



Thematic Analysis of interviews undertaken to  
inform the interim progress report of the  
Initial Mental Health and Wellbeing  
Commission

On the Government's priorities in response to He Ara Oranga

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The Initial Mental Health and Wellbeing Commission would also like to acknowledge Allen + Clarke for undertaking the thematic analysis of the interview transcripts and the preparation of this report.

## Introduction

This report comprises a thematic analysis of 41 interviews conducted by the Initial Mental Health and Wellbeing Commission (Initial Commission) from March to May 2020 about progress since the Government response to He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction, 2018.

Interviews were conducted to inform an Interim Report of the Initial Commission to the Minister of Health on progress made against the Government's four priority areas:

- Establishing the Mental Health and Wellbeing Commission
- Publishing the Suicide Prevention Strategy and establishing the Suicide Prevention Office
- Repealing and replacing the Mental Health (Compulsory Assessment Treatment Act 1992
- Expanding access and increasing choice.

Interview questions were asked against these four priority areas, however, other topics outside of the Interim Report's scope were also raised during discussion. This report, therefore, includes an analysis of a broader range of topics and themes to reflect the overall discussion.

This report sits alongside the Interim Report of the Initial Commission and provides further detail on the common themes and voices shared than what was included in the Interim Report, which has a greater focus on progress against the four priority areas. This thematic analysis includes markers when the sections or topics align with discussion contained in the Interim Report.

It is important to note that this report provides a snapshot of people's views about progress against specific Government priorities at a moment in time – it does not attempt to link what people said to factual information about investments and progress made since He Ara Oranga, nor draw conclusions about what the next steps may be to fully realise the vision of He Ara Oranga. The Initial Commission understands the Government has committed to transformation in line with the vision of He Ara Oranga but not all of the specific mechanisms proposed in recommendations for achieving this transformation. The Interim Report of the Initial Commission provides more information on government activity and funding since May 2019.

The insights shared by people who were interviewed have been grouped into common themes. It is important to note that these themes may have been top-of-mind for people due to their recency and the questions asked during the interviews. For example, many people discussed concerns about a Request for Proposal (RFP)<sup>1</sup> process for services that,

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<sup>1</sup> An RFP is a request for service providers to provide proposals on how they will deliver the required services

depending on the timing of the interviews, was either recently completed or ongoing. The Initial Commission is delivering a report to the Minister of Health in November 2020, assessing progress of all 38 He Ara Oranga recommendations that were accepted, in some form, by Government. This report will include a follow-up on progress of the four priority areas of the Interim Report.

### People who were interviewed

Specific people were identified for an initial suite of interviews on the four priority areas and therefore are not necessarily representative of the views and experiences of all people with a central interest in mental health and wellbeing. The Initial Commission engaged with the Board and expert advisors to test that the initial group of people interviewed was sufficiently representative.

It is important to note that multiple interviews were conducted with the Ministry of Health (MoH) to capture insights about discrete topics relevant to the four priority areas. The inclusion of multiple interviews with the MoH compared to other perspectives has been taken into consideration when undertaking analysis to ensure that this voice is not over-represented.

It should be noted that throughout the document, representatives from government agencies are referred to as ‘government’ or ‘representatives from government.’ The Initial Commission recognises that those interviewed may not necessarily represent the views of government as a whole.

**Table 1: Organisations that the Initial Commission spoke to**

|  |
|--|
| <b>Primary healthcare organisations:</b> ProCare, Pinnacle, Pegasus, Compass, National Hauora Coalition  |
| <b>Non-government and advocacy organisations:</b> Platform Trust, Mental Health Foundation   |
| <b>Workforce organisations:</b> Te Pou, Te Rau Ora, Le Va  |
| <b>Pacific health services:</b> Vaka Tautua  |
| <b>Kaupapa Māori services:</b> Mahitahi Trust, Te Kuwatawata, Tui Ora  |
| <b>Whānau Ora commissioning agencies:</b> Pasifika Futures, Te Pūtahitanga o Te Waipounamu   |
| <b>Whānau organisations:</b> Supporting Families, Carers Alliance  |
| <b>Consumer organisations:</b> Life Matters Trust, Te Kete Pounamu, Balance Aotearoa, National Association of Mental Health Services Consumer Advisors (DHB-based) |

**Government agencies:** Ministry of Health, Te Ara Poutama / Corrections, Public Service Commission, Health & Disability Commission, NZ Police, Health Quality & Safety Commission, Te Puni Kōkiri,

**District Health Boards:** Waitematā, Counties Manukau, Bay of Plenty, Tairāwhiti, Nelson Marlborough, Southern

## Analysing information from the interviews

All interviews were recorded (with a couple of exceptions due to technical issues) and transcribed for the purpose of identifying key topics and themes on what people were saying.

The content of the interviews was split into topics so information could be grouped and analysed with information from other interviews about similar topics. The qualitative research tool, NVIVO, was used to organise this information. Common themes were then identified based on what people spoke about within each topic. For example, all discussions about funding and procurement were grouped, and then themes identified within the funding and procurement topic.

The number of people who spoke about each topic varied. While there were several consistent and recurring themes identified within topics, the validity of observations or insights shared by people was not weighted by the number of times it was said. The voices of Māori, Pacific peoples, and people with lived experience have been prioritised in this report where possible.

## Glossary

**Table 2: Important terms used throughout the thematic analysis**

| Term                                 | Meaning of the term used in the report   |
|--------------------------------------|--|
| People / people who were interviewed | Throughout this report, the term ‘people’ is used to refer to those people who were interviewed by the Initial Mental Health and Wellbeing Commission. It does not refer to the views of the wider public or others who hold specific interests in mental health and wellbeing |
| Mental health and wellbeing system   | When referring to the mental health and wellbeing system, we refer to all parts that provide support for mental health and addictions, including all those across health and social sectors  |
| Mental health and addiction sector   | This term is used throughout to refer to mental health and addictions services within community, primary, secondary and specialist levels of care  |
| People with lived experience         | This term refers to people from all ethnic backgrounds who have lived experience of mental health and addictions and the recovery journey, normally through their own experiences  |
| Whānau                               | Whānau has been used throughout this report as a self-defined term which can encompass a person’s wider support network, such as family, partners, friends or others   |
| Kaupapa Māori                        | Kaupapa Māori services provide health and social services for Māori within a Māori cultural context  |
| Whānau Ora                           | Whānau Ora is an approach that places whānau at the centre of decision making, recognises the strengths and abilities that exist within whānau, and supports whānau to increase their wellbeing and fulfil their potential   |

# 1. Specific population overviews

The following sections aim to capture and present a more complete narrative on what Māori, Pacific peoples, and people with lived experience have said throughout the interviews.

There are many common themes shared across a range of people who were interviewed during this process, however, there were also some unique differences specifically spoken of by Māori, Pacific peoples, and people with lived experience.

These sections draw out common themes that were spoken of by Māori, Pacific peoples, and people with lived experience. These sections do not, however, include direct quotes as many of these quotes have been used in later sections of the report where discussion across all interviews has been captured.

It is important to note that the following sections place a greater focus on the strongest topics and themes that came through from each respective voice. Therefore, the following sections may not contain every topic or theme that has also been presented when capturing discussion across all interviews.

## 1.1. What are we hearing from Māori?

### Leadership and governance

Leadership and governance is discussed further in **Section 6: Leadership and governance**

Māori that were interviewed called for greater Māori representation in leadership and governance, saying that one or two Māori voices at the table is not enough. Māori organisations reported feeling shut out of leadership and governance positions, despite asking to participate.

We heard that leadership positions are dominated by clinical perspectives. It was suggested that this prevents a holistic approach to wellbeing within the sector, and that when leadership for mental health and wellbeing lies within the health sector, everything is approached with a health lens rather than a holistic wellbeing lens.

Māori<sup>2</sup> said that increasing the representation of Māori with lived experience in leadership and governance is crucial because Māori with lived experience need to be heard and involved in decision-making directly, rather than having others speak on their behalf. They acknowledged that lived experience voices are not well represented in leadership in general – and are often unpaid or poorly paid for their contributions – and identified the lack of Māori lived experience voices in leadership as an example of institutional racism.

Māori with lived experience described how genuine engagement with people with lived experience needs to happen in safe spaces where they can speak freely and be truly heard. It

was noted that this has not always been the approach when the MoH has held hui with people with lived experience.

The need for greater whānau and community representation in leadership was highlighted by Māori organisations, who said that whānau and community participation in funding decisions was crucial to ensuring communities' needs are met. We heard a call for investment in developing specialist knowledge at community and iwi levels, to strengthen the leadership and governance capabilities at all levels of Māori communities.

Māori organisations expressed frustration that people with lived experience are consulted with once decisions have already been made or already set in stone, rendering the consultation a tokenistic exercise.

### The Mental Health and Wellbeing Commission

The establishment of the Mental Health and Wellbeing Commission is discussed further in **Section 6: Leadership and governance**

Māori who were interviewed welcomed the establishment of the Mental Health and Wellbeing Commission. They spoke of a need for independently published reports about the state of the sector and the experiences of people with lived experience and whānau, and that an independent organisation that can monitor the re-orientation of the system following He Ara Oranga would be helpful.

Māori organisations urged the Mental Health and Wellbeing Commission to establish strong Māori and Pacific representation within the Commission's leadership – particularly strong Māori and Pacific lived experience voices.

Māori organisations were concerned about the process of establishing the Mental Health and Wellbeing Commission and asked for greater transparency from the Commission about who is involved. They questioned the influence of the MoH in the establishment of the initial Mental Health and Wellbeing Commission, sharing concerns about the Commission's ability to be completely independent from the MoH, and whether or not the Commission will have the breadth and scope of power it requires to be an independent system leader.

### Funding and procurement

Funding and procurement is further discussed in **Section 7: Funding and procurement**

Māori that were interviewed noted that the RFP process had not changed since He Ara Oranga. RFP time frames remain tight and the RFPs themselves are overly prescriptive, which impedes genuine co-design with whānau. They described how RFPs do not generally have a holistic focus on wellbeing and look for outcomes that are not always aligned with what works for Māori.

Māori organisations said the RFP process is a substantial burden on their time and resources. They noted that despite new requirements for collaboration between non-government organisations (NGOs), primary health organisations (PHOs), and District Health Boards

(DHBs) on some RFPs, in reality, the processes are not always collaborative. Māori organisation described how the agendas of mainstream organisations are often prioritised, and they have to fight to be included and heard.

Māori organisations explained that RFPs are still overly competitive, forcing organisations to compete rather than collaborate. They identified this as a source of inequity for Māori organisations, who have to compete with larger and better-resourced mainstream organisations for funding.

We heard concern that the increasing focus on providing culturally responsive services for Māori within mainstream organisations is undermining Māori organisations, as Māori organisations are losing contracts to mainstream organisations that are not set up to provide effective and genuine kaupapa Māori approaches. This impacts the quality of support available to Māori. They called for greater accountability and leadership from DHBs and the MoH to safeguard kaupapa Māori RFPs and ensure that contracts are given to Māori organisations, rather than mainstream organisations.

Māori organisations spoke of the myriad of support they provide whānau that is outside the scope of their contracts. This included cultural activities that are central to how Māori organisations operate and engage with whānau, such as karakia, attending tangi, pōwhiri, and general manaakitanga to whānau. It was remarked that the people and organisations that are doing transformative and innovative things in the system are not empowered to do so through additional funding – they are making do with the little funding they have.

Māori organisations discussed the increased funding in the sector since He Ara Oranga. There were concerns that the funding made available to date is not necessarily being directed towards culturally responsive services and support that address the needs of Māori. The work to increase access to services through integrated primary mental health and addiction services was one example that was used. They said that GP clinics are not the first point of entry for Māori, and therefore increasing access via general practice settings will not necessarily improve outcomes for Māori.

Māori that were interviewed said that change is needed in how services are funded in order to value and facilitate the full range and scope of work that Māori organisations do for whānau. This was described as “... creating that permissive environment with the contracting form that allows kaupapa to thrive rather than just survive.” They said that a new RFP process would be holistic, would look at the bigger picture of wellbeing, and would prioritise community engagement.

We heard a call for greater leadership and transparency about the RFP timelines and how they link together. It was said that there is a need to move funding decisions away from the MoH, and towards an independent entity that can promote and value kaupapa Māori approaches.

After the interviews to inform the Interim Report were conducted, the MoH released a Register of Interest (ROI) process for kaupapa Māori mental health and addiction services. The Initial Commission's progress report will provide commentary on this process in the November 2020 progress report.

### Workforce development

Workforce development is further discussed in **Section 8: Workforce**

We heard that expanding access to kaupapa Māori models of care is critical to supporting the wellbeing of Māori but warned there must be a workforce that is competent and confident in delivering kaupapa Māori models of care. Māori who were interviewed stressed that there must, therefore, be a continual investment in workforce development. One example raised was Whānau Ora Navigators, who have strong relationships with whānau and are often the first port of call for whānau, but who do not necessarily have the training or support to deal with the range of mental wellbeing issues they come across.

Māori identified some pockets of progress in Māori workforce development, highlighting the work of Te Rau Ora, Kia ora Hauora, the University of Otago, and others. There was concern that the primary care workforce is running thin and does not have the resourcing to support the extra workload coming from programmes to locate more mental health care in primary care.

We heard that the increased emphasis on improving outcomes for Māori and Pacific peoples has led mainstream organisations to seek to grow their capabilities in supporting Māori and Pacific communities. As a result, they have experienced what they described as workforce poaching by mainstream organisations.

We also heard that current progress in the development of the peer-support workforce is leaving Māori behind, as the training programmes are costly and do not align with Māori needs or understandings of peer-support. They warned that this will ultimately lead to a gap in the Māori peer support workforce. It was recommended that there be a clear understanding of what a peer support workforce is and does, particularly from a Māori perspective. They said that overseas models of peer-support are often used, but that Māori have ways of engaging in peer to peer support that need to be recognised and valued.

### Access and choice for Māori

Access and choice is further discussed in **Section 9: Service design and delivery (access and choice)**

Māori who were interviewed said that access to kaupapa Māori services, including peer-support for Māori, needs to be expanded. They said there is currently a high level of regional variation in access to kaupapa Māori services and cultural support. It was described how cultural support should be considered as a normal option of support for Māori, and that cultural supports need to be easily accessible.

Māori organisations described how they were already enacting many of the He Ara Oranga principles and recommendations before He Ara Oranga, such as supporting people’s holistic wellbeing needs and working in an integrated manner. We heard positive stories of co-designed services that have been successfully established since He Ara Oranga. Māori organisations spoke of kaupapa Māori services as a beacon of hope in the system because they embody the transformation that much of the system is looking for. They said that kaupapa Māori services can be beneficial for people of all cultures.

We heard concerns about ongoing barriers Māori face to accessing specialist mental health services in many regions due to workforce shortages. Māori who were interviewed said that expanding access and choice is not only about adding more services – it’s about working directly with whānau to address their holistic needs as they arise. We heard that this is often outside of current contractual obligations, but the support is critical to whānau wellbeing. Where there are efforts to expand access and choice, Māori called for greater genuine engagement and co-design with whānau, because whānau know what they need, what is important to them, what is and isn’t working, and what could be done better.

### Suicide prevention

Suicide prevention is further discussed in **Section 10: Suicide prevention**

Māori who were interviewed felt that engagement and genuine co-design with Māori, including Māori with lived experience and whānau, in suicide prevention could be strengthened. They said that from a kaupapa Māori perspective, this needs to involve building whānau capabilities and resilience.

We heard that the overseas models of suicide prevention that are often used by mainstream services don’t work for Māori. It was recommended that suicide prevention for Māori needs to be led by Māori, explaining that there are success stories in the community of suicide prevention done in ways that are effective for Māori that should be amplified and resourced.

We also heard that suicide prevention efforts are impeded by limited access to specialist mental health services, especially in non-urban areas. There was a call for cross-sector collaboration in suicide prevention and greater access to postvention support for whānau and communities bereaved by suicide.

### The Mental Health Act

The Mental Health Act is further discussed in **Section 11: Rights and legislation governing mental health**

We heard positive feedback about work to repeal and replace the Mental Health Act (the MH Act), describing how engagement from the MoH had been genuine, and they felt their feedback had been heard and incorporated.

Māori who were interviewed shared concerns about the inequities Māori face with the current use of the MH Act, and pointed to the disproportionately high rates of Māori placed

on Compulsory Treatment Orders as one example. We heard how, given the inequities Māori face in the application of the MH Act, there should be strong Māori representation in all aspects of the MH Act repeal and replacement process.

Māori that were interviewed said that, although there has been some positive progress in moving away from seclusion practices, such as the Health Quality and Safety Commission's Zero Seclusion 2020 programme, other restrictive and coercive practices still take place.

## 1.2. What are we hearing from people with lived experience?

### Leadership and governance

Leadership and governance is discussed further in **Section 6: Leadership and governance**

Consumer organisations recognised that some organisations within the sector have implemented strong lived-experience representation in leadership. However, consumer organisations also described how, generally, lived experience voices are not well represented in leadership and governance. There was a perception of an “us vs them” attitude from leadership towards lived experience advocates and suggested it may stem from concerns among leadership that people with lived experience will apply pressure and stir the pot. They called for lived experience leadership to be strengthened at all levels, and for consumer and advocacy and representative organisations to be brought into consultation and co-design processes.

Consumer organisations described how lived experience leaders and organisations are feeling left out of decision-making. They noted that although some DHBs seem to be willing to co-design with people with lived experience, they sometimes lack the capabilities and understanding to do so effectively. We heard how whānau voices are often not included in leadership and said there needs to be a strong independent voice for whānau.

Consumer organisations explained that people with lived experience – who are experts through their experience – need to be supported to take their seat at the table. It was noted that often people with lived experience are expected to participate in co-design or other processes for free while other participants from DHBs and Ministries are paid to be there. They said this creates a significant barrier to participation in leadership and governance and suggested that lived experience is not valued enough as a form of expertise.

### The Mental Health and Wellbeing Commission

The establishment of the Mental Health and Wellbeing Commission is discussed further in **Section 6: Leadership and governance**

Consumer organisations viewed the establishment of the Mental Health and Wellbeing Commission as a positive step. They recommended that the Commission be an independent monitor of the system. We heard that in order to maintain independence, the Commission should not be involved in setting the strategy or plan for implementing He Ara Oranga throughout the system, as it would be difficult to independently monitor and assess a plan

that the Commission created themselves. It was emphasised that strong representation and inclusion of lived experience and Māori voices is critical for the effectiveness and credibility of the Mental Health and Wellbeing Commission.

### Funding and procurement

Funding and procurement is further discussed in **Section 7: Funding and procurement**

Consumer organisations noted that in general, the increase in funding since He Ara Oranga has yet to trickle down to the frontline and create a tangible improvement to access and choice. They said that the focus on championing lived experience voices in He Ara Oranga and the increase in funding available in the system has not been translated into expanding access to lived experience services yet, such as peer-support and peer advocacy.

