BRIEFING TO INCOMING PARLIAMENT

Mental Health Foundation of New Zealand briefing 2020-2023

Mental Health Foundation
OF NEW ZEALAND
mauri tū, mauri ora
www.mentalhealth.org.nz

The Mental Health Foundation of New Zealand is a leading mental health promotion organisation that strives for a society where all people flourish.

Our strategic mission is to grow mental and emotional wellbeing and expand mauri ora – create space for the life force found in all things.

We believe positive mental health and wellbeing can be increased in Aotearoa New Zealand by promoting safe, strong, and supportive cultures within workplaces, schools, whānau and communities.

We do this by:

- Putting into action our commitment as a *Te Tiriti o Waitangi/The Treaty of Waitangi* partner
- helping people understand positive mental health and wellbeing and apply strategies to live well
- advocating for system changes to improve social, economic and cultural determinants of mental health and wellbeing, for example preventing racism, discrimination, poverty, and trauma such as abuse and neglect.

Tēnā koutou

Kua tangi te karanga o te pūtātara
Kua rere atu rā i te motu whānui
Kua mana ai e ngā tōrangapū o te tini me te mano
Ka moko ai te turu hirahira, te turu mō ngā manukura
Tēneki te mihi atu ki a koe, ki a koutou katoa
Kia manawanui

We have clear recommendations for change from the 2018 Inquiry into Mental Health and Addiction, *He Ara Oranga*, which sets an ambitious new direction for the sector.

The 38 recommendations made by the Inquiry, and accepted by the Government, are built upon expert input, and the equally important personal journeys and stories shared by individuals, whānau and communities about what needs to change.

As members of parliament you have a duty to see these recommendations put into action.

We join others[1] in advocating for the creation of a plan of action for delivering on the remaining *He Ara Oranga* recommendations as a matter of priority.

Since the Inquiry report was published, COVID-19 has created new challenges for our mental health, but the Mental Health Foundation considers *He Ara Oranga* continues to be the best guide we have to protect and improve wellbeing and support people experiencing mental distress now and in the long-term.

We know it's not as immediately sympathetic as calling for new beds in mental health units or more hours of funded counselling.

But a plan to enact *He Ara Oranga* will ensure the balanced and holistic approach recommended by the Inquiry is put into place. This includes greater access to services but also health promotions to empower communities to uplift their mental wellbeing and prevent distress; as well as meaningful action on the factors that contribute to poor mental health – such as poverty, racism, colonisation, discrimination, family violence, poor housing, bullying and isolation.

The establishment and work of the cross-party Mental Health and Addiction Wellbeing Group is a tangible demonstration of collective and enduring political commitment to improved mental health and wellbeing. We encourage MPs to unite in longer-term thinking about the mental health and wellbeing of New Zealanders and how to move forward together over the next three years.

Mauri ora

Shaun Robinson
Chief Executive Officer

What you need to know about mental distress and wellbeing

1 in 5 New Zealanders live with mental illness and/or addiction each year. Some population groups are more at risk that others: Almost 1 in 3 Māori, 1 in 4 Pacific peoples, 2 in 3 people in prisons.[2]

Mental distress is common, with almost one third of people reporting personal experience of mental distress. **Mental distress is highest among young people** (15-24-year-olds), **and disproportionately affects people in the most deprived areas and rural communities**.[3]

Mental distress-related discrimination can impact peoples' ability to contribute and participate in society. One in five people who had experienced mental distress avoided doing something or were afraid to do something because they anticipated being discriminated against.[4]

12 percent of all health loss in New Zealanders is attributable to mental distress and addiction.[5]

Economic costs of mental distress and/or addiction are high at $6.2bn (2.6 percent of GDP).[6]

Every year, hundreds of people die by suicide. In 2016, 553 people died by suicide in Aotearoa New Zealand. Māori, particularly young Māori, are significantly more likely to die by suicide than non-Māori.[7] In 2020, there was an increase in suspected suicides for the Asian population and older people.[8] For every suicide, on average six people experience intense grief and 129 people are affected.[9]

EVERYONE (20%)

MĀORI (ALMOST 33%)

PASIFIKA (25%)

PEOPLE IN PRISONS (66%)

New Zealanders living with mental illness and/or addiction each year

New Zealanders reporting personal experience of mental distress

The sector refers to 'people who experience mental distress' or 'tangata whaiora'

'Tāngata whaiora' means a person seeking health/ wellness

'Mental distress' (rather than mental illness) captures the broader range of peoples' experiences, demonstrates respect for the preferences of those with lived experience, and better reflects Māori and Pasifika views of health and wellbeing.

