Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

18 May 2018

Professor Ron Paterson
Chair of the Government Inquiry into Mental Health and Addiction
PO Box 27 396
WELLINGTON 6141

By email: mentalhealthinquiry@dia.govt.nz

Dear Professor Paterson

Request for information — HDC views

This letter expands on my initial response to your request for information, dated 6 March 2018, in relation to HDC "views on what is working well in mental health and addiction (as well as suicide prevention), where the gaps and unmet needs are, who you feel the priority groups are and where the focus should be in the future". I also respond to the question asked in your consultation document — "[W]hat sort of society would be best for the mental health of all our people?"

In summary, this submission outlines:

- The growing pressure on acute and community mental health and addiction services;
- Known areas for improvement, including: improving outcomes for Māori, people in prison, and children; reducing seclusion and other coercive practices; continuity of care; shared care planning and physical health and social outcomes;
- A need for earlier and broader responses to mental health and addiction need — more of the same responses will not deliver the well-being and recovery-oriented system that is desired;
- The encouraging work being undertaken by the sector to address issues and deliver innovation;
- A loss of traction to deliver timely and meaningful change across the whole system;
- A need for collaborative leadership to align the sector to shared goals, plans, practices and culture, and to implement change, and some measures to achieve this;
- The need for a statutory requirement, similar to that for disability, for an all-of-government mental health strategy to improve the mental well-being of New Zealanders, including through primary, community, and secondary health services; and
- HDC's support for the establishment of a new Mental Health Commission to provide strong, independent monitoring of, and advocacy for, a mental health strategy. The new Commission should be seen as an important component of sector leadership and accountability, not the only component. It should have a broad mental well-being and recovery focus, clear functions, independence, and adequate powers and resources.

Focus and scope of submission

I am making this submission on behalf of the office of the Health and Disability Commissioner. My role, as Mental Health Commissioner, is delegated pursuant to the Health and Disability Commissioner Act 1994 and has two major responsibilities:

1. To ensure that the rights of consumers of mental health and addiction services are upheld. An important aspect of this is making decisions on over 200 complaints each year in relation to mental health and addiction services; and
2. To monitor and advocate for improvements to mental health and addiction services.

My statutory monitoring and advocacy role is focused on mental health and addiction services, which I take to include all health and disability services that respond to mental health and addiction need (e.g., primary care, ACC, and private providers, as well as specialist services). Prevention, health promotion, community activity, and services that are not health or disability services are outside of my legislative scope but are important context for understanding service performance.

As you are aware, in February this year I released a public monitoring and advocacy report into mental health and addiction services, drawing on information from complaints, consumer and whānau feedback, sector engagement, and performance information. I provided you with this report and other relevant documents in my letter to you of 6 March 2018, and I have attached it again for your convenience. The report focuses on the performance of publicly funded Vote Health and Vote Corrections services in their response to the needs of people with mental health and addiction issues at a national level.

This submission should be considered alongside my report, which forms the basis of this submission. I also expand on system leadership and oversight, and considerations for a new Mental Health Commission.

Findings of *New Zealand's Mental Health and Addiction Services — The monitoring and advocacy report of the Mental Health Commissioner*

What is working well?

In my report I identify many areas where services are working well or showing promise:

- A range of innovative service delivery models are being trialled to integrate primary and secondary responses to get people the support they need quickly and in a range of settings.
- Outcome measures suggest that people generally improve in services; and the majority of consumers and their family and whānau report positive experiences of services through our Mārama Realtime Feedback survey.
- There are many existing well-being models of care that are being used to respond to the whole person's needs, such as Te Whare Tapa Whā.
- Interventions that show promise in randomised control trials, including e-therapy and peer support, are growing.
- The development of mental health and addiction services by the Department of Corrections (while noting that continued effort is needed to ensure that services keep up with a rapidly rising prison population).
- A commitment by the Ministry of Health to re-introduce the collection and reporting of discharge planning information.

The sector is also working to address a number of the service quality concerns I identify in my report, including through the Mental Health and Addiction Quality Improvement Programme led by the Health Quality & Safety Commission. Other learning and quality improvement forums also exist, including the Key Performance Indicator Programme, the clinical leadership forums (including the General Managers and Clinical Directors group), sector leadership days, and the national consumer and family/whānau advisors forums.

I also acknowledge the Government's commitment to address pay issues for mental health and addiction workers arising from pay equity settlements, to ensure that workforce capability is retained.

