

At a practice and implementation level, we need to see more examples of genuine co-design processes and more people with lived experience supported in governance and leadership roles in agencies commissioning and delivering services. Shifting to a person-centred model of care encompasses everything from service delivery to governance and decision-making. Having consumers' voices in isolation or providing only tokenistic involvement in processes, is not enough to have a positive impact. Including the voices of people with lived experience in our system means we need to actively facilitate their involvement in processes, including by supporting individuals and groups with the time, resources and training required to engage in effective co-design.

¹⁷⁸ Such a principle would be consistent with rights 1 and 3 of the Code of Health and Disability Services Consumers' Rights and with the 'fairness for all' approach of the Office of the Ombudsman to complaints about unreasonable action by government agencies.

Awhi Ora – community co-design in action

Awhi Ora is a community initiative using co-design to deliver mental health support and services in Tāmaki Makaurau (Auckland). This initiative is based on what the community has identified as being important and enables primary care practices and cross-sector agencies to work with a lead non-governmental organisation.

Awhi Ora responds to a variety of needs that most commonly relate to physical health and healthy lifestyles, emotional health and mental wellbeing, managing problem drinking, drug use or gambling, and family and whānau, money, and housing problems. This means options for addressing these concerns can be offered alongside traditional clinical care options.

Following an introduction, people are seen by a support worker. This may be in a general practice clinic, their home or the community. A plan to address the person's needs is developed with the support worker. Support is usually brief – typically weekly for up to three months – but varies according to need. Sometimes one-off support is all that is required (for example, providing navigation support to connect people to resources). Other people, with multiple or more complex issues, may require support for a longer period.

Awhi Ora is being expanded across the Auckland and Waitemata DHB areas and delivered through non-governmental organisation providers who work closely with general practices.

This can be achieved in a variety of ways and at a variety of levels. For example, in chapter 4, we recommend that a full spectrum of mental health and addiction services be developed through a co-design process. In chapter 12, we highlight the importance of the representation of people with lived experience in the makeup of the new Mental Health and Wellbeing Commission. We also need to plan for, train and support a greatly expanded peer and cultural workforce (discussed in chapter 4), which is a highly valued and important part of service delivery teams.

Service planning should start with knowing who service users are and understanding their needs and circumstances. Feedback from these people and their families and whānau is a critical component of service improvement and should be built into processes (for example, by using a real-time feedback tool like Mārama¹⁷⁹). Other approaches include using methods such as Knowing the People Planning¹⁸⁰ and filling key data gaps (discussed in chapter 4). The summary of submissions from this Inquiry – capturing the voices of the thousands of tāngata whaiora and families and whānau who shared their stories with us – is a valuable resource for future planning, funding and design of services and will be published separately.

179 Mārama was developed for the Health and Disability Commissioner: <http://hdcrf.co.nz> (accessed 16 October 2018).

180 D King and B Welsh. 2006. *Knowing the People Planning (KPP): A new, practical method to assess the needs of people with enduring mental illness and measure the result*. London: Nuffield Trust.

Finally, the variation across DHBs in how people with lived experience are involved in governance, policy, planning and service development needs to be addressed. The work of the Health Quality and Safety Commission, through its Mental Health and Addiction Quality Improvement programme, provides a national model of partnership between a national leadership body, people with lived experience (and their families and whānau), and providers. The Health Quality and Safety Commission also leads a Partners in Care work programme for DHBs, which provides strong guidance on how to involve people with lived experience and their families and whānau. This includes a guide for DHBs on improving engagement with consumers, a co-design Partners in Care process, training modules for service user representatives, establishment of service user advisory councils, and case studies on including service users in governance.

We know that some DHBs consult people with lived experience, but often the big strategic decisions have been made without their input. We were told, for example, of DHBs that consulted well on the design of new inpatient facilities, but only after they had made the decision to build them. People with lived experience need to be involved earlier, in governance and strategic decisions about priorities before decisions are made that often bed in existing service models. Leadership, advice and participation help ensure mental health and addiction services are consumer- or people-focused, with an emphasis on recovery and wellness.

Consumer input should be a standard part of experience-based co-design. DHBs should be required to include and support people with lived experience in mental health and addiction governance, planning, policy and service development. This requirement should include developing a well-supported group of consumer advisors who are resourced to provide their DHBs with meaningful, long-term engagement in mental health and addiction processes. Similar requirements could extend to other organisations such as primary health organisations and non-governmental organisations (NGOs).

Recommendations

Strengthen consumer voice and experience in mental health and addiction services

20. **Direct** DHBs to report to the Ministry of Health on how they are including people with lived experience and consumer advisory groups in mental health and addiction governance, planning, policy and service development decisions.
21. **Direct** the Ministry of Health to work with people with lived experience, the Health Quality and Safety Commission and DHBs on how the consumer voice and role can be strengthened in DHBs, primary care and NGOs, including through the development of national resources, guidance and support, and accountability requirements.
22. **Direct** the Health and Disability Commissioner to undertake specific initiatives to promote respect for and observance of the Code of Health and Disability Services Consumers' Rights by providers, and awareness of their rights on the part of consumers, in relation to mental health and addiction services.

8.2 Partner with families and whānau

8.2.1 Introduction

We heard about the vital support and advocacy many families and whānau provide on behalf of family members who are experiencing mental health and addiction problems.

Key themes raised were:

- the desire of families and whānau to provide and receive information about their family member and to share in aspects of the care and treatment process
- the challenges facing families and whānau who are supporting family members, including the need for services that sustain their own wellbeing
- the importance of supporting people within their family and whānau and, for Māori and Pacific peoples, the advantages of Whānau Ora to health and wellbeing.

Families and whānau called strongly for more services to support those bereaved by suicide and for changes to the processes following suicide. This is discussed in chapter 10.

Families and whānau expressed differences of opinion, including about the diversity of support required, the level of actual and preferred family and whānau involvement, and the nature of interaction with their family member. However, many regarded family as critical to positive outcomes, providing a sense of belonging, identity, support and love.

Exclusion of family and whānau

A significant area of dissatisfaction for many families and whānau, including parents, partners, adult children, siblings, grandparents, and other relatives and friends, was their experience of marginalisation and frustration in trying to access services for their loved one and of frequent exclusion from communication. This was often despite their day-to-day role in providing support.

For many families and whānau, their main concern was positive outcomes for their family member experiencing mental health and addiction challenges. Families and whānau often felt compelled to advocate on behalf of their family member, because easy access to timely, relevant, accessible and integrated services was limited. Where services were available, despite families and whānau sometimes having an intimate understanding of their family member's needs and history, their views were ignored, treated indifferently or given limited credence. For many families and whānau, this contributed to increased distress, anger, worry and, in some cases, tragic outcomes for their loved ones.

The importance of family and personal relationships in recovery is well recognised, yet the current mental health service model tends to be individualistic in its approach. There is growing evidence of the effectiveness of family inclusive practices, such as Open Dialogue,¹⁸¹ which aim to collaboratively support people seeking mental wellness.

For most Māori and Pacific peoples, the concept of whanaungatanga (extended family and relations) is critical to health and wellbeing,¹⁸² and the practice of working with an individual in isolation from their whānau is not culturally appropriate. Some services seek to be inclusive, but the lack of appropriate approaches makes doing that difficult. We heard that for whānau, Whānau Ora approaches, Kaupapa Māori services and Pacific-led services are strongly preferred. They are fully inclusive of whānau and value relationships as strongly as medicine.

Privacy and involvement in care and treatment

The complex issue of the privacy of people accessing services and family and whānau involvement in their care, treatment and recovery was raised repeatedly. Despite some polar positions on privacy, most families and whānau expressed a desire to receive and provide relevant information about their family member and to be involved in a way that supports good outcomes. Many submitters described themselves as being in a de facto caring role without the right information.

Some people with lived experience noted that it is crucial to uphold the rights of the individual to choose *not* to include others in their care and treatment and even to refuse the sharing of information about their care and treatment with family and whānau. They stressed that inclusion and partnership of family and whānau is context specific.

Clinicians sometimes choose to cite the Privacy Act 1993 rather than engage effectively with family and whānau, recognising the specific and different needs of the various participants and seeking mutual understanding.

181 Open Dialogue involves a consistent family or social network approach to care, in which the primary treatment is carried out through meetings involving the patient together with their family members and extended social network.

182 Office of the Auditor-General. 2017. *Mental Health: Effectiveness of the planning to discharge people from hospital*. Wellington: Office of the Auditor General, p 56. www.oag.govt.nz/2017/mental-health/docs/mental-health.pdf/view.

Striking a balance between privacy and participation is difficult, exacerbated by the stigma some people feel when accessing mental health and addiction support. Many families felt that confidentiality can be maintained – while still giving them information and seeking their input – if there are clear guidelines for service providers that are understood and applied in practice.

Lack of support services for family and whānau

We heard from many families and whānau about the lack of services to support their own wellbeing during particularly difficult times when caring for a loved one. Many feel isolated and experience anxiety or depression themselves. They may support their family member at a high cost to their own mental and physical health.

Although some families and whānau find support networks and professional services in their community, limited support and respite options are available and not all families can afford them. This difficulty is exacerbated when a family member has complex needs, multiple challenges, chronic physical conditions or no agreed diagnosis. Not knowing where to go and the services available for support compounds the situation.

Family and whānau may also be struggling with their own complex challenges such as addictions, mental health problems, financial stress, discrimination, housing difficulties and other social determinants that are compounding stressors.

8.2.2 What needs to happen

Inclusion of family and whānau

Acknowledging the positive role of families and whānau in providing belonging, identity, support and care for their family member requires a more holistic approach to wellbeing, while respecting an individual's right to privacy and autonomy. Families and whānau also have a vital role to play in the recovery of a family member from addiction.¹⁸³ People accessing mental health and addiction services have a legal right to be supported by the presence of a person (or people) of their choice.¹⁸⁴

Access to well-integrated, timely and appropriate services is essential for family and whānau advocating on behalf of their family member, as is a variety of service options from individual to family-inclusive approaches. Families feeling excluded by current processes need clear guidelines about the exchange of information, consistent communication and integrated processes.

Services that use more person-centred, holistic approaches were viewed positively by consumers and family and whānau submitters. Some noted that the introduction of Whānau Ora in 2010 represented a more whānau-centred approach to treatment and care, providing more holistic and wrap-around support for families and whānau in our communities than is commonly experienced. Whānau Ora services identify whānau priorities to enable autonomy and self-management and help develop a plan for realising whānau aspirations, providing what could be a useful service model for holistic care involving family and whānau.

183 P Adams. 2016. Switching to a social approach to addiction: implications for theory and practice. *International Journal of Mental Health and Addiction* 14: 86–94.

184 Code of Health and Disability Services Consumers' Rights, right 8; "except where safety may be compromised or another consumer's rights may be unreasonably infringed".

We acknowledge that meaningful engagement with family and whānau is not always easy and may require more time and effort than just dealing with an individual. However, a health system that focuses on the treatment of individuals, without seeing their family and social context, is limited in what it can achieve and fails to take adequate account of vital supports for healing and recovery.

Balanced approach to privacy

Striking a balance between enabling the inclusion of family and whānau and protecting individual privacy can be challenging. The 1996 Mason Inquiry report discussed exactly this issue.¹⁸⁵ The submissions quoted in that report are almost identical in tone and content to the many submissions we received about families and whānau being excluded from the treatment of family members and loved ones. These issues are not new. It appears that much of the exclusion of family and whānau is driven by service practices, not the family member receiving the service.

We think the balance should shift towards embracing the benefits of including family and whānau to improve outcomes, while keeping legal protections in place to respect individual privacy. From our examination of the Privacy Act 1993 and the Health Information Privacy Code 1994 and discussions with the Privacy Commissioner, we conclude that the basic legal framework is sound and provides sufficient protection for individuals while still allowing family and whānau to be included in care and support.

As with any legal framework, guidance is crucial if the intent of legislation is to translate into good practice by the people at the front line. A variety of information is available, including extensive guidance from the Privacy Commissioner as well as guidance from the Royal Australian and New Zealand College of Psychiatrists, Ministry of Health, and Health and Disability Commissioner. This is a problem in itself – different messages from different organisations can cause confusion.

We consider these guidance documents should be combined into consolidated, updated guidance that key agencies endorse. The Ministry of Health should lead a process to develop this guidance, involving people with lived experience, families and whānau, the Privacy Commissioner, the Royal Australian and New Zealand College of Psychiatrists, the Health and Disability Commissioner, the Children’s Commissioner and other interested parties.

