

Office of the Minister of Health

The Chair, Cabinet Business Committee

Establishing an Inquiry into Mental Health and Addiction

Proposal

- 1 This paper seeks agreement in principle to establish a government inquiry into mental health and addiction in New Zealand, under the Inquiries Act 2013. This is a coalition commitment under the Government's 100 Day Plan [CAB-17-Min-0486 refers].
- 2 This paper is the first of two establishment papers. It covers the purpose, scope and timeframe for the inquiry, and inquiry arrangements including the proposed Chair. A draft terms of reference is included for feedback. A second paper in December will seek decisions on the final terms of reference, appointment of inquiry Chair and members, their fees, and the necessary inquiry budget and appropriations.

Executive Summary

- 3 The key drivers for the inquiry are addressing inequalities in mental health and addiction outcomes, concerns about underfunding of mental health and addiction services and stubbornly high suicide rates. There is strong support from consumers, providers, experts and the wider public for changing New Zealand's approach to mental health and addiction.
- 4 Existing services that prevent and respond to poor mental health and addiction issues are not well connected, creating difficulties for individuals and families who are navigating them. Neither do they provide a holistic response to the issues faced by communities, including addressing the social determinants of health. It is likely that we need a radical transformation of our approach to mental health and addiction including how these services connect with other services that meet broader social needs (including education, welfare, housing, justice, disability support, accident compensation, workplace relations and health and safety, and emergency response).
- 5 The inquiry is an opportunity to obtain an accurate picture of how well our current approach to mental health and addiction is promoting mental well-being, preventing poor mental health and addiction issues, and identifying and responding to the needs of people experiencing mental health and addiction problems. It will help build consensus on the specific changes that are needed to provide equitable and improved mental health and addiction outcomes. There are particular inequalities for Māori, Pacific peoples, people with disabilities, refugees and youth.
- 6 The inquiry will need to understand and acknowledge the wider social and economic determinants of mental health and addiction (for example poverty, inadequate housing, family violence or other trauma) and consider the implications of these for the design and delivery of mental health and addiction services. Its commentary on these matters will help inform the Government's work programmes in these areas, including our priorities of child poverty and housing.

- 7 The inquiry's recommendations will inform the Government's decisions on future arrangements for mental health and addiction, future investment priorities, and provide a benchmark of current performance that will enable future improvements to be demonstrated.
- 8 Some actions cannot wait until the inquiry is completed. Alongside the inquiry, we are already taking steps to address some immediate service gaps and pressures, as outlined under our coalition commitments.

Background

- 9 The Government has committed to setting up an inquiry into mental health and addiction as part of its coalition programme of work for the first 100 days. This is an opportunity to learn and develop a shared vision for the path ahead to create mental wellbeing for New Zealanders.
- 10 The drivers for an inquiry into mental health and addiction are:
- 10.1 addressing inequalities in mental health and addiction outcomes
 - 10.2 concerns about underfunding of mental health and addiction services
 - 10.3 stubbornly high suicide rates.
- 11 Poor mental health increases the likelihood of suicidal behaviour. However, not everyone who plans, thinks about, attempts or dies by suicide has a diagnosable mental disorder.
- 12 People can experience a broad range of mental health issues on a spectrum from mental distress to enduring psychiatric illness requiring on-going interventions. Substance use problems (addiction) often occur together with mental health issues. In this paper the term *poor mental health* is used to encompass the full spectrum of mental health and addiction problems.
- 13 Services for people requiring mental health care and assistance with their substance use problems are diverse, ranging from universal (health and other sectors) to specialist depending on level of severity.
- 14 The specialist workforce which includes those in child and youth, and the disciplines of psychology, nursing and psychiatry is struggling to meet demand.

