Mental Health

New Zealand College of Public Health Medicine Policy Statement

Policy Statement

The New Zealand College of Public Health Medicine (NZCPHM) is committed to improving the mental health and wellbeing of our communities. Mental health is a core component of good health, and mental wellbeing is crucial for communities to thrive. The NZCPHM is committed to creating a society that supports all populations to have flourishing mental health.

Public mental health is a core component of public health medicine. It includes using a public health medicine approach to promote mental health and to prevent, effectively treat, care for and support recovery from mental illness.[1]

The NZCPHM calls for New Zealand to act in three key ways to improve mental health and wellbeing.

1. Address current problems by: prioritising and funding the prevention of mental illness and the promotion of mental wellbeing, which includes addressing the determinants of mental health; focusing on achieving equitable mental health outcomes; improving data collection, which includes collecting and using information on primary mental health care and improving the Programme for the Integration of Mental Health Data (PRIMHD) so that it better captures diagnoses and contains more holistic and functional outcome measures; and supporting and funding regular national mental health and addiction surveys.

2. Take a public health approach to mental health by: addressing the determinants of mental health and wellbeing; improving the mental health and wellbeing of Māori and eliminating inequities; investing in early life – infant, child and youth mental health; and using evidence to inform policies and funding decisions.

3. Build a society that: embraces equity; adopts a comprehensive and holistic view of health; implements strong policy to reduce violence and alcohol-related harm; includes mental health and wellbeing in all policies; includes the wellbeing of children in all policies; and recognises and gives effect to te Tiriti o Waitangi.

The NZCPHM supports the direction and recommendations of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (2018),[2] including both the recommendations Government has accepted and those that it has not yet fully accepted. In particular, the NZCPHM strongly endorses the recommendations to enhance wellbeing promotion and prevention, take strong action on alcohol and other drugs, prevent suicide, and establish a mental health and wellbeing commission.

The NZCPHM supports the policy directions in New Zealand set by the former Mental Health Commission[i] and the national mental health service development plan relating to public mental health.[3,4]

[i] The Office of the Health and Disability Commissioner took over the functions of the Mental Health Commission in 2012.

The NZCPHM also supports in general the 2016 report of the UK Faculty of Public Health (FPH) on public mental health, *Better Mental Health For All*.[1] The NZCPHM endorses the FPH's call for public health practitioners to become advocates for public mental health, providing strong leadership and prioritising mental health within public health practice. Recognising the ethnic and socioeconomic inequities in mental health in New Zealand, the NZCPHM supports the equity-focused public mental health approach that the FPH advocates. At the same time, it recognises the particular additional responsibilities for New Zealand's health sector and health practice that come with the partnership between the Crown and Māori under te Tiriti o Waitangi.

The NZCPHM also supports in general the statements on public mental health by the UK Royal College of Psychiatrists and the UK Chief Medical Officer.[5,6]

Key messages

The NZCPHM is committed to improving the mental health and wellbeing of our communities and having a society that supports the mental health of all.

It supports the direction and recommendations of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (2018), particularly the recommendations to enhance wellbeing promotion and prevention, take strong action on alcohol and other drugs, prevent suicide, and establish a mental health and wellbeing commission.

The NZCPHM calls for action to:

- take a public health approach to mental health that is evidence-based and addresses the determinants of mental health and wellbeing;
- achieve equitable mental health outcomes, with a focus on the mental health and wellbeing of Māori and eliminating inequities;
- invest in early life – infant, child and youth mental health;
- prioritise and fund mental illness prevention and mental wellbeing promotion;
- implement data collection and outcome measures (including outcome measures by ethnicity grouping);
- establish strong policy to reduce alcohol-related harm;
- establish strong policy to identify and address the causes and effects of physical, emotional and sexual violence in our families and communities;
- include mental health and wellbeing in all policies;
- build a society that embraces equity, has a comprehensive holistic view of health, includes the wellbeing of children in all policies and lives te Tiriti o Waitangi.

The context of public health and NZCPHM policy statements

Public health is the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society.[7]

Public health has historically been the main cause of improvements in human health.[8] Advances in public health in the last 100 years – such as vaccination, control of infectious diseases through clean water and improved sanitation, and the recognition of tobacco use as a health hazard – have led to improvements in health and wellbeing, and a substantial increase in life expectancy.[9]

The NZCPHM represents the medical speciality of public health medicine in New Zealand. Public health medicine is defined as the branch of medicine concerned with the epidemiological analysis of the health and health care of populations and population groups. It involves assessing population health and health care needs, developing policy and strategy, undertaking health promotion, controlling and preventing disease, and organising services. Public health is focused on achieving health equity across ethnic, socioeconomic, age, ability, gender, sexual identity, and cultural groups, and promoting environments in which everyone can be healthy.[10]

Public health medicine specialists have a professional responsibility to act as advocates for health for everyone in society.[11-13] For this reason, the NZCPHM advocates for and supports evidence-informed,[13] equity-enhancing[14] policy on mental health for health and wellbeing that accords with te Tiriti o Waitangi, the United Nations Sustainable Development Goals, and health promotion and Health in All Policies approaches, recognising that each of these is grounded in the societal,[ii] economic and environmental determinants of health.[12-22] In keeping with its commitment to mental health, the NZCPHM calls for both national and local action to address the social determinants of mental health, a focus on equity and improving Māori mental health, and a reorientation of health systems towards prevention.

For further information on the context of public health and NZCPHM policy statements, go to the NZCPHM website.

Mental health needs in New Zealand

Mental illness is the leading cause of disability and ever increasing as a leading cause of overall loss of disability-adjusted life years (DALYs) in the world.[23,24] In New Zealand, mental disorder is both more common and more prevalent in some groups than in others.[3,25,26] Neuropsychiatric disorders (mental health disorders and dementia) are increasing in their disease burden and are now the leading cause of health loss in New Zealand, accounting for 19% of total DALY loss.[27] Māori and Pacific peoples experience inequity in their access to services, experiences of determinants of mental health and mental health outcomes.[3,25,26,28]

Mental illness is hugely costly to the individual and to society.[29] The former Mental Health Commission has described both the extent of disease burden and inequities and its vision for a wider public health approach (including whole-of-health-sector and whole-of-government approaches) to address these issues. Government national mental health planning has taken a similar perspective.[4,26]

In December 2018, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*[2] was published. This Inquiry resulted from widespread concern about mental health services within the mental health sector and the broader community, as well as from calls for a wide-ranging inquiry on New Zealand's current approach to mental health and addiction and what needs to change. *He Ara Oranga* set out 40 recommendations to improve the mental health and wellbeing of New Zealanders.[2] The Government accepted in principle, or for further consideration, all but two of these recommendations. Key actions and recommendations were and are:[30]

- The Government accepted that a mental health and wellbeing commission would be established as an independent Crown entity to oversee mental health and addiction

[ii] Societal determinants of health include commercial, political, governance, economic, cultural and even religious determinants. Together these societal structures help create the conditions for health and disease. Each of them eventually impacts on a person's health in a positive or negative way.

services. The Initial Mental Health and Wellbeing Commission was set up in September 2019 to maintain the momentum of *He Ara Oranga* until the permanent Commission was established. The Mental Health and Wellbeing Act passed into law in August 2020.

- Suicide prevention is a key focus. *Every Life Matters: He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand* was published in September 2019.[31] The Suicide Prevention Office was opened in November 2019 to provide central leadership and coordinate suicide prevention work.
- The Government accepted a recommendation to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- The Inquiry recommended strong action on alcohol and other drugs. This included taking a stricter regulatory approach to alcohol informed by the 2010 Law Commission review and replacing criminal sanctions for possession for personal use of controlled drugs with health approaches. The Government decided these recommendations need further consideration.
- Another priority area was to expand access to and choices of publicly funded services to help those suffering with addiction or their mental health.

