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Mental Health and Addiction Directorate
Ministry of Health

Submitted via email to mhaengagement@health.govt.nz

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Tēnā koe Mental Health and Addiction Directorate,

Thank you for the opportunity to submit on the draft Mental Health and Addiction System and Services Framework ('the draft framework').

Who are we?

Atamira | Platform Trust (Platform) is a peak body organisation representing the mental health and addiction (MH&A) non-governmental organisation (NGO) and community sector. We represent 82 MH&A NGOs and community organisations that provide support to tāngata whaiora (people seeking wellness) including Māori and Pasifika providers, and whānau and peer-led services. Platform has sought input from our members as part of this submission.

In addition to our members, Platform represents a wider network of MH&A NGOs who share the same aspiration of an MH&A system and sector that is driven by the need for better and more equitable outcomes for all. Collectively across 2020/21, MH&A NGO and community providers have supported over 80,000 tāngata whaiora[1], approximately 42% of all people accessing specialist support for their mental health or addiction needs in Aotearoa (1).

Introduction

Thank you for the opportunity to provide feedback on the draft framework. Overall, the draft framework provides a high-level strategic purpose, and sets the mental health and addiction sector on the pathway for enabling better mental wellbeing for all. We welcome the opportunity to contribute to the refinement of the draft framework.

[1]Data from Programme for the Integration of Mental Health Data (PRIMHD) data set, sourced 27/03/22.

Our submission is set out in sections, as defined by the questions asked in the draft framework document for discussion. These sections are as follows:

1. General comments
2. Is there anything else you think we should know to inform further development of the framework?
3. Are there any system or practice principles missing or that you disagree with?
4. Are there any critical shifts missing that you would include (and why), and if so, which lower priority critical shift would you drop?
5. Are there any key types of service missing, any included but should not be, or any that you believe are in the wrong category (and if so, what is your reasoning)?
6. Are there any enablers for implementing the framework that are missing, or that you think should not be included?

1. General comments

We support the strong commitment to Te Tiriti o Waitangi principles of tino rangatiratanga, equity, active protection, options, and partnership, and the aspiration for the draft framework to progress these in all aspects of commissioning and service provision.

Right now, there is a huge opportunity to transform the MH&A system amongst the wider health reforms. We believe it is important that there is a clear line of sight between He Ara Oranga (2), Kia Manawanui (3), and the draft framework, and that this is clearly noted.

We also believe the core concepts can be improved by the inclusion of a more holistic, person-centred, integrated, and transformational approach when defining the MH&A system and services. The draft framework could be further strengthened by including an accountability lens to set out clear expectations for implementation of action, such as quantification of services matched against population needs and projected growth.

We note that it is signalled that quantifying the services will follow the finalisation of the draft framework. This is an integral component of the draft framework for commissioning purposes and setting future service models, informing policy and strategy development, and laying the foundation for changes that service providers, tāngata whaiora, whānau, and communities can expect.

2. Informing further development of the framework

The draft framework states that it will 'identify the amount of services required based on population need, which in turn will make it possible to quantify the gaps and plan both future investment and the workforce needed to deliver the future services'. We commend this important point and recommend that the draft framework be improved by specifying the mechanism and process by which this will happen.

The draft framework can be strengthened by including a section about quantification of services, need, gaps, investment priorities, and workforce requirements. Access to up-to-date data on mental health and addiction need in Aotearoa New Zealand will be vital to inform the quantification of the draft framework.

We note that the most recent mental health survey, Te Rau Hinengaro: The New Zealand Mental Health Survey (4), was carried out 18 years ago in 2003/04. This survey collected information on the prevalence and impact of mental health and addiction within the community. Access to good data to inform planning both now, and in the future, is critical to understanding two of the expectations as identified in the draft framework:

1. **what** mental health and addiction services will be available to individuals and whānau

2. **how** services should be organised locally, regionally, and nationally

Fundamentally, the quantification of services and investments will define how the draft framework will be used for commissioning and procurement purposes. There should be a guide to how funding models will operate e.g., population-based resource guidelines, such as in Blueprint (1998).

We strongly believe the quantification of services matched against population needs should be included, to fully understand the expectations and principles of the draft framework.

Evidence-base and background

We recommend the context and evidence-base used to inform the framework be provided as an appendix. Where data and information was not available, such data on the prevalence and impact of mental health and addiction within the community, this should be explicitly stated.

