



**Royal Commission into  
Victoria's Mental Health System**



## **WITNESS STATEMENT OF MARY O'HAGAN**

I, Mary Anne O'Hagan, MNZM, Manager Mental Wellbeing, Te Hiringa Hauora, of 101 The Terrace, Wellington, New Zealand, say as follows:

### **Background**

- 1 I am providing evidence to the Royal Commission into Victoria's Mental Health System in my personal capacity.

### **Overview of my experience**

- 2 I have been involved in mental health and disability issues for over 30 years. I used mental health services in New Zealand for eight years as a young woman. Ever since then, I have worked to make a difference to the way society and services respond to people with major mental distress.
- 3 I have held various advocacy, advisory, provision, funding, consultancy and commissioner roles – at the local, national and international levels. I have experience working in the Netherlands, Britain, Canada, Australia and New Zealand. In addition to my previous role as a Mental Health Commissioner for New Zealand (which I discuss further below):
  - (a) I was a key initiator of the mental health service user movement in New Zealand in the late 1980s;
  - (b) I was the founding chairperson of the first worldwide service user network in the early 1990s (the World Network of Users and Survivors of Psychiatry); and
  - (c) I have been an advisor to the United Nations and the World Health Organization.
- 4 I am an international keynote speaker, consultant, writer and thought leader on service user perspectives. I am regularly sought out for my unique expertise in recovery, wellbeing and discrimination.
- 5 In 2015, I received the Insignia of a Member of the New Zealand Order of Merit (MNZM) for my services to mental health.
- 6 Attached to this statement and marked 'MOH-1 is a copy of my CV.

*Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.*

### ***My previous roles and responsibilities***

- 7 I was a Commissioner for the New Zealand Mental Health Commission (“**NZ Commission**”) for six and a half years, from 2000 to 2007. At that time, the NZ Commission had three Commissioners. One of those three positions was informally allocated to a person with lived experience, and that was my role.
- 8 I was a working Commissioner, by which I mean I worked for 4-5 days a week for the NZ Commission, as opposed to it being more of a part time role like a director of a board.
- 9 In that role, my main responsibilities were to work to embed a “recovery approach” in mental health services in New Zealand, and to support efforts to reduce stigma and discrimination against people who experience mental distress. I was the sponsoring Commissioner for those two areas of work.
- 10 Throughout my time at the NZ Commission, we connected with people with lived experience of mental distress in a range of different ways. We undertook many consultations and workshops, prepared a lot of publications and visited the public mental health services.
- 11 When I left the NZ Commission, I became self-employed and set up a social enterprise called PeerZone. As a Commissioner, I was working at the systemic level and when you are working at that level it can be very hard to see the impact you are having on the day-to-day lives of people with lived experience. This was what motivated me to start PeerZone. We didn’t have a grand plan to start with, but the first thing we did was to develop peer-led workshops for people with lived experience. The workshops aren’t just about questions like “how do I deal with my symptoms and how do I recover from this?”; they span all areas of life, from employment to housing to relationships, and include a section about exploring our unique identity. We have also developed Māori and Pasifika workshops, a toolkit of resources and workshops for young people.
- 12 We disseminated the original suite of workshops throughout Australia and New Zealand initially, and they are now taking place in places like Canada and the United States. We have also prepared “train the trainer” materials, which equip people with the skills to deliver the workshops. The defining feature of peer-led workshops is that only people with lived experience can deliver them. The people who we train to deliver PeerZone workshops are mostly peer support workers.
- 13 In addition to peer-led workshops, PeerZone has also provided one-to-one peer support. We were involved in a pilot delivering peer support to people receiving the Supported Living Payment, which is a long term benefit that people with a health condition, injury or disability can receive in New Zealand. PeerZone is now providing peer support in a

government-run pilot for 18 to 25 year olds who have experience of distress in the Wellington region. Since its inception, PeerZone has been involved in a wide range of initiatives, but the core from our work remains group peer support and one-to-one peer support. I have very recently resigned as the Director of PeerZone.

***My current role and responsibilities with the Like Minds, Like Mine programme***

- 14 My current position is Manager Mental Wellbeing at Te Hīringa Hauora which until recently was called the Health Promotion Agency (a New Zealand crown agency). Te Hīringa Hauora means 'the relentless pursuit of wellbeing'. In this role, I am responsible for the strategy and delivery of Like Minds, Like Mine as well as wellbeing promotion campaigns and community partnerships. Most recently in my role with Te Hīringa Hauora I have been working on New Zealand's psychosocial response to COVID-19, which I discuss further below. Prior to commencing in my current position (in April 2020) I was the Programme Lead for Like Minds, Like Mine at Te Hīringa Hauora.
- 15 Like Minds, Like Mine is a programme that seeks to reduce stigma and discrimination against people with mental distress in New Zealand. The programme is funded by the New Zealand Government, and a number of government and non-government agencies are also involved in the delivery of the programme. Te Hīringa Hauora is the lead operational agency, the Ministry of Health has strategic responsibility, and the Mental Health Foundation of New Zealand co-leads national coordination and communications with Te Hīringa Hauora.
- 16 The Like Minds, Like Mine programme started in New Zealand in 1997. It is founded on the following core principles:
  - (a) **The social model of disability**, which views disability as a process that happens when one group of people creates barriers by designing a world only for their way of being.
  - (b) **A human rights approach**, which values the dignity of all people and asserts their right to be free of discrimination.
  - (c) **The power of contact**, encouraging equal contact between members of excluded groups and those that exclude. This approach has been shown to promote attitude change.<sup>1</sup>

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<sup>1</sup> Like Minds, Like Mine, 'About' <<https://www.likeminds.org.nz/about/>> [accessed 4 June 2020].

- 17 The most recent National Plan for the Like Minds, Like Mine programme covered the period 2014-2019.<sup>2</sup> A lot of the programme's work is currently contracted out to different service providers, and all the contracts come to an end at the end of January 2021. So, we are now entering a new phase. This provides a unique opportunity to reassess and redesign the strategic direction and priorities of the programme going forward. This is our focus for this year (2020), however the COVID-19 pandemic may delay this stream of work.
- 18 The foundation of our new strategic direction is that all New Zealanders uphold the *mana* and human rights of people who experience mental distress. Mana is a Māori word which in this context refers to your inherent authority or status as a person. The new direction signals more centralised leadership and coordination as well as ensuring we embed Te Tiriti o Waitangi and equity into the programme. Over the next few years, we will be narrowing the settings we work with in Like Minds, Like Mine to focus on employment, and how we can address the difficulties in securing work.

### ***New Zealand's psychosocial response to COVID-19***

- 19 At the end of March 2020, the New Zealand government invested money to develop a psychosocial response to COVID-19. Rather than taking a service-led approach, the government's investment has focused on promotion and prevention by funding the following three areas:
- (a) a generic campaign called Getting through Together – Whāia e Tātou Te Pae Tawhiti.<sup>3</sup> The wellbeing messages of this campaign are being delivered through a variety of channels, including a website and advertising on billboards and television;
  - (b) apps or other digital tools which focus on wellbeing, including Mentemia (which was co-founded by ex-All Black player Sir John Kirwan),<sup>4</sup> the online course called Just a Thought adapted by a New Zealand-based NGO from the Australian-based

<sup>2</sup> Like Minds, Like Mine, 'National Plan 2014-2019' <<https://www.likeminds.org.nz/assets/National-Plans/like-minds-like-mine-national-plan-2014-2019-may14.pdf>> [accessed 4 June 2020].

<sup>3</sup> For further information see All Right, 'Getting Through Together' <<https://www.allright.org.nz/campaigns/getting-through-together>> [accessed 4 June 2020] and Mental Health Foundation of New Zealand, 'Getting Through Together' <<https://www.mentalhealth.org.nz/get-help/getting-through-together/>> [accessed 4 June 2020].

<sup>4</sup> Mentemia, 'Helping you cope & thrive through Covid-19' <<https://www.mentemia.com/>> [accessed 4 June 2020].