The starting point should be that family and whānau can be involved in treatment and care, subject to the wishes of the individual patient. This should be supported by service cultures that promote connection and whanaungatanga. Some people may decide to give full access to their family or whānau, others may authorise access only to information about medication and discharge, and some may refuse to allow any access. In addition, family and whānau should be given the opportunity to provide information relevant from their perspective about their family member, recognising the valuable role that contextual information plays in improving outcomes.

185 Committee of Inquiry into Mental Health Services (K Mason, Chair). 1996. *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley*. Wellington: Ministry of Health, p 61. <https://tinyurl.com/y6w4nqr5>.

The new guidance will need to be widely communicated and promoted, with ongoing training for the sector. The training should include a focus on the requirement for consultation with family and whānau under section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (or the equivalent provision in any replacement statute) and the application of Health Information Privacy Rule 11(1)(g).¹⁸⁶

The new guidance should also be built into relevant contracts, standards, specifications, guidelines, quality improvement processes and accountability arrangements.¹⁸⁷

Better support for families and whānau

Families and whānau are seeking more support for their own wellbeing. This is often so they can continue to effectively provide care for their family member. The support being sought includes information and advice, access to respite services, community support, peer support, and secondary and primary care options. The options available should reflect the diversity of families, including holistic family- and whānau-based services as well as individual-based support.

DHBs directly fund or contract with NGOs to deliver family and whānau support, and most also have mental health and addiction family advisors. However, support for families and whānau within the mental health and addiction sector is relatively underdeveloped.

Financial strain is evident among some families and whānau who find themselves in supporting roles. This strain is often due to having to minimise work commitments to support their family member, the cost of services, respite and specialised help, and travel and time costs.

The wellbeing support provided to families and whānau needs to be reviewed by the Ministry of Health and other relevant agencies such as the Ministries of Education and Social Development and Te Puni Kōkiri and improvements made. Consideration should be given to successful international models. We note that the United Kingdom and Australia have adopted partnership standards for working with carers of a person with mental illness and Australia has developed guidance and tools for implementing such support.¹⁸⁸

186 In 2016, the average rate of family and whānau consultation during compulsory assessment and treatment was 61%, even though it is required by law: Ministry of Health. 2017. *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health, p 32. www.health.govt.nz/publication/office-director-mental-health-annual-report-2016.

187 The Ministry of Health has started recording the contacts that service providers have with family and whānau, either with or without the consumer present: HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

188 See, for example, Mind Australia, Helping Minds, et al. 2016. *A Practical Guide for Working with Carers of People with a Mental Illness*. <https://mhaustralia.org/publication/practical-guide-working-people-mental-illness>. See also A Worthington, P Rooney and R Hannan. 2013. *The Triangle of Care: Carers included – a guide to best practice in mental health care in England* (second edition). London: Carers Trust. https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf.

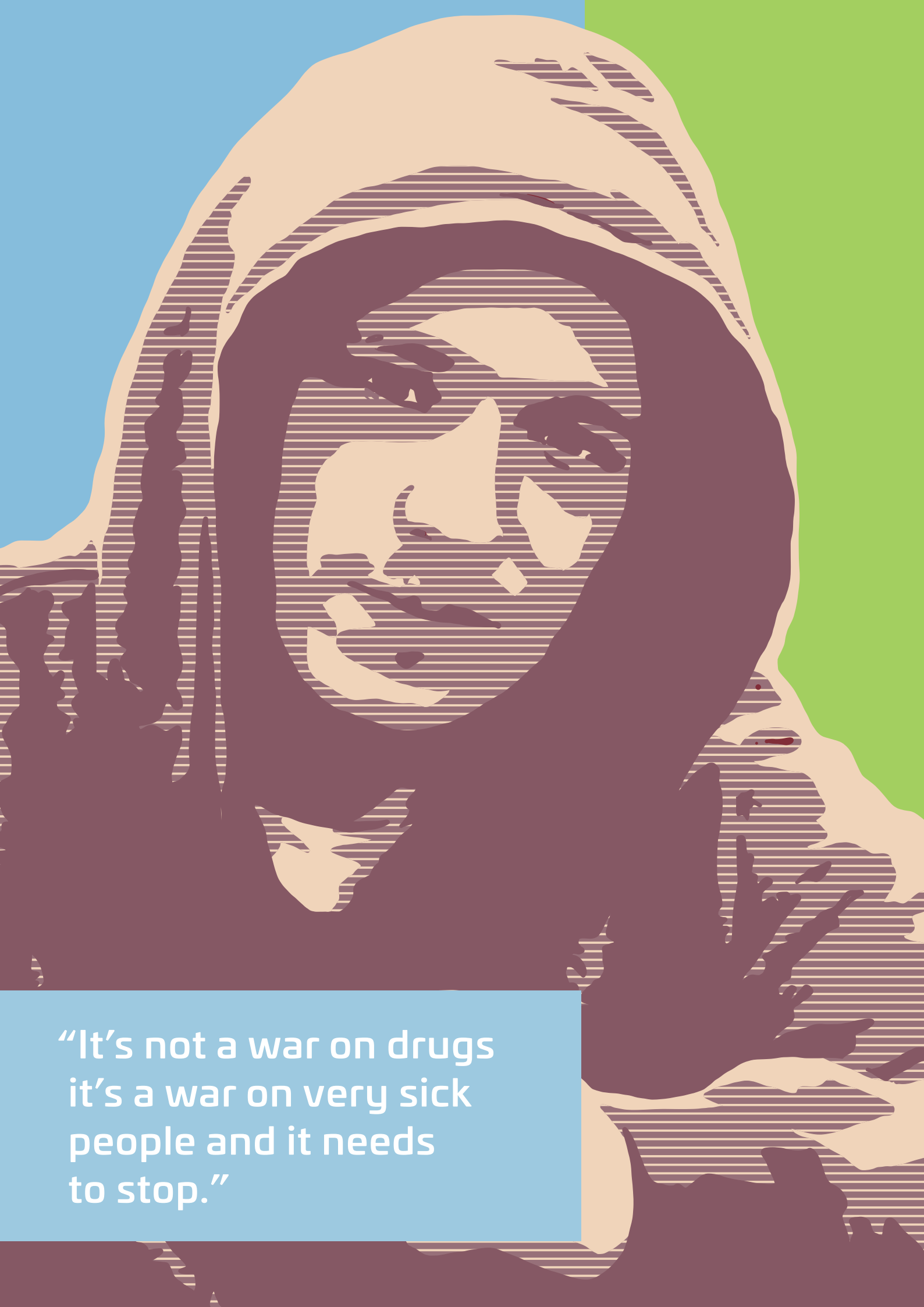
Recommendations

Support families and whānau to be active participants in the care and treatment of their family member

- 23. Direct** the Ministry of Health to lead the development and communication of consolidated and updated guidance on sharing information and partnering with families and whānau.
- 24. Direct** the Ministry of Health to ensure the updated information-sharing and partnering guidance is integrated into:
- training across the mental health and addiction workforce
 - all relevant contracts, standards, specifications, guidelines, quality improvement processes, and accountability arrangements.

Support the wellbeing of families and whānau

- 25. Direct** the Ministry of Health, working with other agencies, including the Ministry of Education, Te Puni Kōkiri and the Ministry of Social Development, to:
- lead a review of the support provided to families and whānau of people with mental health and addiction needs and where gaps exist
 - report to the Government with firm proposals to fill any gaps identified in the review with supports that enhance access, affordability and options for families and whānau.



“It’s not a war on drugs
it’s a war on very sick
people and it needs
to stop.”

Chapter 9

Action on alcohol and other drugs

Main points

- The harmful use of alcohol and other drugs has significant, widespread impacts on individuals, families and whānau and the whole community.
- New Zealand needs to take bolder measures to minimise the harm associated with alcohol and other drugs. Addiction should be viewed as a health and social issue that requires care and support (including more addiction treatment services) for effective management. We need a clear home for alcohol and drug policy within government, and a cohesive and evidence-based approach to policy and legislative reform.
- The promotion, socialisation and ease of access to alcohol in New Zealand is a major problem. Over the past 10 years, the government has been presented with many recommendations for reducing the impact of harmful alcohol use. They need to be actioned.
- The criminalisation of illicit drugs poses a barrier to seeking help, and convictions for personal drug use have far-reaching consequences on people's lives. Criminal sanctions for the possession for personal use of controlled drugs should be replaced with civil responses, such as fines or treatment programmes.

9.1 Introduction

Addiction is an important part of our Terms of Reference. We focused on addiction issues as they relate to alcohol and other drugs but heard about, and recognise, the harms caused by other forms of addiction, such as gambling, pornography and e-addictions. Addiction is intimately linked, through social determinants of health such as discrimination, isolation, poverty, trauma and stigma, with poor mental health outcomes. Over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems.¹⁸⁹

189 FC Todd. 2010. *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems*. Wellington: Ministry of Health. www.health.govt.nz/publication/te-ariari-o-te-oranga-assessment-and-management-people-co-existing-mentalhealth-and-drug-problems.

We heard many stories across New Zealand about the harms caused by a wide range of addictions. While we acknowledge that every form of addiction is harmful, we chose to focus more broadly on the harmful use of alcohol and other drugs because of their significant, multifaceted impacts, not only on an individual now and into the future, but also on communities, families, and whānau.

We know young people are particularly vulnerable to harms from alcohol and other drugs and that harmful use is significantly implicated in crime – around 60% of community-based offenders have an identified alcohol or other drug need and 87% of prisoners have experienced an alcohol or other drug problem over their lifetime.¹⁹⁰ We also know that people suffering from addiction often have poor long-term physical health and die at a much younger age. Young people who use alcohol and drugs early have adverse outcomes due to their still-developing brains and the lifelong dependency that early use can precipitate.

New Zealand has taken steps towards a stronger health-based approach to alcohol and other drugs, but the evidence suggests a much bolder approach is required to minimise the harms associated with alcohol and other drugs.

In this chapter, we identify a pathway for improving New Zealand's approach to addressing alcohol and other drug challenges. Our recommendations require a shift in the national mindset away from stigmatising addiction towards viewing addiction as a health issue that requires care and support for effective management. These issues are not unique to New Zealand – they are challenges all countries face.

9.2 What needs to happen

9.2.1 Issues

We heard extensively across New Zealand that alcohol and other drugs are viewed as serious public health concerns and a blight on our communities. Alcohol, in particular its promotion, socialisation and ease of access, was a specific concern, and we heard from submitters concerned about the number of liquor outlets in their communities and their lack of power to influence this. Alcohol is the most common substance of addiction, and in any given year nearly 20% of New Zealanders' drinking could be classified as hazardous.¹⁹¹

190 D Indig, G Gear and K Wilhelm. 2016. *Comorbid Substance Use Disorders and Mental Health Disorders among New Zealand Prisoners*. Wellington: Department of Corrections. www.corrections.govt.nz/resources/research_and_statistics/comorbid_substance_use_disorders_and_mental_health_disorders_among_new_zealand_prisoners.html.

191 Ministry of Health. 2017. Annual Data Explorer 2016/17: New Zealand Health Survey (data file). <https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-update> (accessed 19 October 2018).

Harmful alcohol use has significant impacts on an individual's health and society, including causing damage to developing brains (from *in utero* to adolescence),¹⁹² impairing self-control, and playing a role in at least half of youth suicides¹⁹³ and one-third of recorded offences.¹⁹⁴ Further, alcohol use can negatively affect personal relationships (causing harm to the wellbeing and health status of others),¹⁹⁵ decrease work productivity and increase absenteeism,¹⁹⁶ negatively affect educational outcomes,¹⁹⁷ and cause public nuisances such as litter, noise and property damage.¹⁹⁸

Despite alcohol's harm, New Zealand has a normalised heavy drinking culture that, by and large, does not recognise current alcohol use as a crisis. Strong vested interest groups have incentives to resist change. We see parallels with tobacco control and smoking, and believe a similar approach will be needed to tackle the harmful use of alcohol.

In relation to illicit drugs, we heard how their illegality poses a barrier to seeking help and how a criminal conviction for drug use has far-reaching impacts across a person's life; for example, by negatively impacting on employment or eligibility for access to housing. We also heard very strongly about the impact of methamphetamine (or 'P') on users and on their families, whānau and communities. While only just over 1% of New Zealanders are estimated to use amphetamines (including methamphetamine),¹⁹⁹ the impacts of methamphetamine are substantial, and it is a significant problem for some communities.

