A society where all people flourish
a submission to the Government Inquiry into Mental Health and Addiction – Oranga Tāngata, Oranga Whānau
from the Mental Health Foundation of New Zealand

Thank you for the opportunity to comment on the Government Inquiry into Mental Health and Addiction – Oranga Tāngata, Oranga Whānau. This submission is made by the Mental Health Foundation of New Zealand (MHF).

We consider that New Zealand needs:
- a new paradigm for understanding mental health
- a clear strategy and effective, well-connected leadership
- oversight through an independent Mental Health and Wellbeing Commission
- a clear, accountable national structure for operational delivery
- a broad range of services and supports that meets individual needs
- increased capacity of whānau and communities to build wellbeing and support people through distress
- local research about what works

Introduction
The MHF welcomes the Inquiry – we sees it as an opportunity to completely rethink government and society’s approach to mental health over the longer term.

Over the last three decades, New Zealand has moved from an institutional asylum model of care to a medical service model that provides support to people in hospital and community settings. Within our mental health services, there are thousands of people working hard to support people through times of mental distress and helping them to recover. Public awareness campaigns have made it more acceptable for New Zealanders to talk about mental health problems, to seek help and to support each other. People who experience distress have clearer legal protections against discrimination at work and in their everyday lives, and now have their rights described in the Human Rights Act, the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Declaration on the Rights of Indigenous Peoples.

During this time, our national understanding about mental health has developed, through progress in research and scientific explanations of distress, advancement of indigenous models of care that incorporate matauranga Māori and traditional Pacific knowledge, development and strengthening of the peer workforce and lived experience leadership, and changing social understandings of diversity.
The pressures that have led to the need for this Inquiry are immediate and obvious. Our growing and changing population, increased awareness of mental health issues and changing pressures in society are increasing demand for services and raising challenges for communities. People who use, and work within, mental health services have been vocal about the need for change over many years. The limitations in our current system have been made clear by research, mental health and suicide statistics, mortality reviews, service investigations, regular monitoring data and advocacy led by people with lived experience of distress and addiction.

The time is right to review our national understanding of mental health and seek to shift the paradigm away from medical model focused on risk and deficit, towards a social model that recognises and promotes positive mental health, and provides meaningful support to people when they experience distress.

We support evidence based adjustment of current service models of mental health, as part of the transition into the future and to alleviate current service pressures. But what Aotearoa really needs is a vision and strategy for the future based on a complete rethinking of the mental health support needs of communities. This needs to be combined with the opportunity to create optimal wellbeing as a country, through thriving communities, and resilient individuals.

A new paradigm for understanding mental health

We see that New Zealand needs a broad approach, informed by principles of public health, to promote mental health and wellbeing, prevent distress and support people to recover in ways that maintain their dignity and autonomy. This approach needs to be based in an understanding of the centrality of social drivers of wellbeing and distress at an individual, whānau and population level. This contrasts with our current national approach which is largely focused on medical understandings of distress as mental illnesses or disorders, and individual treatment models including significant use of compulsory treatment.

We understand mental health as a positive state of emotional and psychological wellbeing. As defined by the World Health Organization, it is “a state of well-being 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.” Mental health is not defined by the absence of experiences that are understood as symptoms of illness. The experience of wellbeing includes self-acceptance, mastery, warm relationships, vitality, optimism, a sense of meaning and purpose, positive affect, resilience, contribution and accomplishment.

Mental health is a positive resource that every New Zealander should have access to. Positive mental health leads to increased creativity, better social relations, increased productivity and better physical health. The mental health of individual and whānau can be maximised and protected throughout their lives. It needs positive social conditions and adequate personal resources to flourish.

We understand distress as a common part of the human experience, and “a recoverable social, psychological, spiritual or health disruption” rather than a permanent health deficit. Support should be available to guide people through human experiences of distress, rather than being focused on treating symptoms of diagnosed disorders. Our support systems need to understand distress in broader terms than diagnostic frameworks and health paradigms. For these reasons we avoid the framing of distress as ‘mental illness’, and encourage language that acknowledges individuals’ social and psychological pain, and defines their experience using their own frames of understanding. We
would like to see greater public debate about current diagnostic labelling, its cultural biases and flaws, and exploration of more appropriate alternatives.