This Way Up<sup>5</sup> and a local start-up called Melon Health who are developing a range of digital therapeutic tools;<sup>6</sup> and

- (c) the project we are leading at Te Hiringa Hauora.
- 20 The psychosocial response we are leading at Te Hiringa Hauora involves developing messaging and resources for the following five priority groups. These groups are considered to be at greater psychosocial risk from COVID-19:
- (a) Māori;
  - (b) Pasifika people;
  - (c) Young mothers and babies;
  - (d) People with long term physical health conditions; and
  - (e) Older people.
- 21 We are working very closely with the 'Getting through Together' campaign, and also with affected communities to develop material that speaks to the issues faced by these five groups. The messages and resources are being shared through many different local groups and other channels, including social media and our own platforms at Te Hiringa Hauora.
- 22 Because of COVID-19 restrictions, all the community engagement to develop these resources has been conducted virtually. In my observation, everyone has adapted very well to working together in a virtual way because we all know it is our only option. I was recently speaking with some Māori and Pasifika people who said that not being able to meet face-to-face has been challenging at times (as they have a strong cultural preference for face-to-face engagement), but they said that they have adapted to this new way of connecting and working together.
- 23 There is nothing like a crisis to get people work together. In fact, it has been quite a remarkable and positive surprise how easily people have pulled together to get the job done. In the pre-COVID-19 world, getting a project like this off the ground would have taken a lot longer. There would be more politics, bureaucracy and other challenges that get in the way. In this crisis situation, those barriers have fallen away because everyone realises that we don't have any time to spare and we need to work together to develop a response quickly.

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<sup>5</sup> This Way Up, 'Supporting You Through the COVID-19 Pandemic' <<https://covid19.thiswayup.org.au/>> [accessed 4 June 2020]; Just a Thought, 'Staying on Track' <<https://www.justathought.co.nz/>> [accessed 4 June 2020].

<sup>6</sup> Melon Health, 'Covid-19' <<https://www.melonhealth.com/covid-19/>> [accessed 4 June 2020].

### **The need for a long term psychosocial response**

- 24 Our psychosocial response project is funded for six months, until the end September 2020. However, I expect that a response will continue on beyond that point. One of the challenges of running this programme is that it is very difficult to predict what people's psychosocial needs will be going forward, in one month or two month or six months. We need to keep evolving our responses according to what is happening in this very unpredictable world.
- 25 Even with all the work that has been done to contain the virus and support the economy, there are and will be people with psychological distress as a result of COVID-19. We need to provide additional resources and support for people in distress, across the whole spectrum from promotion and prevention through to service delivery. In my view, governments need to invest more resources to bolster this aspect of the response to COVID-19.
- 26 Government investment in the psychosocial response to COVID-19 must continue over the long term. During the initial phase of a crisis, there is usually quite a lot of anxiety about immediate issues like health and money. However, my concern is that the real danger to people's wellbeing will come in the next phase, as the crisis goes on and the adrenalin wears off. I think the real danger time is when people are picking up the mess and trying to get on with their lives and realising that things are not the same as they were. I expect we are getting close to that next phase.

### **The importance of economic support and containing the virus**

- 27 While our work at Te Hīringa Hauora is an important part of developing a psychosocial response to COVID-19, in my view, the most significant way to reduce any sort of psychosocial fallout from COVID-19 is for the government to contain the virus and support the economy. Containing the virus and supporting the economy is ninety percent of what is needed to reduce the amount of psychological distress.
- 28 As part of its support for the economy, the New Zealand government is investing in extra financial support for people on low incomes. We also need to find a way to support unemployed people to keep engaged in the economy in some way. This may be through encouraging retraining in a different industry. For example, there are a lot of new environmental and infrastructure projects coming up in New Zealand which will need workers.

### ***Designing and evaluating programs to reduce stigma and discrimination***

- 29 Programs that are effective at reducing stigma and discrimination of people with mental distress are those that promote human rights and greater social inclusion. I think the

ultimate indicators of whether people who use mental health services are socially included at a population level are things like: *What is our participation in the labour market? How many of us are partnering and having children and keeping them? How many friends do we have? What are our relationships like with our families of origin? Are we in stable housing?* The challenge is that we don't have very good data on these indicators.

- 30 Of the people who experience mental distress, it is the people with *severe* mental distress who are most likely to experience stigma and discrimination. However, around the world, programmes to reduce stigma and discrimination often target what I would call 'the middle ground' of mental distress, such as people who have mild depression and anxiety. Such programmes often promote anti-stigma messages to remove the barriers to people *seeking* help, but the people who are already in the mental health system don't really need these messages; they need a programme that promotes their human rights and social inclusion.<sup>7</sup>
- 31 The Like Minds, Like Mine programme is not primarily for that 'middle ground' of people. Rather, it is for the people who have already been in the mental health system, whether they wanted it or not. It is for people whose life chances have been eroded by their experiences with mental distress, through their life experiences, being in the mental health system and being subjected to social prejudice and discrimination.
- 32 That said, the initial advertising campaigns run by Like Minds, Like Mine in the early 2000s talked mostly about depression and anxiety. Even back then, my strong view was that we needed to also refer to people experiencing severe mental distress. But the advertisers argued that for the public to respond well to the adverts, they needed to start in the less scary middle ground and move onto people with severe distress over time. So, the campaigns started by focusing on the middle of the spectrum and, over several years (by the end of the 2000s), they referred more to people at the far end of the spectrum, such as people identified as having psychosis or bipolar.
- 33 Every time an advertising campaign was released, surveys were conducted with around 1,000 people in New Zealand to seek to measure the effectiveness of the campaign. The surveys repeated the same questions, and they found that people's attitudes to mental illness improved; the level of prejudice and the desire for social distance got noticeably less over time. The questions were along the lines of: *Would you feel uncomfortable talking to someone who had a mental illness? Would you want to work with someone with*

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<sup>7</sup> This is based on my own observations, as well as the observations of others, for example in the book Liz Sayce, *From Psychiatric Patient to Citizen Revisited* (Palgrave Macmillan, 2015). An earlier version of this book was published 20 years ago: Liz Sayce, *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion* (Palgrave, 2000).

*mental illness? Would you like someone with schizophrenia to be a babysitter for your children?*<sup>8</sup>

- 34 While tracking attitudes is quite an easy thing to measure, it's not clear whether it is a helpful measure – attitudes are poor predictors of behaviour in the area of mental distress and discrimination, and measuring *behaviour* change is difficult.
- 35 I think it's really quite remarkable how attitudes have changed over the last 20-30 years. When I look back to when the Like Minds, Like Mine programme started in the late 1990s, nobody wanted to talk about mental health. It was viewed as a scary subject that was swept under the carpet. Now, we find that everyone is talking about it. I think, to a degree, people have got a bit better at including people at the more extreme end of the mental distress spectrum. But there is still a long way to go.
- 36 This is highlighted by the Australian Government's study of people living with psychotic illness, which involved two national surveys. The first survey was conducted in 1997-1998, and the second survey was conducted in 2010.<sup>9</sup> Around 1,800 people assessed as having psychosis were interviewed as part of the second survey. That study gave a really depressing snapshot of the kind of multiple forms of social exclusion that people with psychosis experience. It's enough to make you want to weep.
- 37 So, while I think there's much more openness about talking about wellbeing and mental distress issues, life opportunities are dire for people who use mental health services and have had a prolonged period of their life living with the impacts of: their trauma (which often precedes their mental distress); their experience of mental distress; all of the terrible consequences that come from being labelled as 'mentally ill' and put in the system; and the stigma and discrimination that result from that. This impact is amplified if you are Māori, Pasifika or come from other groups that already experience prejudice and discrimination. That is why Like Minds, Like Mine needs to respond equitably to these

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<sup>8</sup> The results of this campaign are described in the following research report prepared for the Ministry of Health: Allan Willie and James Lauder, *Impacts of National Media Campaigns to Counter Stigma and Discrimination Associated with Mental Illness – Survey 12: Response to Fifth Phase of Campaign*, June 2012 <<https://www.mentalhealth.org.nz/assets/ResourceFinder/Impacts-of-national-media.pdf?>> [accessed 4 June 2020]. An earlier research report prepared for the Ministry of Health describes the results of surveys conducted to measure the levels of discrimination experienced by users of mental health services, and the perceived impact of the Like Minds, Like Mine programme: Allan Willie and James Lauder, *Discrimination reported by users of mental health surveys: 2010 survey*, July 2011 <<https://www.mentalhealth.org.nz/assets/ResourceFinder/Discrimination-reported-by-users.pdf?>> [accessed 4 June 2020].

<sup>9</sup> Vera A. Morgan et al, *People living with psychotic illness 2010: Report on the second Australian national survey*, November 2011 <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-psych10?>> [accessed 4 June 2020].

groups—particularly Māori—in its responses. Prejudice and discrimination are still a big problem.