People with lived experience described how the then-current RFP process for mental health and addiction services does not enable time for meaningful co-design with people with lived experience and whānau. It was reiterated that a new funding process should involve meaningful co-design with people with lived experience and whānau, as well as increased support for people with lived experience to contribute at governance and leadership levels.

People with lived experience spoke of a significant need for lived experience organisations in the sector, but that the competitive nature of funding and procurement processes create barriers for small consumer organisations to be sustainable when they must compete with larger and more well-resourced organisations for funding. We heard described a significant amount of work that is undertaken that is not funded, particularly around engaging with the community and with other NGOs.

### Workforce development

Workforce development is further discussed in **Section 8: Workforce**

Organisations that represent lived experience, stated that the peer support and cultural support workforce is under-developed, yet they often described the value that peer support workers bring to mental health and wellbeing services. Consumer organisations called for an increase in consumer advisors or peer support workers, and that there should be national guidelines and requirements regarding the increased number of FTE positions for consumer advisors and peer support workers throughout the sector, including in DHBs and NGOs. We heard concerns at the lack of peer support workers who were independent of the system and called for the creation of independent peer support roles.

### Suicide prevention

Suicide prevention is further discussed in **Section 10: Suicide prevention**

Consumer organisations highlighted that the Suicide Prevention Office must have strong lived experience and whānau involvement. They recommended that the Suicide Prevention maintain its independence from the MoH and called for a mechanism of accountability

between the Suicide Prevention Office and other agencies that adds weight to the Office's work.

Consumer organisations said that people with lived experience want to lead the way in suicide prevention, including in leadership discussions, but say they feel excluded from such discussions or are included at the last minute.

We heard that meaningful engagement with lived experience voices must include people who run peer-support groups and bereavement support groups. They recommended that independent lived experience and whānau advisors at the DHB level would be a helpful way to include lived experience voices in suicide prevention decision-making.

Consumer organisations reflected that the impacts and recommendations from He Ara Oranga have not materially changed the suicide prevention landscape as of yet. They said that people in distress have limited access to support, as they often do not meet the threshold of severity to access services.

We heard that oftentimes, the type of support that people in distress need – such as sitting down to talk and have a cup of tea – is not provided in primary care settings. They described how GPs have limited time and that other supports such as peer-support are valuable in this space. It was suggested that an ideal model of supporting people experiencing suicidal distress would be a 24/7, drop-in support service where people can talk things through and be connected with additional support as required.

### The Mental Health Act

The Mental Health Act is further discussed in **Section 11: Rights and legislation governing mental health**

Consumer organisations noted that overall progress on the repeal and replacement of the Mental Health Act had been slow. They described how consultation on MH Act guidelines felt like it had been rushed and was not broadly advertised, resulting in some voices not being sufficiently heard. Consumer organisations raised concerns with a lack of co-design and inclusion of whānau and people with lived experience throughout all stages of work to address the MH Act. It was noted that in parts of the Disability sector, co-design is being done well, in accordance with the United Nations convention of the rights of peoples with disabilities (UNCRPD), however, co-design is not happening in the same way in the mental health and addiction sector.

We heard that, for lived experience communities, the 'repeal and replace' terminology was important as it indicated addressing the MH Act from a blank slate, rather than amending the MH Act as it currently stands. This was considered important to build new legislation upon the basis of tino rangatiratanga (self-determination).

### 1.3. What are we hearing from Pacific peoples?

#### Leadership and governance

Leadership and governance is discussed further in **Section 6: Leadership and governance**

We heard said Pacific organisations are often called upon at the last minute to provide a (single) Pacific voice in a conversation. It was described as unfair to expect a lone Pacific representative at the leadership table to speak on what is needed for all Pacific peoples. They called for a strategy to strengthen a diverse representation in leadership and governance positions so that individual representatives do not have to hold the weight of their entire communities on their shoulders.

The appointment of the Director of Pacific Health within the MoH was referred to, noting that it is a positive step and addresses a clear gap in leadership. They noted that Pacific representation in leadership and governance is important, but that we cannot rely on specific individuals in positions of leadership to see change – that there must be a system-wide transformation that supports Pacific aspirations for wellbeing. Another Pacific organisation mentioned that Pacific workforce development should be Pacific-led and called for the establishment of a Pacific mental health workforce development centre of excellence.

#### Funding and procurement

Funding and procurement is further discussed in **Section 7: Funding and procurement**

Pacific organisations that were interviewed raised concerns that the increased funding available since He Ara Oranga has not made it to the frontline services yet.

Pacific peoples who we spoke to explained that the short time frames and competitive nature of RFPs are a burden on small NGOs who have to compete with larger, better-resourced mainstream organisations for funding. Pacific organisations said that RFPs have not been truly collaborative – explaining how some PHOs had “dominated” conversations, and that NGOs and community perspectives are not always valued in the RFP process. We heard that Pacific NGOs felt used to secure funding, but that Pacific voices are not genuinely listened to or engaged as equal partners from the beginning.

Pacific organisations suggested that to date, RFPs have not necessarily reflected the priorities or needs of Pacific communities. For example, they said that the parameters of the primary care RFP are at odds with Pacific views of primary care, which take a broader and more community-focused approach. Pacific organisations shared frustration that sometimes mainstream programmes will be funded, but culturally aligned programmes (which exist and are effective) will not.

We heard described how Pacific organisations undertake a lot of work that is not funded and noted the difficulty of securing funding for this work. They questioned why Pacific organisations were not experiencing increases in funding, given improving Pacific wellbeing

is a priority. We also heard about inequities in funding allocation, saying that despite their higher caseload than non-Pacific organisations, they receive less funding. There were also concerns that Pacific organisations are not being awarded multiple contracts to deliver a suite of services, while other non-Pacific organisations are.

We heard that since He Ara Oranga, the ability to secure funding has worsened, as they now must compete for funding with larger, better-resourced mainstream organisations that are expanding their Pacific services. They described how this is re-directing funding away from small Pacific providers and called for Pacific mental wellbeing funding to be given to Pacific providers, not to mainstream organisations that are looking to step into Pacific mental health and wellbeing.

We heard of a disconnect between what funders call co-design, and what NGOs and communities consider (or want) co-design to be. They said that funders often have specifications that must be met that are at odds with what the community needs, and that it is generally the funders' views that are prioritised. Pacific organisations noted that co-design with communities has always played an integral part of the way they work. They spoke of preferring that co-design come before funding so that community voices and needs are prioritised, rather than needing to co-design within the restrictions of an RFP.

#### Access and choice for Pacific peoples

Access and choice is further discussed in **Section 9: Service design and delivery (access and choice)**

We heard that efforts to expand access and choice for Pacific peoples are not working, because current efforts – such as increasing access via GP clinics – do not meet Pacific needs. They noted that the first point of entry into the health system for Pacific peoples is in the community or through Pacific organisations, not GP clinics. They explained that, because Pacific NGOs are still stretched, access and choice for Pacific peoples has not improved yet.

We also heard of how, outside of main centres, there is little access to culturally responsive support for Pacific communities. Particular concerns were raised about Pacific youth access to support for their mental wellbeing. Pacific peoples that were interviewed regarded genuine co-design to be the key to improving access and choice for Pacific communities.

## 2. Feedback on He Ara Oranga (the report)

This section includes explicit references to He Ara Oranga as its importance as a document. It does not include discussion on actions taken as a result of He Ara Oranga.

### 2.1. He Ara Oranga provided hope, affirmation, direction

DHBs, PHOs, NGOs, and Māori and Pacific providers spoke positively about the 2018 Government Inquiry into Mental Health and Addiction and the subsequent report, He Ara Oranga.

Consumer and whānau organisations and government acknowledged the Inquiry process and the levels of engagement that the Inquiry achieved.

“I will say that I thought the mental health review was one of the best run processes I’ve personally ever been involved with. Considerable respect and thought and time have gone into it.” (Whānau voice)

“I thought the process was really important, the process was probably as important as the document and that it engaged a huge number of people, it developed some really important narratives that haven’t really been there before and it kind of put everything out there in terms of raising profile around mental health needs and around mental health within a broader context and framework.” (Government agency voice)

NGOs, in particular, spoke of how He Ara Oranga had provided a clear direction, mandate, and a sense of hope for change.

“I think He Ara Oranga does what it says, it’s setting a pathway, a new direction and I think once people have come to terms with it then I think there is pretty strong support for the direction that’s outlined in the report.” (NGO voice)

“I believe the recommendations that came from the panel and the review actually confirmed what we in the community always know, what our whānau have been telling us, and it’s given us license to be able to do things differently.” (Māori voice)

It was noted that some parts of the community were already working in a wellbeing-focused way that aligned with the vision of He Ara Oranga, such as Māori and Pacific providers. These people felt that He Ara Oranga had endorsed their way of working.

“But the great thing is [...] He Ara Oranga did endorse our more holistic way of working. And so, we, and we’re really thankful for that.” (Pacific voice)

“We already knew what our community were needing and wanting in order to make change. And then it was confirmed by He Ara Oranga.” (Māori voice)

DHBs and PHOs noted that there had been some discussions, strategic planning or initiatives in place before He Ara Oranga, and that He Ara Oranga provided affirmation of the direction that this work was taking.

“I think this is what we live and eat every day. This, this is our mahi, this is our work. He Ara Oranga almost verbalised this and made it alive for, on a strategic level and for our exec and the wider community and just gave it a kind of a priority.” (DHB voice)

“So, He Ara Oranga, for us, provided endorsement for what we were trying to do.” (PHO voice)

## 2.2. Some perspectives were missing

While discussion around He Ara Oranga as a report was largely positive, concerns were raised that some perspectives were not sufficiently captured within the recommendations or the wider report.

Pacific organisations in particular raised concerns with a lack of focus on Pacific peoples.

“I was disappointed in the report overall. I don’t think it represented Pacific well at all.” (Pacific voice)

Whānau and consumer organisations were concerned that consultation with people with lived experience had not been sufficient or far-reaching, and that the voice of those with lived experience was not strong enough throughout He Ara Oranga.

There was concern from DHBs and government that specialist services had been neglected in the recommendations of He Ara Oranga, and that guidance on how specialist services should be transformed was missing.

## 2.3. The intent behind the recommendations of He Ara Oranga also need to be considered

**Interim Report reference:** this section aligns with Part 2: Section 1 - Transformation will occur not only from the recommendations of He Ara Oranga but also from the intent behind them

NGOs, workforce organisations and government highlighted the importance of recognising the intent behind the recommendations of He Ara Oranga.

“If there’s a focus purely on the recommendations of He Ara Oranga, some of the really key themes that are picked up in the report could get lost if we just focus on the recommendations.” (Workforce organisation voice)

It was suggested that the recommendations of He Ara Oranga outlined a pathway towards a whole system transformation, and some warned against considering and implementing He Ara Oranga in parts – that is, implementing some recommendations and not others.

“I think we have quite a big concern that it’s going to get cherry-picked and that it’s not going to be implemented as a total package, and it’s very clear in the report that it’s written as a total package.” (NGO voice)

“I guess one of the challenges is that it’s got forty recommendations and it feels a bit like, just pick those three and we’ll do those three first. But of course, actually everything all fits together.” (NGO voice)

## 3. System culture

This section includes discussion around the values, attitudes, biases, and behaviours of people and organisations in the mental health and wellbeing system.

### 3.1. Shifting the culture of the mental health and wellbeing system

People that were interviewed acknowledged that a system-wide culture shift takes time and investment. Workforce organisations and Pacific organisations expressed that structural cultural changes need to happen first, to create environments and processes that uphold behavioural and attitudinal changes in the workforce.

“It’s like turning the Titanic, you have to actually do some big structural changes before behaviour change.” (Pacific voice)

NGOs, Māori organisations, government and whānau organisations said that the culture of the current system remains medically focused and deficit oriented. They said people in distress are still often labelled as risky or dangerous, which reinforces a paternalistic and risk-averse approach to services.

“Kia aroha, me aroha. [...] Which is what our whānau are saying is missing from services and missing from the people that are working in services. Because it’s very much, the approach is very much clinical.” (Māori voice)

Māori organisations, government, DHBs, and consumer organisations said that the impacts of colonisation and breaches of te Tiriti o Waitangi remain unaddressed in the current system and that institutional racism persists, such as the disproportionately high rates of seclusion experienced by Māori. Seclusion practices are further discussed in Section 11.3 under Rights and legislation governing mental health.

Māori organisations spoke of being consistently under-represented in leadership and decision-making.

“Part of it is the institutional racism thing out there [...] we get cut out of it because there is a fear that we will push hard – and we will [...] we were very much shut out of some quite crucial pieces of work that made it quite difficult that, yeah, where there should have been a voice of Māori with lived experience.” (Māori NGO voice)

We heard of wanting to shift from a risk-focused system towards a safety-focused system. It was also recommended avoiding paternalism by instead focusing on the empowerment of people with lived experience and viewed an alternative system culture as one that is strengths-based, where the system trusts and believes in people’s capacity and potential for recovery.

“That we can trust people that are dealing with a health problem that’s a mental health problem, we can trust them to become well like we might trust [someone] to get well after she had a cold. And building that sort of trust is, I guess one of the cultural shifts that we need to do in New Zealand.” (Māori voice)

“And it might unfold, this huge history of the untold story but it’s about going forward, not about going back. It’s acknowledging what’s behind and be able to go forward so that people can live a flourishing life. It’s not rocket science.” (Lived experience voice)

Government, Māori organisations, and workforce organisations described that kaupapa Māori approaches are under-valued in the current system and are discouraged from extending their reach.

“I think there was comment made recently [...] which I found really weird is ‘[the Kaupapa Māori organisation] should stay in their lane’. I thought ‘What do you mean by that?’ We’re Tangata Whenua, this is our lane.” (Māori voice)

They said a transformed system culture would value and promote kaupapa Māori approaches in recognition that what works for Māori, works for everyone.

“And I also think that kaupapa services are the beacon of hope [...] there’s a lot of non-Māori that are looking for a lot more than what they’re getting. And I think that kaupapa offers some of those answers and solutions that others are looking for.” (Māori voice)

Māori organisations, Pacific organisations, PHOs, and DHBs said that a transformed system culture would value whānaungatanga (relationships, connections). They explained that this includes having a relationally focused ‘one team’ approach and attitude across services.

“So, from the Ministry down encouraging high trust relationships with people that are delivering the face to face care [...] having a high trust environment about the money that you put into primary care for delivering mental health services that are, will be well spent. People have good ideas and that they want to be able to put those into practice.” (Māori voice)

NGOs – Māori, Pacific, and mainstream NGOs alike – said they already operated in a relationship-focused way but recognised that it will take time for other players in the system to undergo the cultural shift towards an integrated, collaborative approach.

“It will take a huge cultural change, and I understand. I mean I sit there in meetings and I listen to these PHOs go ‘Oh, such a new way of working!’ This is our life, this is the way, we always having to go like this. This is NGO.” (Pacific voice)

Māori organisations said that a transformed system culture seeks to empower and give voice to marginalised communities. This includes valuing and amplifying lived-experience voices, and meaningfully partnering with people with lived experience.

### 3.2. Shifting the culture of the mental health and addiction workforce

Māori organisations expressed concern that Māori were sometimes still facing stigma, racism, and discrimination when engaging with specialist mental health and addiction services, which impacts upon quality of care and outcomes for Māori. Whānau groups reported that whānau still do not feel listened to by service providers.

“Even without the funding, even without a process of system transformation, we’re still not seeing an impact at a human level behind the behaviours the families are reporting; ‘I didn’t feel listened to.’ ‘Who do I talk to?’” (Whānau voice)

Workforce organisations spoke of an increase in demand for training around cultural competency (including unconscious bias training). However, it was noted that workforce training alone will not change workforce culture if the prevailing deficit-oriented culture of services is not addressed.

We heard of the need for a shift in the culture and mindset within the mental health and addiction workforce but recognised the significant difficulty of shifting what is strongly ingrained.

“Some of the problems that we’ve had actually have been with our colleagues [...] people are used to working in one way for a very, very, very long time and making shifts is very difficult. Even though you can see the advantage of a shift and a way of working, being able to physically and mentally and emotionally make that shift as a clinician is very difficult. So, I think we’re still fronting some of those challenges at the moment.” (Māori voice)

Māori organisations, government and consumer organisations highlighted the importance of a culture of compassion, kindness, aroha, and respect among the workforce. They said that empathetic and trauma-informed care, where people experiencing distress are listened to and respected, is a crucial output of the workforce culture shift needed.

“You know what it boils down to for me, you’ve got to love your people. Even if you’ve never met them you’ve got to love your people. Because that’s the driver. If you’re not in for that then don’t bother.” (Māori voice)

“It is about aroha ki te tangata. Aroha ki te whānau. Because that’s what actually drives us to continue doing what we do.” (Māori voice)

“Respect them rather than [...] saying ‘Well it doesn’t matter, we know best, medication is right’. And yeah and listen. Because that person is the most experienced person because they’ve been on that journey for a really long time.” (Lived experience voice)

Workforce organisations acknowledged that resourcing is a barrier to embodying the compassionate and empathetic workforce culture described above.

“You know, they were so rushed off their feet during a winter [...] and the kindness, dignity and respect is the first thing that goes. [...] you’re needing to focus on [...] interpersonal skills but you do also make sure that the people have time to do that.” (Workforce organisation voice)

We heard of the impact that workforce culture can have on the use of seclusion practices. This is further discussed in Section 11.3: More needs to be done to reduce seclusion practices.

## 4. System transformation

This section includes discussion around the setup and operation of the mental health and wellbeing system, (including health, mental health, and other sectors involved in the wellbeing of New Zealanders), and the general direction that the system is heading.

### 4.1. Shifting toward a new direction will take time

It was noted that, throughout the system, there was a general recognition, desire, and willingness for the system to operate in a different way.

“And I think that when we, when you look at the recommendations there is that need, too, where you’ve just got to change the way you’re doing things now. And maybe not so much in needing more funding, it’s just trying another way.” (Māori voice)

DHBs, NGOs and government described the wider system as being at the very early stages of transformation. They noticed some evidence that the system is beginning to shift towards a new direction or a new way of thinking and working, however, progress in that direction will take time.

“I think we have to be real in relation to where we’re at right now and the end goal. We’re on a journey and [...] we’re nowhere near it, that’s what I’m saying. But things are improving.” (DHB voice)

“This is quite a lengthy journey, it’s not a quick fix. It’s been described as a marathon and not a sprint and I think that’s true. But having said that we can’t lose momentum and so there’s a number of parts we need to keep an eye on to make sure that we have small steps but we also need a big direction there.” (Government agency voice)

“I think there’s definite progress but it’s slow.” (Pacific voice)

“So, most of the transformation vision there is about pretty significant change and so that doesn’t happen quickly.” (Government agency voice)

There was some discussion by NGOs and DHBs that people perceive little progress had been made to date as system transformation involves significant changes to the culture within the system, and other enablers such as workforce development and procurement processes, to shift the way the system operates.