Across the country there was a clear call to adopt an approach to drug use that minimised harm. Minimising harm from drug use requires viewing use as a health and social issue that can be solved, or at least managed, by providing support, compassion and access to treatment for users. It also requires us all to counter prejudices about people who use drugs.²⁰⁰

192 K Stratton, C Howe and F Battaglia (eds). 1996. *Fetal Alcohol Syndrome: Diagnosis, epidemiology, prevention, and treatment*. Washington DC: Institute of Medicine; S Bava and SF Tapert. 2010. Adolescent brain development and the risk for alcohol and other drug problems. *Neuropsychology Review* 20(4): 398–413.

193 P Gluckman. 2017. *Youth Suicide in New Zealand: A discussion paper*. Wellington: Office of the Prime Minister's Chief Science Advisor. www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf.

194 New Zealand Police. 2010. *Framework for Preventing and Reducing Alcohol-related Offending and Victimization 2010–2014*. Wellington: New Zealand Police. www.police.govt.nz/sites/default/files/publications/alcohol-safety-strategy-2010-2014.pdf.

195 S Casswell, RQ You and T Huckle. 2011. Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives. *Addiction* (13 January). <https://doi.org/10.1111/j.1360-0443.2011.03361.x>.

196 Law Commission. 2010. *Alcohol in Our Lives: Curbing the harm* (NZLC R114). Wellington: Law Commission. www.lawcom.govt.nz/our-projects/regulatory-framework-sale-and-supply-liquor?id=897.

197 Law Commission. 2010. *Alcohol in Our Lives: Curbing the harm* (NZLC R114). Wellington: Law Commission. www.lawcom.govt.nz/our-projects/regulatory-framework-sale-and-supply-liquor?id=897.

198 Law Commission. 2010. *Alcohol in Our Lives: Curbing the harm* (NZLC R114). Wellington: Law Commission. www.lawcom.govt.nz/our-projects/regulatory-framework-sale-and-supply-liquor?id=897.

199 The 2015/16 New Zealand Health Survey reports that in 2015/16, 1.1% of adults (aged 16–64) used amphetamines in the past year. For Māori, amphetamines were used by 2.9% of adults. Ministry of Health. 2016. *Amphetamine Use 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health. www.health.govt.nz/publication/amphetamine-use-2015-16-new-zealand-health-survey.

200 Global Commission on Drug Policy. 2017. *The World Drug Perception Problem: Countering prejudices about people who use drugs*. Switzerland: Global Commission on Drug Policy. www.globalcommissionondrugs.org/reports/changing-perceptions/#.

New Zealand's National Drug Policy 2015–2020, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and the Psychoactive Substances Act 2013 are all intended to minimise harm and promote and protect wellbeing. They are also, however, fundamentally underpinned by an approach that criminalises personal drug use. These issues are playing out on the international stage also; for example, the 2018 Global Commission on Drug Policy report recommended responsible approaches to the regulation of drugs as the best way for governments to take control of illegal drug markets and weaken the hold of organised crime.²⁰¹

Demand for addiction services is already increasing, and current issues associated with the capacity and capability of addiction services to meet the needs of New Zealanders will continue to increase, yet very little has been invested into services such as residential treatment.

9.2.2 What needs to happen

Alcohol

Action on reducing the harmful use of alcohol has stalled. Current policy approaches are not having the required impacts, particularly for some groups who are disproportionately affected by harmful alcohol use such as Māori and people living in the most socioeconomically deprived areas. We believe the Government has already been presented with evidence-based options for reducing the impact of harmful alcohol use and that immediate action is needed to curb New Zealand's problematic drinking culture.

In 2008, in an attempt to respond to the harms associated with alcohol, the Law Commission was tasked with examining and evaluating the laws and policies relating to the sale, supply and consumption of alcohol in New Zealand and formulating a policy framework covering the principles that should regulate the sale, supply and consumption of alcohol. While the Government adopted most of the Law Commission's recommendations, the most substantial and potentially reformative recommendations were not implemented. These recommendations were to:

- increase the price of alcohol through excise tax increases
- regulate promotions that encourage increased consumption or purchase of alcohol
- move, over time, to regulate alcohol advertising and sponsorship
- increase the purchase age of alcohol to 20 years
- reduce the hours that licenced premises are open.

201 Global Commission on Drug Policy. 2018. *Regulation: The responsible control of drugs*. Switzerland: Global Commission on Drug Policy. www.globalcommissionondrugs.org/reports/regulation-the-responsible-control-of-drugs/.

Further work on alcohol pricing that considered the potential impact and effectiveness of a minimum price regime²⁰² and on advertising and sponsorship has been undertaken. The Ministerial Forum on Alcohol Advertising and Sponsorship, for example, reported in 2014 and made several recommendations with a focus on reducing harm to young people arising from alcohol advertising and sponsorship.²⁰³ However, there has not yet been a comprehensive government response to recommendations about combating harmful alcohol consumption and to the work on pricing or on advertising and sponsorship.

In relation to alcohol reform, it has long been argued that most New Zealanders drink responsibly and should not be ‘punished’ for the actions of the small minority who do not drink responsibly. We do not believe one in five New Zealanders drinking hazardously each year is a small minority. We also know that alcohol’s reach across society is far greater than simply the sum of its impacts on individual drinkers; families, friends and communities are all touched through one person’s drinking.

Throughout the Inquiry process, we heard a strong appetite for strengthening alcohol reforms, particularly around decreasing the exposure of young people to alcohol advertising and promotions. We believe the case for change has been made and action on alcohol reform is required.

In our view, the main impediment to stronger alcohol reform is a lack of political will.

Other drugs

The criminalisation of drugs is widespread around the world, yet it has failed to decrease drug use or the harmful effects of drug use and has contributed to social issues such as gangs’ involvement in the supply of drugs, prison overcrowding, unemployment and family separations. Criminalisation downplays the health and social impacts of drug use that can best be managed by providing support to people early and throughout their lives. Having a conviction for a drug offence can affect an individual’s ability to gain employment, maintain relationships and travel, and the fear of these long-term consequences (in addition to potentially serving time in prison) creates a significant barrier to a drug user seeking support for recovery.

The fear of having children removed by Oranga Tamariki—Ministry for Children or being sent back to prison for alcohol or other drug use while on probation was highlighted to us as examples of other barriers to seeking treatment. We also heard that while great strides have been made in reducing stigma associated with mental health, significant stigma is still associated with drug addiction, potentially compounding existing barriers to people seeking help.

202 Ministry of Justice. 2014. *The Effectiveness of Alcohol Pricing Policies: Reducing harmful alcohol consumption and alcohol-related harm*. Wellington: Ministry of Justice. www.justice.govt.nz/justice-sector-policy/key-initiatives/sale-and-supply-of-alcohol/alcohol-minimum-pricing-report/.

203 Ministerial Forum on Alcohol Advertising and Sponsorship (G Lowe, Chair). 2014. *Ministerial Forum on Alcohol Advertising & Sponsorship*. www.health.govt.nz/system/files/documents/publications/ministerial-forum-on-alcohol-advertising-and-sponsorship-recommendations-on-alcohol-advertising-and-sponsorship-dec14.pdf.

It is clear to us that New Zealand's approach to drugs needs to change. While New Zealand was the first country to introduce a state-sponsored needle exchange programme, we seem to have lost our spirit and failed to put people's health at the centre of our approach. In its review of the Misuse of Drugs Act 1975, the Law Commission made a range of recommendations for reforming our drug laws that focused on minimising harm and promoting health. Potentially transformative recommendations from the review that were not adopted include:

- repealing the Misuse of Drugs Act 1975 and replacing it with new legislation rooted in a health-based approach that the Ministry of Health would administer
- introducing a mandatory cautioning scheme for personal possession and use of drugs
- removing prison sentences for low-level drug dealing.

In addition to considering these recommendations, we had the opportunity to consider how other countries have adopted health-based approaches to drug use. Some of these approaches, such as from Portugal, appear to be generating great success, are widely advocated for across New Zealand, and show great promise for transforming our current approach.

Portugal's approach to personal drug use

A drug crisis during the 1980s and 1990s led Portugal to dramatically overhaul its approach to personal drug use. In 2001, Portugal decriminalised the purchase, possession and consumption of all drugs for personal use. In lieu of traditional justice sector processes, three-member Dissuasion Commissions were established as the sole bodies responsible for adjudicating administrative drug offences and imposing potential sanctions. While various sanctions are available to the commissions, they are often used as a last resort, particularly if the drug user seeks treatment for their drug use.

As was hoped, decriminalisation removed the most substantial barrier to drug users seeking treatment – their fear of being treated as criminals and entering the justice system. Now, more people than ever are receiving treatment for their drug use, and Portugal has experienced significantly decreased incidence of new HIV infection, decreased use of almost all drugs by people under 18, and a lower prevalence of drug use than the European Union average in schools and across the overall population.

Another benefit is that the quality and response capacity of healthcare networks for people with addictions improved dramatically across the country, so treatment is available to all people with addictions who seek treatment.

Although there were concerns Portugal would become a drug haven for tourists, these concerns are unfounded; roughly 95% of those cited for drug offences each year are Portuguese nationals.²⁰⁴

204 G Greenwald. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Washington, DC: Cato Institute.

In summary, we note that New Zealand's current official National Drug Policy is based on harm minimisation, but that this needs to be extended given it is still underpinned by the criminalisation of drug use. The criminalisation of drug use has failed to reduce harm around the world and a shift towards considering personal drug use as a health and social issue is required if we are to minimise the harm associated with drug use. This approach runs counter to the views of a minority of submitters who supported a 'tougher' approach to drug use. However, we believe the 'war on drugs' approach has been ineffective and has done little to address the myriad of harms that drug use causes, including the increasing role of organised criminal organisations.

Alcohol and other drug policy does not have a clear home within government

Central government appears to have lost traction on alcohol and other drug issues, although we note the recent formation of a cross-party group on drug harm reduction. Overall, leadership is weak and it is unclear where responsibility for coordinated strategy and policy lie.

Given the significant role that alcohol and other drugs play in people's wellbeing across New Zealand, a unit with a strong cross-sectoral focus dedicated to advancing alcohol and other drug policy is critical. One option is for the proposed social wellbeing agency (discussed in chapter 7) to take on this role and provide strong, coordinated leadership. Whoever is tasked with leadership should be mandated to tackle alcohol use in the same way as New Zealand successfully tackled smoking. Although the approach to alcohol use will differ, the same kind of focus and commitment to reducing harmful alcohol use is needed.

Investment in addiction services

It is difficult to determine a desirable balance between spending on addiction treatment and mental health services. However, addiction services receive a relatively small proportion (about 11%)²⁰⁵ of the total public expenditure on mental health and addiction services, and the addictions sector has long been considered the 'poor cousin'. An injection of investment into the addictions sector is required to increase the number of services available to people across the country and to promote better collaboration between the mental health and addiction sectors. There should be a comprehensive range of culturally responsive, evidence-informed options that give people choices.

Over time, additional investment in addiction services should lead to savings and enable resources to be shifted towards earlier intervention, for example, through a decrease in the prison population. In the short term, the investment we recommend for services in the 'middle ground' (chapter 4) should also increase access for people requiring support for alcohol and other drug challenges. This will include a range of services, from brief interventions in general practice and primary care settings through to social and detox options and follow-up community-based services.

205 HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

Therapeutic support programmes

Two Alcohol and Other Drug Treatment (AODT) Court pilots were established in Auckland in 2012. The objective is to help repeat offenders deal with their drug and addiction and criminal behaviour through a model of intensive therapeutic interventions. The AODT Court is founded on evidence-based policies and procedures and has embedded Kaupapa Māori approaches through appointment of a cultural advisor (Pou Oranga), and use of peer-support workers. Each AODT Court can take a maximum of 50 participants per year. Participation is voluntary, but allows an opportunity to avoid jail on graduation from the programme, which takes about 18 months.

In a collaboration between the judiciary, Ministry of Justice, Ministry of Health, Department of Corrections and New Zealand Police, each person receives a customised treatment programme that best suits their recovery and is assigned a multidisciplinary team. In addition to clinical interventions (such as treatment through programmes such as those run by Higher Ground and Odyssey), the team also helps participants repair stressful social and emotional situations, such as homelessness and relationships with whānau.

The AODT Court is the point of ‘control’ and holds the participant and providers to account during once-weekly hearings.

