Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

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Mental Health and Wellbeing Commission
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Tēnā koe

He Ara Āwhina Framework consultation

Thank you for the opportunity to provide feedback on the He Ara Āwhina framework.

The Mental Health Foundation of New Zealand (MHF) was pleased to provide early conceptual feedback on the framework in 2020 and again on a draft in 2021. We are grateful to have been involved throughout the process and thank you for incorporating some of our previous suggestions. We also acknowledge the extensive engagement undertaken with a range of communities and the expert opinion sought by the Commission in developing the framework, particularly with Māori and tāngata whaiora.

1. **Does He Ara Āwhina reflect your hopes for a mental health and addiction system?**

We support the application of the dual perspective to demonstrate the framework's commitment to Te Tiriti o Waitangi. We also endorse the framework's wide scope, including the broad definition of whānau to include settings like schools, workplaces and communities interacting in virtual/digital spaces; and references to mental health, wellbeing, and harm from substance use and gambling rather than a narrow view of the acute end of the mental health and addiction/s spectrum.

We appreciate the framing of the goal to be inclusive of leading wellbeing and recovery. As you know, when people are mentally well, they are not just free from mental illness, but are thriving and experiencing attributes such as optimism, vitality, meaning and purpose, high quality relationships and social engagement, contribution to society, emotional stability and resilience. We recommend the final Framework link the reader to your *He Ara Oranga Wellbeing Outcomes Framework* to provide them with a comprehensive understanding of the full range of positive mental wellbeing outcomes.

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We are, however, very concerned the overall structure, aspirations and outcomes in the draft reflect a narrative of mental health supports and services and thereby reinforce the dominant medical model of mental health that has not served the system well. Promoting wellbeing was one of the three key planks of the recommendations in *He Ara Oranga* and is further reflected in *Kia Manawanui Aotearoa's* mental wellbeing framework. As such, our expectation is that He Ara Āwhina would include visible and clear aspirations and outcomes for tāngata whaiora and whānau to be supported to apply strategies to live well, and to experience positive mental wellbeing or 'flourishing'. Wellbeing is not a privilege reserved for those who do not experience mental distress or illness – it is possible to live with a diagnosed mental illness and still flourish and applying wellbeing strategies is an important component of recovery journeys.

We recommend a specific aspiration in the shared perspective that provides space for tāngata whaiora and whānau (and all New Zealanders) to develop and apply skills, literacy and behaviours to uplift their mental wellbeing and prevent and reduce distress where possible. While there is a reference to 'access [to] tools and information to respond to distress, reflect on and minimise harm from alcohol, other drug use, or gambling, find support, and lead our wellbeing and recovery' it is forced to fit into an aspiration of 'connected care', which is clearly framed with services and supports in mind.

We also wish to make clear that while mental wellbeing promotion is interwoven with prevention or addressing the determinants of mental health, they are distinct areas that require dedicated efforts. See *appendix 1: What is mental health promotion?*.

It will be a fundamental flaw if He Ara Āwhina does not make mental wellbeing promotion more visible given that it is a core component of *He Ara Oranga*.[1] If the framework does not sufficiently measure wellbeing promotion and prevention the Commission will not be honouring their role to ensure that *He Ara Oranga* is implemented, and the Commission will not be contributing to transforming our response to mental health, in fact it will be reinforcing some of the status quo biases. The MHF would welcome the opportunity to present to the Commission's Board and leadership on the role of good mental wellbeing promotion and its positive impact on tāngata whaiora, whānau and communities.

[1] "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." Page 15, *He Ara Oranga*.

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Scope and language

Related to our concerns above, we strongly recommend the Commission clarify the scope of the framework, including defining the term 'system'. We understand the Commission's intention is to have a broad scope that includes mental wellbeing promotion tools and resources as well as mental health and addictions services, support and help seeking. We recommend this is made explicit and clear. It would also appear the scope includes determinants that sit outside of the mental health and addictions sector, such as the justice system, the wider health system, and the many social, economic, environmental, and commercial determinants. You may wish to be clarify that the 'system' refers to both the factors within the mental health and addictions sector itself and those that sit outside the sector but have an external influence.

