Submission on the Reform of the State Sector Act 1988

The State Sector notoriously responds to complexity with siloed and fragmented responses, in part because of limitations on it under the current structure. The effect of this is acutely felt in the mental health and addictions system. Within the State Sector, mental health and addiction services are currently commissioned and/or delivered by:

- district health boards;
- the Department of Corrections (primary mental health and addictions);
- the Ministry of Social Development (child and youth, employment support, family violence, housing);
- the Ministry of Health;
- Oranga Tamariki;
- the Ministry of Education; and
- other entities such as ACC and local government.

To put it another way, a recent survey of 760 people with lived experience of mental health and addiction issues and their families identified 450 distinct services or groups that people or their families had accessed.[1]

In this siloed environment, community organisations have become adept at doing what needs to be done to meet contractual and reporting requirements while focussing on meeting the needs of the people they work with.

The State Sector must be enabled to:

- take collective responsibility for the complex challenges it is seeking to resolve,
- present a united front for citizens and the community sector to work with, and
- acknowledge when it is not the most appropriate service provider and when it needs to support or get out of the way of good work.

The Reform of the State Sector Act 1988 offers an opportunity for the structural changes to be made that will enable an environment where the State Sector can act in a way that offers more cohesive and connected services to the public (including through increasing the array of possible organisational arrangement options to improve collaboration). However, we note that changes to the Public Finance Act will also need to be made. Additionally, legislation can only prescribe expectations around principles and values, but real behaviour change will need to be led from the agencies themselves.

[1] Atkinson, M. (2018) Changing Minds Submission. *The voices of people with lived experience and their whanau. Mental health and addiction inquiry panel.* Auckland, New Zealand. Retrieved from https://changingminds.org.nz/mental-health-and-addiction-inquiry-submission/

Collective accountability means a focus on results, not risk

The structures proposed in the Reform of the State Sector Act 1988 document have the potential to offer improved opportunities for the State Sector to focus on collectively achieving results, rather than focussing excessively on public risk to an individual government agency. If agencies were jointly accountable for results, the barriers that could otherwise exist, for example in relation to resource reallocation, could be minimised in the name of achieving the collective goal.

What happens when there is one lead agency?

In mental health and addictions, the Ministry of Health is the steward of the mental health and addiction system and the government agency that sets the mental health and addiction strategy for the country. However, Treasury last year criticised the then Minister of Health and Ministry of Health for being unable to *"articulate a clear picture of the mental health landscape, including the mental health population (and how it overlaps across agencies), unmet need, the workforce (including capacity), and the nature and effectiveness of interventions available"* (Treasury, 2017).[2]

The Ministry of Health delegates funding and responsibility to others such as district health boards (DHBs). DHBs delegate some of their responsibilities to community sector organisations and others. Sitting somewhat outside of this chain of funding and contracting are private sector organisations such as general practices, counsellors and psychiatrists. And outside of the health sector, other government agencies (listed in the introduction to this document) also have discrete and varied levels of interest in mental health and addictions service provision.

In the mental health and addiction sector there are hundreds of stories of people and families in New Zealand falling between gaps in support services, often with terrible consequences. These came to light throughout the election period and through submissions to the Mental Health and Addiction Inquiry. In many cases nobody took responsibility for the person experiencing a mental health or addiction issue or their family's wellbeing – it was someone else's responsibility because it didn't meet the criteria for their service.

So, can collective accountability work in mental health and addictions?

To put it simply, yes – it's already working. In 2014, one of Platform's member organisations believed that the problem of homelessness in Hamilton was one that required collective action, including through their organisation. The Wise Group founded The People's Project together with Hamilton City Council, New Zealand Police, Ministry of Social Development, Child, Youth and Family, Housing New Zealand, Department of Corrections, Waikato District Health Board, Midlands Health, Hamilton Central Business Association and Te Puni Kōkiri. The People's Project uses the Housing First model that means that all agencies are working toward the goal of supporting people to attain and sustain suitable housing as a step toward addressing the issues that led to homelessness. The People's Project has housed 959 adults and families with children. And the Housing First model is now in action around New Zealand in Christchurch, Tauranga and Auckland.

As another example, Equally Well was founded as a Collective Impact initiative in 2014 with Te Pou o te Whakaaro Nui taking on the backbone function. More than 100 organisations from all across the health and social sector (and beyond eg Community Energy Network) are working toward the common goal of reducing the physical health inequities experienced by people who experience mental health and addiction issues. While this example speaks more to collective action than shared accountability, the public nature of commitments to Equally Well means that if an organisation was acting in a way that contradicted the Equally Well principles, it could conceivably be held accountable.