***Working with governments to support programs that reduce stigma and discrimination***

- 38 One of the key roles of Like Minds, Like Mine going forward will be to work with politicians and officials to get the issue of social inclusion for people with mental distress much higher up their priority list, and to give them some ideas about effective ways to tackle the problems of stigma and discrimination. I think governments have been trying to solve this problem for a long time, but they haven't come up with very compelling answers to it yet. We need to help these key decision makers realise that the current health-centric and coercive responses to people with mental distress don't work and their poor health and life statistics are scandalous. This needs to be addressed as a matter of urgency.
- 39 At Like Minds, Like Mine, we are in a good position to work behind the scenes with government officials. We have relationships with the Ministry of Health and the Ministry of Social Development as well as other government agencies that oversee the area of employment, for instance. We also have inroads into the Cross-Party Mental Health and Addictions Wellbeing Group, which was launched in August 2019 in response to a recommendation from the 2018 New Zealand Government Inquiry into Mental Health and Addiction, He Ara Oranga ("**NZ Mental Health Inquiry**"). The Cross-Party Group aims to "raise awareness of the issues and challenges surrounding mental health in New Zealand, such as suicide". Its mandate also includes making recommendations and holding the Government to account over policies relating to mental health.<sup>10</sup>
- 40 Another way of making social inclusion for people with mental distress more of a priority for government, and championing programmes such as Like Minds, Like Mine, is to find ways of mobilising a social movement. There are plenty of people out there – people with lived experience, their families and NGOs working in the area – who all feel quite strongly about this issue. If we come together as a social movement, that puts pressure on politicians and helps to facilitate change.
- 41 I think it takes a lot of dedicated people to drive change. It is also essential to have a programme lead, someone to oversee and bring together all the different components of the programme. That role is especially important to the success of a programme.

<sup>10</sup> New Zealand Parliament, 'Parliamentary cross-party groups' <<https://www.parliament.nz/en/visit-and-learn/how-parliament-works/parliamentary-cross-party-groups/>> [accessed 4 June 2020].

## The Wellbeing Manifesto and Big Community

### ***An overview of 'The Wellbeing Manifesto'***

42 The Wellbeing Manifesto was a major submission to the recent NZ Mental Health Inquiry. The Wellbeing Manifesto was created largely by people with lived experience, as well as input from a lot of allies and experts. The underlying principle of the Wellbeing Manifesto is: *Me mahi tahi tatou mo te oranga o te katoa* – *We must work together for the wellbeing of all*. It calls for a broad and comprehensive range of services and supports for people with mental distress, and it stresses that those responses must be accessible to everyone. In order to achieve this we must end the health-led system.

43 In the Wellbeing Manifesto, we asked the New Zealand Government to commit to the following seven wellbeing priorities to prevent, respond to, and lessen the impact of mental distress and addiction – we called for a commitment to ensuring that *all* people:

- (a) Live in social conditions that enable them to look after their own and each other's wellbeing.
- (b) Know how to recognise and respond to stress, distress and addiction.
- (c) Can easily find services and supports for people with distress and addiction.
- (d) Get timely, respectful and helpful responses from them.
- (e) Have access to a comprehensive range of community-based services and supports.
- (f) Are supported by people who have 'walked in their shoes', as well as professionals.
- (g) Are enabled to reconnect with themselves, their whānau (extended family) and valued roles in their communities.<sup>11</sup>

44 Attached to this statement and marked 'MOH-2' is a copy of the Wellbeing Manifesto.

### ***A 'Big Community' approach: Key features, benefits and supporting structures***

45 The Wellbeing Manifesto called on the New Zealand Government to develop and fund the following 12 responses from the Big Community wheel of responses:

- (a) Wellbeing promotion and self-management
- (b) Stable housing
- (c) Whānau (extended family) and parenting support

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<sup>11</sup> MOH-2, Wellbeing Manifesto, page 3.

- (d) Psychiatric treatments
- (e) Physical healthcare
- (f) Talking therapies
- (g) Education and employment supports
- (h) Income support
- (i) Community and home-based crisis support
- (j) Cultural and spiritual healing
- (k) Community connection
- (l) Advocacy and navigation<sup>12</sup>

- 46 These responses seek to improve life and health outcomes across the lifespan. The basic thesis is that Big Psychiatry (our medical-led mental health and addiction system) has dominated the world view, language, resources and the way people understand mental distress and addiction:

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

*Big Community needs to replace Big Psychiatry at the hub of the system and position psychiatry as one of its many spokes, so that everyone with mental distress and addiction has open access to a comprehensive range of responses.<sup>13</sup>*

- 47 The Wellbeing Manifesto includes a summary of the main differences between Big Community and Big Psychiatry.<sup>14</sup> I elaborate on some of these key points below.

### **Recovery approach**

- 48 Medicine has been incredibly successful in some ways, but unfortunately psychiatry as a branch of medicine has been less successful. For some medical issues, a deficit approach (which is premised on the idea that something is 'broken' and needs to be fixed, or removed) may be appropriate. For example, if I have appendicitis, I probably just want it taken out, and taken out quickly. But if I'm experiencing despair, an altered reality or having an existential crisis, a deficits approach is not be the best way of dealing with it.

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<sup>12</sup> MOH-2, Wellbeing Manifesto, pages 5-6.

<sup>13</sup> MOH-2, Wellbeing Manifesto, page 3.

<sup>14</sup> MOH-2, Wellbeing Manifesto, page 2.

- 49 Whereas Big Psychiatry defines mental disorder as a health deficit (such as a chemical imbalance), Big Community views mental distress as a recoverable, social, psychological, spiritual or health disruption. There may be a health element to the mental distress, but it's much bigger than that. Indeed, when we look at the social determinants of mental distress, we can see that there are many different factors at play. For example, a lot of people experiencing distress have had trauma in their lives.
- 50 The mental health system cannot be solely responsible for people's recovery; it is a whole of society responsibility.

### **Multiple entry points**

- 51 One of the key structures that needs to be in place to support a Big Community approach is to have a range of entry points for people experiencing mental distress. At the moment, when people are desperate and looking for help, there's only one entry point and that is through a health door (such as your GP or the emergency room). Having the health system as the gatekeeper is frankly ridiculous.
- 52 In contrast, Big Community is a holistic well-being system. It has multiple entry points and is led by multiple sectors and communities. For example, in Big Community, I could go down to the local community centre and there might be peer support workers there and if they think I would benefit from engaging with a clinical service, they could help to connect me with that service. So even though I may use a health service, the key difference is that I have come in through a door I felt comfortable accessing.

### **Funding and resources**

- 53 In a Big Psychiatry system, most of the resources are used for hospital based treatments. In a Big Community system, we use resources for a broad menu of comprehensive community based responses, many of which do not exist inside the mental health system. Further, a Big Psychiatry system employs mainly medical and allied professionals, whereas in a Big Community we have a mix of peer, traditional, cultural and professional workforces.
- 54 I have found that, when you ask people, "*What helped you recover?*", psychiatry is usually only a small part of their answer, if it features at all. For most people, the things that are really important are having a job, forming friendships, finding a house and feeling better about yourself. However, the way our systems are funded, most of the funding goes into pills and pillow services and only a little bit goes towards all these other things that people find very important. The Big Community approach seeks to change that.

### **Long term partnerships and outcomes**

- 55 The Big Community approach is committed to human rights and partnerships at all levels. In contrast, our traditional psychiatry system has a potent legacy of paternalism, human rights breaches and causing routine harm to people. Big Psychiatry tries to stop harm from happening by using coercion. But they don't understand the harm that coercion creates. In fact, the harm caused by coercive treatment can often be greater than the harm they were trying to address by using it.
- 56 Further, traditional psychiatry has a focus on treatment compliance, symptom reduction and short-term risk management. The system is skewed towards a reliance on the short-term risk management tools of medication, hospitals and the Mental Health Act. This has led to a situation where the mental health system is very focused on making sure that someone who they're responsible for doesn't go and do something like kill themselves or do something anti-social. The system views itself as very accountable for that, and often unrealistic community expectations drive this accountability.
- 57 Against this backdrop, we have to ask – are people working in the mental health system accountable for long term outcomes, such as how many of the people they've been serving go out and get jobs, get partners, have and keep babies and have stable housing? From what I see, no one in the current system is accountable for these long term outcomes. If you look at the long term outcomes of the mental health system, the results are horrific; if it was a private business, it would have gone broke in the 1860s when the asylums started to fill up.
- 58 In contrast, the Big Community approach focuses on equity of access, building strengths and improving long term life and health outcomes.

