Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

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Tēnā koe Arran

MHF feedback on draft Mental Health and Addiction System and Service Framework 2022 - 2023

Thank you for the opportunity to comment on the draft Mental Health and Addiction System and Service Framework 2022 – 2023 ('the SSF'). We write to reinforce and build upon preliminary feedback provided to Sue Hallwright on 16 May.

The SSF has been positioned as the next phase of evolution from the *He Ara Oranga* report and subsequently *Kia Manawanui*. As the light bearer for delivery of the mental health and addiction system transformation within the new health system the SSF will be one of the most important tools employed to ensure the locality approach does in fact take a broad approach to mental wellbeing and decision makers place the mental wellbeing of their community at the forefront of actions.

We understand and fully support the commitment to align the SSF with the Mental Health and Wellbeing Commission's own He Ara Āwhina monitoring framework. The direction settings and monitoring mechanisms for the mental health and addictions system clearly need to be strongly aligned.

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Phased action and accountability

To increase the confidence of the sector that the SSF will culminate in tangible change and action, we recommend a 10-year phased plan of action or progressive targets as part of the initial Health Plan and refined in the 2023/24 Health Plan. We would expect to see, for example, a clear action enabling the SSF's components to be actively reflected in locality protocols and decision-making. Actions like these should be couched with a timeframe, a lead agency, investment stream, clear outcomes and milestones, reporting timeframes and accountability mechanisms so progress is clearly visible to the sector and public.

We recommend the SSF provide a clearer commitment that the Ministry of Health, Health NZ and the Māori Health Authority are required to adhere to and deliver on the content of the SSF (rather than the SSF 'give direction to' or 'guide' the work of these entities). Similarly, we recommend the SSF identify which entity/ies, such as the Ministry of Health and/or the Mental Health and Wellbeing Commission, will hold the agencies to account on their commitment to delivering on the SSF, with specific and regular reporting timeframes reinforced by the Health Plan.

Prevention and mental wellbeing

Kia Manawanui instructs us to think broadly about how to support the whole population to stay well (p. 25) but we are concerned the SSF, as whole, does not reflect the very deliberate and strong emphasis placed on the prevention and promotion aspects of *Kia Manawanui's* mental wellbeing framework. If the whakapapa of the SSF is to reflect and embed the intentions of *He Ara Oranga* and *Kia Manawanui* then it needs to strike the right balance across all three pou – "*prevent problems developing, respond earlier and more effectively and promote mental health and wellbeing…*". (p.15, *He Ara Oranga*).

To achieve this, we recommend:

1. **A new critical shift for prevention and promotion.** Currently, no critical shift adequately reflects prevention even though "all services will have a role to play in promoting wellbeing and prevent distress" (p.12) and mental wellbeing promotion is inappropriately merged into the critical shift 4: 'get in early to support whānau wellbeing'. Mental wellbeing promotion is not the same as help seeking, brief interventions or early intervention.

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Mental wellbeing promotion is activity that increases the factors that are likely to lead to 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/adaptable communities. It works to prevent mental distress and to support those experiencing distress and recovery.

2. **A new 'wellbeing' system-wide principle** to support the shift towards preventing mental distress and promoting mental wellbeing, in line with *Kia Manawanui*'s holistic and population-based mental wellbeing framework.

We appreciate and support the various references to mental wellbeing promotion at national and local levels.

Scope

We suggest the SSF clarify upfront that its scope applies to mental distress/illness, wellbeing, addictions, suicidal distress/suicidality and substance-related harm. We recommend there is consistent use of the agreed terms throughout. It is not clear if the scope includes gambling-related harm. We recommend it does, noting the draft He Ara Āwhina framework includes a broad scope to this effect.

We recommend the SSF define the scope and intent of what is meant by 'system' so it is clear which organisations, providers and networks are required to adhere to the SSF.

Context and evidence base to drive decisions

We understand there has been a significant undertaking to explore the current context and available data to help inform decision-making about the content of the SSF. We recommend this information be provided as part of the final SSF, for example as an appendix, to justify the rationale behind the core components of the SSF. At a minimum this should include demographic trajectories, rates of psychological distress, status of wellbeing indictors, inequities, demands and pressures on the system, workforce including the peer workforce capacity and capability trajectories, and innovations. Where important contextual information is not available, for example, in depth national data on mental distress prevalence, this needs to be acknowledged. See our comments on enablers: information.

