

**Draft Action Plan to
Implement Te Tāhuhu –
Improving Mental Health
2005–2015: The Second
New Zealand Mental Health
and Addiction Plan**

Analysis of submissions

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Executive Summary

This document summarises the range of views given in consultation meetings and written submissions in response to the consultation document *Draft Action Plan to Implement Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Ministry of Health 2006).

The consultation document sought people's views on a draft action plan setting out specific actions for addressing the 10 leading challenges identified in *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005). The leading challenges are:

- Promotion and Prevention
- Building Mental Health Services
- Responsiveness
- Workforce and Culture for Recovery
- Māori Mental Health
- Primary Health Care
- Addiction
- Funding Mechanisms for Recovery
- Transparency and Trust
- Working Together.

The draft action plan also identified the key stakeholders and organisations responsible, outlined milestones and measures, and set timeframes for achieving the actions.

The overall response to the draft action plan was very positive, with submitters generally agreeing that the plan reflected the intent of *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005).

Introduction

Background to this report

In March 2006, the Ministry of Health released for consultation a draft action plan to implement *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005; Minister of Health 2006).

The draft action plan presented actions to address the 10 leading challenges discussed in *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005):

- Promotion and Prevention
- Building Mental Health Services
- Responsiveness
- Workforce and Culture for Recovery
- Māori Mental Health
- Primary Health Care
- Addiction
- Funding Mechanisms for Recovery
- Transparency and Trust
- Working Together.

The draft action plan was directed at achieving the Government's intentions for the mental health and addiction sector over the next 10 years.

Consultation process

Consultation on the draft action plan took place in the five weeks between 24 March and 28 April 2006.

People made submissions on the draft action plan to the Ministry of Health by:

- emailing or posting a written submission to the Ministry
- attending one of six consultation meetings facilitated by Ministry staff throughout the country.

People were asked to consider five questions (see also Appendix B).

1. Does the action plan accurately reflect the intent of *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan*?
2. Are there any actions you particularly endorse?
3. Are there any actions you think need to change?
4. Have any key actions been missed?
5. Do you have any other comments on the action plan?

Content and structure of this report

This report overviews the submissions received and the process by which those submissions were analysed. It presents the views of those who contributed to the consultation process by attending consultation meetings or writing submissions. Submissions from the consultation meetings then the written submissions are analysed.

Submission responses to the five questions are organised under each of the 10 leading challenges. Many of the comments received in response to questions 4 and 5 could be directly related to a leading challenge and to either of question 2 or question 3, so all responses have been collated and reported together.

Nature of Submissions

Consultation meetings

Six consultation meetings were held in Whangarei, Auckland, Hamilton, Wellington, Christchurch and Dunedin.

The meetings were open to everyone and attended by 132 people. Table 1 shows the number of people who attended meetings in each region.

Table 1: Consultation on draft action plan to implement Te Tāhuhu – Improving Mental Health: attendance at consultation meetings by region

Region	Number attending	Percentage of total attending (%)
Northern	24	18
Midland	43	33
Central	23	17
Southern	42	32
Total	132	100

Individuals and organisations who attended consultation meetings are listed in Appendix A.

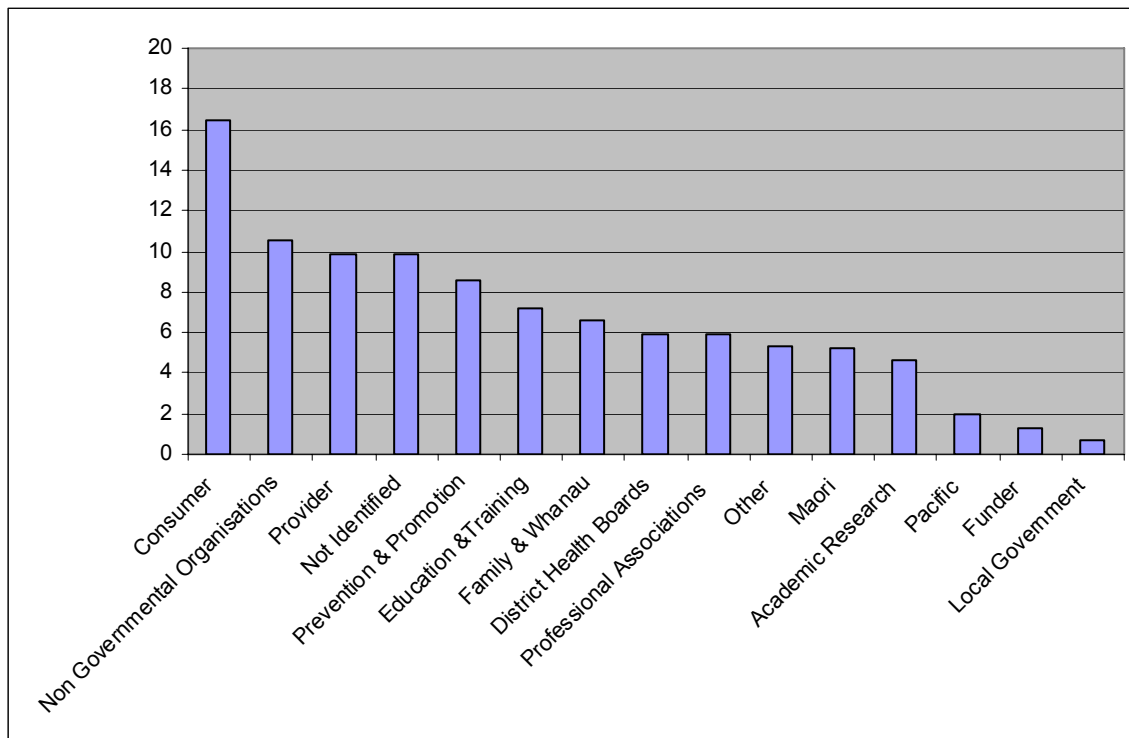
Written submissions

The Ministry of Health received 80 written submissions in response to the consultation document.