We see recovery as possible and meaningful, and see the need for recovery-focused support that is therapeutic, rights-based and well connected with individuals’ support networks and life contexts. As well as providing safe, effective and culturally-relevant support services, our approach to supporting recovery from distress should include building individual and whānau resilience, enabling self-care and strengthening the capacity of communities and whānau to support each other.

Within this framework, we see people with lived experience of recovery as holding important expertise that can help inform and guide others. This expertise should be central to provision of individual peer support, design and delivery of support systems, and leadership of our national and regional responses to mental health and addictions.

The social determinants of mental health are social, cultural and economic factors that contribute to mental distress and create barriers to achieving optimal mental health. In New Zealand, these include:

- Ongoing effects of colonisation and intergenerational trauma for Māori
- Substance use, alcohol, addictions and drug policy
- Social exclusion (through discrimination, racism, homophobia and transphobia)
- Chronic social stress and loneliness
- Family violence and adverse childhood experiences
- School and workplace bullying
- Sexual harm including child sexual abuse
- Poverty, debt, unemployment, homelessness and economic inequalities
- Incarceration and justice policy
- Physical health including sedentary lifestyles, sleep patterns and nutrition
- Changing technology, online social connections and patterns of information consumption
- Unequal access to healthcare (because of geographical differences, institutional racism and discrimination, and diagnostic overshadowing – that is overlooking the mental health support needs of people who have a diagnosis of physical illness, are disabled or experience addiction)

The causes of wellbeing are similarly social, cultural and economic, and include:

- Supportive social communities
- Supportive families and whānau
- Physical and psychological safety
- Stable housing
- Meaningful work
- Financial security
- Cultural identity and engagement (for example access to reo, whenua and whakapapa for Māori)
- Good physical health, and regular physical exercise
- Mindfulness practices
- Positive cognitive appraisal
- Emotional regulation skills
A clear strategy and effective, well-connected leadership

Strategy and action plan
To enable the change that is required, New Zealand needs a high level strategy that clearly articulates our approach to mental health and wellbeing. There should be a statutory requirement for a cross-government mental health, wellbeing and addictions strategy to be developed that would sit alongside the legally-mandated Health Strategy and Disability Strategy.

The strategy needs to value mental health as a positive resource that every New Zealander should have access to, which can be maximised and protected throughout life, and needs social conditions and personal resources to flourish. It needs to recognise distress as common, recovery as possible and meaningful, and people with lived experience of recovery as holding important expertise that can help inform and guide others. The strategy needs to articulate hope, confidence and commitment to continually learning and improving.

It should be based in principles of:
- upholding Te Tiriti o Waitangi and addressing New Zealand’s colonial legacy
- respecting human rights, dignity, self-determination and autonomy
- eliminating inequalities in mental health and addictions outcomes
- being guided and led by lived experience perspectives
- systems that are based on human connections, belonging and purpose

Alongside the strategy, a long-term plan of action is needed that is well resourced and includes mechanisms to continuously evaluate and learn from research and practice. The plan should include actions at multiple levels: social policy reform, wellbeing promotion and population level public health initiatives, cross government and community-led responses to promote wellbeing and support people through distress, research and evaluation, and delivery of joined-up social and medical support to individuals and whānau.

Connected leadership at multiple levels
To guide this, leadership and action is needed at national, local and whānau levels, by people in a range of roles. Strong, well-connected leadership is needed to coordinate our national approach:

- **at Ministerial level**, with a named Minister responsible for mental health and wellbeing, and a cross-Ministerial structure that includes relevant portfolios (such as Education, Justice and Corrections, Work and Income, Oranga Tamariki and Te Puni Kōkiri).
- **across political parties**. While we welcome debate across the political spectrum, we want to see a cross party approach to mental health from our political leaders that avoids using the issue of mental health as a political football, or a device to discredit other political parties to cynically win votes. Improving the mental health of New Zealanders must have a long-term plan that survives terms of government.
- **at policy level**, with strong cross-agency oversight (for example, from the new Mental Health Commission) and a clear collaborative, coordinated approach across all relevant agencies.
- **outside of government**, with approaches led at community level that are well connected with the national vision and strategy, and contribute to developing the local evidence base. We need collective leadership across the health, social, business, education and community sectors to work together to bring a range of perspectives from Te Ao Māori, diverse communities and social groups, wellness practitioners, health promotion, researchers and people with lived experience of distress. A range of different skills, resources and ways of
thinking are needed to address mental health from a social model rather than an individual medical treatment model.

