GOVERNMENT INQUIRY INTO
Mental Health and Addiction
Oranga Tāngata, Oranga Whānau

He Ara Oranga

Report of the Government Inquiry into Mental Health and Addiction

Executive Summary and Recommendations

Executive summary

Background

The Government Inquiry into Mental Health and Addiction was announced early in 2018. The catalyst for the inquiry was widespread concern about mental health services, within the mental health sector and the broader community, and calls for a wide-ranging inquiry from service users, their families and whānau, people affected by suicide, people working in health, media, Iwi and advocacy groups.

This document comprises the Executive Summary and Recommendations from *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. The full report is available at: www.mentalhealth.inquiry.govt.nz/inquiry-report/ .

Purpose of Inquiry

The purpose of this Inquiry is to:

- **hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction and what needs to change**
- **report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems**
- **recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.**

The full Terms of Reference are available at:

https://www.mentalhealth.inquiry.govt.nz/about-the-inquiry/terms-of-reference/

Inquiry panel members

The members of the Inquiry panel are:

Professor Ron Paterson (Chair)	**Sir Mason Durie**
Dr Barbara Disley	**Dean Rangihuna**
Dr Jemaima Tiatia-Seath	**Josiah Tualamali'i**

Inquiry process

The Inquiry commenced work in February 2018 and reported to the Minister of Health in November 2018. The Inquiry process involved widespread public consultation and high media interest. In April 2018, a consultation document was released in multiple languages and formats. The level of public and mental health and addiction sector engagement with the Inquiry was remarkable.

Over 2,000 people attended public meetings at 26 locations around the country. Over 5,200 submissions were made to the Inquiry. Over 400 meetings were held with tāngata whaiora,[1] their families and whānau, other members of the public, health and other service providers, Iwi and Kaupapa Māori providers, community organisations, researchers and other experts.

The Inquiry obtained information from a wide variety of sources, including a stocktake of government-funded services and programmes and perceived gaps and opportunities. A report was commissioned from the University of Otago, Wellington, on the determinants of mental health and wellbeing, specific populations' experiences of mental health and wellbeing, and opportunities for service improvements and a move to a wellbeing approach.

1 Literally translated, 'tāngata whaiora' means 'people seeking wellness', and is generally used in preference to 'service users' and 'consumers'. See also the explanation in Table 1 of the report.

Approach to report

We recognised from the start that this Inquiry represented a 'once in a generation' opportunity for change. All over the country, people told us they wanted this report to lead to real and enduring change – a 'paradigm shift'.

There has been no shortage of mental health inquiries and reviews in the 22 years since the last national mental health inquiry in New Zealand, led by Judge Ken Mason in 1995–1996. It too was born out of heightened public concerns and calls for change. It came in the wake of deinstitutionalisation in the 1980s and 1990s, with patients being moved out of psychiatric hospitals and into the community.

We note two important differences about this Inquiry. One is the breadth of its Terms of Reference, including mental health problems across the full spectrum from mental distress to enduring psychiatric illness, and a mandate to look beyond the health sector to other sectors and social determinants that influence mental health outcomes. We are also asked to advise how to promote mental health and

wellbeing for the whole community. The inclusion of addictions and harmful use of alcohol and other drugs is also different from past reviews.

The second main difference that emerged during this Inquiry is the striking degree of consensus, from most parts of New Zealand society, about the need for change and a new direction: an emphasis on wellbeing and community, with more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau- and community-based responses and cross-government action.

Given the degree of consensus, why hasn't change occurred already? In many respects, we have the system we designed. The target set in the 1996 Mason Inquiry report, of having specialist services available for the 3% of people with the most severe mental health needs, has been achieved. But the subsequent goals of more prevention and early intervention, and more support in the community, have not been realised, despite worthy policies and strategies. Much time and effort has gone into planning,

with lots of good work by hardworking people. Yet, apart from some pockets of success, little progress has been made. The fact that other countries are facing similar challenges and asking the same questions gives us no comfort.

So, we have taken a different approach. We have deliberately taken a 'people first' approach in writing this report, being guided by the needs of people and communities rather than the preferences of the various groups accustomed to the way the system is structured and services are delivered at present.

We have sought to be bold and bring some fresh thinking to old and complex problems. Rather than develop a strategy or lay out a 'shopping list' of new services to be funded, we have analysed the underlying reasons why New Zealand's mental health and addiction system has not really shifted over the past two decades.