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Core concepts

The definition of 'mental wellbeing' identifies appropriate aspects but could be strengthened with a reference to health literacy and by incorporating other aspects of different theoretical approaches to positive psychology including engagement, interest, positive emotions (good emotional balance), vitality, self-esteem, optimism, and self-determination (sense of agency). We also note feedback from the Canterbury DHB Public Health Unit that the concept of resilience is moving away from locating and identifying adversity as a necessary condition, with a preference for the term 'adaptability' and 'adaptation' as a more realistic objective/outcome. This sees wellbeing as a collective experience and resource with many determinants beyond the individual, and that does not require adversity to measure whether a person (or community) is resilient. This was a key learning for communities and populations following the earthquakes in Canterbury. You may also wish to reference other models of mental wellbeing such as Te Whare Tapa Whā, which embodies social, physical, spiritual and cultural wellbeing.

Commitment to Te Tiriti o Waitangi

The upfront recognition and explicit commitment to Te Tiriti o Waitangi is appreciated. We suggest an explicit reference (and ideally action) to address/eliminate institutional and interpersonal racism. The next step will be to transform these sentiments into tangible actions and targets with clear outcomes. We hope this will be the focus on the initial Health Plan and refined in the 2023/24 Health Plan.

System-wide principles

Overall, we believe the system principles are too heavily based on a deficit model and have been written with services in mind, for example, there are several references to 'care' and 'services.' As discussed above, the 'system' (and the principles that guide the system) must not only support commissioning services but also robust prevention and promotion activity.

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We make the following comments on the specific principles.

Whānau- and person-centred	• We support this principle, but recommend its description and application be broader than 'care'. • This principle may mean different things to different people and communities – we recommend a clearer picture of what the principle means in practice. • We are concerned the reference to 'shared decision-making' may detract from the principles of supported decision-making. • This principle could helpfully be expanded to capture and support the voice and rights of lived experience communities within the system too.
Equity-driven:	We recommend including equity of access to physical healthcare for people who experience mental health issues or substance-related harm.
Human rights:	We recommend naming the conventions Aotearoa New Zealand has ratified.
Accessible:	Accessible should also mean providing services to people where they are, such as in their homes and in communities.
Anti-discriminatory:	We suggest this principle seek to 'eliminate' rather than 'reduce' discrimination, including diagnostic overshadowing.
Collaboration and innovation	We recommend an explicit commitment to collaborate with the whole of government to prevent mental distress by addressing the determinants of mental illness and distress.

Practice principles for all services

We broadly support these practice principles. The principles could be expanded to reinforce:

- the importance of a whole-life-course approach and theory,
- services need to be connected and joined up within health e.g., primary and secondary, and across sectors e.g., employment and housing, and
- services must support or be able to connect whānau with supports that enhance wellbeing through mental wellbeing promotion and prevention.

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Some of these concepts are carried through in other parts of the document but they appear disconnected from the guiding principles (see page 12 for our comment about integrating all components of the SSF).

You may wish to consider the role of kaupapa Māori principles here for services and in the delivery of clinical practice such as manaakitanga, whanungatanga, wairuatanga, whānau, and tino rangatiratanga. These themes came through strongly when the MHF talked to people with recent experience of mental health services about what needs to change. Such an approach would demonstrate evidence of Māori values and expectations influencing and holding authority in the policy processes.

We make the following comments on the specific principles.

Recovery-oriented:	We suggest the description of 'recovery-oriented' be reviewed to ensure it fully connects to understandings of the recovery movement.
Harm reduction	We support the Equally Well amendment: 'prevent and reduce avoidable harms from substance use… *and unrecognised and untreated physical health issues'*.
Suicide prevention:	In line with *He Tapu te Oranga o ia Tangata*, please extend this to include 'supporting people bereaved by suicide' too.
Strengths-based:	• We suggest adding a reference here to 'supported decision-making' and stating that service responses must be compassionate and culturally responsive. • The reference to compulsory treatment being 'rare and brief' appears to pre-empt policy decisions regarding the new mental health legislation. The system and service changes to support the law change will be vital and must be intentional and embedded. See comment on page 12.

Critical shifts

We broadly support there being a limited number of critical shifts, and notwithstanding our recommendation for an additional shift for prevention and promotion (pages 2-3) we support the general categories chosen.

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Additional critical shifts that could be included, or where existing shifts could be extended, relate to dignity and perceptions of safety (which can encompass respecting autonomy, supported decision-making principles, ending solitary confinement etc), high trust models to support communities and NGOs to deliver services, and a stronger emphasis on harm reduction.

We make the following comments on each critical shift.