- space for **communities and individual champions** to contribute to a shared vision.
- linked with **international leadership, research and action**. Many trends that we see in New Zealand relating to mental health and wellbeing are common across high income countries. New Zealand’s population is rapidly diversifying, and the mix of mental health supports needed will change in response to changing population stressors, cultural mental health issues population-specific issues. New Zealand’s response to mental health can learn from international knowledge and practice.

### Lived experience leadership

At each of these levels, our national approach needs to value and include leadership from people with lived experience of distress, suicidal behaviour and suicide bereavement. Lived experience leadership needs to be resourced beyond the existing peer workforce, and have influence at all levels to define and guide the required change.

People who have experienced distress or addiction, including those who have used mental health and addiction services, have a critical role to play in sharing experiences and insight about what was effective for their recovery, the impact of service delivery approaches and actions, and what is needed to support prevention and early intervention. In developing approaches for the future, we also need to acknowledge and learn from failures, including historic abuse associated with institutionalisation, and current over-use of compulsory treatment, seclusion and restraint.

### Oversight through an independent Mental Health and Wellbeing Commission

It has already been signalled politically that it is intended a Mental Health Commission will be re-established following the Inquiry to help guide change in our mental health systems. We welcome the establishment of an independent body to monitor and guide the change in mental health that is needed.

We consider that the commission should be the guardian of the strategy, with oversight over the plan of action. It should explicitly have a focus on wellbeing, and have as its goal the achievement of psychological wellbeing or optimal mental health for all New Zealanders, rather than solely focusing on distress and the treatment of medically-framed ‘mental disorders’. This should include addressing structural and social barriers to achieving optimal mental health, prioritising the needs of Māori and other populations who are most likely to face barriers.

Given this broader focus, it may be appropriate to name this new body the Mental Wellbeing Commission or the Mental Health and Wellbeing Commission.

Governance of a Mental Health and Wellbeing Commission would need to be based on a bicultural approach across all areas of their mandate, and include experts and leaders in the fields of wellbeing science, addictions, social psychology, social inclusion, suicide prevention, matauranga Māori and cultural understandings of mental health and wellbeing. This should include people who have lived experience of distress and addiction, and have used public services and resources relating to mental health and wellbeing.
We consider that the Commission should have eight broad mandates:

1. **Oversight of the social determinants of mental health** – that is the risks from factors that contribute to mental distress and create barriers to achieving optimal mental health.

This oversight should include an overt framework of policies that address population drivers of poor mental health, including a focus on inequities for Māori and other population groups, as outlined earlier in this submission.

The Mental Health and Wellbeing Commission should monitor the implementation and effectiveness of this framework, and have the ability to recommend changes to the policy and service responses that address these issues.

2. **Oversight of the holistic support options available for people experiencing distress** that are provided by government, local service providers and communities. This should include:
   - Supporting service innovation
   - Measuring quality, safety and ease of access
   - Ensuring cultural equity in use and ownership of services
   - Ensuring lived experience leadership and adequate access to peer-led models of support
   - Ensuring that service providers work well together so that a person experiencing distress gets connected, context-specific support for their medical needs, housing, family wellbeing, employment and education as relevant

3. **Oversight of actions and opportunities to increase population wellbeing.** This should include:
   - Promoting initiatives and actions to build resilient and inclusive communities, and health-promoting environments including schools, workplaces and communities
   - Influencing behavioural norms toward mentally healthy behaviours
   - Championing evidence based self-help activities that improve mental wellbeing and reduce mental distress
   - Maintaining an overview of wellbeing research and influencing the national research agenda

4. **Focusing on children and youth** to mitigate increasing problems in this age group and the follow-on into adulthood, working closely with the Office of the Children’s Commissioner. This should include oversight of:
   - Economic supports to families
   - Changing social norms to better support parents and positive parenting
   - The quality of care and education in early life
   - Enhancing parenting skills to promote health childhood development
   - Interventions that lessen harms and prevent future risk, such as providing safe and supportive school environments that are free of bullying and discrimination
   - Identifying and mitigating the harms of social media, advertising and consumerism on children and young people.