What is already working well in mental health and wellbeing in New Zealand

There are signs that societal awareness of the importance of mental wellbeing is growing, as is the expectation that we need to invest in prevention. New Zealand already has many hard-working and skilled mental health clinicians and other mental health workers, who are dedicated to improving the lives of the people and communities they work with.

In addition, some local responses to mental health challenges, such as the response to the mental health effects of the Canterbury earthquakes, have been effective and we can learn from them. In 2011, in the wake of the second Canterbury earthquake, the Prime Minister's Chief Science Advisor called for a comprehensive and effective psychosocial recovery programme to support the Christchurch community.[32] The All Right? campaign (www.allright.org.nz) is a population-based mental health promotion campaign developed for this purpose, and it has been consistently evaluated as highly successful. Its key ingredients include having: a clear mandate; ongoing funding, research and evaluation; established practice models and theories; a diverse, multidisciplinary team; a responsive, adaptable approach; community involvement and trust; and tools to promote engagement. This model was responsive to local contexts and emerging issues, informed by local research alongside wider evidence and practice related to mental wellbeing promotion. These ingredients could make it a useful prototype for developing a national programme of action in which population mental wellbeing initiatives are regionally owned and developed.

What is not working well

a) Overwhelming mismatch between demand and supply

The burden of disease from serious mental illness is large, accounting for an estimated 95,700 DALYs in New Zealand annually.[33] Population survey data indicate:

1. mental distress is common – about four in five adults (aged 15 years or older) have experience of mental distress personally or among people they know;

2. although disadvantage is a strong influence on mental distress, anyone and everyone can experience it;

3. people can experience mental distress in many ways beyond standard diagnoses of illnesses like depression and anxiety;

4. feeling isolated from others is strongly associated with symptoms of depression, anxiety and other forms of mental distress, as well as with lower levels of life satisfaction;

5. young people aged 15 to 24 years report high levels of isolation and mental distress;

6. awareness of mental distress in self or others is associated with more positive attitudes (eg, being willing to work with someone with experience of mental distress), but people are reluctant to disclose their experience of mental distress, particularly at work.[34]

Yet, in the face of this evident widespread need, mental health services in Aotearoa New Zealand are able to care only for those with more severe and acute conditions. This is because demand for those services far exceeds the available supply: current service and funding provision is necessarily heavily weighted towards specialist services and those specialist services are struggling to cope with demand. Funding for many mental health services is inadequate, including for early intervention, child and youth mental health, maternal mental health, and primary care mental health support and community services.

Crucially, services aimed at preventing mental illness and supporting community and whānau wellbeing face a significant lack of funding and are not prioritised.

b) Inequitable mental health

Data continue to indicate that we have significant rates of mental illness, suicide and unmet need for mental health services, and that these are unequally distributed in the population.

In particular, research shows that Māori, socioeconomically deprived populations and gender or sexual minorities are disproportionately affected by mental illness.[25,35,36] Notably, Māori males have the highest rate of death by suicide, which is also the second leading cause of 'years of life lost' for them.[37] Māori and people who identify as LGBTIQA+[iii] experience higher rates of mental illness and suicide, partly because both these groups suffer more discrimination, prejudice and social isolation.[34,38-42]

He Ara Oranga[2] identified 12 groups who share a common identity, experience or life stage that increases the risk that they will experience poor mental health or wellbeing. These groups include Māori, Pacific peoples, refugee and migrant groups, rainbow communities, rural communities and disabled people. The Suicide Mortality Review Committee's report *Understanding deaths by suicide in the Asian population of Aotearoa New Zealand* highlights how the incidence of deaths by suicide is rising and health policy is underdeveloped for this ethnic group.[43]

[iii] L – lesbian; G – gay; B – bisexual; T – transsexual; I – intersex; Q – queer; A – asexual, agender, aromantic; + – other diverse sexual orientations and gender identities.

The physical health of people with mental illness is another area of great concern.[44] New Zealand data indicate that people with mental illness experience more ill health than their peers without mental illness and have higher rates of premature morbidity.[44,45]

c) Māori mental health connection with colonisation and racism

Māori mental health is strongly connected with colonisation. Colonisation is a story of "depopulation, disease and dispossession".[46] The impact of colonisation – both historically and in the present day – has been profound for the mental health of many Māori in Aotearoa.[15,39,47]

European colonisers viewed Māori as a 'lesser race' and challenged their authority over political control and resources.[46] The legacy of this colonial past has been ongoing prejudice and racism, cultural suppression and inequitable access to resources.[15] The outcomes have been devastating for Māori in terms of their loss of resources, economic power, cultural identity and self-determination and their disconnection from places of spiritual and cultural importance.[46,47]

Socioeconomic deprivation does not adequately explain the differences in rates of mental illness between Māori and non-Māori.[36,39,48] Racism, and loss of cultural identity and connection to whānau and land play critical roles in the development of mental distress, mental illness and suicide.[36] New Zealand data indicate that Māori are more likely to experience interpersonal racism than non-Māori in New Zealand.[39,48] Furthermore, research has found a dose–response relationship between exposure to racism and measures of mental health[39,48] and that socioeconomically deprived people experience worse outcomes from racism.[42]

Unfortunately, a common view is that Māori are 'the problem', rather than that Māori inequities are a consequence of colonial systems that were set up based on a Pākehā worldview. Yet colonisation can be seen in the establishment and maintenance of systems that privilege non-Māori across all government sectors, including education, justice, health and welfare.[15,49] Its impact is evident in the way government institutions have treated Māori, which has ranged from deliberate exploitation, such as by acquiring their land and resources, through to neglect and more subtle breaches of te Tiriti o Waitangi, such as in the failure of the health and education systems to support Māori.[15,49]

d) Mental health data collection and outcome measures

The national mental health data collection for specialist mental health services, PRIMHD, collects secondary service data on the diagnoses and treatment of people with the most severe mental illness in our communities (approximately 4% of the population). However, it has no primary care mental health data from practices other than non-governmental organisations. This is despite New Zealand research indicating that general practitioners identified approximately half of all their patients as having psychological problems in the past year, of which around one in ten was moderate or severe.[50]

The quality and type of data in PRIMHD is a further concern. Some important data fields are substantially missing and/or of low quality. Data also vary considerably between DHBs; for example, the proportion of clients who have a current diagnosis recorded ranges across DHBs from as low as 15% of clients to as high as 85%.[51] Moreover, while there are moves to include social outcomes data in PRIMHD, currently the information captured is of low quality.

Despite these issues, PRIMHD does have data that could provide many insights into secondary mental health services. Unfortunately, it is an underused resource and reporting of the activities and outcomes of mental health services is limited.

Te Rau Hinengaro,[25] the most recent national mental health survey, was conducted in 2006 and used a clinical interview (CIDI 3.0) to estimate the prevalence of mental health conditions in different population groups. Mental wellbeing questions have been included in the New Zealand Health Survey, the Mental Health Monitor and the New Zealand General Social Survey. However, these surveys do not provide sufficient information to estimate the prevalence of mental health conditions and therefore to understand the degree of unmet need. A repeat of *Te Rau Hinengaro* is needed, after considering how it can be improved to measure the prevalence of unusual conditions and to more thoroughly examine differences between groups including differences relating to sexual orientation, ethnicity, gender identity and disability status.

It is also crucial to build on current mental health surveillance in New Zealand by obtaining high-quality population wellbeing data in the New Zealand Health Survey. There is a need to introduce a strengths-based measure (for example, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[52,53] or the World Health Organization- (WHO-) 5 Well-Being Index[54]) to assess and monitor population wellbeing and provide longitudinal data to inform and evaluate population mental health strategies. Another need is for New Zealand-specific and Māori-centred measures of mental wellbeing.[15]

What could be done better

The NZCPHM contends that a population approach to mental wellbeing will improve the overall mental health status of the New Zealand population.

