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Tēnā koe New Zealand Productivity Commission,

Thank you for the opportunity to submit on the interim report ('the report') for the 'a fair chance for all' inquiry.

Who are we?

Atamira | Platform Trust (Platform) is a peak body and membership organisation representing the mental health and addiction non-governmental organisation (NGO) and community sector. We directly represent 83 mental health and addiction NGOs and community organisations that provide support to tāngata whaiora (people seeking wellness), including kaupapa Māori and Pasifika providers, and whānau and peer-led services.

In addition to our members, Platform promotes a wider network of mental health and addiction NGOs (~200 service providers in 2021[1]) who share the same aspiration of a mental health and addiction system and sector that is driven by the need for better and more equitable outcomes for all.

Collectively across 2020/21, mental health and addiction NGO and community providers supported over 80,000 tāngata whaiora, 36.5% of which were Māori and 6% Pacific Peoples[1], approximately 42% of all people who access specialist support for their mental health or addiction needs in Aotearoa New Zealand (Mental Health and Wellbeing Commission, 2022).

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

Introduction

Overall, the report is a thorough and well-explained journey into persistent disadvantage in Aotearoa New Zealand, exploring the different lenses and aspects through which it can be examined. We strongly support the cross-sector approach to the inquiry, addressing the fact that for many, persistent disadvantage is broader than the scope of one public sector agency or sector.

We agree with many of the statements in the report, including the statement that system-wide change is needed, starting with rethinking the values and assumptions the public management system is built on. The next stage of the inquiry, outlining the recommendations for system-wide change, will help to create a pathway for those experiencing persistent disadvantage to build on their own strengths and find a journey towards better wellbeing and mauri ora.

We strongly agree with the inclusion of an acknowledgment (Box 3.1) between the tensions of quantifying deficits for people (such as lack of housing), while also taking a strengths-based approach to identifying persistent disadvantages. This is a crucial point to include in the ongoing inquiry.

Although we support the general direction of travel of the inquiry, we do have one significant point to make about strengthening the visibility of people with experience of mental health and addiction, recognising the importance of priority groups for equitable outcomes. Further, we believe that the ongoing inquiry should be strongly grounded or framed in human rights frameworks and standards, as every person has a right to a reasonable standard of living.

We have kept this submission very high level, but as a network of 83 mental health and addiction NGO and community providers, we are committed to and are available to engage in any further questions you may have.

Definitions and meaning

It would be good to clarify the definition of ‘disabled people’ to know if people with experience of mental health and addiction are included within this definition. Further to this, we believe that people with experience of mental health and addiction should have increased visibility in the inquiry.

We believe that the inclusion and visibility of tāngata whaiora or people with experience of mental health and addiction could be considerably strengthened in the ongoing inquiry, particularly by having a separated population group from disabled people. Whilst some people with experience of mental health and addiction are implicitly included in the definition of disabled people, many will not be. Therefore, we strongly recommend that 'people with experience of mental health and addiction' are separately identified as a priority group facing persistent disadvantage.

The framing of wellbeing and persistent disadvantage

We agree that any new values that come out of this inquiry must be grounded in te ao Māori, in recognition of Te Tiriti o Waitangi. We support the strengths-based approach to defining persistent disadvantage, and the inclusion of He Ara Waiora (a tikanga Māori wellbeing framework), alongside the systems approach in the Pacific Wellbeing Strategy, and the Treasury's Living Standards Framework.

We think that better inclusion and understanding of mental distress, mental illness, and addiction could be strengthened within certain areas of the report and ongoing inquiry. For example, on page 20 when defining life events and circumstances that influence wellbeing or mauri ora, we suggest that "being affected by harmful alcohol, drug or gambling use" be re-worded to "being affected *by addiction, such as* harmful alcohol, drug or gambling use". This is more inclusive of all addictions and their impact on wellbeing and mauri ora.

We also wonder if the He Ara Oranga wellbeing outcomes framework could be further utilised when defining positive wellbeing. This framework outlines the outcomes that will ensure that Aotearoa New Zealand is making a real difference in improving mental health and wellbeing (Te Hiringa Mahara-Mental Health and Wellbeing Commission, 2021), and it was formed out of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (Mental Health and Addiction Inquiry, 2018).

Strengthening the visibility of tāngata whaiora (people seeking wellness)

From data in the report, we can see that sole parents, people from families with no high school qualifications, Māori, Pacific peoples, and disabled people were generally between one-and-a-

half and three times more likely to experience persistent disadvantage in one or both domains than the average New Zealander.