5. **Focusing on Māori**, reflecting the disproportionate burden of mental distress and suicide experienced by Tangata Whenua, the Māori-specific responses required to address this, and the Crown’s responsibilities under Te Tiriti o Waitangi. This should include:
   - Championing indigenous solutions such as the *Turamarama Declaration* and *Turamarama ki te Ora: National Māori Strategy for Addressing Suicide*.
   - Strengthening whānau, hapū and iwi, encouraging Māori service innovation, and building mainstream services that are inclusive and relevant for Māori.

5. **Oversight of changes to the Mental Health Act** towards a framework that better protects people’s rights and minimises compulsory treatment and coercion.
6. **Oversight of specific responses to reduce the pathway of poor mental health to prison**, and to mitigate the damaging effects of prison and the justice system on the mental health of those who interact with it.

7. **Monitoring the expenditure and results of the national operational structure** that would purchase services, build community partnerships and identify community wellbeing capital.

**A clear, accountable national structure for operational delivery**

The Inquiry should consider the agencies and structures that are best placed to lead the provision of population wellbeing promotion and support for people experiencing distress. An effective operational structure is needed that focuses specifically on creating better mental health across the New Zealand population, by reducing illness and distress and increasing wellbeing.

Just as a wide range of social, cultural and economic factors influence mental health and wellbeing, a range of socially oriented supports are required to assist individuals and whānau through recovery from times of distress and mental health problems. Medical or clinical support can form one important part of this support, but should not be dominant.

Moving away from diagnostic medical definitions of mental health problems and medically-defined symptoms, and focusing more on individuals’ full experience and context allows for a fuller response that may include elements such as practical support with housing, employment and income, support to re-integrate into education or work settings after an experience of distress, support to build whānau cohesion and social connection, spiritual and cultural support that acknowledges different understandings and values placed on experiences of distress, peer support, counselling, and medical approaches including psychology and psychiatry. Support for individuals and whānau would be embedded in a context of community-wide promotion and action to reduce stigma and discrimination associated with distress and increase social inclusion.

The commissioning, funding and coordination of such supports must be rooted in a holistic understanding of mental health, including wellbeing, distress and recovery. Supports should be delivered across a range of community, health and social service organisations, and would not all be conceptualised as health services or funded by Vote Health. Delivery would require effective inter-agency ways of working.

While current approaches to mental health are led by Health agencies – the Ministry of Health and District Health Boards – it may be difficult for these agencies to work outside of medical paradigms, and to collaborate across sectors to promote wellbeing, address social determinants of health and create coordinated wellbeing supports for individuals and whānau.

Consideration should be given to shifting funding from these agencies and developing non-health based structures, or to having a much stronger and more explicit public health or population wellbeing approach that does not prioritise clinical practice and treatment over social wellbeing, recovery and health promotion.

An operational structure would need to be responsible for:

- Purchasing the right mix of national, regional, and local medical and social services for people with ongoing mental health problems, people in crisis, and people experiencing distress or addiction. These services would be purchased from DHBs, non-government organisations,
Primary Care Organisations, community leaders and the private sector using integrated approaches to service cooperation and individual pathway models.