The essential elements of a population health approach to mental health and wellbeing for New Zealand are that it:[55]

- focuses on the 'causes of the causes': the socioeconomic determinants of mental wellbeing and mental ill health;
- emphasises prevention;
- considers whole communities and population groups;
- works in partnership with populations;
- is centrally concerned with equity;
- uses evidence to inform policy development and funding;
- recognises the central importance of te Tiriti o Waitangi to population mental health.

Noting these elements, the NZCPHM recommends:

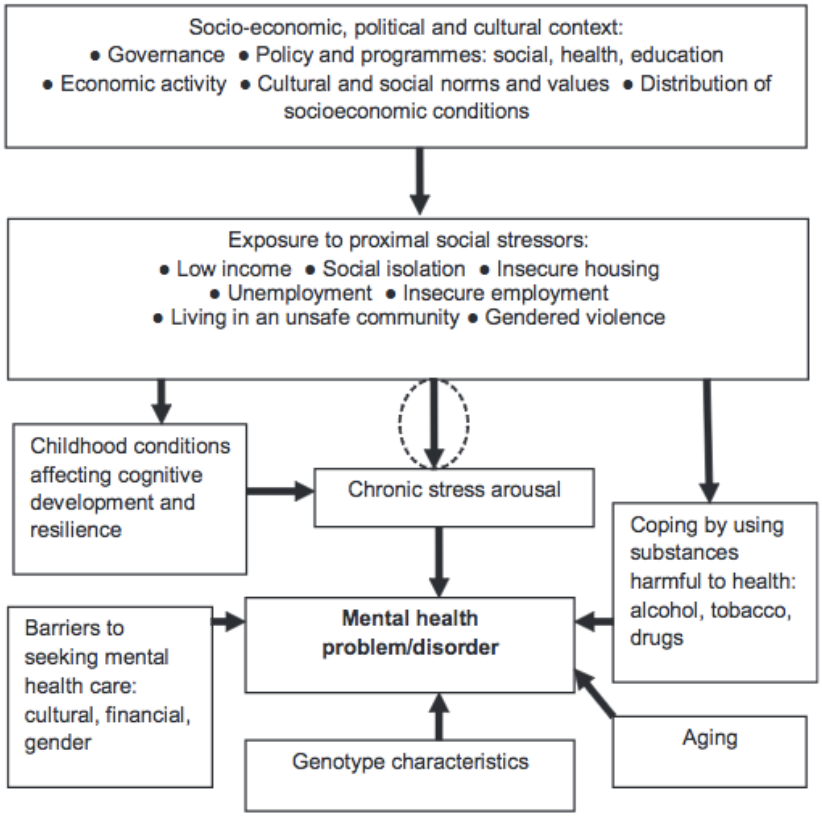
1. taking a population approach to mental wellbeing;
2. prioritising health and equity;
3. prioritising infant and child mental health.

Each of these approaches is detailed below.

a) Taking a population approach to mental wellbeing

A population approach lifts the gaze from the presenting clinical symptoms or illness to deal with the 'causes of the causes' of the symptoms or illness. Similar terms for this bigger-picture view are 'upstream factors', 'social determinants' and 'wider determinants' of health.

Figure 1. Factors influencing individual onset of a mental health problem or disorder (adapted from Commission on the Social Determinants of Health)[56]



Common popular discourse frequently blames the development of mental illness on both 'bad genetics' and 'bad lifestyle choices' such as drug and alcohol consumption. However, neither of these 'bads' should be viewed in isolation from the environment in which a person lives and has lived in. Many people use alcohol and drug intake as a coping mechanism for significant stress and trauma such as poverty, violence and isolation.[56]

The causes of poor mental health are often intertwined and bidirectional; for example, homelessness can cause or exacerbate mental illness and mental illness can contribute to homelessness.[56-58] Any type of trauma and stress, especially when chronic, increases the risk of mental distress and mental illness.[56] Figure 1 above illustrates how these factors interact and can lead to mental illness.[56]

One of the challenges for policy makers is to move away from individually focused solutions, such as funding more health services. Indeed, history shows that prevention strategies frequently move rapidly from population approaches towards victim blaming and individual interventions focused on addressing behaviour through education – a phenomenon known as 'lifestyle drift'.[59] Strategies to improve the wellbeing of our communities, reduce mental illness and reduce suicide must include solutions that sit outside of the health system and address upstream factors.[57,60] Prevention strategies must address all the determinants shown in Figure 1. These determinants include poverty, employment security, safety and the impact the socio-political landscape, and they give rise to the need for action to address discrimination, racism, gender norms and policy across the welfare, justice, health and education sectors.

A population approach to mental wellbeing uses 'proportionate universalism', where the aim is to move the whole population towards better mental health with greater targeting of resources for people at high risk.[14,61,62] This type of approach is crucial as mental distress, in the absence of a diagnosable mental illness, affects a far larger proportion of the population than clinical mental illness and collectively represents a larger burden of morbidity.[34,61] Proportionate universalism benefits the whole of society and has a greater positive impact on societal mental wellbeing, mental illness and suicide prevention than purely targeted approaches.[14,61,63,64] Proportionate universalism includes strategies at every tier: improving the quality and access to health care services, providing early intervention supports to whānau and families who need them[65] and addressing societal determinants of mental illness.[56,58,62,66]

A focus on the 'causes of the causes' recognises that determinants of mental wellbeing are often social and economic and therefore amenable to change.[1,56,57,67] The disparities in mental health outcomes by ethnicity and by socioeconomic deprivation are likewise amenable to change.[1,35,56,57,67] The key message here is that the current rate of mental illness and distress is not fixed; we can improve the situation and reduce mental health service demand and current inequities.

Mental wellbeing is not only a crucial aspect of individual health. It is also essential for vibrant, flourishing and resilient communities[1] and is a fundamental pillar of Māori models of health.[68]

The NZCPHM supports the view of the Health Quality & Safety Commission's mortality review committees, who stated in their submission to the 2018 Mental Health Inquiry that:

> *It is critical that all services increase awareness of treating the whole person; the co-occurrence and interdependence of drug and alcohol abuse, mental health issues, family violence, and poverty must be factored into treatment and prevention policy and practice. Services must work together, and wrap around the individual, family and whānau. This includes extending awareness of the causes and complexities around mental health issues beyond the mental health and addictions system*.

b) Prioritising Māori mental health and equity

At a population level, equity of mental health outcomes must be prioritised. Inequities arise not only through unequal determinants of health, but also through unequal access to care and quality of health care itself.[69]

Providing services according to need will mean that our most vulnerable populations are able to have a fair chance of care and recovery. High-quality services must be able to adapt their care to suit the people they care for. To do so, they must focus on co-design with consumers and their families and whānau, cultural competence, and using data in service design and monitoring so that they can see what is working and what isn't working for different populations.[70] Leadership for equity is paramount; creating flexible services requires commitment and advocacy to enable 'difference' to be celebrated.

Racism and discrimination are key drivers of mental illness. Racism and the impacts of colonisation have had, and continue to have, a significant impact on the development of mental illness. High-quality services must also eliminate current institutional racism.[48]

For Māori, as Tiriti partners, the design of high-quality service includes providing them with the opportunity to attend kaupapa Māori services that centralise te ao Māori concepts.

The Puahou plan, named after the 'five fingers' of the puahou tree, recommends five strategies for Māori mental health: enhance a secure cultural identity; enable active Māori participation in society and in the economy; align health services to coincide with Māori realities; accelerate workforce development; and increase Māori autonomy and control.[71] Underlying these strategies are themes of Māori-centred values and beliefs, intersectoral collaboration, positive Māori development and the need to link health with the broader arenas of cultural enhancement and socioeconomic advancement.

