



## Submission to the Ministry of Health on *Mental Health and Addiction System and Service Framework 2022-2032*

### INTRODUCTION

1. Thank you for the opportunity to submit on the Mental Health and Addiction System and Service Framework 2022-2032. Transforming our Mental Health and Addictions system to ensure it promotes mental wellbeing whilst providing quality care to those who require services is essential going forward.
2. For too long, social workers have felt the frustration of working within an inequitable system where services are not accessible until very late in a client's journey with mental illness. We have watched the despair of whānau who feel powerless within traditional biomedical approaches to mental health treatment, despite a 'recovery approach' being the dominant rhetoric since the first Blueprint was released in 1998<sup>1</sup>.
3. We welcome this framework as it signifies a significant step change from outdated values and approaches. Both principles and critical shifts as detailed in the consultation document are highly aligned with social work professional values and ethics<sup>2</sup>. Our values and ethics, which over our long history as a profession have become the foundation by which we establish caring and respectful relationships to empower and enable change in individual and whānau circumstances, promoting autonomy and self-determination, respect, and mana-enhancing collective responsibility to improve individual and community wellbeing. This framework suggests transformation at all levels, and we hope it will result in professionals partnering with individuals and their whānau, family, hapū, iwi, and support networks to achieve the holistic concept of pae ora<sup>3</sup>.
4. We thank you for facilitating a hui with our members who practice within the mental health setting. The following is a summary of the points raised with some additional content gathered since.

<sup>1</sup> Ministry of Health. (2012). Blueprint II. Improving mental health and wellbeing for all New Zealanders: How things need to be. Retrieved from: <https://www.hdc.org.nz/media/1075/blueprint-ii-how-things-need-to-be.pdf>

<sup>2</sup> ANZASW. 2019. Code of Ethics. Retrieved from: <https://www.anzasw.nz/public/150/files/Publications/Code-of-Ethics-Adopted-30-Aug-2019.pdf>

<sup>3</sup> Ministry of Health. (2015). Pae ora – healthy futures. Retrieved from <https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures>

### PRINCIPLES

5. We support both the system-wide and practice principles detailed in the consultation document and are pleased to see the overlay of Te Tiriti o Waitangi principles across system objectives. We strongly support the transfer of decision making and commissioning power through to the Māori Health Authority and Iwi Māori Partnership Boards to ensure the design and delivery of mental health services for Māori encapsulates mātauranga Māori and elevates rongoā to its rightful place within treatment options.
6. We caution around the use of ‘trauma-informed’ as a principle. Trauma-informed risks pathologising individuals by focusing on the relationship between their individual experiences and their current presentation. It minimises other contributing environmental and social factors on wellbeing, such as poverty, homelessness, or the impacts of colonisation. There are definitional issues arising with the concept of trauma with the DSM classifying a traumatic experience as “actual or threatened death, serious injury, or sexual violence”, which does not fully encapsulate all experiences that may cause an individual to feel distress (i.e., divorce, losing a job, the death of a loved one, becoming homeless). We would recommend that a **determinants-informed principle** is more appropriate to ensure all experiences and impacts are considered.
7. We recommend that the principle ‘strengths-based’ is amended to ‘strengths based and safety-focused’ in reference to the high rate of complex social issues faced by those seeking mental health services, such as family violence, insecure housing, poverty, and self-harm. For example, there can be a strong relationship between family violence and mental health and addictions<sup>4</sup>. The framework needs to consider and explicitly incorporate concurrent psychosocial issues which impact on personal safety to ensure this is front of mind for mental health practitioners, whilst drawing on the strengths of the individual *and* their whānau. We recommend including the strengths of the whānau in this section as well.
8. We have concerns about the statement ‘compulsory treatment will be rare and brief’ within the ‘Strengths-based’ principle. This does not encapsulate the seriousness of compulsory treatment in relation to a deprivation of human rights. We recommend that reference to compulsory treatment includes the direction that it may only be used in situations where an individual’s will and preference would result in significant risk of imminent and serious harm to self or others, and treatment must be the least restrictive measure, brief and proportionate. Similarly, in the description, this principle should also specify that restraint and seclusion should be avoided given such practices are incompatible with strengths-based approaches. We would support a framework where compulsory treatment, seclusion and restraint aren’t available as management options at all, however, realise that this is an aspirational goal.
9. We recommend that ‘supported decision making’ is also specifically identified as a system-wide principle. The supported approach should adapt for an individual’s capacity, and an individual’s family/whānau, hapū, iwi, and family group should be involved in this process. This again mitigates against traditional biomedical approaches of medical expert decision making, and clearly communicates that substituted decision-making practices are no longer fit for purpose within a human-rights based approach. Central to the approach is the implementation of external support

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<sup>4</sup> Mason, R., Wolf., M., O’Rinn, S. & Ene, G. 2017. Making connections across silos: intimate partner violence, mental health, and substance use. BMC Women’s Health, 2017, 17:29.

<https://bmcmenshealth.biomedcentral.com/articles/10.1186/s12905-017-0372-4>

mechanisms, including ensuring access to programmes and support to enhance quality of life. Consideration and addressing the social determinants of mental health becomes essential. Furthermore, an individual's culture and worldview must be a paramount consideration within this approach.