Inequalities of outcome

- 15 Across the spectrum of poor mental health are inequalities in mental health and addiction outcomes:
- 15.1 Māori experience disproportionately higher rates of poor mental health and suicide than any other ethnic group. In 2016, Māori were 3.6 times more likely than non-Māori to be subject to a community treatment order, 3.4 times more likely to be subject to an inpatient treatment order, and 4.8 times more likely to be secluded.
 - 15.2 Pacific people have a higher prevalence of diagnosable mental disorder (25 percent per year) than the total population (20 percent per year).
 - 15.3 Suicide is one of the leading causes (35 percent) of youth deaths. In 2013, New Zealand's male youth suicide rate was the third highest in the OECD and the female youth suicide rate was the highest.

15.4 People with disabilities, the rainbow/LGBTIQ community, and refugees (among others) also experience disproportionately poorer mental health than the total New Zealand population.

16 Current data indicate that these inequalities may be worsening.

Recent commentary

17 The *People's Mental Health Report* highlights New Zealanders' concerns about mental health services including: access to services and wait times, limited treatment options in primary and community care, compulsory treatment and seclusion practices, ineffective responses to crisis situations, and adequacy of funding for mental health services. The report notes the impacts of wider social and economic factors on mental health, including discrimination, family and sexual violence, and economic stressors such as job insecurity, low paid work and lack of affordable housing.

18 The Government's Chief Science Advisors have recently released a report, *Toward a Whole of Government/Whole of Nation Approach to Mental Health*. This report draws on local and international literature to shed light on factors contributing to the growing number of people experiencing poor mental health. The report's key points are:

18.1 Poor mental health is relatively common and prevalence is increasing. Approximately 20 percent of New Zealanders are predicted to meet the criteria for a diagnosable mental disorder each year, including substance use disorder. It is estimated that between 35 percent and 50 percent of people with poor mental health receive no treatment.

18.2 There are inequalities in mental health outcomes, for example, Māori experience disproportionately higher rates of mental disorder and higher suicide rates than any other ethnic group.

18.3 The personal, social and economic costs of poor mental health are substantial and wide-ranging – cutting across the interests of the health, social and justice sectors.

18.4 Many risk factors associated with poor mental health sit outside of the realm of the health sector – for example, poverty, inequality, inadequate parenting, exposure to abuse, neglect, family violence or other trauma, social isolation and discrimination.

18.5 These risk factors can contribute to a wide range of other poor life outcomes including low levels of educational achievement, poor employment outcomes, inadequate housing and criminal offending.

18.6 There is strong evidence that early intervention – in the illness and in the life-course - is most beneficial and cost effective. Often mental disorders are recognised only after they become severe and consequently harder to treat. Half of all lifetime cases of mental disorder begin by age 14 and three-quarters by age 24.

18.7 There needs to be a whole-of-government, whole-of-nation, long-term commitment to supporting the mental health of New Zealanders. This approach needs to address gaps in services for people experiencing poor mental health while, at the same time, reducing wider environmental stressors across the community and building the psychological and emotional resilience of individuals, family, whānau, and community.