- Ensuring multiple access points and a range of options for people needing mental health and addiction support.
- Building the right partnerships, nationally, regionally and locally (including partnerships with iwi Māori and kaupapa Māori organisations) to prevent distress and addictions and provide early intervention when support is needed.
- Using an additional national mental wellbeing budget to purchase:
  - educational services and programmes that enable schools, employers, government agencies, community organisations, marae, hapū and iwi to create health-promoting environments, build the personal wellbeing of the people they work with, and gain basic mental health support skills including how to support someone in crisis or distress, cognitive behavioural strategies, conflict resolution and de-escalation.
  - engaging social marketing campaigns and health promotion programmes that promote and enable behaviours that grow positive mental health and wellbeing.
- Expanding on current peer-led support models and building the peer support workforce.
- Building and training a primary care sector that:
  - continues to develop the stepped care approach
  - is able to respond well to psychological distress in their patients and has regular mandated training in suicide prevention
  - can make longer appointment times when needed
  - is resourced to provide ongoing care to patients with complex needs
  - has easy and affordable access to trained counsellors
- Having support available at all levels across the community by enabling self-management and self-care, equipping whānau and communities with the skills, confidence and knowledge to support each other through life events as well as major psychological, emotional and social difficulties and distress.
- Building the mental health and wellbeing workforce to ensure that it is competent and compassionate, able to deal positively and proactively with social diversity, and that people providing care have tools and support to manage their own mental health and wellbeing.
- Building partnerships with NGOs, creatives, social entrepreneurs and philanthropists to socialise evidence based approaches where individuals and communities can take more control of their own mental health and wellbeing. Existing examples include the Farmstrong programme for farmers, Tane Ora Alliance for Māori men, and Peerzone for mental health service users.
- Having regionally specific strategies to mental health and wellbeing to align with local challenges. An existing example of this is the All Right? campaign in Canterbury.
- Working with local authorities to integrate mental wellbeing into regional and city council strategies, and to acknowledge the role that local authorities already play in providing parks and nature reserves, recreation facilities, community events and cohesion, local identity, arts and social support. These are all areas that have evidence to show that they contribute to wellbeing.
- Purchasing population or public health services that understand population dynamics and can design programmes that leverage community resources to improve overall population mental health. This would include alcohol and drug harm reduction, suicide prevention, reduction of stigma against psychological vulnerability, and wellbeing education and skills.
Investing in change

While some of the funding for this operational approach could come from reprioritised use of Vote Health, additional investment would be required, as well as links made between services funded by different government agencies.

The OECD estimates that in high income countries poor mental health costs about 3.5% of GDP.\textsuperscript{xiv} In New Zealand that means the cost is around $8.4 billion. There is a fiscal rationale to invest more in reducing distress and mental illness; directly through early intervention and quality treatment and follow up; and indirectly, through building community and individual resilience and mental health and wellbeing self-knowledge.

Current mental health funding resides in DHBs. While a small amount is ‘ring-fenced’ to provide support to those with the highest needs for support, other funding is provided through general allocations and subject to competing budget requirements.

We believe that the Inquiry should consider alternative models of allocating and coordinating this funding to enable cross-agency collaboration, and more creative and locally responsive decisions to meet the needs of different population groups.

A broad range of services and supports that meets individual needs

We need to design a support system that can help to guide recovery for individuals and whānau. Support systems should be strictly therapeutic, uncompromisingly rights-based and well connected with individuals’ support networks and life contexts.

To do this, we need to give people a range of support options, and to address the pressure points within mental health and social support services. Support options should include:

- **Easier, cheaper access to talking therapies and early-intervention services, including peer support.** New Zealand needs increased access to free or heavily subsidised therapies and supports, so that help is accessible and affordable for all. These supports must be available in a variety of forms including face-to-face, online and via telephone, as well as through schools, GPs and community organisations so individuals and whānau can get mental health support quickly and affordably, and can choose what works for them. There must be increased promotion of and continued investment into effective locally-developed e-therapies such as The Journal and SPARX.

- **Support for individual and whānau wellbeing** (understood as including mental, emotional, social, physical and spiritual wellbeing\textsuperscript{xxvii}) This includes promoting individual wellbeing skills (such as mindfulness, distress tolerance, sleep hygiene, physical activity, stress management and nutrition), whānau cohesion\textsuperscript{viii,xvii} and supportive environments within schools\textsuperscript{xviii}, workplaces\textsuperscript{xxix} and communities\textsuperscript{xx} across New Zealand.

- **Improved support through primary health care providers.** Primary care doctors are often the first people that individuals reach out to when they feel unwell. GPs need ongoing training to ensure they can effectively respond to people experiencing distress, and understand the range of further support options that are available. GPs should be enabled to spend more time with patients who need extra support, should have regular mandated suicide prevention training, and should be able to make urgent referrals to counsellors and other mental health supports.

- **Support people with achieving valued life outcomes.** Many clinical services remain too focused on diagnosis and the subsequent treatment of symptoms without prioritising a need to understand the full picture of each individual’s life circumstances and experiences. It is essential
individuals are given the holistic social and clinical support they need to function well and control their own lives. Services should connect and work alongside social services such as housing, Whānau Ora, employment and education to support individuals to lead lives where they have choices, dignity and control. They should also connect with medical services to provide joined-up care for people with more than one diagnosis (for example a mental illness and a drug addiction, or an intellectual disability as well as a mental illness).