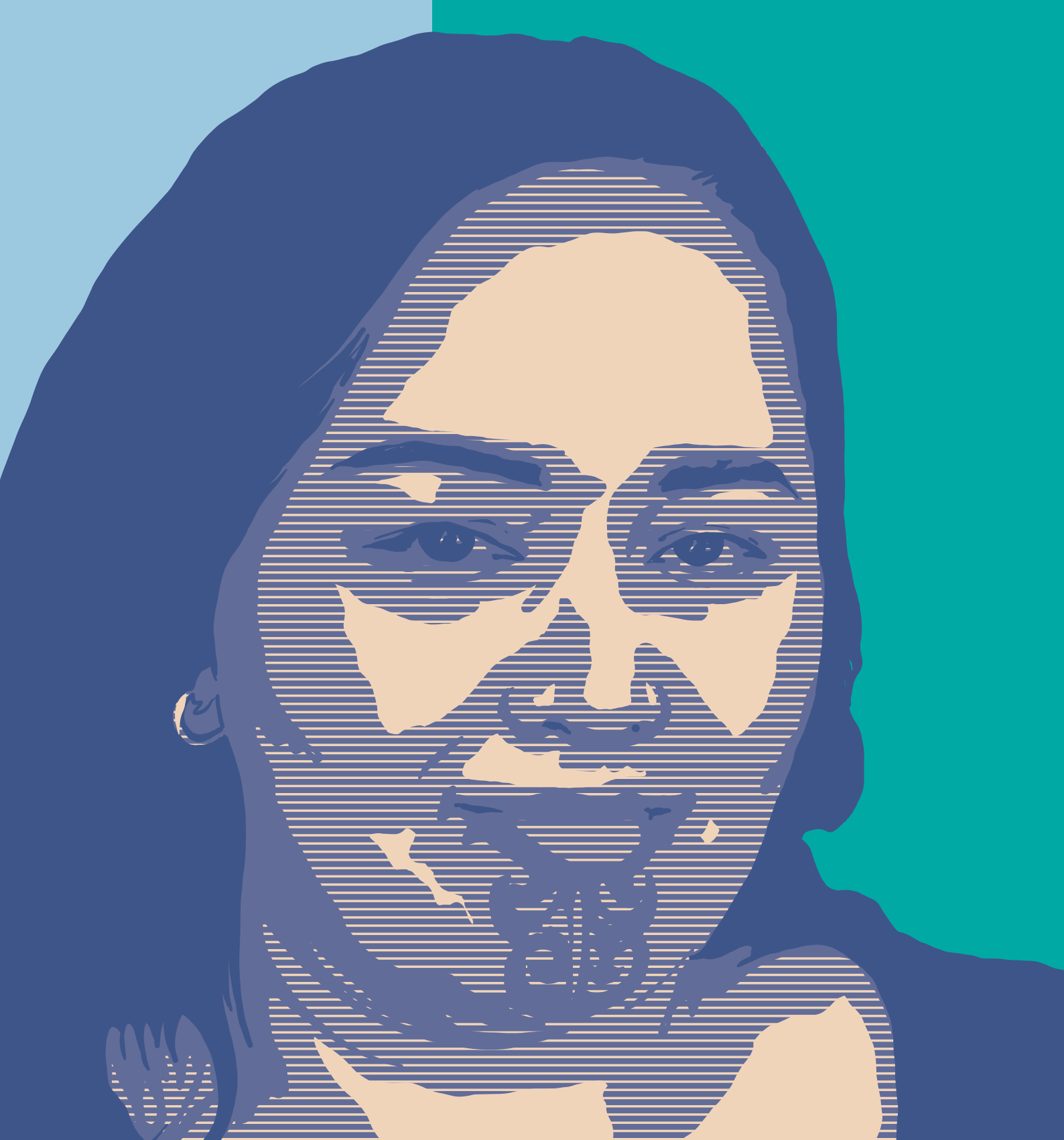
Preliminary evaluation suggests the AODT Courts have reduced the likelihood of reoffending by around 15% when measured against offenders who go through the standard court process, and that around 60 prisoner places per year may be saved.²⁰⁶

206 Cabinet Social Policy Committee. 2018. *Report-back on the Alcohol and Other Drug Treatment Court Pilot and other AOD-related Initiatives*. www.justice.govt.nz/assets/Documents/Publications/Report-back-on-the-Alcohol-and-Other-Drug-Treatment-Court-Pilot-and-other-AOD-related-Initiatives-Paper.pdf.

Recommendations

Take strong action on alcohol and other drugs

- 26. Take** a stricter regulatory approach to the sale and supply of alcohol, informed by the recommendations from the 2010 Law Commission review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship and the 2014 Ministry of Justice report on alcohol pricing.
- 27. Replace** criminal sanctions for the possession for personal use of controlled drugs with civil responses (for example, a fine, a referral to a drug awareness session run by a public health body or a referral to a drug treatment programme).
- 28. Support** the replacement of criminal sanctions for the possession for personal use of controlled drugs with a full range of treatment and detox services.
- 29. Establish** clear cross-sector leadership and coordination within central government for policy in relation to alcohol and other drugs.



“Those of us bereaved by suicide are the forgotten group, we’re expected to get over it, ... and fall back into life as it used to be.”

Chapter 10

Suicide prevention

Main points

- Reducing New Zealand's suicide rates and providing better support for people who have experienced the suicide of a loved one should be a cross-party and cross-sectoral national priority.
- Suicide prevention has suffered from a lack of resources and effective implementation. Stronger and sustained leadership is required, including the establishment of a suicide prevention office.
- A comprehensive, well-resourced suicide prevention strategy and implementation plan must be urgently completed.
- The strategy should include a suicide prevention target of 20% reduction in suicide rates by 2030.
- More investment is required to support bereaved families and whānau.
- The processes for investigating deaths by suicide should be reviewed, to make them less adversarial, more streamlined and responsive to the needs of bereaved families and whānau.

10.1 Introduction

New Zealand's persistently high suicide rates were one of the catalysts for this Inquiry, with many groups petitioning for government action. Every year, an estimated 150,000 people think about taking their own life, 50,000 make a suicide plan and 20,000 attempt to take their own life. In 2015, 525 people died by suicide.²⁰⁷ While New Zealand has made some progress in reducing suicide rates since the late 1990s, annual suicide rates reported by the Office of the Chief Coroner have increased over the last four years, with the current suicide rate the highest since 1999.²⁰⁸ In addition to the number of lives lost, every suicide creates significant, far-reaching impacts on the person's friends, family and whānau, and the wider community. All of these aspects support the prevention of suicide as being a key focus, as outlined in our Terms of Reference (see Appendix A).

207 Ministry of Health. 2018. *Submission to the Inquiry into Mental Health and Addiction*. Wellington: Ministry of Health. www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry/submission-government-inquiry-mental-health-and-addiction.

208 Suicide deaths reported by the Chief Coroner differ from those reported by the Ministry of Health, because the Chief Coroner's data includes all deaths initially identified as self-inflicted, while only those deaths ultimately reported as intentionally self-inflicted are reported as suicide deaths by the Ministry of Health. Because of the time taken to complete a coroner's inquiry, Ministry of Health data trails data reported by the Chief Coroner by a number of years.

Many people raised the limited awareness about suicide, with many bereaved families and whānau reporting they were not aware of the early signs of suicide risk or what they should do to support someone at risk of suicide. We also heard strong concerns about the responsiveness of services, including that people needed to be acutely suicidal to access services (although even this was sometimes not enough) and that people at risk of suicide were discharged from care without an appropriate suicide prevention or follow-up plan.

Families and whānau told us that support for people bereaved by suicide was often inadequate, and that children and young people should be the focus of attention. Families and whānau also said they were not adequately included in formal processes following a suicide.

In this chapter, we focus on identifying a pathway to reduce suicide in New Zealand and providing better support for people who have experienced the suicide of a loved one. Our recommendations require a concerted effort across government to achieve sustainable decreases in suicide across the country.

10.2 What needs to happen

10.2.1 Issues

Suicide affects people of all ages and from all walks of life, but populations such as young people, males and Māori experience disproportionately high numbers. We also heard of the deep concern from Rainbow communities about suicide within their communities. Our suicide rate for young people is among the worst in the OECD.²⁰⁹ New Zealand data show that considerably more than half of youth suicides involve alcohol or illicit drug exposure.²¹⁰

In terms of absolute numbers, our greatest loss of life through suicide occurs among people older than 24 (404 lives lost), particularly males aged 25–44 (136 lives lost).²¹¹ These statistics alone emphasise the magnitude of the problem. But we also heard many stories about how the lives of those affected by the suicide of a friend or loved one are forever changed – thousands of New Zealanders are touched by suicide in some way every year.

New Zealand has various suicide prevention initiatives in place. We heard many times that preventing suicide should be everyone's business, and we agree with that sentiment. Literacy around this sensitive topic is low in New Zealand. In recent years there has been much more openness and public discussion about suicide. However, it is essential that there is safe messaging around these discussions and that they are culturally sound. Appropriate support and resources must be readily available immediately following public engagement with families and whānau and communities.²¹²

209 For the age group 15–19, the OECD reports that in 2015 the highest suicide rates among OECD countries were observed in Canada, Estonia, Latvia, Iceland and New Zealand, with New Zealand having the highest rate overall. OECD. 2017. *CO4.4: Teenage suicides (15–19 years old)*. OECD Family Database. www.oecd.org/els/family/CO_4_4_Teenage-Suicide.pdf.

210 P Gluckman. 2017. *Youth Suicide in New Zealand: A discussion paper*. Wellington: Office of the Prime Minister's Chief Science Adviser. www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf.

211 Ministry of Health. 2013. Suicide data and stats. www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/suicide-data-and-stats (accessed 30 October 2018).

212 Media Roundtable. 2011. *Reporting Suicide: A resource for the media*. Wellington: Ministry of Health. www.health.govt.nz/publication/reporting-suicide-resource-media; Le Va. 2016. *Pasifika Media Guidelines for Reporting Suicide in New Zealand*. Auckland: Le Va. www.leva.co.nz/uploads/files/resources/PasifikaMediaGuidelines_A5_PDF.pdf.

Nearly half of New Zealanders who die by suicide had recent contact with mental health services,²¹³ and the Chief Coroner told us that many more are likely to have had contact with a general practitioner over the previous year.²¹⁴ This suggests we are missing opportunities for preventative action and early intervention. In addition, mechanisms exist for reviewing how a suicide could have been prevented, such as district health board (DHB) sentinel event panels, the Suicide Mortality Review Committee and coronial inquiries.

Unfortunately, we heard that the coronial process is often extremely drawn out, especially for cases of suspected suicide, taking up to four years to complete. Some submitters described delays in the coronial process as adversarial and re-traumatising and said that communication and information sharing were inadequate. We understand that the coronial service has limited capacity, which contributes to lengthy delays.

It is unsatisfactory that grieving families are subject to extensive delays and that it is unclear whether coronial and Health and Disability Commissioner review processes should be put on hold pending the outcome of another statutory process or the findings of a DHB review. We also note the concerns of families who feel compelled to hire their own lawyer, if they can afford to, whereas clinicians and DHBs are generally represented by publicly funded legal counsel.

We think it is time for the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review the processes for investigation of deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews. The aim should be to develop less adversarial processes that are undertaken within acceptable timeframes, ensure families and whānau are not disadvantaged by lack of access to publicly funded legal counsel, ensure clear pathways and better integration of reviews, provide greater support for bereaved families and whānau, and identify opportunities to improve services and prevent suicide.

We are aware of services that engage in routine quality improvement processes, including DHBs that have adopted a Zero Suicide in Services approach. These types of processes can be extremely beneficial, providing opportunities to learn from suicides and implement best practice. Such initiatives should be implemented more broadly across services.

213 Ministry of Health. 2016. *Office of the Director of Mental Health Annual Report*. Wellington: Ministry of Health. www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports.

214 The Chief Coroner recorded that in 183 suicides between 1 July 2017 and 1 August 2018, 44% were recorded as having had contact with their general practitioner.

The suicide of someone close – a parent, sibling, friend, or family or whānau member – is highly associated with increased suicide risk, although evidence is limited about the effectiveness of interventions to support people who have lost someone to suicide. Support for people who are bereaved by suicide is extremely important. Access to support and services that are timely, culturally appropriate and respectful can accelerate healing processes, while services that are not, can impede recovery. Support by others with experience of being bereaved by suicide has also been described as helpful by some submitters. We are aware that support for those bereaved by suicide is available, but is not consistent across the country. Concerns were also raised about whether the current workforce has appropriate skills and training and about a lack of culturally sensitive approaches to support people after someone has died by suicide.

