Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

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Partners in Care
Health Quality & Safety Commission
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Tēnā koe

Health Quality and Safety Commission draft code of expectations

Thank you for the opportunity to be provide feedback on the draft code of expectations. We apologise for the late submission and hope that it can still be considered.

We are supportive of the intention of the code, however, we make a number of recommendations to clarify the scope of the code, accountability structures and implementation pathways, and strengthen the language of the code.

We support the submission developed by Magdel Hammond on behalf of the Lived Experience Team – Mind and Body and Emerge Aotearoa, in particular the need for participation and engagement to be by choice, and that the lived experience engaged with is as near as possible to the expertise needed.

1. Te Tiriti o Waitangi

We acknowledge the strong reference to Te Tiriti o Waitangi and principles. As currently drafted, the code separates Te Tiriti o Waitangi principles from the general values of the code. This creates some disconnect, for example, under the 'equity' value, there is no specific reference to Māori, which would seem to conflict with Te Tiriti of Waitangi principles. We recommend strengthening the connection between the values of the code and Te Tiriti o Waitangi and its principles. Alternatively, models such as the Mental Health and Wellbeing Commission's He Ara Oranga Mental Welling Outcomes Framework provide a separate Māori perspective and a shared perspectives, an approach that may help strengthen each component of the code.

2. The broad scope of the code is challenging

It is very helpful that the code's definition of 'consumer' includes an explicit reference to mental health and disability services.

In line with Te Tiriti o Waitangi and the equity principle, you may wish to consider framing the scope of the code with a focus on consumers/population groups that are more likely to experience poorer health outcomes. This will include, for example, Māori, Pasifika, ethnic minority communities of colour, people living in poverty, people with experience of mental distress or 'illness' addictions and harm from substance use, disabled people, immigrant populations, people with refugee backgrounds and rainbow communities.

More clarity is needed around what and who the draft code applies to. The purpose refers to 'health and disability service providers and organisations' but other parts of the draft refer to 'Health services and the system.' We also note the Pae Ora (Healthy Futures) Bill, which sets the legal mandate for the 'Code of Consumer Participation', states specifically that it is health entities that must act in accordance with the Code when engaging with consumers. It is our view that a helpful outcome from the establishment of the code would be to direct the way new health entities (Health NZ and the Māori Health Authority) engage with consumers as part of the significant design and commissioning of new services and models of care. As such, we recommend the code apply to all health and disability service providers and all health entities that undertake governance, leadership, commissioning, design, planning, development, delivery, measurement, and evaluation.

We are concerned by the intention to apply the code to 'direct care'. Health care and treatment is already covered by the Code of Health and Disability Services Consumers' Rights and, if the code also applies to consumers using health and disability services for care and treatment, it may lead to sector and consumer confusion about the purpose and application of the two codes. It may also be unclear how the two codes would interact where there is a conflict. For example, we would be concerned about the use of 'shared decision making' as it applies to 'direct care'. 'Shared decision-making' does not sufficiently provide for, in this context, self-determination and maximum autonomy principles like the concept and practice of 'supported decision-making'[1], which is endorsed by the Code of Health and Disability Services Consumers' Rights. The use of the term 'shared decision-making' in the context of direct care may also undermine advocacy efforts to

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[1] At its most basic supported decision-making can be defined as requiring all forms of support, including the most intensive, being based on the will and preferences of the person concerned

embed supported decision-making principles into Aotearoa's mental health laws, guidelines and clinical practice.

Finally, to any avoid confusion and doubt, we recommend the final code specify how it relates to the Code of Health and Disability Services Consumers' Rights and the Health Charter.

3. Clarify and strengthen the language of the code

Some statements in the code are vague, for example, 'There is a clear commitment to achieving equity of health outcomes' and 'Health services and the system recognise engaging appropriately with consumers/whānau will support appropriate responses to greater health need….'. We recommend the code provide guidance about *how* service providers and health entities must demonstrate adherence to these principles/values, such as through explicit accountabilities (see point 4) and exemplars or case studies of these principles/values working well in practise.

The code refers to co-design of interventions, processes and measures. We recommend the use of 'co-create' and co-produce to recognise, in line with the advice from the Wellbeing Coalition Aotearoa and Balance Aotearoa.[2]

4. Clarify accountabilities

Overall, the language of the code is not compelling. While we acknowledge the code is not legally enforceable, it should be framed in strong active language (e.g., 'providers must…') and, as an absolute minimum, a requirement that the principles/values of the code must be embedded into policies and procedures, contract service specifications and enforceable through auditing process and functions.

5. Clarify implementation pathways

We recommend communication about the final code clarify a) how and when service providers and health entities must implement the code (see above) and b) how consumers will be made aware of the code, and whose role it is to communicate the code to consumers.

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[2] Co-design is only one phase of a larger collaborative improvement process (design, development, delivery and evaluation) that is better captured in the terms co-production or co-creation. https://www.balance.org.nz/images/Home-WBC/Report_-_Lived_experience_and_whanau_response_to_MHA_inquiry_17_Feb_2019.docx

We recommend the final code include a clear programme logic to help measure effective behaviour and culture changes, and consumer outcomes, as a result of the code.

6. Discrimination and prejudice

We recommend the 'Relationships of mutual respect' value acknowledge the barrier that prejudice and discrimination may pose in participation, engagement and partnership, and require service providers and health entities to actively address this barrier, for example, through workforce training and power of contact[3] models.

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

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive Officer

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[3] https://www.likeminds.org.nz/assets/National-Plans/1power-of-contact.pdf