- **Services that include and value family, whānau and culture.** Services are more effective when they understand and respect individuals’ support circles and identities, and how they are supported by and support others. A person’s connection with their family, culture and identity can be a significant source of strength and recovery. Staff training, flexible systems and inclusive practices are needed. This is true for all people and is especially relevant for those populations whose needs are not routinely well met by current services: men, children and young people, older people, Māori, Pacific, Asian, Deaf, disabled, rainbow/LGBTI+ and refugee communities.

**Integrated, person-centred crisis responses**

When a person is in mental health crisis or is severely suicidal, support should be joined-up, timely, person-centred and available whether they reach out through a helpline, mental health crisis team, Emergency Department, Police, ambulance services, addiction service, disability service, primary care or social services provider, or to a support person in the community, or they are identified to Police or health services through a third party.

Crisis and distress support should be available based on an individual’s need rather than, for example, their sobriety or alignment with diagnostic criteria for mental illness. It needs to be culturally-relevant, trauma-informed, and driven by best practice (for example, incorporating safety planning and timely, caring follow-up). Whānau or support networks need to be supported to be part of this process as relevant, guided by the individual’s circumstances and context.

Safe physical spaces and compassionate service delivery models are needed that address the needs of people in acute distress, to replace the current reliance on emergency departments, psychiatric acute wards and Police cells. Emerging peer-led crisis services offer promising and effective models of care that are based in peer support principles valuing self-determination, participation and mutuality, respecting the status of lived experience expertise, and nurturing hope.

Through our work with communities, we are aware of significant gaps in crisis provision, with individuals or their support people left trying to navigate an over-complicated, under-resourced system at a time when they are extremely vulnerable. Service gate-keeping (for example, a mental health crisis team being unable to support a person who is not already registered with mental health services) result in significant missed opportunities to support people when they reach out for help.

There is growing use of Police to respond to individuals in crisis which can result in use of force and non-therapeutic detention practices. Our national response should include timely, multi-disciplinary crisis response (for example, Police supported by a peer support worker, mental health professional or cultural support person) that has a clear therapeutic focus. Wider Police training is needed to enable more effective de-escalation and therapeutic responses to people in distress.

**Eliminating coercive treatment**

New Zealand’s mental health services need to move away from over-use of compulsory treatment and outdated, non-therapeutic practices such as seclusion and restraint, which are used more with Māori than other groups.
Compared to other, similar countries, New Zealand makes excessive use of compulsory treatment for individuals experiencing mental distress. This removes individuals’ rights to decide, with or without their chosen support, at the time or in advance, on their own medical treatment. Across the country, many services continue to use non-therapeutic practises such as seclusion and restraint, causing distress to both patients and staff. The use of these practices differs significantly between DHBs and across population groups. As a country we must take swifter steps to entirely eradicate the use of seclusion, minimise the use of restraint, promote supported decision making to avoid the use of compulsory treatment, and modernise the Mental Health Act to ensure the protection of rights and wellbeing.

The new Mental Health and Addiction Quality Improvement Programme led by the Health Quality and Safety Commission is promising, and should continue focus on service issues relevant to suicide prevention.

Not enough support is being provided to divert people experiencing mental distress from prison. More than 90% of New Zealand’s prison inmates have a diagnosis of a mental health or substance use disorder.

**Increased capacity of whānau and communities to build wellbeing and support people through distress**

Whānau and communities are the settings where people live their everyday lives. To build population wellbeing, it is critical to build whānau and community capacity to provide mentally healthy environments, build wellbeing and support people through distress.

Our experience at the MHF is of increasing community and public interest, enthusiasm and involvement in mental health and wellbeing initiatives. Community-led initiatives include using and spreading the Five Ways to Wellbeing as a focal point for mental wellbeing, sharing personal experiences of distress to reduce stigma and increase understanding, running workplace wellbeing programmes, engaging in mindfulness practices, introducing wellbeing curricula into schools, and leading advocacy on local issues. We see this willingness across communities as a valuable resource to be encouraged and grown.