Purpose, Objectives and Scope of the Inquiry

- 19 There is strong and vocal support from consumers, providers, experts and the wider public for changing New Zealand's approach to mental health and addiction.
- 20 I am conscious that there is a need for, and expectation of, swift action to address known service gaps and pressures. Some stakeholders consider that we simply need to get on with addressing these rather than conducting an inquiry.
- 21 We are already taking steps to address some immediate service gaps and pressures. Our coalition commitments include increasing funding for alcohol and drug addiction services, increasing resources for frontline health workers, putting more nurses into schools, extending free doctors' visits to all under 14 year olds, providing teen health checks for all year 9 students and providing free counselling for those under 25 years of age. I will continue to work closely with my colleagues from the wider social, justice and education sectors given the inter-relationships between our portfolios in relation to mental health and addiction.
- 22 Simply responding to service gaps and pressures in a piecemeal way will not be sufficient to address the mental health crisis that New Zealand is experiencing.
- 23 Existing services that prevent and respond to poor mental health and addiction issues are not well connected, creating difficulties for individuals and families who are navigating them. Neither do they provide a holistic response to the issues faced by communities, including addressing the social determinants of health. It is likely that we need a radical transformation of our approach to mental health and addiction including how these services connect with other services that meet broader social needs, including education, welfare, housing, justice, disability support, accident compensation, workplace relations and health and safety, and emergency response (this is not an exhaustive list).
- 24 In making these comments about current services, I want to acknowledge the efforts of, and pressures faced by, the current mental health and addiction workforce. The current arrangements make their jobs harder than should be the case.
- 25 I consider that a formal independent inquiry is necessary to ensure that there is an accurate picture of how well our current approach to mental health and addiction is promoting mental well-being, preventing mental health and addiction problems, and identifying and responding to the needs of people experiencing poor mental health and addiction issues. An inquiry will help build consensus on the specific changes that are needed to provide equitable and improved mental health and addiction outcomes.
- 26 To do this the inquiry will:
- 26.1 identify the variety of mental health and addiction needs that people have and how well these needs are currently being met, creating a baseline from which a proposed pathway for improvement can be outlined
 - 26.2 identify those groups of people (including those who are currently not accessing services) for whom there is the greatest opportunity to either prevent mental health and addiction problems from arising or to improve the response to their mental health and addiction problems
 - 26.3 outline a vision for what is required to ensure the mental wellbeing and high functioning of each of these groups of people
 - 26.4 identify the underlying drivers that will enable this vision

- 26.5 recommend specific changes that effectively promote mental well-being, prevent poor mental health, and identify and respond to the needs of people with mental health and addiction problems
- 26.6 recommend which entities should progress the inquiry's recommendations, including a re-established Mental Health Commission.
- 27 I consider that the inquiry should have a broad focus on both meeting the needs of people with poor mental health and addiction issues as well as prevention and promoting mental well-being. This encompasses services provided not only by the broader health and disability sector (in both primary and secondary care) but also by other sectors (including the social, justice and education sectors) where these directly relate to mental health and addiction. The inquiry could also advise on opportunities to build on the efforts of whānau, communities, employers and others to promote mental health.
- 28 The inquiry will need to understand and acknowledge the wider social and economic determinants of mental health and addiction (for example poverty, inadequate housing, family violence or other trauma) and consider the implications of these for the design and delivery of mental health and addiction services. Its commentary on these matters will help inform the Government's work programmes in these areas, including our priorities of child poverty and housing.
- 29 I expect that the recommendations from the inquiry will help inform our decisions on future arrangements for mental health and addiction, including:
- 29.1 roles and responsibilities of agencies in the health sector including a re-established Mental Health Commission
 - 29.2 approaches to service design and delivery (e.g. kaupapa Māori approaches to mental health)
 - 29.3 the suite of relevant regulatory frameworks, including the Mental Health (Compulsory Assessment and Treatment) Act 1992
 - 29.4 accountability levers
 - 29.5 funding arrangements
 - 29.6 information flows
 - 29.7 workforce planning and management.
- 30 The inquiry's recommendations will also inform the Government's future investment priorities, and provide a benchmark of current performance that will enable future improvements to be demonstrated.
- 31 As an independent inquiry, the Chair and members will decide how to conduct the inquiry within the terms of reference set by the government. To guide their approach, the draft terms of reference (Appendix A) outline several principles. These principles should help ensure that they draw on a wide range of perspectives without unnecessarily duplicating engagement that has happened through a number of recent government and non-government reviews and policy development processes. The principles also reference the special relationship between Māori and the Crown under the Treaty of Waitangi.

- 32 To give effect to this special relationship I expect the inquiry will incorporate the voices of whānau, hapū, iwi and tangata whaiora in addressing Māori inequalities in mental health outcomes. Through this the inquiry is likely to build a deeper understanding of:
- 32.1 the unique determinants of presenting Māori mental health conditions
 - 32.2 how well services respond to Māori
 - 32.3 what would be required to better address the prevention and treatment of Māori mental health, which may be outside of traditional services and informed by a Māori world-view.
- 33 It will be important that this inquiry is cognisant of and interfaces with other relevant inquiries such as the inquiry into the abuse of children in state care; and the Wai 2575 Health Services and Outcomes Kaupapa Inquiry, which will hear all claims concerning grievances relating to health services and outcomes of national significance.