## CRITICAL SHIFTS

10. The framework represents a significant step change from previous Blueprints. Social workers already practice according to these principles so are key allies for the Ministry of Health in implementing these changes. However, we have very recently seen evidence of the persistent biomedical narrative via the mental health workforce "Are You Ready" campaign<sup>5</sup>. This campaign has prioritised need for medical mental health nurses over professions such as social work, who already possess the practice approaches, knowledge, and skills to support individuals and whānau in a way which is entirely consistent with the aspirations of this framework.
11. In light of this, we recommend that careful consideration is given to the process of embedding the framework within training institutions which are traditionally focused on a biomedical approach (a deficit based, fix-it model) to wellbeing. Additionally, this challenge extends to the existing widely medicalised workforce. Human rights based, whānau-centred and holistic approaches are currently overshadowed by the positioning of medical professionals as experts, prioritising their knowledge and value base in offering limited treatment options<sup>6</sup>. Professions such as social work often feel undervalued by medical staff in this setting, as they do not practice within this biomedical lens. Prioritising different practice approaches must occur for this framework to be effectively implemented.
12. We note the critical shift around tailoring services for life-stages and population groups with the goal of improving equity. However, we want to be sure past mistakes of creating age-determined siloes for services is not repeated. If we are to be whānau-centred, we must eliminate hard transitions between services and 'age eligibility', given that chronological age does not always correlate to life stage. We recommend that the age ranges on the landscape diagram are removed, and broad life-stage categorisations or a service continuum is used instead to reduce the likelihood that hard age criteria are implemented by designers and commissioners and promote continuity of care.

## KEY FEATURES OF SERVICE LANDSCAPE

13. We do not feel a person's journey through 'the system' has been mapped when developing the SSF services landscape. Holistic wellbeing and an emphasis on the determinants of mental health need to be considered. The service landscape diagram currently conveys that mental health difficulties are experienced and treated in isolation from each other, and in isolation from related social stressors which is not the reality for many. We recommend an integrated service framework which places the person in the centre, contextualised within their environment, with the goal of consistency of support and as few service transitions as possible.

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<sup>5</sup> Ministry of Health. (2021). Mental Health and Addiction Nursing Recruitment. Retrieved from: <https://www.health.govt.nz/our-work/mental-health-and-addiction>

<sup>6</sup> Cooper, S. (2016). Global mental health and its critics: moving beyond the impasse. *Critical Public Health*, 26:4, 355-358. DOI: 10.1080/09581596.2016.1161730

14. We recommend that technology equity is carefully considered when making decisions around access for locality-based and multi-locally services. The growth and availability of digital tools is strongly supported and hugely valuable in improving access for certain population groups such as younger people or those with disabilities. However, we still have several rural or geographically isolated communities across the motu where internet access is problematic, creating a digital barrier to services. Additionally, access to smartphones, laptops or ipads is limited for whānau and communities who experience financial hardship and are unable to pay for these items, internet connections or data. Lastly, there are still groups of the population who struggle with digital literacy, and so accessing services remotely is an additional stressor for them.

## SYSTEM ENABLERS

15. Investment - we recommend that communities are resourced adequately to provide tailored services within their neighbourhoods. Early intervention with whānau in the community would best reflect the principles of the framework, however at present prescriptive commissioning arrangements has resulted in an 'ambulance at the bottom of the cliff' situation where whānau must meet certain eligibility criteria for community services to obtain funding to support them. To tackle the determinants of mental health, we need to take a different approach and invest early in whānau wellbeing, providing more options, particularly around maternal mental health, and support of whānau with young children which have lifelong impacts.
16. Workforce – it is important to reiterate the value of social workers within mental health. There is a very clear need for the Ministry of Health to acknowledge and help elevate the social work profile within this setting. Current power imbalances and hierarchical structures within the mental health setting prioritise psychiatric and nursing roles which limit the impact professions, such as social work, can have in this important sector. Rebalancing these power structures is likely to attract more social workers into this field and ensure the mental health workforce retains the personnel with the right skills to achieve this system change and support pae ora for all who have contact with the mental health and addictions system.

## CONCLUSION

17. Thank you for providing the opportunity to submit on the Mental Health and Addiction System and Service Framework. We strongly support the direction communicated by the Ministry of Health in this document. Our population's mental wellbeing is too important to continue down the path we have been travelling for the past 2 decades.
18. We look forward to seeing how these principles and system shifts will be implemented and welcome any further opportunity to work with the Ministry around implementation.

## ABOUT ANZASW

The Aotearoa New Zealand Association of Social Workers (ANZASW) is the professional association for social work in Aotearoa New Zealand. We have over 3,600 members who work throughout the community in both statutory social work and community social work settings. We advocate on behalf of members for social change and justice.

### Definition of social work

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice,

human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing.<sup>7</sup>

### **Social work in Aotearoa New Zealand**

Social workers in Aotearoa are required to be registered with the Social Workers Registration Board. Social workers are registered under the Social Workers Registration Act 2003 and are not included in the Health Practitioners Competence Assurance Act 2003.

### **Contact details**

If you have any questions or require any clarification about this submission, please contact:

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<sup>7</sup> Global Definition of Social Work - International Federation of Social Workers and International Association of Schools of Social Work