10.2.2 What needs to happen

Develop a comprehensive, long-term, cross-sectoral national suicide prevention strategy and implementation plan

A draft national suicide prevention strategy was consulted on in 2017. Its progress was suspended pending the outcomes of this Inquiry. We believe a new suicide prevention strategy should be developed rapidly on the understanding that suicide prevention is a cross-party and cross-sectoral national priority and that implementation must be well resourced. A national suicide prevention target could be a component of the strategy. An implementation plan outlining required resources, assumptions, short- and long-term outcomes, and roles and responsibilities should accompany the new prevention strategy.

In addition to a strong long-term commitment to suicide prevention, including a bold national suicide prevention target, the suicide prevention strategy should:

- provide a clear vision and direction that recognise the complexity associated with suicide
- include processes for supporting people who have been bereaved by suicide that are timely, culturally appropriate and inclusive
- be responsive to Māori and Pacific world views
- be responsive to the needs of at-risk communities and population groups
- contain a coherent suite of complementary initiatives that put people at the centre, target priority population groups, and are evidence-informed and designed to allow for rigorous monitoring and evaluation
- include a strategic research agenda to systematically build our knowledge of the factors that contribute to suicide for different populations, strategies that are effective in reducing suicidal behaviours, including through appropriate reporting about suicide in the media, and the most effective ways to support people bereaved by suicide.

Set a medium-term national suicide reduction target

Views are mixed about establishing a suicide reduction target. On the one hand, suicide is complex and many factors contributing to it cannot be controlled for, making it challenging to achieve a target. On the other hand, setting a target sends a clear signal that suicide prevention is a priority and can galvanise energy around suicide prevention. Evidence from Scotland suggests a suicide target was important for decreasing rates of suicide in that country.

Advice received during consultation on the national suicide prevention strategy recommended that a target of 20% reduction in suicide rates over 10 years be adopted. We believe 20% reduction by 2030 is achievable if we intensify and sustain our suicide prevention efforts. This target must apply to all population groups – not only to the total population. We also need to be clear in setting a medium-term suicide reduction target that no suicide rate is acceptable – we should be aspiring to zero suicide.

We cannot expect to see an immediate decrease in suicide rates at a national level. While some strategies are available for delivering relatively rapid decreases, other opportunities for reducing suicide rates, such as addressing poverty and family violence, supporting and strengthening parenting, and nurturing resilience during the early years of life, may not show up in reduced suicide rates for a generation. This highlights that suicide reduction requires sustained and intensive effort over a long period, with strong cross-party and cross-sectoral commitment.

Access to the range of services and models identified earlier (Table 3 in section 4.4.1) will also be important. People who attempt suicide or express suicide ideation need to be able to access a wide range of therapies and interventions. Whether they present via their general practitioner, police, an emergency department or mental health services, clear avenues should be available for them to receive immediate access to appropriate, wrap-around support, including counselling and talk therapies and peer and whānau support, as well as access to alcohol and drug interventions.

Reducing suicide rates will also require a whole-of-government approach to supporting wellbeing and addressing multiple social determinants, as recommended in chapter 7.

Resource implementation well

Previous strategies have suffered from insufficient resourcing and a lack of attention to effective implementation. In addition to focusing on what needs to be achieved, a national cross-sectoral suicide prevention strategy must be accompanied by a concrete implementation plan that specifies the actions to be undertaken and the associated resources required to support effective implementation.

Suicide prevention receives relatively little funding and dedicated resources and expertise are lacking in central government. This lack of investment and focus does not support suicide prevention. We believe that a significantly increased strategic investment in suicide prevention is warranted.

Strengthen leadership

Better, stronger, sustained leadership is required to reduce our rates of suicide. One avenue for achieving this would be the establishment of a suicide prevention office. Such an office could serve as a repository of suicide information, support local implementation of programmes and coordinate cross-agency activities. It could be located in the Ministry of Health, in the new Mental Health and Wellbeing Commission (chapter 12) or elsewhere in government, for example as part of the proposed social wellbeing agency (chapter 7). We note some precedents overseas for having a named Cabinet Minister responsible for suicide prevention or forming a cross-sectoral steering and implementation group.

The new Mental Health and Wellbeing Commission would be well placed to undertake critical functions associated with the prevention of suicide, including leading development and reviews of national suicide strategies and championing their implementation, ensuring robust evaluations of strategy implementation and reporting on progress.

Recommendations

Prevent suicide

- 30. Urgently complete** the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention.
- 31. Set** a target of 20% reduction in suicide rates by 2030.
- 32. Establish** a suicide prevention office to provide stronger and sustained leadership on action to prevent suicide.
- 33. Direct** the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.



“Psychiatrist number 4 was time pressured ... and he couldn't quite figure me out, so he sectioned me.”

Chapter 11

Mental Health Act reform

Main points

- New Zealand’s mental health legislation should reflect modern approaches to human rights, supported decision-making and informed consent.
- The Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) is out of date, and does not reflect best practice or align with our international commitments. We have high rates of compulsion and seclusion.
- The Mental Health Act should be repealed and replaced. Any new law needs to reflect a human rights–based approach, align with modern models for mental health care and minimise the use of compulsion, seclusion and restraint.
- New Zealand needs a national–level discussion to reconsider beliefs, evidence and attitudes about mental health and risk.

11.1 Introduction

New Zealand’s legislative framework for mental health and addiction is dispersed across several legislative instruments. Two primary statutes, the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act), set out the circumstances in which people can be compulsorily assessed and treated for a ‘mental disorder’ and severe substance addictions, respectively.

Other laws provide options for the compulsory care, treatment or detention of individuals with intellectual disabilities who have been found unfit to stand trial or convicted of an imprisonable offence or individuals found not guilty by reason of insanity. New Zealand also has several rights-based statutes and is a party to the main international human rights instruments relevant to mental health and addiction law.

Throughout this Inquiry, many people shared their experiences of being held and compulsorily treated under mental health legislation. Submitters described the trauma of compulsory detention and treatment, the loss of their right to participate in decisions about their treatment and recovery, the adverse impacts of forced medication, and the harm and powerlessness they experienced through practices of seclusion and restraint and prolonged use of the Mental Health Act. Many submitters across the country emphasised the need for New Zealand legislation – and the practices enabled under it – to comply with international and domestic human rights instruments.

In particular, national consumer groups and individuals (including through the Wellbeing Manifesto and the Changing Minds survey) resoundingly called for the urgent review and replacement of the Mental Health Act.²¹⁵

In this chapter, we address New Zealand's legislative framework for mental health and addiction and the need for change.

11.2 What needs to happen

11.2.1 Issues

International developments and changing approaches to mental health care

Over the last 20 years, the emphasis in mental health care has moved to a recovery and social wellbeing model of health, with more emphasis on human rights. Concepts of individual autonomy and informed consent to treatment are central tenets in contemporary health ethics. They are also emphasised in the New Zealand Bill of Rights Act 1990 and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Decisions should be made by a person only once they have received all the necessary information, and people are generally presumed to be competent to consent unless reasonable grounds exist for believing they lack capacity.

The treatment philosophy of recovery also emphasises the importance of services involving consumers as equal partners in treatment and offering the greatest possible independence and choice. Over time, the recovery model has been seen, not only as good practice, but as an explicit governmental goal of mental health services in New Zealand. For example, the recovery approach is set out in national strategies and plans such as the Mental Health and Addiction Service Development Plan 2012–2017.²¹⁶

Another shift is the growing human rights focus of international instruments, in particular the United Nations Convention on the Rights of Persons with Disabilities, which New Zealand ratified in 2008.²¹⁷ The purpose of this convention is to promote and protect equal human rights for disabled people. While interpretation of the convention is not yet settled,²¹⁸ comments and further guidance from the United Nations Committee on the Rights of Persons with Disabilities indicates that the convention was intended to apply to mental illness.

215 M O'Hagan. 2018. *Wellbeing Manifesto for Aotearoa New Zealand: A submission to the Government Inquiry into Mental Health and Addiction* (prepared for PeerZone and ActionStation). www.wellbeingmanifesto.nz/; Changing Minds. 2018. *The Voices of People with Lived Experience and their Whānau: Submission to the Mental Health and Addiction Inquiry Panel*. <https://changingminds.org.nz/mental-health-and-addiction-inquiry-submission/>.

216 Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health. www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017.

217 In New Zealand, international conventions such as the United Nations Convention on the Rights of Persons with Disabilities are not directly enforceable through the courts as they are in some other countries. Nevertheless, by entering into and ratifying these conventions, New Zealand is signalling its intention to comply with their provisions.

218 This is due, in part, to difficulties in reconciling or giving full effect to the convention because of textual ambiguities and inconsistencies. Commentators raised concerns with the interpretation of the text offered by the United Nations committee. Specifically, the committee proposed a total repeal of all laws allowing involuntary treatment without giving any indication of how threats to a person's safety or to others around them would be handled. See, for example, J Dawson. 2015. A realistic approach to assessing mental health laws' compliance with the UNCRPD. *International Journal of Law and Psychiatry* 40(May–June): 70–79.

New Zealand's mental health statutes have not kept pace with these shifts. Our legislative framework is still largely based on a 'substituted decision-making' model and does not provide a 'supported decision-making' framework.²¹⁹ Our framework fails to fully recognise the rights of people with mental health and addiction challenges and that the 'rights, will and preferences'²²⁰ of the person lacking capacity should be ascertained or respected. Notably, the legal tests for meeting the criteria for compulsory treatment under different statutes vary significantly – in part, because New Zealand legislation does not have a consistent definition of 'mental capacity' (or 'incapacity'). Nor is capacity always relevant when exercising statutory powers. Safeguards are insufficient for people detained or treated without informed consent, which is inconsistent with international human rights developments and the recovery approach to treatment.

New Zealand's Mental Health Act is outdated and inadequate

While we acknowledge the considerable breadth and complexity of issues spanning the legislative framework as a whole, the Mental Health Act is particularly problematic and outdated in its approach. This Act's provisions do not adequately reflect the international principles and standards that New Zealand has signed up to and are inconsistent with newer domestic legislation, such as the Substance Addiction Act.

The Mental Health Act was enacted over 20 years ago and has never been comprehensively reviewed. The definition of 'mental disorder' in the Act governs entry into and exit from compulsory assessment and treatment. It is a legal definition, rather than a medical concept. The definition of 'mental disorder' has two aspects. First, a person must be assessed as having an 'abnormal state of mind'. Second, this abnormal state of mind must be of such a degree that it poses a serious danger to the health or safety of that person or others or it seriously diminishes the capacity of that person to take care of themselves. A person may be certified by a doctor for compulsory assessment when there are 'reasonable grounds to believe' they are mentally disordered. A judge may make a compulsory treatment order for a person who is mentally disordered, and a person may remain under compulsory treatment for as long as they meet this test.

Significantly, the Mental Health Act does not require an assessment of mental capacity. This means that under the Act, a 'competent' person's wishes can be overridden, based on an assessment of their 'risk' or 'dangerousness', even if they have the capacity to make their own decisions. This can be contrasted with the criteria for compulsory treatment under the Substance Addiction Act, which places greater weight on the rights and interests of patients. Unlike the Mental Health Act, the Substance Addiction Act requires a finding of 'incapacity' before the Act is triggered. Incapacity follows from an assessment that the person is unable to make a legally effective decision to consent to or refuse treatment.²²¹

219 Supported decision-making allows an individual to make choices about their own life with support from a team of people, including people they know and trust as part of their support network to help with decision-making.

220 See article 12 of the United Nations Convention on the Rights of Persons with Disabilities.

221 Incapacity is the inability to understand information given, appreciate the consequences of acting (or not acting) on that information, and therefore make an informed choice.

The concept of ‘consent’, as referred to in the Mental Health Act, is also not the same as ‘informed consent’. Informed consent should be free of coercion. However, under a compulsory treatment order, ‘consent’ to treatment necessarily implies a degree of coercion. However, a proposed patient or patient under the Mental Health Act may not refuse consent to any form of compulsory treatment for mental disorder or to sedation where a clinician believes it is urgently required.²²²

The current situation raises ethical issues and is inconsistent with the rights applicable to general health care in New Zealand, including the right to refuse medical treatment. The denial of the right to refuse medication under the Mental Health Act is particularly problematic when significant side-effects (such as significantly premature mortality rates) are known and the patient is competent to make treatment decisions and wants to avoid these effects. Over-reliance on medical treatment is also contrary to section 66 of the Mental Health Act, which expressly provides for the right to both medical treatment and ‘other health care appropriate to [the patient’s] condition’.