The majority of submissions (59%) were from groups or organisations. These organisations included consumer groups, District Health Boards (DHBs), academic and research organisations, education and training establishments, providers or funders of mental health or addiction services, and professional associations. Just over one-fifth (21%) of submissions were from individuals either as a single signatory or as one of multiple signatories. These individuals included consumers, family and whānau of consumers, and providers of mental health or addiction services. The remaining submissions were from people or organisations that identified as 'other' or did not provide identifying information.

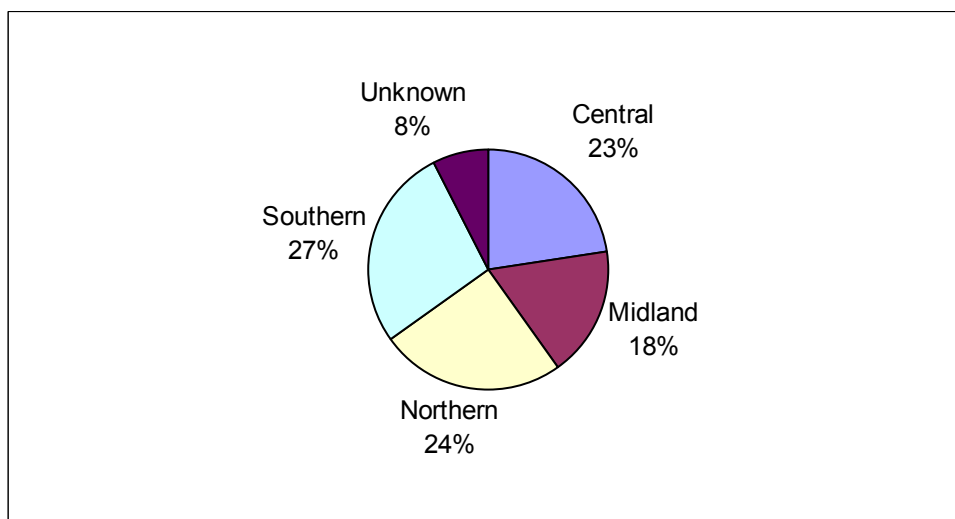
Individuals and groups who made written submissions were asked to identify the sectors they represented (Figure 1). Submitters could identify more than one sector and some submissions were from groups representing a broad range of stakeholders. Therefore, the percentages supporting Figure 1 add up to more than 100.

Figure 1: Consultation on draft action plan to implement Te Tāhuhu – Improving Mental Health: written submissions by sector



Submissions came from all over New Zealand (Figure 2). A slightly higher percentage (27%) of submissions came from the southern region than the northern (24%) and central (23%) regions, with the smallest percentage coming from the midland region (18%).

Figure 2: Consultation on draft action plan to implement Te Tāhuhu – Improving Mental Health: written submissions by region



Individuals and organisations who made written submissions are listed in Appendix A.

Analysis of Submissions

This section summarises the responses from the consultation meetings and the written submissions.

Ministry of Health staff took notes at each consultation meeting, so participants' views could be summarised and analysed. These views were not necessarily held by everyone who attended a particular meeting.

Some written submissions followed the format suggested, others came in various formats, including letters. Many submitters did not answer every question. Therefore, a count of the number of submissions or people holding particular views is neither possible nor meaningful.

All written submissions were analysed in detail. Their contents were included in a database, which enabled all responses to a particular question to be viewed at once. The range and patterns of responses were analysed and are reported on here.

It should be noted that some submissions contained comments, queries or suggestions for the ongoing process for implementing particular actions. Some submitters put their names forward for involvement in particular actions or projects.

The details in many comments and suggestions are relevant to future project work when aspects of the action plan will be implemented. This information will be referred to at that stage.

Responses to the actions were wide ranging, with some actions receiving no or only a few comments.

Feedback from Consultation Meetings

Introduction

Six consultation meetings were held in Whangarei, Auckland, Hamilton, Wellington, Christchurch and Dunedin. The meetings were open to all and were attended by 132 people. Notes were taken at each meeting and considered for this analysis.

Participants at the consultation meetings represented a broad range of stakeholders, including service users, family members, DHBs, non-governmental organisations (NGOs), clinicians, and people involved in prevention, promotion and education.

On the whole, the draft action plan was received positively. Some people had read the draft action plan before attending a consultation meeting and had specific feedback, while others had not read the document and took the opportunity to have points clarified. Several people raised general issues or made general comments about the mental health and addiction sector that did not relate to the plan's scope or content. Suggestions for developing or strengthening the document were made.

