



Wellbeing Manifesto

for Aotearoa New Zealand

A submission to the Government Inquiry
into Mental Health and Addiction

Prepared by Mary O'Hagan for PeerZone and ActionStation

The problem

Big Psychiatry (our medical-led mental health and addiction system) was created around 200 years ago in an historical moment that established the construction of madness as an illness. The new profession led a medicalised, institutional and coercive system, where even the best intentions led to routine harm and poor outcomes.

Despite the closure of the old psychiatric hospitals and the addition of some community support services, Big Psychiatry still sits at the hub of our mental health and addiction system, where it shapes the world view and draws on most of the available resources. Its medical lens and expensive, narrow interventions focus on symptom reduction and short-term risk rather than holistic wellbeing and long-term outcomes. Big Psychiatry has also contributed to colonisation through imposing an alien system on a disproportionately large number of Māori.

New Zealand led the world by taking the first significant steps in the transformation from Big Psychiatry to Big Community (a multi-sector, community-led wellbeing system) in the 1990s and 2000s, through the closure of the large psychiatric hospitals and growth in community support services.

However, in the last decade a crisis has developed from persisting inequality, loss of leadership, lack of investment in Big Community and a complex, inflexible and fragmented system. There is widespread public concern about levels of distress and suicide, especially among Māori and youth. Many people cannot access help until they are in a deep crisis. People who use services are poorly served, with increasing rates of coercion, traumatising crisis interventions and a paucity of comprehensive responses.

More of the same will not fix the problem.



What is Big Psychiatry and Big Community?

BIG PSYCHIATRY	BIG COMMUNITY
<ul style="list-style-type: none"> • Mental disorder is viewed primarily as a health deficit. 	<ul style="list-style-type: none"> • Mental distress is viewed as a recoverable social, psychological, spiritual or health disruption.
<ul style="list-style-type: none"> • A mental health system with a health entry point led by medicine. 	<ul style="list-style-type: none"> • A wellbeing system with multiple entry points led by multiple sectors and communities.
<ul style="list-style-type: none"> • Most resources are used for psychiatric treatments, clinics and hospitals. 	<ul style="list-style-type: none"> • Resources are used for a broad menu of comprehensive community-based responses.
<ul style="list-style-type: none"> • Employs predominantly medical and allied professionals. 	<ul style="list-style-type: none"> • Employs a mix of peer, cultural and traditional professional workforces.
<ul style="list-style-type: none"> • Has a legacy of paternalism and human rights breaches. 	<ul style="list-style-type: none"> • Has a commitment to partnerships at all levels and to human rights.
<ul style="list-style-type: none"> • Focused on compliance, symptom reduction and short-term risk management. 	<ul style="list-style-type: none"> • Focused on equity of access, building strengths and improving long term life and health outcomes.
<ul style="list-style-type: none"> • Responds to people at risk with coercion and locked environments. 	<ul style="list-style-type: none"> • Responds to people at risk with compassion and intensive support.
<ul style="list-style-type: none"> • A colonising medical system that excludes other world views. 	<ul style="list-style-type: none"> • A bi-cultural system that embraces many world views.



Our calls to the Mental Health Inquiry

*Me mahi tahi tatou mo te oranga o te katoa.
We must work together for the wellbeing of all.*

We must restart the journey to Big Community and resist pressure to pour more resources into the current obsolete model.

Big Community needs to replace Big Psychiatry at the hub of the system and position psychiatry as one of its many spokes, so that everyone with mental distress and addiction has open access to a comprehensive range of responses.

1. Commitment to the seven wellbeing priorities

The government needs to commit to seven wellbeing priorities across the spectrum – to prevent, respond to, and lessen the impact of mental distress and addiction. All people:

1. Live in social conditions that enable them to look after their own and each other's wellbeing.
2. Know how to recognise and respond to stress, distress and addiction.
3. Can easily find services and supports for people with distress and addiction.
4. Get timely, respectful and helpful responses from them.
5. Have access to a comprehensive range of community-based services and supports.
6. Are supported by people who have 'walked in their shoes', as well as professionals.
7. Are enabled to reconnect with themselves, their whānau and valued roles in their communities.

Foundational principles of wellbeing

The foundational principles of wellbeing¹ underpin Big Community. They are unique to New Zealand and incorporate Te Pae Mahutonga (a health promotion framework) and Te Whare Tapa Whā (the dimensions of wellbeing), both developed by Mason Durie.