Gaps and unmet needs

While growing numbers of New Zealanders are accessing health services for mental health and addiction issues, these services are under pressure, and many needs are left unmet. Often services are available to people only once their condition deteriorates, and the dominant treatment options (medication and therapy) do not address the broader social factors that help people be well and support their recovery. Areas I am concerned about are set out below and reinforced by the complaints we receive about mental health and addiction services:

- A lack of early intervention options;
- Low commitment by services to shared planning with consumers and their family and whānau. Many of the family and whānau to whom I and my team spoke for my report identified a lack of services to support them;
- Coordination challenges within and between services, including difficulties joining up with Oranga Tamariki for children in care, and between mental health and addiction services for people with co-existing needs;
- High users of compulsory treatment, especially for Māori;
- Stagnation in seclusion reduction;
- Poorer physical health outcomes for people with serious mental health and/or addiction issues; and
- Disparity in outcomes for Māori and other population groups.

There are signs of workforce pressure. Challenges for the mental health and addiction workforce include: recruitment and retention; funding pressures; working with diverse cultures; under-representation of Māori and Pacific health professionals; and supporting and growing the peer and consumer workforce.

The quality of data to identify need and service response to need is also concerning. The last national mental health and addiction survey to establish prevalence and help-seeking behaviour, *Te Rau Hinengaro,* was published in 2006 and misses many important groups including children, people outside of households, and people with less common conditions. While the PRIMHD database provides a rich source of information about DHB services, it does have quality issues that prevent the data from being used as well as it could be, and NGO information is patchy. In contrast, data in relation to primary and community care services is extremely limited, which is of concern given the need to expand early intervention and other primary and community care responses. I am also concerned that there is no reporting on pharmaceutical use in inpatient units. With the drive to eliminate seclusion, it is important that chemical restraint is monitored to ensure that it is not used inappropriately as an alternative option.

Priority groups

My report looked at service performance in relation to Māori, Pacific peoples, infants and young people (including children in care), and people in prison, because of known high levels of need and disparity in outcomes for those groups compared to the general population. The Government also has specific obligations to Māori to honour the Treaty principles of partnership, participation, and protection in the design and delivery of services.

There are many other groups who experience high need and disparity of outcome and require tailoring of responses to be effective. Feedback from the sector in developing my report suggests that other priority groups include: people with disabilities; people with both mental health and addiction issues; older people; people in rural communities; lesbian, bisexual, gay, transsexual, asexual, intersex + communities; Asian communities; migrant and refugee communities; and people in contact with the criminal justice system (not just the prison population). There is a lack of comprehensive and robust information about many of these groups in order to identify need and assess the extent to which services are meeting their needs. An evidence base needs to be built in order to understand diversity of need and to support appropriate responses.

Mental health and addiction also covers a wide range of need, experience, and system response. Care must be taken to ensure that addiction is not subsumed into mental health. The alcohol and other drug sector has particular characteristics that set it apart, including its commitment to NGO partnering, its relationship with the criminal justice system, and the absence of investment in any public de-stigmatisation campaign. Likewise specialist services also have distinct issues and characteristics that need to be considered, including in relation to eating disorders, transgender support services, and problem gambling.

Where the focus should be in the future

More of the same will not deliver the well-being and recovery-oriented system that is required. A broader range of health interventions is needed, to be available earlier, and be better connected into other community and social supports. The health sector needs to be seen as only one part of an effective system response.

At the same time, action is required to relieve pressure on existing mental health and addiction services and the workforce that delivers them. Access to these services has grown 73% over the last decade, while funding has grown only 40%. This growth is not sustainable, and does not necessarily respond to what matters to people. Access targets for mental health and addiction services were set over 20 years ago and were based on assumptions of prevalence and service delivery models known at that time. Better information and a broader re-think of system design and financial arrangements is required to understand current and future need and plan for and deliver the right responses across a spectrum of need.

The overarching strategy/plan for service development of mental health and addiction services, *Rising to the Challenge*, has expired. The suicide prevention strategy also has lapsed, despite extensive public consultation to replace it. There needs to be a new action plan for mental health and addiction to regain traction in the sector and deliver results. This action plan needs to:

- Broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery.
- Increase access to health and other support services.
- Improve the quality of mental health and addiction services.

- Ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice.
- Implement a workforce strategy that enables the sector to deliver better, more accessible services.
- Achieve the required changes through collaborative leadership, supported by robust structures and accountabilities to ensure successful, transparent results.