Around 3 in 5 adults experiencing mental health issues report having one or more long-term physical health issues. People who experience mental health and addiction issues have **a reduced life expectancy of up to 25 years**, with two thirds of premature mortality due to preventable and treatable health conditions, particularly cancers and heart disease.[10] These inequities exist for everyone with mental health and addiction issues but are much greater for Māori and Pasifika, and for people who are in contact with secondary mental health and addiction services.[11] Poorer physical health outcomes are influenced by socioeconomic determinants, the availability and quality of health care, as well as stigma, discrimination, racism, and diagnostic overshadowing.†

Nearly 1 in 4 New Zealander adults experience 'poor' mental wellbeing

Nearly 1 in 4 New Zealand adults experience 'poor' mental wellbeing, with one-third (35.1%) of adults identifying as bisexual experiencing 'poor' mental wellbeing. Māori rate their family wellbeing lower than other ethnicities (at 7.4 out of 10, compared to 7.8 for European and Pacific, and 8.2 for Asian).[12]

Overall wellbeing indicators found life satisfaction remains high; older people find life more worthwhile; most New Zealanders are not lonely; overall health rates are good; New Zealanders have high trust in each other, but one in 16 New Zealanders do not have enough money for everyday needs and unemployed people experience high rates of discrimination.[13]

† Diagnostic overshadowing is when symptoms of a physical condition are assumed to be related to a person's mental health or addiction experiences, often resulting in missed or delayed physical health screening and diagnoses.

16%

% of Māori population in New Zealand

28%

% of Māori mental health service users

Between 10–35 percent of workers experience some form of **bullying in the workplace**.[14] New Zealand has the **third highest rates of school bullying** out of 36 OECD countries.[15] Students who had been frequently bullied were also more likely to avoid going to school, have significant depressive symptoms or attempt suicide.[16]

NZ Health Survey found **36 percent of adults had used some type of help** (e.g., health services, the internet, talking to family/whānau) for their mental health or substance use and **30 percent of all families had used help** (including informal help) for their child's emotions, behaviours, stress, mental health or substance use.[17]

Māori make up approximately 16 percent of New Zealand's population, yet they account for 28 percent of all mental health service users.[18]

Rates of compulsory treatment under the Mental Health Act are high, and disproportionately high for Māori. In 2018 and 2017, 38 percent of people who were subject to a compulsory treatment order were Māori.[19]

Māori are significantly more likely to experience seclusion practices.[20]

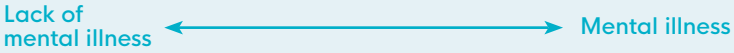
50% of people accessing mental health services have a substance use disorder.

70% of people accessing addiction services have a mental health need.[21]

Positive mental health, wellbeing and flourishing – what is it?

The term 'mental health' is often used as a euphemism for mental illness or having a mental health problem. For many people 'mental health' implies one either has a mental illness or does not have a mental illness (see figure 1).

FIGURE 1: SIMPLISTIC VIEW OF 'MENTAL HEALTH'



But mental health also has a positive side to it. Like other forms of health, **mental health is an asset that we can work on, grow and develop together, through the ups and down of life.** Everyone has mental health.