Some facts and figures

Mental health and addiction problems touch the lives of many people in New Zealand. Each year around one in five of us experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition to the human costs, the annual cost of the burden of serious mental illness, including addiction, in New Zealand is an estimated $12 billion or 5% of gross domestic product.

Any one of us can be affected: over 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. But some people are more at risk. A range of social determinants are risk factors for poor mental health: poverty, lack of affordable housing, unemployment and low-paid work, abuse and neglect, family violence and other trauma, loneliness and social isolation (especially in the elderly and rural populations) and, for Māori, deprivation and cultural alienation.

New Zealand has persistently high suicide rates. Annual suicide rates reported by the Office of the Chief Coroner have increased over the last four years, with the 2017/18 suicide rate the highest since 1999. Every year, 20,000 people attempt to take their own life. In 2015, 525 people died by suicide. Our suicide rate for young people is among the worst in the OECD. The greatest loss of life through suicide occurs among people older than 24, particularly males aged 25–44. Every suicide creates significant, far-reaching impacts on the person's friends, family and whānau, and the wider community.

Addiction to alcohol and other drugs is causing widespread harm in New Zealand communities. A heavy drinking culture harms health and wellbeing. Harmful use of alcohol and other drugs is significantly implicated in crime – around 60% of community-based offenders have an identified alcohol or other drug problem and 87% of prisoners have experienced an alcohol or other drug problem over their lifetime. Well over half of youth suicides involve alcohol or illicit drug

exposure. Over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems.

Voices of the people

Early on in the Inquiry, we consulted Judge Ken Mason. "Listen to the people", he said. "They will tell you what to do." We did, and the voices of the people were powerful and compelling. We have reported them faithfully and they have guided our approach.

Strong themes emerged from the people we met and submitters. People shared deeply personal experiences, motivated by a desire to tell their stories and bring about change. We heard a lot of heartache and sorrow, but also stories of hope and recovery.

This report records the main themes from the voices of the people: a call for wellbeing and community solutions – for help through the storms of life, to be seen as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self.

For Māori health and wellbeing, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and Iwi.

For Pacific peoples, the adoption of 'Pacific ways' to enable Pacific health and wellbeing – a holistic approach incorporating Pacific languages, identity, connectedness, spirituality, nutrition, physical activity and healthy relationships.

People said that unless New Zealand tackles the social and economic determinants of health, we will never stem the tide of mental health and addiction problems. There are clear links between poverty and poor mental health. People need safe and affordable houses, good education, jobs and income for mental wellbeing.

Addictions are recognised as a serious public health issue in New Zealand. Alcohol and other drugs are tearing families and communities apart. People and communities called for decisive action to limit the sale and promotion of alcohol, particularly around children and young people. As well as more treatment and rehabilitation services, people argued for a mature drug policy, with addiction treated as a health, not a criminal justice issue.

Families and whānau described patient privacy as a barrier used to exclude them from treatment and discharge planning, even though they are the ones there for the long haul. They asked for help for their family members, and more support for their own needs as carers. Families bereaved by suicide described a lack of support, and the delays and trauma of current suicide review processes.

Children and young people are exhibiting high levels of behavioural distress leading to deliberate self-harm, risk-taking, anxiety and other troubling behaviours. Parents are concerned about the harms of bullying and misuse of the internet and social media. School counsellors and teachers are overwhelmed by the number of students in distress. New Zealand's high rates of youth suicide are a national shame. Students and teachers highlighted the importance of learning about mental health as part of the health curriculum and helping young children develop resilience and learn how to regulate their emotions.

People wanted support in the community, so they can stay connected and receive help for a variety of needs – crisis support and acute care, addiction recovery, long-term support, respite care, drop-in centres, social support, whānau wrap-around services and employment support. They sought access to an expanded range of therapies, and resources to shift from district health boards (DHBs) to non-governmental organisation (NGO) providers, which are closer to the community.

Problems of access, wait times and quality were reported all over the country – having to fight and beg for services, not meeting the threshold for treatment, and the cruelty of being encouraged to seek help from unavailable or severely rationed services. Gaps in services, limited therapies, a system that is hard to navigate, variable quality and shabby facilities added up to a gloomy picture of a system failing to meet the needs of many people.

