He Ara Āwhina Service-Level Monitoring Framework

Submission Form

How to have your say

To give us your feedback, you can:

1. email us to set up a time to discuss via Zoom or phone (email jane.carpenter@mhwc.govt.nz to set up a time Monday - Wednesday)
2. complete this submission form and email it to us at kiaora@mhwc.govt.nz
3. take an oline survey on the Initial Commission website – www.mhwc.govt.nz

We would like to hear from you by Wednesday 9 December 2020.

Questions

You do not have to answer all the questions.

This submission was completed by:	*(name)*	Jim Miller
Email:		di@nzcphm.org.nz
Organisation (if applicable):		New Zealand College of Public Health Medicine
Role (if applicable):		President

Are you submitting this as *(tick one box only)*:

- ☐ An individual or individuals (not on behalf of an organisation)
- ☒ On behalf of an organisation(s)

Please indicate which groups of people you identify with or represent *(tick all that apply*

- ☐ People with lived Experience of mental distress Illness and/or addiction
- ☐ Families and whānau with Lived experience of mental distress, illness and/or addiction
- ☐ Māori
- ☐ Pacific Peoples
- ☒ Other (please specify) the health and wellbeing of all populations
- ☐ Young People
- ☐ Rural Communities
- ☐ Rainbow Communities
- ☐ Disabled People
- ☐ Prisoners
- ☐ Older People
- ☐ Children in state care
- ☐ People who have experienced adverse childhood events
- ☐ Refugees and Migrants

Please indicate which sector(s) your submission represents *(tick all that apply)*:

☐	Māori	☐	Families and whānau
☐	Pacific	☐	Consumer
☐	District Health Board	☐	Government organisation
☒	Non-governmental organisation	☐	Commissioning agency
☐	Advocacy organisation	☒	Professional association
☐	Academic/research	☐	Other service provider
☐	Addiction	☐	Other *(please specify)*: _____

Consent - Individuals

How we will use your information
We will use what you and others tell us to develop the He Ara Āwhina service-level monitoring framework.

We will publish a summary report about the feedback we receive on our website to show how we are working, including what people said.

Protecting the privacy of individuals
We will report individual submissions by groups people identify with and represent. We will not publish individual names unless you ask us to. This means when you make a submission, your name will not be included in the list of submitters - unless you ask us to.

Attributing quotes
We will not attribute quotes in the summary report to named individuals. Any quotes used in the report from individuals will be de-identified and as the group the individual identifies as and/or represents.

1. Do you consent to the Initial Commission naming you as a submitter in the published summary report (default is you will not be named)?

    ☐ No – I do not want the Initial Commission to list my name
    ☒ Yes- I want the Initial Commission to list my name

Consent -Groups or Organisations

How we will use your information
We will use what you and others tell us to develop the He Ara Āwhina service-level monitoring framework.

We will publish a summary report about the feedback we receive on our website to show how we are working, including what people said.

Publishing submitters names
We will publish a list of submitters in the summary report. This means when you make a submission, we will include your group or organisation name in the list of submitters, unless you ask us not to.

Attributing quotes
In the summary report we may quote from responses. We will attribute quotes to groups or organisations unless you ask us not to.

If your group or organisation consents to its name being used, but there are particular areas of the submission you do not wish to be made publicly available, please identify this within the question as being IN CONFIDENCE.

1. Do you consent to the Initial Commission naming your group or organisation as a submitter in the published summary report?

    ☒ Yes- the Initial Commission can name my group or organisation
    ☐ No – I do not want the Initial Commission to name my group or organisation

2. Do you consent to the Initial Commission attributing quotes to your group or organisation in the summary report?

    ☒ Yes- the Initial Commission can attribute quotes to this group or organisation
    ☐ No – We do not want the Initial Commission to attribute quotes to this group or organisation

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1. Why monitor services?

The purpose of this question is to ensure that the Mental Health and Wellbeing Commission's function to monitor and advocate for improvement to mental health services and addiction services has the greatest impact. This function is currently carried out by the Mental Health Commissioner under the Health and Disability Commissioner Act 1994 and will be transferred to the Mental Health and Wellbeing Commission in February 2021.

How the Commission best delivers on this function needs to be designed in-light-of its objective, powers and functions, and the broader monitoring and advocacy landscape.

a. What qualities and attributes would you like to see in the Mental Health and Wellbeing Commission's function to monitor and advocate for improvement to mental health services and addiction services?