[2] Meier, C. 2017, August 2. *Treasury found Minister of Health's mental health strategy not 'coherent' two months before Budget.* Retrieved from https://www.stuff.co.nz/national/health/95329870/treasury-found-minister-of-healths-mental-health-strategy-not-coherent-two-months-before-budget

Government can take collective accountability too

We do not have to look to far to find examples of the government agencies taking collective accountability for issues, although as the Productivity Commission report observes, these have often been programme specific[3]. Smaller scale integrated case management examples such as Strengthening Families and larger scale commissioning examples such as Whanau Ora offer insights into what can be accomplished with shared goals between government agencies.

Our submission to the Mental Health and Addiction Inquiry urged collective accountability from our Parliament and public servants, with our recommendations being to:

- generate cross-party commitment to setting a long term vision for the future;
- establish independent commissioning; and
- invest in the capacity and capability of the community sector.

We would recommend that you read our submission to the Inquiry as a companion document to this submission. It is available on our website by clicking here.

Ultimately, we believe that there must be a more joined-up response to mental health and addictions as one of those areas where outcomes require coordinated efforts of more than one government agency. Enabling structural changes that facilitate a collaborative approach and that place collective accountability at all parties' feet can only improve what is currently a fragmented mental health and addiction support system.

[3] New Zealand Productivity Commission (2015). *More effective social services.* Wellington, New Zealand

The public, and the community sector, aren't really concerned with what's on your letterhead

It makes sense that every Ministry and every public servant should be held to a shared set of principles and values. We already have these expectations of how you should behave toward the public and your Ministers.

Should navigators be necessary for people to access the support they need?

The public service should do whatever is needed administratively to ensure that the burden of connecting multiple services is not shifted to the person seeking support or services. We would see this as a commitment to service articulated in the consultation document.

'…a caring society requires public services that are coordinated and easy to navigate, and whose systems work with one another to meaningfully address people's needs.'[4]

Citizens and community organisations don't care what's on a government agency's letterhead or what's going on behind the curtain to get them the support that's needed. When a person needs support or services from the public service, they shouldn't need to first find a person to help them to find the right doors to knock on.

'The fragmentation of social services to the detriment of clients with complex needs, such as Denise is a long-standing issue that has proved difficult to resolve, despite many attempts. Fragmented services make it difficult to provide the best mix of services at the right time for such clients. As a result, services are often ineffective at improving outcomes for clients. Fragmented delivery is usually a symptom of problems in the way social services are commissioned and contracted.'[5]

We have high expectations of public servants, wherever they work

The proposed principles and values set out in the consultation document describe what we would consider a minimum standard for the public service. We would expect this of the wider group described in the consultation paper as the Public Service that includes Crown Entities.

Of the principles, we particularly value the reinvigoration of the concept of free and frank advice. We believe that Ministers need to be informed of the true nature of the things they are making life altering decisions about. The expectation of bold, honest and evidence-driven advice to Ministers would be welcomed by our sector.

Overall, the principles nicely align to the standards that we expect from the public service, and we agree with the fundamental values that you have identified for public servants. We understand that leadership is one of the drivers of culture in government agencies and that the legislation alone cannot create a culture that upholds those principles and values, but we appreciate that explicitly articulating the principles and values in legislation gives them strength.

[4] Atkinson, M. (2018). *Changing Minds Submission. The voices of people with lived experience and their whanau. Mental health and addiction inquiry panel.* Pp. 63-64. Auckland, New Zealand. Retrieved from https://changingminds.org.nz/mental-health-and-addiction-inquiry-submission/

[5] New Zealand Productivity Commission (2015*). More effective social services.* P.17

Government can't and shouldn't do it all

We know that the discussion of when the Government should be the health and social services provider and when others should be is, in many respects, an ideological and/or political one. But, beyond the strong values and connections to community that community organisations have, we think there is growing evidence that the community sector is punching above its' weight for both innovating and implementing internationally evidenced approaches in their communities with great success.

The community is already responding

While we note that a number of the reforms suggested in the consultation document exist for the purpose of enhancing the agility of the State Sector, we believe that the limitations of that agility must be clearly understood. Further, others who are already working effectively in key areas should not be undermined in their work by government agencies' preference to do the work in house.

People who experience mental health and addiction issues make up the largest group of people on sickness-related benefits, and this is increasing. In fact, it may be even larger - long term worklessness negatively impacts many people's mental health, so there will be many people claiming benefits who have mental health or addiction issues, it just won't be their primary reason for claiming. Of concern, people accessing a Jobseeker allowance who were identified as having a mental health condition as their main health condition and who moved off a benefit 'had a lower chance of maintaining substantial earnings and a higher chance of returning to benefit than those with other health conditions or disability'[6].

More than 26 randomised controlled trials have shown that a person's chance of getting a job is more than doubled, if you align employment support practices to the individual placement and support (IPS) approach. The United Kingdom support this approach and are scaling up these services, in secondary and primary health services. In New Zealand, a number of non-government organisations routinely use the IPS approach. One of our members successfully supports 75 percent of people into a job.