“In terms of getting the change bottom-up, part of the problem is I don’t think there is a quick solution. Some of this is we’ve got workforce issues, we’ve got capacity issues, we’ve got capability issues, but the sector had been run down substantially over a long period of time and you can throw money at it but it’s not going to change quickly.” (NGO voice)

“You can’t just move one part of the system on its own, you’ve kind of got to lift it all up and move it, but not too much so that you cause chaos, you know you don’t want to cause harm. But you do have to sort of disrupt most, right across in a way so that people can be freed up to do something a little bit differently.” (DHB voice)

## 4.2. But there is ultimately a long way to go

A collective, system-wide response to transformation is needed

PHOs, consumer organisations and government described the response to He Ara Oranga’s call for transformation as varied and uncoordinated. They noted a lack of a joined-up, system-wide response to changing the way the system operates, with different ‘parts’ of the system responding in different ways.

“And one big issue with DHB structures and health structures, we’ve got 20 different DHBs often having 30 different ways of doing things and that variation is almost increasing rather than decreasing, really.” (Lived experience voice)

We heard that any change that is happening is often spearheaded by individuals who have the right resources and people around them.

“So, we do not have a systemic approach to change. So, it’s reliant again, on the right people being in the right positions at the right time and trying some stuff. So, I do see people trying some stuff. It feels like it’s against the tide rather than with the tide, so they’re doing it at personal cost.” (NGO voice)

Concerns were raised with the decentralisation of decision making in the current system, suggesting that this decentralisation was a barrier or made system transformation difficult.

“I would say one of the challenges that we have is that we’ve got a decentralised system, our decision-making processes are all over the show. We’ve got multiple decision-making processes to solve the same problem. And the systems that we’re using are no longer fit for purpose.” (NGO voice)

NGOs in particular pointed to the Health and Disability Sector Review and suggested that this review might have an impact on how the mental health and wellbeing system is structured and operates moving forward.

“And the transformational systems change, I don’t know about other people, but I sort of deducted at a really early stage of the Inquiry that it would be the Health and Disability Systems review that was actually going to do the transformational systems change not He Ara Oranga.” (Pacific voice)

#### We need a long-term implementation plan

**Interim Report reference:** this section aligns with Part 3: Area 4 – A clear, long-term plan we develop together

NGOs, DHBs, government and consumer organisations spoke of the need for a long-term plan surrounding the implementation of He Ara Oranga. It was noted that the implementation of the He Ara Oranga recommendations could not happen all at once, but that a long-term implementation plan could guide what work needs to be underway now to achieve long-term transformation. An implementation plan and clear communication were considered critical to ensuring that the vision of He Ara Oranga was retained, and that everyone involved in the system understands the journey.

“Well actually there is no plan, it’s just a statement. And yes, the Government has picked a few of those recommendations that it wanted to get early wins on, but it’s very concerning that they haven’t given us a plan and any sort of formal commitment to actually following through on those 38 recommendations.” (NGO voice)

“I think one important factor is having a clear roadmap about where we’re heading to, that is well owned, I think that’s the most powerful lever.” (Government agency voice)

#### The response has been more of the same

**Interim Report reference:** this section aligns with part of Part 2: Section 4 – Systems and processes have not changed enough to support transformation

We heard that it may be easier for those in government or DHBs to see evidence of progress, however those on the front lines may not have the same line of sight.

“I’m just really mindful that we are in a fortunate position that we can talk about these documents and the vision and where we’re going and the strategy around it, but I think if we had this meeting with our 300 staff and the community providers and even with the whaiora they might have said that, in response to your question ‘What has changed?’ Nothing has changed.” (DHB voice)

Indeed, those on the front lines – such as NGOs, Māori, Pacific, and consumer organisations – often expressed that they have not yet seen signs of system transformation, or evidence that the system is trying to do things differently. They spoke of the system as continuing to do more of the same.

“He Ara Oranga called us to disrupt the system and transform it. But we don’t see too much disruption that’s enabling a different way of doing things yet. And [...] we need to do that; we need to encourage disruptive ways of doing things.” (Lived experience voice)

“And so, we’ve, we’re forced into doing the same old, same old, and calling it transformative and it’s seriously not.” (NGO voice)

### A focus on health and illness

**Interim Report reference:** this section aligns with Part 2: Section 3 – We need a system focussed on wellbeing instead of health and illness

NGOs in particular, noted that the system still largely operates under a biomedical and deficit-based paradigm, with a focus on illness, diagnosis, and cure as opposed to wider wellbeing and recovery.

“The current paradigm is very much rooted in the notion of mental illness being something that people somehow catch or get because they’re broken and then they get fixed by doctors and nurses and counsellors and services fix people who are somehow in deficit, are somehow broken. That’s not the vision of He Ara Oranga but the strong focus on services just reinforces that unless we have a very clear commitment to the overarching plan of the full 38 recommendations.” (NGO voice)

Māori providers, DHBs, consumer organisations and PHOs wanted to see a paradigm shift in the way the system operates, with a much stronger focus on wider wellbeing, equitable outcomes, taking a strengths-based approach, working together in a joined-up way, and addressing the social determinants of mental health and addiction.

“I still think that the system is still too driven by a psychiatric model – and I know that’s really important but if you think about wellbeing models, they’re much broader than just the psychiatric type response and we need to have a much more holistic response around mental health and wellbeing, I think.” (DHB voice)

“Our overarching concern is that we desperately do need to see a major paradigm shift in the way we approach mental health and wellbeing, and that paradigm shift means that it’s not just about service delivery. The report is really clear about that and indeed things like addressing social determinants of all mental health outcomes, creating positive social determinants, and

promoting wellbeing, promoting the skills, environments, behaviours, habits, health practices that uplift wellbeing, and go beyond a deficit model.” (NGO voice)

A system shift towards wellbeing was described as needing to be people-centred and informed by those with lived experience. Māori and Pacific peoples, in particular, wanted to see a commitment to system transformation and doing things differently from a wellbeing perspective. This meant looking to communities for solutions and planning system transformation around what people said they need to address their wider wellbeing.

“Because if you don’t flip it, you’re just tinkering, you’re tinkering. So, I think as long as we say, ‘Here’s a system’ and fit Māori and Pacific into it, rather than say ‘Here’s Māori and Pacific, what does the system need to look like?’ We’re going to be the same.” (Pacific voice)

### The impacts of COVID-19

Government agencies noted that the challenges of COVID-19 have shifted the national conversation around mental health and addiction towards one of wellbeing.

“There has been a significant increase in focus on the promotion of mental wellbeing and resilience in response to COVID-19. There has been more collective effort to promote wellbeing in the last month than has been done in the recent past, and we should continue to build on that.” (Government agency voice)

The interagency response to COVID-19 has shown that different agencies and providers can work together to put people first. Government suggested that the situation around COVID-19 has provided a unique opportunity to assess what the system’s ‘new normal’ might look like coming out of COVID-19, including an opportunity for a greater whole-of-government joined-up response to wellbeing.

“There is a really good opportunity right now for joint Government effort to do its utmost to make sure that peoples wellbeing is looked after. It makes it even more important than it was when He Ara Oranga was done.” (Government agency voice)

“We’ve been able to show during COVID that we’ve been able to actually come together across agency, share information and make contact in a proactive way with vulnerable people in our community, to check-in. Is there anything we can do to keep you well, to keep you safe, what do you need from us for us to keep you, in your bubble or isolating well or free from harm or whatever.” (DHB voice)

“How do we not go back to business as usual; how do we maintain this momentum and this different focus; you know the improved collaboration.

[...] how do we stop this going back to the way things were?” (Government agency voice)

## 5. Partnership throughout the system

### 5.1. Partnership with Māori, Pacific peoples, whānau and people with lived experience

This section includes discussion around the partnership with, and participation of, Māori, Pacific peoples, whānau, and people with lived experience through the mental health and wellbeing system including involvement in planning and governance decisions as well as involvement in service design.

The terms used to describe partnership and co-design varied across the interviews. For example, there were references to co-design, co-production, consultation and engagement, and partnership. It is important to note when reading this section that the terms used can mean different things to different people.

There has been some progress to improve partnership and participation

DHBs, PHOs, government and consumer organisations described or noticed some steps that have been taken to increase partnership with and participation of Māori, Pacific peoples, whānau, and those with lived experience in decision making and planning discussions.

“When we started this [...] there were very few Māori in the room, very few consumers, very few family members, and over the last two and a half years now we’ve got in our project teams, consumer, family, and some Māori.”  
(Government agency voice)

“We had to do something differently and we had to put the people first, not necessarily what, you know, what the care worker wanted, it was actually more about ‘What do the people need to stay well over this time?’ And to me that’s co-design. ‘What do you want?’” (Lived experience voice)

Māori organisations, in particular, reported developing successful partnerships with whānau and people with lived experience when designing and evaluating services.

“So, I think that co-design has been evident all the way through. [...] we absolutely welcome any type of feedback and that is part of that design process because unless you experience it you can’t feed into it. So, whether that feedback was negative or positive it helped us to develop what needed to be developed, it helped us to get rid of what needed to be gotten rid of that wasn’t working for our whānau, for our community.” (Māori voice)

“Nothing got approved unless our whaiora approved it. So as to give the whaiora an idea of what each whare looked like, we mapped out on the floor, we put tape on the floor to show how big it was, where the doors were going

to be so people could walk in and out of it, we stuck a bed in there and a chair in there and we kind of said to them, 'Is this something you think you'd like? Do you want it bigger? Do you want it smaller? Do you want that over there? That over there?' We had so much fun doing that, so much fun."

(Māori NGO voice)

Progress included how some organisations, such as DHBs and PHOs, have taken steps towards building up leadership capability by establishing leadership groups and networks for those with lived experience.

"So [we are] looking to prioritise that come July in terms of establishing some peer-led roles across east and west and kaupapa to help pull together a lived experience network. But they've already started those discussions and started to sort of socialise that idea." (DHB voice)

### Partnership and participation need to be strengthened

While there were reports of efforts to increase participation, there were concerns, particularly from workforce organisation, NGOs, PHOs, and consumer organisations, that these efforts did not always result in meaningful participation of Māori, Pacific peoples, whānau, and those with lived experience in planning, decision-making, and service design and delivery.

We heard disappointment that so far, co-design has been led by government, rather than those with lived experience.

"What we're seeing with the Ministry of Health stuff is that rather than being involved in a co-design sense from the get-go, we're being presented with fully developed documents and asked to provide feedback. And that's not the expectation that our community has for how that should be happening."

(Lived experience voice)

PHOs and DHBs highlighted that there are some areas where co-design efforts are lacking and need to be improved.

"So, we're partnered with [consumer group] to help link into that consumer voice at a national collaborative level but locally, yeah, I'm not convinced that we know how to do that well. Even if we get people to the table, I'm not sure that we're doing a good service in that space, unfortunately." (PHO voice)

Others noted specific groups that have been missing in co-design processes.

"Co-design and partnership have not been evident and at all layers in the system there is what looks to be like very limited or no kind of relationship or consultation with the Pacific mental health community, never mind the Pacific community." (Pacific voice)

“Because I think that’s the other voice that we’re missing, that we’re actually missing in here, it’s actually ‘Where is the whānau voice? What do the whānau want?’ They know the person best and yet we’re not listening to them.” (Lived experience voice)

Māori and Pacific organisations, whānau groups, and consumer organisations often pointed to a continued struggle to be included and listened to at the decision making and planning table. They reported feeling like they have to fight to be included at the table, or noted they were brought into the discussion late in the process and their inclusion felt like an afterthought.

“We’re fighting to be in those conversations. We’re still not hearing any evidence of what people are doing to make it a different experience for our people.” (Pacific voice)

“My struggle has been sitting in a room with non-Māori trying to get your point across. [...] there’s probably 20-odd people on that and I’m the only Māori voice there. You know. And unless I do a real haka, which of course I do, because they don’t understand it, it just doesn’t get the attention that it deserves.” (Māori voice)

Consumer organisations spoke of an expectation that people with lived experience would contribute their time for free, while others around the same table are paid for their work.

“So, the people with a lived experience are either in employment so they have to take a day’s annual leave. All the other people that attend those meetings they get paid to attend those meetings because they’re under the DHB employment. So therefore, the lived experience voice is diluted out.” (Lived experience voice)

“We need to have some petrol in the tank if we provide lived experience leadership too because it’s really quite hard to survive when no one puts any wages in your bank account.” (Lived experience voice)

We heard of inconsistent understandings between community providers and government about what co-production and co-design looks like in practice.

“There seems to be little understanding of how those services might be developed using principles of co-production where family and whānau are actually engaged as part of the process. Family and whānau continue to be a little bit of an afterthought.” (Whānau voice)

“So, when the Government talks about co-design, they talk about officials talking to officials. When we talk about co-design, we talk about going to our families and going to our communities and co-designing with them about what system works for them. Hence why we’re so successful. And so, I think

the issue is around using the term ‘co-design’ and that process.” (Pacific voice)

### Greater and more meaningful, partnership and participation are required

We heard a call for greater participation of Māori, Pacific peoples, whānau, and people with lived experience in decision making and planning, at all leadership and governance levels.

“I do believe that if He Ara Oranga is wanting to pitch this new system then [...] at the heart of that is making sure that when it comes to governance not just your usual lived experience people are involved but a lot more involved in the, when it comes to certain Boards, Commissioning Boards or panels that we, as people with lived experience have a huge stake when it comes to those governance structures because I definitely do feel like everything stems from the top and filtering out the legislation and the policies that filter down to the DHBs [...] I’d like to see things done a bit more robustly to ensure that when it does come to people with lived experience and our peers that we are not only at the table but that we are playing a huge role in the governance of what happens.” (Lived experience voice)

“[We see] the need for more collaborative leadership and that’s about making sure the right people are at the table in the discussions. That includes consumers, people with lived experience, at some point whānau and also NGOs and other players along the way.” (Government agency voice)

“We need to have lived experience engagement in design right from the start, in the governance of both the [business unit] but also the wider sector.” (Government agency voice)

Whānau Ora commissioning agencies, consumer organisations, DHBs and government raised the importance of shifting power, listening to the needs of communities, and enabling greater partnership with, and participation of, people with lived experience.

“I think when we always say ‘we know best’ rather than allowing whānau to come up with their own solutions we miss out on the change that’s possible, but we also have the risk of denigrating, dismissing, marginalising, excluding the very people that we want to be change makers of their future.” (Whānau Ora voice)

“Those holding the resources and the ability to move that actually have no idea what the communities are actually going through and don’t live it. [...] Get into the families, stop talking about it, we know that’s where it’s got to happen, make it happen, and listen to the families. They know what’s going on.” (Pacific voice)

“So, I think really, as I say, it goes back to co-design, it goes back to listening to people, it goes back to be amongst the people and appreciating anybody and everybody’s voice.” (Lived experience voice)

“Good health doesn’t get imposed from above, it comes from within communities. I think we need to recognise that the solutions aren’t clinicians bring technical skills, but solutions coming from whānau, they come from the people.” (Government agency voice)

We heard that facilitating greater participation of Māori, Pacific peoples, whānau, and those with lived experience requires setting aside enough time to enable co-production and co-design processes to occur.

“Slow down, notice, notice things, notice what’s happening and noticing means you’ll have to listen to some of the people that are affected, you have to notice what’s happening for them. So, we just have to do better on it.” (Māori voice)

In addition, NGOs and consumer organisations saw the need to create more opportunities for people with lived experience to provide feedback and evaluation of services – continually checking in with people with lived experience to ensure that services are meeting their needs in the way that they want.

“So we have, what we call whitiwhiti kōrero and I meet with our community whaiora and I, I ask them ‘Is there anything more we can do. Is what we’re doing, is it shit or do you want something, you know, how are you being treated? Are you being treated with dignity and respect?’ And then our housing recovery, we’ve got two services - I bring them in and we have a whitiwhiti kōrero together. And I say to them, ‘Have you got everything you need in your whare?’ ‘Are you getting the right support from the kaimahi?’ What do you need?” (Māori NGO voice)

“For me, when we do our consumer forums it’s an open door. [...] So I think we have to be open to people from all walks of life and people may just come along and might just want to add something the first time but as time goes on and you build that relationship they’ll then actually open up to more. I think things need to be regular because if they’re ad hoc that’s when people forget about it, but if they know the first Monday of every month there’s some shared kai, we’re going to get together and hear about the new ward and [...] we have to listen to feedback and try and get some quick wins from people.” (Lived experience voice)

DHBs and government noted the need, in some situations, to find a balance between extensive consultation and engagement, and not delaying important work that needed to be done.

“Because I know a lot of people talk about getting the community voice at the table and involved and having the community lead like the development of services of what they want but [...] often people just, they want to be able to contribute their thinking and, but equally they want you to get on and do your job as well.” (DHB voice)

“Some of the feedback we got from Māori in particular were ‘We’re being over-consulted, we’ve got multiple parts of Health coming out wanting to do co-design and hear from us, we’ve got Oranga Tamariki, we’ve got Corrections, we’re ‘over hui’d’ and can’t you guys actually talk to each other and do this across Government.” (Government agency voice)

## 5.2. Collaboration and partnership across sectors

This section includes discussion on how mental health and the broader health sector have been working together with non-health sectors to support the mental health and wellbeing of New Zealanders.

### Partnership across sectors is increasing

Government and DHBs described instances throughout the country where the mental health and addiction sector has been partnering with non-health sectors – such as education, housing, police, corrections, social development, and local government – to address mental health and wellbeing.

“We’ve really got a mantra of ‘It doesn’t matter who employs you, if you’re working with a person, you’re part of the team and then you will need to communicate and be clear who’s role is it to do what’. Otherwise we have clients that have got a case manager for mental health, a case manager from ACC, a case manager from Work and Income, a tenancy manager from Housing New Zealand, and they’re just so over-managed.” (DHB voice)

“I found that my colleagues at the Ministry of Health have been incredibly keen to engage with us and have had numerous conversations with them [...] particularly in mental health and addictions.” (Government agency voice)

“We’ve started to get together some regular meetings of other Government agencies to try and cross-pollinate and identify areas where we have common problems or we can help each other out. And every time we sit around a table there’s at least one or two areas where we can connect people. There’s not enough connection between the agencies.” (DHB voice)

Some evidence of increased partnership was seen at service delivery level, with government and DHBs describing instances of collaboration across sectors to improve some service responses, such as a more integrated crisis response.