The views expressed at the consultation meetings were not necessarily the opinions of all who attended a particular meeting.

This section identifies the key issues raised at the consultation meetings and is structured around the draft action plan's chapters, which reflect each of the 10 leading challenges in *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005).

General comments

Some participants said the diagram depicting the weaving of the 10 leading challenges to improve mental health (Minister of Health 2006: Figure 2, page 5) did not weave Māori and mainstream together, and the connection between whānau ora and recovery needed to be made clearer. It was also pointed out that using Māori words resulted in mixed interpretations of concepts, some of which were often narrower than the original concept, for example, whānau ora.

The action plan's definition of recovery was endorsed, especially the recognition of different addiction approaches and the specific process approach taken in the definition.

Clarification was sought on how *Our Lives in 2014: A recovery vision from people with experience of mental illness* (Mental Health Commission 2004) and how the Mental Health Commission's work on services might fit with the plan.

Leading Challenge: Promotion and prevention

Very little feedback was given on promotion and prevention.

It was suggested at one meeting that the structural separation between promotion and prevention and the delivery of services needed to be addressed, and that promotion work needed to focus on community wellness and Māori mental health promotion in particular.

Clarification was sought about:

- why the specific examples were given under Action 1.4
- whether the plan addressed youth suicide.

Leading Challenge: Building mental health services

Participants' comments about the building mental health services leading challenge generally related to access, transitions between services, and the importance of communication, information sharing and collaboration between providers.

Comments on access were about service users' lack of choice and the limited range of service options available, the lack of independent access to mental health services, and knowledge about, and access to, kaupapa Māori services not being widely available.

A few comments were made about practice issues, including that it appeared that service provision and practice were not always consistent with policy and best practice.

One participant talked about specific problems with the restrictions placed on general practitioners, so they could prescribe only certain medicines (ie, not hospital-only medicines), early discharges from hospital inpatient units without appropriate follow-up, and the difficulty they had getting back into primary health care once they had entered a specialist service.

Some participants said knowledge and information should be more readily available for service users and that communication problems with hospitals existed, especially for consumers wanting to make complaints.

One participant asked how the Ministry of Health monitored DHBs.

A few people commented on the need for better integration of, and collaboration between, mental health and addiction services. One person expressed the view that the lack of collaboration and integration made it difficult for people to access services, resulting in interventions occurring too late and delays in the recovery process. This meant some people (eg, transient populations) sometimes missed out on services.

It was suggested that mental health and addiction services needed to have links with community support services, the Ministry of Justice and the Department of Corrections.

Two people raised the issue of service responsiveness to trauma, noting that treatment itself can be traumatic. They asked whether the action plan went far enough. One participant suggested New Zealand needed to develop a trauma-informed model of care, noting that other countries had done this and had made good progress.

Other comments included the following.

- ‘Effective’ services rather than ‘more and better’ services need to be developed.
- International best practice needs to be acknowledged and promoted.
- The draft action plan’s approach to treating the whole person was endorsed.
- The Nationwide Services Framework (NSF) needs to be reviewed. There was general agreement about this.
- How did the NSF renovation project previously undertaken relate to the action proposed in the draft plan?
- The impact on specialist services of other government activities such as the location of new prisons was noted.
- Would *Blueprint* funding continue? (See Mental Health Commission (1998).)

Leading Challenge: Responsiveness

Participants supported the draft plan’s acknowledgement of caregivers and its family-inclusive nature, and endorsed its broad definition of family and whānau.

One participant asked whether the family and whānau actions were too broad, so open to misinterpretation and likely not to be acted on.

More specific actions aimed at supporting caregivers (eg, workforce development, education and respite care) and more readily available information on services were suggested.

The draft plan’s definition of ‘Asian’ was queried, as was the separate listing of Asian and other ethnic communities and refugees and migrants. It was suggested that the focus on the settlement process for refugee and new migrants needed to be made clearer and that issues specific to resettlement could emerge at a later time and over the longer term.

One participant said service users’ spiritual needs should be included in recovery planning (Action 3.2). This had appeared in *Te Tāhuhu – Improving Mental Health*, but had not come through in the action plan.

Another comment was that children needed to be specifically mentioned in Action 3.18 (initiatives for family and whānau).

Leading Challenge: Workforce and culture for recovery

A few people commented that NGO and Māori providers find it difficult to recruit and retain skilled staff, because of workforce shortages and competition for skilled staff. A comment was made that Māori workforce development should be whānau driven, rather than reliant on Ministry of Health directions.

Increasing the consumer workforce was said to be important.

Two participants commented that a large number of mental health and addiction workforce development plans existed and national consistency was needed.

Two participants commented on the importance of specialists who have immigrated to New Zealand having a good understanding of New Zealand culture, as well as New Zealand policy, legislation and social services. Training in cultural competency could be part of the recruitment process for these specialists, although a greater focus on training New Zealand specialists was needed.

Several participants noted that positive workforce development relied on all parts of the sector working well together and that NGOs needed to market their services and network.

One participant commented that specialist mental health services have tended to act in an 'exclusive' way.

Other comments included the following.