Comment:

- It is 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)[1] or the World Health Organization- (WHO-) 5 Well-Being Index)[2] 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.[3] Various national and regional surveys already use the WHO-5, including the General Social Survey, Te Kupenga, Quality of Life project surveys, and Canterbury Wellbeing Survey. When the WHO-5 is used at population level, the data should be presented using descriptive statistics such as mean and distribution rather than in a binary format. This approach is used in the Canterbury wellbeing survey reports and associated Canterbury Wellbeing Index.

- Inclusion of primary care mental health data in data collection. This will provide insight into the mental health needs of the vast majority of people who access mental health services, not just those who meet the criteria for severe disease.

- Improving the quality of the existing PRIMHD data system, including improving completeness of data collection, consistency of data quality across DHBs and reviewing whether the data that is currently being collected is fit for purpose.

- Repeat Te Rau Hinengaro (national mental health survey), this is required to estimate the prevalence of mental health conditions and understand the degree of unmet need. This repeat needs to consider how the survey 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.

For more details (including the references mentioned), please see the NZCPHM's updated Policy Statement on Mental Health at https://www.nzcphm.org.nz/media/142946/2020_mental_health_policy.pdf

1. 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 wellbeing in diverse populations and projects. J Epidemiol Comm Health 2011;65(Suppl 2):A38-A39.

2. Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, et al. The Warwick-Edinburgh mental wellbeing 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)

3. 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/maorihealth-models-te-pae-mahutonga) Durie, M. Te Pae Māhutonga: a model for Māori health promotion. Health Promotion Forum of New Zealand 1999:Newsletter 49. (https://www.cph.co.nz/wp-content/uploads/TePaeMahutonga.pdf) Community and Public Health, Canterbury District Health Board. Using the Te Pae Māhutonga framework in public health [internet]. (https://www.cph.co.nz/about-us/te-pae-mahutonga/)

b. How could the Commission best add value and provide the greatest impact to improve wellbeing outcomes for people and whānau accessing those services?

Comment:

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:

- 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.

A strength-based approach should be taken wherever possible, considering carefully the place and robust presentation of measures such as those relating to suicide and service measures such as Compulsory Treatment Orders.

Quality criteria should be deliberately applied to all measures- eg. considering meaningfulness, interpretability, and face validity. See the NHS Good Indicators Guide.[4]

Further details can be found in the NZCPHM's updated Policy Statement on Mental Health at https://www.nzcphm.org.nz/media/142946/2020_mental_health_policy.pdf

4. NHS Institute for Innovation and Improvement. The Good Indicators Guide: Understanding how to use and choose indicators. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/The-Good-Indicators-Guide.pdf

c. How could the Commission provide greatest impact for equitable outcomes for Māori in its monitoring of and advocacy for service improvement?

Comment:

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.[5]

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.[6] 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.

For more details (including the references mentioned), please see the NZCPHM's updated Policy Statement on Mental Health at https://www.nzcphm.org.nz/media/142946/2020_mental_health_policy.pdf

5. 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.

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

2. Monitor what?

The purpose of this question is to define the scope of services that will be monitored as part of the *He Ara Āwhina Service-Level Monitoring Framework.* As there is no common definition of mental health services and addiction services, we are seeking your views on the following proposed draft definition: ***Hauora services that are responsive to the wellbeing aspirations and mental health and/or addiction needs of tangata whai ora and/or their whānau*.**

Definition of a mental health service and addiction service

a. What are your views on the draft definition of mental health services and addiction services?

Comment:

The exclusion of health promotion and community development from the current definition is potentially problematic, as it restricts the focus of the Commission's monitoring to the maintenance of mental health and/or addiction needs rather than improving wellbeing and preventing poor mental health.

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'.[7] 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.

With this in mind, the Commission has a mandate to explicitly monitor access to the determinants of mental health and wellbeing, with a strong equity focus.

For more details (including the references mentioned), please see the NZCPHM's updated Policy Statement on Mental Health at https://www.nzcphm.org.nz/media/142946/2020_mental_health_policy.pdf

[7.] 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 Promotion International 2016;32(4):755-61.

b. Are you aware of any other definitions of mental health and/or addiction services that can be drawn on?

Comment:

We support the use of Corey Keyes' Mental Health Continuum Model.[8]

[8.] Keyes, C. The Mental Health Continuum: From Languishing to Flourishing in Life, Journal of Health and Social Behavior 2002; (43):207-222.