Members of the workforce told us of their love of their jobs, but reported stress, burnout and exhaustion from overwork and an increasing risk of assaults. One manager warned, "All the dreams of the Inquiry will come to naught if we don't have a workforce". There were loud and clear calls for more peer-support workers; more staff trained in Māori culture and Pacific cultures; and more training in mental health and addiction within primary health care and other sectors (education, corrections, police and social work).

We heard that New Zealand needs a human rights and mental health approach to be recognised in law to honour our international treaty obligations. People called for repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) and an end to seclusion and restraint. Even in 2018, shame and stigma shape attitudes and act as barriers to seeking help. The Mental Health Act embeds archaic and risk-averse attitudes that cause clinicians to opt too readily for coercion and control.

Submissions described a lack of clear leadership and oversight at a national level. People talked about what can be achieved when mental health and addiction is a priority area for government and there is clear leadership and direction from a mental health commission with a powerful statutory mandate. They asked for local leadership and innovation to be supported. We saw and heard about many examples of grass-roots leadership by people with lived experience.

Our conclusions

New Zealand's mental health and addiction problems cannot be fixed by government alone, nor solely by the health system. We can't medicate or treat our way out of the epidemic of mental distress and addiction affecting all layers of our society. We need to ensure practical help and support in the community are available when people need it, and government has a key role to play here. But some solutions lie in our own hands. We can do more to help each other.

Wellbeing has been a theme during this Inquiry and in national conversation in recent years. It's hard for people struggling with poverty, abuse and deprivation to take steps to become well – yet, every day, people recover from distress, overcome addictions and find strength in their lives. Sleep, nutrition, exercise and time outdoors help recovery. So too does strengthening one's cultural identity and helping others.

We have a solid foundation to build on: New Zealand's mental health and addiction system has valuable strengths. Many people in the system receive good care and we have a skilled and committed workforce. But the system is under pressure and unsustainable in its current form. Signs include escalating demand for specialist services, limited support for people in the community and difficulties recruiting and retaining staff.

Despite the current level of investment, we're not getting the outcomes we want for our people. The outcomes for Māori are worse than for the overall population, and Māori are subject to much greater use of compulsory treatment and seclusion. There are also unmet mental health needs for Pacific peoples, disabled people, Rainbow communities, the prison population, and refugees and migrants. The estimated reduction in life expectancy of people with severe mental health or addiction challenges is 25 years. Our persistently high suicide rates are of major concern.

Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed. Even when it responds to people with a mental illness, it does so through too narrow a lens. People may be offered medication, but not other appropriate support and therapies to recover. The quality of services and facilities is variable. Too many people are treated with a lack of dignity, respect and empathy.

We do not have a continuum of care – key components of the system are missing. The system does not respond adequately to people in serious distress, to prevent them from 'tipping over' into crisis situations. Many people with common, disabling problems such as stress, depression, anxiety, trauma and substance abuse have few options available through the public system. By failing to provide support early to people under the current threshold for specialist services, we're losing opportunities to improve outcomes for individuals, communities and the country.

We also fail to address people's wider social needs. Initial expansion of culturally appropriate services has stalled, and there has been little investment in respite and crisis support options, forensic step-down services in the community, and earlier access to a broader range of peer, cultural and talk therapies.

Despite a lot of consensus about the need for reform, we are yet to take a bold, health-oriented approach to the harmful use of alcohol and other drugs and to provide a wider range of community-based services to help people recover from addiction. Our approach to suicide prevention and the support available to people after a suicide is patchy and under-resourced. Tackling the social and economic determinants of mental health and wellbeing requires a coordinated, integrated approach from social services.

It's time to build a new mental health and addiction system on the existing foundations to provide a continuum of care and support. We will always have a special responsibility to those most in need. They must remain the priority. But we need to expand access so that people in serious distress – the 'missing middle' who currently miss out – can get the care and support they need to manage and recover.

The new system should have a vision of mental health and wellbeing for all at its heart: where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience, tools and support they need to regain their wellbeing.

We set out Whakawātea te Ara, clearing the pathways that will lead to improved Māori health and wellbeing. We outline *Vai Niu*, a vision of Pacific mental health and wellbeing. We believe that many dimensions of the aspirations of Māori and Pacific peoples, especially the call for a holistic approach, point the way for all New Zealanders.