However, in Aotearoa New Zealand, there is a significant intersection between ethnicity, mental health and distress, addiction, and physical health, with further health inequities for Māori and Pasifika peoples (Cunningham et al., 2020). It is also globally and nationally acknowledged that people with experience of mental health and addiction have disproportionate mortality rates and comorbidities when compared to the general population, particularly due to untreated or unrecognised physical illnesses (Cunningham et al., 2014; Te Pou o Te Whakaaro Nui, 2014, 2020; Thornicroft, 2011).

Further to this, data also shows that tāngata whaiora Māori have the highest ethnic representation across mental health and addiction services, with 6364 clients accessing services for every 100,000 Māori population (Ministry of Health, 2022a), alongside higher rates of seclusion and inpatient and community treatment orders (Ministry of Health, 2022b).

Therefore, we think it is critical to see an explicit inclusion of tāngata whaiora and people with experience of mental health and addiction within the stratification of data when looking at groups or people experiencing persistent disadvantage (chapter three). We believe that tāngata whaiora may also be experiencing persistent disadvantage across the three domains and would like to see this explored within the analysis and reporting.

As an example, this could be done by linking the measures used to assess persistent disadvantage with access to specialist mental health and addiction services through the Programme for the Integration of Mental Health Data (PRIMHD), one of the Ministry of Health's national data collections.

Data on mental health, addiction, and wellbeing

We agree that Aotearoa New Zealand has poor data records and practices for looking at mental health, addiction, wellbeing, and general disadvantage across people, whānau, and communities.

We strongly agree that on recommendation R3.1 that the Government should commit to a long-term investment in a survey that explores measures of wellbeing, and set up longer-term plans to allow wellbeing and persistent disadvantage to be measured over the life course and between generations.

We think it is crucial to note that the most recent mental health and addiction survey, Te Rau Hinengaro: The New Zealand Mental Health Survey, was carried out 18 years ago in 2003/04. This rigorous population survey collected information on the prevalence and impact of mental health and addiction within the community (Oakley Browne et al., 2006). Current and accurate data on the levels of mental distress and addiction need in the population is something that we do not currently have, but urgently need.

We agree that the current analysis is lacking in some measures (such as discrimination and stigma, relationships and connections with others, and community) that are critical for the exclusion domain. We acknowledge that the incorporation of data from the General Social Survey in the final report may go somewhat towards alleviating this gap. However, we are interested to know what measures will be used to assess the exclusion domain from the General Social Survey.

We strongly agree with the recommendation R3.2 that efforts be made to ensure appropriate sample sizes are created within existing and new surveys and data collections for population groups, such as Pacific peoples, disabled people, and diverse communities, and for a broader range of exclusion measures, particularly regarding social connection, discrimination, sense of identity and belonging, and community participation.

We also recommend that existing surveys build in more robust methods of mental distress, mental illness, and substance use, rather than relying solely on brief screening tools, like WHO-5 or K10.

Causes of persistent disadvantage

We agree that a lack of adequate income, wealth, housing, health, social connection, cultural identity and belonging, knowledge and skills, employment, unstable relationships and families, and inadequate government policies and supports are all causes of persistent disadvantage. We also agree that knowledge, skills, and employment can help people exit persistent disadvantage.

We agree that the current Government policy approach and public management system is not geared towards addressing the interconnection of these determinants to affect positive wellbeing and remove persistent disadvantage.

We also consider that systemic discrimination against tāngata whaiora and people with experience of mental health and addiction also contributes to persistent disadvantage. For

example, access to the funded influenza vaccination in Aotearoa New Zealand for people with experience of mental health and addiction. Although as discussed earlier, there are huge physical health inequities and increased mortality rates, this population group has only been recognised as a group eligible for funded influenza vaccines in 2022, after five years of applications to Pharmac.

Barriers and siloes

Overall, we agree with the four barriers outlined in the report that contribute to some people in Aotearoa New Zealand experiencing much more disadvantage in their lives than others. These barriers inhibit the public management system from being able to address persistent disadvantage, and are identified as follows:

- Power imbalances
- Discrimination and the ongoing impact of colonisation
- Siloed and fragmented government
- Short-termism and status quo bias

We agree that inadequate government services can increase a person's chance of becoming persistently disadvantaged and can make it harder for people to use their own strengths and resilience to live the life they want to live. We also strongly agree that siloed and fragmented approaches persist, limiting a whole-of-system approach to preventing disadvantage.

In Table 5.1, the health contributory factor (poor access to primary health care, including mental health) is a necessary area for policy reform in Aotearoa New Zealand. We are currently undergoing a huge health and disability system reform, alongside a smaller but equally as important, transformation to the mental health and addiction system. However, these policy and legislative reforms probably won't go far enough to remove persistent disadvantage, because of the siloed nature of only focusing on the broader health sector.