Accountability

There is a lack of accountability or goals mentioned within the draft framework, that could be improved by including a section on accountability. The document specifies that accountability of the draft framework will be outlined in future Health Plans. However, we believe that the accountability of the draft framework should be included within the draft framework, not as an add on. This will ensure accountability measuring is all in one place, to help guide the Ministry of Health (MoH), Mental Health and Wellbeing Commission, Māori Health Authority, and Health NZ, to contribute to an effective MH&A system and its transformation.

Furthermore, the right balance needs to be struck between the requirement for central accountability for the health system (such as within the NZ Health Plan), and the need for regional and local accountability to reflect contextual issues and demands within communities. There needs to be a clear relationship defined for who holds accountability, otherwise, we risk no one taking responsibility for upholding the draft framework principles and guidance.

We suggest joined-up accountability arrangements across all appropriate health entities involved in monitoring the MH&A system – Māori Health Authority, Health NZ, and the Ministry of Health, alongside the Health Quality and Safety Commission and the Mental Health and Wellbeing Commission. This is to recognise the relevant legislative requirements placed on these entities to monitor the performance of the health system, and the work that they are already undertaking.

A specific example would be the current work being undertaken by the Mental Health and Wellbeing Commission with the He Ara Āwhina (Pathways to Support) Framework. This monitoring work will provide accountability towards achieving MH&A system transformation, by using a quality and outcomes-focused lens and determining monitoring measures. We would suggest furthering a relationship with the Mental Health and Wellbeing Commission and the He Ara Āwhina Framework, as a first port of call for examining accountability measures and testing the alignment of system or practice principles.

Language and wording

We suggest removing or minimising ambiguity in some wording of the draft framework. In particular, defining the term ‘system and services’ with particular regard to the ‘system’. This will enable a consistent understanding for all parties and clarify the scope and audience of the draft framework.

There are times in the framework document where uncertain language is used. An example of this is the use of ‘may’ on page 9 – ‘this may include personally-determined use of funding to enable good lives and prevent harm’. Using uncertain wording and indicating the possibility of something happening, but not the certainty, does not allow for good accountability measuring.

Another example of undefined and ambiguous wording is on page 13 – ‘in all areas where there is a sufficiently large Pacific population’ and ‘sufficiently large Asian population’ – but there is a lack of definition and data around the meaning of ‘sufficiently large’.

Priority populations

The draft framework could be improved by referencing the populations that experience worse mental health and addiction outcomes, and ensuring they are well reflected within the draft framework. Priority populations were outlined in He Ara Oranga (2) as Māori, Pacific peoples, refugees and migrants, rainbow communities, rural communities, disabled people, veterans, prisoners, young people, older people, children experiencing adverse childhood events, and children in State care.

Whilst Māori are well reflected, other ethnically diverse and priority populations are not. Cultural issues around stigma and discrimination, lack of culturally safe services and workforces, awareness of available services, and language barriers, make people reluctant or unable to access MH&A services.

In particular, more research needs to be done into understanding the needs for culturally and linguistically diverse services. Furthermore, the current evidence base of research into these priority populations in Aotearoa New Zealand, regarding MH&A service access and issues, needs to be thoroughly reviewed. All of this is vital for the quantification of MH&A service planning, and the need to further understand the prevalence and impact of mental health and addiction within the community (as discussed in more detail on page 3).

Some specific examples of research that have examined issues associated with mental wellbeing for priority populations, includes improving access and choice for the Deaf MH&A community – research by Jo Witko (5), and the Gaps, Challenges and Pathways to Improve Asian Mental Wellbeing report completed by Asian Family Services (6).

Commissioning

Two of the audiences of the draft framework are Health NZ and the Māori Health Authority, as the future commissioners of MH&A services. Therefore, the draft framework needs to clearly signal to commissioners that future MH&A services will deliver integrated services that are innovative and person- and whānau centric. We welcome the inclusion of 'new commissioning approaches' under the investment system enabler on page 14 of the draft framework, but we recommend that this is expanded upon.

The Ministry of Health published a Commissioning Framework for Mental Health and Addiction in 2016 (7). We suggest that the draft framework specifies the relationship between these two documents. In particular, it is important to know whether the 2016 commissioning framework has any role alongside the draft framework.

Refreshing the framework

The draft framework needs to provide an indicative timeline for reviewing or refreshing the document. As currently drafted, the framework has a time span of 10 years. We suggest that the draft framework should be reviewed at the five-year point, or more frequently, to ensure it remains current and to take into account updated data and information about need, population growth, and service gaps.