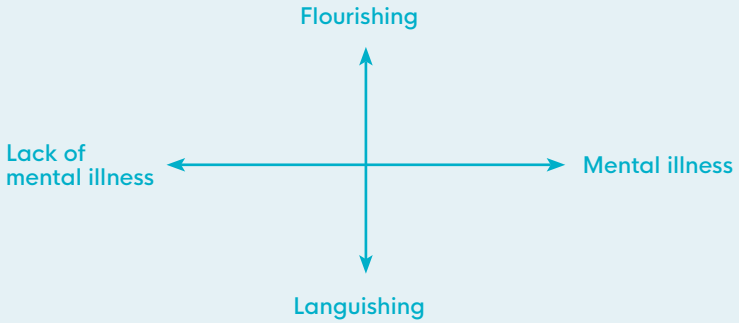
Positive mental health is the presence of behaviours, skills and attitudes that enable a person to enjoy life within a supportive context, to feel good and function well and to cope when difficult situations arise.

Flourishing is a useful descriptor of positive mental health that allows for broader social experience and meaning. Flourishing people feel good, feel interested in, connected to and engaged with the world around them and feel their lives have purpose and meaning. They're not immune to life's challenges but they have the resources, skills and support they need to get through tough times. The environments and support that allow people to flourish help to prevent mental distress and support people who experience mental health challenges. It is possible to live with a diagnosed mental illness and still flourish (see figure 2).

At the other end of the spectrum is **languishing**. Languishing is associated with disengagement and an inability to cope. It does not mean a person has a mental illness, although it is a risk factor for mental illness. Languishing can affect a person's life, whānau/family and community, even if it does not reach the level of a diagnosable mental illness.

FIGURE 2

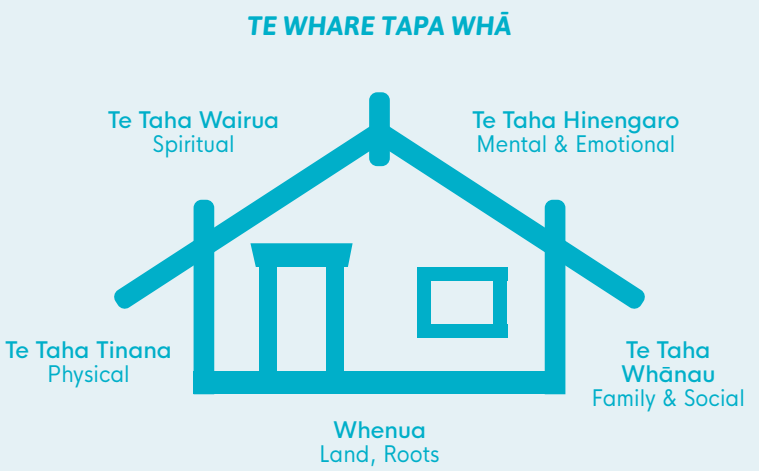
FOUR DIMENSIONS OF MENTAL HEALTH



Adapted from Dr Corey Keyes 2002

Positive mental health is a core component of a person's entire **holistic experience of health or wellbeing**. This is the heart of indigenous models of wellbeing, such as **Te Whare Tapa Whā** (figure 3), where it is not possible to separate mental wellbeing from social, physical, spiritual and cultural wellbeing, nor is it possible to think of the whare as isolated from the whenua it sits on. In other words, the whole person is always the consideration, and the whole person is always considered within their environment, culture and context.

FIGURE 3: TE WHARE TAPA WHĀ



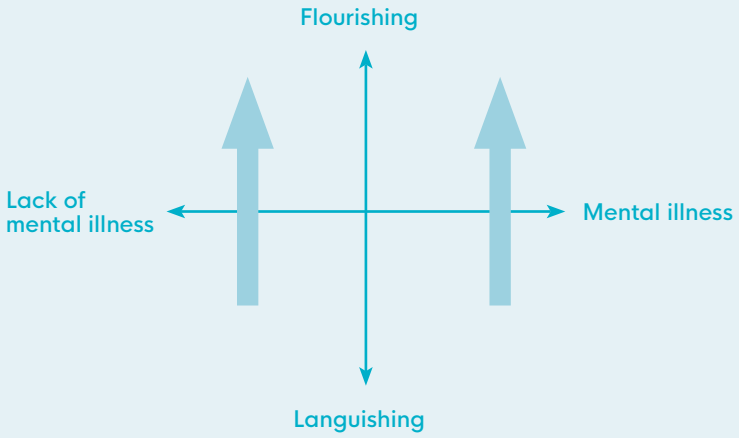
Positive mental health promotion and prevention – what is it?