Timing and Resourcing for the Inquiry and Subsequent Government Response

- 34 Based on commencement in December 2017, I propose that this inquiry reports by October 2018. This timeframe would allow the Government response to the inquiry recommendations to feed into Budget 19 decisions.
- 35 Conducting a major inquiry such as this in a relatively short period of time will require considerable resource. The Department of Internal Affairs has some cost data from recent inquiries that will be considered in developing a proposed budget for the inquiry. Recent inquiries including Royal Commissions have ranged in cost between \$1.8 million and \$10.1 million. From past inquiry experience, costs can be difficult to forecast accurately until the inquiry panel has developed its work programme. Historically, almost all inquiries have sought further funding to complete the work of the inquiry.
- 36 As the Government intends to act swiftly in response to the inquiry's report, it is important that the Government is kept appropriately informed about the inquiry's progress. To achieve this, the inquiry terms of reference will require the Chair to provide me with regular updates on the inquiry's progress. I expect a number of government agencies to be involved in responding to the inquiry's report and ultimately implementing the Government's decisions.

Arrangements for the Inquiry

Type of inquiry

- 37 I have considered a number of types of inquiry, including those under the Inquiries Act 2013 and non-statutory ministerial inquiries. I consider that the most appropriate form for this inquiry is a government inquiry, established under the Inquiries Act 2013.
- 38 A government inquiry under that Act is independent, impartial and fair. It has statutory powers to require the production of evidence, to compel witnesses and most importantly provides protection to witnesses giving them the same immunities and protections they would have before the courts. Inquiry members are also protected.
- 39 Stakeholder views on this matter indicated a strong preference for the gravitas and protections offered by an independent statutory inquiry rather than a non-statutory ministerial inquiry. In particular, experience with previous reviews has shown that many people, particularly amongst the health workforce, fear reprisals for expressing their views. The protections for

those providing evidence to a government inquiry under the Inquiries Act are therefore likely to be important for the inquiry to obtain the information it requires.

Appointing Minister

- 40 The “appointing” minister of a government inquiry, as defined in the Inquiries Act 2013, is the minister responsible for establishing the inquiry and receiving the inquiry’s report.
- 41 I have consulted the Prime Minister and the Attorney-General, as required when establishing a government inquiry. We are in agreement that I am the most suitable appointing minister.

Administering agency

- 42 Under the Inquiries Act 2013 the Department of Internal Affairs is the default department for the administration of inquiries. I seek Cabinet’s agreement for the Department of Internal Affairs to be responsible for the administration of the inquiry, supporting its establishment and operation. This would foster appropriate perceptions of independence from health sector interests.
- 43 Subject to Cabinet’s agreement, the Minister of Internal Affairs, as the Minister of the administering agency, will be the “appropriate” Minister for the inquiry and will be responsible for the funding to support the inquiry, which will be sought through the second Cabinet paper in December 2017. Neither the Department of Internal Affairs nor the Ministry of Health have baseline funding to support inquiries and cannot absorb inquiry-related costs.

Chair and membership

- 44 The Chair for this inquiry must be viewed as credible by the public and within the mental health and addiction sector without the perception of being captured by the sector. The following are key attributes for the Chair of this inquiry:
- 44.1 proven ability to lead complex, system-level reviews drawing on a wide range of perspectives
 - 44.2 experience in transforming services
 - 44.3 governance experience
 - 44.4 familiarity with machinery of government and government processes.
- 45 I intend to bring an oral recommendation to the Cabinet Business Committee regarding the proposed inquiry Chair.
- 46 Membership of the inquiry panel will be proposed in the second paper.

Next Steps

- 47 Subject to Cabinet’s approval, I intend to invite the proposed Chair to lead this inquiry, and consult them on the draft terms of reference and potential inquiry members.
- 48 I will present the final terms of reference for Cabinet approval in December 2017. This next paper will also seek decisions on the appointment and fees of inquiry members and, jointly with the Minister of Internal Affairs, the budget, appropriations and establishment of the inquiry.