3. System and practice principles

We agree that person- and whānau-centred principles are critical to enacting transformation in the MH&A sector.

We suggest including a definition of 'system-wide principles' and 'practice principles for services', and their respective scopes. Further to this, the 'practice principles for services' includes 'services and supports', but 'supports' is not defined. We recommend defining this term to ensure continuity.

We acknowledge the holistic system-wide principle and the values behind it, but we believe that the draft framework can be improved by including the integration of social determinants of health. This would take into account the evidence that shows the social determinants can be more important than health care or lifestyle choices in influencing health outcomes (8).

The principles need to reference the inter-relationship between housing, employment, physical health, education, social, community, and cultural access, environment, and economic stability. These factors are both determinants of poor health, as well as consequences of poor health.

It is also important to note that different audiences will use the principles for different purposes. It would be good to include a statement outlining what the different purposes will be for the MoH, Health NZ, the Māori Health Authority, MH&A service providers, tāngata whaiora and their whānau, and other interested parties.

Further to outlining the purpose of the principles, it is also important that the principles have a direct relationship with the critical shifts and enablers, rather than as an add-on. Outlining clearly how these relationships fit, will help to better inform the implementation of the draft framework.

We therefore suggest the following changes to the principles (italicised terms are specific changes):

Practice principles

- Recovery-orientated principle – this should be reworded as '*self-determined recovery*.'
- Equity-driven principle – 'the system will take intentional action to achieve equity of outcomes, ensure equitable access to quality *mental and physical health* care for all, and remove racism *and bias*.'
- Harm reduction principle – this principle is not well defined. The term 'harm reduction approach' needs to be clearly defined.

System-wide principles

- The system-wide principles are lacking a focus on housing, employment, physical health, education, social and community access, environment, and economic stability.
- Anti-discriminatory principle – it is important to explicitly call out and address systemic disadvantages, stigma, and discrimination. We suggest this principle is reworded as '*eliminating stigma and discrimination'* – 'the system will be inclusive and will actively seek to *eliminate* discrimination and stigma associated with drug use and mental health issues.'
- Collaboration and innovation principle – include '*reducing silos across sectors and organisations and forming meaningful, effective relationships.'*

- Add new principle – '*leadership.'*
- Add new principle – '*an engaged, supported, and knowledgeable workforce*.'
- Add new principle – '*evidence-based and innovative services*.'

4. Critical shifts

Critical shifts are currently defined in the framework as having implications for the way in which services are delivered, the types of services delivered, and future funding priorities. We suggest that critical shifts as a concept should be more defined. Further to this, an indication of measures or timelines for when the shifts will be enacted, would strengthen the draft framework and show the impact of accountability and a plan to measure transformation.

We suggest adding information as a critical shift. Information is currently a system enabler in the framework; however, we need information and data to gather and understand service needs, prevalence, and gaps. So as defined above, it has direct implications for the way in which services are delivered, the types of services delivered, and future investment priorities in the MH&A system.

Data and information are also integral to achieving equitable outcomes for both tāngata whenua, and tāngata whaiora and whānau. The gaps within our current data reporting urgently needs to be addressed, to ensure resources and services are delivered proportionate to need or level of disadvantage. Further to this, is the need for wider understanding and investment into Māori data sovereignty, alongside strengthening general transparency of information where people have easy access to information about them.

We also recommend that 'critical shift 3: build peer-led transformation' is amended to remove the first statement - 'there will be peer support specialists in all specialist mental health and addiction services.' We fully support peer-led transformation, but this first statement does not echo this – instead, it puts the onus on the peer workforce to fit within a clinical setting and model. We recommend changing this statement to '*power-dynamics will change. There will be peer support specialists with equal status to clinical specialists in all specialist mental health and addiction services.'*

The focus of the peer-led shift should be on peer-led transformation as the title states. Peer-led transformation also means creating space for peer-led services to grow in both strategic

advocacy and leadership, and within service capacity and capability. This should explicitly be supported by nationally consistent infrastructure and investment.

5. Key types of services

The future services section sets out the MH&A services 'that will be available to individuals and whānau, no matter where they live'.

Networks

When discussing the future services structure, the draft framework states that 'mental health and addiction services will be organised nationally, regionally and locally, with networks providing support for excellence in implementing the framework and its principles'.

This statement is great in principle. It could be improved with specificity or detail. We suggest that the draft framework should include more detail about what the networks are, if they already exist or not, what organisation/s will lead them (MoH, Health NZ, Māori Health Authority, etc), including how the networks will be supported through additional resourcing and financial support, to adhere to upholding the draft framework principles and values.