Growing communities’ capacity to ability to support each other includes building social inclusion for people experiencing distress and eliminating the prejudice and discrimination they face. Awareness and behaviour change campaigns such as Like Minds, Like Mine and the National Depression Initiative have helped people to talk about mental health and distress. Growing and strengthening these approaches will help to address barriers to people seeking support and participating in work, education and life.

The support of loved ones can be critical in getting through times of mental health crisis and recovering from distress. Growing community capacity also includes equipping people with empathy, skills and knowledge to have safer conversations about suicide and mental health, be supportive of whānau, colleagues and friends who are experiencing distress or addiction, and know how to access additional help.

Approaches that could be developed, based on programmes that are working currently, include:

- Region wide coordinated activity, messages and wellbeing resources, based on the needs of that region, such as the All Right? campaign that was developed in response to the Canterbury earthquakes
• Industry-led initiatives such as Farmstrong
• Workplace programmes that give employers and employees strategies to provide healthy environments, build wellbeing and develop skills to support people appropriately with mental health problems.
• School based programmes around building emotional awareness and regulation through mindfulness.
• Arts-based programmes that build wellbeing and social cohesion.
• Sports bodies, for example the NZ Rugby Programme Head First.
• Supporting local lived experience leaders and champions, such as through the leadership initiative Rakau Roroa.
• Increasing access to community-based suicide prevention gatekeeper training, such as the locally-developed Lifekinders programme.

Depending on their focus, these types of initiatives build psychological wellbeing, community confidence around addressing mental wellbeing and distress, and mental health first aid skills.

Workplaces
Workplaces are arguably the third biggest mental health support sector across the country, after the formal mental health system and primary care. Every day many employers provide EAP services and support staff through mental health crises, and increasingly employers are building psychological health into their health and safety plans.

Work can be of major benefit in people’s recovery from mental health problems. As well as improving life outcomes for employees, improved mental health in the workplace can lead to higher productivity and better business results. Workplaces can also cause distress and mental illness.

Supportive, healthy workplaces can have a significant positive impact not only on staff, but on their families, friends and the wider community.

There are three broad areas that employers can adopt to improve mental health in the workplace. These include:
• building a positive, psychologically healthy workplace environment
• taking a proactive, fair and empathetic approach to distress, addiction or mental health problems in the workplace
• supporting employees to adopt behaviours that boost positive mental health and wellbeing

Workplace wellbeing programmes and mental health training should be heavily promoted, including supporting and ensuring quality control for the growth of new mental health and wellbeing trainers. The health and safety sector should be trained and supported to develop competency in mental health and wellbeing.

The national response to workplace health and safety should prioritise workplace mental health and wellbeing. New Zealand has joined, with Ministry of Health and Ministry of Social Development support, the OECD working group on integrated mental health skills and work policy. This group has made a number of recommendations that will be useful in driving the promotion of mental health and wellbeing in the workplace. These recommendations should be prominent in national health and safety strategy, policy and support.

Schools
Schools have a critical role to play in supporting young people’s mental health and wellbeing. As well as providing support for young people who are experiencing distress, schools can support mental health through building positive and safe environments, and developing skills and attitudes for
wellbeing, resilience and acceptance of diversity. As well as reducing student distress, promoting wellbeing can contribute to education outcomes that schools aim for.

School-based approaches to mental health and wellbeing should include:

- Creating safe and supportive learning environments for all students – addressing bullying, homophobia and transphobia.
- Partnering with other sectors to address social determinants of mental health, including poverty, housing issues and social inequalities.
- Educating students about mental health and diversity, developing skills to look after themselves and each other, and positive attitudes to accept and include peers experiencing distress. A structured mental health and wellbeing curriculum could be strengthened in schools, building on current positive developments.
- Teaching skills for wellbeing and resilience, and incorporating wellbeing activities across the curriculum and through extra-curricular activities. Mindfulness has particular value for building school students’ wellbeing, for example through the locally-developed Pause, Breathe, Smile programme.
- Ensuring teachers and support staff are trained to support students experiencing distress, and are well supported with policies and referral pathways.
- Providing well-resourced health and social support services within schools, such as counsellors, nurses and social workers.
- Supporting school communities after traumatic incidents including suicide and attempted suicide.