Consultation

- 49 The Ministry of Health has prepared this paper in consultation with the Ministries of Business, Innovation and Employment, Education, Justice, Primary Industries, and Social Development; Departments of Internal Affairs and Corrections; and ACC, Crown Law, Health Promotion Agency, Housing New Zealand, New Zealand Police, Oranga Tamariki, State Services Commission, Te Puni Kokiri, The Department of Prime Minister and Cabinet (Policy Advisory Group), and The Treasury.
- 50 I have consulted the Prime Minister and the Attorney-General on the proposals in this paper, as required when establishing a government inquiry. I have also consulted the Minister of Internal Affairs on the proposed establishment of the inquiry. Given the broad proposed scope of this inquiry and the potential for it to result in recommendations that affect a number of other sectors in addition to the health portfolio (including the social, justice, education, workplace relations and health and safety sectors)", I have consulted other appropriate ministers.

Financial Implications

- 51 The proposals in this paper have no financial implications. However, the subsequent paper will seek new funding appropriations for the inquiry (as expenses to be managed against the operating and capital spending set out in the government's Fiscal Plan and reflected in the Half-Year Economic and Fiscal Update).
- 52 It is likely that the Government's response to the inquiry will have financial implications.

Human Rights

- 53 The proposals in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Legislative Implications

- 54 There are no legislative implications from this paper. However, it is possible that the inquiry may signal changes to be considered in subsequent regulatory reviews.

Gender Implications

- 55 The proposed inquiry will, as part of its purpose, support the rights of all New Zealanders and aim to improve the experience of all New Zealanders in relation to poor mental health and mental wellbeing.

Disability Perspective

- 56 The proposed inquiry will, as part of its purpose, support the rights and aim to improve the experience of people living with disabilities and who are needing to manage poor mental health.

Publicity

- 57 Officials are working with my office on a communications approach and supporting material, including announcement of the inquiry Chair and membership once appointed through the subsequent Cabinet paper. The announcement will acknowledge the efforts of, and pressures faced by, the mental health workforce.

Recommendations

The Minister of Health recommends that the Committee

- 1 **Agree** in principle to establish a government inquiry under the Inquiries Act 2013 to:
 - 1.1 provide an accurate picture of how well our current approach to mental health and addiction is promoting mental well-being, preventing mental health and addiction problems, and identifying and responding to the needs of people experiencing poor mental health and addiction issues
 - 1.2 build consensus on the specific changes that are needed to provide equitable and improved mental health and addiction outcomes
- 2 **Agree** that this inquiry will:
 - 2.1 identify the variety of mental health and addiction needs that people have and how well these needs are currently being met, creating a baseline from which a proposed pathway for improvement can be outlined
 - 2.2 identify those groups of people (including those who are currently not accessing services) for whom there is the greatest opportunity to either prevent mental health and addiction problems from arising or to improve the response to their mental health and addiction problems
 - 2.3 outline a vision for what is required to ensure the mental wellbeing and high functioning of each of these groups of people
 - 2.4 identify the underlying drivers that will enable this vision
 - 2.5 recommend specific changes that effectively promote mental well-being, prevent poor mental health, and identify and respond to the needs of people with mental health and addiction problems
 - 2.6 recommend which entities should progress the inquiry's recommendations, including a re-established Mental Health Commission
- 3 **Agree** that the inquiry will report back on these matters in October 2018
- 4 **Agree** that the Minister of Health will be the 'appointing' Minister for the inquiry, responsible for establishing the inquiry and receiving its report
- 5 **Agree** that the administering agency for the inquiry will be the Department of Internal Affairs
- 6 **Note** that the Minister of Internal Affairs will be the 'appropriate' Minister for the inquiry, responsible for the funding to support the inquiry
- 7 **Note** that I intend to bring an oral recommendation to the Cabinet Business Committee regarding the proposed inquiry Chair
- 8 **Invite** the Minister of Health and the Minister of Internal Affairs to report to Cabinet in December 2017 on the final terms of reference, inquiry membership, members' fees, inquiry budget and appropriations, and any other matters that may be required