TE PAE MAHUTONGA	Mauriora	Cultural identity
	Waiora	Physical environment
	Toiora	Healthy lifestyles
	Te Oranga	Participation in society
	Ngā Manukura	Community leadership
	Te Mana Whakahaere	Autonomy and self-government
TE WHARE TAPA WHĀ	Taha wairua	Spiritual wellbeing
	Taha hinengaro	Mental wellbeing
	Taha whānau	Social wellbeing
	Taha tinana	Physical wellbeing

2. Comprehensive responses available to all

We need to design a system that gives people and their whānau easy access to a range of comprehensive services and supports:

- Give practical application to Ti Tiriti o Waitangi by embedding Tikanga Māori responses to population wellbeing, distress and addiction.
- Provide acceptable responses to diverse populations, including Māori, Pasifika, refugees, people in the criminal justice system, disabled people, the Deaf community, veterans, rural people, LGBTIQ, the young and the old.
- Develop and fund the twelve core Big Community responses to improve life and health outcomes across the lifespan:



Wellbeing promotion and self-management



Education and employment supports



Stable housing



Income support



Whānau and parenting support



Community and home-based crisis support



Psychiatric treatments



Cultural and spiritual healing



Physical healthcare



Community connection

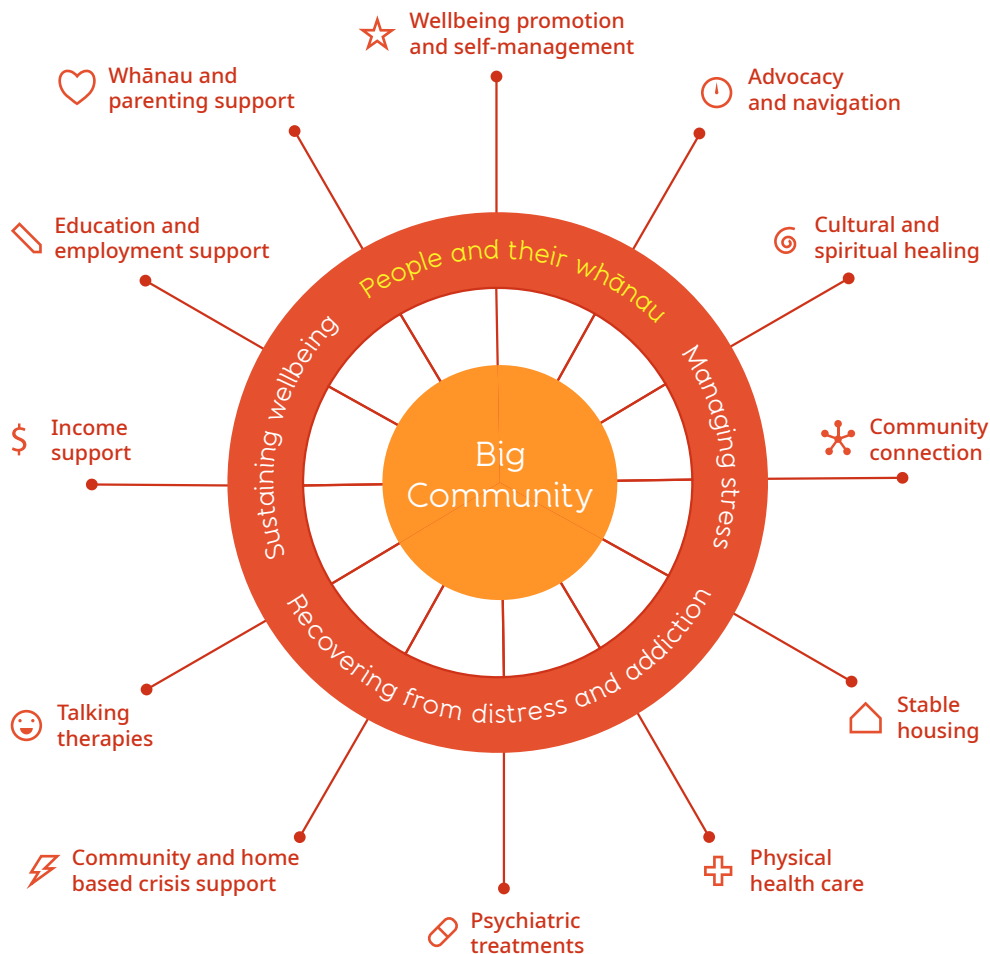


Talking therapies



Advocacy and navigation

The Big Community wheel of responses and workforces



Note:

- The responses represent a focus of attention and are not necessarily separate services.
- Many people will only need one or two of the responses. For instance, everyone needs wellbeing promotion but very few people in the population need crisis support.

3. Major expansion of peer and cultural workforces

We need to develop an equitable balance, in status and in numbers, of three workforces to share in the delivery of all the Big Community responses, across the lifespan:

- Peer workforce (including people with lived experience of distress/addiction and whānau).
- Cultural workforces (including Māori and Pasifika).
- Traditional workforces (such as medical professionals, allied professionals and support workers).