Even with a definition of mental health services and addiction services there will be grey areas. To help navigate those grey areas, factors could be applied to differentiate whether a service is a 'mental health service and addiction service' as distinct from other health or wellbeing services. These could include whether:

- the primary reason for accessing the service was for a mental health or addiction need
- the service provided responded to a mental health or addiction need
- mental health and addiction workforce training is required to deliver the service
- the intention of the funder is for the delivery of mental health and/addiction support
- the service is provided to individuals (including whānau and group settings) as opposed to the public or populations.

Factors to help apply the definition in practice

c. Are factors needed to further define mental health services and addiction services in practice?

Comment: None that we are readily aware of

d. What are your views of the listed factors? Are any missing? Are some more important than others?

Comment: None that we are readily aware of

3. How to monitor?

The purpose of this question is to test whether the existing Mental Health Commissioner's framework for monitoring mental health and addiction services is 'fit for purpose' for the permanent Commission and what other models, frameworks and approaches we should consider.

The Mental Health Commissioner's framework draws on four information streams to support monitoring and advocacy: complaints to the Health and Disability Commissioner about mental health and addiction services; consumer and whānau feedback; sector engagement; and service performance information. From these information streams a set of annual quantitative measures are derived to track trends over time. At the heart of the framework are six monitoring questions:

- Can I get help for my needs?
- Am I helped to be well?
- Am I a partner in my care?
- Am I safe in services?
- Do services work well together for me?
- Do services work well together for everyone?

Mental Health Commissioner's Monitoring and Advocacy Framework

a. What are your views on the Mental Health Commissioner's framework for monitoring mental health services and addiction services and advocating for improvements? Do the monitoring questions resonate with you?

Comment:

There is a clear user/patient/consumer focus to the questions which is commendable. However, as written there may be too much emphasis on the experiences of individuals, with the exception of the last question. This may not be a good fit for people who have a more collective understanding and approach to achieving mental health and wellbeing.

The College also suggests additional monitoring questions:

- Has my mental wellbeing been enhanced by early childhood/family services?
- Has my cultural identity been supported? (Culture here including gender identity, sexual identity (LGBTQIA), ethnicity).

b. Would you change any of the monitoring questions? How?

Comment:

Although the discussion paper notes that these questions can be read inclusive of whānau, revising the wording of the questions to explicitly include the individual and their family/whānau may improve their ability to monitor the performance of mental health and wellbeing services for a wider group of people who experience these services.

c. Are any monitoring questions missing?

Comment:

There appears to be scope for a specific line of questioning related to Māori mental health and wellbeing. This is in keeping with a willingness to correct the course of the chronic and systemic inequities Māori currently experience within our health system. The use of Māori health performance indicators is one way of monitoring for improvement in mental health and wellbeing, as stasis or worsening health status may be obscured when looking at overall monitoring.

The College suggests that broader determinants should be explicitly considered from a te ao Māori perspective including tribal identity, connection to tūrangawaewae, engagement with Māori culture, access to cultural support. All of these aspects are included in the post-censal Te Kupenga survey and as indicators in He Tohu Ora, within the Canterbury wellbeing Index.

Other models, approaches and frameworks

d. What other models, approaches and frameworks should we consider for the Mental Health and Wellbeing Commission's framework?

Comment: None that we are readily aware of

Te Tiriti o Waitangi

e. What could a Te Tiriti o Waitangi partnership approach look like in relation to the Commission's function to monitor mental health services and addiction services and advocate for improvement? Can you provide examples of successful Te Tiriti partnership approaches for the Commission to consider?

Comment:

Professor Sir Mason Durie has described his vision for an independent Māori health and well-being authority (Te Rūnanga Whakapiki Mauri). This authority, "would be defined by the norms of te ao Māori. It would favour Māori decision-making at all levels and would foster an integrated approach that saw all Kaupapa Māori Organisations working towards the same goals and with the same values. It would bring together mental health, child health, health generally, kōhanga reo [language nest], kura kaupapa [Māori primary school], whare kura [Māori school], housing and other aspects of wellness."[9]

[9.] M. Durie, Whakaahu whakamua: Decades of Māori advancement; At Toi tu Hauora 2019 (Wellington: Te Rau Ora, 2019), p. 9.

Ngā mihi nui. Thank you for your feedback – it is much appreciated.