- 9 **Note** that the second Cabinet paper will seek agreement for expenses to be managed against the operating and capital spending set out in the government's Fiscal Plan and reflected in the Half-Year Economic and Fiscal Update
- 10 **Note** that, subject to Cabinet confirmation of the proposed Chair, I will consult the proposed Chair on the draft terms of reference and potential inquiry members prior to lodging the second Cabinet paper
- 11 **Note** that I will keep relevant Ministers informed about the inquiry's progress.

Authorised for lodgement

Hon Dr David Clark

Minister of Health

Inquiry into Mental Health and Addiction - Draft Terms of Reference

Background

The catalysts for this Mental Health and Addiction Inquiry are addressing inequalities in mental health and addiction outcomes, concerns about underfunding of mental health and addiction services and stubbornly high suicide rates.

People can experience a broad range of mental health issues on a spectrum from mental distress to enduring psychiatric illness requiring on-going interventions. Substance use problems (addiction) often occur together with mental health issues. Poor mental health increases the likelihood of suicidal behaviour. However, not everyone who plans, thinks about, attempts or dies by suicide has a diagnosable mental disorder.

Poor mental health and addiction issues are relatively common (approximately 20 percent of New Zealanders are predicted to meet the criteria for a diagnosable mental disorder each year) and prevalence is increasing. Between 35 percent and 50 percent of people with a mental health problem receive no treatment.

Many risk factors associated with poor mental health sit across a range of social determinants such as poverty, inequality, inadequate parenting, lack of affordable housing, low paid work, exposure to abuse, neglect, family violence or other trauma, social isolation and discrimination. These risk factors can contribute to a wide range of other poor life outcomes including low levels of educational achievement, poor employment outcomes, inadequate housing and criminal offending.

Across the spectrum of poor mental health are inequalities in mental health and addiction outcomes including for Māori, Pacific and youth. People with disabilities, the rainbow/LGBTIQ community, and refugees (among others) also experience disproportionately poorer mental health than the total New Zealand population.

Recent reports, such as the *People's Mental Health Report* have raised concerns around access to services and wait times, limited treatment options in primary and community care, compulsory treatment and seclusion practices, ineffective responses to crisis situations, concerns about high suicide rates, and adequacy of funding for mental health services.

Existing services that prevent and respond to poor mental health and addiction issues are not well connected, creating difficulties for individuals and families who are navigating them. Neither do they provide a holistic response to the issues faced by communities, including addressing the social determinants of health. It is likely that we need a radical transformation of our approach to mental health and addiction including how these services connect with other services that meet broader social needs, including education, welfare, housing, justice, disability support, accident compensation, workplace relations and health and safety, and emergency response (this is not an exhaustive list).

Some actions cannot wait until the inquiry is completed. Alongside the inquiry, the Government is already taking steps to address some immediate service gaps and pressures, including increasing funding for alcohol and drug addiction services, increasing resources for frontline health workers, putting more nurses into

schools, extending free doctors' visits for all under 14 year olds, providing teen health checks for all year 9 students and providing free counselling for those under 25 years of age.

Purpose and objectives

The purpose of this inquiry is to:

- provide an accurate picture of how well New Zealand's current approach to mental health and addiction is promoting mental well-being, preventing poor mental health and addiction issues, and identifying and responding to the needs of people experiencing mental health and addiction problems
- build consensus on the specific changes that are needed to provide equitable and improved mental health and addiction outcomes.

To do this the inquiry will:

- identify the variety of mental health and addiction needs that people have and how well these needs are currently being met, creating a baseline from which a proposed pathway for improvement can be outlined
- identify those groups of people (including those who are currently not accessing services) for whom there is the greatest opportunity to either prevent mental health and addiction problems from arising or to improve the response to their mental health and addiction problems
- outline a vision for what is required to ensure the mental wellbeing and high functioning of each of these groups of people
- identify the underlying drivers that will enable this vision
- recommend specific changes that effectively promote mental well-being, prevent poor mental health, and identify and respond to the needs of people with mental health and addiction problems
- recommend which entities should progress the inquiry's recommendations, including a re-established Mental Health Commission.