The three workforces need to have the capacity to:

- Respect human rights.
- Work in partnership with people and their whānau.
- Focus on improving their self-defined health and life outcomes.
- Connect them to their personal, whānau and community resources.
- Apply Tikanga values.
- Work with people from different cultures and backgrounds.
- Recognise and respond to trauma.
- Offer harm minimisation and abstinence options to people with addiction.
- Collaborate closely with communities and other workforces.

Tikanga Māori

Big Community encompasses Tikanga Māori – the customs and norms governing Te Ao Māori. The expression of Tikanga values enhances the mauri or life force of all people. These values in the service delivery context include:

- Aroha: Concern and sympathy for others.
- Manākitanga: Respect and hospitality.
- Wairuatanga: Connection to a greater source.
- Whakapapa: Whānau and kinship ties.
- Tūrangawaewae: Identity and a place to stand.
- Whānau ora: Support for whānau to thrive.

Peer Workforce

A peer is someone who has ‘walked in your shoes’. Peer workers are trained, employed and supervised to openly use their lived experience of mental distress or addiction in their work. The peer workforce includes support, advocacy, education, research and advisory roles. Peer workers are powerful role models for recovery and use mutuality to create deep connections with the people they work with. Peer support work has a robust evidence base and is a rapidly growing occupational group in mental health and addiction across the world. However, peer workers in advisory and support roles make up only 2.7% of the mental health and addiction workforce in New Zealand.



4. Multi-sector planning and funding

We need to develop a system where population wellbeing, distress and addiction are a multi-sector responsibility and not primarily a health one:

- Trial the removal of mental health and addiction funding from the District Health Boards with a view to localised multi-sector pooling of all planning and funding functions within the next decade.
- Set up district or regional governance of planning and funding led by people with lived experience, whānau, Social Development, Health, Education, Housing, Corrections, ACC and others.
- Māori design and deliver services for Māori.
- Equitably plan and fund all the Big Community responses with flexible and individualised funding models.
- Use incentives and accountability levers for providers to achieve improved social, education, employment, financial, housing, personal, health and mortality outcomes for people with distress and addiction, with an emphasis on outcomes for Māori.
- Test and scale up indigenous, national and international promising and evidence-based practices that enhance Big Community.

The system may require additional funding, but the cost-effective redirection and pooling of existing resources may be sufficient.

Improving equity and outcomes

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There is ample evidence that people with mental distress, addiction and loss of wellbeing often experience inequitable responses from services as well as poor life and health outcomes. Big Community must give the highest priority to benchmarking and improving the following types of inequities and outcomes:

Use of services and welfare benefits

- Around 50% of people with disabling mental distress do not or cannot access services.²
- Māori make up 15% of the population and 25% of people who use mental health services.³
- In 2017, 45% of people on Jobseeker Support (for a health condition) and 35% of people on Supported Living Payment had a mental health condition.⁴

People with 'serious mental illness'

- 77% experience social isolation compared to 25% with no 'mental illness'.⁵
- 27% are employed compared to 67% of people with no 'mental illness'.⁵
- 43% live in hardship compared to 13% of people with no 'mental illness'.⁵
- They die up to 25 years younger than average.⁶
- Recovery outcomes for people with a diagnosis of schizophrenia are better in low income countries than high income countries.⁷
- There has been no sustained change in recovery outcomes for populations with a diagnosis of schizophrenia since longitudinal studies began in the 1880s.⁸
- In 2014, the cost of the 'burden of serious mental illness' and opioid addiction in New Zealand was \$17 billion (7.2% of GDP).⁹

Compulsory treatment

- Community treatment orders 'do not result in better service use, social functioning, mental state or quality of life compared with standard voluntary care'.¹⁰
- In 2014:
 - 103 people per 100,000 were on inpatient or community treatment orders on any given day³ – this rate is extremely high by New Zealand historical standards¹¹ and international standards^{12,13}.
 - There was 6-fold variation in the use of community treatment orders and a 15-fold variation in the use of inpatient orders, between District Health Boards.³
 - Māori were 3.5 times more likely to be subject to a community treatment order than non-Māori.³
 - Māori were secluded almost four times more than non-Māori.³

Suicide

- New Zealand has the highest youth suicide rate for adolescents aged 15–19 across 37 OECD and EU countries (15.6 per 100,000) – nine times higher than Portugal, the country with the lowest rate.¹⁴
- In 2012, 17.6 per 100,000 of the Māori population completed suicide, compared with 10.6 per 100,000 of the non-Māori population.¹⁵
- In 2014, the suicide rate among people who had been in contact with mental health services in the year prior to death was 136.2 per 100,000 compared with 6.3 per 100,000 for the rest of the population.¹⁶