We describe a vision for mental health and addiction services, with people at the centre; responsive to different ages, backgrounds and perspectives; centred on community-based support and local hubs, using a mix of peer, cultural, support and clinical workforces; providing support for people in crisis; a comprehensive harm-minimisation approach to alcohol and other drug use; more community-

based addiction services to help people recover; and a broader range of therapies for people who are detained and support for their transition back to the community. Psychiatrists and appropriate medications will continue to be important – but they are only part of the picture.

Honouring the voices of the people who shared their stories with the Inquiry means there must now be decisive action. Our approach is to focus on a few critical changes to shift the system. In addition to the gains in health and wellbeing, a strong economic case exists for further investment in mental health and addiction. The key principles that underpin our recommendations are a commitment to equity and the Treaty of Waitangi; putting people with lived experience and consumers at the centre of the system; recognising a shared responsibility for improving mental health and wellbeing in our society; and building on the foundations already in place, with mental health and addiction services remaining part of the health system.

Rationale for recommendations

We propose major changes in current policies and laws, supported by significant increases in funding. Our recommendations cover 12 broad areas. They are summarised, with the supporting rationale, below.

Expand access and choice from the current target of 3% of the population being able to access specialist services to provide access to the 'missing middle' of people with mental illness or significant mental distress who cannot access the support and care they need. Given current prevalence data suggesting one in five people experience mental health and addiction challenges at any given time, an indicative access target may be 20% within the next five years. New Zealand has deliberately focused on services for people with the most serious needs, but this has resulted in an incomplete system with very few services for those with less severe needs, even when they are highly distressed.

An explicit new access target must be set, supported by funding for a wider range of therapies, especially talk therapies, alcohol and other drug services, and culturally aligned services. This expansion will transform mental health and addiction services. Making it happen requires the involvement of all key players in a co-design process and implementation support for the change process itself. It also requires workforce development, better information, a commitment to a clear funding path, new funding rules and expectations, and strong leadership. (recommendations 1–12)

Transform primary health care so people can get skilled help in their local communities, to prevent and respond to mental health and addiction problems. Responding appropriately to people with these challenges should be part of the core role of any general practice or community health service. The capability of the primary care workforce needs to be enhanced, with additional mental health and addiction training for general practitioners, practice nurses and community health workers.

The transformation envisaged by the 2001 Primary Health Care Strategy is yet to happen. Affordability remains an issue, models of care have largely not evolved, and primary, community and secondary services are not well integrated. The Health and Disability Sector Review should focus on the wider transformation of primary health care as this will be a critical foundation for improved mental health and addiction care and support. (recommendations 13 and 14)

Strengthen the NGO sector to support the significant role NGOs (including Kaupapa Māori services) will play with the shift to more community-based mental health and addiction services. The NGO sector is an increasingly important contributor to the delivery of government-funded mental health, addiction and wider health and social services. But factors such as short-term contracts, high compliance costs and reporting requirements, multiple funders and contracts, and a power imbalance impact on the sustainability of NGO providers and the service they can provide. We recommend a clear stewardship role within central government to support NGO development and sustainability and improve commissioning of health and social services with NGOs.

(recommendation 15)

Take a whole-of-government approach to wellbeing to tackle social determinants and support prevention activities that impact on multiple outcomes, not only mental health and addiction. Despite the substantial benefits of focusing on prevention and promoting wellbeing, especially early in life, the balance of resources has not shifted to prevention and long-term investment in our future. Multiple agencies are engaged in fragmented and uncoordinated activities that target similar outcomes. A proposed social wellbeing agency would provide a clear locus of responsibility within central government for social wellbeing, with a focus on prevention and tackling major social determinants that underlie many inequitable outcomes in our society. (recommendations 16 and 17)

Facilitate mental health promotion and prevention with leadership and oversight from a new commission, including an investment and quality assurance strategy for mental health promotion and prevention. Although there have been some excellent national campaigns, such as Like

Minds, Like Mine, a plethora of different programmes are delivered by many organisations; some may not be sound. A more organised approach, with quality-assured programmes, would benefit schools, workplaces and local communities. (recommendations 18 and 19)

Place people at the centre to strengthen consumer voice and experience in mental health and addiction services. People with lived experience are too often on the periphery; they should be included in mental health and addiction governance, planning, policy and service development. Consumer voice and role should be strengthened in DHBs, primary care and NGOs. Families and whānau should be supported to be active participants in the care and treatment of their family member, subject to the wishes of the individual patient. Too often they are excluded by service practices, based on misconceived privacy concerns. New, consolidated guidance should be developed on information-sharing and partnering with families. A review is needed of the wellbeing support provided to families and whānau, given the high emotional and financial costs of caring for family members. (recommendations 20–25)