Local research about what works

As New Zealand designs campaigns, systems and services to improve wellbeing for all of us, we need to evaluate new approaches and share successes across the country. We should be committed to continuously learning through ongoing research, evaluation and refinement, valuing matauranga Māori, traditional Pacific knowledges, lived experience expertise, and outcomes of co-design and engagement processes with young people and other population groups, alongside research evidence.

A long-term view and decades-long plan for New Zealand’s mental health and wellbeing will be important so that we can begin to plan and evaluate life course approaches. For example, research is needed to see how investment into more psychosocially healthy parenting will flow through into the wellbeing of children, adolescents and adults in the next generation.

In developing approaches for the future, we also need to acknowledge and learn from failures, including historic abuse associated with institutionalisation. The current Royal Commission of Inquiry into Historical Abuse in State Care is a promising initiative, and its outcomes should inform our planning for the future by reminding us of past failings.

We would see future policy and practice development being informed by a range of social measures and psychological measures relevant to mental health and wellbeing. This would include data from:

- The national health survey, including a continuation of the time series using the K10 measure of psychological distress.
- A range of relevant indicators on quality of life such as social connection, income and hours of work from the New Zealand Household Survey
- Surveys and real-time feedback on people’s experience of mental health support services
- A new national annual wellbeing survey measuring wellbeing outcomes and demographics
- A periodic national youth survey such as the Youth 2000 series from the University of Auckland
- A new periodic national survey to measure the complete state of mental health, including a set of questions around symptoms of common mental illnesses, and a set of questions around psychological, emotional and social wellbeing.
- Reports showing inequalities in wellbeing experience, mental distress prevalence and mental health service access at a population level.

Conclusion
We have outlined what we believe to be the main components of a mental health system for the future. We consider that New Zealand needs:

- a new paradigm for understanding mental health
- a clear strategy and effective, well-connected leadership
- oversight through an independent Mental Health and Wellbeing Commission
- a clear, accountable national structure for operational delivery
- a broad range of services and supports that meets individual needs
- increased capacity of whānau and communities to build wellbeing and support people through distress
- local research about what works

This future mental health system would engage all New Zealanders in promoting and supporting mental health and wellbeing, and would provide clear strategy, leadership and oversight to guide national responses that work for all New Zealanders.

The system would move away from medical and individualised understandings of mental health, and recognise that most mental health problems and solutions have their origins in, or are exacerbated by, social conditions at macro or micro levels. As our social world becomes more complex, a medically driven and medically structured model of population mental health will not only be inadequate, but potentially harmful. We need to be creating a nationwide social environment that builds individual and social support at every level, creates resilience in individuals, whānau and communities, and acknowledges psychological distress as universal. Psychological distress also deserves universally compassionate responses, coupled with opportunities to recover and grow into experiences of wellbeing.

We need a strategy that will move us from the current system that defaults to service models based on individual diagnosis, treatments and medications, to one that prioritises the broad social foundations for wellbeing and good mental health throughout the life course.

Investing in this approach would improve population wellbeing, which would in turn improve our national levels of social cohesion, innovation, productivity and physical health. It would lead to reduced distress, and reduced rates of common mental health problems, self harm and suicide. A determined focus on addressing inequalities and the social determinants of mental health would result in reduced inequities in mental health outcomes for Māori and other populations.
About us

The MHF is a non-government organisation that works towards creating a society where all people can flourish – that is, feel good and function well most of the time.

Since our establishment in the late 1970s, the MHF has worked to build understanding of mental health and wellbeing, improve the quality of services and supports available for people experiencing mental distress, and help people develop skills and behaviours to support their mental health.

The MHF takes a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing.

Our positive mental health programmes include Farmstrong (for farmers and growers), All Right? (supporting psychosocial recovery in Canterbury, Kaikōura and Hurunui), Pink Shirt Day (challenging bullying by developing positive school, workplace and community environments), Open Minds (encouraging workplaces to start conversations about mental health) and Tāne Ora (working with tāne Māori and their whānau to build wellbeing skills).

Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing and help guide them through distress and recovery. In the last financial year, people interacted with our positive mental health campaigns two million times.

Contact

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References


For example, see the range of research on the All Right? population resilience campaign in Canterbury: https://allright.org.nz/our-research/