Specific actions for the Inquiry to consider relate to the Mental Health (Compulsory Assessment and Treatment) Act 1992; suicide prevention; and information collection and dissemination:

- The development of an action plan, in collaboration with Māori experts and leaders, and other sector leaders and providers, to reduce the exceptionally high rate of Compulsory Treatment Orders for Māori.
- The adoption of a specific reduction target in the Government's suicide prevention plan (noting that the World Health Organization suggests a target of 10%, but that some countries may go further).
- The adoption of a goal of zero tolerance of suicides in services, informed by the strategies adopted by Mersey Care, with support for providers to work together to develop a consistent approach in achieving it.
- The introduction of a regular assessment of prevalence, help-seeking behaviour, and access to mental health and addiction services across the whole population, to identify and respond to changing needs.
- The introduction of a requirement on DHB-funded providers to undertake comparable, representative sampling of consumer experience of mental health and addiction services, and to report annually, from 2019, on that information and actions taken to improve services as a result of the information.

I have recommended that the Ministry progress work on changes required to the Mental Health (Compulsory Assessment and Treatment) Act 1992 to ensure that it aligns with current expectations about human rights, supported decision-making and best practice in the provision of therapeutic health services, and with the United Nations Convention and the Code of Health and Disability Services Consumers' Rights so that this can be progressed quickly in any regulatory review following the Inquiry. I also recommended that the Ministry record and, by 2019, report on prescriptions in mental health inpatient units so that any unintended consequences from the zero seclusion programme can be monitored.

There is strong evidence that investing effectively in mental health and addiction can make a positive difference, both to people's health, as well as to the economy — see, for example, reports produced by the World Health Organization, New Zealand Science Advisors, and the Mental Health Commission of Canada.[1] Future investment and service development should be focused on where the evidence suggests greatest impact.

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[1] World Health Organization, *Investing in mental health: evidence for action.* Geneva: World Health Organization, 2013; Gluckman, P, *Toward a Whole of Government/Whole of Nation Approach to Mental Health.* Auckland: Office of the Prime Minister's Chief Science Advisor, 2017: http://www.pmcsa.org.nz/wp-content/uploads/17-08-14-Mental-health-long.pdf (accessed 7 June 2017); *Making the Case for Investing in Mental Health in Canada.* Ottawa: Mental Health Commission of Canada, 2013: https://

What sort of society would be best for the mental health of all our people?

There is strong evidence that social factors (including a person's access to adequate housing, education and employment, the quality of their relationships, and their sense of meaning and purpose) play an important role in personal well-being, recovery journeys, and population outcomes. A society that supports well-being and recovery and positive population outcomes is one that provides people with equitable chances to participate, belong, and thrive in their communities. It addresses negative social contributors such as poverty, violence, and discrimination, and strengthens community connectedness, building of identity, and social and cultural inclusion. Contributions to positive outcomes come from many sectors and emphasise the need for a whole of community, whole of system response.

When people want help for mental distress or addiction, or are supporting others, the right help should be easy to find and available at the right time. Services should be centred on people and what matters to them. Once a person accesses services, those services need to help them to live their life by supporting them to get where they want to be, whatever that means for them.

System leadership and oversight

Current landscape

Like the healthcare sector as a whole, leadership of the mental health and addiction sector sits within a complex structure with disaggregated leadership. There is no single leader, and limited levers to direct (as opposed to influence) change. Collaborative leadership is required to align the sector to shared goals, plans, practices and culture, and implementation of change.

The sector has many parts and many different people and organisations with leadership roles, including the Minister of Health, Ministry of Health (and the Director of Mental Health), the 20 DHBs (with planning, funding, and provider functions), other service providers (including NGOs and primary care providers), professional bodies, workforce organisations, and consumer and family and whānau advisors and representative groups.

There are also a number of watchdog organisations that provide oversight and accountability of the sector, including mental health and addiction services. A snapshot of some of the agencies is provided in Appendix 2.

Beyond the health sector, other social sector Ministers and agencies have roles in collectively setting strategic direction and delivering and overseeing responses that will improve mental well-being and outcomes for people with mental health and addiction issues. In 2013, changes were made to the State Sector Act 1988 to extend the responsibilities of public service chief executives to their Ministers, including matters relating to the collective interests of government, and stewardship of the interests of the Crown and departments in the medium and long term. Changes were also made to the Public Finance Act 1989 introducing multi-category appropriations — making clear that one department can use an appropriation administered by another department.