Take strong action on alcohol and other drugs by enacting a stricter regulatory approach to the sale and supply of alcohol; replace criminal sanctions for the possession for personal use of controlled drugs, with civil responses; support that law change with a full range of treatment and detox services; and establish clear cross-sector leadership within central government for alcohol and other drug policy. These steps are needed in response to the harmful use of alcohol and other drugs and the devastating impact on individuals, families and communities.

A much bolder approach to alcohol law reform is justified, given community concerns and evidence-based recommendations from the Law Commission and other agencies. The criminalisation of drug use has failed to reduce harm around the world. A shift towards treating personal drug use as a health and social issue is required to minimise the harms of drug use. Demand for addiction services is increasing and investment in more services is needed, from brief interventions in general practice and primary care settings to social and detox options and follow-up community-based services. Alcohol and other drug policy

leadership and coordination also needs a clear home within government. (recommendations 26–29)

Prevent suicide. Urgently complete and implement a national suicide prevention strategy, with a target of a 20% reduction in suicide rates by 2030. New Zealand's persistently high suicide rates were one of the catalysts for this Inquiry. Suicide affects people of all ages and from all walks of life, with thousands of New Zealanders touched by suicide every year. Suicide prevention has suffered from a lack of coordination and resources. Reducing suicide rates should be a cross-party and cross-sectoral national priority. Suicide prevention requires increased resources and leadership from a suicide prevention office. Suicide bereaved families and whānau, who are at increased risk of suicide, need more support, and the processes for investigation of deaths by suicide, which are often slow, traumatic and costly, need to be reviewed. (recommendations 30–33)

Reform the Mental Health Act. **Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992, to reflect a human rights approach, promote supported decision-making and align with a recovery and wellbeing model, and minimise compulsory or coercive treatment. The Mental Health Act is out of date, inconsistent with New Zealand's international treaty obligations and sometimes results in trauma and harm to compulsorily treated patients. The use of compulsory treatment orders varies around the country, and there is far too much use of seclusion and restraint, especially for Māori and Pacific peoples. Clinicians working under the Act have developed a culture of risk aversion and defensive practice. New Zealand needs a national level discussion, carefully crafted, to reconsider beliefs, evidence and attitudes about mental health and risk. (recommendations 34 and 35).**

Establish a new Mental Health and Wellbeing Commission to act as a watchdog and provide leadership and oversight of mental health and wellbeing in New Zealand. There has been a general lack of confidence in leadership of the mental health and addiction sector over many years, since disestablishment of the original Mental Health Commission. A new Commission is needed to provide system leadership and act as the institutional mechanism to hold decision-makers and successive governments to account. It should publicly report on progress in mental health and addiction, including on implementation of the Government response to this Inquiry's recommendations. (recommendations 36–38)

Refer to the Health and Disability Sector Review for consideration, broader issues such as the future structures, roles and functions in the health and disability system, including the establishment of a Māori health commission or ministry. During the Inquiry, significant structural and system issues, including concerns about the current DHB model, and the transformation required in the primary health care sector, were raised. The Health and Disability

Sector Review, announced part way through this Inquiry, has a wider scope and is better placed to consider those issues. (recommendation 39)

Establish a cross-party working group on mental health and wellbeing to reflect the shared commitment of different parties to improved mental health and wellbeing in New Zealand. Mental health is too important to be a political football. Similar initiatives are in place in the United Kingdom and Canada, and some support exists for a similar concept in New Zealand. A cross-party working group would provide an opportunity for members of the House of Representatives to collaborate and advocate for education, leadership and legislative progress on mental health and wellbeing. (recommendation 40)

Closing thoughts

This is not simply a report calling for more money for mental health and addiction services – though it is clear further investment is needed in Budget 2019 and in the future. It is a whole new approach to mental health and addiction in New Zealand. It sets out He Ara Oranga – Pathways to Wellness.

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. Implementation will require policy decisions and legislative change backed by a commitment to a long-term funding path. We are confident of the cost-effectiveness of greater investment in the targeted areas.

Change will take time. It must be sustained over a long period, but we need to start now. Some of the necessary changes can and must happen promptly. People have waited long enough.