Achieving mental health equity also requires making appropriate mental health services more available for those ethnically, culturally and linguistically diverse communities who currently experience disproportionate rates of poor mental health outcomes.

c) Prioritising infant and child mental health

Adult mental illness should be viewed as an outcome of child and adolescent mental distress and mental illness, and infant and child mental health as a consequence of the early childhood environment.[1,49,56,74] Epidemiologic studies indicate that approximately half of all mental illness experienced begins by the mid-teenage years, and three-quarters of mental illness has manifested by the mid-20s.[49] Onset of mental illness in later years is typically a secondary condition, and severe disorders usually begin in childhood or adolescence with less severe presentations that go untreated.[49]

Maternal mental health is another area to invest in, as a way of improving the health and wellbeing of young children. Maternal mental health problems are often seen as an adult mental health issue. However, given the effects poor maternal mental health can have on attachment and a mother's ability to care for and sensitively nurture a child, it is necessary to see maternal mental health as a part of the investment in infant and child mental health and as part of a focus on the first 1000 days of life.[65,72]

It is crucial to invest in children and caregivers to build a healthy and flourishing society. Strong evidence indicates that deprivation and toxic stresses in early life lead to poorer physical and mental health outcomes, and that poorer mental health outcomes are linked with lower educational attainment, poverty and material hardship – creating intergenerational cycles of ill health and deprivation.[56,57,73] Crucial actions in prioritising infant and child mental health are to: provide adequate family incomes, paid parental leave and housing; prioritise, set targets for and invest in the eradication of child poverty; ensure family-friendly working conditions; support and value skilled and attentive parenting; and address family violence, child maltreatment and tobacco-, drug- and alcohol-related harm (intrauterine and in the family environment).[74]

A vision for a society that would be best for the mental health of all

An Aotearoa New Zealand society that supports the wellbeing of all people would:

1. value equity and diversity;
2. adopt a comprehensive and holistic view of health;
3. include mental health and wellbeing in all policies;
4. include the wellbeing of children in all policies;
5. recognise and give effect to te Tiriti o Waitangi.

This vision should include all of the following features.

a) A holistic view of health promotion– Te Pae Mahutonga

Mental health and wellbeing cannot and should not be separated from other aspects of health, including the health of communities. *Te Pae Mahutonga, a Māori model of health promotion*[75] provides a framework for considering all of the aspects that are required for a healthy, vibrant and resilient community and the strengths in our communities that we should build on.

The Appendix to this policy statement lists aspects of a healthy vibrant society, using Te Pae Mahutonga framework. To improve mental health and wellbeing, investment is required at every level.

b) Physical health

Our health care system treats physical and mental health separately. Yet physical and mental health are inextricably linked, and mental wellbeing is a fundamental component of good health.[57] Physical and mental health also have a strong mutual relationship: poor physical health is linked to worse mental health, and mental illness negatively impacts on physical health.[1,76-78] Lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequities in health.[57]

A healthy society supports and enables people to live long and healthy lives. Our current society is far from this, particularly for people with experience of mental illness. Serious mental illness is associated with high levels of physical morbidity and reduced life expectancy.[33,76,77] Reduced life expectancy and poor health for people with mental illness have multiple causes – many of which are preventable. The numerous causes include: the impact of psychiatric medication; risk factor behaviours such as smoking; poorer access to health services and 'diagnostic overshadowing' of physical health problems; higher rates of injury, violence and suicide; and the impact of socioeconomic factors that disproportionately affect people with mental illness, such as poverty and poor-quality housing or homelessness. In New Zealand, people using specialist mental health services are twice as likely to die before the age of 65 years compared with the general population, and most premature deaths are due to 'natural causes', namely cancer and cardiovascular disease.[45]

International evidence indicates that the gap in life expectancy between those with serious mental illness and those without is increasing because public health and clinical advances disproportionately benefit those without mental illness.[79] In New Zealand, people with mental illness consumed an estimated one-third of cigarettes consumed in New Zealand in 2008,[80] indicating that public health's success in reducing smoking has not been spread equitably through the population.

Action on the physical health of people with serious mental illness needs to build on the successes of the Equally Well collaboration.[81] The NZCPHM has endorsed specific calls for action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction.[82]

c) Whānau and community

The health of the individual cannot be separated from the health of the whānau and family. For mental health in particular, connectedness is vital. Isolation and loneliness are known to both cause and be exacerbated by mental ill health.[83,84] By contrast, connected whānau and families are protective and support positive mental health outcomes.

People with mental illness and mental distress frequently face stigma and discrimination.[41,85,86] Discrimination against people with mental illness can have multiple detrimental effects, including unemployment, poor educational attainment, poverty, homelessness and social isolation.[35,41,85-87]

These outcomes, and the effects of stigma and discrimination alone, can exacerbate symptoms of mental illness.[85-87] A healthy society accepts mental distress and grief as a normal part of the human experience, and supports those with mental illness to return to wellness and to remain connected and included.

Further, a healthy society supports, nurtures and accepts diversity and is built on a foundation of human rights and equity. A healthy society promotes, supports and legislates for policies that support whānau and families to remain connected. Examples include policies that provide affordable access to reliable public and active transport networks, access to community and recreational spaces, accessible contact with whānau and family members who are incarcerated, and adequate incomes (particularly for families and the elderly).

Multigenerational relationships are also crucial to societal wellbeing; healthy societies value their members across all ages and promote and support multigenerational relationships. Finally, a healthy society acknowledges the rights of its members to health, education, employment and participation in society.

d) Reducing alcohol-related harm

Alcohol is a major contributor to the harm caused by mental illness, addiction and suicide in New Zealand. Heavy alcohol use increases the risk of depressive disorders, is common among people who have mental health problems and is strongly associated with suicide.[88,89] Alcohol was the most common substance of abuse and dependence in the 2006 mental health survey *Te Rau Hinengaro*, and its use commonly co-occurs with use of other substances and mental health problems.[25] Alcohol is also a contributing factor in the majority of suicides in New Zealand.

Policies to reduce the availability of alcohol, including increasing the price and increasing the purchase age, have been linked to reductions in suicide rates.[90]

New Zealand should accept the Law Commission's recommendations from its 2010 review of alcohol policy,[91] including increasing the price of alcohol through minimum pricing, reducing the density of alcohol outlets, increasing the purchase age and restricting alcohol advertising and sponsorship. These approaches appear to have worked well in the response to tobacco-related harm and are needed to reduce the harm of alcohol in our society. *He Ara Oranga*[2] has echoed these recommendations.

e) Mental health and wellbeing in all policies

Mental health is affected by a broad range of factors outside the health sector, including education, housing, employment, income, transport and others. To address these factors, action is needed across sectors and in all policies to prioritise mental health and wellbeing.

For example, poverty is significantly associated with the development of mental illness – both as a cause of mental illness and because it can result from mental illness.[1,57] A key driver of this connection is the impact of financial debt.[92,93] In addition, evidence suggests that inequality itself may contribute to mental illness through the mechanisms of stigma and social exclusion,[94,95] and residing in an area of high social deprivation is strongly associated with mental ill health, even after adjusting for household measures of deprivation.[73] New Zealand data from *Te Rau Hinengaro* show a strong gradient between mental illness and increasing social deprivation.[25] On the other hand, strong social welfare supports are reported to protect against unemployment and poverty [96]

Health in All Policies (HiAP)[20,19] is about promoting healthy public policy. HiAP is a structured approach to working across sectors and with communities on public policies. It promotes trusting relationships and engages stakeholders to systematically take into account the implications of decisions. HiAP seeks synergies to improve societal goals, population health and equity.[20] It is an approach that aims to "improve the health of the population through increasing the positive impacts of policy initiatives across all sectors of government and at the same time contributing to the achievement of other sectors' core goals".[97]

'Mental health in all policies' approaches aim to promote population mental health and wellbeing by initiating and facilitating action within different non-health public policy areas. The European Commission Framework for Action on Mental Health and Wellbeing includes mental health in all policies as a priority area, and identifies incorporating mental health into policies at all levels as a specific action.[98]