“So one of the best things I’ve done is introduce my team in mental health to people in the Police or people in Education that they then need to liaise with so they don’t have to come back up through me to get permission [...] to talk to someone, they can just go straight through, cell phone number, ‘We’ve got this situation, can you help?’ It really gets down to that kind of level, I think. I’m just making sure that people are connected to the right people so they can solve things at the right level.” (DHB voice)

Government agencies noted that collaborative discussions and recognition of collective responsibility were also beginning to take place at higher levels across government.

“I think that there’s a growing realisation that that’s where they [the Social Wellbeing Board] need to be putting more of their oversight and their focus is how those inter-relationships work. So where there have been those discussions you know there’s a real willingness across that Chief Executive group to take responsibility across the board. So I think that’s a strong positive.” (Government agency voice)

We heard of how strong relationships built on trust, and having a collective purpose were key factors in successful partnership across sectors.

“I think probably it’s relationships. And I guess joint purpose, really. So, when we do team up with the Police or we’re teaming up with the Ministry of Education or whatever, that you’ve got a really good relationship and you can have a chat and bring resources to the table at both places.” (DHB voice)

“We’ve got those similar interests and similar objectives to achieve, so I think that’s really helpful. That’s been a helpful thing to understand right from the very beginning, as well as understanding who your people are but it’s also can we form a common goal, if you like, about what we’re wanting to achieve.” (Government agency voice)

However partnership and collaboration across sectors remains largely disconnected

NGOs and government spoke of activities to address mental health and wellbeing as being largely disconnected across sectors. There were reports of different agencies not talking to each other, and a lack of joined-up decision making and action to address common problems.

“So, both at the policy design level and the service delivery level. This requires shared vision and commitment and a whole lot of work.” (Government agency voice)

“So, we’re currently sitting in a position where Government agencies, so Health and MSD for example, are competing with each other about ‘We’re going to do this wellbeing thing and that wellbeing thing’. And it’s very

unhelpful. In the meantime we continue, I think, to be neglected.” (Pacific voice)

NGOs, consumer organisations and whānau groups reported facing continued challenges with agency ‘boundaries’ and a lack of partnership and collective responsibility at service delivery level. It was noted that when an individual’s needs spans across sectors, but sectors aren’t working together, this creates service gaps that people are falling through.

“So [the system] works if your need is straight forward, if it is with one organisation [...] if you’ve got to engage with multiple agencies it doesn’t work for you.” (NGO voice)

“So, those boundary issues around ‘Oh, it’s a Correction’s issue’, ‘Oh, it’s a drug or addiction issue’, or ‘It’s a mental health issue’. And that seesaw or that tossing it to here and tossing it to there, those are the sorts of things that need to go.” (Whānau voice)

“They’ve probably already talked to their doctor, they’re probably having some frustration with their mental health team, they might have been dealing with WINZ or Oranga Tamariki or things like that. And the system, there’s these big, big, well resourced, well-funded institutions do not talk to each other.” (NGO voice)

“And I think it particularly feels like that when you don’t fit into a neat box. Where intersectionalities come in then support falls away.” (NGO voice)

Government and DHBs spoke of the difficulty with using and sharing data across different sectors and called for greater data sharing practices to improve coordination.

“The biggest problem we have in data and analysis is the way that our system is set up and the devolution of different agencies, which has historically made it difficult to look across services and to collect information in a way that’s comparable across agencies.” (Government agency voice)

“I think it all comes down mostly to relationships to build trust. And be willing to be vulnerable around showing what you’re not doing well, being transparent with data. Sharing data is really, really helpful.” (DHB voice)

Issues regarding data sharing are also raised in Section 5.3: Collaboration and partnership within the mental health and addiction sector.

#### More can be done to improve partnership across sectors

There was a strong call from government and DHBs for increased partnership and working together proactively across sectors to address mental health and wellbeing.

“We’re all talking about the same people and we all want to help the same people and we can do that more effectively together than in silos.”  
(Government agency voice)

“The agencies could talk to each other and say ‘Hey, we’ve got a red flag here, do you know this individual?’ They would actually be able to design interventions that aren’t at the pointy end of things. That could actually put those young people, those rangatahi on a different course as opposed to being locked up.” (Government agency voice)

Government noted the importance of and potential for greater collaborative efforts to occur across sectors at a policy setting and decision-making level.

“The importance of having policy responses that enable intersecting ‘variables’, [...] for example, someone who has mental health concerns that also has housing concerns that also has children and the children have had interactions with Oranga Tamariki and they have a disability and they’re a single parent, so thinking about all of those compounding factors and how they can need, that even more sophisticated responses are needed from the system.” (Government agency voice)

There was also recognition from government and DHBs that greater partnership and collaboration across sectors at the service delivery level was needed.

“In the social care space it’s amazing how many different people are involved with the same person or family or whānau and actually we’ve just got to do it smarter together, and therefore we need to design it together and make sure we’re sharing information and we know each other and we’re actually partnering up to deliver that service so the right people are responding responsively.” (DHB voice)

“If we work together in the right way, we’re going to provide such a better service for these people who are in mental distress and it’s just a matter of working better together.” (Government agency voice)

“As we recover from COVID-19 there may be more problems with having housing, having food, having people be able to afford to live and the problems that come from that. And that’s why joint effort needs all of the different social sector agencies and others to actually make sure that you’re meeting to the extent possible, people’s basic needs.” (Government agency voice)

As previously discussed in Section 4: System transformation, COVID-19 has provided evidence that the system can partner up to address the wellbeing of New Zealanders.

“But I still think as agencies we were still stuck in silo behaviours and I think what COVID has done is kind of bust that down. And I think even if we were to reflect on our journey the first week or so there was quite a lot of tension about who does what and no that’s what we do, no that’s not what you do. And by now we actually just go let’s figure out how we do this together and all of these agencies put their hand up.” (DBH voice)

Comments around system-wide leadership to drive cross-sector partnership is discussed in Section 6.1 under Leadership and governance.

### 5.3. Collaboration and partnership within the mental health and addiction sector

This section includes discussion around how the mental health and addiction sector works together, including the integration of primary, community, and specialist services.

The mental health and addiction sector is beginning to work in a more integrated way in some areas

DHBs, PHOs and government described some examples around the country where the mental health and addiction sector has been working together in more collaborative and integrated ways. These examples included PHOs and DHBs that had made steps towards better integration between primary, and secondary care.

“It’s a different approach and what we’ve tried to do is that’s very much joining, we’ve been joining the system so we don’t have ‘You see this in primary care and you see this in specialist care’, we’ve been trying to join it up so has a much better flow.” (DHB voice)

“So working together on projects across the sector is really helpful in terms of developing the capability, the leadership across the sector, and just that cooperation and collaboration that occurs.” (DHB voice)

NGOs noted that community organisations are particularly willing to work in partnership across the mental health and addiction sector, and that this had been the case since long before He Ara Oranga.

“We only work in collaboration, we call it collaboraction [sic] ‘cause we prefer action rather than just talking.” (Le Va)

“In our current situation we’re working with a number of different community organisations to look at how we can deliver our services differently. ‘I have the technology for this, can we do this together?’ ‘I have this, can we do this together?’ It feels, from a community perspective, quite collegial.” (Lived experience voice)

“I think NGOs, NGO providers here in the mental health space have always worked together. I think the provider arm philosophy is still that divide and conquer philosophy.” (Māori voice)

PHOs noted that a significant amount of collaboration had gone into increasing access through integrated primary mental health and addiction services, and that this collaboration was evolving over time.

Increased access is further discussed in Section 9: Service design and delivery (access and choice).

“Everyone looks at the model of care, but people miss the collaboration that underpinned it [...] we couldn’t have done that without the bedrock of collaboration that underpinned it. So it’s, the service will evolve and it will mould but it’s the collaboration, it’s the relationships have been [key] really to that success of that program.” (PHO voice)

We heard that the work to increase access through integrated primary mental health and addiction services has contributed to improvements in the way primary and secondary care work together.

“I think this, the new models for Access and Choice, enhanced primary care, they are requiring specialist services to think about how they interact differently with primary care.” (Government agency voice)

However some consider that the sector is still largely fragmented

DHBs, PHOs, consumer organisations, Māori organisations and government spoke of a mental health and addiction sector that is still largely fragmented and disconnected.

“It’s very fragmented, secondary mental health services and NGO services and the primary care services. They’re not well integrated.” (PHO voice)

“I was at the same meetings in 2000 talking about fragmented services, uncoordinated, segmented, siloing of funding. You know, 20 years on we’re still there.” (PHO voice)

“We’re drifting back into old ways. We’re not thinking about how all the services can work together as one but it’s thinking about them, it’s still that ‘them and us’ thinking that we’re seeing is all pervasive.” (Lived experience voice)

“We’re finding people, individual organisations are making individualised decisions which they think is best for them without fully understanding what the impacts might be.” (DHB voice)

“But actually, the challenging thing is not having us all rush off and do our own thing without really thinking about the implications of how a decision in

one part of the health system will and do have significant implications into another.” (DHB voice)

This fragmentation included poor electronic record keeping and data sharing systems that don’t talk to each other. There were calls for improvements to be made in this area to improve integration.

“So I truly do believe that an electronic system that talked to each other nationally, that everybody had, would make a huge difference in the way we delivered service and access to services. Then I could go on and see that [person] needed a counselling session and she was available on Thursday night and I could see on that that there was three counsellors that had an opening on a Thursday night so that person’s not spending two hours in distress ringing round trying to get an appointment when it’s sitting in front of me.” (Lived experience voice)

“And then address issues of technology that stop us working in that way, like how we share information, how we get quick specialist advice when we need to so that we can keep people in the community because all they needed is just a quick check on a medication thing or some input into some specialist interventions.” (DHB voice)

We heard how integration and collaboration varies throughout the sector and country, with different parts of the system connecting in different ways.

“So there is connection at different levels in different ways.” (DHB voice)

“We’ve got a few practices which have arrangements with the local community mental health team for a psychology kind of liaison, a psychologist will come once a fortnight to put a few hours in [...] But it’s just ad hoc, it’s just because that psychiatrist agreed to do it with that practice. We don’t have a system that says that’s the way it should work.” (PHO voice)

“If you think about all of the different roles that people have got, so we’ve got the DHBs, from their world view, some of them work collectively and collaboratively, some of them don’t. Some of them are much more engaged in their own self than they are in their community. Some of them have got impossible Boards to work with and I absolutely get that.” (NGO voice)

We also heard how partnership within the sector appeared to be the exception, rather than the rule.

“A lot of people don’t want to collaborate. And sometimes there are nice examples of it working but you have to kind of go to heroic efforts to make it work at the moment.” (PHO voice)

DHBs suggested that the disconnect that ‘mental health’ has experienced from ‘health’ has had a negative impact on integration efforts.

“I think for far too long mental health has set itself up as a silo as special. And I think that has disadvantaged both the mental health system and the people going through it.” (DHB voice)

“But mental health I think has suffered from being almost a forgotten child in the DHB for so long and actually just sitting always on the side. If we’re truly going to deliver health in an integrated fashion it has to be fully integrated into the health system we’re delivering.” (DHB voice)

### Stronger partnerships and a culture of collaboration are needed

PHOs, DHBs, and government indicated that strong partnerships and a culture of collaboration within the mental health and addiction sector were considered necessary to address the mental health and wellbeing needs of New Zealanders. Having the structures and processes in place to support working collaboratively was also seen as important.

“What we don’t want is to set up angst between the Ministry and us, and between DHBs, well between DHBs and NGOs, and between DHBs and primary care, we all need to stay, we’re in it together and we need to somehow be, yeah, the processes need to bring us together rather than tear us apart, I guess.” (DHB voice)

“That would be a great thing if we can all agree to get under a big umbrella because we’d be much stronger together.” (Government agency voice)

“I honestly believe it’s the most fundamentally important thing for the sector in New Zealand because, through this next change that people don’t fight and compete but that they collaborate and support.” (PHO voice)

DHBs in particular spoke of the importance of adopting a ‘one team’ approach that recognises, understands and values the role that each part of the sector plays.

“I would say generally people don’t want to acknowledge what different parts of the system have to offer in terms of secondary care compared to NGOs compared to general practice primary care delivered. And I think there needs to be a greater understanding about how they interface and the roles that each of them plays. So I still think that’s a big challenge we have to work through.” (DHB voice)

## 6. Leadership and governance

This section includes discussion around the structure and approach of leadership and governance throughout the mental health and wellbeing system.

## 6.1. System-wide leadership to drive a joined-up approach is necessary

Government and NGOs described a current lack of leadership to drive cross-sector partnership, and a lack of clear accountability to ensure sectors are working together to address wellbeing.

“Since the Budget last year [agencies] have been running off going ‘We’re into wellbeing, we’re into wellbeing, we’re into wellbeing’ – which is great – but it’s not really being brought together and there’s potential to duplicate effort or even get competing things happening.” (NGO voice)

“But there needs to be clear accountability for leading the whole of Government agenda [...] it’s not clear to me that is happening at the moment.” (Government agency voice)

We heard that system-wide, whole-of-government leadership is crucial to bring sectors together and drive a collective, partnership-based response to mental health and wellbeing.

“It needs that cross-agency leadership, doesn’t it, at a Government level to look at what’s Local Government’s responsibility? What are all the Government departments going to do around responding to this? Because you’re right, [mental health and wellbeing] is a big, broad issue.” (Government agency voice)

“But there’s a challenge to lay down to SSC [now the Public Service Commission] and the Prime Minister, let’s role model whole of community and whole of Government action in delivering the He Ara Oranga agenda.” (Government agency voice)

Government noted that this system-wide leadership did not necessarily have to come from Health.

“If you leave health to design the wellbeing side of things it will be all designed around health rather than around wellbeing.” (Government agency voice)

“I may be missing it but I’m not seeing a whole of Government view and agenda shaping up and that, at the moment the way things are structured, that can only happen by the Government choosing to give that whole of Government leadership role to an entity. A number of entities could be given that role.” (Government agency voice)

“So to a certain extent [mental health] can lead the string section because that’s what they’re used to doing but right now they’re having to conduct an orchestra that has a whole lot of players that aren’t even in the health sector.” (Government agency voice)

## 6.2. Establishment of the Mental Health and Wellbeing Commission

Interim Report reference: this section aligns with Section 1: Part 1 - Establishing a Mental Health and Wellbeing Commission sends the right signals

PHOs, NGOs and government were supportive of the establishment of the Mental Health and Wellbeing Commission since He Ara Oranga.

“I think what the Commission is looking like so far, while it’s not exactly what we said, it’s certainly gone more than just a nod in the directions that we were advocating for. So it is really encouraging.” (NGO voice)

“I was really, real thankful that we decided to have a Commission again because I think that’s what got lost as it slowly lost its emphasis through the early 2000s until it was disestablished.” (PHO voice)

“I’m just delighted that the Commission has been set up, that we’re taking the wellbeing and mental health of the people in Aotearoa so seriously.” (Government agency voice)

We heard doubts and concerns that the establishment of the Mental Health and Wellbeing Commission would not achieve change for Pacific peoples.

“Even the development of a Commission, I have to say, I wasn’t really happy with. We’ve been there before and my experience was that it became a talkfest, even though it had a monitoring and advocacy role, I don’t think it represented Pacific well at all in those years and I don’t think we achieved anything out of it.” (Pacific voice)

There were some concerns raised by consumer organisations around the lack of engagement with Māori and those with lived experience during steps to set up the Commission.

“We haven’t really been asked a lot of questions in contribution to what the Mental Health Commission’s been setting up, so it’s quite sad when we talk about a new system involving people with lived experience.” (Lived experience voice)

NGOs in particular described the importance of having a diverse leadership team within the Commission to reflect the voices of the community.

“Mental Health Commission needs to have a leadership structure that the community is truly reflected in.” (Māori NGO voice)

“Just one thing I’d say about the Commission too is ensure that you have the voice of lived experience and the voice of Māori, and really the voices of the most marginalised represented within the Commission. That’s going to be absolutely vital.” (NGO voice)

## The role of the Mental Health and Wellbeing Commission

Government noted that the Initial Mental Health and Wellbeing Commission, and the permanent Commission, will need to consider its positioning and operation within the system.

“There are some really important strategic discussions that the Board will need to have in terms of what values it wants to bring, how it wants to operate and where it positions itself.” (Government agency voice)

It was noted that there may be varying public expectations and awareness of the Initial Mental Health and Wellbeing Commission’s role, including an inaccurate perception of it having decision-making ability.

PHOs, NGOs, Māori and Pacific organisations, consumer groups, and government all discussed what the role of the Mental Health and Wellbeing Commission could look like.

There was interest in the Commission maintaining independence and acting as a monitor of the government and the system’s progress towards transformation.

“I think a critical role is to monitor and keep the plot of He Ara Oranga. Keep the Government honest around that, or successive governments honest around that. I would hope that the Commission is unflinchingly independent and will hold the mirror up.” (NGO voice)

“One of the exciting things about the standpoint that’s been taken by the Commission, I think, is that you’re invited from your place to apply scrutiny of the Government’s progress. So you’re almost set up to succeed from the start because the motivation of the Government is to say look closely at us, what are we doing, how are we succeeding. So I’m struck by that from the outset.” (Māori voice)

“But I think what strikes me about the Commission, you know, that’s something we’ve been talking about for a long time is how do you have an independent body that advocates in the right way for those things that we strongly want to get better improvement in and [...] this is a great platform that it’s a starting point.” (PHO voice)

“I think there are some very good things about having the entity as an independent Crown entity.” (Government agency voice)

It was considered important that the Commission have the ability to influence and shape the sector and to hold the sector to account.

“But it does need to critically have some ability to actually shape the sector. I need to know, for example, that the Commission have got the ability, that when they speak that I will listen.” (PHO voice)

“What extent will the Mental Health and Wellbeing Commission be able to influence policy? Because I think it needs to have some quite powerful levers to be able to do that.” (Lived experience voice)

This included playing a key role in sharing learnings and evidence across the system, and facilitating a consistent, evidenced-based approach to certain issues (such as seclusion and restraint).

“I think there’s a real opportunity as an independent entity to try and create thought pieces and supporting material to help kaimahi and the public learn and understand. Because the stigma has come all the way back again.”  
(Māori NGO voice)

“It’s really hard for any one DHB to put their hand up and take that leadership role and it’s really hard for the DHBs collectively to have that sort of leadership role. So it almost needs to be some sort of neutral independent agency that does have the ability to do the, you know the convening groups, looking at evidence, looking at best practice, looking at information and making, and almost facilitating a process whereby people then come up with a position on a particular topic.” (Government agency voice)

We heard of the potential for the Commission to act as a ‘bridge builder’ – to role model and encourage greater collaboration within the mental health and addiction sector, and across other sectors that contribute to wellbeing.