There are also other times where 'networks' are referred to. We suggest being specific so that the networks can easily be distinguished within the draft framework to provide better clarity of network type. For example, when outlining regional services – 'for each type of regional service, there will be national networks formed with participation from each of the four regions, to guide planning, best practice, models of care and quality improvement.'

We suggest being explicit when defining networks, to ensure consistency and clarity for all audiences of the framework – service providers, commissioners, tāngata whaiora, whānau, and communities.

Services landscape

The services landscape is a useful diagram to show what services will be available nationally, regionally, and locally in a visual display. However, the services landscape diagram as it is currently designed seems very linear and defines the services that we have now. Visually displayed as it is, we suggest that this be modified to include a focus on integration and a person- and whānau centred perspective (as described in the system-wide principles on page 5 of the draft framework).

We recommend providing a description or reference as to what ‘primary’ and ‘specialist’ services are, to provide clarity to all audiences who will read the draft framework. It may also provide clarity if ‘inpatient’, ‘residential’ and ‘community’ services (as tabled in the regional section of the services landscape) are also defined. This could be as simple as stating that ‘specialist services will be run by NGO or community providers, or through Health NZ hospital and specialist services or the Māori Health Authority’, or through providing a diagram such as the one below.

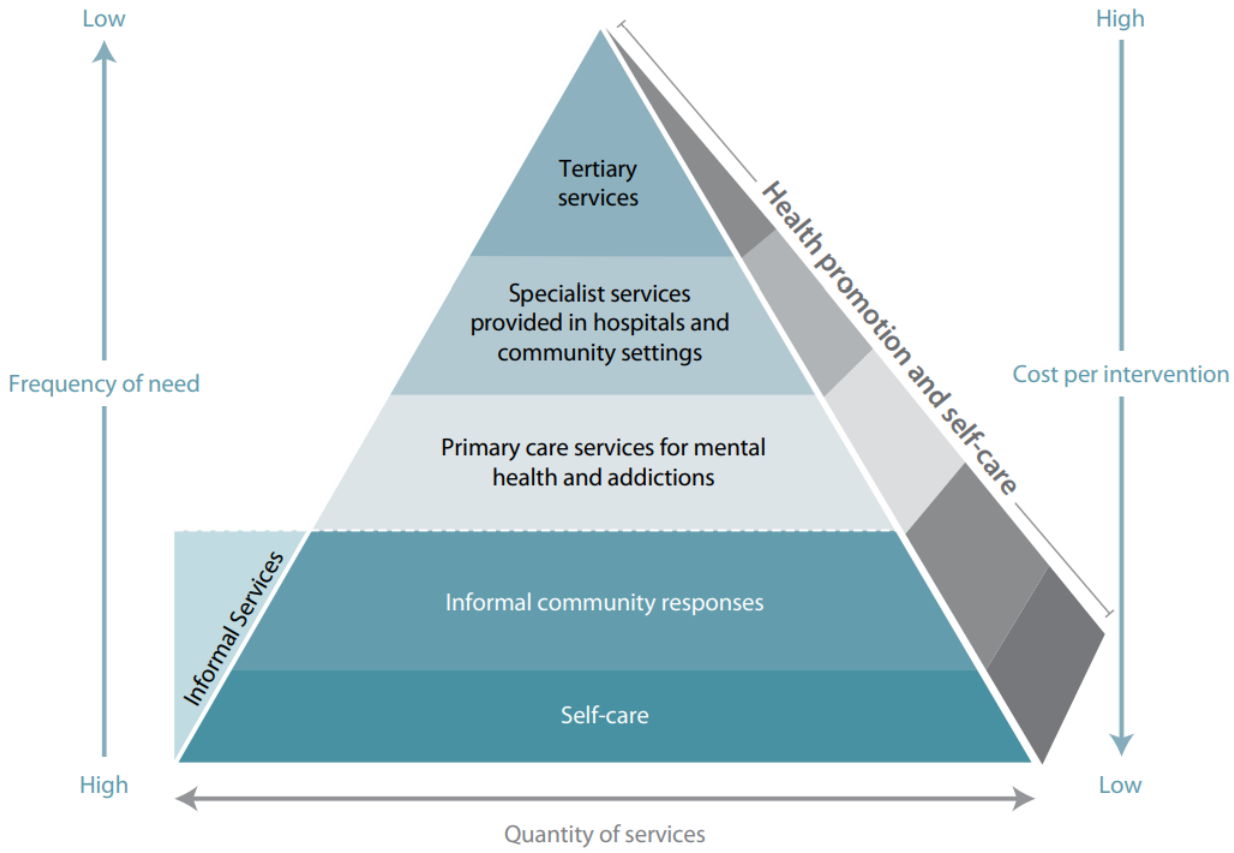

Diagram 1. A stepped care approach showing integration and formality of services (Reference from Blueprint II: Improving mental health and wellbeing for all New Zealanders (9))