As long as we are alive, we have some kind of mental health; poor, good or middling. But most mental health doesn't just happen by accident, it is affected by how we live, think and what's happening around us.

Mental health promotion is activity that increases the factors that are likely to lead to positive mental health and wellbeing, and help people shift upwards towards the flourishing space (see figure 4). This is a benefit in and of itself, and it helps **prevent** some people from becoming mentally unwell or more unwell.

FIGURE 4

FOUR DIMENSIONS OF MENTAL HEALTH



Positive mental health and wellbeing promotion works to **integrate social and system change with personal change**.

This means:

- **improving the factors that boost positive mental health and wellbeing**, such as supporting whānau and improving relationships, boosting individuals' psychological and emotional skills and behaviours that increase wellbeing, and building supportive and resilient communities, and
- **preventing and mitigating against factors that contribute to poor mental health and wellbeing**, such as racism, discrimination, poverty, and trauma.

Implement He Ara Oranga as a matter of priority

We all want a nation 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 can achieve this if we implement the remaining recommendations outlined in *He Ara Oranga*.

To do this, we need a plan.

This plan needs to be simple, focus on the long-term, apply to both health and non-health sectors, be transparent, and show how the sector and communities can contribute to its success. Without a plan, we risk losing traction and direction for successive governments.

The plan should make the following ten priority areas front and centre.

1. **Applying a *Te Tiriti o Waitangi* and equity lens**

    - *Te Tiriti* principles of tino rangatiratanga, equitable outcomes, active protection, options and partnership must be understood and upheld in the delivery of *He Ara Oranga*'s recommendations.

    - Inclusive decision-making will support the recommendations' delivery to achieve equitable outcomes for Māori, Pasifika, people with disabilities, LGBTQI+, children and youth, rural populations and those that experience overlapping and interdependent systems of discrimination or disadvantage (intersectionality).

2. **Implementing a whole-of-government approach to wellbeing, prevention and social determinants** (*He Ara Oranga* rec. 16)

    - Some of the most powerful determinants of good health lie outside the health system. The Government must have a long-term plan about how to best measure and incentivise cross-government efforts and investment in the prevention of mental and emotional harm by improving the determinants that impact mental health and wellbeing outcomes and inequities.

3. **Developing a strategy for achieving positive mental health and wellbeing** (see *He Ara Oranga* recs. 18 & 19)

    - The community can and should be empowered to adopt behaviours and actions that build positive mental health, resilience and wellbeing. Mental health promotion makes a difference, for example, of 46 percent of all adults saw the 2020 Mental Health Awareness Week campaign; of these, half agreed it helped them do something about their wellbeing.

    - The Mental Health and Wellbeing Commission or another appropriate agency needs to develop high-level principles and a strategy to invest in, and ensure the quality of, Aotearoa's mental health and wellbeing promotion and prevention. This will ensure mental health promotion and prevention is safe and effective, and funding is appropriately directed.

4. **Repealing and replacing the Mental Health Act, and starting national conversations about mental health and risk** (*He Ara Oranga* recs. 34 & 35)

    - The replacement of the Mental Health (Compulsory Assessment and Treatment) Act must gain momentum to ensure the Act reflects a human rights approach and *Te Tiriti o Waitangi* principles, is aligned with modern models of mental health care, minimises the use of compulsion and restraint, and eliminates seclusion practices.

    - Lived experience/tāngata whaiora must inform the outcomes of legislative change. Public discussion about beliefs, evidence and attitudes about mental health and risk is a vital part of this work.

5. **Publishing two implementation plans to enact the national suicide prevention action plan** (related to *He Ara Oranga* rec. 30)

    - It is time to show us how the actions in the suicide prevention strategy *He Tapu te Oranga o ia Tangata – Every Life Matters* will be prioritised and implemented to prevent suicide in Aotearoa.