It would be helpful for the framework to identify the population groups that are more likely to experience poor mental wellbeing outcomes and are not traditionally well served by the system, and thereby warrant careful monitoring of how the system is meeting their needs in the future. *He Ara Oranga* identified 12 groups[2] and we would add Asian communities given their increasing suicide rate and high rates of mental distress.[3]

We recommend a statement upfront to make clear that all 'what good looks like' statements relate to all areas of scope, including mental distress, enhancing wellbeing, and harm from gambling and substance use, unless it is absolutely necessary to be exclusionary. As currently drafted, some statements are selective but could and should apply across the full scope. For example, 'Strategies are led by those of us with experience of gambling harm, alcohol harm, and harm from other drugs to eliminate the prejudice, self-stigma and discrimination we experience….' should also apply to mental distress and suicidal distress.

The description of 'whānau dynamic' could be made clearer by providing examples of what 'extending the boundaries of whānau centered' looks like in practise.

[2] Māori, Pacific peoples, refugees and migrants, rainbow communities, rural communities, disabled people, veterans, prisoners, young people, older people, children experiencing adverse childhood events, and children in State care.
[3] Wong, Sally F. 2021. Asian Public Health in Aotearoa New Zealand. Auckland: The Asian Network Inc.

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It is unclear how or if the framework applies equally to forensic mental health. Some outcome statements may not equally apply to forensic mental health, for example around positive risk taking (under 'safety and rights'). We recommend you clarify the scope in this regard.

2. **Is He Ara Āwhina missing anything that is important to you?**

The Framework does not **acknowledge suicidal distress as distinct from mental distress.** We see He Ara Āwhina as contributing to suicide prevention as much as it contributes to mental wellbeing outcomes - as *He Tapu te Oranga o ia Tangata* states "a transformed [mental health and addiction] system will support and work toward reducing suicide" (page v) and we recommend the framework explicitly acknowledge this. While the umbrella term 'mental distress' is useful, it may imply mental distress is the same as suicidal distress, or that mental 'illness' or addictions, in and of itself, leads to suicide. Modelling the correct language in a national framework document is suicide prevention in action.

We recommend **applying a 'COVID-19 lens'** and acknowledging the need for the system to be well resourced for a sustained response to the current pandemic and the unprecedented demand and strain it continues to place on the sector and workforce. The balance between the public health needs of tāngata whaioa (e.g., increased risk of infection, morbidity and mortality[4]) and the impacts of potential restrictions on access to kanohi ki te kanohi interactions with mental health and addictions staff and whānau are on-going challenges.

There are a number of other outcomes the framework could reference, and which align with *He Ara Oranga* and *He Tapu te Oranga o ia Tangata,* although we appreciate these might be addressed by other activities or levels of monitoring by the Commission. These include:

- strengthened cross-government collaboration and action
- safe reporting of mental distress, 'illness' and suicide by the media
- increasing community and health-based responses to acute mental health and suicide distress and crisis, and
- kaupapa Māori NGOs and services experience the same compliance requirements and equitable funding as mainstream providers.

[4] Mazereel V, Van Assche K, Detraux J, De Hert M. COVID-19 vaccination for people with severe mental illness: why, what, and how? Lancet Psychiatry. 2021 May;8(5):444-450.

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Specific comment on sections

Te Ao Māori Perspective: Mana Whakahaere

- "Te Tiriti o Waitangi is the foundation to develop legislation and policy" could be strengthened to 'Te Tiriti o Waitangi is the foundation of all legislation and policy."
- "Whānau are enabled to apply mātauranga Māori in the course of their work "- we are not clear how 'whānau' applies in the context. It may make more sense to instead refer to the workforce.
- "Environments where whānau Māori feel culturally safe are enabled to facilitate restoration processes, including pae oranga to address disparities inherent in criminal justice approaches." – this may fit better in 'mana Tangata' and/or it could be strengthened to support full reform of the criminal justice system so these disparities can be eliminated.
- "Whānau determine workforce needs, and barriers to equitable 'Mana Whakahaere' recruitment are removed, including lack of pay parity and processes that prejudice" - We also recommend an explicit outcome statement for an increase in the Māori workforce.

Te Ao Māori Perspective: Manawa Ora

- "Rangatiratanga is embraced in services, enabling mana Motuhake" – we recommend simply stating 'services embrace diversity of experiences, aspirations and needs for Māori'.

Te Ao Māori Perspective: Mana Tangata

- "Whānau experience support that prioritises wairuatanga and physical wellbeing" – this could be broader, such as 'prioritises holistic wellbeing - wairuatanga, physical, mental, emotional, and environmental wellbeing.'