We also suggest that MH&A services are integrated with functions and support that help to address the wider determinants of health. Such functions could include integrated employment, education, and housing support, physical health checks, screening, and support, and social, community, and cultural support.

An important feature of the future MH&A system is that people will be more able to access culturally capable, trusted, and valued support as and when they need it, according to their personal preferences. In doing so, the gaps and concerns regarding timely access, entry points to services, degree of integration and continuity can be shown.

This would show what is needed for tāngata whaiora and whānau to be supported in a timely and appropriate way – no matter their age, ethnicity, gender, or where they live. This would overall ensure that tāngata whaiora and whānau have the ability to self-determine their own pathway to recovery and wellbeing, so that the full continuum of services can meet the person where they are at.

Furthermore, we know that reorientating our MH&A system towards primary and community services will shorten the response pathway for tāngata whaiora, and increase access to services and support (9).Therefore, the services diagram is a fundamental tool as to how we can utilise the impending locality prototypes and collaborative networks and relationships, to best demonstrate the different components of an integrated, cohesive MH&A system.

In terms of specific types of services as outlined in the service landscape diagram on page 11, if the diagram is to stay in its current format, to improve it we suggest the addition of the following services:

i. Comprehensive integrated physical health checks, screening, and support for youth, adults, and older adults in specialist services *(add to 12 – 24 year olds / 20+ year olds / 65+ year olds / Kaupapa Māori).*

ii. Comprehensive integrated education support in primary and specialist services, with a specific focus on youth (*add to 4 – 14 year olds / 12 – 24 year olds).*

iii. Comprehensive integrated emploment support in primary and specialist services for youth and adults *(add to 12 – 24 year olds / 20+ year olds / Kaupapa Māori).*

iv. Facilitation and navigation support in primary and specialist services for all ages, to facilitate access to the wider system and services outside of mental health and addiction *(add to all ages).*

v. Specialist AOD services for youth and older adults *(add to 4 – 14 year olds / 65+ year olds).*

vi. AOD harm reduction services for youth and older adults *(add to 12 – 24 year olds / 65+ year olds / Kaupapa Māori).*

vii. Gambling harm reduction support and services for youth, adults and older adults *(add to 12 – 24 year olds / 20 + years old / 65+ year olds / Kaupapa Māori).*

viii. Peer advocacy for youth and adults *(add to 12 – 24 year olds / 20+ year olds / 65+ year olds / Kaupapa Māori).*

ix. Peer support for youth and adults *(add to 4 – 14 year olds / 65 + year olds).*

x. At a national level, promotion and prevention should be expanded to include campaigns to address prejudice, stigma, and discrimination in relation to mental distress, gambling, or addiction challenges.

6. Enablers for implementing the framework

We support the enablers as defined in Kia Manawanui (3) and as transferred to the draft framework. However, we note that 'policy' has not been carried over and we recommend that this be included as an enabler. Strategic documents such as this one, alongside operational guidance and service standards, are critical to supporting transformational system and service change.

We recommend that the system enabler 'leadership' is further expanded to include reference to leadership for outcomes, transformational change management, and supporting implementation. This is an area which has lagged in investment and development yet is so fundamental to the success of system transformation, alongside the other enablers.

We recommend that either the system enabler 'leadership' or 'information' is expanded to include a focus on quality and safety improvement, measurement, monitoring, and analysis to inform change and system improvement at national, regional, and local levels of the system.

Conclusion

Thank you for the opportunity to comment on the draft Mental Health and Addiction System and Services Framework. The draft framework has a great high-level strategic purpose that will support the MH&A sector to enact transformational change. We appreciate the sector consultation and extension to the deadline, and we welcome the opportunity to contribute to the refinement of the draft framework.

If you have any questions, please contact Abigail Freeland, Policy Analyst, at abigail@platform.org.nz.

Ngā mihi,

Memo Musa
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