### **Performance monitoring and evaluation**

- 59 Monitoring and evaluating 'success' is a challenge in the Big Community system because of ingrained community expectations. Many people, including politicians and families of people with lived experience, have unrealistic expectations of the extent to which people working in the mental health system can predict risk. Evidence shows that psychiatrists' abilities to predict harmful behaviour happening are only slightly greater than chance.<sup>15</sup> So they have to catch many, many people in their risk management net in order to stop one or two bad things happening.
- 60 We need to create incentives or other measures to make the system accountable for long term outcomes, which are much more meaningful indicators of 'success' for the people

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<sup>15</sup> See, for example: George Szmukler and Nikolas Rose, 'Risk Assessment in Mental Health Care: Values and Costs' (2013) 31(1) *Behavioral Sciences & The Law* 125-140.

who are using the services. There are some efforts towards creating key performance indicators for mental health services,<sup>16</sup> such as employment rates. However, a medically centred, siloed system can't achieve an improvement in employment rates on its own and its treatments can stop people from moving on with their lives. More needs to be done to break the cycle of short term risk management and instead address long term inequities. This is a difficult task because the short-term risk management is all about responding to the community's attitudes and fears, and creating the illusion of control and safety.

- 61 In Big Community, the *whole* system (including the agencies responsible for policy and funding) are made accountable for long term indicators. The two key indicators I think should be paramount are: 1) an increase in participation of the labour market of people who have experienced major mental distress; and 2) more people from that population in stable housing. Another relevant indicator would be reduced rates of medication, because in the current system many people are overmedicated.
- 62 Governments need to start measuring the right things, and not too many of them, because if you start measuring the right things then you have an effective lever to influence the behaviour of people in the system. They should also give some independence to the monitoring function. For instance, New Zealand is getting a new Mental Health and Wellbeing Commission that will monitor whole of system performance and outcomes for people, including the performance of government.
- 63 Traditionally systems have measured performance and outcomes that mean very little to people who use services. For instance, HoNOS is a widely used international mental health clinical scale that is used on individuals and aggregated in many countries to help monitor system performance.<sup>17</sup> It is very clinical, deficits-based and institutionalised as the four section headings reveal: behavioural problems; impairment; symptomatic problems; and social problems – which include relationships, activities in daily living, living conditions and occupational and recreational activities. Anecdotally, I have heard that psychiatrists don't always fill in the social problem section because they don't know about that dimension of people's lives.
- 64 If the people who use services designed these measures they would look completely different. They would not obsess over symptoms and risks and deficits but would be focused on holistic wellbeing and on the things that are important to us all: *How do I feel*

<sup>16</sup> See, for example: Key Performance Indicators for the New Zealand Mental Health and Addiction Sector, 'NZ MHAS Key Performance Indicator Framework – Adult Stream' <<https://www.mhakpi.health.nz/Data/KPI-Framework/Adult-Stream-Framework>> [accessed 4 June 2020].

<sup>17</sup> Te Pou o te Whakaaro Nui, *HoNOS - a New Zealand clinician's guide to ratings and use*, June 2014 <<https://www.tepou.co.nz/uploads/files/resource-assets/honos-ebook-final.pdf>> [accessed 4 June 2020].

*about myself? Am I connected to a social network and a cohesive culture and family? Do I have secure housing? Do I have a valued contributing role? Do I have enough income to live on?* Reducing symptoms only becomes important if symptoms get in the way of these things, but Big Psychiatry often forgets this and treats symptom reduction as an end in itself.

### ***Response of the New Zealand government to the Big Community approach***

- 65 It has been more than a year since the Wellbeing Manifesto was submitted to the NZ Mental Health Inquiry. Perhaps the most important underlying message of the Wellbeing Manifesto is the end of a health-led system. I don't think we can truly achieve a Big Community system until we end the health-led system. Disappointingly, the New Zealand government is still adopting a health-led approach, which is run by health professionals.
- 66 While we have seen a huge injection of funds by the New Zealand government since the Inquiry concluded, those funds are mainly being directed to primary mental health service responses. The process is being led by the Ministry of Health, and the contracts are mostly being awarded to Primary Health Organisations (which are roughly equivalent to Australia's Primary Health Networks although they have not had a big mental health role in the past). I have also not seen any real movement in terms of introducing indicators for long term health and life outcomes. Essentially, it is business as usual where the government is gap-filling mainly in primary health, but there are no indications at this stage that they are changing the paradigm.

### **Integrated community delivery**

#### ***The core features and service components of a well-functioning community-based wellbeing system***

- 67 For as long as I can recall, the issue of integration or collaboration has dogged the mental health and other systems. The Wellbeing Manifesto details the importance of developing community-based services and supports that deliver a range of comprehensive responses for all people on the continuum from 'severe distress and addiction to wellbeing promotion'.<sup>18</sup>
- 68 So far, this issue has not been resolved. In my view, the key reason for this lack of progress is because of the health-led approach. Greater integration and collaboration is urgently needed at all levels, including planning, funding, delivery and governance.

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<sup>18</sup> MOH-2, Wellbeing Manifesto, page 11.

### **Inclusive, multi-sector planning and funding**

- 69 The Wellbeing Manifesto recommends a multi-sector planning and funding approach for mental distress, addiction and wellbeing across the spectrum.
- 70 As I discussed above, the Big Community approach sets out a series of responses and services that people say they want. All the sectors or agencies that regulate those responses, or provide those services, should pool their funds. This could happen at a district or regional level. Importantly, the pool should include funding from the health system.
- 71 All the relevant agencies then need to sit around the table, together with their affected communities, and allocate the pooled funds to the different elements within the Big Community wheel.
- 72 This decision making process must include people with lived experience and people with experiences of mental distress in their families. In New Zealand, this must be done in partnership with Māori.

### **Co-delivery and co-location**

- 73 There could be wellbeing hubs in neighbourhoods, large workplaces, educational institutions, primary health settings and marae ( Māori meeting grounds), which respond to people across the full spectrum, including people in severe distress and people with mild distress. These hubs could serve people who just want to maintain their wellbeing or go to a yoga class, to people with severe distress.
- 74 The aim here is to bring together as many different supports and services under as few roofs as possible. For example, a wellbeing hub would ideally have workers who can assist with housing, budgeting, supported employment and income support, together with psychiatrists, doctors, talking therapists and, importantly, peer support workers. These hubs might also offer educational programs about self-managing distress and provide a spiritual or cultural healing place.

### **From hospital based to community based crisis services**

- 75 Another feature of Big Community delivery is the drastic downsizing of hospital beds, which are replaced with community and home-based responses for people in crisis. Institutionalised 'warehousing' responses to people at their most vulnerable do not work. Acute inpatient units are unsafe and untherapeutic. It is a tragedy that we keep building hospital beds in the hope that this time we will get it right for people, when in fact the model itself is wrong. People in crisis need intimate, homelike, calm places where they feel safe and cared for. A large, locked hospital ward full of people experiencing different

types of distress, being supervised by staff whose main role is containment of risk, will never work. There is good evidence that home and community based acute options are preferred by staff and guests and that they achieve better or the same outcomes.<sup>19</sup>

- 76 There are many successful alternatives to acute inpatient units. These include crisis houses, sometimes run by peers; crisis respite services in which people go to motel or hotel rooms where they are supported by mental health workers; home based treatment where clinical and support staff visit or stay with the person in their home; and family crisis houses where families are trained and resourced to support someone who is in crisis while they stay at their house.
- 77 In Wellington, one of the acute wards was closed in the mid-2000s and replaced with five community houses with four to five beds in each of them. The houses are run by NGOs with clinical input. One is a kaupapa Māori service<sup>20</sup> and one is a peer-led service. My understanding is that beds in the community cost 40% of the cost of a hospital bed and people overwhelmingly prefer them to being in hospital. It's a no-brainer. My question is: Why aren't we downsizing our hospitals beds as a matter of urgency? If the mental health system was based on ethics, evidence, cost-effectiveness and the wishes of people who used services, this would have been done a long time ago. This is why I consider the Royal Commission's recommendation in its interim report to create 170 new acute hospital-based mental health beds to be a grave mistake.