- The implementation of a recovery model placed a strain on staff in terms of training, funding and reporting.
- The word 'cultural' should be removed from Action 4.5 (strengthen the cultural capability of workers in mainstream services), as it made the action too narrow.

Leading Challenge: Māori mental health

Feedback on the Māori mental health leading challenge included participants saying the connection between whānau ora and recovery was not always clear (eg, Figure 2 was unclear (Minister of Health 2006: page 5)).

It was suggested that care is needed when using Māori terms such as whānau ora, as interpretations of such terms are often much narrower than their actual meanings. This has important implications for Māori and for services.

The Mental Health Information National Collection's suitability for Māori was questioned. Mainstream reporting processes were seen as ineffective for Māori ways of working and services.

It was questioned whether information about the availability of, and contracting for, kaupapa Māori services was well known and available to everyone.

Leading Challenge: Primary health care

Participants were pleased to see a focus on physical health in the draft action plan.

One participant noted that new primary health care funding did not seem to be reducing the barriers between primary and secondary care.

Another participant commented on primary health care issues and the lack of specialist services in rural areas.

Participants asked whether the results of the research and primary health organisation (PHO) evaluations mentioned in Action 6.1 would be published.

Leading Challenge: Addiction

The draft plan's integration of addiction and mental health received a positive response. A few participants commented that someone needs to make sure the integration happens.

One participant questioned the focus on opioid treatment, in particular methadone, suggesting that clients seemed to be moving from opioids to P (methamphetamine) and that treatment approaches were moving away from using methadone.

A few participants were concerned about people becoming addicted to mental health prescription drugs.

Participants had differing views about problem gambling's place in the addiction field. Some said problem gambling services needed the same stewardship from the Ministry of Health and DHBs as they gave other addiction services. Listing problem gambling separately could create a split between problem gambling and addiction such as had happened between mental health and addiction. Others said problem gambling was a social issue, so should not be defined as an addiction disorder. Labelling problem gambling as an addiction could release the gambling industry from responsibility. It was suggested that problem gambling did not belong in a 10-year plan and should be treated as a short-term issue.

Participants asked about the Ministry of Health's role in the revision of the Gambling Act 2003 and DHBs' role in problem gambling.

Comments were made about people falling through gaps in services (eg, people with personality disorders or poly-drug users who come into contact with the justice system, have addiction issues, and cannot always access services). It was suggested the plan's addiction section needed an action addressing intersectoral work by the Ministry of Justice and Department of Corrections, as this was a major issue, particularly for funding and people's access to services.

Other comments included the following.

- Action 7.2's focus on respite care was endorsed.
- Funding and training for co-existing disorders was needed.

Leading Challenge: Funding mechanisms for recovery

Very little discussion about funding occurred at the meetings.

Some participants were pleased to see the actions for reviewing funding models to support consistency and equity across providers and regions and piloting different funding models (Actions 8.1–8.6).

A Pacific NGO representative noted that their service needed more funding to continue supporting clients when they moved into hospital care. At present this support was not included in their funding, but it was an essential part of their service, because clients would return to their care when released from hospital.

Leading Challenge: Transparency and trust

Action 9.10 (promote collaborative note-taking and recovery planning) was endorsed.

Several participants raised the issue of the action plan indicating additional reporting requirements, but NGOs feeling ill-equipped to manage them.

Other comments were that DHBs did not have the capacity to improve their data. It was suggested that support and funding would be needed to achieve the new requirements and that funding should be tagged to reporting.

Current reporting mechanisms were considered unreflective of the current situation and irrelevant for planning. For example, problems with existing data mean the numbers do not always provide an accurate picture, so narrative information is also important. Providers said they wanted feedback on the information and reports they provide to funders.

Other comments included the following.

- More information for service users about what different services provide needs to be available.
- Information systems and information sharing need development. The Mental Health Standard Measures of Assessment and Recovery Initiative's lack of funding is a problem.
- When would the results of the epidemiology study be released and would the results be readily available?

Leading Challenge: Working together

Comments on the working together leading challenge included the following.

- Efforts to share information regionally had been good, but need to occur nationally.
- The roles of local and national government need to be emphasised, with a greater focus on community development models.
- It is important the Ministry of Health and DHBs work intersectorally and take a whole of government approach.

- What is the link between government policy, such as that underpinning the action plan, and DHBs' regional plans? For example, the draft action plan is more specific than the regional mental health plans.
- The Ministry of Health needs to continue to develop its relationship with the sector, especially consumers.
- The action plan's success depends on good relationships being developed across the sector.
- Action 10.6 (about DHBs and territorial local authorities) needs a different milestone; one with results rather than just involvement.

Ongoing implementation and monitoring

Participants at one meeting generally agreed that the action plan was good, so 'just do it'.

The plan's implementation process and ongoing sector involvement were discussed. Clarification was sought on whether the plan's actions would be prioritised further, whether there was flexibility to incorporate new actions or lessons learned from the first five years, and whether there would be a formal mechanism for incorporating any changes.

General comments concerned whether the support for ongoing implementation would be offered to DHBs such as funding, the upgrading of toolkits or the provision of specific information and tools.