    - Given the inequity in impacts of suicide for Māori a separate Māori-specific implementation plan needs to be developed alongside an overarching plan. The indigenous suicide prevention *Tūramarama Declaration* should be used as the basis for delivering many of the actions.

6. **Continue increasing access and choice in mental health and addiction services, at pace** (*He Ara Oranga* recs. 1-6, 10 &12)

    - Early intervention through primary mental health and addiction services requires accelerated roll out. New Pasifika and kaupapa Māori service providers should be prioritised and given ongoing support that focus on ending persistent community inequities.
    - All service commissioning should be streamlined so providers are not overburdened with compliance requirements and offered longer-term contracts.
    - We must ensure the increasingly-available e-mental health supports and treatments are safe, effective and accessible to all, particularly Māori and Pasifika.

7. **Keeping momentum on the co-design process for system transformation** (He Ara Oranga recs. 7-9)

    - The Government needs to be clear about the timeframe and phases of work for the co-design process. The voices of people with lived experience/tāngata whaiora and Māori must be at the heart of any co-design process, so the new mental health and addiction system is built around and by the people who use it.

8. **Stepping-up workforce development and supported employment initiatives** (*He Ara Oranga* rec. 10)

    - Boosting the Māori and Pasifika-led mental health and addictions workforce – and making the overall workforce culturally safe – should be a priority. This should be achieved not only through cultural safety training, but also ongoing monitoring of organisational systems to ensure cultural bias is removed in decision-making and a culture of equity is created.

- To help lower unemployment during the COVID-19 recovery phase, we must support people who experience mental distress to gain and maintain employment through integrated employment support.[22] This should be provided to everyone with experience of distress and throughout employment, not just at the start.

9. **Improving the commissioning of kaupapa Māori services** (*He Ara Oranga* rec. 15)

    - National consultation is needed about what powers the proposed Māori Health Authority will have to reduce health inequities and improve health outcomes for Māori (see the *Health and Disability System Review*). Expert advisory groups recommend commissioning powers with a variety of functions, including commissioning for outcomes.

10. **Commissioning a rapid review to identify gaps in whānau support** (*He Ara Oranga* rec. 25)

    - A rapid review is urgently needed to identify the most significant gaps in support for families and whānau where a person is experiencing significant mental distress. Services and groups that already experience these gaps will have the immediate answers to the most pressing areas of concern. Addressing these concerns will ensure families and whānau can receive the support they need for their own wellbeing and assist in the support of their family member.

How to talk about mental health and suicide safely

Suicide and mental health are pressing public health issues MPs discuss with constituents and the public. Here is our advice about what to do (and what to avoid) when talking about suicide and mental health and the reasons why thinking about these issues and speaking about them with kindness is critically important.

Talking about suicide safely

DO	DON'T	WHY?
✓ Talk about people '**dying by suicide**' e.g. "I had a friend who died by suicide."	✗ Use the term **"commit"** or **"committed"** suicide e.g. "he attempted to commit suicide".	The word "commit" increases the stigma around suicide – both for people who have had their own experience of suicidal thoughts or suicide attempts and for those bereaved by suicide. The word "commit" is generally only used when talking about crime.
✓ **Know your stats** and only use official suicide data (either provisional data via the Chief Coroner or official data via the Ministry of Health).	✗ **Share, discuss or speculate** about increases in suicide for certain groups, areas, professions.	Rumours about suicide clusters/spikes/increases are often false but can increase a sense of hopelessness for people and can normalise suicide as a response to tough situations.
✓ Remind your audience that **suicide is complex** and there is no single cause of suicide.	✗ Attribute suicide to a **single cause** (e.g. bullying, COVID-19, working in a particular profession).	Suicide is always complex, and there is hardly ever a single reason why someone takes their own life. Simplifying the causes of suicide both puts more people at risk (if they identify with that cause) and contributes to misunderstandings about how suicide can be prevented.