“I really want to stress and make this point around the importance of the role for the Commission around fostering collaboration -the kotahitanga. It’s just so important because it’s what’s missing in the sector and that’s it, just the unique kind of apolitical position that [...] they’re uniquely placed to play that role.” (PHO voice)

NGOs, Pacific organisations, and government saw an important role that the Commission could play in promoting and safeguarding effective innovation and ideas within the sector.

“We innovate, we have an idea, and then it just disappears. So the consistency and that’s where we’re looking to the Commission to be a home for, I suppose a safeguard or kaitiaki of this stuff that happens in New Zealand rather than it just running through our fingers.” (NGO voice)

### 6.3. Leadership within the mental health and addiction sector

Government agencies spoke of instances of organic leadership that have arisen throughout the mental health and addiction sector, particularly from within NGOs.

“There’s always a huge amount of organic leadership and activity going on and the institutional leadership at times is almost insignificant compared with

the informal leadership and dynamic things that happen.” (Government agency voice)

“There are good people that are taking leadership, for example, there’s been some really good work in the NGO sector in response to the COVID-19 crisis. The Māori Council are doing quite a lot of innovative work.” (Government agency voice)

However DHBs and government noted that more could be done to address variation around the country to improve leadership and connect all parts of the mental health and addiction sector together.

“But one of the things that, I think, has perpetuated in mental health is that actually we don’t have good system-wide leadership. And what we do have is often good, we have very isolated leadership that is only concerned about secondary services. And lots of leadership is concerned about community facing or NGO type leadership. We need whole of system leadership.” (DHB voice)

#### Representation of Māori, Pacific peoples, and people with lived experience in leadership

We heard how organisations such as DHBs, PHOs and government have established new leadership positions for Māori, Pacific peoples, and people with lived experience.

“I think we’re very lucky in that the last week the Ministry of Health has finally made the appointment for the Director of Pacific Health within the Ministry [...] Because that leadership within the Ministry was missing.” (Pacific voice)

“Over recent times we’ve just appointed a Hauora Māori and Equity Manager [...] And with really very much the mandate to make sure that we’re well connected to our, in her case primarily our Māori communities.” (PHO voice)

“We now have dedicated positions around Māori advice and lived experience.” (Government agency voice)

Māori and Pacific organisations noted that greater representation of Māori and Pacific peoples still needs to occur within leadership positions throughout the sector.

“That needs to happen more too, aye. More Māori in those leadership roles. [...] You know I think Māori leadership makes a difference; it makes a huge difference.” (Māori voice)

“So if you ask me where do we need to be? Of course, we need to be at all levels, but we also need a system that is responsive to Māori and Pacific. Not us always having to keep pushing. It’s a fight.” (Pacific voice)

However, those organisations cautioned that representation cannot be tokenistic; the system needs to enable meaningful leadership that does not place significant burden on an individual to represent the voice of Māori, Pacific peoples or those with lived experience.

“There’s only one consumer rep here in [DHB] and that’s me. And so all these committees that are getting formed for various initiatives, I’m the one that’s always on those various committees so there’s a heck of a lot – [...] And so the responsibility that’s placed on one person being the consumer representative here is huge.” (Māori voice)

“Don’t [just] put one Māori on there or one PI on there, that’s not fair, aye. Cause your voice is forever drowned out. And then you’ve got to do a haka and then you get a reputation.” (Māori voice)

“We get called upon at the very last minute or we get called upon to be the Pacific rep [...] And I said to them it’s a very unfair question to ask me what I think for Pacific. The plan should have a Pacific strategy, a Māori strategy, an Asian strategy, so that it’s not limited to what an individual can come and bring to the table.” (Pacific voice)

Partnership with Māori, Pacific peoples, whānau and people with lived experience is discussed further in Section 5: Partnership throughout the system.

### The Mental Health and Addiction Directorate

It was noted how the creation of the Mental Health and Addiction Directorate within the Ministry of Health was a first key step in placing increased emphasis on mental health and wellbeing.

“Previously, the functions to support mental health and addiction were dispersed throughout the Ministry. In our new structure it was acknowledged that mental health and addiction is a priority for this Government and warrants a dedicated directorate to focus on it. We were establishing the new Directorate as we were responding to the Inquiry and going through the Budget 2019 process, and we are now implementing the Government’s response. That was a transformation for all of us.” (Government agency voice)

NGOs and government recognised some of the challenges that the Mental Health and Addiction Directorate have faced in getting set up while beginning to implement the Government’s response to He Ara Oranga.

“I think it has been very challenging to progress the big He Ara Oranga agenda and, particularly for the Ministry’s staff trying to lead that while, at the same time, having to build a team that can do that alongside a whole Ministry wide restructure as well.” (Government agency voice)

“I think the Ministry [of Health], to be fair on the Ministry they’ve been putting together the Directorate for Mental Health [and Addiction] whilst trying to do this. And I think we’re all really aware of that.” (NGO voice)

### Senior leadership within the sector can influence change

DHBs and government noted that those in senior leadership positions can play a critical role in driving change in DHBs, or greater collaboration across the sector. They described successes by building trust and achieving buy-in from senior leadership.

“I was very fortunate the CEO just said, ‘Just get on and do what you want’, because it’s what I wanted to get out of it so I managed to get a few leaders within primary care and the NGO sector and the Treaty partners saw it as an opportunity to improve outcomes for Māori.” (DHB voice)

“A lot of good ideas may not progress if they’re not well supported systemically. It requires support from senior leadership in DHBs to consider and progress ideas.” (Government agency voice)

“What I observed here was that this DHB had a real commitment to doing things differently with the community and integration. And I think that that is important for it. People need to be pressured to do things differently.” (DHB voice)

### New generation of leadership and governance at a local level

We heard a number of ideas relating to how leadership and governance could be changed or built upon moving forward.

We heard of the need for alternative leadership arrangements, with a greater focus on building relationships and a ‘network’ of leadership.

“He Ara Oranga’s asking us to network more, much more with people at the centre rather than be a hierarchy and be a pawn in a hierarchy with all the power located at the top of a pyramid. So I think we could substantially transform the way health leadership or positions are organised to be much more of a network way of doing things rather than a hierarchy.” (Lived experience voice)

We also heard of the potential to create local governance structures to improve accountability at a local level.

“One of the models that we’ve kind of like looked at various stages is we have a kind of a local commissioning something, a local entity that makes sure that things will happen [...] setting up a Commission mental health group that’s representative of the community.” (NGO voice)

PHOs, DHBs and government suggested that a new wave of leadership, and different ‘voices’ within leadership, might be necessary to see transformational change.

“Because there’s a whole crop of new leadership that’s needed, it comes through, like I think it’s a leadership thing [...] And it’s about opening up the space for new leadership to come to, new voices to come through and just get, politely maybe asking some of the older voices to let that, to open up that space.” (PHO voice)

“I think for me, there’s a couple of key ingredients for the right sort of leadership. This actually requires some quite distinct leadership skills and, in this generation, it requires almost a new style of leadership. So leadership I think is absolute fundamental to this.” (DHB voice)

We heard that the system requires strong central leadership regarding policy direction and outcomes, but that local communities/regions should retain the autonomy to consider how best to address the needs in their communities.

“I worry a little bit at the moment what a lot of the approaches are trying to be led everywhere from the centre. What we want is for policy direction and good outcome expectations and then leave us to resources and leave us to figure out how we solve it locally and deliver back to you the outcomes you’re looking for.” (DHB voice)

We want to work quite differently. We will certainly step in where we should, for example around regulation, but our view is that we are in this together and must collaborate with the sector. (Government agency voice)

## 7. Funding and procurement

This section includes discussion around the funding and procurement systems and processes within the mental health and addiction sector. It is noted that people had a variety of different experiences and views, and that there are tensions between objectives and desires, and the feasibility and timeliness of meeting them in the collaborative way people want.

Please note that feedback was gathered in March – May 2020 and does not reflect new RFP processes or procurement activity, such as the Ministry of Health’s kaupapa Māori RFP process.

### 7.1. There is increased funding in the sector – but where is it going?

Interim Report reference: this section aligns with Part 1: Section 4 - There is money flowing into mental health to support more people

NGOs, workforce organisations and government recognised that there has been significant investment into the mental health and addiction sector since He Ara Oranga.

“There is money flooding the sector, which in one way that is great but you can’t map where all this money links in with each other and how it’s integrated, you know.” (Māori voice)

“The Wellbeing Budget I guess for us it’s been a huge growth in the working area of Access and Choice. That would be the most tangible change in terms of what we’re doing.” (Workforce organisation voice)

“The investment in Access and Choice has been unprecedented. It has given us a mandate and freedom to think bigger than we’ve been able to in the past.” (Government agency voice)

However, NGOs and consumer organisations, in particular, raised concerns that this additional funding had not yet trickled down to service providers.

“One significant thing, we haven’t seen financial resource to make things happen arrive yet. So without resourcing quite a few of the changes and transformation can’t really happen.” (Lived experience voice)

“The funding might be there but it’s just not coming out from the Government departments to wherever it should go, to whether it’s DHBs, PHOs, NGOs or communities.” (NGO voice)

“Where has the money gone? Why haven’t we seen the changes? They walk away with a bag of gold and we haven’t seen the changes. And I tell you why. Because they haven’t talked to the people with the lived experience. They haven’t listened.” (Lived experience voice)

It was noted that there has been some confusion around how investment is being rolled out to the sector, and that communication around this funding has perhaps not been as strong as it needed to be.

“The funding increases incrementally each year, because it is a five-year programme of work. We have been sharing information to help people understand that. We did not suddenly receive \$455 million dollars on the 1st of July 2019. We recognise that improving communications will help to clarify this.” (Government agency voice)

NGOs, Māori and Pacific organisations, in particular, raised concerns that funding isn’t being appropriately directed to the parts of sector where needs are greatest, such as services and supports that address the needs of Māori or Pacific communities. We heard about the current work to increase access through primary mental health and addiction services. There was criticism that this increasing access through general practices would have limited impact for Māori, Pacific, and other vulnerable communities, such as those at risk of suicide.

“Māori and Pasifika are unlikely to go to the GP until things are really bad. And so a wellbeing coach probably isn’t going to be – at least as I understand

them – going to be the answer by the time you’re really distressed, you’re really unwell and you really need help.” (NGO voice)

Work to increase access through integrated primary mental health and addiction services is discussed further in Section 9: Service design and delivery (access and choice).

Government agencies recognised that there were concerns within the sector around general practice settings and reiterated that primary care is wider than GP clinics.

“The first RFP was integrated services accessed through general practice. We noticed some tension that people thought that all we were going to do was focus on general practice and that isn’t the case. Primary care includes general practice but it is not just general practice. We are investing in kaupapa Māori primary mental health and addiction services, as well as Pacific services and youth-specific services accessed through a range of settings.” (Government agency voice)

## 7.2. The RFP process should change

**Interim Report reference:** this section aligns with part of Part 2: Section 4 – Systems and processes have not changed enough to support transformation

DHBs, PHOs and consumer organisations described procurement processes that are old and outdated, perpetuate ‘more of the same’, and continue to silo services instead of promote integration and collaboration.

“I suppose in that procurement what’s happened is the names, the language is slightly it isn’t followed with a commitment to what that means in practice and I think, you know, it’s easy to say ‘Choice and Access’ and then to actually follow a procurement process which is just how it’s always been was a bit disappointing for us.” (PHO voice)

### There is a need for collaboration when developing RFPs

DHBs and PHOs spoke positively about the collaboration process when developing RFPs and gave examples of how they have worked collaboratively with others such as NGOs, Māori and Pacific providers on RFPs.

“I think the first RFP around Access and Choice saw a number of people come together and work really collaboratively on preparing proposals, thinking about how that might work as a system, and I think that was one of the things that really stood out in that process.” (DHB voice)

“And so when we responded to the Access and Choice, we got together with our NGO colleagues, the three PHOs, and we had our Māori and Pasifika providers understanding what was happening knowing the RFPs going to

come from them. And we responded, we had a big workshop and responded to that as one collaborative.” (PHO voice)

However, this positivity was not held by all. Māori, Pacific and whānau groups spoke of a fight to be heard within collaborative discussions, or a lack of equal and meaningful partnership when developing RFPs.

“To be honest, in all of those, especially the Access and Choice one, it has felt like master servant all over again. Where your NGOs are at the bottom of the heap. In fact in some conversations NGOs didn’t even enter into it.” (Māori voice)

“The PHOs had taken control, even though it was meant to be a partnership between PHOs, DHBs, NGOs, meant to be an equal partnership, it hasn’t turned to that.” (Pacific voice)

“Where I live in [region] there seems to be a much more collegial approach to working with family whānau between the consumer services, the DHB, and family and whānau.” (Whānau voice)

While it was recognised that RFPs are beginning to require collaborative responses, DHBs and NGOs and government noted significant challenges, and that collaboration is not always happening effectively or in a meaningful way.

“If you haven’t got existing networks that are working together, you’re in a competitive process. If you’re new to that, working in that way that creates whole extra challenges for people.” (Workforce organisation voice)

DHBs and NGOs described how collaborative responses to RFPs has required significant investment of time and resources, and that this had become particularly burdensome for NGOs.

“I watch the NGO community almost die with the volume of work that was asked of them to try and get a submission, a collaborative submission in to try and secure funding and even then, if you didn’t succeed all of that work felt like well it was just lost.” (DHB voice)

“The cost to the NGO sector of even responding to the last lot of tenders has been phenomenal. And although it’s absolutely rightly these things must be joined up, you know, we must join up on this, but the skills and resources to engage in these tenders are limited in the community and unequally distributed.” (NGO voice)

“And so that is still one of our biggest challenges going forwards, getting people to listen, to consider and respond appropriately with all the voices that are around the table. So it takes a huge amount of effort to get that in place.” (DHB voice)

Government recognised the significant effort that has been put into collaborative RFP responses.

“It is not an easy or straight forward process for the sector or for us. It takes a bit more time because you’ve got consensus decision making, multiple players, there are tensions, but I’m really heartened by the fact that people did come together and do this.” (Government agency voice)

#### Timeframes in recent RFPs could be longer

DHBs, PHOs, and NGOs raised concerns with the timeframes given to respond to RFPs. Short timeframes were discussed as limiting the ability for effective collaboration or meaningful co-design with communities to take place.

“But again, just because of those short timeframes to get the RFPs in I don’t think there was a lot of co-design.” (Lived experience voice)

“Some of the RFPs that’s come out and the timeframes around them seems hurried and it seems like a lost opportunity to actually use what is happening and to then get back to He Ara Oranga and to give DHBs the opportunity to respond to that with their communities.” (DHB voice)

The RFP for Youth Primary Mental Health and Addiction Services was an example used to highlight the issues with limited timeframes, and the resulting inability to involve youth and young people with lived experience in the development of the RFP.

“If we use the recent RFPs, the youth one which was due in yesterday], we had four weeks to write a collaborative RFP. There was no time for consulting with our rangatahi. No time at all.” (Māori NGO voice)

“[We] didn’t think there was enough time for us to actually get the, to find out where the gaps were because when I sat at the table on the Youth RFP, for example, the conversation appeared that there weren’t actually any gaps. But if you go out there and talk to people that are using the services there are gaps and there are problems and I don’t think we did have time to identify where those specific gaps were.” (DHB voice)

Government noted the challenge of balancing the time it takes to respond to RFPs with the need to move quickly to address people’s needs.

“It is going to be a bit of a balancing act over the next little while as we work through the response to COVID-19 and its impact on our frontline services. Smaller NGOs, including kaupapa Māori and Pacific NGOs, are out there working in their communities. We need to balance the desire to keep moving really fast with what NGOs have capacity to respond to.” (Government agency voice)

### 7.3. RFP processes are competitive

Interim Report reference: this section aligns with part of Part 2: Section 4 – Systems and processes have not changed enough to support transformation

NGOs, DHBs, and PHOs all viewed procurement processes as remaining largely competitive.

“It’s the way it’s set up. It is the way the system is set up. It’s set up to compete so that NGOs are competing with each other.” (NGO voice)

“There is probably a bit of, you know, cutthroat competitiveness within the people that deliver services whether it’s DHBs or PHOs, not so much NGOs, I think NGOs work together better, but and I think that can hold things up.” (Pacific voice)

“And there’s still a tension between the competitive process and securing funding and there still needs to be some balancing.” (PHO voice)

“Because everyone was going ‘Yep, that’s the right thing to do, let’s work closely together’. Then once the money arrives that’s the problem. Because that’s when the competition comes.” (PHO voice)

PHOs, Māori and Pacific organisations and government noted that the competitive environment was particularly challenging for smaller service providers who lack the capacity and capability to compete with the greater resourcing of larger organisations. Māori and Pacific providers expressed frustration around having to compete with mainstream providers.

“There’s got to be some recognition that not everyone in the sector is resourced the same and therefore their ability to respond in that way can be challenging for some people. So we have a myriad of small NGOs that have limited capacity in quite niche markets, and [...] there hasn’t really been a lot of development of Māori and Pasifika providers.” (DHB voice)

“The Ministry has pitted us up against mainstream organisations who have more money, more resources to draw on, who sell themselves as serving all people, including Māori and Pacific, that we have to write four, five, six RFPs and they have whole teams.” (Pacific voice)

Māori and Pacific peoples suggested that competition in the current procurement processes can perpetuate inequity, particularly where equity is not well defined and established, and where Māori and Pacific providers are missing out on contracts to more well-resourced mainstream providers.

“As a kaupapa Māori organisation, you know, nothing wrong with competing with other kaupapa Māori organisations but when you’ve got to compete with non-Māori that’s just not fair.” (Māori voice)

“I absolutely acknowledge the priority placed around equity and Māori and Pacific, however, when you throw that into the mix with mainstream providers obviously wanting to do all things for all people, there’s a real challenge in regard to interpreting, defining, and trying to prioritise equity in the conversation as well.” (DHB voice)

#### 7.4. Funding and procurement systems need to change

We heard of a number of issues still present in the way the mental health and addiction sector funds and procures services, including restrictive contracting and procurement processes and rules, complex funding arrangements, and time-intensive compliance activities that place a greater burden on NGOs.

“A typical NGO in New Zealand will be funded by maybe one, two or three DHBs depending on how big they are. The bigger ones may hold up to 20 different contracts. So MSD will be funding people for sort of maybe some employment work, Oranga Tamariki will be funding them, Corrections will be funding them, some of them may have a bit of ACC money, some of them will be funded by various multitudes of pockets of money coming out of state education. Each one of those people is having to report separately and fund separate. This is a nonsense.” (NGO voice)

“Planning and funding is a challenge across the country. There are so many ways that the same framework can be being applied and contracts and relationships are managed.” (Government agency voice)

NGOs in particular spoke of continued concerns with funding decisions, such as how that funder ensures the funding will meet the needs of the community.