Existing tools for a 'mental health in all policies' approach are Health Impact Assessments and the Health Equity Assessment Tool (HEAT). Health Impact Assessments are vital for assessing the intended and unintended consequences of policy on health and wellbeing outcomes. However, guidance is lacking for mental health impact assessments that incorporate the New Zealand context; namely the importance of te Tiriti o Waitangi and the impact of colonisation in our history. Furthermore, HEAT is a useful and practical tool that policy makers need to use routinely to ensure health equity is a key focus of health policies. The UK Mental Well-being Impact Assessment toolkit could be useful model to adapt to the New Zealand context.[99]

The WHO and the international health promotion movement provide important approaches and tools to help embed a wellbeing and equity focus throughout public policy.[96,100,101]

f) Children in all policies

The first 1000 days of life (from conception until approximately two years of age) are a crucial period of development.[72,102,74] Toxic stress during the first 1000 days of life, such as from neglect, abuse or caregivers who are unable to be emotionally available or nurturing, is associated with worse mental health outcomes throughout life.[56,57,72,102] A growing body of literature links exposure to adverse events in early childhood with increasing vulnerability to mental illness, to a greater extent than when exposed to the same adverse events at older ages.[73,102]

For emotional and cognitive development, children require "warm, reliable and appropriately responsive care".[65] Toxic stress as a young child impacts on a person's ability to regulate behaviour and emotions,[72] and a person's emotional health as a child is one of the strongest predictors of their mental wellbeing in adulthood.[66] The presence of attentive and caring parents is protective against other forms of stress for young children.[65] New Zealand data indicate that connection to whānau and the belief that their family is caring and supportive are protective factors against suicidality for Māori rangatahi.[103] Social and economic stresses, including poverty and housing insecurity, and parents' own mental health concerns, pose barriers to nurturing and responsive parenting.[56-58,65,103] Exposure to high levels of prenatal alcohol is another cause of toxic stress on early development. High foetal alcohol exposure is associated with high levels of impulsivity and increased levels of comorbid mental illness.[104-106]

A focus on mental health and wellbeing in all policies therefore requires a focus on children in all policies. The focus on children at the policy level is growing in New Zealand, with a Minister for Children, a child poverty reduction unit and a child wellbeing unit within the Department of Prime

Minister and Cabinet, and a child wellbeing strategy being developed. In addition, improvements have occurred in primary care affordability, paid parental leave, Whānau Ora services and the legal protections from assault. However, Aotearoa New Zealand still fares worse in child wellbeing compared with most other advanced economies, and continues to have high rates of childhood poverty, housing problems, preventable diseases, youth suicide, mental health disorders and violence to children.[107]

A practical example of what is possible comes from Sweden's approach of creating a system of child-friendly public policy and structurally embedding a 'children in all policies' approach. Crucial elements will be to build a culture of prioritising children throughout the policy development and decision-making process, and to ingrain in society the idea that it is important for a country to prioritise the care of its children.

g) Addressing violence in society

Violence in all its forms is both a major cause and a major symptom of mental distress and loss of wellbeing in society. Its causes are complex, but its consequences are profound in both the short and long term. Strong policy responses are essential to identify and address the causes and effects of interpersonal physical, emotional and sexual abuse, violence and neglect in our families and communities.[108-117]

h) Te Tiriti o Waitangi

Colonisation has led to poor mental health outcomes for Māori in Aotearoa.[15,47,118] Māori experience worse mental health than non-Māori populations through multiple mechanisms, including racism,[36,40,48,69] loss of cultural identity and access to language and cultural heritage[47] and the impacts of poverty and social deprivation.[47,71,118,119]

To create a healthy and vibrant society, we first need to acknowledge the disparities in mental health outcomes for Māori as unjust and amenable to change.[15] Improving Māori mental health outcomes and eliminating inequities requires an approach that addresses these drivers of poor mental health for Māori, supports the development of strengths and capacity building in Māori communities and engages Māori communities in co-designing services and solutions across the health, social, education and justice sectors.

Mental health in the practice of public health medicine, including resources

In the United Kingdom, the FPH's commissioned 2016 report *Better Mental Health for All*[1,29,120] has promoted a public health approach to mental wellbeing and the primary prevention of mental illness. It is a call to action for public health practitioners to develop and use knowledge and skills in public mental health.

The FPH notes how mental health and physical health should be treated with 'parity of esteem'. Achieving such parity needs enhanced knowledge of and skills in the mental health components of public health practice.[29]

The FPH's complementary *Better Mental Health for All* resource[29] provides further practical resources. This includes important commentary on the UK Chief Medical Officer's Annual Report 2013,[6] which is itself an extensive statement on public mental health priorities (the epidemiology of public mental health, the quality of evidence, possible future innovations in science and technology, the economic case for good mental health – and both treating mental health as equal to physical health and focusing on the needs and safety of people with mental illness). The FPH in turn has

welcomed many features in the report[6] but has also reflected on limitations and unresolved issues, described online.[121]

The whole *Better Mental Health for All* resource[29] also provides complementary resources covering a variety of topics such as: Why public mental health matters; A good start in life; Concepts of mental and social wellbeing; Relationship with physical health and healthy lifestyles; Measurement of mental health, outcomes and key sources of data; and The economic case for better mental health.[122,123]

Key Recommendations

The NZCPHM calls for the following actions:

1. Address current problems by:
    - prioritising and funding mental illness prevention and mental wellbeing promotion, including addressing the determinants of mental health;
    - focusing on achieving equitable mental health outcomes through monitoring equity of outcomes in the clinical and public health sectors;
    - improving data collection, including by collecting and using information on primary mental health care and improving PRIMHD, to better capture diagnoses, and by including more outcome measures that are holistic and functional and that enable the monitoring of health equity;
    - supporting and funding a national mental health and addiction survey;
    - developing a New Zealand-based guidance document for mental wellbeing impact assessments;
    - integrating physical and mental health care.
2. Take a public health approach to mental health by:
    - addressing the determinants of mental health and wellbeing;
    - improving the mental health and wellbeing of Māori and eliminating inequities;
    - investing in early life – infant, child and youth mental health;
    - using evidence to inform policies and funding decisions.
3. Build a society that:
    - adopts a comprehensive and holistic view of health;
    - implements strong policy to reduce alcohol-related harm, including increasing the price and reducing the availability of alcohol;
    - includes mental health and wellbeing in all policies;
    - includes the wellbeing of children in all policies;
    - implements strong policy to identify and address the causes and effects of physical, emotional and sexual violence in families and communities;
    - recognises and gives effect to te Tiriti o Waitangi;
    - prioritises children and in particular the first 1000 days of life, including by valuing and supporting the role of parents;
    - supports Māori through social connection, cultural identity, and eliminating material poverty and institutional racism;

- supports other groups who face discrimination and prejudice, including minoritised ethnic and LGBTIQA+ communities.

The NZCPHM acknowledges and supports some overall public mental health strategic policy directions set previously. These are, in New Zealand, the directions of the former Mental Health Commission and the national mental health service development plan[3,4] and, overseas, the UK Royal College of Psychiatrists' position statement on public mental health.[5] The NZCPHM also supports much of the content of the UK Faculty of Public Health report,[1] especially the FPH's call for public health practitioners to become advocates for public mental health, providing strong leadership and prioritising mental health within public health practice. The NZCPHM recognises the ethnic and socioeconomic inequities in mental health in New Zealand and supports the equity-focused public mental health approach that the FPH advocates, but recognises too the particular additional responsibilities for the health sector and health practice in New Zealand with the partnership between the Crown and Māori under te Tiriti o Waitangi. The NZCPHM further notes both the UK Chief Medical Officer's Annual Report 2013[6] and the FPH's reflections on that report,[121] and supports the common elements of the two sets of views.[6,121]

Links with other NZCPHM policies

Health Equity
First 1000 Days of Life
Child Poverty and Health
Māori Health
Pacific Peoples' Health
Alcohol
Housing
Physical Activity and Health
Transport
Climate Change
Tobacco Control

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References

1. Better Mental Health for All: A public health approach to mental health improvement. London: Faculty of Public Health and Mental Health Foundation, 2016. (https://www.fph.org.uk/media/1915/better-mh-for-all-web.pdf)
2. He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. Wellington: Government Inquiry into Mental Health and Addiction, 2018. (https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/)
3. Mental Health Commission. Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be. Wellington: Mental Health Commission, 2012. (https://www.hdc.org.nz/media/1075/blueprint-ii-how-things-need-to-be.pdf)

4. Ministry of Health. Rising to the challenge: The Mental Health and Addiction Service Development Plan 2012–2017. Wellington: Ministry of Health, 2012. (http://www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge)

5. Royal College of Psychiatrists. No health without public mental health: the case for action. Position Statement PS4/2010. London: Royal College of Psychiatrists, 2010. (https://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf)

6. Department of Health. Annual Report of the Chief Medical Officer 2013. Public mental health priorities: investing in the evidence. London: Department of Health, 2014. (https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf)

7. Acheson D. Public health in England: the report of the Committee of Inquiry into the Future Development of Public Health Function. London: HMSO, 1988.