Te Tiriti o Waitangi	• We suggest an explicit reference to Māori leadership, including Māori lived experience leadership, and for Māori to lead or partner in decision-making (not inform). • An action from this shift should include consistent acknowledgement in decision-making of: the cumulative impact of pre-existing, historic and generational impacts of colonisation; the impact of cultural alienation; and affirmation of indigeneity, and the importance of cultural as well as clinical approaches to wellbeing, and emphasising ties to whānau, hapū; actively address systemic racism within services and reference to a culturally competent workforce and cultural safety for Māori in mainstream services. • See comment above about high trust models which is a particular barrier faced by Māori providers.
Design out inequities	• We suggest an explicit recognition of people with disabilities and what will change for them. • We suggest a recognition here of intersectionality of inequity i.e., the overlapping and interdependent systems of discrimination or disadvantage, and how this will be considered. • 'People who have high and complex MH&A needs will have ready access to effective general health services, including comprehensive primary care teams'…we support the Equally Well suggestion for the additional sentence of *'Shared care arrangements which provide holistic support across MH&A services, general health and primary care will be the norm not the exception'*.

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Build peer-led transformation	• We recommend 'what will change' include a commitment that services will be co-produced with tāngata whaiora. • 'Lived experience and peer leadership will be strengthened across the board…' – this should include within decision-making. • Peer-led transformation should be supported by nationally consistent infrastructure and investment.
Get in early to support whānau wellbeing	• 'Recognising that whānau wellbeing is essential to individual wellbeing' – whānau wellbeing is important in and of itself, without needing to justify it with a westernised concept. • 'Actively involving whānau'. This is critical and very much needed. Whānau know their loved one the best and can guide services as to how they can be the best support the individual. • We fully support the increased emphasis on the first thousand days of life. We note the Ministry of Health's maternal mental health service stocktake notes the SSF will provide "opportunities to ensure that maternal mental health is considered in a holistic manner across the continuum of care and need." The current draft notes specialist mental health services and parenting supports but should list other essential gaps identified by the stocktake such as kaupapa Māori models specifically tailored for maternal mental health, respite services and boosting the capacity and capability of the maternal mental health workforce. • We support defining young people as up to 25 years.
Connected, locally driven networks	• Instead of 'cross-sector supports' please explicitly name employment, income, education and housing supports and recognise these must be *seamlessly integrated* into primary mental health and addiction services. • Include 'hospital, *general health* and MH&A services'. • 'The future system will be digitally enabled, with virtual access to advice and specialised expertise that is not available locally.' – we recommend this is couched with 'appropriate checks and balances to ensure safety and efficacy'.

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	• 'Specialist mental health and alcohol and other drug services will work seamlessly together…' please emphasise we need *separate* mental health and alcohol and other drug facilities, which *work seamlessly together*. • Include effective and routine discharge plans for tāngata whaiora and their whānau to support transitions between residential and inpatient care and community and home care. This needs to include support for housing needs. We recommend the SSF support government commitments[1] to improve transitions for people leaving IPUs to receive housing support, which has not progressed sufficiently.[2] • Recognise local informal and formal peer networks and their role in supporting people at all stages, from crisis through to recovery journeys.
Do whatever it takes: Choice and control	• We recommend a stronger focus here on self-determination and supported decision-making. • 'There will be more service choices, including…' – we would include in this list employment, education, housing and income support; peer-led acute alternatives; respite services; and community-led crisis solutions. • We recommend including more support and navigation for whānau who are supporting a loved one with mental distress, and strengthening whānau inclusive decision-making and responses as options and approaches.

Future services

The mental wellbeing networks sound promising, but it is unclear how these networks will operate and make local decisions under the very broad remit to 'support… communities to strengthen their collective mental wellbeing…and address the broader social determinants of health', nor what actions they will undertake or how they will make a difference to the current landscape. It will be important for the SSF

[1] Action: Improve transitions from acute mental health and addictions inpatient units (p.39) https://www.hud.govt.nz/assets/Community-and-Public-Housing/Support-for-people-in-need/Homelessness-Action-Plan/271a3c7d79/Homelessness-Action-Plan.pdf
[2] https://www.stuff.co.nz/national/politics/300362410/government-plan-to-move-mental-health-patients-into-housing-helps-just-three-people-in-18-months

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to provide this information. We recommend the SSF describe visually where these networks fit within the service landscape diagram.

Service landscape

Prevention/promotion: We recommend the SSF provide an indication of how promotion and prevention work will be undertaken. It is the view of the MHF that implementation should focus on targeting a specific community and that planning, stewardship, and community engagement of mental wellbeing promotion should be devolved to the NGO and community sector. The government's role is to provide an overarching strategy, operational framework, and investment. Also see our comments below about eliminating prejudice and discrimination.