5. Integrated community delivery

We need to develop community-based services and supports for everyone on the continuum from severe distress and addiction to wellbeing promotion:

- Organise service agencies and workforces from different sectors and disciplines to integrate and collaborate.
- Co-design open-door, one-stop-shop community wellbeing hubs that deliver a range of comprehensive responses – in primary health settings, marae, community centres, churches, workplaces, schools, higher education and online.
- Reduce and eventually phase out inpatient units and replace them with home and community-based services for people in crisis or with high needs.
- Build the capacity of the population to take care of their own and each other's wellbeing, to respond to people in distress, and to utilise Big Community.

New language to replace 'mental illness' and 'mental health'

From time to time we need to change our terminology. In the early 1900s people stopped using the term 'lunatic' and after World War Two they stopped referring to 'mental hygiene'. We think 'mental health' and 'mental illness' have now reached their use-by date. Both terms confine the issues to health; they don't convey the wider social, psychological and spiritual determinants and consequences or the need for comprehensive responses. We propose that 'wellbeing' replaces 'mental health' and 'distress' or 'mental distress' replaces 'mental illness'.



6. Active government

Politicians must work to achieve long-term, bipartisan government commitment to Big Community:

- Articulate the vision for Big Community, grounded in human rights and the social model of disability, and counter resistance to it.
- Test and refine the economic, social, cultural and health rationales for Big Community and use the results to provide regulation and resources for Big Community.
- Fund social inclusion programmes with urgency and create a culture where social exclusion is unacceptable.
- Lead public acknowledgement of the harm done by Big Psychiatry and the State.
- Review mental health and related laws to comply with the UN Convention on the Rights of Persons with Disabilities.
- Target and measure the growth of wellbeing as much as the growth of wealth.
- Invest in prevention and support in the first three years of life.
- Reduce the social determinants of distress, particularly early-life trauma, inequality, poverty, homelessness, and the impact of colonisation.
- Establish a Wellbeing Commission to oversee the transition to Big Community.

Human rights

All Big Community values, legislation, policies, practices, services and standards are founded on cultural values of equality, respect and dignity which have shaped New Zealand human rights legislation and international human rights agreements that New Zealand has ratified. These include the United Nations Declaration on the Rights of Indigenous Peoples, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, and the Convention Against Torture, Other Cruel, Inhuman or Degrading Treatment or Punishment.



Sign up to the Wellbeing Manifesto

The Government Inquiry into Mental Health and Addiction gives us a rare opportunity to restart the transition from Big Psychiatry to Big Community. New Zealand can lead the world in giving its people open access to a full menu of resources and services to sustain and restore wellbeing.

Please support the Wellbeing Manifesto by signing up to it as an individual or as an agency at

<https://our.actionstation.org.nz/p/wellbeingmanifesto>.

Visit the Wellbeing Manifesto Facebook page at

<https://www.facebook.com/wellbeingmanifesto>.

This open submission will be presented to the Inquiry panel at a public meeting in early August. All people who sign up will be invited.

References

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PeerZone is a social enterprise that develops and delivers supports and resources by and for people with mental distress. We believe that with social justice and the right kind of support all people with experience of mental distress can lead great lives:

<https://www.peerzone.info>



ActionStation is a community of everyday New Zealanders who act together in powerful and coordinated ways to create what we cannot achieve on our own: a society, economy and democracy that serves all of us - everyday people and Papatūānuku, the planet we love:

<http://www.actionstation.org.nz>

The People's Report on Mental Health

This report summarised the stories of 500 people who use or work in mental health and addiction services. Action Station presented the report to Health Minister David Clark, who confirmed that his government will implement its recommendations, starting with the Mental Health and Addiction Inquiry. The Wellbeing Manifesto starts where the People's Report ended with more system-based, long-term recommendations.

For info on the People's Report go to

<https://www.peoplesmentalhealthreport.com>



Acknowledgements

This manifesto was conceived by Mary O'Hagan, a lived experience advocate, and former mental health commissioner with a long-held interest in system transformation. It was refined at a PeerZone seminar in November 2017 and through further consultation with Māori, Pasifika people, health promotion experts, mental health professionals, mental health system leaders and people with lived experience. We would like to thank all who gave feedback. You made this manifesto stronger. This manifesto has also taken note of the stories, evidence and advocacy in several recent New Zealand and international publications.¹⁷⁻²¹

Contact

Mary O'Hagan

mary@peerzone.info

021 736 452

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<https://www.wellbeingmanifesto.nz>