Te Ao Māori Perspective: Mana Whānau

- We recommend you clarify what you mean by 'mauri ora' in this section. For example, it may refer to the definition of mauri ora (healthy individuals) in *Kia Manawanui Aotearoa* or a more generic reference to mauri ora that refers to the unleashing of this energy to actively support and create wellbeing.

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Share perspective: Equity

- We recommend this includes outcomes for a culturally safe mainstream workforce system, and service decision-making that is based on a culture of equity.

Share perspective: Participation

- The statement "When using services, we are leaders in our care and decision-making" could acknowledge the active duty services have to enable supported decision-making, such as providing access to the support tāngata whaiora need and want, available every day of the week and at any time of day.
- "Our feedback actively shapes community facilities, public spaces, support services, and policy" – we suggest using the term 'engagement' or even partnership rather than feedback to reflect that tāngata whaiora deserve to be actively supported (rapport and trust built, given time and space) to share their feedback.

Share perspective: Access and options:

- "Communities are enabled to develop and deliver their own responses to distress, trauma, harm from alcohol, other drugs, or gambling" – we recommended it includes a reference to 'responding to stress' or 'responding well to life's challenges' and building resilience.
- "Our options include kaupapa Māori, peer-led, trauma-informed, and family-based supports, harm reduction approaches, and access to community and home-based support" – this should also include low-stimulus environments (both in the community and in-patient units) and respite options. Tāngata whai ora and whānau told us they want to see more respite beds available for community mental health service users. Whānau saw this as a helpful way to transition tāngata whai ora from inpatient settings to the community and whare and to reduce admissions.

Share perspective: Safety and rights

- It would be useful to refer/footnote to the relevant rights, such as the Code of Rights and rights protected under the Mental Health (Compulsory Assessment and Treatment) Act.
- The framework could support timely access to complaints process where there has been a breach of rights, supported by legal and peer advocacy.

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- Tāngata whaiora have told us they would like an apology for past trauma, indignity and abuse in the mental health system, redress, and system changes so the cycle of trauma is broken. The framework could support suitable reconciliation avenues, such as confidential forums.[5]
- This section could also seek to achieve *timely* access to care, which is closely related to safety and effectiveness of care.
- We suggest the culture of the mental health and addictions system also needs to be *adaptable* to best practice, evidence and innovations; and where a certain level of *distress is tolerated*. Some of the success of alternative models to coercion documented in the 2021 WHO report were attributed to emotional distress, thoughts or even a plan of suicide not considered a medical emergency and where staff are trained to support people in these situations (e.g., Afiya House-MA, USA).

Share perspective: Connected care

- We assume 'social' services includes high equality employment-related support (e.g., individual placement and support), and education, income and housing support but given the importance of these services, and the poor integration of these support in the sector at present, we recommend they are specifically identified in the framework.
- We recommend an explicit reference to effective connection between mental health and other primary and secondary health services to address the systematic barriers to physical health equity for tāngata whaiora.
- The framework could identify an outcome of established and well-resourced pathways of care from early interventions through to specialist support, for example for perinatal mental distress and eating disorders, where we know there is a significant gap.
- It is not clear what 'critical thinking skills' are being referred to here. It might be helpful to link to critical thinking about personal and public/media perceptions of mental 'illness', understanding of risk, safety, and 'dangerousness'.
- This section could be strengthened with an outcome to actively support whānau (as opposed to 'whānau…find support'). Whānau have told us they

[5] Te Aiotonga https://ndhadeliver.natlib.govt.nz/ArcAggregator/arcView/frameView/IE12126512/http://www.dia.govt.nz/Ag ency-Confidential-Forum-for-Former-In-Patients-of-Psychiatric-Hospitals-Index

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would like more active help and support to navigate the system well. They have also told us they feel unprepared and unsupported to care for tāngata whaiora when they transition from an inpatient unit to the whare/community. This aligns with *He Ara Oranga* recommendations 23-25.

- Tāngata whaiora told us they would like more connection with their whānau, friends and community groups whilst in an in-patient unit. This connection would reduce the likelihood of institutionalisation and a better transition back to the community.
- We recommend an explicit outcome that tāngata whaiora have wrap-around support to transition between services (including between primary and secondary) and their community.

Share perspective: Effectiveness

- This section could include an outcome where physical settings or environments where care is delivered are 'appropriate', including being designed with safety and dignity in mind and supporting connection to self, culture and the taiao. This is an important contributor to the effectiveness of care.