### **Governance, regulation and commissioning**

- 78 To facilitate the genuine partnerships described above, government agencies need to relinquish some control. The government needs to focus on ensuring it appropriately regulates Big Community approaches to funding, planning and delivery, and enables them to be embedded in communities.
- 79 One governance issue we have been looking at very closely at in New Zealand is how we commission services. Some innovative commissioning approaches use the following principles: commission for equity; scope what is needed with the affected communities; create a level playing field for applicants so that large agencies with professional tender writers don't get an advantage; fill the selection panel with people from affected communities so they decide who will provide the service or resource; include affected

<sup>19</sup> See, for example: Mary O'Hagan, *The Acute Crisis: Towards a recovery plan for acute mental health services in New Zealand*, 2006 (Mental Health Commission, New Zealand) <[https://www.moh.govt.nz/notebook/nbbooks.nsf/0/84A900EC043A5F9FCC2573C9006FF462/\\$file/The-Acute-Crisis-O'Hagan.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/84A900EC043A5F9FCC2573C9006FF462/$file/The-Acute-Crisis-O'Hagan.pdf)> [accessed 4 June 2020],

<sup>20</sup> "Kaupapa is a plan, a set of principles and ideas that inform behaviour and customs": Te Ara: The Encyclopedia of New Zealand, 'Story: Papatūānuku – the land' <<https://teara.govt.nz/en/papatuanuku-the-land/page-8>> [accessed 4 June 2020].

communities in performance monitoring. These commissioning principles are a key ingredient in ensuring a Big Community wellbeing system.

- 80 The traditional way of commissioning services is that the public servants, or the health system funders, might do a needs assessment, identify what they think is best for the target population and then they go out and call for proposals. That way of commissioning is flawed. I think this approach makes our system like a dictatorship when it needs to be run more like a democracy.
- 81 The decision-making process associated with commissioning of services can be done in a way that is much more participatory, and much more involving of the affected communities. An example of this is the approach recently taken by a health service in New Zealand. The service had a package of money for antenatal services for women in the region. They went out and spoke with pregnant women and their families and supporters in the region and asked them, “*What do you need?*”. They then invited a number of women from the region to participate in a panel and decide who would be the successful proponent/s to deliver these services. I would call that a Big Community solution because it is about giving communities real power over their services, and over the resources that are going to directly impact them, and that they have paid for with their taxes.<sup>21</sup>

### ***Limitations of a multi-sector planning and funding approach for mental health and addiction***

- 82 Because this kind of multi-sector approach to planning and funding has not been tried before, one possible limitation of introducing it is that there might be backlash from the status quo. This backlash would need to be carefully managed, because the status quo is a powerful force.

### ***The role of district health boards in a multi-sector planning and funding approach***

- 83 Currently, the district health boards lead the planning and funding processes for mental health addiction. In a multi-sector planning and funding approach, district health boards would not be in the lead; rather, a cross-sector agency would receive funding from various government sectors, including the district health board. District health board representatives would be involved in decision making processes about the use of funds,

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<sup>21</sup> For more information about this example, see Health System Committee of the Capital & Coast District Health Board, ‘Commissioning for Equity – Antenatal Education’, 16 October 2019 at pages 13-17 <<https://www.ccdhb.org.nz/about-us/advisory-committees/hsc-public-16-october-2019.pdf>> [accessed 4 June 2020].

but their involvement would be done in a more collaborative, cross-agency and cross-sector way, together with the affected communities.

***Responding to and valuing the preferences and needs of consumers in a multi-sector planning and funding approach***

84 A multi-sector planning and funding approach would better respond to the value and the preferences of consumers in two main ways:

- (a) First, the decision-making process would be guided by the principle that each of the 12 responses from the Big Community wheel should be funded equitably. This would be a major change from the current Big Psychiatry approach, where funding is skewed heavily towards hospitals and medication. In my observation, people who believe the psychiatric interventions they received were helpful to them generally say that those interventions were still only a small part of what they needed to recover. A multi-sector planning and funding approach would provide a funding and planning structure that moves away from the sort of inequitable funding we currently see between Big Psychiatry and all the other services and responses for people in mental distress. In doing so, this approach would respond better to the preferences and needs of the people who use these services; and
- (b) Second, people who use services would be central to planning and funding decisions. Instead of bureaucrats making decisions about what people 'need', they would be working *with* communities to understand what they need. People who use services would be sitting at the decision-making table, which immediately provides influence over how money is spent.

***Examples of effective community-based services in New Zealand***

85 A good example of an effective community-based service in New Zealand is the Youth One Stop Shop ("YOSS").

86 YOSS was established in 1994 and offers a wide range of community-based services and supports to young people (10-24 years) and their whānau. YOSS's services include youth work (information, support and advocacy), counselling, health services, alcohol and drug support, clinical psychology and social work.<sup>22</sup> YOSS also offers life skills programmes and holiday programmes. All of these services are offered under the one roof. In my view, this is a sensible model not just for youth but also for the rest of the population.

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<sup>22</sup> See further: Youth One Stop Shop, 'What we do' <<http://www.yoss.org.nz/what-we-do.html>> [accessed 4 June 2020].

***Family-centred approaches to service delivery of community-based services in New Zealand***

- 87 The health system is very much focused on individuals and their particular pathology. Many people with medical training have traditionally had a sort of microscopic view of the individual, without really seeing the bigger picture.
- 88 In New Zealand, those old ways are still very strong, but we are starting to learn more about family-centred care from the Māori approach. The Māori people take a much more collectivist approach; they wouldn't even think about doing something with or to an individual, unless the whole family were 'on board'.
- 89 There are many high users of health and social services in Māori and Pasifika communities. There is also a lot of duplication across those services. For example, a single Māori or Pasifika family might be receiving multiple different services from multiple different agencies. From my experience working with Māori and Pasifika communities, many people in those communities find the individual approach to service delivery to be quite alienating – it does not resonate with them. Of course, many white people also feel alienated from the current approach to service delivery, however in my experience this is a particularly key issue in Māori and Pasifika communities because of their collectivist culture.

**Whānau Ora approach – a model for family-centred care**

- 90 In recognition of the particular needs of Māori and Pasifika communities, the previous New Zealand government, in coalition with the Māori Party, introduced the Whānau Ora approach.<sup>23</sup> Whānau Ora means healthy families. As mentioned above, whānau is a Māori language word that means extended family. This concept of family is much broader than the nuclear family of parents and children – it can refer to any sort of collective where there is a close bond.
- 91 The Whānau Ora approach focuses on the family, not the individual. It offers a much more family-centred and integrated approach to responding to the social and health needs of families in Māori and Pasifika communities. It also adopts a strength based approach. Whānau Ora workers provide a lot of navigational support – they help to coordinate the various services or resources that a family needs to be a healthy family.

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<sup>23</sup> For further details of the Whānau Ora approach, see: Te Puni Kōkiri Ministry of Māori Development, 'Whānau Ora' <<https://www.tpk.govt.nz/en/whakamahia/whanau-ora>> [accessed 4 June 2020].

- 92 There are three commissioning bodies for Whānau Ora – two that work with Māori families (one for the North Island and one for the South Island) one that works with Pasifika families for the whole of New Zealand.
- 93 In a sense, the Whānau Ora approach is already doing a lot of what the Big Community proposal calls for. In other words, there is already a model operating in quite a lot of the same ways as a Big Community model would operate. Family-centred responses are also a core part of the Big Community philosophy; it is about not treating people in isolation, but as part of our family or community. A Big Community approach also aims to help restore people's place in those families and communities, because often that gets disrupted when someone is experiencing mental distress or trauma.
- 94 In my view, the Whānau Ora approach could be applied with great benefits beyond the Māori and Pasifika communities, to other communities across New Zealand, including white communities.

***The key functions, merits and limits of independent mental health commissions***

**Threshold considerations**

- 95 As a general proposition, I think a Mental Health Commission should have a broad mandate and as much independence as can be achieved.
- 96 To ensure independence, it is important that the Commission has the structural and practical ability to be critical of the government of the day. This is of course a difficult balancing act for the Commissioners – like the dancers in Fiddler on the Roof who dance with bottles poised on their heads, trying not to drop the bottle.
- 97 It is also important that the Commissioners have the ability, and indeed the right, to obtain a broad range of information from other government sources to inform their work. And in addition to all of the structural considerations, you need to get the right people in the job.

**Monitoring**

- 98 I think the key function of an independent Mental Health Commission is monitoring. A monitoring commission has the benefit of sitting a little bit outside the system. This gives it the ability to apply pressure to the people or agencies responsible for policy, funding and delivery.