Multi-locality services: Multi-purpose teams and multi-skilled staff is a good approach in principle, but the SSF should identify how the system will ensure the model and reliance on multi-skilled staff is practicable and safe for staff and tāngata whaiora.

National consultation liaison services: We suggest these services also provide support to rural populations and migrant communities in general. It might also capture people with disabilities if there is not the critical mass in a population.

We have identified the following services as missing from the service landscape.

National	• Services and supports relating to gambling harm • National campaigns to address prejudice, stigma and discrimination in relation to mental distress, gambling and addiction challenges • Inpatient beds for eating disorders (expanding on the current total of 27 beds). The SSF currently only lists eating disorders in residential and community settings.
Regional	• Rural services • Residential mental health and AOD services and respite for mothers and babies
Multi-locality	• Community-led solutions to mental and suicidal distress and crisis in the community • Whānau support *and navigation and education* • Comprehensive physical health checks, screening and support

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	• Mental health and AOD respite services • Peer advocacy and peer networks • Integrated employment, income, education and housing support • Specialist maternal MH *and AOD* (0-4 years) • Maternal mental health support interface with maternal care sector (0-4 years) • Education-based services (12-24 years) • AOD services in the 65+ age bracket, as well as community support and peer support options

System enablers

It is unclear why 'policy' is not listed as an enabler as it is in *Kia Manawanui.* The SSF applies to the Ministry of Health, which holds the policy and regulatory functions of the health system, and critical strategy documents such as the SSF and the upcoming mental health law change create significant policy shifts that will impact service provision and clinical practice and culture.

Leadership	'the voice of lived experience being strongly represented among leadership' is vague and passive. We recommend 'lived experience and peer leadership at all levels, including Māori lived experience…'
Investment	• We support progressively increasing and prioritising investment in the system of services, and investment based on Te Tiriti, epidemiology/needs, population characteristics and gaps in existing services and investment. We also recommend investment is apportioned equally across the three areas supported by *He Ara Oranga* recommendations: prevention, promotion and early intervention. • We recommend a clear long-term investment strategy to support delivery of the Health Plan.
Workforce	• This enabler should incorporate delivery of a culturally safe workforce, and investing and growing the wellbeing promotion workforce. • 'expanded Māori and peer workforces playing an essential role in transforming the mental health and addiction system, with recognition and active support for their roles' –

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	this could be reframed as an active commitment to investing in and growing the Māori and peer workforces. • We recommend a thorough workforce assessment to assess capacity and capability against need/volume/complexity. • As well as redesigning the workforce we recommend also developing the capacity of the workforce, which is a fundamental problem in the existing system.
Information	• We strongly recommend a commitment to obtain an evidence base to understand the current level of need in Aotearoa whether that be prevalence data or other methods. This information is an essential enabler to system transformation and to guide investment decisions (see *He Ara Oranga* recommendation). • We recommend strengthening the link between a) gathering information about how the system is performing and improving lives and b) then using this data to monitor and evaluate the system and make on-going quality improvements.
Technology	• As well as 'assessing against a standard' we recommend careful monitoring, regulation of unsafe digital tools and quality assurance to ensure safety and efficacy. • The use and expansion of health technology must be accompanied by actions to address inequity of access and actively support people with low access to digital resources (e.g., older people, people without devices, families sharing devices).

Other comments

As a general comment we feel the SSF could better integrate the various components of principles, critical shifts, and enablers and to demonstrate how they will drive system change and the new service landscape. It will be important that all components of the SSF can be monitored and supported.

We recommend the SSF build in a period of review so that it can be updated to reflect the policy decisions and direction of the new mental health legislation. The success of law reform implementation will rely on parallel system and service changes that will need to be guided and reinforced by the SSF.

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Finally, the SSF is currently silent on how it will embed and progress actions in *He Tapu te Oranga o ia Tangata*, the national suicide prevention strategy and action plan. The system must continue to evolve to support our national suicide prevention and postvention aspirations. For example, there are opportunities here to explicitly enable communities to nurture and support their whānau and families and community members when they are experiencing suicidal distress, workforce capacity and capability, the peer support workforce, and a national quality framework for monitoring and managing suicidal distress and behaviour.

Thank you again for this opportunity to provide feedback. We appreciate the extension to the public consultation and the various opportunities to meet and share the MHF's views on this important document.

Mauri tū, mauri ora,

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