An Inter-Agency Committee on Drugs (IACD) exists to govern policy development in relation to alcohol and other drugs. IACD membership comprises the Ministries of Health, Justice, Social

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www.mentalhealthcommission.ca/sites/default/files/2016-06/Investing_in_Mental_Health_FINAL_Version_ENG.pdf (accessed 15 January 2018); Mental Health Commission of Canada, *Strengthening the Case for Investing in Canada's Mental Health System: Economic Considerations*. Ottawa: Mental Health Commission of Canada, 2017: https://www.mentalhealthcommission.ca/sites/default/files/2017-03/case_for_investment_eng.pdf (accessed 15 January 2018).

Development, Education, New Zealand Policy, Department of Corrections and New Zealand Customs Service.

Other administrative mechanisms can be developed to deliver collective impact across government and non-government settings.

What is working well?

As noted above, the health sector has a number of forums and programmes in place to share learnings and support quality improvement, including the Mental Health and Addiction Quality Improvement Programme led by the Health Quality & Safety Commission and others.

There are current strategies in place in relation to gambling and alcohol and other drugs: the *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19* and the *National Drug Policy 2015–2020*. Both strategies address prevention, early intervention, and harm reduction, in addition to treatment services, and seek to strengthen communities and apply an inter-sectoral approach.

The Ombudsman and Human Rights Commission monitor places of detention, including mental health inpatient units, and prison units (which have a high proportion of people with mental health and addiction needs). This has resulted in a number of high-profile reports into the treatment of people with mental health need in places of detention, and has resulted in changes in practice, including in relation to the use of restraints. My monitoring framework has been developed to provide a way to consistently assess and report publicly on service performance in order to amplify consumer voice and increase transparency and accountability of service delivery in order to improve services.

Where gaps and unmet needs exist

Two of the key challenges I identified in my recent monitoring report were a loss of traction in the sector and, underpinning that, a lack of collaborative leadership. The high level of disaggregation of leadership in the health sector provides an inherent challenge. New Zealand is a village of under five million people with 20 DHBs each working out, often in relative isolation, how best to support people with a diverse range of needs in relation to mental health and addiction issues. We need to do better at using our collective skills, experience, and commitment to set a direction, and then implement a plan to achieve it. We also need to ensure that consumers and their family/whānau are an integral part of that leadership. The Inquiry provides an important opportunity to provide greater integration in the mental health sector. Success in this could benefit other parts of the sector. It would be reflected in the ability to agree a coherent, whole of sector strategy and, just as importantly, implement the strategy consistently, track progress transparently, and ensure that intended results are achieved and outcomes understood.

Sector vision and action planning

Also as noted above, there is a loss of traction to deliver change in the mental health and addiction sector. There is no clearly articulated goal or vision for mental health and addiction, no overarching strategy, and no current plan for service development or a wider plan to deliver on a system vision. There is no statutory requirement for the government to have a mental health strategy. It is also unclear how much of *Rising to the Challenge* was delivered and what results the plan achieved.

Shared learning and implementation

Inefficiencies and barriers exist to make change as a result of shared direction. There are considerable variations throughout DHBs as to how things are done, and a lack of mechanisms to

recognise and share success and excellence. Too often services are not aware of, or are not learning from, innovations happening in other DHBs or NGOs (or overseas initiatives). This is despite existing forums and programmes to encourage shared learning and quality improvement. Investing in change is often seen as risky or not feasible when services are already under pressure and there is limited support for change.

Monitoring and oversight
With 100 actions and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, there is no basis to measure progress at the completion of *Rising to the Challenge*. There is also no tracking of population level outcome measures to assess well-being at a national level, with the extensively consulted *He Tangata* still in draft form.

Media reporting suggests a lack of public confidence in the ability of mental health and addiction services to respond to population need. Strengthened independent monitoring and advocacy would shed light on and strengthen accountability for the Government's response to mental health and addiction issues. Current independent oversight of the sector focuses on health services and places of detention, which captures only some of the responses needed for a well-being and recovery-oriented system.

Levers for change
The health system provides for very little ministerial or Ministry direction, even where what works well is known. There is a tension between local decision-making in relation to local need, and ensuring that the basic building blocks of system design support the national outcomes and evidence of best practice. These issues are complex and broader than mental health and addiction.

There are divergent views about the effectiveness and transparency of the ring-fence, with some in the sector considering that funding continues to be reprioritised into other parts of the DHB budget, and others concerned that innovation is stymied by the ring-fence. Monitoring of DHB performance, including ring-fence spending, is a function of the Ministry of Health, but the Ministry's view on these matters is not readily accessible or transparent.

Where the focus should be in the future

We need to regain traction in the sector, increase integrated collaborative leadership, and ensure that there is:

- A statutory requirement for an all-of-government strategy to improve the mental well-being of New Zealanders — including the health, justice, housing, education, and other sectors; and
- A mental health and addiction services strategy — as part of the wider strategy — that will deliver optimal outcomes through well aligned primary and secondary services.