- 99 While a monitoring commission may be interested in the sum of individual complaints and the themes that come out of them, they would not deal with individual complaints.
- 100 In New Zealand, we are introducing a Mental Health and Wellbeing Commission. The primary function of that Commission is a monitoring function, which is going to span the full wellbeing spectrum, from the outer ring of social determinants to the next ring of mental health promotion and prevention, and the inner ring of mental health services and support. In contrast, the previous NZ Commission (which was closed down as an entity in 2012) was very much focused on mental health services; I think that kind of limited focus can reinforce the (problematic) idea of a health-led system.
- 101 In principle, I agree with having a Commission that looks across the whole system and spectrum of wellbeing. That said, I think it will be a huge job for the NZ Mental Health and Wellbeing Commission to manage and execute. That challenge is even greater given that the new Commission also has a range of other aligned functions.<sup>24</sup> For example, the Commission is tasked with promoting “alignment, collaboration, and communication between government and non-government contributors to mental health and wellbeing.”<sup>25</sup> It will also look at how the system (as a whole) promotes wellbeing, builds resilience and identifies and responds to people experiencing mental distress, and the people who support them.

#### **Other functions?**

- 102 Other potential functions of a Mental Health Commission include funding (e.g. Western Australian Mental Health Commission) and complaints (e.g. the Victorian Mental Health Complaints Commissioner). For my part, I think limiting the Victorian Commissioner’s functions to complaints was a mistake because a complaints commission has far less scope, levers and influence than a monitoring commission. In relation to funding commissions, I think there is a compelling argument that once a commission engages in funding, they become part of the system and then they’re no longer independent.

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<sup>24</sup> The wide-ranging functions of the Commission are set out in the Mental Health and Wellbeing Commission Bill 2019, which is currently at Third Reading stage: New Zealand Parliament, Mental Health and Wellbeing Commission Bill <[https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL\\_93099/mental-health-and-wellbeing-commission-bill](https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_93099/mental-health-and-wellbeing-commission-bill)> [accessed 4 June 2020].

<sup>25</sup> Mental Health and Wellbeing Commission Bill 2019, section 11(1)(d) <<http://legislation.govt.nz/bill/government/2019/0188/latest/LMS281163.html>> [accessed 4 June 2020].

## Lived experience in governance

### ***Ensuring that people with lived experience have a meaningful and enduring voice in decision-making***

- 103 There is still a lot of stigma, discrimination and negative assumptions about people with lived experience in the mental health system. I think some people still hold a view that people with lived experience don't possess the capabilities required to perform certain roles. There needs to be greater recognition of the expertise, supports and services that people with lived experience have to offer.
- 104 There is a good evidence base for the effectiveness of peer support for people in mental distress.<sup>26</sup> In fact, peer support has a better evidence base than many other interventions currently delivered in mental health services, such as acute inpatient wards.
- 105 We need to nurture peer-led organisations and grow the peer workforce. The way the system currently operates, peer-led organisations tend to be poorly funded and they can't grow because all of the resources are essentially gobbled up by Big Psychiatry and the standard NGOs.
- 106 Importantly, roles for people with lived experience should not be limited to roles that require lived experience, like a peer support role. Rather, we need to develop the capacity for people with lived experience to take on generic roles – to be the managers, receptionists, chief executives, analysts, social workers, doctors or nurses. This would be one solution to the problem of low labour market participation of people with mental distress.
- 107 One very simple way to support people with lived experience to enter or re-enter the workforce is to expressly say in job advertisements that applications from people with lived experience and mental distress are especially welcomed. This can help to break down the stigma.
- 108 In addition, people who have experienced mental distress have often had an interrupted education. It would be fantastic if there were scholarships available so they can go and resume their education, because that is the first step on the ladder toward career advancement for most people. The government should really step up and provide that sort of financial support.

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<sup>26</sup> See, for example, Flick Grey and Mary O'Hagan, *The effectiveness of services led or run by consumers in mental health: rapid review of evidence for recovery-oriented outcomes: An Evidence Check rapid review brokered by the Sax Institute for the Mental Health Commission of New South Wales*, August 2015, <<https://nswmentalhealthcommission.com.au/resources/the-effectiveness-of-services-led-or-run-by-consumers-in-mental-health-rapid-review-of/>> [accessed 4 June 2020].

### **Elevating the peer support workforce**

- 109 In New Zealand, we have been developing peer support for the last 20 years, and yet there has never been a wholehearted, sector-wide, well-resourced approach to developing the peer workforce. As a result of that very lacklustre effort, the peer support workforce only makes up around 4% of the whole mental health and addictions workforce in New Zealand.
- 110 We know from other past experience that it is possible to effectively roll out and elevate a new workforce. For example, in the early 1990s a new workforce called Community Support Workers emerged. There was a very concerted roll out of that workforce and it remains a key part of the fabric of the mental health and addiction workforce today. Frustratingly, there has not been the same roll out of the peer support workforce.
- 111 In my view, we cannot just leave the task of building the peer support workforce up to the goodwill of individual service providers. I think we need genuine political leadership, commitment and funding to roll out the peer support workforce in communities and in primary and specialist mental health services. The ideal time to develop a new workforce is when there is new money coming into the sector. While we do have a lot of new money being invested in the sector, I don't see the political leadership and commitment we need for the peer support workforce.

### ***Giving greater voice to the values and preferences of people with lived experience***

- 112 In my view, the reforms we need are not about 'giving greater voice' to people with lived experience. Rather, we need to transform the system from within, so that those voices are central to the discourses and are deeply heard. We need to change the whole way we think about people with distress and about the system, so that we make decisions and distribute resources in a way that creates the space for the lived experience voice to be strong. Otherwise, the values and preferences of people with lived experience are no more than an afterthought, tacked on to a system that doesn't truly notice or value them.

### ***Supporting peer-led organisations to flourish***

- 113 As I mentioned above, PeerZone is a social enterprise that delivers individual and group based peer support. As a small business, one of the big difficulties we faced at PeerZone was that there were not many organisations in the mental health marketplace who wanted what we were offering – because the system is skewed towards 'pills and pillows' responses and traditional community service responses.
- 114 For as long as we have a Big Psychiatry system, peer-led organisations will not flourish as they can and should. It is not enough to just to tick the box by investing in a few peer workers. If the system itself is alienating to peer workers, if there isn't an awareness of

how best to utilise peer workers and if there are not funding streams from which peer works can expand their service delivery, then the system is merely setting peer workers up to wither on the vine.

- 115 To support peer-led organisations to flourish, we need to address the way the system as a whole is organised and the biases in the system which influence how we think about and value different ways of responding to people in distress. Peer-led organisations would thrive if we had a Big Community lived experience centred system.
- 116 In my observation, NGOs have more freedom to innovate than public or clinical services. An example of an organisation in New Zealand that supports innovation is Piri Pono, which is a community-based, peer-led acute residential service. Despite the demands from and challenges with the health funder, this service has held to the peer values of self-determination, participation, equality, lived experience knowledge and mutuality, without any of the 'critical incidents' seen in our hostile and unsafe acute units.<sup>27</sup>

### ***The necessary capabilities and skills of lived experience workforces***

- 117 In my view, our focus should not be on how to support people with lived experience to develop the skills and abilities to run mental health organisations. We need to locate the deficits in the *system* and not in people with lived experience. We need to remove the biases in the system so that people with lived experience are on a level playing field with equitable opportunities for education, career advancement and to work in a system as essential workers, where they are respected and their values are upheld. That system does not exist now.
- 118 Like any other business leaders, people running independent peer-led organisations should bring in people with particular expertise where that is required – if a person has both a lived experience and the particular expertise required, that is great. However, I don't see why a peer-led organisation cannot also draw on expertise from the wider world.

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<sup>27</sup> For further discussion of Piri Pono, see Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, November 2018, page 116 <<https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf>> [accessed 4 June 2020]. See also: Centre for Public Impact, 'Piri Pono – a peer-led acute residential service in New Zealand' <<https://www.centreforpublicimpact.org/case-study/piri-pono-peer-led-acute-residential-service-new-zealand/>> [accessed 4 June 2020].