The Productivity Commission report highlights that, unlike Australia, less than 20% of employment support is contracted out to the non-government sector in New Zealand. There is huge potential to increase the provision of evidence-based employment support services by non-government providers, who have the expertise and knowledge of their local communities. Of course the same goes for many other forms of support already provided by the community sector, such as housing support.

The success of many of these approaches relies on relationship development and skillsets that are intrinsically found in the community sector. Most community organisations take a strengths-based approach to working with people and will do whatever is needed to walk alongside someone for as long as needed. Community organisations are often more agile than government agencies and can more flexibly respond to emerging needs in their communities. There has been a trend for government agencies to acknowledge models developed or tested in the community sector and to appropriate them into government agencies, often drawing the workforce away with higher paid positions than community organisations can compete with. This trend undermines the community sector.

Existing data and evidence don't tell the whole story

We are excited to see the Living Standards Framework and Indicators Aotearoa work underway to begin to measure and value the factors of life that are important to New Zealanders beyond economic measures. However, there are risks in government agencies relying too heavily on data and evidence that is within easy reach.

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[6] Ministry of Social Development (2018). *What happened to people who left the benefit system during the year ended 30 June 2014.* P. 55. Wellington, New Zealand. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/benefit-system/people-leaving-benefit-system-online.pdf

Measuring social outcomes is a challenging business and one that we and others have been working on for some time. You can view *A Review of the Use of Social Outcome Indicators* report on our website[7]. Were policy to be created by public servants in a vacuum, without input from the community sector and the people we work with, it would miss the nuance and context so vital to success and recovery (outcomes) for the people our members work with. Data in the IDI has its limitations around both data quality and its ability to determine causality, and traditionally most of the evidence or literature in mental health and addictions is borne out of the biomedical model. The community sector has little capacity to evaluate its work. In the absence of robust evidence about the social determinants of health and wellbeing and the factors that contribute to achieving social outcomes, we are concerned that government may choose policy interventions that perpetuate the status quo or do harm.

Throughout the consultation document there is a great deal of discussion about the State Sector improving its ability to work with itself, but it also needs to understand the necessity to work collaboratively with others outside. And we believe it needs to know when to support or simply get out of the way of good work.

[7] Gaines, P. (2017). *A review of social outcome indicators.* Wellington, New Zealand. Retrieved from https://www.platform.org.nz/OurPublications

A note on pay equity

Our recent experience in negotiating the Mental Health and Addiction Support Worker Pay Equity Settlement has been that, while extremely positive for support workers as the lowest paid but largest workforce group in mental health and addictions, there are unintended consequences. The community sector has experienced decades of stagnant contract funding from the Crown and, as a result of the increase in pay for support workers, the pay gap has closed between them and their colleagues, such as team leaders or managers. If community organisations are to continue to deliver essential services they will need funding to adequately remunerate others in their workforce in this new and unanticipated environment.

The nursing multi-employer collective agreement (MECA) and the proposed social worker pay equity settlement, which will only apply to Oranga Tamariki employed social workers, mean that the gap between pay rates for these workforces employed by non-government organisations and government agencies has grown. These workforces may be drawn away from the non-government sector into government agencies for employment conditions that the community sector simply cannot compete with, putting at risk the service quality in the non-government sector. Indicatively, Platform's members employ more than 200 nurses and social workers.

We wanted to acknowledge the suggestion that the Commissioner have oversight of the flow on effects of pay equity settlements on the wider economy. Community organisations support 65,000 people in mental health and addiction services. It is important to the viability of the mental health and addiction system that improved working conditions in one part of the system don't unintentionally undermine another part of the system. An independent oversight of these impacts would be beneficial.

About Platform

Platform Trust is the national network of community organisations providing a wide range of services that respond to the mental health and addiction needs of individuals, families and communities in New Zealand. Some examples of the work our members undertake are:

- Social housing, housing brokerage
- Employment support
- Healthy lifestyle intervention programmes
- Advice and advocacy
- Vulnerable child, child and youth services
- Peer support
- Education and training
- Family support
- Suicide prevention
- Arts programmes
- Addiction counselling, clinical support and methadone treatment
- Whanau ora services
- Respite and crisis services
- Intellectual disability services
- Specialist services such as eating disorders, refugee and migrant, trauma support
- Residential services
- Strategic sector workforce development
- Social services
- Software solutions for the sector

Platform's membership provides information and intelligence about mental health and addiction service delivery across the country, which in turn drives the strategic vision of the Trust. Access to the perspective and experience of Platform's membership has proved critical in a dispersed health purchasing system, and Platform is one of the few agencies able to provide a national overview across DHB areas.

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