“So our system is fundamentally flawed to develop community responses and community initiatives because the funder is not independent.” (NGO voice)

“Okay, you have the money funder but actually if I listen to my community, they’re saying A, B, C but you’re saying X, Y, Z. So how do we negotiate that? Whose views is higher, valued more? So when you get to it, of course it’s the funders.” (Pacific voice)

#### Suggestions for changes to funding and procurement processes

When considering how funding and procurement could change moving forward, we heard a range of suggestions, including wanting to see:

- a clear map of funding and procurement across the sector to enable providers to plan and prepare, for example, responses to RFPs

“The Ministry should have a map, aye. This is what’s coming out, this is how it’s linking and this is where we want it to go. So everybody could look at it

and go right, I am there. And actually I could provide a little bit over there because we're doing A, B, and C, so we might go for that little bit there."  
(Māori NGO voice)

If we had a framework that we knew what was coming down the pipe and when, that would enable us to really focus our efforts on understanding in advance where are the gaps in our system, and then streamlining our effort and knowing exactly where we are going to support our efforts. (DHB voice)

- contracts that are flexible and enable providers to pivot when the needs of their communities change

"We're talking constantly about things like flexi-funding, you've got to be able to free up money when you need it do stuff, you know." (NGO voice)

"You couldn't have done that if your contract just said 'You're to deliver this many programs by December', you wouldn't have been able to say 'Actually we want to pivot, we want to change halfway through, we want to make sure more of the focus is on [the right people]'." (Māori voice)

- funding and procurement processes that values and facilitates the range and scope of wellbeing-based work that Māori and Pacific organisations do

"I think it would just be really creating that permissive environment with contracting that allows kaupapa to thrive rather than just survive." (Māori NGO voice)

"If you sincerely believe what's good for Māori is good for everybody, if you sincerely believe that these services will make a transformational change to the mental health support that people are receiving, then invest in them and promote them and tell their stories, show how they are effective. Show how they help people; show how they change." (NGO voice)

- RFPs that move away from siloed criteria, instead enable providers to take a holistic, big picture approach when demonstrating their ability to address needs

- a procurement environment built on relationships and trust

"I got no problem with the concept of loosening the procurement rules to make the money more available but I absolutely think if we are going to do that, we should be doing what we should've been doing all along which is manage contracts really well, have really good relationships with our providers [...] High trust relationships so they don't feel like, 'Big brother's watching and I can't do anything' but it's like it is public money and we are responsible for it and we need to trust they're doing the job and they need to trust that our interest is ensuring it's being well used not that we don't trust them to use it properly." (Government agency voice)

- a shift around what is viewed as priorities for funding for all entities involved in service design and implementation

“Funders are going to have to learn how to do some dis-investment in things that maybe aren’t productive or don’t work that well. They were good last century but not so good in 2020. And certainly not good going forward with what we now know.” (NGO voice)

“Ninety-seven percent or so is spent on secondary mental health. That’s where a lot of the resource is and we could free up so much by changing the way things are done.” (PHO voice)

Māori and Pacific organisations, NGOs, in particular, suggested that funding power be shifted away from those at the top – such as DHBs and government – and instead let funding be more closely driven by communities.

“If there’s Pacific mental health money give it to Pacific to do. Give it to us.” (Pacific voice)

“And I think that’s the opportunity that Government misses, is that when the people themselves create the idea they’ll stop at nothing to make it happen. When you tell them ‘this is what we want to see’ you’ll get, you know, resistance or it’s called ‘negotiation’.” (Whānau Ora voice)

“It needs a new fresh way of doing things and that is about getting the resource out and directly to the people.” (Māori voice)

“Mental health and addictions is way beyond just vote health. So we’ve got to begin to actually have mechanisms that include the purchase of services for communities and what communities need, which includes domestic violence, it includes addictions, it includes the whole range and gambit of, you know, people’s mucky lives.” (NGO voice)

This included enabling communities to determine what the need is, and have the funding following on behind that.

“To take a place-based approach and say ‘This is the funding that we have available in this place, even if it’s mental health and addiction or whatever, mental health and disability, whatever it is, and this is how, this is where we need services and who’s up for it? Basically. And how we’re going to apportion that amongst the needs of the population. So that’s flipping the whole thing on its head and saying, population need then drives service delivery in various parts.” (NGO voice)

“And I think that that’s something that Ministries could take advantage of, that instead of simply thinking ‘we want this product achieved’, reframing the question in terms of ‘what is it that you think is going to work for your

people’ and taking some risks and being prepared to suspend your judgement.” (Whānau Ora voice)

Māori and Pacific organisations and Whānau Ora commissioning agencies in particular described the different ways that they invest funds and evaluate for outcomes. Wider wellbeing was said to play a central role, and these organisations often spoke of having accountability back to communities.

“We’re not just investing in the product or the entity, it’s focused on the outcomes and the outcomes are stronger if they’re able to be shared between other entities working together.” (Whānau Ora voice)

“Well, firstly profit and surplus is not the aim, and our surplus or our profit is when we have good outcomes for Pacific families and that’s like, for us that’s money in the bank for future generations and so that’s how we invest.” (Le Va)

“[In our region there] is a reconnection fund. So it’s just a small amount and there’s an assessment process that’s based on culture and identity, like a pepeha, and that flexi-fund you can apply to, to be supported to go back to your marae, be connected with whānau, and it will pay for the travel, the koha, the kai, and there is two components to the flexi fund, the first is for up to \$1500 and the second is \$500 and that is for whanau to make a second trip once the initial reconnection has occurred. The successes that have come from that are phenomenal.” (Māori NGO voice)

## 8. Workforce

This section includes discussion about the workforce delivering mental health and addiction services and support as well as broader discussion about the workforce in other connected sectors that contribute to wellbeing.

### 8.1. There has been some new investment into the workforce

Government and workforce organisations spoke of the workforce as being crucial to system change and realising the aspirations of, He Ara Oranga.

“When you’re thinking about service change, you’re actually talking about workforce change, you can’t do one without the other. And what’s going to hold you back from bringing about system change is actually the workforce.” (Workforce organisation voice)

“We know the workforce is going to be absolutely critical to achieving the changes that we want to see, which are laid out in the Government’s response to He Ara Oranga. We are focused on growing and supporting a fit

for purpose, resilient, culturally appropriate mental health and addiction workforce.” (Government agency voice)

Growth in the number of nurse practitioners, registered nurses, psychologists, was highlighted as well as the development of new workforces such as health improvement practitioners and health coaches.

DHBs and Pacific organisations mentioned how they had developed cross-sector partnerships with workforce organisations in order to support their workforce development efforts.

It was noted that there has also been an increased focus on improving cultural competency and capabilities to engage effectively with Māori and Pacific peoples. Workforce organisations recognised an increase in funding available to expand cultural competency training, however, despite the increase in funding for cultural competency, there is more work to be done to build a culturally safe workforce.

“You can have all the qualifications under the sun but if you can’t engage, you’re not getting anywhere. And that’s [...] for Māori and Pacific [communities], but it’s really other cultures as well and it’s also particularly [important] with youth. So [...] we’re actively recruiting [and] building our capability to do that. And that’s quite new for us to be doing that.” (PHO voice)

“But the cultural competency training, no we need a lot more [...] I don’t know if it’s seen as a priority enough yet [...] although it’s good that people are talking about it. They didn’t used to.” (Workforce organisation voice)

Workforce organisations noted that increasing workforce training is not sufficient to bring about the transformation envisioned in He Ara Oranga. They explained that training staff in cultural competency has limited effectiveness without the leadership, structures and processes required to support culturally competent practice.

“We can train people and we talk about wellbeing but if they’re in a system that’s fundamentally flawed then that’s not going to, that’s not going to change it. You know it’s just not going to change.” (Workforce organisation voice)

DHBs acknowledged that secondary mental health and addiction services can be high pressure environments, and said they are committed to workforce wellbeing. We heard it was important to support a cultural and mindset shift within services towards recovery-focused, trauma-informed approaches.

“One of the things we’re really trying to get across our services being a lot more trauma informed. And from within our existing resources we’re trying to turn trauma inform training and trauma informed care training and things

into mandatory training across our services [...] I think that kind of approach is a game changer in mental health and addictions.” (DHB voice)

## 8.2. A long-term workforce development plan is needed to drive further investment

Interim Report reference: this section aligns with Part 3: Area 5 – A strategy that supports and develops our wellbeing workforce

DHBs, NGOs and workforce organisations were concerned by the lack of a long-term, system-wide, workforce development strategy. Without a clear and consistent workforce strategy, NGOs and workforce organisations expected persistent under-investment in workforce development.

“Who’s accountable for the fact we still really don’t have a workforce, a coherent workforce plan? A system change is workforce change. Mason Durie and others of 2011 predicted exactly what we have before us today, nothing happened. It’s almost unethical.” (NGO voice)

“It does sort of feel like we’re all inventing the wheel in our own little space (DHB.” voice)

Government recognised that a strategy was necessary to ensure that workstreams align with and support the program to expand Access and Choice. They acknowledged that longer-term workforce development planning was underway.

Government and PHOs said that in addition to growing existing workforces, new workforces that align with the vision of He Ara Oranga also need to be developed.

“People are talking lots about the challenges around the workforce but I’m not really sure that they’re thinking broadly enough or creatively enough around that.” (PHO voice)

“There has been very limited development of the workforce right across the sector in various cadres of workforce.” (Pacific voice)

“We need more of our traditional workforces but we also need to be thinking about what new workforces we want to have and new ways of working.” (Government agency voice)

PHOs, NGOs, DHBs and consumer organisations described the need for nation-wide consistency and leadership concerning growing and training new workforces. This included health improvement practitioners, consumer advisors, and peer-support workers.

“I don’t know that anybody’s doing the workforce planning around sustainability of these roles. They need to be a profession in them in their own right, I think, and they need to be able to move around the country and know that if they are a [health improvement] practitioner in Christchurch

they can then get a job in Rotorua if that's where they want to go and that the training and everything is all consistent." (PHO voice)

"It would be good to have some more support and guidance around the new types of training people need around if they are peer support of lived experience support workers, what that looks like in terms of what their role is." (DHB voice)

### 8.3. Addressing workforce development, capacity, recruitment and investment is crucial to enabling access and choice

#### Recruiting and retaining the workforce

DHBs, PHOs, Māori organisations, workforce organisations and government reported a workforce shortage, including particular concerns about the shortage of Māori and Pacific staff.

"I don't think there has been the right level value attributed to this workforce [...] I mean how do we attract people into this sector? How do we value people? How do we support their ongoing development? I just think even for secondary services, one of their big struggles is actually getting the workforce." (PHO voice)

DHBs expressed commitment to developing a diverse workforce that reflects the community, including growing the Māori, Pacific, and lived experience workforces. We heard that Pacific workforce development should be Pacific-led and called for the establishment of a Pacific mental health workforce development centre of excellence.

"Unless we have the opportunity to develop it within our own Pacific centre of excellence and work out from there, properly resources with the opportunity to make our own decisions. I can't see it working, ever working coming from DHBs, PHOs, GP primary care service, they're just not going to represent us as a Pacific community." (Pacific voice)

They also noted that when growing the Pacific workforce, it is important to reflect and honour the diversity within the Pacific community and between different Pacific ethnicities.

"At the moment it's like one size fits all Pacific and that's false because we have different ethnicities [...] So say for example with the different ethnicities, are they represented in the workforce? And that's a big issue, [...] there's intricacies of each ethnicity, that there is some variation, and we need a workforce to be able to address that, especially when it comes to the cultural, pastoral, welfare, and psychosocial health of the individual. It's steeped in our different ethnicities and we must pay attention to that." (Pacific voice)

Most NGOs that were interviewed described a struggle to recruit and retain staff. This is a particular issue for NGOs located outside of main centres. NGOs pointed to pay parity as a

significant barrier to recruiting and retaining staff within their organisations, as mainstream services are able to offer higher pay. DHBs acknowledged these disparities in pay and suggested that there is a lack of leadership or cohesive pricing frameworks that would support NGOs to offer competitive salaries. This creates inequities, particularly for Māori organisations.

“We have to do some special makutu on our doctors to keep them in the chair. I do my Jedi mind tricks on them about why, you know, when you work for an organisation like this, you’re genuinely making a difference in people’s lives. But it does take its toll.” (Māori voice)

“People who work in kaupapa Māori mental health services are not being paid the same as people who are working in mainstream services, and I think that that’s a major equity issue.” (NGO voice)

Māori and Pacific organisations described experiences of staff poaching by better-resourced mainstream organisations that offered higher pay and were looking to expand their service delivery to Māori and Pacific communities.

“I think as Māori providers it’s a significant challenge because everybody wants “a Māori” at the moment. The poaching that goes on. Oh my god.” (Māori NGO voice)

“And of course now, aye, the spotlight since the report came out is improving health outcomes for Māori and Pacific. So you’ve got mainstream organisations wanting to beef up their Māori side so that they can say, ‘We can deliver to Māori!’ You know.” (Māori NGO voice)

DHBs, NGOs and government expressed concerns about the capacity of the existing workforce to support initiatives to increase access and choice.

DHBs and workforce organisations were concerned that the work to increase access through integrated primary mental health and addiction services could pull staff away from secondary services and into primary care, exacerbating the workforce shortages experienced in secondary services. We heard that retraining secondary care clinicians to work in primary care environments can be challenging and would not address the primary care workforce shortage.

“Training secondary care clinicians to work in a primary care environment in a really different way is not necessarily the answer to the workforce.” (PHO voice)

Hope was expressed that in the long run, the work to increase access through integrated primary mental health and addiction services will ultimately relieve pressure on secondary services.

“I think over time the specialist services can see that developing these other options [in primary care] will have benefit for them as services. So, fewer people will be coming to the top-end of the continuum and [instead will seek] care more appropriately in other places.” (Government agency voice)

### Developing new workforces

Māori organisations, consumers organisations, workforce organisations, DHBs, PHOs and government spoke of the need to prioritise the development of the peer-support workforce.

“I think we have a very underdeveloped peer workforce in this country. Again we’ve got pockets of that but I think we need to be thinking much more about how we can use peers in the workforce and what that looks like in different contexts, what that looks like for young people, and what that looks like in a primary setting.” (Government agency voice)

“As He Ara Oranga says, it’s the building of our lived experience workforce. And that’s an area that’s not going to happen overnight, that is going to take time to have done, but that’s what needs to be incorporated throughout the whole system.” (Māori voice)

We heard that the peer workforce is currently undervalued, as many peer support workers are unpaid. Concerns were also raised that there is a lack of consistency across the sector about what peer support workers do, and how their role differs from other support workers. Māori organisations said that the understanding of ‘peer’ can differ throughout the sector.

We also heard that lived experience workforce training can often not be culturally relevant to Māori, and that the cost of these training programmes can be prohibitive.

NGOs, government and consumer organisations explained that building a community workforce and supporting whānau to care for their loved ones is critical to the transformation envisioned in He Ara Oranga. It was said that the community workforce should reflect the diversity and needs of the communities they service and exist not just in the mental health and addiction sector, but across the range of determinants of wellbeing. This included cultural workers who can provide support for investment in kaupapa Māori initiatives.

“I think we need a community sector workforce and I don’t necessarily think it needs to be merely just mental health or just disability or just whatever, we need a community sector workforce in New Zealand.” (NGO voice)

## 9. Service design and delivery (access and choice)

This section includes discussion related to service design and delivery and the rollout of the Access and Choice programme of work since He Ara Oranga

In this report, **access** refers to the number of people getting access to services. There is often a distinction between accessing specialist services for those with moderate to severe mental health needs and accessing community or primary services for those with low to moderate mental health or addiction needs. **Choice** refers to the availability of different types of support so that people receive support that works for them.

**Interim Report reference:** further discussion on the current government response to expanding access and choice to primary mental health and addiction services can be found in Part 1; Section 4 - Significant investment has been provided to expand access and choice.

### 9.1. There has been some progress to increase access, with more to be done

**Interim Report reference:** this section aligns with Part 1: Section 4 - There are pockets of success to improve access to services (and improved access between services)

#### Increasing access through integrated primary mental health and addiction services

We heard of the rollout of the work to increase access through integrated primary mental health and addiction services as a central activity that has occurred as an initial response to expanding Access and Choice since He Ara Oranga.

PHOs, in particular, welcomed the work to increase access through integrated primary mental health and addiction services, and spoke positively of the opportunity for warm handovers, improved integration and navigation of the system, and the value of easily accessible specialist knowledge to support the provision of care in general practice.

“Te Tumu Waiora Access and Choice. The pilots have been fantastic in terms of the model works so well for so many people, having that warm handover, not having referrals, not wasting time bouncing people around the system but instead of having a real human you can see and touch, who’s down the corridor, that if someone needs some help they can be led to and supported to use that service. It’s worked so well; we’ve had really good feedback from GPs and patients and from the people working in it.” (PHO voice)

“In terms of access to primary care psychiatrists’ role has been really, really effective in improving access to psychiatric advice for GPs [...] that ability to talk to somebody on the phone when you need to and get written advice when you need to and talk through cases, I’d love to see that expanded further so that a psychiatrist could actually do one-off assessments.” (PHO voice)

While there was recognition that the work to increase access through integrated primary mental health and addiction services was a positive step forward, DHBs, consumers organisations and government noted that this work did not address every gap regarding access to services, particularly in relation to equitable access to mental health and addiction.

“I think definitely it will be expanding access to early support for a good number of people. So being able to provide a level of mental health support at essentially a primary practice level, whether that’s marae-based or community centre or whether it is a traditional GP practice, that’s a big step forward. There’s no doubt about that. But it certainly doesn’t fill that whole gap, there’s still going to be a lot of people that miss out.” (NGO voice)

“The health improvement practitioner and health coach model is a positive step, but there’s a lot more we can do to expand access and choice of primary mental health and addiction support more broadly. This is just the beginning. We are also investing in tailored services accessed through kaupapa Māori, Pacific and youth settings.” (Government agency voice)

NGOs, DHBs, and government raised concerns that increasing access through general practice settings would not necessarily improve access for Māori, Pacific, and vulnerable communities such as those at risk of suicide, or those experiencing economic deprivation. We heard how the GP clinic was not a commonly used ‘door’ among those communities to access mental health and addiction support.

“But there’s a huge proportion of whānau who don’t rock up to the GP, especially for mental distress.” (Māori NGO voice)

“It’s just at that primary care level isn’t it, a lot of them don’t access their care through a general practice which is where the focus is at the moment.” (Workforce organisation voice)

“So while the Te Tumu Waiora model’s been shown to be reasonably effective in what it does, we have limited evidence and information that Māori and Pasifika actually are going to engage in that appropriately [...] So we want to actually explore what are the other doorways in the services for those populations.” (DHB voice)

“What we do need to be mindful of in the access and choice area is that populations which are often most vulnerable and have high needs don’t necessarily access GP services.” (Government agency voice)

“The focus has been on primary care. Now we acknowledge the importance of primary care. However it’s a very narrow focus. For Māori and Pacific primary care is not their GP.” (Pacific voice)

“Well you’ll still not be meeting the needs of over half the people who’ll die by suicide because over half of them haven’t seen a GP in the year before they die.” (NGO voice)

Pacific organisations noted that, for many communities, the ‘boundaries’ of primary care span much broader than that of a GP clinic.