More of the same will not improve the mental health of New Zealanders and is likely to result in growing pressure on specialist services and growing distress for consumers and their families/ whānau.

Setting a direction — a statutory requirement for a mental health strategy for New Zealand
It has proven to be difficult to ensure that there is an all-of-government strategy to improve the mental well-being of New Zealanders (and a mental health and addiction services strategy aligned to it).

A statutory amendment to the New Zealand Public Health and Disability Act 2000 is required to ensure that we have an all-of-government New Zealand Mental Well-being Strategy to stand

alongside New Zealand's Health Strategy and Disability Strategy. This would ensure that there is a long-term strategy to promote mental well-being as well as address mental illness and addiction, and that the strategy is not put to one side because of other priorities.

The collective experience and commitment of the health sector and other sectors needs to be harnessed to ensure that the strategy and a plan of action to implement it has widespread support and, just as importantly, that there is a robust leadership structure and transparent tracking of progress to ensure that the plan gets traction and is delivered.

No one part of the sector can develop or deliver an action plan alone. A draft plan followed by written feedback will not achieve the required results. People with lived experience need to be an integral part of change leadership, as do leaders from district health boards, NGOs, primary health organisations, and the justice, social, employment, and housing sectors. Collaborative leadership is required.

Leadership to deliver the strategy

Collaborative leadership requires people who are skilled in working across functional, organisational, cultural, and sectoral boundaries.

At a ministerial level, there needs to be a commitment to collaborate for shared goals, decisions on resource allocations, and priorities. Government departments need structures and processes to support shared analysis, advice, and funding and delivery mechanisms to deliver on an inter-sectoral strategy. Regardless of what mechanisms are decided on, including in relation to the new Mental Health Commission, the Ministry of Health will need to play a leading role in developing and ensuring the delivery of a mental health strategy. It is the Ministry's responsibility to advise the Minister of Health on matters of policy and strategy and act as a steward of the health system. That requires leadership skills and policy and analytical capacity strongly linked to its specialist mental health and addiction experts, and excellent relationships with sector stakeholders and across government.

Support is needed to build collaborative leadership capacity where things happen in local communities — e.g., DHBs, health providers, social services, marae, and community organisations. In doing so, the voice of consumers and their whānau in leadership needs to be protected and strengthened, the Treaty partnership must be honoured, and a diversity of perspectives, experiences, and expertise must be represented.

One of the most complex challenges to address is the disaggregated leadership in the health sector. There is a real risk that a robust national strategy will falter at implementation stage if 20 DHBs each have to work out how to deliver it in isolation. We need a better way to do this. We may need a stronger focus on both outcomes — a clear understanding of how we will know if we are making progress — and increased integration of service models and change management. The latter could be achieved by a national planning and funding framework developed collaboratively either by the Ministry with sector input or by DHBs through a mandated collaborative mechanism overseen by the Ministry.

Another component required for successful delivery of the strategy is core tools for any successful programme: clear priorities, accountabilities, milestones and measures of success, and transparent reporting on progress and results. Those components were not always present to support *Rising to*

the Challenge. They will be essential for successful implementation of an inter-sectoral mental well-being strategy.

Supporting implementation and promoting excellence

In order to reduce duplication of effort and ensure that services and interventions are focused on the right things, there needs to be a central or networked collection of best practice and research with broad and easy access, dissemination, training and support, and feedback loops to strategy, policy, and planning. Delivery of that support may be by a range of existing or new organisations such as current workforce organisations, a centre of excellence (such as the New South Wales model), or a new Mental Health Commission. Best practice co-design with consumers and family/whānau should be a core component (as is being modelled in the HQSC improvement programme at present).

An office similar to the Office for Disability Issues may also be required to support and oversee an all-of-government implementation of the Mental Health Strategy.

Strengthening monitoring and oversight

Independent monitoring and advocacy brings transparency and accountability to support improvement, and can provide an avenue for the voice of consumers and family/whānau. This is particularly important if there is to be increased investment and focus on mental health and addiction. Consideration needs to be given to both whole-of-system interventions and population-level outcomes, and the quality of services and outcomes for people who access services. The work undertaken by the Ministry and the sector to develop the population outcomes framework *He Tangata* should not be lost. Likewise, HDC's monitoring framework, developed with input from the sector, may be generic enough to allow it to be expanded to non-health services. Further comment in relation to the new Mental Health Commission is provided below.