Participants asked for clarification about the monitoring and performance management of services, DHBs and the Ministry of Health, and how the plan's implementation would be reported. A participant asked who would monitor the sector if the Mental Health Commission did not continue beyond 2007.

Feedback from Written Submissions

Introduction

This section summarises the written submissions. The overall response to the draft action plan was positive, with submitters generally agreeing that the plan reflected the intent of *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005).

Many written submissions reflected the comments made at the consultation meetings, with comments tending to be suggestions for developing, strengthening or improving the plan, rather than negative criticisms of the plan.

This section is structured around the draft plan's chapters, which reflect each of the 10 leading challenges in *Te Tāhuhu – Improving Mental Health* (Minister of Health 2005). Many submitters did not follow the submission template and made one-off general comments in response to questions 4 and 5. These comments have been included under the most relevant leading challenge.

General comments

The action plan was generally endorsed for being comprehensive and providing guidance and direction. People were happy to see family and whānau included throughout the plan. However, a small number of submitters said the plan did not align with *Te Tāhuhu – Improving Mental Health*, because they felt a particular issue was not emphasised or referred to specifically.

Other general comments included the following.

- A trauma-informed model of care needs to be acknowledged in the plan.
- Early intervention services for addiction and psychosis are important.
- More concrete mechanisms for achieving actions and measuring outcomes are necessary.
- Better access to specialist mental health services in rural areas is needed.
- Research and evaluation should be more prominent in the plan.
- Can the current workforce manage the workload needed to implement the plan?

Leading Challenge: Promotion and prevention

The actions for the promotion and prevention leading challenge were widely endorsed. Most of the feedback was on Action 1.1 (review the national strategic framework for mental health promotion and prevention, *Building on Strengths* (Ministry of Health 2002)).

Submitters were pleased to see the promotion of social inclusion and the acknowledgment of the broader social, economic and cultural determinants of mental health and wellbeing.

Others were happy to see families included, as well as the focus on reducing suicide and the National Depression Initiative. The link between mental and physical health was also endorsed.

Several submitters were keen to see the existing national strategic framework reviewed. They hoped a new framework would have a broader 'wellness' focus and a stronger emphasis on prevention and early intervention. One submitter noted the need to move away from a deficit focus for promotion and prevention. It was suggested that a Māori mental health promotion framework should be developed and mental health promotion should be through all the leading challenges.

A strengthening of initiatives to prevent addiction and address the stigma and discrimination associated with addiction was suggested.

One submitter noted that the best time to focus on mental health promotion is early in life, especially programmes targeted at children and families at risk. It was suggested that more prevention and promotion pilots should be undertaken and evaluated, and the evaluation outcomes disseminated.

Leading Challenge: Building mental health services

The actions for the building mental health services leading challenge received the most comments, with about two-thirds endorsing the actions. Many submitters applauded the emphasis on treating both physical and mental health needs.

Action 2.5 (expand the range of effective and integrated services) received the most comments. This action was strongly supported, particularly for its inclusion of psychological therapies and peer-led and respite services.

Actions 2.10 (review the policy framework for child and youth) and 2.14 (develop a policy framework for older people), received the second largest number of comments. These comments were generally supportive. Submitters were pleased addiction was included and the children of parents with a mental illness were specifically mentioned in Action 2.10. Some suggested a review of the current model, because it is not delivering agreed access targets. An action on respite care was also suggested.

Action 2.14 was endorsed for focusing on older people's mental health. Several submitters commented on the importance of a holistic and integrated approach.

One submitter noted that practical interventions are needed rather than a policy framework. The development of consistently collected data on older people was endorsed.

One submitter commented that assistance for people with dementia needed to be referred to specifically in the plan.

Action 2.21 (meet the physical health needs of people severely affected by mental illness) was generally welcomed. Several submitters suggested the plan include specific physical health issues, helping people to come off prescription medications, and addressing discrimination in general health settings.

A range of one-off comments were made on the remaining actions, including endorsements and suggestions for developing the plan.

The actions focusing on building more integrated services were widely supported (2.4 and 2.6). People were pleased to see the focus on integrating primary and secondary services, although some said that funding needs to be provided to support transition and collaboration among services, and primary health care needs to be adequately resourced to cope with meeting mental health needs.

People supported reviews of the Nationwide Services Framework and Forensic Framework, noting that consumer input would be important in these reviews. Action 2.5 (expand the range and quality of services for people with high and complex needs) was supported, although one submitter felt the focus on high and complex needs was limiting.

Better links were suggested between the mental health sector and the Department of Corrections and Ministry of Justice in relation to addiction, particularly among young people.

Other comments included the following.

- Acute, sub-acute and early intervention psychosis services should be core priority services.
- More emphasis on family group therapy is needed.
- Maternal mental health should be specifically mentioned in the plan.
- More links are needed between mental health and physical health services.
- Actions strengthening the links between specialist services and primary health care services were endorsed.

Leading Challenge: Responsiveness

The actions for the responsiveness leading challenge received wide-ranging and specific feedback, which was often on a single issue. Some actions received only two or three comments or were endorsed without any feedback.

The plan's inclusion of specific population groups, particularly family and whānau, was broadly supported. One submitter suggested more actions be included for Asian peoples and other ethnic communities, as well as having readily available interpreters for non-English speakers. A few submitters suggested some specific groups had been left out and should be mentioned (eg, the Deaf, people with brain injury, and lesbians and gays).