In addition, we consider the checks and balances under the Mental Health Act to be insufficient. For example, the Act permits a person to be indefinitely held under the Act.²²³ It also permits the use of seclusion (at the discretion of the clinician), as well as the use of ‘reasonable force’ under specified circumstances when detaining, taking and retaking a patient for treatment. Again, this can be contrasted with the Substance Addiction Act that specifies that compulsion should be used only as a ‘last resort’ (and that those exercising powers should use the least coercive means and take into account the views of patients and their families and whānau), provides time limits on compulsory treatment (with no ability to make indefinite orders), prohibits seclusion and puts a greater emphasis on rehabilitation.

The disparity of approach between the Mental Health Act and the Substance Addiction Act has no justification in policy.

As with many of the things we heard through the Inquiry process, the issues around the Mental Health Act have long been recognised and agreement is widespread that change is needed. In 2014, the United Nations Committee on the Rights of Persons with Disabilities highlighted the Mental Health Act’s inconsistency with the principles of the Convention on the Rights of Persons with Disabilities, in particular its lack of human rights principles. The Committee recommended that the Act be amended to comply with the Convention. In response, the Ministry of Health began work to better understand how New Zealand’s mental health legislation relates to our human rights law and obligations under international conventions. A discussion document released in 2016, and followed by a thematic analysis of submissions, outlined many of the same issues.²²⁴

222 But see sections 64 (general rights to information) and 67 (right to be informed about treatment) of the Mental Health Act.

223 Once statutory timeframes have expired, and the court has made an indefinite compulsory treatment order, which is then not subject to ongoing judicial oversight.

224 Ministry of Health. 2016. *The Mental Health Act and Human Rights: A discussion document*. Wellington: Ministry of Health. www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment.

The Mental Health Commissioner, in his 2018 monitoring and advocacy report, endorsed a review of the Mental Health Act and recommended that the Ministry of Health advise on the changes required to that Act to align it with current expectations about human rights and support decision-making and best practice in the provision of therapeutic health services.²²⁵

Risk aversion and the Mental Health Act

Clinicians working under the Mental Health Act, particularly psychiatrists and mental health nurses whose decisions have been subject to criticism from DHB reviews, coroners' inquests and Health and Disability Commissioner investigations, have unsurprisingly developed a culture of risk aversion and defensive practice. This is a problem that extends beyond interpretation and application of the Mental Health Act, but many highly publicised cases involve decisions made under the Act. It is based on the flawed premise that risk prediction is an exact science. Instead of focusing on the patient's best interests, too often clinicians attempt to 'manage risk'. The results are not always good for patients, clinicians or, ultimately, the community.

11.2.2 What needs to happen

About 10,000 people a year are subject to compulsory assessment and treatment under the Mental Health Act.²²⁶ The use of compulsion, seclusion and restraint needs to be reduced, especially for Māori and Pacific peoples, for whom the rate of use is disproportionately high.²²⁷ The numbers of compulsory treatment orders vary across the country. The fact that some regions show relatively low rates suggests scope exists to reduce the overall use of compulsory treatment.²²⁸ We commend the work of the Health Quality and Safety Commission to end seclusion by 2020.²²⁹ We are pleased that all DHBs are participating in the national collaborative Towards Zero Seclusion in 2020 that includes training in techniques and practice such as SPEC (Safe Practice Effective Communication). This quality improvement work is governed by a leadership group that includes consumers.

While legislative change cannot be the sole driver of changes in practice, if government commitment to recovery and people-centred services is to be meaningful, it must be supported by our mental health laws. Law reform should enshrine a framework that enhances and protects people's rights to participate in and make decisions about their health and life and respects their autonomy.

225 HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

226 Ministry of Health. 2016. *Office of the Director of Mental Health Annual Report*. Wellington: Ministry of Health. www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports.

227 S Shalev and New Zealand Human Rights Commission. 2013. *Thinking Outside the Box? A review of seclusion and restraint practices in New Zealand*. Auckland: Human Rights Commission.

228 HDC. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018.

229 Health Quality and Safety Commission New Zealand. 2018. New projects seek to eliminate seclusion and improve service transitions for mental health consumers (web page). www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/3162/ (accessed 17 October 2018).

We note the need, in the longer term, for review and reconciliation of all mental health and addiction (and related) legislation for consistency and compliance with the United Nations conventions. This could be through the adoption of a universal regulatory approach to capacity (for example, England and Wales' Mental Capacity Act 2005 or Ontario's Health Care Consent Act 1996) or a single unifying statute (for example, India's Mental Healthcare Act 2017).

As an initial step towards legislative reform, we recommend the immediate repeal and replacement of the Mental Health Act. Any new Act needs to reflect a human rights-based approach, align with the recovery and social wellbeing model of mental health, and support the role of families and whānau and significant others, while retaining and building on the strengths of existing legislation. We commend the Substance Addiction Act's purpose of 'enhancing mana' and 'restoring capacity' and its requirement that those exercising powers under the Mental Health Act recognise the importance and significance to the person of their ties with their family and whānau, hapū, iwi or other family group and the need for mandatory consultation with them.

As noted, legislative change on its own will not drive systemic change. New Zealand's legislative framework for mental health and addiction can work only in a well-functioning system that recognises human rights and supports recovery, participation, capacity-building, prevention and early intervention, thereby reducing the need to invoke powers of coercion and enforced treatment. Legislative change also needs to be supported by clear guidance and clinical best practice that promotes supported decision-making and provides measures to minimise compulsory or coercive treatment.

We also think New Zealand needs a national level discussion, carefully crafted, to reconsider beliefs, evidence and attitudes about mental health and risk. Media leaders, mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission should all be engaged in the debate. The aim should be to increase understanding about mental health and risk, confirm the proper role of review processes, discuss responsible reporting of sad and difficult cases, and support good clinical decision-making in the interests of patients and the community. A new Mental Health and Wellbeing Commission could play a role in facilitating the debate.

Recommendations

Reform the Mental Health Act

- 34. Repeal and replace** the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights–based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.
- 35. Encourage** mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.



**“Our mental health
and addiction services
are literally all over
the place.”**

Chapter 12

A new Mental Health and Wellbeing Commission

Main points

- Strong and sustained national leadership is needed to achieve the vision set out in this report, and the system transformation required.
- There is a lack of confidence in the leadership of the mental health and addiction sector, which stretches back over many years. There are also key gaps in leadership of the system – particularly around independent and cross-sectoral oversight and support for implementation.
- A new Mental Health and Wellbeing Commission should be established to provide system leadership for mental health and addiction, implementation support for system transformation, and independent monitoring and oversight.

12.1 Introduction

In chapter 7, we identified a lack of locus of responsibility and coordination within central government on the underlying and interconnected drivers of wider social wellbeing, including prevention and social determinants. We noted that many agencies operate in the wellbeing space without strategic leadership or coordination. To address these issues, we recommended a new social wellbeing entity be set up within government.

Throughout this Inquiry, we also heard about a general lack of confidence in the leadership of the mental health and addiction sector over many years. Submitters highlighted shortcomings and documented ways the sector has failed to improve outcomes, reduce disparities, and reduce the number of suicides or the rate of suicide. Many submitters who shared their views on mental health and addiction leadership proposed the establishment of an independent agency to ensure sustained, transformational change and oversee the mental health and addiction system.

We agree that national leadership will be essential to achieve the vision set out in this report. Mental health and addiction issues are complex and interconnected and touch on many aspects of people's lives – it would be easy to lose direction in an attempt to solve every issue at once. Leadership is needed to keep the focus on where we need to get to and to bring clarity to how we get there without getting lost in detail or being overcome by paralysis.

We view a reinvigorated and expanded mental health commission – the Mental Health and Wellbeing Commission – as a crucial mechanism to enhance the leadership of mental health and addiction issues and to provide independent monitoring and oversight. We are clear that the new Commission would have a strong addiction focus.

In this chapter, we discuss the role and functions of the new Commission.

12.2 What needs to happen

12.2.1 Issues

Transforming the mental health and addiction system will take at least a generation. The changes required will depend on careful management, new ways of working, cultural change, and sustained system improvement and learning. New Zealanders need confidence that decision-makers will hold the vision and deliver the strategy, and that the directions will stay broadly consistent, despite political change.

Transformation requires strong leadership and accountability. Leadership of the mental health and addiction sector is necessarily dispersed across a complex system. The sector has many parts and many different people and organisations with leadership roles (including the Minister of Health, the Ministry of Health, 20 district health boards (DHBs), other service providers (including non-governmental organisations (NGOs) and primary care providers), and professional and representative groups. Several ‘watchdog’ organisations are responsible for advocacy and rights protection (such as the Health and Disability Commissioner) and quality improvement (such as the Health Quality and Safety Commission).

We note the criticisms heard during this Inquiry of mental health and addiction leadership, particularly in relation to the Ministry of Health. We have not dwelt on this, choosing instead to focus on looking forward and supporting the new Director-General of Health to provide much-needed leadership to the health and disability sector, and in particular to mental health and addiction issues. It will be important to rebuild trust and relationships with the mental health and addiction sector.

We also heard criticisms of the diminished role of the Mental Health Commissioner. The former Mental Health Commission, established in 1996, performed the role of independent oversight and was seen as a strong and effective watchdog. It had a specific function of monitoring the implementation of the national mental health strategy, including the performance of the Ministry of Health and regional health authorities (the precursors of DHBs). It developed the Blueprint on how things needed to be to guide sector development and support a monitoring framework. The Blueprint provided leadership and accountability to the sector and set funding priorities.

Over time, the powers, effectiveness and funding of the Commission were substantially reduced. It was disestablished in 2012, with the position of Mental Health Commissioner subsumed into the Office of the Health and Disability Commissioner. The statutory functions of the Mental Health Commissioner within the Office of the Health and Disability Commissioner were narrowed to focus on mental health and addiction services rather than the broader focus and functions of the disestablished commission.

The role of independent oversight of the whole system by a powerful commission is an important and missing piece of the puzzle.²³⁰

12.2.2 What needs to happen

The Government has signalled its intention to re-establish a stand-alone mental health commission. We recommend that this occur as a matter of urgency and that it be named the Mental Health and Wellbeing Commission to emphasise the focus on shifting from an illness approach to a wellbeing approach.

We assessed options for a new commission's scope, functions, powers and form, taking into consideration what we heard through submissions, advice from state sector organisations and our own commissioned research.

We consider that the fundamental purpose of the independent Mental Health and Wellbeing Commission should be to act as a system leader of mental health and wellbeing in New Zealand, with a strong oversight and monitoring role. In all its endeavours, the Commission should uphold and actively promote the Treaty of Waitangi and its principles, and this requirement should be set out in legislation. (See Figure 4.)

As noted in chapter 4, we consider that an immediate priority for the new Commission is to support the Ministry of Health in facilitating a national co-design service transformation process. The purpose of this process is to extend access to and choice of mental health and addiction services in New Zealand. The Commission should also be funded to provide 'backbone support' for national, regional and local implementation of the change process.

In the future, the Commission may develop a new mental health and wellbeing strategy, although we see the co-design process as being its initial priority. In addition, we consider that the Commission should play a leading role in the development and ongoing review of an investment and quality assurance strategy for mental health promotion and prevention (chapter 7). Other functions could include hosting the suicide prevention office and completing the suicide prevention strategy and implementation plan (chapter 10).

230 R Cunningham, A Kvalsvig, D Peterson, S Kuehl, S Gibb, S McKenzie, L Thornley and S Every-Palmer. 2018. *Stocktake Report for the Mental Health and Addiction Inquiry*. Wellington: University of Otago.

The Commission should also act as an important institutional mechanism to help New Zealanders hold decision-makers and successive governments to account. It can do this by monitoring the degree to which national strategies relevant to mental health and wellbeing are being implemented by responsible agencies and by publicly reporting on progress. It should also regularly report publicly on the progress against implementation of the Government's response to this Inquiry's recommendations, with the first report to be released one year after the response.

The Commission should also have the ability to provide independent expert advice to the Government, on its own initiative or as requested, on any matters relevant to mental health and wellbeing (including resources and funding). The important role of the Health and Disability Commissioner continues in promoting and protecting the rights of consumers under the Code of Health and Disability Services Consumers' Rights and resolving individual complaints. However, the new commission should be responsible for advocating for the collective interests of people with mental health and addiction challenges and their families and whānau.