“For our community, for our people, primary care is not the clinic. It is the community, it’s a wider space.” (Pacific voice)

#### Access to services will take time to improve

PHOs, consumer organisations and Māori and Pacific organisations raised views that access to mental health and addiction services has largely not improved since He Ara Oranga.

“I don’t think there’s been a dramatic difference if you asked people on the ground what better their access has been.” (PHO voice)

“And there’s just so many barriers, around travel, money, all those things that we know about. Moving forward with the expanding Access and Choice that should change.” (Māori voice)

“So I think people need to pay attention to what’s going on in the country because it’s not just that we don’t have Pacific mental health services, but in fact large sectors of our communities cannot access any mental health services. And that’s really concerning.” (Pacific voice)

“And for people in the community thinking, ‘Great I need help now,’ if you go to the wrong part of the country they say, ‘Sorry we don’t know about this Access and Choice or we haven’t rolled it out yet.’ So it will take a while for all that to start up, gain momentum and have a helpful impact for people.” (Government agency voice)

Government, Pacific organisations, and consumer organisations described secondary services as being inundated with those experiencing distress due to a lack of services geared up to meet the needs of the ‘missing middle’ population.

“The people that we’re talking about that have all these range of stressors don’t have mental health, and this is what the barrier is for them accessing the services. Because you have to have been so bad. Your situation has to be so bad to access the services.” (Pacific voice)

“Accessing acute services. Some of the bigger DHBs are seeing quite a turnover and a much-shortened length of stay and that’s where you’ll see the general population actually struggling to cope with normal crises, marriage breakups, financial turmoil, and that’s putting added strain on the system.” (Government agency voice)

“It’s important to recognise that there are also extraordinary pressures on specialist services as well. And part of that pressure is probably people that don’t need to be there but they’re going there by default because there aren’t alternatives.” (Government agency voice)

We heard of how access points and pathways to mental health and addiction support are still limited. It was considered that mental health and addiction is not yet at the stage where

‘any door is the right door’. It was also noted that this approach could take a number of years.

“That’s still a big challenge for us and I think the mental health sector is the doorways are pretty limited at the moment in terms of how people get into the system and we need to widen that up for those populations.” (DHB voice)

“That’s where the huge bottleneck is, that help is not available in communities, it’s not available at the times it’s needed and therefore the person who’s in distress can be in distress in a Police cell for six hours and by the time the crisis team gets there that distress has passed.” (Government agency voice)

“[We] are seeing an increasing number of people in distress and in need of support coming via social media. And they do not have phones. Or they have a real fear of talking on the phone. And they don’t have a car, they can’t go to the hospital. There are all these barriers and if any door is going to be the right door, there is nowhere I can point to them, for the most part.” (NGO voice)

It was noted that the initial response to expanding Access and Choice has involved a tension between needing to get things rolled out quickly to address immediate need, and the need for meaningful co-design around what Access and Choice should look like.

“The tension between people needing support now and the expectation of collaborative design or co-design means it takes time, and so you can’t put support in place instantly.” (Government agency voice)

It was noted that extensive consultation has been undertaken to seek sector involvement around what Access and Choice should look like.

“We’ve also spent some time this year doing collaborative design and engaging through the national roadshows that we did earlier this year and Māori hui, to try to get a better understanding of what those core components of a primary mental health and addiction model look like for Māori and for whānau, and similarly with Pacific. Having focus groups around the country to tease out and to understand what those core components are. That’s very much informed the procurement of services.” (Government agency voice)

## 9.2. There has been some progress in providing more choice, with more work to do to increase options

Interim Report reference: this section aligns with Part 1: Section 4 – There have been some improvements in providing choice in services

We heard specific examples of service providers, including DHBs, PHOs, and NGOs, who have endeavoured to provide a range of service options.

“We have a day program that is chock-a-block full of CBT type options, it means whānau have a choice. We have an open day a few times a year, we explain what it is, mindfulness, you know, and they go ‘I want that and I want that and I want that’.” (Māori NGO voice)

“So we’re starting to ask people ‘Do you want to be seen? Do you want someone to ring and talk you through some counselling on the phone? You know, what can we do to make your life better?’ So we’re trying to give the choices back to the people that use our services rather than us telling them how to do business with them.” (Lived experience voice)

“They say, ‘Well you’re only funded to do this bit, only do that’. But of course our people are people regardless and when they come to us, we don’t just look at one thing, we look at the whole person, it’s the whole wellbeing. And just, and we are so fortunate to be able to provide a whole suite of services that, our motto to our whānau is ‘Every door is the right door’.” (Pacific voice)

“What we’re trying to achieve is services that are more joined up, services that are more flexible, that are more in a suite of services versus a whole lot of contract lines that people have to work to. Our vision is of people being able to be more flexible, being offered different choices in their local area and that we build on the community, services that are in the community that everybody can access to help people be joined up.” (DHB voice)

However, we also heard that the suite of options available to choose from has largely not improved or expanded since He Ara Oranga.

“So where have all those other options gone for people? They’re just not there. Most places where people have to go, they’ve got to pay and people can’t afford. And it actually puts you even back further because your mental health is getting worse.” (Lived experience voice)

“There is not an emphasis on the whole continuum of support that families need [...] we have substantive information and evidence that say that people cannot access services.” (Pacific voice)

We heard of difficulties accessing a range of support options including:

- little change in access to talking therapies
- limited progress in access to alcohol and other drug services
- concerns that access to peer support hadn’t increased yet

- limited supports in the community for those with enduring mental health and addiction challenges

DHBs and government mentioned that there are some pockets of progress to increase the availability of culturally aligned therapies and supports.

“But what we’re finding is that there’s not enough, I guess, Te Ao Māori intervention for them. So by us creating a rōpū Māori to respond to Māori needs I guess that’s the innovative thing that I’m looking at the moment for that, that area.” (DHB voice)

“In terms of our program delivery, there are elements of kaupapa Māori in that space and in our, we have a range of tikanga programmes, which also have a kaupapa Māori holistic approach to the way in which those are delivered.” (Government agency voice)

However, NGOs, Māori, and Pacific peoples raised views regarding access to culturally aligned services. They noted large variations across the country, with some regions having good access to culturally aligned therapies and supports, while other regions had severely limited access. Māori and Pacific providers reported being over-worked and under-resourced, which has limited their ability to expand service delivery to meet demand.

“What real choice in Access and Choice do our Pacific people have? I can’t see that.” (Pacific voice)

PHOs and NGOs spoke of a limited ability for people with lived experience to choose the level of support that would best address their needs. For example, we heard of a lack of ‘light touch’ intervention options for those who required support, but who did not need the full ‘bells and whistles’ of an inpatient admission.

“Accessing inter-services has got a lot of barriers around it. Where do you get help? And how do you access into just getting a little bit of help because you only need a little bit. You don’t need a big admission. You don’t need that. So light touch, we don’t do any of that.” (NGO voice)

“So one of the things I would like is a kind of a continuous transition and levels of support, so that if a community organisation or a GP says ‘This person is in distress, they need some support,’ then we’ve got ways of them getting a little bit of support if they only need a little bit of support, or a lot of support if they need a lot of support, rather than this whole you get nothing and then when you’re really, really unwell, yes, you can get a whole huge wrap around thing for quite a long time and then you get chucked out and you get nothing again.” (PHO voice)

### 9.3. There is a lot to learn from community providers and kaupapa Māori approaches

Interim Report reference: this section aligns with Part 2: Section 2 - We need to do more to support the successful work already happening in communities

Māori, Pacific and consumer organisations, PHOs and government described how community-based providers, such as Māori and Pacific organisations, provided innovative, responsive services that place people in the centre and meet people's need in a holistic, wellbeing-focused way – and that these organisations have been working in this way since long before He Ara Oranga.

“Our methodology is we call it the three Cs and that everything we do has to be culturally relevant, clinically safe and community led [...] we've found that that, those three Cs are pretty much the magic in our work.” (Le Va)

“I mean we do work in different ways, we're quite responsive to whānau needs.” (Māori voice)

“I'm an NGO, we deal with people. We don't deal with mental health. Mental health is not what we look for [...] we see people. We don't see primary care, mental health, we don't see all those barriers. We see people and we offer them help.” (Pacific voice)

For example, Māori organisations highlighted the ways in which they have addressed the wellbeing needs of communities during the challenges of COVID-19.

“We would prioritise [...] and make calls to the ones that we felt were the most vulnerable and reach out and just put a korowai of aroha around them and whatever that looked like, whether it meant that they needed a load of firewood or contributions towards people's car bills for the next six months, giving people credit if they didn't have data or WIFI in their home we would put credit on their cell phone to enable them to keep communicating with whānau, which just would make a considerable difference to somebody's wellbeing [...] So those are the kinds of things that we've been doing over the past five weeks.” (Whānau Ora voice)

“I had one team member just on the phone so she would ring around and see how whānau are, if they had kai, if they needed kai parcels and we hadn't actually done that before.” (Māori voice)

However, both Māori and Pacific providers expressed frustration and disappointment that they are not properly resourced to work in a holistic, person-centred way.

“You know, many of the things we do, we're not funded to provide. [...] And so what I done was I wrote down all those cultural things that we do and I put a median time to it and a median hourly rate. So to do all of those cultural

activities cost us about \$300,000 a year which we're not funded for. They're getting the same money next door but not providing nearly as much [support], you know. This is also not reflected in any of the reports we send to the DHB/Ministry." (Māori NGO voice)

"We actually provide a considerable amount of mental health care unfunded. Which is huge for an NGO when our FTEs are reliant on funding from contracts." (Pacific voice)

Those from the health sector, government, and Māori and Pacific peoples conveyed the value and insights that kaupapa Māori and whānau ora approaches can provide to support the mental health and wellbeing of all New Zealanders.

"We have all these amazing Māori models, mātauranga Māori, that give us a lot of places to go in terms of thinking about wellbeing. So I sort of think we've got this unique opportunity to really draw on that knowledge and that understanding that's so well established for this unique context that we're in." (Government agency voice)

"And I also think that kaupapa services are the beacon of hope [...] what I'm noticing in general society that the, there's a lot of non-Māori that are looking for a lot more than what they're getting. And I think that kaupapa offers some of those answers and solutions that others are looking for." (Māori voice)

"But it's about shifting power and re-establishing closer links to kaupapa services but also strengthening Māori approaches to mental health." (PHO voice)

#### 9.4. Expanding access and choice is more than simply adding more services into the mix – it requires doing things differently

We heard of the need to do things differently in order to see improved access and expanded choice. They said that it required thinking outside the box, beyond 'clear cut services' and towards building the capabilities and resilience of communities, and empowering whānau and communities to address their own wellbeing in a way that works for them.

"So I guess that's what we're saying is that sometimes a treatment option or a clinical plan or a residential stay, they're not going to achieve what your aunties and uncles or the hope of your mokopuna can." (Whānau Ora voice)

"What Whānau Ora offers is direct access into our families and they can identify what the issues are for them and let's build from there." (Pacific voice)

"I want it to be common knowledge as much as going to get blood tests done and going to see your podiatrist and checking your diabetes, that I can ring

my GP clinic and say ‘Actually, I just think I need some cultural support. I need somebody to come and have a karakia with me and sing a waiata. I need somebody to sit with me at my urupa when I’m grieving for my whānau.’ You know, because that is mental wellbeing.” (Māori NGO voice)

“What we would like to see is a world where people and their whānau are at the centre, but we also have communities that are much more able to recognise and respond to distress. And that within those communities we have formal and informal groupings of people who feel comfortable talking about distress, are able to recognise when somebody around them is beginning to experience distress, have skills that they can use themselves for responding to that, recognise when people might need more formal supports and be able to know exactly what’s available in the community and provide people with information about that.” (Government agency voice)

It was commented that transforming access and choice requires a shift to being people-centred – working in an individual, holistic way, and orienting services around the person, instead of having siloed criteria for services and making people ‘fit’ into predetermined service boxes.

“I mean you need psychiatrists, you need nurses, you need psychologists, you need all those people, but they need to be responding to the needs of the people they’re dealing with, not have the people fit into the boxes that they’re carving out for them.” (Government agency voice)

“To me that’s increased access and choice, giving someone a cell phone and saying we’ll top it up twenty dollars a month, keep it on you, try not to lose it – we know some people will lose it but we can call you any time and if you’re not feeling that great you can call us.” (Lived experience voice)

“And I think it has to be more people-centred as opposed to the agencies centre, so you know agencies are open nine to five, but people are in distress at nine o’clock, you know how do you respond to people’s needs versus what an agency may be resourced or funded to supply.” (Government agency voice)

“Almost like the old style when we had a house the people could just pop in for a cup of coffee and something to eat or a cup of tea till ten o’clock at night rather than being home, isolated, lonely, and then getting home and then ringing the crisis team and then going to the ward, actually having those peer support hubs.” (Lived experience voice)

## 10. Suicide prevention

This section includes discussion relating to suicide prevention efforts within the system, and discussion around the Suicide Prevention office and suicide prevention strategy.

### 10.1. Building blocks are in place to improve suicide prevention

**Interim Report reference:** this section aligns with Part 1: Section 2 - The Suicide Prevention Office provides a focal point

We heard of the steps that have been put in place since He Ara Oranga to improve leadership, coordination and resourcing for suicide prevention. Establishment of the Suicide Prevention Office received strong support from DHBs, government, NGOs and Māori organisations. Discussion was hopeful that the Suicide Prevention Office would provide greater leadership, guidance and direction in suicide prevention.

“I think the fact that the Suicide Prevention Office has been established within the Ministry of Health is a very good thing because you’ve got to build that capability, rather than have fragmentation.” (Government agency voice)

“Getting the Suicide Prevention Strategy and office underway. I think those early choices have largely been good choices.” (Government agency voice)

“We’re really pleased and really looking forward to working with the Suicide Prevention Office.” (DHB voice)

“I’ve noticed in the new suicide prevention office and the new suicide prevention action plan that they are having a community bottom-up view on things so that’s really refreshing and I do think that’s a step forward.” (Pacific voice)

NGOs and consumer organisations commented on what had happened in suicide prevention since the establishment of the Suicide Prevention Office.

“There was one other thing about the Suicide Prevention Office. There’s a little bit of concern being expressed that not much has happened since its creation. People are really interested to know what’s going to happen there and what are the, what are its plans, how are things going to unfold around that work.” (Lived experience voice)

“If I just talk about suicide prevention, I have to be really honest, I don’t know what’s happening in that space. I believe there’s a new plan that was circulated but I haven’t, it hasn’t really like, you know, gone up in flashing lights on my desk [...]to me I think it’s just business as usual in that space.” (Lived experience voice)

Government agencies noted that the Suicide Prevention Office was in the early stages of being established and was still undertaking critical activities such as scoping the extent of

suicide prevention efforts in the system, establishing the Māori Advisory Group, and determining the role and purpose of the Office.

“It’s still very early days. The Office has only just put a team in place.”  
(Government agency voice)

“The Suicide Prevention Office has continued to consider its role and the principles of what Suicide Prevention Office should do.” (Government agency voice)

“A lot of time this year has focused on establishing the Māori Advisory Group, which was a key priority for the Suicide Prevention Office.” (Government agency voice)

“Having the Suicide Prevention Office up and running is a very good thing, it is a lean machine. I don’t envy [the Office] trying to do so much with such a very small team.” (Government agency voice)

The fact that a suicide prevention strategy has been developed was also supported by those that were interviewed, particularly NGOs and government.

“I guess we don’t think the strategy’s perfect by any manner of means, but at least it is a strategy, at least it does have some key elements like wellbeing promotion, like a strong focus on trauma informed approaches built in there which are really positive.” (NGO voice)

“We now have a strategy that’s been signed off, there has been extensive input to that pre He Ara Oranga and post He Ara Oranga, and I think it does have that whole of community lens.” (Government agency voice)

Although, there were concerns from Māori, Pacific consumer organisations that some voices were not fully engaged, or that feedback had not been fully incorporated, during the suicide prevention strategy development process, and that meaningful co-design with Māori and whānau was missing.

“There was quite a bit of feedback around the plan itself – some of which wasn’t incorporated – so there were some remaining concerns about that.”  
(Lived experience voice)

“You just need to bring those Māori whānau together and even if they are survivors of or whānau who have lost members of, what would have helped for you. But they’re not asking those questions. They’re bringing in strategies from overseas.” (Māori voice)

“I think it’s all very good, to have a suicide prevention focus is very good but it was thin, once again, on family whānau.” (Lived experience voice)

## 10.2. Communities are leading the way in suicide prevention efforts

Interim Report reference: this section aligns with Part 1: Section 2 - Communities are leading the way in improving our suicide prevention efforts

NGOs and government noted that communities are leading the way forward regarding suicide prevention efforts, however these efforts on the front lines need more resourcing and attention.

“We know what the solutions are but we’re not getting any support [...] why should we give all the answers and we get nothing? We get nothing, not that we want recognition but we don’t get any funding from the Government.”

(Lived experience voice)

“I think that community-based places are where I would like to see, you know, being supported to. Cause they’ve got a lot of answers and a lot of knowledge.” (Government agency voice)

DHBs also described work that was underway to improve suicide prevention efforts, such as the development of individual DHB suicide prevention plans, seeking greater collaboration with communities, strengthening relationships and networks, and increasing education and training around suicide awareness and prevention.

“We’ve been one of the first DHBs to investigate what training, suicide prevention training is there for specialist mental health and addiction staff.”

(DHB voice)

We heard that DHBs are working towards improving suicide prevention efforts but expressed frustration that the situation largely has not changed yet.

“Hearing some good things that are happening in some DHBs [...] and it sounded like they did have some good things happening but I work every day in this area on the coalface, I go to the acute wards, we have people, and when we talk about there’s some really good things to come, it doesn’t help the person today [...] it doesn’t help the person on the ward right now, it doesn’t help that family right now. So we’re often hear ‘Look, all this is happening, this is going to happen’. Excuse me but right now, what do you tell the family? What do you tell the person?” (Lived experience voice)

It was suggested that communities – particularly Māori, Pacific, and whānau bereaved of suicide – should be looked to for solutions and ideas for suicide prevention work, and that effective suicide prevention work needs to be amplified and resourced.

“So we’ve got big untapped resource, whānau are our biggest NGO. No matter which way you look at that, whānau are our biggest NGO. [...] Tap into all those resources that we already know are out there. Don’t bring in, you

know, this project manager that's writing that Zero Suicide thing [...] Bring our whānau together. They've got the solutions." (Māori voice)

"There are shelves of Pacific and Māori programs sitting in books, in folders, in DVDs, and it's not new. We have things that we can use straight away." (Pacific voice)

"You give us a million bucks and we'll show you how it's done." (Lived experience voice)

We heard there is an opportunity to build up whānau resilience and capability to support wellbeing within their own whānau networks as an alternative approach to suicide prevention for Māori.