Ongoing support for family/whānau advisor positions was endorsed. However, one submitter suggested that caution should be exercised when involving family and whānau to ensure service users' wishes are protected.

Several submitters suggested revising the kaupapa Māori service specifications and better links made with Māori frameworks for monitoring.

One submitter raised the problem of lack of access to specialist services in rural areas.

Leading Challenge: Workforce and culture for recovery

The actions for the workforce and culture for recovery leading challenge were generally endorsed, although submitters offered several specific suggestions for strengthening and further defining the actions.

Actions 4.1, 4.4 and 4.8 (implement and develop workforce plans and training) were supported, particularly for the NGO and service user workforces. A couple of comments were made that workforce development seemed fragmented and needed more leadership. Several people commented that broader training needs to be available for Māori, Pacific peoples and service users.

People provided diverse feedback and suggestions for the remaining actions. Several NGOs and a DHB service provider commented on the difficulties recruiting and retaining staff. One submitter noted that more money needed to be spent on training and staff than on developing frameworks. Clarification and analysis of what cultural capability entails is needed.

Submitters suggested more money being made available for consumer advisors as well as better support for key groups providing training. It was also noted that the workforce of skilled people able to deliver psychological therapies needs to be increased and an environment and management structure that will support the provision of those services developed.

Several people sought more detail on service user workforce and leadership and suggested additional stakeholders. A few people commented that the mental health workforce development plan (Ministry of Health 2005) does not address the needs of addiction service users, and that they probably align better with the addiction sector workforce development programme (National Addiction Centre 2005).

Leading Challenge: Māori mental health

The actions for the Māori mental health leading challenge were largely endorsed. Suggestions were made for clarifying the actions, in particular, with additions to the milestones and stakeholders.

Submitters were pleased to see the review of the Nationwide Services Framework and kaupapa Māori service specifications.

Action 5.6 (develop and implement a research agenda) was endorsed, with a few submitters asking who would lead the research agenda's development and suggesting that the timeframe for development was too long.

The importance of Māori-specific workforce strategies was reinforced.

A number of submitters noted that disparities between Māori and non-Māori have not been adequately addressed. One submitter stated that demonstrating engagement with Māori did not equate to partnership and a particular focus on engagement with urban Māori, especially young urban Māori, was needed. A specific Māori mental health promotion action plan was suggested to address ongoing disparities and continued high Māori suicide rates.

Responses to Actions 5.3 and 5.10 (increase services and continuity of care between mainstream and kaupapa Māori services) suggested that increases in services need to be matched by a focus on quality, and that the milestones could include quality assurance goals.

Leading Challenge: Primary health care

While many of the actions for the primary health care leading challenge were generally endorsed, suggestions were made for how the actions could be strengthened. Several comments were made that the actions would set a positive direction for the future.

The focus on physical health and early intervention was endorsed, as was Action 6.1 (provide advice, especially about funding). The importance of the primary health care sector being involved in developing this advice was noted.

One submitter felt this section could be extended as much was already being done in primary health care. The actions and milestones could be more concrete and robust, and consideration should be given to existing successful primary health care, mental health interventions as well as the current PHO demonstrations.

Comments reinforced that a primary health care approach to mental health and wellbeing was not just about physical health, but had to be holistic and acknowledge peoples' social, spiritual and emotional wellbeing.

A couple of comments were received about the importance of wider community engagement in the planning of mental health and addiction services in primary health care and making sure the addiction sector is included.

Some submitters noted the pressures on the primary health care sector and suggested the timeframes for achieving the actions needed to be extended because of the high workload associated with the ongoing implementation of the primary health care strategy.

Action 6.5 (make mental health and addiction integral parts of PHO primary health care promotion) received several comments: PHO mental health promotion needs to link with the *Building on Strengths* framework and the milestone should change to PHOs demonstrating, rather than promoting, activities.

Leading Challenge: Addiction

The actions for the addiction leading challenge received the second highest number of comments overall. These actions were widely supported. Of the comments made, over three-quarters endorsed the actions. Most comments were in relation to Action 7.1 (improve access to addiction services), with general endorsement and suggestions for improvement.

Feedback included that gaps in access to acute and crisis services in particular were problematic. Actions 7.2 and 7.3 (addressing respite and acute services, and strengthening residential treatment services) were supported. One submitter said respite and kaupapa Māori residential services needed to be developed. One submitter felt it was unhelpful to focus on respite and residential treatment services as these are not the only models of care that should be considered.

Several submitters supported Action 7.15 (provide training in co-existing disorders).

A couple of submitters noted the problems associated with the mental health of the prison population and other people in the justice system. They felt a specific action should be that the Ministry of Health and Department of Corrections work together to address these groups' mental health and addiction needs.

One submitter noted that if the primary health care sector was to address problem gambling then resources, in terms of funding and support, would need to be available, and that problem gambling needed to be better linked with substance abuse.

One submitter suggested the review of the Alcoholism and Drug Addiction Act 1966 should consider whether the imperatives that drive the Mental Health (Compulsory Assessment and Treatment) Act 1992 could be replicated in the former Act, specifically consideration of the role of compulsion in addiction.