Partnerships (across government, sectors and communities) are essential because the Commission cannot achieve the desired outcomes on its own. The Commission needs to drive change while bringing others along. This work will include spreading information, innovation and best practice (including on mental health promotion and prevention) and promoting collaboration, communication and understanding about mental health and wellbeing and contributory factors to mental distress. For example, we see the Commission having an important relationship with the proposed social wellbeing agency, with the Commission having an oversight role of the mental health sector's contribution to the wider wellbeing agenda.

Figure 4: Mental Health and Wellbeing Commission's purpose, functions and powers

Overarching purpose	<ul style="list-style-type: none"> • To act as a system leader for mental health and wellbeing in New Zealand • To uphold and actively promote the principles of the Treaty of Waitangi in all its endeavours
Core functions	<ul style="list-style-type: none"> • Report on progress against implementation of the Government's response to the recommendations of the Government Inquiry into Mental Health and Addiction • Facilitate a national co-designed service transformation process and provide backbone support for national, regional and local implementation • Develop an investment and quality assurance strategy for mental health promotion and prevention • Ensure any national strategies relating to mental health and wellbeing are implemented by responsible agencies and publicly report on progress • Advocate for the collective interests of people with mental health and addiction challenges and their families and whānau • Provide advice to the Government, at the Commission's discretion, on any matters relevant to mental health and wellbeing (including funding) • Facilitate best practice, innovation and evaluation • Promote collaboration, communication and understanding about mental wellbeing and issues that contribute to mental distress
Other possible functions	<ul style="list-style-type: none"> • Host the suicide prevention office and complete the national suicide prevention strategy and implementation plan
Powers	<ul style="list-style-type: none"> • Obtain information or data from government departments and other state services agencies • Initiate investigations and inquiries on systemic issues • Publicly report on any matters relating to mental health and addiction services or impacting on the mental health and wellbeing of New Zealanders • Develop other mental health and wellbeing strategies as appropriate • Appoint advisory or expert committees and seek expert advice • Review and comment on the annual and/or strategic plans of agencies responsible for delivering services that affect people with mental health and addiction challenges and their families and whānau

For the Commission to effectively undertake these functions, it must be able to obtain information or data from government departments and other state services agencies, initiate investigations and inquiries on systemic issues, publish its advice and reports, appoint advisory and expert committees, seek expert advice, and engage and consult widely in the course of its work. It should also be able to review and comment on the annual and strategic plans (and associated funding and expenditure) of agencies responsible for delivering services that affect people with mental health and addiction challenges and their families and whānau.

The Commission should be established as an independent Crown entity with a board of about three commissioners. Collectively, board members should have expertise in crucial areas (including tikanga Māori), have lived experience, and reflect the community the Commission serves. This means the form and operating model of the Commission and its board need to be informed by a strong commitment to the Treaty relationship and ensure a robust role and voice for people with lived experience.

The Commission should have the necessary resources to do its job, including stable and ongoing funding and a capable secretariat with access to data from across government.

To maintain momentum on this issue, an interim commission, established as a ministerial advisory committee, should be set up early in 2019 to undertake priority work in key areas, ahead of the Commission's formal establishment. This could include development work with the Ministry of Health on the national co-design process.

As part of this process, legislative amendments will be needed to the Health and Disability Commissioner Act 1994 to shift some of the Health and Disability Commissioner's current functions to the new Commission.

Recommendations

Establish a new Mental Health and Wellbeing Commission

- 36. Establish** an independent commission – the Mental Health and Wellbeing Commission (with the functions and powers set out in Figure 4 in section 12.2.2) – to provide leadership and oversight of mental health and addiction in New Zealand.
- 37. Establish** a ministerial advisory committee as an interim commission to undertake priority work in key areas (such as the national co-designed service transformation process).
- 38. Direct** the Mental Health and Wellbeing Commission (or interim commission) to regularly report publicly on implementation of the Government's response to the Inquiry's recommendations, with the first report released one year after the Government's response.

A final note



Main points

- Our focus in this report has been on how to support real and decisive change.
- The Health and Disability Sector Review has a key part to play in considering broader system and structural issues.
- Improving New Zealand's mental health and wellbeing is a long-term challenge. Collective and enduring political commitment is essential. We recommend the establishment of a cross-party working group in the House of Representatives.

At this point, *He Ara Oranga* passes from our hands to the Government's.

Others will be tasked with assessing it, weighing options and preparing a response. Like us, they will be acutely aware of the hopes and high expectations of all those who participated in the Inquiry process.

We have set a clear path for the future. In saying this, we are aware that as our report moves out of our control, other issues come into play. They include the decisions the Government takes, any flow-on effects (including to the range of other inquiries and reviews that are under way), the available resources and how quickly changes can be implemented.

These are not things we can predict. In preparing our recommendations, we knew there would be issues around phasing, resourcing and how quickly some decisions could be implemented. Our approach has been to identify how to support real and decisive change, while other processes are under way.

That is why we have given precedence to the service co-design process, but have been silent about whether or when a new mental health and wellbeing strategy should be developed. We see little value in putting effort into a formal strategy at this point. The direction is clear and can guide decision-making from this point. Implementing the Government's decisions on this inquiry should be the priority, and progress should be monitored by the new Mental Health and Wellbeing Commission. Development of a strategy may be useful in the future. That option should be left open.

We recognise that funding will be required to extend access to, and choice of, mental health and addiction services. We have suggested some areas where decisions around early investment can be made easily, while a full staged funding path is developed and agreed. Additional resources will also be required to implement the other recommendations in this report.

Legislation will be required to establish the new Mental Health and Wellbeing Commission. The legislative process may take some time, but we need a change agent now. We suggest that a ministerial advisory committee be established as an interim body while the Commission is being set up, to lead or participate in urgent tasks.

We have not specified which agency should develop a new suicide prevention strategy and implementation plan. We are aware that the Ministry of Health has already completed significant preparatory work for the strategy. The strategy and implementation plan need to be completed urgently and funded, probably before new organisations can be established. Similarly, we have not specified where our proposed suicide prevention office should reside. This will depend on the wider decisions the Government makes around agency roles and functions.

We emphasise that our recommendations are intended to work together as a cohesive and comprehensive package for change, which builds on the structures and systems in place now.

Over the course of the Inquiry, there were significant structural and system issues we discussed at length. We comment on these issues throughout Part 2 of this report, including concerns about the current district health board model and the transformation required in the primary health care sector (chapter 5). Part way through the Inquiry, the Government established the Health and Disability Sector Review. That review has a wider scope than our Inquiry, and is better placed to consider broader issues such as the future structures, roles and functions in the health and disability system, including the establishment of a Māori health commission or ministry. We refer these important issues to the Health and Disability Sector Review for its consideration.

In closing, we respond to the call we heard from people up and down the country for a collective and enduring political commitment to improved mental health and wellbeing in New Zealand.

Mental health is too important to be a political football. Although different parties have differing priorities, we believe they all share a commitment to improved mental health and wellbeing in New Zealand. We think an opportunity exists for politicians to work together on these important issues. Similar initiatives are in place in the United Kingdom and Canada, and some support exists for a similar concept in New Zealand. We note that a cross-party working group on drug harm reduction already exists.

We recommend the establishment of some form of cross-party working group on mental health and wellbeing, supported by a secretariat. This would provide an opportunity for members of the House of Representatives to collaborate and advocate for education, leadership and legislative progress on mental health and wellbeing. It would also provide a forum for members to collectively connect with New Zealanders about mental health and wellbeing on topical issues of concern.

Recommendations

Wider issues and collective commitment

39. Ensure the Health and Disability Sector Review:

- assesses how any of its proposed system, structural or service commissioning changes will improve both mental health and addiction services and mental health and wellbeing
- considers the possible establishment of a Māori health ministry or commission.

40. Establish a cross-party working group on mental health and wellbeing in the House of Representatives, supported by a secretariat, as a tangible demonstration of collective and enduring political commitment to improved mental health and wellbeing in New Zealand.

Kua takoto te manuka – the challenge has been laid

Appendices

Appendix A:

Terms of Reference

Background and Matter of Importance

The Government has committed to setting up an inquiry into mental health as part of its first 100 days' work programme.²³¹ The catalyst for the inquiry has been widespread concern about mental health services, within the mental health sector and the broader community. Service users, their families and whānau, people affected by suicide, people working in health, media, iwi and advocacy groups have called for a wide-ranging inquiry.

The *People's Mental Health Report (2017)* highlighted a range of problems, including: access to services and wait times, limited treatment options in primary and community care, compulsory treatment and seclusion practices, ineffective responses to crisis situations and underfunding of mental health and addiction services in the face of rising demand. There have been calls for a transformation in New Zealand's response to mental health and addiction problems. Major concerns are stubbornly high suicide rates, growing substance abuse and poorer mental health outcomes for Māori.

People can experience a broad range of mental health problems on a spectrum from mental distress to enduring psychiatric illness requiring ongoing interventions. Substance abuse often occurs together with mental health problems. Poor mental health increases the likelihood of suicidal behaviour. However, not everyone who plans, thinks about, attempts or dies by suicide has a diagnosable mental disorder, and factors that contribute to suicide differ markedly across age groups.

Mental health and addiction problems are relatively common (approximately 20 percent of New Zealanders are predicted to meet the criteria for a diagnosable mental disorder each year) and prevalence is increasing. Unmet need is substantial, with at least 50 percent of people with a mental health problem receiving no treatment. This situation reflects both people not recognising their own needs for mental health support and a lack of capacity to meet those needs. Families and whānau of service users, and of New Zealanders lost to suicide, report little or no support or treatment.

Risk factors include ease of access and cultural attitudes to alcohol (which is implicated in over 50 percent of cases of youth suicide) and continued dislocation of Māori from their whānau, communities and iwi. There is also increasing dislocation within our ethnic migrant and refugee communities. Many other risk factors associated with poor mental health sit across a range of social determinants such as poverty, inequality, inadequate parenting, lack of affordable housing, low-paid work, exposure to abuse, neglect, family violence or other trauma, social isolation (particularly in the elderly and rural populations) and discrimination.

²³¹ These Terms of Reference are set out in Establishment of the Government Inquiry into Mental Health and Addiction (notice number 2018-go318). 2018. *New Zealand Gazette* 30 January. <https://gazette.govt.nz/notice/id/2018-go318>.

Risks are higher where deprivation persists across generations. These risk factors can contribute to a wide range of other poor life outcomes including low levels of educational achievement, poor employment outcomes, inadequate housing and criminal offending. On the positive side, many resilience and mental health-enhancing factors can be found even in difficult and deprived social settings.

There is strong evidence that prevention and early intervention is most beneficial and cost-effective. Often mental disorders are recognised only after they become severe and consequently harder to treat. Half of all lifetime cases of mental disorder begin by age 14 and three-quarters by age 24. New Zealand's current approach to mental health is not geared towards prevention and early intervention.

Across the spectrum of poor mental health are inequalities in mental health and addiction outcomes. In addition to Māori, disproportionately poorer mental health is experienced by Pacific and youth, people with disabilities, the rainbow/LGBTIQ community, the prison population and refugees.

Many interventions, particularly in relation to preventing mental health and addiction problems and suicide, lie outside the health system. There needs to be better coordination and a more integrated approach to promoting mental well-being, preventing mental health and addiction problems, and identifying and responding to the needs of people experiencing mental health and addiction problems. Models of care such as Whānau ora and whānau focussed initiatives offer significant potential benefit. New approaches will have implications beyond the health system, for example, for education, welfare, housing, justice, disability support, accident compensation and emergency response systems.

Some actions cannot wait until the inquiry is completed. Alongside the inquiry, the Government is already taking steps to address some immediate service gaps and pressures, including increasing funding for alcohol and drug addiction services, increasing resources for front-line health workers, putting more nurses into schools, extending free doctors' visits for all under 14 year olds, providing teen health checks for all year 9 students and providing free counselling for those under 25 years of age.

Purpose and objectives

The purpose of this inquiry is to:

1. hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction, and what needs to change;
2. report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems; and
3. recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

To do this the inquiry will:

1. identify unmet needs in mental health and addiction (encompassing the full spectrum of mental health problems from mental distress to enduring psychiatric illness);
2. identify those groups of people (including those not currently accessing services) for whom there is the greatest opportunity to prevent, or respond more effectively to, mental health and addiction problems;
3. recommend specific changes to create an integrated approach to promoting mental well-being, preventing mental health and addiction problems, and identifying and responding to the needs of people experiencing mental health and addiction problems; and
4. specify which entities should progress the inquiry's recommendations, including relevant ministries and a re-established Mental Health Commission.