***What is needed to support innovation***

- 119 Over the last 200 years the fundamentals of the mental health system have not changed much – it continues to be a psychiatry-led system that pours most of its research, workforce, attention and resources into the main tools of public psychiatry – hospitals, psychiatric treatments and the Mental Health Act. Big Psychiatry and its tools do significant harm and often have a weak evidence base. But I learnt some time ago that reason, evidence and ethics are not the main drivers of the system – instead the drivers are vested interests and a blinkered adherence to the status quo. It takes leaders at all levels with courage and imagination to drive deep change. The status quo, as flawed as it is, has all the advantages of incumbency and familiarity. There are rare moments when the waves crest for change. We need to seize those moments to take us further on the journey from Big Psychiatry to Big Community.

sign here ►



print name Mary O'Hagan

date 16 June 2020



**Royal Commission into  
Victoria's Mental Health System**



## **ATTACHMENT MOH-1**

This is the attachment marked 'MOH-1' referred to in the witness statement of Mary O'Hagan dated 16 June 2020.

# MARY O'HAGAN CV

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## SUMMARY AND HIGHLIGHTS

I have been involved in mental health and disability issues for over 30 years, initially as a user of mental health services – then in various advocacy, advisory, provision, entrepreneurial, funding, consultancy, board and commissioner roles – at the local, national and international levels.

My work strengths are vision, strategy and innovation. My personal strengths are persistence, collaboration and respect for all people. My most significant contributions have been expressed through writing, speaking and developing new frameworks, approaches and products.

I initiated the mental health service user movement in New Zealand in the late 1980s and was the founding chairperson of the first worldwide network by and for people with mental distress in the early 1990s (World Network of Users and Survivors of Psychiatry).

From 2000 to 2007 I was one of three commissioners at the Mental Health Commission of New Zealand. I have been a mental health advisor to the United Nations and the World Health Organization, as well as an international keynote speaker, consultant and workshop facilitator.

For 20 years I was an international leader in the recovery movement in mental health services, particularly at the level of system transformation and empowerment for people who use services.

From 2007-2018 I was an international consultant in services and system transformation, peer workforce and social inclusion. I have created a social enterprise, PeerZone, that develops resources and supports for people with mental distress and the people who support them. I am currently the Programme Lead for the Like Minds, Like Mine Programme at the Health Promotion Agency.

I have written an award-winning memoir called 'Madness Made Me'. I was made a Member of the New Zealand Order of Merit for services to mental health in 2015 and was awarded the Wellington Gold Awards New Thinking Award in 2017.

All my work has been driven by the quest for social justice for people who experience severe mental distress. This is of the most marginalised groups in the community and many experience multiple inequities, particularly Māori. I am continually learning how to support the practical expression of Te Tiriti o Waitangi in the work I do.

## WORK POSITIONS

2020	<b>Manager Mental Wellbeing, Te Huringa Hauora   Health Promotion Agency</b> , responsible for strategy and delivery of Like Minds, Like Mine as well as wellbeing promotion campaigns and community partnerships.
2019 -2020	<b>Programme lead, Like Minds, Like Mine, Te Huringa Hauora   Health Promotion Agency</b> , working on the Like Minds strategic direction and transition for New Zealand's programme to uphold the mana and human rights of people with mental distress.
2018-2019	<b>Principal advisor mental health and consultant, Te Huringa Hauora   Health Promotion Agency</b> working on the Like Minds, Like Mine Programme, the National Depression Initiative and the development of a wellbeing approach in health promotion.
2007 on	<p><b>Director PeerZone, social entrepreneur and international consultant</b> in Australia, New Zealand, the Netherlands, the United Kingdom, Canada, Hong Kong and Denmark, specialising in:</p> <ul style="list-style-type: none"> <li>• <b>System transformation</b> – Service and programme reviews; development of systemic recovery measures; research and publication of vision statements, including the Wellbeing Manifesto – a major submission to the Mental Health and Addiction Inquiry.</li> <li>• <b>Peer support</b> – research and reviews of peer support; development and delivery of one-to-one and group peer support.</li> <li>• <b>Lived experience perspectives</b> – Writing from a lived experience perspective on systemic advocacy; population wellbeing; insurance discrimination; compulsory treatment.</li> </ul>
2000-2007	<p><b>Commissioner, Mental Health Commission</b>, appointed by the Minister of Health</p> <ul style="list-style-type: none"> <li>• A member of the Board.</li> <li>• Sponsored Commission's recovery, consumer participation and anti-discrimination workstreams.</li> <li>• Thought leadership through writing, speaking and media engagements.</li> <li>• Represented the Commission nationally and internationally.</li> </ul>
1996-2000	<p><b>Self-employed consultant</b></p> <ul style="list-style-type: none"> <li>• Various reviews and reports.</li> <li>• Member of anti-discrimination team, Mental Health Commission.</li> <li>• Wrote the recovery content for the Mental Health Commission's Blueprint.</li> </ul>
1993-1996	<b>Project Manager, Consumer Development, Northern Regional Health Authority</b> , New Zealand – developed processes for consultation with service users, purchased consumer run initiatives and new services, took part in monitoring.
1992-1993	<b>Consultant, Centre for Mental Health Services Development, Kings College London</b> , England – developed user participation in Health Authority districts where the Centre was providing advice on community-based services.
1990-1992	<b>Manager, Aotearoa Network of Psychiatric Survivors (ANOPS)</b> – set up and developed the consumer run organisation to provide information, networking and representation for service users nationally.
1986-1989	<b>Coordinator, Psychiatric Survivors, Auckland</b> – set up and developed consumer run self-help and advocacy organisation – the first of its kind in New Zealand.

## NEW ZEALAND LEADERSHIP ROLES

2019	<b>Abuse in State Care Royal Commission of Inquiry</b> - Expert witness to contextual hearings on abuse in mental health services.
2016-2017	<b>'Fit for Purpose' reference group</b> set up by the Ministry of Health – member. <b>'Mental Health Act' reference group</b> set up by the Ministry of Health – member.
2013-2015	<b>Richmond Services Ltd</b> (a national mental health NGO in New Zealand) – board member.
2006-2009	<b>Frozen Funds Charitable Trust Board</b> , first chairperson – funds service user-run initiatives in the mental health and intellectual disability sectors in New Zealand.
2000	<b>New Zealand Disability Strategy</b> , Ministry of Health, Sector Reference Group member.
1997-2009	<b>Like Minds, Like Mine</b> , Ministry of Health, Advisory Group for TV advertising campaign to reduce mental health discrimination.
1998-2000	<b>Mental Health Commission</b> , Advisory Board member.
1995-1996	<b>National Workforce Development Taskforce</b> , Ministry of Health – consumer representative.
1995-1996	<b>National Mental Health Strategy Advisory Group</b> , Ministry of Health – consumer representative.

## GLOBAL LEADERSHIP ROLES

2020	<b>Royal Commission into Victoria's Mental Health System</b> – expert witness at public hearing on mental health system transformation (pending)
2004	<b>United Nations, development of Convention on the Rights of Persons with Disabilities</b> . Member of New Zealand delegation to meeting in New York.
2002	<b>International Foundation for Electoral Systems</b> & Institute for Democracy and Electoral Assistance. Represented people with psychiatric disabilities and contributed to a bill of electoral rights and standards for disabled people.
1999-2001	<b>World Health Organisation</b> , Disability and Rehabilitation Unit's Rethinking Care Project – Advisor, report writer and speaker.
1995-2001	<b>United Nations</b> panel to monitor 'The Standard Rules on the Equalization of Opportunities for People with Disabilities' – mental health representative.
1991-1995	<b>World Federation for Mental Health</b> – board member.

1991-1995    **World Network of Users and Survivors of Psychiatry** – first chairperson and facilitator of meetings to form the network.