A couple of submitters felt the timeframes for Action 7.9 (develop addiction-related outcomes measures) needed to be brought forward to 1–3 years rather than 1–5 years and a consumer outcome indicator needed to be included.

Leading Challenge: Funding mechanisms for recovery

The actions associated with the funding mechanisms leading challenge attracted a very small amount of feedback (Actions 8.1–8.6). The actions relating to flexibility in funding and contracting mechanisms and building DHBs' funding and planning capacity were endorsed (Actions 8.1, 8.2, 8.3).

Piloting 2–3 outcome-based funding models was also endorsed (Action 8.6). It was suggested that these pilots needed good outcome assessments and evaluations.

Additional one-off comments included the following.

- The review of funding models is urgent and funding models need to be locally appropriate.
- Resources need to be transferred to community services.
- Contract reporting mechanisms need to include qualitative (narrative) information and quantitative data.
- It is important to address NGO sustainability.

Leading Challenge: Transparency and trust

Actions 9.10, 9.11 and 9.12 were the most commented on actions for this leading challenge.

Action 9.10 (collaborative note-taking and recovery planning) was endorsed, with a suggestion that advance directives become part of all recovery planning.

Action 9.11 (service users and their family and whānau know and understand what they can expect from mental health and addiction services) was endorsed.

Action 9.12 (service user satisfaction survey) was endorsed. It was noted that consumer feedback surveys are essential, and that alcohol and other drug service users need to be involved in such surveys.

One submitter commented that an independent evaluation of the effect of the Mental Health (Compulsory Assessment and Treatment) Act 1992 was needed (Action 9.14).

Another submitter said the focus should be less on audits and more on talking with professionals.

Leading Challenge: Working together

The actions for the working together leading challenge received the smallest number of comments overall.

The importance of social inclusion and the impact of social and economic determinants on mental health and wellbeing were reinforced.

The critical role of intersectoral collaboration was endorsed, as was Action 10.1 (clarify the role of the regional mental health networks).

It was suggested that other government strategies could be referenced more in the plan.

Appendix A: Participants at Consultation Meetings and Submitters of Written Submissions

Participants at consultation meetings

The following list is of those who attended consultation meetings, except those individuals who requested confidentiality.

Name	Organisation
Adele Winikerei	Richmond Fellowship
Adrienne Transom	Problem Gambling Foundation
Alana Ruakere-Mack	Lakes District Health Board
Alex Handiside	Hutt Valley District Health Board
Alexis Nathan	Funder/Planner, Mental Health and Addictions Northland District Health Board
Ann Grennell	Rostrevor House
Anne Shackleton	
Barbara Halliday	Community Support Services Industry Training Organisation (CSSITO)
Carol Gray	Planning and Funding Otago District Health Board
Caroline Nicholls	SF Otago
Cate Kearney	Alcohol Drug Association of New Zealand (ADANZ)
Cathy Cooney	Lakes District Health Board
Cazna Luke	Te Korowai Hinengaro
Char Macpherson	Alcohol Drug Association of New Zealand (ADANZ)
Cheryl Billett	Bay of Plenty District Health Board
Cheryl Williams	Te Paepae Arahi
Claire Aitken	Moana House
Cyndi Kohunui	Mahitahi
Deb Fraser	Mirror Counselling Service
Debra Wells	Wellsprings Unlimited Trust
Deidre Thompson	Christchurch School of Medicine, New Zealand Medical Student Association
Denis Warren	Petersgate Counselling Centre
Di Sargent	Stepping Stone Trust
Diana Grace	Operations Manager, Mental Health Services Canterbury District Health Board
Diane Gooch	Schizophrenia Fellowship Pegasus Bay
Donna Tamaki	Whakatohia te Hauora o te Tangata Trusts
Donny Rangiaho	Mahitahi
Edna Heled	Pacificare
Egan Bidois	Te Whare Marie Ki Puketiro
Eileen Hughes	Waikato District Health Board
Fiona Fowles	TAS
Geraldine Karaitiana	Richmond Fellowship

Name	Organisation
Gillian Adams	PACT Group
Hemaima Tait	Waikato District Health Board
Hugh Norriss	Capital & Coast District Health Board
Huia Haunui	Ngati Ranginui
Ian MacEwan	Matua Raki
Ivy Churchill	Pura Pura Whetu
Jenny Wolf	Mental Health Programmes
Jill Collins	Needs Assessment and Service Co-ordination Canterbury District Health Board
John Strachan	Health Waikato
John Boreham	CAM
Judy Buchanan	Corstosphine Baptist Community Trust
Judy Davis	Piritahi Hau Ora
Julie Fidoe	Pathways Trust
Julie Nelson	WISE
Katherine Fell	Waikato District Health Board
Kathryn Johnston	SEC Primary Health Organisation
Kerry Hawkes	Pathways
Kerry Hand	Miramare
Kitty Marshall	Mental Health Services Capital & Coast District Health Board
Larissa Clarke	Bay of Plenty District Health Board
Laurie Hakiwai	Te Awhi Whanau
Leigh Brash	SF Auckland, Chairperson of Northern Region Family Whanau Forum
Lyndsay Hain	Northcare Trust
Lynne Wilson	Bipolar Support Canterbury
Lynne Bucher	Te Tai Tokerau Mapo
Maoitele Silafau Lowen	Kaute Pasifika Services
Marie McKay	Wairarapa District Health Board
Marlene Matehuria	Te Ngara o Maniapoto
Mary Smith	Lakes District Health Board
Mary Aramoana	Whakatohia te Hauora o te Tangata Trusts
Maryanne Frazer-Jen	Maniapoto Marae Pact Trust
Michelle Pentland	Salvation Army Bridge Treatment Programme
Mike Dove	PathwaysTrust
Mike Fitzgerald	Lakes District Health Board
Mino'aka Kapuaawaiahi-Fitzsimmons	Te Runanga o Kirikiriroa Charitable Trust/Rango Atea
Moe Milne	Te Moemoea
Dr N Rasalingam	Ethnic Voice New Zealand, Refugee Council of New Zealand
Nick Vegt	Patients Rights Advocacy
Nikki Woolley	Mental Health Foundation
Owen Lloyd	Tairawhiti District Health Board
Paul Rout	SISSAL