The recommendations of the inquiry will help inform the Government's decisions on future arrangements for the mental health and addiction system, including:

- roles and responsibilities agencies in the health sector including a re-established Mental Health Commission
- approaches to service design and delivery (e.g. kaupapa Māori approaches to mental health)
- the suite of relevant regulatory frameworks, including the Mental Health (Compulsory Assessment and Treatment) Act 1992
- accountability levers
- funding arrangements
- information flows
- workforce planning and management.

Scope

In identifying the issues, opportunities, and recommendations the inquiry will consider the following:

- mental health and addiction needs from the perspective of both:
 - identifying and responding to people with mental health and addiction issues
 - preventing mental health issues and promoting mental well-being
- activities directly related to mental health and addiction undertaken within the broader health and disability sector (in both primary and secondary care), as well as the education, justice and social sectors
- opportunities to build on the efforts of whānau, communities, employers and others to promote mental health.

The inquiry will need to understand and acknowledge the wider social and economic determinants of mental health and addiction (for example poverty, inadequate housing, family violence or other trauma) and consider the implications of these for the design and delivery of mental health and addiction services. Commentary on these matters is welcome to help inform the Government's work programmes in these areas.

The inquiry may signal changes to be considered in subsequent regulatory reviews. It will not undertake these reviews itself.

The following matter is outside the scope of the inquiry:

- Individual incidents or cases within current services. The inquiry panel will refer these to the appropriate pathway, for example, the Health and Disability Commission or relevant authorities.

Principles

The inquiry will take an approach that:

- ensures consumers, carers, family and whānau feel they have been included and heard, which may include the acknowledgement and consideration of input from previous consultation
- attempts to build consensus between consumers, potential consumers, carers, family, whānau and providers about what government needs to do to transform the mental health and addiction system
- fulfils the special relationship between Māori and the Crown under the Treaty of Waitangi, with a view to improving health outcomes for Māori and reducing inequalities
- recognises and respects the needs of different population groups, including Pacific people, refugees, migrants, LGBTIQ, young people and rural populations
- reflects a person-centred approach in recommending system changes
- takes a whole-of-system approach, focused on all component sectors and services and how they can work better together to improve mental health and addiction outcomes
- focuses on opportunities to intervene earlier in the life course and illness course as there is strong evidence that this is the most beneficial and cost effective approach
- is based on the best available evidence, both national and international.

Report back

The inquiry is to report its findings and opinions, together with recommendations, to the Minister of Health in writing no later than 31 October 2018. In order to ensure the Minister is kept appropriately informed as to progress, the Chair will provide regular updates to the Minister on the inquiry's progress throughout the course of the inquiry.

Related work

The inquiry will consider previous investigations, reviews, reports and consultation processes relating to mental health and addiction. The inquiry is not bound in any way by the conclusions or recommendations of these processes. Related work includes (but is not limited to):

- the *Peoples' Mental Health Report*
- *Blueprint II: Improving mental health and wellbeing for all New Zealanders*
- reports from the Government's Chief Science Advisors into mental health and suicide
- various workforce reviews including *Mental Health and Addictions Workforce Action Plan 2016-2020*
- consultation on *A Strategy to Prevent Suicide in New Zealand: Draft for public consultation*
- consultation on *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*
- *Mentally Healthy Rural Communities. RHANZ Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand (2016)*
- *Fit for the Future – Summary of Stakeholder Feedback (2017)*.

The inquiry will need to consider and interface with other relevant inquiries and reviews currently underway, including (but not limited to):

- the Wai 2575 Health Services and Outcomes Kaupapa Inquiry
- the inquiry into the abuse of children in state care
- Disability Support Transformation.

Authority

The inquiry is established as a government inquiry under the Inquiries Act 2013, with the Minister of Health as the appointing Minister.