Acting collectively, we can improve our mental health and wellbeing.

In unity there is strength

… he toa takitini[2]

***So'o le fau i le fau*[3]**

2 The complete whakatauki is 'Ehara taku toa i te toa takitahi, engari he toa takitini' (My strength is not that of a single warrior, but that of many'').

3 A well-known Samoan proverb that means to join the hibiscus fibre to hibiscus fibre. Metaphorically, it conveys that unity is strength.

Recommendations

Expand access and choice

Expand access

1 **<u>Agree</u> to significantly increase access to publicly funded mental health and addiction services for people with mild to moderate and moderate to severe mental health and addiction needs.**

2 **<u>Set</u> a new target for access to mental health and addiction services that covers the full spectrum of need.**

3 **<u>Direct</u> the Ministry of Health, with input from the new Mental Health and Wellbeing Commission, to report back on a new target for mental health and addiction services.**

4 **<u>Agree</u> that access to mental health and addiction services should be based on need so:**

- **access to all services is broad-based and prioritised according to need, as occurs with other core health services**
- **people with the highest needs continue to be the priority.**

Increase choice of services

5 **<u>Commit</u> to increased choice by broadening the types of mental health and addiction services available.**

6 **<u>Direct</u> the Ministry of Health to urgently develop a proposal for Budget 2019 to make talk therapies, alcohol and other drug services and culturally aligned therapies much more widely available, informed by workforce modelling, the New Zealand context and approaches in other countries.**

Facilitate co-design and implementation

7 **<u>Direct</u> the Ministry of Health, in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body) to:**

- **facilitate a national co-designed service transformation process with people with lived experience of mental health and addiction challenges, DHBs, primary care, NGOs, Kaupapa Māori services, Pacific health services, Whānau Ora services, other providers, advocacy and representative organisations, professional bodies, families and whānau, employers and key government agencies.**

- **produce a cross-government investment strategy for mental health and addiction services.**

8 **<u>Commit</u> to adequately fund the national co-design and ongoing change process, including funding for the new Mental Health and Wellbeing Commission to provide backbone support for national, regional and local implementation.**

9 **<u>Direct</u> the State Services Commission to work with the Ministry of Health to establish the most appropriate mechanisms for cross-government involvement and leadership to support the national co-design process for mental health and addiction services.**

Enablers to support expanded access and choice

10 **<u>Agree</u> that the work to support expanded access and choice will include reviewing and establishing:**

- **workforce development and worker wellbeing priorities**
- **information, evaluation and monitoring priorities (including monitoring outcomes)**
- **funding rules and expectations, including DHB and primary mental health service specifications and the mental health and addiction ring fence, to align them**

with and support the strategic direction of transforming mental health and addiction services.

11 **Agree to undertake and regularly update a comprehensive mental health and addiction survey.**

12 **Commit to a staged funding path to give effect to the recommendations to improve access and choice, including:**

- **expanding access to services for significantly more people with mild to moderate and moderate to severe mental health and addiction needs**
- **more options for talk therapies, alcohol and other drug services and culturally aligned services**
- **designing and implementing improvements to create more people-centred and integrated services, with significantly increased access and choice.**

Transform primary health care

13 **Note that this Inquiry fully supports the focus on primary care in the Health and Disability Sector Review, seeing it as a critical foundation for the development of mental health and addiction responses and for more accessible and affordable health services.**

14 **Agree that future strategies for the primary health care sector have an explicit focus on addressing mental health and addiction needs in primary and community settings, in alignment with the vision and direction set out in this Inquiry.**

Strengthen the NGO sector

15 **Identify a lead agency to:**

- **provide a stewardship role in relation to the development and sustainability of the NGO sector, including those NGOs and Kaupapa Māori services working in mental health and addiction**
- **take a lead role in improving commissioning of health and social services with NGOs.**

Enhance wellbeing, promotion and prevention

Take a whole-of-government approach to wellbeing, prevention and social determinants

16 **Establish a clear locus of responsibility for social wellbeing within central government to provide strategic and policy advice and to oversee and coordinate cross-government responses to social wellbeing, including:**

- **tackling social determinants that impact on multiple outcomes and that lead to inequities within society**
- **enhancing cross-government investment in prevention**

and resilience-building activities.