"I think that it's in some ways giving whānau back their own power that in your DNA and your history and your traditional knowledge, you know, you've got a lot of value there for hauora and the wellbeing of yourself and your children, your people. And that, I think, just needs drawing out and developing. And if they haven't got it, [then give them] the opportunity to access it. Because I think often we do look at professionals in organisations for the answers and I think that they are there at a certain level, you do need specialist professional physical care, absolutely, but there's a whole other space where you can do for yourself as long as we support that to be brought about." (Government agency voice)

### 10.3. Suicide prevention efforts need to be collaborative and focused on wellbeing

There was strong support among those we spoke to – including DHBs, government, and NGOs – for taking a broad, holistic view of suicide prevention. This included recognising the role that social determinants play in suicide prevention, and that suicide prevention is wider than a health issue.

"We're not going to bring our suicide rate down if everyone thinks it's Health's responsibility." (Government agency voice)

"We have to talk about promoting and improving wellbeing at a population level. We need to do better with people who present with very high needs as well as improve the wellbeing of the whole population to change our suicide rate." (Government agency voice)

There were also calls to not limit suicide prevention to secondary services, but instead take different approaches, such as population-level approaches to suicide prevention.

"Think there's still an aspect, there's a public health wide, you know, population-based strategy that needs to occur." (Māori voice)

“Key determinants [of suicide] include poverty, trauma, social and cultural alienation and isolation. Many of these occur together and have a compounding effect. If we focus prevention at a population level rather than only focusing on preventing suicide in specialist services, we will have a better chance at reducing suicide rates, including our youth suicide rate.”

(Government agency voice)

We heard of the desire on the ground to work together to improve responses to people in need.

“We certainly put things forward and we were very much hoping for a co-response design that we could move forward with and in fact we [...] have moved ahead with a co-response design anyway because we see acute benefits for our mentally distressed people.” (Government agency)

Taking a joined-up, collaborative response to suicide prevention – both within the health sector, and across government – was considered critical for maximising suicide prevention efforts. This included taking a relational approach and sharing knowledge and learnings.

“Because when you think about health, education and employment or economic wellbeing for people are all huge factors in our suicide prevention approach and not one system can do it on their own and we need to understand that how interlinked we are. And our planning and our actions need to start reflecting that.” (DHB voice)

“And looking at the Kaupapa Māori approaches and what’s available in our community, [...] there needs to be a bit more partnership [...] Because we all, and I know that Māori do have their ways and means of nipping this in the bud as much as they can but we still all have to work together. We still need opportunities to be able to, in the waka, row it. We’re all heading to that same outcome of no suicide, you know?” (Lived experience voice)

“Like say in relation to suicide prevention, [...] I think that we can learn more together on that rather than everybody doing it by themselves. There’s some collective force and also some economy of scale in thinking common issues through together.” (Government agency voice)

#### 10.4. There is a need for alternative support pathways for people in distress and greater access to post-vention support

Multiple NGOs raised views that the situation on the ground has not changed for those bereaved by suicide, or those trying to support others bereaved by suicide. They noted a lack of support available to manage the impact of losing a loved one.

“So how am I supposed to process complicated grief if I don’t get support? And where is that support?” (Lived experience voice)

A wider discussion around access and choice can be found in Section 9: Service design and delivery (access and choice).

PHOs and government spoke of the challenges that people face accessing support when experiencing crisis or distress. We heard a call for alternative ways to access support outside of the secondary care pathway.

“So there’s a real lack in New Zealand of any place of safety to take people under mental distress.” (Government agency)

“We do know that a lot of people reach out for some help prior to suiciding and don’t always get the help they want, so the more that we’ve got channels that make it really easy to get help that doesn’t feel like it stigmatises and is really responsive, then I think it’s got to be one of our major strategies.” (PHO voice)

“So crisis response is not, suicide prevention is not just a health response, it’s a societal— [...] And we need community responses not health responses. [...] But when people are in crisis and are seeking help from health services, having all our crisis existing in a secondary service is not practical or helpful.” (PHO voice)

“The feedback and things I’ve seen and heard in the community are that sometimes people have suicided after they’ve sought help but haven’t been able to access help.” (Government agency voice)

Concerns were raised by a consumer organisation that whānau bereaved of suicide are not being fully and meaningfully engaged in the co-design of postvention support services.

“I was just really, really disappointed because we support whānau right through New Zealand. [...] We were either actively excluded or forgotten and then added at the end. We have not had another opportunity.” (Lived experience voice)

Further discussion around the participation of whānau and people with lived experience in co-design processes can be found in Section 5.1: Partnership with Māori, Pacific peoples, whānau and people with lived experience.

## 11. Rights and legislation governing mental health

This section includes discussion related to aspects of rights and mental health legislation within Aotearoa, including the impact of how the current Mental Health Act is implemented and the use of Compulsory Treatment Orders.

### 11.1. Work is underway to repeal and replace the Mental Health Act

**Interim Report reference:** this section aligns with Part 1: Section 3 – Work is underway to repeal and replace the Mental Health Act 1992

Government and whānau and consumer organisations welcomed the work being undertaken to repeal and replace the Mental Health Act 1992 (the MH Act).

“We absolutely support that the Mental Health Act does need reforming.”  
(Whānau voice)

“On the Mental Health Act we are as determined as anybody to make sure that Act is reviewed and replaced with an Act that is much more for New Zealand now and the future which recognises the very big move in our expectations about how we work with people in mental distress, how we include their family and whānau in that process and also how we support them best as we can, to make decisions about what happens to them when and how. Supportive decision making as distinct from substituted decision making.” (Government agency voice)

“My understanding was that they were going to go out for public consultation on the reform of the Act and we think that’s really important to do. I think that needs to be a very wide, society wide conversation about how we approach mental health from a legislative framework.” (Government agency voice)

Government noted that work underway has initially focused on a revision of the guidelines for the current MH Act.

“We’ve been in the process of revising the guidelines under the current Mental Health Act. Those were targeted to be published in April but that has been pushed out a bit due to COVID-19. We revised the guidelines based on consultation feedback [...] which included feedback from service providers, consumer representatives, NGO representatives, Māori representatives, Pacific people representatives and a wide range of views.” (Government agency voice)

“This year we’ve focused on improving practice under the current Act and updating guidelines for how the Act should be applied to take steps towards where we want to go through that longer-term repeal and replacement of the Act.” (Government agency voice)

We heard acknowledged aspects of consultation around the MH Act guidelines – expressing that engagement appeared to be genuine, and that feedback was heard and incorporated.

Others mentioned that consultation on the MH Act should not be rushed, and must involve engagement with whānau, advocacy and representative groups, or people with lived experience.

“What’s the hurry? Why don’t we take a bit longer, inform all people and get everybody’s voice just to take a little bit longer and get it done. Hopefully

right instead of rush jobs because that's what's happening." (Lived experience voice)

"The process I think is in early days, I think there's been early engagement with officials more than with the wider community. The sense I get is there's concern from consumers, whānau, NGOs and advocacy and representative groups about the level of engagement they have in work to change the Act." (Government agency voice)

"Because I think that's the other voice that we're missing, that we're actually missing in here, it's actually 'Where is the whānau voice? What do the whānau want?' They know the person best and yet we're not listening to them." (Lived experience voice)

Māori organisations and representatives from government recognised the importance of taking a focus on equity and partnering with Māori when undertaking work to repeal and replace the MH Act, particularly given the disproportionate rates of Māori sectioned under the MH Act.

"Well it should have. I mean Māori have the highest rate under CTO than any ethnicity. So absolutely should have that Māori flavour, well eyes at least look over it. Absolutely should have." (Māori voice)

"New legislation needs to ensure equity for individuals because we know Māori are disproportionately represented under the current legislation." (Government agency voice)

NGOs and consumer organisations raised the need for greater communication surrounding the MH Act. Consumer organisations involved in consultation wanted to be more informed of progress with the MH Act, and clear communication was considered an important part of achieving public buy-in.

"I don't think enough work has been done to communicate why, or the more holistic approach to mental health in a way that makes people feel safe. So we still are inundated with whānau and friends who are worried about someone and want them locked up. And those people have the best of intentions, as far as we can tell, they are not going to be supportive of a reformed Mental Health Act. [...] And so I really worry that this whole strategy will fall over if you can't find a way for the public to buy into it." (NGO voice)

"Even the Mental Health Act for instance, the changes, we have meetings at work, submissions were put forward. You never hear anything back [...] we don't hear where it's at." (Lived experience voice)

Government agencies reiterated that feedback about communication is being taken on board.

“I can say that when [the sector] provides feedback to us, we take it to heart. We are open to re-tooling and re-tailoring where needed and try to take on all of the feedback as much as possible. Because we do want to get it right.”  
(Government agency voice)

We heard that, for lived experience communities, it was important that the MH Act is addressed from a blank slate, rather than amending the Act as it currently stands.

“So ‘repeal and replace’ is the terminology that people seem to be preferring, the way that it’s stated in the document we received that it’s termed as ‘reform the Mental Health Act’. The feedback we’ve been getting is that when people hear the word ‘reform’ it sounds like we’re going to take what we’ve got and fiddle with it a bit. Whereas ‘repeal and replace’ says ‘We’re getting rid of what we’ve got and we’re starting again’.” (Lived experience voice)

This approach was considered important in order to build new legislation based on Treaty principles and tino rangatiratanga (self-determination).

“Because fundamentally it comes down to how are you ever going to incorporate Te Tiriti o Waitangi into what we’re doing if you’re fundamentally removing tino rangatiratanga from people under the Act. It really comes down to that. If that’s going to continue to happen then the alignment is never going to be complete.” (Lived experience voice)

### Approach to new legislation

Intentions for new legislation to be built on the following principles were noted:

- te Tiriti o Waitangi,
- taking a Human Rights approach,
- enabling maximum independence for individuals and inclusion of people in society,
- a recovery approach to care and treatment,
- timely access to services,
- least restrictive care,
- respect for whānau (taking a community focus not individualistic focus).

“I’m keen that we move away from a primarily risk based and coercive approach to a more rights based and supportive decision-making framework.” (Government agency voice)

It was indicated that current work on the MH Act is looking to international examples who have reformed, or repealed and replaced their Mental Health Acts, and that some stakeholders have supported looking at Northern Ireland as an example.

“Northern Ireland has moved to a ‘fusion’ model [...] they don’t have a standalone Mental Health Act anymore, they have an overarching Mental Capacity Act, essentially, that covers situations such as financial, personal welfare, mental health, physical health, several things that you could potentially compel treatment for if they lack mental capacity. So it’s not based on the presence or absence of mental disorder, it’s based on someone’s capacity to make a decision to invest their money in a certain way or to decline a lifesaving physical health treatment.” (Government agency voice)

However there was recognition that any new legislation will need to reflect a Māori world view.

“Most of the other comparable countries that we have looked at are Western-European countries and they don’t have that indigenous perspective reflected. We’re very cognisant of that fact, it’s not just enough to copy another country, we need to make sure it applies correctly in New Zealand with our indigenous cultures. So that’s going to be a critical discussion that we need to have: What does this look like from a Māori world view and how does it need to be tailored and changed to reflect that appropriately?” (Government agency voice)

There was discussion around a shift from a risk-based approach, to one that takes a human rights and safety focus.

“So we’ve been involved in the early discussions with Health [...] We know the shift that they’re looking for is away from restraint and seclusion and more human rights approach in the, you know, reformed Act.” (Government agency voice)

“If you’re trying to protect an individual then the focus should be on the safety of that individual, not, is that individual a risk? The concept of an individual person posing a risk is very stigmatising and centre focused. When you start to ask the question of ‘Is a person safe’ you can consider factors of ‘Is their behaviour safe’ and how do you ensure their behaviour is safe. But then you also start to look at the environmental factors around them; Are they in a safe environment? Are they in a safe home? Are they surrounded

by individuals that are posing any risk to their safety? It starts to take the lens beyond just that person, which is really critical.” (Government agency voice)

## 11.2. The system needs to support the appropriate use of the Mental Health Act

DHBs and government discussed the need for the mental health and wellbeing system to be appropriately structured and resourced in a way that supports people who are sanctioned under the MH Act, and reduces the inappropriate use of the MH Act.

“But we also have issues like with [...] where people get put into compulsory treatment for their addiction, so we’ve got these services for the detox type thing, but once they come out, they’re basically allowed to go back to their old situation, there’s not a range of supports to support them afterward. And whatever the Act requires needs to have the resources in the system to respond appropriately. And that’s a challenge and it needs to be thought through as the Act really works, so what does that mean from an infrastructure and resourcing requirement from the sector to respond to the Act appropriately.” (DHB voice)

“It’s not enough to get a nice shiny piece of legislation but then the system hasn’t been built up to support that framework that you put in place, so if you don’t have that expanded Access and Choice then you’re not going to really be able to catch the people who potentially fall out of a [...] a tighter framework that limits who can come under compulsory treatment.” (Government agency voice)

Particular concerns were raised by Māori, consumer advocates and government departments around the disproportionate use of the MH Act and compulsory treatment orders (CTOs) on Māori, and the need to address issues such as the culture and inequitable practices surrounding CTO use.

“And further to that, when they’re out in the community and unwell, when the Police are called is there a CTO? They’re treated differently because there’s a CTO. What that says to them is ‘Danger! Danger! Danger!’ They’re at risk, risk, risk, you know. That’s what that impacts on. Because we’ve tried here to say, ‘We’ll pay for the medication then’. If the only reason they’re on that CTO is medication we’ll pay for it. But they won’t take them off it. It’s about power and control.” (Māori voice)

“[DHB is] trying to reduce the rate of Māori on Compulsory Treatment Orders. However, that has focused more on raising awareness and education of service users and whānau around the processes and people’s rights, or lack thereof, when it comes to the Act. Which is good, it’s part of the equation,

but when you have certain inequitable clinical practices in place there seems to be a lack of tackling the actual clinical practice of the Act and how that's applied inequitably." (Lived experience voice)

"Māori are about four times more likely to be under a Compulsory Treatment Order under the current legislation. We have concerns that systemic inequities in the system contribute to this, and so our hope is that new legislation can try to reduce those systemic inequities and be applied on a more neutral basis." (Government agency voice)

"We are failing with Māori, that Māori are moving backwards in relation to the Mental Health Act and have been consistently for some years. That is not okay." (Government agency voice)

Māori organisations and whānau groups in particular highlighted the challenges that people face in receiving the care and support that they need, and how the MH Act is viewed by some as a means of accessing the system.

"Which leads to me thinking about the reform of the Mental Health Act. There are a number of families who in our organisation are very concerned about that prospect. They're saying 'The Mental Health Act saved my family member's life. It was the wake-up call. It was the only way that we could see of getting out of the situation that we're in.' The situation that might be life threatening to both the person and their extended family. The accessing treatment and the way in to access treatment. Often, it's not about, it's about getting in the front door, is one of the very biggest parts of holding on to that Mental Health Act, it's the only way we can get in. It's the only way we can get something done, it's the only way we can change what's happening for us." (Whānau voice)

"And my concern is that even with the review of the Mental Health Act I can't see coercion disappearing from the system anytime soon. [...] if you're under a CTO Section 29 you get reduced expenses for your medication. [...] And you also have a return back to the acute unit plan as a part of that order. So actually that's the coercion, not actually being under the Act. So staff actually think they're doing a good thing putting our Māori whānau under a CTO because they get cheaper medication and they can get back to the acute unit." (Māori voice)

Improving access to services and treatment, such as reducing the cost barriers to medication, was considered an important step for reducing the inappropriate use of the MH Act and CTOs.

"There's that stigma for people that have been with us for a long time and they're on CTO so they can get free medication. So what this has done for us

is we're looking at what does it cost the DHB to pay for that medication? Do we have to keep people on a Compulsory Treatment Order to pay for their medication? No, we don't. All they need is the money for their medication, they don't need to be under a CTO." (Lived experience voice)

"Families have told us in the past that often while the Mental Health Act has been the only way that they can get into services, it's also often been used as a threat. And that's abhorrent to us as well." (Whānau voice)

"If that's the only thing that a person needs and that's the only reason, they would be on a Compulsory Treatment Order, that's not right, we need to find another way to make sure they have the access to that treatment."  
(Government agency voice)

### 11.3. More needs to be done to reduce seclusion practices

We heard about a large amount of variation across the country around the use of seclusion practices in DHBs, with some DHBs continuing to use seclusion, while others have reduced or removed the use of seclusion in inpatient units. Those DHBs that had reduced use of seclusion had often implemented multiple initiatives and creative means of reducing this practice.

"So, we have some DHBs where seclusions become a very rare event and other DHBs that are continuing to seclude." (Government agency voice)

"Some DHBs have really succeeded in reducing [seclusion] so there does seem to be progress being made." (Government agency voice)

We heard of the impact that workforce culture and the working environment can have on the use of seclusion.

"So if you look at mental health services it's traumatic for people being secluded and it's traumatic for staff. And so until we shift some of that dynamic, we're probably not going to see that much change. [...] This is the challenge." (Workforce organisation voice)

"And it seems in more recent times in inpatient settings we've lost the therapeutic [environment] and returned back to containment and [...] managing." (Māori voice)

"[DHB] for instance, so they have one unit where seclusion has become a very rare event and another unit where seclusion occurs more often, so they're trying to look at the different cultures of those two staff groups and look at what learning can be shared." (Government agency voice)

A workforce culture and working environment based on respect, compassion, and empathy were considered important to reduce the use of seclusion practices in inpatient units.

“And some DHBs will say it is a bit about a culture and how do you bring about that culture of respect, compassion, empathy, trauma informed care. There’s some beautiful words for it but how do you bring all that about in your units.” (Government agency voice)

We heard that some training, education and initiatives have been introduced to address negative workforce culture and working environment that might contribute to the use of seclusion.

“Another initiative was after nurses at the end of handover, coming out feeling quite heightened by the handover being given by the morning shift about ‘this happened’ and ‘that happened’, so they were quite wound up themselves and that’s probably not a good place to be when you’re meeting your service users for the afternoon. So they lead them through – and they’re just testing this at the moment – a mindfulness exercise. So staff can calm down and relax and be in a better space when they actually go out. So again, saying what’s the problem here? Is it a staff issue? Not necessarily a service user consumer issue.” (Government agency voice)

“And so some of the zero-seclusion work has been, in this area has been education sessions with the Police, and so that people are responded to more quickly, more therapeutically, and they’re not arriving in such distress [...] the Police are absolutely hungry for this education. They can’t get enough of it.” (DHB voice)