Thank you again for the opportunity to provide feedback in the draft Framework. If you have any questions, in the first instance please contact Olivia Stapleton, Policy and Advocacy Manager, by email at olivia.stapleton@mentalhealth.org.nz.

Mauri tū, mauri ora,

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Appendix 1: What is mental health promotion?

Extract (page 5) from *Rationale and evidence for investing proactively in the mental health of communities: Using mental health promotion and wellbeing science methodologies.* Report from the Mental Health Foundation of New Zealand. August 2021.

https://mentalhealth.org.nz/resources/resource/investing-in-the-mental-health-of-communities

The purpose of MHP is to use a range of methods to keep people mentally well in their communities and normal lives wherever possible. When people are mentally well, they are not just free from mental illness, but are thriving and experiencing attributes such as optimism, vitality, meaning and purpose, high quality relationships and social engagement, contribution to society, emotional stability and resilience. This reverses the current dominant and policy narrative of 'mental health' being seen as a liability to be fixed, to one where mental health is a resource to be protected. This is consistent with the current World Health Organization definition of mental health as "the foundation for the well-being and effective functioning of individuals. It is more than the absence of a mental disorder; it is the ability to think, learn, and understand one's emotions and the reactions of others. Mental health is a state of balance, both within and with the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors participate in producing this balance."3

MHP does not have a service mentality, because it goes to where the people are in their community settings. MHP will generally see the people it aims to serve as having significant expertise (understanding their own experience and aspirations), so MHP programmes are not suited to exact replication into different populations.

Because of its flexibility, MHP is better suited to responding to the 'wicked problem' of protecting mental health in an increasingly psychologically challenging world. Wicked problems consist of social complexity, contradictory information and lack of clear cause-and-effect solutions.

MHP looks at population- and community-wide health rather than clinical outcomes for individuals, understanding that healthier populations will have fewer ill individuals.

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MHP recognises that the quality of people's mental health is a healthy balance of different life domains and therefore uses holistic health models such as Te Whare Tapa Whā.

MHP uses a multidisciplinary approach including public health surveillance, epidemiology, wellbeing science, social and positive psychology, behavioural economics, indigenous and crosscultural understandings of wellbeing, behavioural change science and nuanced skills such as mentoring, life coaching and storytelling.

MHP is effective through two general approaches:

1. *Responding to external threats to mental health and wellbeing, which are found in social and structural determinants and occasional population-wide shocks such as disasters and recessions.*

   These are best approached at the macro social-policy level, by advocating that all citizens have fair and equitable access to basic resources, healthy food, education and health services, and that minority groups are free from discrimination. The MHP tools are the social Rationale and evidence for investing proactively in the mental health of communities 5 policy levers that create a public service and social direction for the population that is fair, safe, reduces uncertainty, provides stability, social inclusion, supportive communities and opportunity. Reducing community and psychological stress at this level decreases risk factors for mental distress such as depression, anxiety and addiction problems, and creates stable living conditions where people can thrive and reach their potential. This approach is best led by MHP-informed central and local government in co-creation with communities, wherever possible.

2. *Creating opportunities to protect and grow people's internal psychological wellbeing and empower community wellbeing.*

   This involves recognising people's individual vulnerability to stress, level of healthy coping skills and extent of supportive interpersonal relationships. A range of mass media and social and individual learning methods can be used to change attitudes, behaviours and thinking styles that build resilience and empowerment. This approach can work very well when provided in a

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geographical area or other community with a shared identity. Existing community networks, sense of identity and 'ways of doing things' can be used to enhance social learning opportunities. Resilience can be built by spreading knowledge, hope and skills through communities, flowing on to individuals, creating greater personal agency and empowerment. These are psychologically healthy responses to stressful circumstances.

These two approaches are necessary in combination for effective mental health promotion. If only the first approach is applied, then the response tends to be top-down and negate people's agency to build resources of their own to deal with setbacks in life and define their own path to thriving.

Only applying the second approach can cause people to become disillusioned if their efforts to improve community and individual wellbeing is consistently undermined by harmful social policy, social exclusion or prejudice.

It is well accepted that unrelenting stress leads to, or exacerbates, mental health problems relating to depression, anxiety and addictions. Data from the New Zealand Health Survey shows lower socio-economic groups experience high levels of psychological distress. Other data shows indigenous populations and rainbow communities, facing higher chance of social exclusion through prejudice, racism and neglect, will have poorer mental health.

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