Name	Organisation
Paul Toth	
Philippa Fletcher	Community and Public Health
Phillip Kohunui	Mahitahi
Rachel Dekel	Midland Regional Mental Health Network
Rachel Cooper	MASH Trust
Rene Andre	Oasis Gambling Centre
Ric Tobeck	Miramare
Rima Pieian'a	Problem Gambling Foundation
Roera Komene	Te Wakahauora, Public Health South
Ronald Twidle	Matamata Piako Community Health Forum
Rowena McDowell	Te Kotuku Ki Te Rangi Trust
Sally Duncan	Western Bay of Plenty Mental Health Trust
Sam Mclean	Human Rights Commission
Sisitina Fitness	Pacific Peoples Addiction Services Inc
Stephen King	Alcohol and Drug Community Support Trust
Stuart Gray	SISSAL
Suzy Stevens	Kites
Terry Taumaa	Problem Gambling Foundation
Toni Gutschlag	Planning and Funding Canterbury District Health Board
Valerie Mischewski	Northcare Trust
Vicki Crarer	Waikato District Health Board
Vicki Lewis	Lakes District Health Board
Vince Barry	Canterbury District Health Board
Vito Malo	Planning and Funding Capital & Coast District Health Board
Wendy Atutahi	Hauora Waikato
Wendy Creuver	PACT Southland, Southland Mental Health Network

Submitters of written submissions

The following list is of those people who made written submissions, except those submitting as individuals who requested confidentiality.

Name	Organisation
Alison Morris	Consumer Forum Group of Mental Health
Ancylla Wijkstra	Grow NZ Inc
Andrea Bunn	Whanganui District Health Board
Ann Grennell	Rostrevor House
Barbara Banford	SF Whanganui
Bradley Ng	Australia New Zealand Association of Psychiatrists in Training
[No individual identified]	Community Support Services Industry Training Organisation
Coral Beadle	
Debra Wells	Mental Health Commission Trauma Group

Name	Organisation
Deidre Thomson	New Zealand Medical Student Association
Diana Grice	Canterbury District Health Board
Dr Ekramui Hoque	The Asian Network Incorporated (TANI)
Glenn Dodson	Stepping Stone Trust
Graham Wolf	Central Potential
Hugh Norriss	Mental Health Funding and Planning Manager Capital & Coast District Health Board
Judi Clements	Mental Health Foundation New Zealand
Judi Clements	Mental Health Advocacy Coalition
Justin Pollock	Mad Mates Peer Support Group
Kara Puketapu	Te Runanganui o Taranaki Whanui Inc
Kathryn Johnston	South East and City Primary Health Organisation
Dr Kathy James	South East and City Primary Health Organisation
Dr Kumanan Rasanathan	The Asian Network Incorporated (TANI)
Kirk Mariner	Waitemata District Health Board
Lynn Allan	Nelson Marlborough District Health Service
Lynne Butcher	Te Tai Tokerau MAPO Trust
Marion Kleist	SF Wellington
Mike Ang	National Early Intervention for Psychosis Steering Group
Dr Patte Randal	International Society for the Psychological Treatments of Schizophrenia, New Zealand branch (ISPS-NZ)
	Moana Pasefika
Pauline Southorn	
Peter Ryder	Alcohol Drug Association of New Zealand (ADANZ)
Raewyn Hall	Whanganui District Health Board
Rebecca Leniston	Pathways
Rhonda Robertson	Community Alcohol and Drug Service
Robert Steenhuisen	Waitemata District Health Board
Sharon Crombie	SF Whanganui
Dr Symon Armstrong	
Thomas Rudegeair	Auckland Hospital
Tracey Potiki	He Oranga Pounamu
Tui Faasili	Pacificare Trust
Victor Yee	

Appendix B: Consultation Questions

1. Does the action plan accurately reflect the intent of *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan*?

Yes
 No

Comments:

2. Are there any actions you particularly endorse?

Yes
 No

Comments:

3. Are there any actions that you think need to change?

Yes
 No

Comments:

4. Have any key actions been missed?

Yes
 No

Comments:

5. Do you have any other comments on the action plan?

Yes
 No

Comments:

References

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