For example, evidence shows the positive impact of employment on people with experience of mental health and addiction in terms of their recovery and journey to better wellbeing (Arends et al., 2014; Peterson et al., 2017; Prinz et al., 2018). Yet, the current availability[2] of evidence-based individual placement and support (IPS) employment support integrated with secondary mental health and addiction services remains low, with no coverage of integrated employment

[2] https://www.workcounts.co.nz/wp-content/uploads/2022/05/Work-Counts-IPS-Coverage-Map_2022.pdf

support across a majority of the Te Wai Pounamu South Island – West Coast, Southern, and Canterbury – or in Manawatū, Wairarapa, Bay of Plenty, and Tairawhiti, in the Te Ika a Maui North Island[3].

A cause of lack of funding and inability to scale-up integrated IPS is in part because of the fractured nature of commissioning and funding services across both health and employment, with numerous programmes and initiatives running in parallel, and highly uncertain funding from several different institutions and authorities (Prinz et al., 2018).

Table 5.2 outlining the risk aversion and power imbalance that constrains the breakdown of government silos, is correct when it talks about the need for certainty and sustainable funding for initiatives such as IPS, which are stifled by risk aversion and siloes caused by the public sector.

Unsustainable and inflexible commissioning of services

This is briefly referred to on page 65, under the heading “short-term approaches dominate”. However, we think this is a significant issue in the mental health and addiction NGO and community sector, as current service commissioning approaches continue to make it difficult to deliver flexible, responsive, integrated, and person-centred services.

Mental distress, mental illness, and addiction issues are both exacerbated and influenced by a wide range of social determinants, such as housing, education, employment, and inequitable physical health. These social determinants are all referred to as causes of persistent disadvantage within the report. However, current commissioning practices within mental health and addiction do not always enable integrated and holistic services that would support tāngata whaiora and whānau to determine their own wellbeing and recovery and address social determinants of wellbeing.

There is cross-government work underway regarding improving commissioning practices for the NGO and community sector, such as the reform surrounding the commissioning of the social sector service that is currently being undertaken[4]. As part of this reform, the recently released Social Sector Commissioning 2022 - 2028 Action Plan looks at current barriers that make a relational way of commissioning difficult, how to build on existing initiatives and successes and

[3]Coverage by Te Whatu Ora-Health New Zealand districts
[4] https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/social-sector-commissioning/index.html

support major social reforms underway, and how to better use continuous learning, monitoring, and information sharing to ensure change (Ministry of Social Development, 2022)

System shifts – accountability

We believe that accountability mechanisms are key for implementing change. Learnings and the implementation of the recommendations from this inquiry will be critical.

We strongly agree with the following comments in the report – reviews are often followed by an official response from the Government making it easy to see whether or not recommendations were accepted. However, evidence that accepted recommendations have been implemented or what progress was made is hard to find. The lack of information or consistency of information makes it difficult for the public sector to learn from the past, provide clearer evidence to inform government decisions, and build public trust and confidence.

Platform recently sent a letter to the interim Chief Executives of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority. In this letter, we referred to the complexities of accountability and the issues it has on the mental health and addiction NGO and community sector. This was outlined as follows:

> Health reforms have the potential to bring about complexities in accountability arrangements for healthcare providers across the system. It is important that any new accountability arrangements are set in a way that liberates the mental health and addiction NGO and community sector from traditional top-down control. We believe this is the only way to secure the right leadership to ensure quality, innovation and productivity needed to continue to transform the mental health and addiction system to realise the aspirations of He Ara Oranga (Mental Health and Addiction Inquiry, 2018)and Kia Manawanui (Ministry of Health, 2021).
>
> We wish to see simplified accountability arrangements which do not create duplication and onerous reporting requirements that do not add value to the role of the mental health and addiction NGO and community sector. We ask for joined-up accountability arrangements across all appropriate health bodies – Māori Health Authority, Te Whatu Ora - Health New Zealand, and the Ministry of Health, alongside the Health Quality and Safety Commission and entities such as the Mental Health and Wellbeing Commission – recognising the relevant legislative requirements placed on these entities to monitor the performance of the health system.

We believe the right balance needs to be struck between the requirement for central accountability for the health system, and the need for local accountability to reflect local contextual issues and demands. We also want to ensure that the mental health and addiction NGO and community sector accountability reflects the need to progress the transformation of the mental health and addiction system, which has a significant change implementation process ahead.

Conclusion

We thank you for the opportunity to comment on the interim report for the 'a fair chance for all' inquiry. As a network of 83 mental health and addiction NGO and community providers, we are committed to and are available to engage in any questions you may have. In the first instance, please contact Abigail Freeland, Policy Analyst, at abigail@platform.org.nz.

Ngā mihi,

Memo Musa
Chief Executive

Abigail Freeland
Policy Analyst

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