## SELECTED KEYNOTE TALKS

- 2016 **International Network towards Alternatives and Recovery (INTAR)** Conference, Pune, India – speaker on lessons from 30 years of social change work.
- Australian and New Zealand Mental Health Association** – 17<sup>th</sup> International Conference – keynote speaker on the need for system transformation.
- Auckland Writers Festival** – gave talk on ‘Madness Made Me’.
- Victorian Mental Illness Awareness Council (VMIAC)** Conference – keynote speaker on an alien view of mental health services on Planet Earth.
- 2013 **Kings College London**, Refocus on Recovery Conference – keynote speaker on international overview of peer support.
- 2012 **Australian College of Mental Health Nurses**, Darwin – keynote speaker on recovery-based systems.
- 2009 **Scottish Recovery Network** Conference, Perth, Scotland – keynote speaker on the fit between recovery and wellbeing.
- 2007 **The Australian and NZ Mental Health Services (THEMHS)** Conference, Melbourne – keynote speaker – on a vision for a recovery-based service system.
- 2005 **World Association for Psychosocial Rehabilitation**, Athens – keynote speaker on service user leadership in mental health services.
- 2004 **World Association for Psychosocial Rehabilitation**, Milan – invited speaker on recovery at service user conference.
- 2002 **Disabled Persons International** World Assembly, Sapporo, Japan – invited speaker and speaker at several other seminars and conferences.
- 2001 **World Health Organization**, Rethinking Care Conference, Oslo – invited speaker on rethinking care from psychiatric disability perspective.
- 1997 **International Leadership Forum for Women with Disabilities**, Washington DC – keynote speaker giving a comparative analysis of the women’s movement and the disability movement.
- 1996 **Rehabilitation International** World Congress, Auckland – keynote speaker on equality through participation from the perspective of a woman and a mental health service user.
- 1993 **World Congress for Mental Health**, Tokyo, Japan – keynote speaker on the experiences of service users throughout the world and the development of the international service user movement.

## SELECTED PUBLICATIONS

- 2018 **'Wellbeing Manifesto for Aotearoa New Zealand'**. A major submission to the Government Inquiry into Mental Health and Addiction supported by 2,000 signatures and quoted several times in its report 'He Ara Oranga'.
- 2015 **'Madness Made Me: A Memoir'**. Wellington: Open Box. Published by Pottton and Burton in 2015. Awarded Independent Publisher silver medal for non-fiction in the Australia/New Zealand region in 2015.
- 2014 **'Competencies for the mental health and addiction service user, consumer and peer workforce'**. Auckland: Te Pou. Auckland Regional Alliance and Midland Mental Health and Addiction Regional Network.
- 2013 **'Recovery and Wellbeing'** – a chapter in 'Public Mental Health: Global perspectives'. Eds. Lee Knifton and Neil Quinn. Published by Open University Press, England.
- 2009 **'Leadership for Empowerment and Equality: A proposed model for mental health user/survivor leadership'**. The International Journal of Leadership in Public Services, Vol 5 No 4.
- 2009 **'On Being One of Them'** – a chapter in 'Stepping Out of the Shadows: Reflections on madness and self-stigma'. Eds. Debbie Peterson and Sarah Gordon. Published by Case Consulting, Wellington.
- 2008 **'Destination: Recovery: Future responses to mental distress and loss of wellbeing'**. Mental Health Foundation.
- 2006 **'The Acute Crisis'** – Towards a recovery plan for acute mental health services in New Zealand. Mental Health Commission.
- 2004 **'Force in Mental Health Services: International user survivor perspectives'**. Mental Health Practice, Vol 7 No 5.
- 2004 **'Our Lives in 2014 – A recovery vision from people with experience of mental illness'**. Mental Health Commission.
- 2001 **'Recovery Competencies for New Zealand Mental Health Workers'** – a resource for mental health workers on how they can practice a recovery approach in their work. Mental Health Commission.
- 1999 **'A Call to Open the Door'** – a paper, from a psychiatric disability perspective, for a publication by the World Health Organisation on 'Rethinking Care' for people with disabilities.
- 1996 **'Two Accounts of Mental Distress'** – a chapter of juxtaposed excerpts from my journal and the hospital notes written about me during an episode of depression – in *Speaking Our Minds*. Eds. Jim Read and Jill Reynolds, Open University, London.
- 1994 **'Stopovers on My Way Home from Mars: a journey into the psychiatric survivor movement in the USA, Netherlands and Britain'** – a book published by Survivors Speak Out, London. Published in Japan in 1999.
- 1989 **'Consumer Participation in Mental Health Services'** – an analysis of neglect, tokenism, paternalism, partnership and self-help in the context of consumer participation - in *National Mental Health Consortium Report*, Departments of Health and Social Welfare.
- 1986 **'From Taking Snapshots to Making Movies'** – a critique of traditional research methods and an alternative method designed to give control of research to service users – in *Community Mental Health in New Zealand*, vol 3 no 1.

## EDUCATION AND AWARDS

2019	<b>Everyday Māori, Level 1</b> - Victoria University Centre for Lifelong Learning.
2107	<b>Wellington Gold Awards New Thinking Award</b> - for intellectual and practical application to the rest of the world in a chosen enterprise.
2015	<b>Independent Publisher silver medal</b> for non-fiction in the Australia/New Zealand region for 'Madness Made Me'. <b>Member of the New Zealand Order of Merit</b> for services to mental health.
1996	<b>Rehabilitation International Distinguished Volunteer Award</b> – for contribution nationally and internationally to the improvement of the quality of life for people with disabilities.
1993	<b>Oranga Kaupapa Trust Award</b> – for 'high achieving people for the work they do to promote positive social change'.
1990	<b>UK Winston Churchill Fellowship</b> – visited the USA, Britain and the Netherlands to report on self-help alternatives and services attempting consumer participation. One of two New Zealand Fellows to be awarded a UK Fellowship to mark the 25 <sup>th</sup> anniversary of Churchill's death. Received a Fellowship medal from the Queen in London.
1977-84	<b>User of mental health services.</b> This is a major qualification for the work I have done.
1976 on	<b>16 papers towards a Bachelor of Arts</b> in English, History, Anthropology, Linguistics, Political Studies, Management and Creative Nonfiction Writing. My tertiary education was stalled by severe mental distress.



**Royal Commission into  
Victoria's Mental Health System**

## **ATTACHMENT MOH-2**

This is the attachment marked 'MOH-2' referred to in the witness statement of Mary O'Hagan dated 16 June 2020.



# Wellbeing Manifesto

## for Aotearoa New Zealand

A submission to the Government Inquiry  
into Mental Health and Addiction

Prepared by Mary O'Hagan for PeerZone and ActionStation

## The problem

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

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

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

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

More of the same will not fix the problem.



## What is Big Psychiatry and Big Community?

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



# Our calls to the Mental Health Inquiry

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

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

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

## 1. Commitment to the seven wellbeing priorities

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

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

## Foundational principles of wellbeing

The foundational principles of wellbeing<sup>1</sup> underpin Big Community. They are unique to New Zealand and incorporate Te Pae Mahutonga (a health promotion framework) and Te Whare Tapa Whā (the dimensions of wellbeing), both developed by Mason Durie.

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

## 2. Comprehensive responses available to all

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

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

☆	Wellbeing promotion and self-management	📎	Education and employment supports
🏠	Stable housing	\$	Income support
❤️	Whānau and parenting support	⚡	Community and home-based crisis support
🔗	Psychiatric treatments	🌀	Cultural and spiritual healing
✚	Physical healthcare	✳️	Community connection
😊	Talking therapies	🕒	Advocacy and navigation

## The Big Community wheel of responses and workforces



Note:

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

### 3. Major expansion of peer and cultural workforces

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

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

The three workforces need to have the capacity to:

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

## Tikanga Māori

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

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

## Peer Workforce

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



## 4. Multi-sector planning and funding

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

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

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

### Improving equity and outcomes

*(Continued on next page)*

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

#### *Use of services and welfare benefits*

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

### *People with 'serious mental illness'*

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

### *Compulsory treatment*

- Community treatment orders 'do not result in better service use, social functioning, mental state or quality of life compared with standard voluntary care'.<sup>10</sup>
- In 2014:
  - 103 people per 100,000 were on inpatient or community treatment orders on any given day<sup>3</sup> – this rate is extremely high by New Zealand historical standards<sup>11</sup> and international standards<sup>12,13</sup>.
  - There was 6-fold variation in the use of community treatment orders and a 15-fold variation in the use of inpatient orders, between District Health Boards.<sup>3</sup>
  - Māori were 3.5 times more likely to be subject to a community treatment order than non-Māori.<sup>3</sup>
  - Māori were secluded almost four times more than non-Māori.<sup>3</sup>

### *Suicide*

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

## 5. Integrated community delivery

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

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

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

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



## 6. Active government

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

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

## Human rights

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



## Sign up to the Wellbeing Manifesto

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

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

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

Visit the Wellbeing Manifesto Facebook page at

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

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

# References

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21. Pūras, D. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Geneva: United Nations Human Rights Office of the High Commissioner.



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

<https://www.peerzone.info>



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

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

## The People's Report on Mental Health

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

For info on the People's Report go to

<https://www.peoplesmentalhealthreport.com>



## Acknowledgements

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

## Contact

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For more information, and to download this document, visit:  
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