Reviewing levers for change, including funding mechanisms

There is a need to critically assess the operation of current levers in supporting change, including how service specifications and guidelines are used and how the ring-fence operates. My monitoring suggests that there are divergent views about the effectiveness of the ring-fence in preventing funding from being reprioritised into other parts of the DHB budget. Questions have also been raised about whether the ring-fence now acts more as a barrier to innovation, rather than protecting investment in mental well-being and recovery. There needs to be improved transparency and ways of tracking real spend on mental health and addiction in both primary and secondary services. The other challenge will be to design funding models and service models that improve inter-sectoral services and support.

Considerations for a new Mental Health Commission

The HDC supports the establishment of a new Mental Health Commission to strengthen independent monitoring and advocacy in relation to promoting mental well-being.

There are many functions a new Mental Health Commission could take on to promote mental well-being and contribute to system leadership, but it should not be expected to resolve all issues. A new Commission should add value to and strengthen the existing system rather than merely duplicate or take over functions that are under-performing. For the Commission to succeed, it is important for it to have a clear focus and to add value.

There are a number of factors I see as important to the success of a new Commission:

- Scope: A broad focus on promoting mental well-being and a whole-of-government approach, and ensuring that mental health and addiction services contribute to that. A narrow focus on monitoring services is insufficient.
- Clear value-add alongside other agencies, including other independent oversight agencies. Duplication of functions will add cost, not benefits. If some parts of the system are not performing, recognise that performance issues need to improve, not be duplicated elsewhere.
- Clear functions: The independent monitoring/watchdog function is particularly important given the high level of current and historical challenges and concerns in this area, the personal, community, and economic cost of mental distress and addiction, and the benefits of increasing mental well-being. A new Commission would be well placed to have statutory responsibility to monitor the all-of-government strategy to improve the mental well-being of New Zealanders and a mental health and addiction services strategy aligned to it (as proposed above). Preferably the scope of monitoring would include both efficiency and effectiveness and have an outcome focus. That level of monitoring would require high-level skills and expertise, including knowledge of international best practice, and sector-level monitoring mechanisms and tools. It would also provide considerable benefits, including guidance on future investment and priorities (and authoritative advice on where the next dollar should be spent for best effect). There are a number of other functions the Commission could have. Appendix 1 provides a partial snapshot of the range of functions such Commissions fulfil. Other models, such as the Commissioner for the Environment, also provide helpful examples of national, sector-level monitoring and advocacy.
- Independence: It is vitally important that the public see the Commission as independent — to afford confidence that it is providing robust advice and assessment about the performance of the sector, and progress in promoting mental well-being. That requires sufficient statutory independence and the avoidance of potential or perceived conflicts of interest. It would be difficult to avoid conflicts if the Commission both set and monitored strategy or both delivered and monitored services. The Commission should, however, be able to provide an independent assessment of, and views about, current or proposed strategies, priorities, and outcomes.
- Powers and resources: It is important for a Commission to have sufficient powers to fulfil its purpose and functions. Powers to obtain information and make recommendations to the Minister/s or others appear to be core requirements, along with an obligation to report publicly on findings from its monitoring function.
- Duration: The previous Mental Health Commission was time limited, given the desire for short-term impact. A number of similar Commissions have review clauses in their legislation. Once the purpose and functions for a new Mental Health Commission have been determined, it is important that careful consideration is given to whether there is an on-going or transitional need for those functions, or if there should be a sunset or review clause so that future requirements can be determined in response to a changing environment.

To support the Inquiry with consideration of options in relation to a new Mental Health Commission, I have attached, in Appendices 1 and 2, brief summaries of:

- The functions of some mental health commissions/commissioners in New Zealand and overseas; and

- The focus of agencies with oversight functions in relation to mental health and addiction services.

Specialist advice — governance and levers

I suggest that the Inquiry panel obtain advice from the State Services Commission about:

- The role, function, and powers of a new Mental Health Commission; and
- Governance structures and levers that can best ensure the development, implementation, and monitoring of:
  - an all-of-government strategy that will improve the mental well-being of New Zealanders; and
  - a mental health and addiction services strategy that will deliver optimal outcomes through well-aligned primary and secondary services.

Transparent advocacy

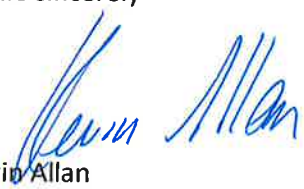
Given HDC's role as an independent advocate in relation to mental health and addiction services, I propose, subject to your agreement, to publish this letter on the Health and Disability Commissioner's website shortly after we meet.