8. World Health Organization. WHO Regional Committee for Europe: Advancing public health for sustainable development in the WHO European Region. EUR/RC68/17. Copenhagen: WHO Regional Office for Europe, 2018. (http://www.euro.who.int/__data/assets/pdf_file/0004/380029/68wd17e_AdvancePublicHealth_180624.pdf?ua=1).

9. Centers for Disease Control and Prevention. Ten great public health achievements -- United States, 1900-1999. MMWR Morb Mortal Wkly Rep. 1999;48(12):241-3. (https://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm).

10. New Zealand College of Public Health Medicine. A prescription for health and equity for all. NZCPHM briefing for the Incoming Minister of Health. Wellington: NZCPHM, 2017. (https://www.nzcphm.org.nz/media/108722/2017_bim_a_prescription_for_health_and_equity_for_all_final.pdf).

11. World Health Organization. Health promotion glossary. Geneva: World Health Organization, 1998. (http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf?ua=1)

12. New Zealand Medical Association. Consensus statement on the role of the doctor in New Zealand. NZMA Position Statement. Wellington: NZMA, 2011. (https://www.nzma.org.nz/publications/role-ofthe-doctor-consensus-statement)

13. Gluckman P. Enhancing evidence-informed policy making: a report by the Prime Minister's Chief Science Advisor. Wellington: Office of the Prime Minister's Chief Science Advisor, 2017. (http://www.pmcsa.org.nz/wp-content/uploads/17-07-07-Enhancing-evidence-informed-policymaking.pdf)

14. New Zealand College of Public Health Medicine / New Zealand Medical Association. NZCPHM Policy Statement on Health Equity (adopting the New Zealand Medical Association Position Statement on Health Equity 2011). Wellington: NZCPHM, 2016. (https://www.nzcphm.org.nz/media/58923/2016_11_17_nzcphm_health_equity_policy_statement.pdf)

15. New Zealand College of Public Health Medicine. NZCPHM Policy Statement on Māori Health. Wellington: NZCPHM, 2015. (https://www.nzcphm.org.nz/media/89786/2015_11_30_m_ori_health_policy_statement.pdf)

16. United Nations. Sustainable Development Goals. (https://www.un.org/sustainabledevelopment/sustainable-development-goals/).

17. World Health Organization. The Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November 1986. (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html)

18. World Health Organization. The Bangkok Charter for Health Promotion in a Globalized World. 2005. (http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf).

19. World Health Organization. Adelaide Statement II. Outcome Statement from the 2017 International Conference Health in All Policies: Progressing the Sustainable Development Goals. 2017. (http://www.who.int/social_determinants/SDH-adelaide-statement-2017.pdf).

20. World Health Organization. Health in All Policies (HiAP) Framework for Country Action. Geneva: WHO, 2013. (http://www.who.int/healthpromotion/frameworkforcountryaction/en/)

21. United Nations. Transforming our world: the 2030 Agenda for Sustainable Development. 2015. (https://sustainabledevelopment.un.org/post2015/transformingourworld).

22. Ministry of Health. Māori health models – Te Pae Mahutonga. 2017. (https://www.health.govt.nz/ourwork/populations/maori-health/maori-health-models/maori-health-models-te-pae-mahutonga)

23. Charlson FJ, Baxter AJ, Dua T, Degenhardt L, Whiteford HA, Vos T, Murray CJ, Vos T, Lozano R, Naghavi M, Flaxman AD, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012;380(9859):2197-223. Erratum in: Lancet 2011;381(9867):628. (http://www.sciencedirect.com/science/article/pii/S0140673612616894)

24. Vigo D, Thornicroft G, Atun R. Estimating the true global burden of mental illness. Lancet Psychiatry. 2016;3(2):171-8. (http://www.sciencedirect.com/science/article/pii/S2215036615005052)

25. Oakley Browne M, Wells J, Scott K, (eds). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health, 2006. (https://www.health.govt.nz/system/files/documents/publications/mental-health-survey.pdf)

26. Ministry of Health. Office of the Director of Mental Health Annual Report 2015. Wellington: Ministry of Health, 2016. (http://www.health.govt.nz/publication/office-director-mental-health-annual-report-2015)

27. Ministry of Health. Health Loss in New Zealand 1990–2013: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study. Wellington: Ministry of Health, 2016. (http://www.health.govt.nz/publication/health-loss-new-zealand-1990-2013)

28. Baxter J. Māori mental health needs profile. A review of the evidence. Palmerston North: Te Rau Matatini, 2008. (https://www.mentalhealth.org.nz/assets/ResourceFinder/Maori-Mental-Health-Need-Profile-full.pdf)

29. Faculty of Public Health (UK). Better Mental Health for All webpage (https://www.fph.org.uk/policy-campaigns/special-interest-groups/special-interest-groups-list/public-mental-health-special-interest-group/better-mental-health-for-all/)

30. Ministry of Health. He Ara Oranga response [internet]. Wellington: Ministry of Health, 2020. (https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction)

31. Ministry of Health. Every Life Matters – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand. Wellington: Ministry of Health, 2019. (https://www.beehive.govt.nz/sites/default/files/2019-09/Suicide%20Prevention%20Strategy%202019-2029%20and%20Plan%202019-2024.pdf)

32. Gluckman P. The psychosocial consequences of the Canterbury earthquakes A briefing paper. Auckland: Office of the Prime Minister's Chief Science Advisor, 2011. (https://www.cph.co.nz/wp-content/uploads/chcheqbriefingpsychosocialeffects.pdf)

33. Royal Australian and New Zealand College of Psychiatrists. The economic cost of serious mental illness and comorbidities in Australia and New Zealand. 2016. (https://www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx)

34. Kvalsvig A. Wellbeing and mental distress in Aotearoa New Zealand: Snapshot 2016. 2018. (https://www.hpa.org.nz/sites/default/files/Wellbeing-And-Mental-Distress-Snapshot-2016-Final-FEB2018.PDF)

35. Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rüsch N. Challenging the public stigma of mental illness: a meta-analysis of outcome studies. Psychiat Serv 2012;63(10):963-73. (https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201100529)

36. Harris RB, Stanley J, Cormack DM. Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLOS ONE 2018;13(5):e0196476. (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0196476)

37. Ministry of Health. Major causes of death. 2015 [internet]. (https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/major-causes-death.)

38. Meyer IH. Prejudice and discrimination as social stressors. In: Meyer IH, Northridge ME (Eds.). The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations. New York: Springer, 2007. pp.242-67.

39. Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Racism and health: the relationship between experience of racial discrimination and health in New Zealand. Soc Sci Med 2006;63(6):1428-41.

40. Peterson D, Pere L, Sheehan N, Surgenor G. Experiences of mental health discrimination in New Zealand. Health & social care in the community 2007;15(1):18-25.

41. Sharac J, Mccrone P, Clement S, Thornicroft G. The economic impact of mental health stigma and discrimination: a systematic review. Epidemiol Psychiatr Soc 2010;19(03):223-32.