The recommendations of the inquiry will help inform the Government's decisions on future arrangements for the mental health and addiction system, including:

1. roles and responsibilities of agencies in the health sector, including a re-established Mental Health Commission;
2. improved coordination between the health system and other systems such as education, welfare, housing, justice, disability support, accident compensation and emergency response;
3. the design and delivery of services (eg, kaupapa Māori approaches to mental health) and effective engagement with all relevant stakeholders including mental health service providers, and consumers and their communities and whānau;
4. governance, leadership and accountability levers to ensure access to an appropriate standard of mental health services across the country;
5. fiscal approaches, models and funding arrangements;
6. data collection, programme evaluation and information flows;
7. the suite of relevant regulatory frameworks, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Substance Abuse (Compulsory Assessment and Treatment) Act 2017; and
8. workforce planning, training, support and management.

Scope

In identifying the issues, opportunities, and recommendations the inquiry will consider the following:

1. mental health problems across the full spectrum from mental distress to enduring psychiatric illness;
2. mental health and addiction needs from the perspective of both:
 - a. identifying and responding to people with mental health and addiction problems; and
 - b. preventing mental health problems and promoting mental well-being;
3. prevention of suicide;
4. activities directly related to mental health and addiction undertaken within the broader health and disability sector (in community, primary and secondary care), as well as the education, justice and social sectors and through the accident compensation and wider workplace relations and safety systems; and
5. opportunities to build on the efforts of whānau, communities, employers, people working in mental health and others to promote mental health.

The inquiry will need to understand and acknowledge the wider social and economic determinants of mental health and addiction (for example poverty, inadequate housing, family violence or other trauma) and cultural factors, in particular the historical and contemporary differences in outcomes for Māori, and consider the implications of these determinants and factors for the design and delivery of mental health and addiction services. Commentary on these matters is welcome to help inform the Government's work programmes in these areas.

The inquiry may signal changes to be considered in subsequent regulatory reviews. It will not undertake these reviews itself.

The following matter is outside the scope of the inquiry:

1. individual incidents or cases within current services. The inquiry panel will refer these to the appropriate pathway, for example, the Health and Disability Commissioner or relevant authorities.

Principles

The inquiry will take an approach that:

1. enables consumers, carers, family and whānau to be included and heard, and ensures acknowledgement and consideration of input from previous consultations and specific consultation with Māori communities and whānau/hapū/iwi;
2. attempts to build consensus between consumers, potential consumers, carers, family, whānau and providers about what government needs to do to transform the mental health and addiction system;
3. recognises the particular mental health and addiction inequalities for Māori, reflects the special relationship between Māori and the Crown under the Treaty of Waitangi, and the value of the work done by Māori experts and practitioners to design and deliver services that are more relevant and effective for Māori;
4. recognises and respect the needs of people with disabilities, and takes into account New Zealand's obligations under the UN Convention on the Rights of Persons with Disabilities;
5. recognises and respects the needs of different population groups, including Pacific people, refugees, migrants, LGBTIQ, prison inmates, youth, the elderly, and rural populations;
6. is person-centred, appreciating the impact of changes on individuals;
7. takes account of the whole system, including all relevant sectors and services and how they can work better together to improve mental health and addiction outcomes;
8. focuses on opportunities for early intervention; and
9. is based on the best research, ongoing evaluation and available evidence, in New Zealand and overseas.

Report back

The inquiry is to report its findings and opinions, together with recommendations, to the Minister of Health in writing no later than 30 November 2018.²³² In order to ensure the Minister is kept appropriately informed as to progress, the Chair will provide regular updates to the Minister on the inquiry's progress throughout the course of the inquiry.

²³² See Amendment to the Notice for the Government Inquiry into Mental Health and Addiction (notice number 2018-go5089). 2018. *New Zealand Gazette* 18 October. <https://gazette.govt.nz/notice/id/2018-go5089>.

Related work

The inquiry will consider previous investigations, reviews, reports and consultation processes relating to mental health and addiction, including:

1. the *Peoples' Mental Health Report*;
2. *Blueprint II: Improving mental health and wellbeing for all New Zealanders*;
3. reports from the Government's Chief Science Advisors into mental health and suicide;
4. report of the Director of Mental Health on the consistency of New Zealand mental health laws with the UN Convention on the Rights of Persons with Disabilities;
5. various workforce reviews including Mental Health and Addictions Workforce Action Plan 2016–2020;
6. consultation on *A Strategy to Prevent Suicide in New Zealand: Draft for public consultation*;
7. consultation on *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*;
8. *Mentally Healthy Rural Communities. RHANZ Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand* (2016);
9. *Puahau: Five Point Plan* (1998);
10. *Fit for the Future – Summary of Stakeholder Feedback* (2017);
11. *Understanding whānau-centred approaches: Analysis of Phase One Whānau Ora research and monitoring results* (2015); and
12. relevant Waitangi Tribunal inquiry reports (including *Ko Aotearoa Tenei*).

The inquiry also consider and interface with other relevant inquiries and reviews currently underway, including:

1. the Wai 2575 Health Services and Outcomes Kaupapa Inquiry;
2. the inquiry into the abuse of children in state care; and
3. Disability Support Transformation.

Authority

The inquiry is established as a government inquiry under the Inquiries Act 2013, with the Minister of Health as the appointing Minister.

Consideration of Evidence

The Inquiry may begin considering evidence on and from **31 January 2018**.

Dated at Wellington this 25th day of January 2018.

HON DR DAVID CLARK, Minister of Health.

Appendix B:

Vote Health funding for mental health and addiction services

Introduction

Most publicly funded mental health and addiction services are funded through Vote Health. Approximately 9% of total Vote Health funding (\$1.4 billion) was spent on mental health and addiction services in 2016/17.

Mental health ring fence

The vast bulk of Vote Health funding set aside for mental health and addictions (\$1.35 billion) is devolved to district health boards (DHBs) and is 'ring-fenced' within overall DHB funding.

The mental health ring fence was introduced following the Mason Inquiry (1995–1996)²³³ to prevent mental health and addiction funding from being reallocated to other service areas in the DHB bulk funding environment. At the time, it was estimated that 3% of the population in a given year would have severe mental health and addiction needs. The level of mental health and addiction services to be provided was therefore benchmarked at 3%.

Specific rules (last updated in mid-2018) set out what the mental health ring-fenced funding can be used for. They include:

- DHBs must maintain or increase mental health and addictions expenditure by applying at least demographic and cost-pressure adjustments each year
- funding must be used for specialist services for people with the most severe mental health and addiction needs
- DHBs must fund specialist services for at least 3% of the population; once that target is reached, DHBs may use any remaining funding for other mental health and addiction services.²³⁴

233 Committee of Inquiry into Mental Health Services (K Mason, Chair). 1996. *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley*. Wellington: Ministry of Health. <https://tinyurl.com/y6w4nqr5>.

234 Ministry of Health. 2016. *Operational Policy Framework 2018/19* (version 28 August 2018). <https://nsfl.health.govt.nz/accountability/operational-policy-framework-0/operational-policy-framework-201819>.

It should be noted that these ‘specialist’ services are not provided exclusively by specialist clinicians. Instead, these services involve a range of providers and different workers, across a mix of non-governmental organisations (NGOs) and community groups and DHB provider arms. In 2016/17, \$954 million was spent through DHB provider arms; \$391 million through NGOs. The proportion of funding allocated to DHB provider arms and to NGOs has remained similar over the last 10 years (72% and 28%, respectively).²³⁵

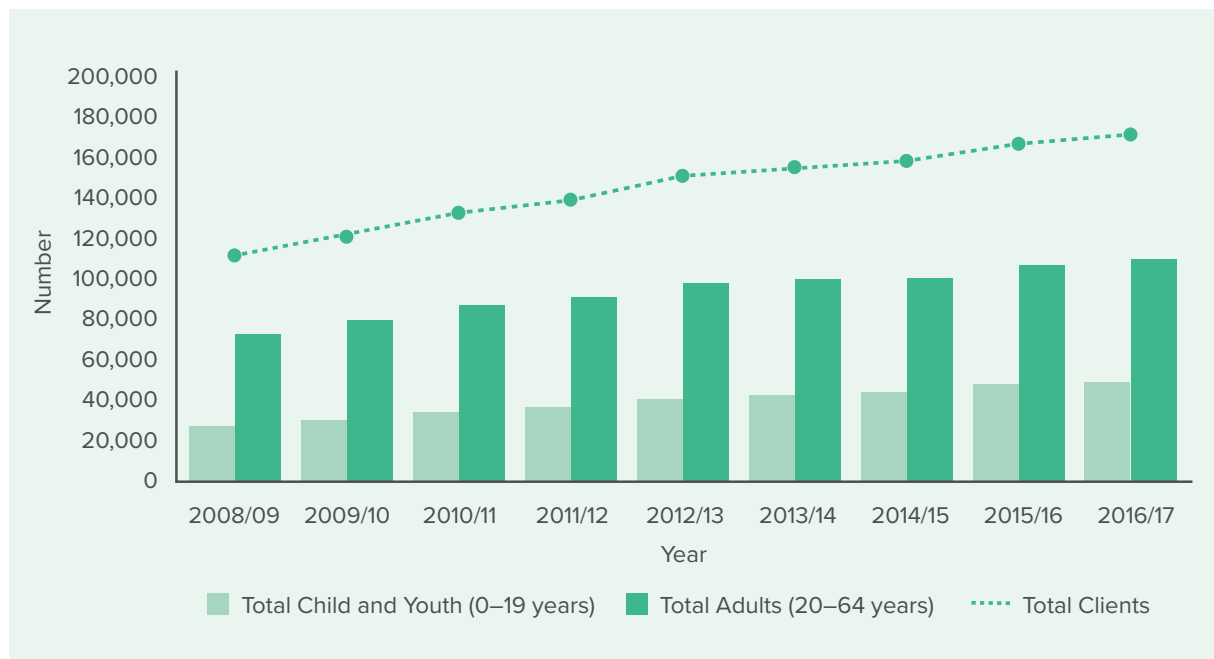
Details of the types of services that must be provided are set out in the service specifications for DHBs issued by the Ministry of Health. There are different specifications for different age groups, ethnicities and service types.

Specialist services can include acute and crisis services, community-based treatment and therapy services, and services to promote resilience, recovery and connectedness (for example, vocational support, living skills and housing coordination services).

Most specialist services are delivered in community settings rather than forensic or inpatient settings.²³⁶ In line with this, in 2016/17, forensic and inpatient services accounted for 22% of total ring-fenced expenditure.²³⁷

The numbers of people accessing specialist services are set out in Figure 5 and Table 4.

Figure 5: Number of people accessing specialist services by age, 2008/09 to 2016/17 (data provided by the Ministry of Health)



235 Based on data provided by the Ministry of Health.

236 Ministry of Health. 2017. *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health. www.health.govt.nz/publication/office-director-mental-health-annual-report-2016.

237 Calculated based on data provided by the Ministry of Health.

Table 4: Summary of specialist service access data, 2008/09 and 2016/17 (data provided by the Ministry of Health)

Category	2008/09	2016/17	Change
Total accessing mental health and addiction services	111,734	171,693	54%
Māori accessing mental health and addiction services	23,762 (21% of total)	46,322 (27% of total)	95%
Pacific peoples accessing mental health and addiction services	6,038 (5% of total)	9,942 (6% of total)	65%
Percentage of population accessing specialist care under ring-fence	3%	4%	–

Funding outside the ring-fence

Primary mental health

Outside of the ring fence, general primary care services are expected to meet mild to moderate and moderate to severe mental health and addiction needs.

‘General primary care’ encompasses a broad spectrum of services and providers, including both generalist services and primary mental health services. Key players include general practice (for example, general practitioners and practice nurses), school-based services, midwifery, Well Child Tamariki Ora, and NGO primary health services.

General primary care services are funded mainly through capitation from government (that is, a form of population-based funding) and co-payments from service users.

There is also approximately \$30 million of additional funding (outside of the ring fence) specifically for primary mental health and addiction services (for example, counselling and extended GP visits). However, this funding is tightly targeted towards youth, Māori, Pacific peoples and people on low incomes.

We received data about the number of people accessing this funded care for one year (2015/16). In 2015/16, an estimated 106,000 adults (aged 20 and over) and 15,800 young people (aged 12–19) were seen by primary mental health services in New Zealand.

Nationally purchased activities

A further \$100 million of nationally purchased services and activities is funded directly by the Ministry of Health through Vote Health. These services and activities include workforce development, adult inpatient and forensic services, and public promotion campaigns.