Meeting 23 May

The people attending from the Office will be: Anthony Hill, Health and Disability Commissioner; Meenal Duggal, Deputy Commissioner, Complaints Resolution; Jane Carpenter, Senior Adviser, Policy and Analysis; and me.

We look forward to meeting with members of the Inquiry on 23 May.

Yours sincerely



Kevin Allan
Mental Health Commissioner

Appendix 1: Mental Health Commissions/Commissioners

Quick reference functions of Mental Health Commissions/Commissioners

Function	MHC NZ	HDC	AUS	SA	VIC	NSW	WA	QLD	CAN	IE	CAL
Promoting the voice of lived experience	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Advocacy for system improvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
AOD	✓	✓					✓	✓			
Prevention	✓		✓	✓		✓	✓	✓	✓		
Facilitating collaboration	✓		✓	✓		✓	✓	✓	✓		Partial
Whole of government			✓					✓	✓		
Strategy				✓		✓		✓	✓		
Monitoring and reporting	✓	✓	✓	✓		✓		✓	✓	✓	✓
Policy adviser to Ministers				✓		✓		✓			✓
Research	✓			✓		✓		✓	✓		✓
Knowledge sharing	✓		✓	✓		✓	✓	✓	✓		✓
Funding or delivering well-being promotion, awareness and early intervention activity	✓			✓		✓	✓	✓	✓		✓
Complaints		✓			✓					✓	
Service planning, commissioning and funding							✓				
Delivery of mental health and/or addiction services							Partial				
Independence from Ministerial direction		✓	✓		✓	Partial				✓	✓

Functions of some Mental Health Commissions/Commissioners — a snapshot

Commission	Establishment	Functions
Mental Health Commission (NZ)	Established in 1996 as Committee of the Minister of Health and then as a Crown entity in 1998 to act as a catalyst to improve performance and lift the priority given to mental health. Disestablished in 2012.	— Advocate for people with lived experience and their families — Promote and facilitate collaboration and communication about mental health issues — Work independently and with others to reduce and eliminate stigma and discrimination — Monitor, report, and advise in relation to the government's mental health strategy — Stimulate and support policy-makers, funders, and providers in providing quality care — Stimulate and undertake research — In 2010/11, the year prior to disestablishment, the Mental Health Commission had an Advisory Board of 12 members, a permanent staff of 19, and received an annual Crown revenue of $2.82m.
Health and Disability Commissioner, Mental Health Commissioner	Established monitoring and advocacy function in 2012 by amendment to the Health and Disability Commissioner Act 1994	— Promote and protect the rights of consumers of health and disability services — Resolve complaints, including in relation to mental health and addition services — Monitor mental health and addiction services and

		advocate for improvements — The monitoring and advocacy function budget was $620,000 in 2017/18.
Australian National Mental Health Commission	Established in 2012 to provide independent reports and advice to the community and government on what's working and what's not	— Advocacy of mental health and well-being as a national priority — Accountability and transparency through monitoring and public reporting (including national reviews of services, report cards, and spotlight reports) — Leadership and information sharing to empower people with lived experience and their families and support people — Working with others to influence decision-making, set goals, and transform systems and supports to improve people's lives — Departmental appropriation of AUS$2.93m in 2016/17
South Australian Mental Health Commission	Established in 2015 under the SA Public Sector Act with the initial task to lead the development of South Australia's new Mental Health Strategic Plan	— Develop the Mental Health Strategic Plan (released in December 2017) — Coordinate, facilitate, and oversee the implementation of the Plan and develop future actions — Expenses of AUS$2.2million in 2016/17
Mental Health Complaints Commissioner Victoria	Created by the Mental Health Act 2014 to be a specialist independent complaints body	— Independent, specialist body established to safeguard rights, resolve complaints about Victorian mental health services, and recommend improvements — Expenses of AUS$2m in 2016/17
Mental Health Commission of New South Wales	Established in 2012 under the Mental Health Commission Act for the purpose of monitoring, reviewing, and improving the mental health system and mental health and well-being of the people of NSW	— Developed *Living Well: A Strategic Plan for Mental Health in NSW 2014–2024*, which was adopted by Government — Monitor and report on *Living Well* and review and evaluate services and programmes provided to people who have mental illness — Undertake and commission research, innovation, and policy development — Fund mental health organisations to engage and empower consumers and carers — Independence in relation to draft strategic plan and other reports — Expenses of AUS$10.5m in 2016/17
Mental Health Commission WA	A government department that reports to the Minister of Health. Established in 2010 to lead mental health reform. Initially created by transferring existing resources of the Mental Health Division of the Department of Health. Amalgamated with the Drug and Alcohol Office in 2015, establishing an integrated approach to mental health and other drug service delivery	— Commissioning, providing, and partnering in the delivery of: prevention, promotion, and early intervention programmes; treatment, services, and supports; research, policy, and system improvements — Developed and are guided by the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 — Cost of services was AUS$863.11m in 2016/17
Queensland Mental Health	Established in 2013 by the Queensland Mental Health	— Develop, support and report on a whole-of-government strategic plan