42. Schmitt MT, Branscombe NR, Postmes T, Garcia A. The consequences of perceived discrimination for psychological well-being: A meta-analytic review. Psychol Bull 2014;140(4):921.

43. Suicide Mortality Review Committee. Understanding deaths by suicide in the Asian population of Aotearoa New Zealand. Wellington: Health Quality & Safety Commission, 2019. (https://www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/3848/)

44. Te Pou o Te Whakaaro Nui. Equally Well: Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction. A consensus position paper. Auckland: Te Pou, 2014. (https://www.tepou.co.nz/resources/equally-well-consensus-position-paper/546)

45. Cunningham R, Sarfati D, Peterson D, Stanley J, Collings S. Premature mortality in adults using New Zealand psychiatric services. N Z Med J. 2014;127(1394).

46. Durie M. Nga Tau Hekenga: Depopulation, disease and dispossession. Whaiora: Māori health development. 2nd ed. Auckland: Oxford University Press, 1998. pp.26-40.

47. Reid P, Robson B. Understanding health inequities. In: Robson B, Harris R, editors. Maori Standards of Health IV: A study of the years 2000-2005. 1st ed. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007. pp.3-10.

48. Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: cross-sectional study. Lancet 2006;367(9527):2005-9.

49. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry 2007;20(4):359-64.

50. Bushnell J, McLeod D, Dowell A, Salmond C, Ramage S, Collings S, et al. The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). 2003.

51. Stace H. PRIMHD classification – summary and metadata. 2017.

52. Stewart-Brown SL, Platt S, Tennant A, Maheswaran H, Parkinson J, Weich S, et al. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a valid and reliable tool for measuring mental well-being in diverse populations and projects. J Epidemiol Comm Health 2011;65(Suppl 2):A38-A39.

53. Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, et al. The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation. Health Qual Life Outcomes. 2007;5(1):63. (https://hqlo.biomedcentral.com/articles/10.1186/1477-7525-5-63)

54. Topp CW, Ostergaard SD, Sondergaard S, Bech P. The WHO-5 Well-Being Index: a systematic review of the literature. Psychother Psychosom 2015;84(3):167-76.

55. The Perth Charter for the Promotion of Mental Health and Wellbeing: An outcome of the Seventh World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders; 2012. (https://www.rsph.org.uk/about-us/news/perth-charter-for-the-promotion-of-mental-health-and-wellbeing.html, https://thl.fi/documents/974282/1449788/perth+charter+mental_health_and_wellbeing.pdf/50c5709a-7bcb-4827-ad24-8654cbee5dc9)

56. Fisher M, Baum F. The social determinants of mental health: implications for research and health promotion. Aust N Z J Psychiatry 2010;44(12):1057-63.

57. Allen J, Balfour R, Bell R, Marmot M. Social determinants of mental health. Int RevPsychiatry. 2014;26(4):392-407. (https://www.tandfonline.com/doi/full/10.3109/09540261.2014.928270)

58. Sederer LI. The social determinants of mental health. Psychiatric Services 2016;67(2):234-5.

59. Carey G, Malbon E, Crammond B, Pescud M, Baker P. Can the sociology of social problems help us to understand and manage 'lifestyle drift'? Health Promot Internation 2016;32(4):755-61.

60. Ryan CJ. Suicide explained! Aust N Z J Psychiatry 2015;49(1):83-4.

61. Pitman A, Caine E. The role of the high-risk approach in suicide prevention. Br J Psychiatry 2012;201(3):175-7.

62. The World Health Organization. Preventing suicide: A global imperative. Geneva: WHO, 2014.

63. Sara GE. Mental disorder and suicide: a faulty connection, or a faulty argument? Aust N Z J Psychiatry 2015;49(1):84-6.

64. Li Z, Page A, Martin G, Taylor R. Attributable risk of psychiatric and socio-economic factors for suicide from individual-level, population-based studies: a systematic review. Soc Sci Med 2011;72(4):608-16.

65. Thompson RA. Social-emotional development in the first three years. 2018.

66. Layard R, Clark AE, Cornaglia F, Powdthavee N, Vernoit J. What predicts a successful life? A life-course model of well-being. The Economic Journal 2014;124(580):F720-F738.

67. Barry MM. Addressing the determinants of positive mental health: concepts, evidence and practice. Int J Mental Health Promotion 2009;11(3):4-17.

68. Durie M. Whaiora: Māori health development. Auckland: Oxford University Press, 1994.

69. Jones CP. Systems of power, axes of inequity: parallels, intersections, braiding the strands. Med Care 2014;52(10 Suppl 3): S71-5.

70. Poynter M, Hamblin R, Shuker C, Cincotta J. Quality improvement: no quality without equity? Wellington: Health Quality & Safety Commission, 2017. (https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf)

71. Durie M. Puahou: A five-part plan for improving Maori mental health. He Pukenga Korero 1998;3:61-70.

72. Mark T. Infant mental health in the next decade: A call for action. Infant Ment Health J. 2015;36(6):538-41.

73. Manseau MW. Economic inequality and poverty as social determinants of mental health. Psychiatric Annals 2014;44(1):32-8.

74. New Zealand College of Public Health Medicine. NZCPHM Policy Statement on the First 1000 Days of Life. Wellington: NZCPHM, 2017. (https://www.nzcphm.org.nz/media/64578/2017_11_15_nzcphm_first_1000_days_of_life__reviewed_2017_.pdf)

75. Durie M, Ministry of Health. Māori health models – Te Pae Mahutonga [internet]. 2017. (https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-pae-mahutonga)

76. Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013;346:f2539.

77. Chang C, Hayes RD, Perera G, Broadbent MT, Fernandes AC, Lee WE, et al. Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. PloS One 2011;6(5):e19590.

78. Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. Br J Psychiatry 2011;199(6):441-2.

79. Doherty AM, Gaughran F. The interface of physical and mental health. Soc Psychiatry Psychiatr Epidemiol 2014;49(5):673-82.

80. Tobias M, Templeton R, Collings S. How much do mental disorders contribute to New Zealand's tobacco epidemic? Tob Control 2008;17(5):347-50.

81. Te Pou o Te Whakaaro Nui. Equally Well: Physical health. May 2018. (https://www.tepou.co.nz/initiatives/equally-well-physical-health/37)

82. Te Pou. Equally Well: Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction. Auckland: Te Pou, 2014. (https://www.tepou.co.nz/uploads/files/resource-assets/equally-well-consensus-position-paper-september-2014.pdf)

83. Courtin E, Knapp M. Social isolation, loneliness and health in old age: a scoping review. Health Soc Care Community 2015;25(3):799-812.

84. Huxley P, Thornicroft G. Social inclusion, social quality and mental illness. Br J Psychiatry 2003;182:289-90.

85. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. World Psychiatry 2002;1(1):16-20.

86. El-Badri S, Mellsop G. Stigma and quality of life as experienced by people with mental illness. Australasian Psychiatry 2007;15(3):195-200.

87. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health 2013;103(5):813-21.

88. Borges G, Bagge C, Cherpitel CJ, Conner K, Orozco R, Rossow I. A meta-analysis of acute use of alcohol and the risk of suicide attempt. Psychol Med 2017;47(5):949-957.

89. Bell S, Britton A. An exploration of the dynamic longitudinal relationship between mental health and alcohol consumption: a prospective cohort study. BMC Medicine 2014;12(1):91.

90. Xuan Z, Naimi TS, Kaplan MS, Bagge CL, Few LR, Maisto S, et al. Alcohol policies and suicide: a review of the literature. Alcoholism: clinical and experimental research 2016;40(10):2043-55.

91. New Zealand Law Commission. Alcohol in our lives: curbing the harm. 2010; Law Commission report no. 114.

92. Jenkins R, Bhugra D, Bebbington P, Brugha T, Farrell M, Coid J, et al. Debt, income and mental disorder in the general population. Psychol Med 2008;38(10):1485-93.