✓ Give people **hope**. Talk about **suicide prevention** – remind your audience that suicide is preventable.	✗ Talk about suicide as though it is **inevitable** – for individuals or for us as a country.	Suicide is preventable. Hopelessness is a feeling many people who are suicidal or who die by suicide have in common. Work to create hope and talk about suicide prevention for individuals, whānau and communities, not just raise awareness of suicide.
✓ Talk about Māori suicide using a **te ao Māori** approach.	✗ Use **one-size-fits-all** approaches to suicide prevention.	Using one-size-fits-all approaches can alienate Māori and contribute to a feeling of not being heard or valued by you. Talk about Māori suicide prevention approaches (see the Tūramarama Declaration for more information).
✓ Talk about **what puts people at risk** of suicide – and how we can address those risks.	✗ **Say all people** in a certain group (e.g. farmers experiencing drought, or all people who have lost their jobs due to COVID-19) are at risk of suicide.	As a country, we all need to understand what puts people at risk of suicide and what we can do to help. We don't want to normalise suicide or increase the risk for people who are experiencing adversity. Suicide is never inevitable.
✓ **Remember the person** – our suicide statistics represent individuals who were loved and had value.	✗ **Sensationalise numbers** and forget the people behind them.	People who have been suicidal or attempted suicide sometimes feel they get lost in the debate when politicians talk about suicide. Remember the humans behind the numbers are the reason why we all care so much about this issue. People who have lost a loved one to suicide are listening when you talk about this issue – remember to consider them.

Talk about mental health and mental illness safely

DO	DON'T	WHY?
✓ Talk about people who use mental health services as our **friends, whānau, colleagues and neighbours** – normal people who need extra support.	✗ **Make jokes** about mental health service users or suggest they are **untrustworthy or weak**.	Many people who use mental health services still experience stigma, discrimination and shame. Making jokes or 'othering' New Zealanders who use these services makes it more likely they won't ask for help for fear of being ridiculed, judged or excluded.
✓ Talk about **mental health as something we all have**, in the same way we all have physical health.	✗ Use "mental health" when you mean **"mental illness"** or **"mental distress"**.	Mental health is something we all have, and how well we are varies for most of us throughout our lives. We want people to know their mental health is something they can build to enjoy wellbeing and live great lives.
✓ Talk about mental illness as a **common, human experience**. Share your own experiences if you feel comfortable doing so.	✗ Suggest people who live with mental illness are **violent, unpredictable, unsafe or unpleasant.**	Up to 80% of us will experience a mental illness in our lifetime. Most of us will recover and won't suddenly become risks to the community. Reinforcing myths about violence and mental illness reinforces shame and decreases the likelihood people in distress will be supported by their whānau, friends and loved ones.
✓ **Think about the language** you use to critique political opponents and opposition policies.	✗ Use names associated with mental illness as **insults or pejoratives** (e.g. schizophrenic, bipolar, psychotic)	Using diagnoses as insults causes hurt for people who have those diagnoses. There are always other words you can choose that convey your point without causing harm to vulnerable people.

✓ **Know your stats** about mental health and mental illness	✗ **Sensationalise** numbers.	100% of us have mental health. At any one time about one in five of us will be experiencing mental illness/distress.
✓ **Be kind** to colleagues and public figures experiencing distress.	✗ Use mental illness or mental distress as an **excuse for poor, unacceptable or predatory behaviour**.	This hurts people who live with mental illness/distress. Using mental illness as an excuse makes it less likely they will feel safe to share their experiences or ask for help, and reinforces myths that people living with mental illness are more likely to harm others or should be held to lower standards.
✓ **Consider Māori worldviews** when talking about mental health.	✗ Use **one-size-fits-all** approaches to mental health.	Using one-size-fits-all approaches alienate Māori and contribute to a feeling of not being heard or valued by you. Talk about Māori mental health supports and services, and te ao Māori worldviews about mental health.
✓ Consider how intersectionality impacts mental health and suicide risk – **people are often members of more than one high-risk group** (e.g. someone may be a young Māori male who is a member of the LGBTQI+ community)	✗ Simplify people's identities or **assume individuals are only members of one high risk group**.	Policies/programmes that target high-risk groups and do not consider that these groups often overlap will not meet the needs of these groups. Overlapping identities can increase discrimination and disadvantage but we often forget this when speaking about suicide, suicide prevention and mental health.

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