Commission	Commission Act to drive reform. Review of effectiveness required within 3 years	— Research and report on issues relevant to Queenslanders — Deliver and support promotion, awareness, and early intervention activities — Engage and enable people to foster an inclusive and responsive system — Commission has an operating budget of AUS$9.02m in 2017/18
Mental Health Commission of Canada	Established in 2007 following a national report on mental health *Out of the Shadows at Last*	— Act as a leading partner — to convene and align stakeholders, and develop, inform, and influence policy — Advance the Mental Health Strategy for Canada (developed by the Commission in 2012) by prioritising need, developing disseminating and information tools, collaborating with provinces, and reviewing and evaluating progress — Develop and share effective and innovative knowledge, including in relation to wellness indicators, best and promising practice, and impacts of social determinants — 2016/17 expenses of $20.5m
Mental Health Commission, Ireland	Established as an independent body in 2002 under the Mental Health Act 2001 to promote, encourage, and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted	— Appointing persons to mental health tribunals to review the detention of involuntary patients and appointing a legal representative for each patient — Establishing and maintaining a Register of Approved Centres, i.e., register inpatient facilities providing care and treatment for people with a mental illness and mental disorder — Making rules regulating the use of specific treatments and interventions such as ECT (Electroconvulsive Therapy), seclusion, and mechanical restraint — Developing Codes of Practice to guide those working in the mental health services and enable them to provide high quality care and treatment to service users — Appointing the Inspector of Mental Health Services who annually inspects mental health services — Outturn for 2016 was €13.2m NB: Some functions similar to the NZ Director of Mental Health
Mental Health Services Oversight and Accountability Commission, California	Established in 2004 by the Mental Health Services Act	— Oversee the implementation of the Mental Health Services Act, including to review and evaluate MHSA funded programmes, support collaborative research, and undertake special projects topics to recommend administrative or legislative changes, and provide training — Develop strategies to overcome stigma — Advise the Governor or the Legislature on mental health policy

Note that the majority of the Acts that establish the various commissions have a review requirement (i.e., that after five years the Act will be reviewed and whether the functions of the Commission etc. continue to be appropriate) and that the Commissioner appointed is appointed for a term; however, the Commission itself does not cease to exist at a certain date per the legislation.

Appendix 2: Overview/Monitoring Agencies

A number of agencies have an overview/monitoring role in relation to mental health and addiction services. A snapshot of some of the agencies is provided below. This information is provided to help assess where there are gaps or opportunities to improve leadership structures or system and sector oversight and where a new Mental Health Commission can best add value.

Government Watchdogs	
Health and Disability Commissioner	Promotes and protects the rights of consumers under Code of Health and Disability Services Consumers' Rights and considers complaints about services. Independently monitors mental health and addiction services and advocates for improvements.
Director of Mental Health	The Director of Mental Health independently monitors the exercise of powers under the Mental Health (Compulsory Assessment and Treatment) Act 1992, including through district inspectors, and issues guidelines in relation to the implementation of the Act. The Director also has other functions including in relation to the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.
Office of the Ombudsman	Independently monitors and oversees State care facilities and places of detention, including mental health and addiction in-patient facilities as part of the National Preventative Mechanism under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Ombudsman is also part of the Independent Monitoring Mechanism that monitors the implementation of the UN Convention on the Rights of Persons with Disabilities.
Children's Commissioner	Takes special interest in services for children and youth. Part of the National Preventative Mechanism under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
Office of the Auditor General	Oversees the effective use of public funds for delivering services. Has powers to initiate inquiries into the performance of public sector mental health and addiction services.
Privacy Commission	Investigates complaints about breaches of privacy.
Human Rights Commission	Monitors and reports on compliance with New Zealand law and international human rights instruments, including the rights of people with disabilities. Part of the Independent Monitoring Mechanism that monitors the implementation of the UN Convention on the Rights of Persons with Disabilities. Coordinates the National Preventative Mechanism under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.