93. Jenkins R, Bebbington P, Brugha T, Bhugra D, Farrell M, Coid J, et al. Mental disorder in people with debt in the general population. Public Health Medicine 2009;6(3):88-92.

94. Pickett KE, Wilkinson RG. Inequality: an underacknowledged source of mental illness and distress. Br J Psychiatry 2010;197(6):426-8.

95. Murali V, Oyebode F. Poverty, social inequality and mental health. Advances in Psychiatric Treatment 2004;10(3):216-24.

96. WHO and the Government of South Australia. The Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being. 2010. (http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf)

97. Department of Health South Australia. The South Australian Approach to Health in All Policies: background and practical guide. 2011; Version 2. (http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/the+south+australian+approach+to+health+in+all+policies+background+and+practical+guide)

98. EU Joint Action on Mental Health and Wellbeing. European Framework for Action on Mental Health and Wellbeing. Final Conference - Brussels, 21-22 January 2016. 2016. (https://ec.europa.eu/research/participants/data/ref/h2020/other/guides_for_applicants/h2020-SC1-BHC-22-2019-framework-for-action_en.pdf)

99. Cooke A, Friedli L, Coggins T, Edmonds N, O'Hara K, et al. The Mental Well-being Impact Assessment Toolkit. 2nd ed. 2010. (https://www.liverpool.ac.uk/media/livacuk/instituteofpsychology/researchgroups/impact/MentalWellbeingImpactAssessmentToolkit2010.pdf)

100. Kickbusch I, McCann W, Sherbon T. Adelaide revisited: from healthy public policy to Health in All Policies. Health Promot Int. 2008. 23(1):1-4.

101. Leppo K, Ollila E, Peña S, Wismar M, Cook S. Lessons for policy-makers. In Leppo K, Ollila E, Peña S, Wismar M, Cook S. Health in all policies. Finnish Ministry of Social Affairs and Health. 2013:325. (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf)

102. Moore T, West S. Early intervention and the first thousand days of child development. Developing Practice: The Child, Youth and Family Work Journal 2016(44):16.

103. Clark TC, Robinson E, Crengle S, Fleming T, Ameratunga S, Denny SJ, et al. Risk and protective factors for suicide attempt among indigenous Maori youth in New Zealand: The role of family connection. Int J Indig Health 2011;7(1):16.

104. Clarke ME, Gibbard WB. Overview of fetal alcohol spectrum disorders for mental health professionals. Can Child Adolesc Psychiatr Rev 2003;12(3):57-63.

105. Mattson SN, Crocker N, Nguyen TT. Fetal alcohol spectrum disorders: neuropsychological and behavioral features. Neuropsychol Rev 2011;21(2):81-101.

106. Rangmar J, Hjern A, Vinnerljung B, Stromland K, Aronson M, Fahlke C. Psychosocial outcomes of fetal alcohol syndrome in adulthood. Pediatrics 2015;135(1):e52-8.

107. UNICEF Office of Research. Building the future: children and the Sustainable Development Goals in rich countries, 2017; Innocenti Report Card 14. (https://www.unicef-irc.org/publications/890-building-the-future-children-and-the-sustainable-development-goals-in-rich-countries.html)

108. Arotake Tūkino Whānau: literature review on family violence. Wellington: Te Puni Kōkiri, 2008. (https://www.tpk.govt.nz/documents/download/262/tpk-family-violence-literature-review.pdf)

109. Slabber M. Community-based domestic violence interventions: a literature review – 2012. Wellington: Department of Corrections, 2012. (https://www.corrections.govt.nz/__data/assets/pdf_file/0011/10721/COR_Community_Based_Domestic_Violence_Interventions_WEB_2.pdf)

110. Current thinking on primary prevention of violence against women. Wellington: Ministry of Women's Affairs, 2013. (https://women.govt.nz/sites/public_files/Final%20Current%20thinking%20on%20primary%20prevention.pdf)

111. Taylor A, Carswell S, Haldane H, Taylor M. Toward a transformed system to address child abuse and family violence in New Zealand. Literature Review – Part One Current knowledge. Submitted to ESR as part of its contract with The Glenn Inquiry. Christchurch: University of Canterbury Te Awatea Violence Research Centre, 2014. (https://www.esr.cri.nz/assets/SOCIAL-CONTENT/TGI-Part-1-literature-review.pdf)

112. Taylor A, Carswell S, Haldane H, Taylor M. Toward a transformed system to address child abuse and family violence in New Zealand. Literature Review Part Two – Effectiveness of Interventions. Submitted to ESR as part of its contract with The Glenn Inquiry. Christchurch: University of Canterbury Te Awatea Violence Research Centre, 2014. (https://www.esr.cri.nz/assets/SOCIAL-CONTENT/TGI-Part-2-literature-review.pdf)

113. Fanslow JL, Kelly P, Ministry of Health. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence. 2nd ed. Wellington: Ministry of Health, 2016. (https://www.health.govt.nz/system/files/documents/publications/family-violence-assessment-intervention-guideline-jun16_0.pdf)

114. Ministerial Group on Family Violence and Sexual Violence. Family Violence, Sexual Violence and Violence within Whānau Workforce Capability Framework. Wellington: Ministry of Social Development, 2017. (https://www.justice.govt.nz/assets/Documents/Publications/family-violence-workforce-capability-framework.pdf)

115. Lambie I. Every 4 minutes: a discussion paper on preventing family violence in New Zealand. Auckland: Office of the Prime Minister's Chief Science Advisor, 2018. (https://cpb-ap-se2.wpmucdn.com/blogs.auckland.ac.nz/dist/f/688/files/2020/02/Every-4-minutes-A-discussion-paper-on-preventing-family-violence-in-New-Zealand.-Lambie-report-8.11.18-x43nf4.pdf)

116. Jan Logie, Parliamentary Under-Secretary to the Minister of Justice (Domestic and Sexual Violence Issues). New steps in improving our response to family violence. Speech to the Auckland Branch of the NZ Law Society, 25 March 2019. (https://www.beehive.govt.nz/speech/new-steps-improving-our-response-family-violence)

117. Reducing family & sexual violence [internet]. Ministry of Justice, 28 September 2020. (https://www.justice.govt.nz/justice-sector-policy/key-initiatives/reducing-family-and-sexual-violence/)

118. King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. Lancet 2009;374(9683):76-85.

119. Berg LD, Kearns RA. Naming as norming: 'race', gender, and the identity politics of naming places in Aotearoa/New Zealand. Environ Plan D 1996 02/01; 2018/05;14(1):99-122.

120. Faculty of Public Health (UK). Parenting one way of improving mental health for everyone. FPH media statement, 15 June 2016. (outlined at https://www.bbc.com/news/uk-36539279)

121. Faculty of Public Health. Reflections on the Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence [internet]. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf)

122. Friedli L, Parsonage M. Promoting mental health and preventing mental illness: the economic case for investment in Wales. All Wales Mental Health Promotion Network, 2009. (http://www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20(English).pdf)

123. Faculty of Public Health. Better mental health for all: the economic case. (https://www.fph.org.uk/policy-campaigns/special-interest-groups/special-interest-groups-list/public-mental-health-special-interest-group/better-mental-health-for-all/the-economic-case/)

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Appendix. Te Pae Mahutonga: a health promotion framework[75]

Ngā Manukura (community leadership)

Te Mana Whakahaere (autonomy)

Mauriora (cultural identity)

- Tikanga and Māori culture embraced and celebrated
- Purpose and hope
- Culture and identity

Waiora (physical environment)

- Safety
- Warm, dry, safe housing
- The natural environment is flourishing
- The natural environment is nurtured and accessible

Toiora (healthy lifestyles)

- Good physical health
- Safe and satisfying employment and education
- No reliance on or hazardous use of alcohol and drugs

Te Oranga (participation in society)

- Adequate income and no debt
- Secure housing tenure and employment
- Access to employment, education
- Celebration of diversity
- Acceptance and belonging
- Community and connectedness
- Gender equity