17 **<u>Direct</u> the State Services Commission to report back with options for a locus of responsibility for social wellbeing, including:**

- **its form and location (a new social wellbeing agency, a unit within an existing agency or reconfiguring an existing agency)**
- **its functions (as proposed in section 7.1.3 of the report).**

Facilitate mental health promotion and prevention

18 **<u>Agree</u> that mental health promotion and prevention will be a key area of oversight of the new Mental Health and Wellbeing Commission, including working closely with key agencies and being responsive to community innovation.**

19 **<u>Direct</u> the new Mental Health and Wellbeing Commission to develop an investment and quality assurance strategy for mental health promotion and prevention, working closely with key agencies.**

Place people at the centre

Strengthen consumer voice and experience in mental health and addiction services

20 **Direct DHBs to report to the Ministry of Health on how they are including people with lived experience and consumer advisory groups in mental health and addiction governance, planning, policy and service development decisions.**

21 **Direct the Ministry of Health to work with people with lived experience, the Health Quality and Safety Commission and DHBs on how the consumer voice and role can be strengthened in DHBs, primary care and NGOs, including through the development of national resources, guidance and support, and accountability requirements.**

22 **Direct the Health and Disability Commissioner to undertake specific initiatives to promote respect for and observance of the Code of Health and Disability Services Consumers' Rights by providers, and awareness of their rights on the part of consumers, in relation to mental health and addiction services.**

Support families and whānau to be active participants in the care and treatment of their family member

23 **Direct the Ministry of Health to lead the development and communication of consolidated and updated guidance on sharing information and partnering with families and whānau.**

24 **Direct the Ministry of Health to ensure the updated information-sharing and partnering guidance is integrated into**:

- **training across the mental health and addiction workforce**
- **all relevant contracts, standards, specifications, guidelines, quality improvement processes and accountability arrangements.**

Support the wellbeing of families and whanau

25 **Direct the Ministry of Health, working with other agencies, including the Ministry of Education, Te Puni Kōkiri and the Ministry of Social Development, to:**

- **lead a review of the support provided to families and whānau of people with mental health and addiction needs and where gaps exist**

- **report to the Government with firm proposals to fill any gaps identified in the review with supports that enhance access, affordability and options for families and whānau.**

Take strong action on alcohol and other drugs

26 **<u>Take</u> a stricter regulatory approach to the sale and supply of alcohol, informed by the recommendations from the 2010 Law Commission review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship and the 2014 Ministry of Justice report on alcohol pricing.**

27 **<u>Replace</u> criminal sanctions for the possession for personal use of controlled drugs with civil responses (for example, a fine, a referral to a drug awareness session run by a public health body or a referral to a drug treatment programme).**

28 **<u>Support</u> the replacement of criminal sanctions for the possession for personal use of controlled drugs with a full range of treatment and detox services.**

29 **<u>Establish</u> clear cross-sector leadership and coordination within central government for policy in relation to alcohol and other drugs.**

Prevent suicide

30 **Urgently complete the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention.**

31 **Set a target of 20% reduction in suicide rates by 2030.**

32 **Establish a suicide prevention office to provide stronger and sustained leadership on action to prevent suicide.**

33 **Direct the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.**

Reform the Mental Health Act

34 **Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights–based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.**

35 **<u>Encourage</u> mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.**

Establish a new Mental Health and Wellbeing Commission

36 **<u>Establish</u> an independent commission – the Mental Health and Wellbeing Commission (with the functions and powers set out in figure 4 of the report) to provide leadership and oversight of mental health and addiction in New Zealand.**

37 **<u>Establish</u> a ministerial advisory committee as an interim commission to undertake priority work in key areas (such as the national co-designed service transformation process).**

38 **<u>Direct</u> the Mental Health and Wellbeing Commission (or interim commission) to regularly report publicly on implementation of the Government's response to the Inquiry's recommendations, with the first report released one year after the Government's response.**

Wider issues and collective commitment

39 **<u>Ensure</u> the Health and Disability Sector Review:**

- **assesses how any of its proposed system, structural or service commissioning changes will improve both mental health and addiction services and mental health and wellbeing**
- **considers the possible establishment of a Māori health ministry or commission.**

40 **<u>Establish</u> a cross-party working group on mental health and wellbeing in the House of Representatives, supported by a secretariat, as a tangible demonstration of collective and enduring political commitment to improved mental health and wellbeing in New Zealand.**