

PROTECTING AND PROMOTING MENTAL WELLBEING: BEYOND COVID-19

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EXECUTIVE SUMMARY

The COVID-19 pandemic struck the world with startling swiftness, bringing with it enormous uncertainty that will continue even after it is brought under control. The ongoing global crisis presents a pervasive challenge to our way of life, testing our long-held beliefs and undermining our basic notions of safety, predictability and agency.

The effects on our collective mental wellbeing are just beginning to be truly appreciated. Not only could COVID-19 have a devastating effect on already vulnerable sectors of society, but also we anticipate a second, and potentially large cohort of newly at-risk people as a result of the economic downturn, both globally and nationally, and expected ongoing rise in unemployment.

A prolonged period of chronic stress means New Zealand's recovery period will also be long term, and considerable socioeconomic and psychosocial support will be required. In the context of an essential 'reset' of many services and functions, the mental health sector has an opportunity to reinvent itself, moving from an outdated lexicon in favour of adaptive and innovative approaches.

A strong consensus exists among mental health professionals that the time is right for a paradigm shift away from mental illness towards mental wellbeing. There needs to be a broader focus on preventive actions and measures designed to keep individuals, families and communities well. First, there is an urgent need for central government to address critical upstream structural drivers of socioeconomic determinants of mental health and wellbeing. This should be complemented by grassroots research, action and empowerment to better understand and meet communities' needs and aspirations. For individuals needing a greater level of professional care for their mental wellbeing, services need to be culturally responsive and evidence-based.

As we enter the recovery period, it will be important to recognise the distinctive needs of those who already had mental wellbeing difficulties pre-COVID-19 (about 20% of the population every year), as well as a 'new' cohort who find themselves unexpectedly at risk as the pandemic's broader psycho-social-economic impacts begin to bite. Those formerly at risk are predicted to become even more so, putting further strain on a system that was already under pressure. Those newly at risk (currently an unknown number, but potentially doubling the overall level of need) may require standard as well as bespoke forms of support and/or intervention. Children and youth, who are experiencing multiple transitions, will have stress compounded by disruption to schooling and future prospects. Adults will be facing loss of jobs and businesses (women may be at particularly high risk of unemployment because of the sectors they are employed in), and possible role changes within families or couples. As such, it will be important to consider the effects of these dynamics on families and relationships more generally.

Rebuilding a sense of individual and collective agency will be key at every level of society for promoting mental wellbeing. Encouraging self-determination in mental health care will be

essential for delivering effective and acceptable services guided by best practice.

For Māori and Pacific populations, the impacts of COVID-19 will be great, as intergenerational disadvantage and high levels of deprivation are already a reality. The effects of the global pandemic and lockdown period will bring more stress, and many have already felt extensive employment impacts. As such, culturally aligned psychosocial support and services are urgently needed, beginning with those communities with the greatest risk and need.

RECOMMENDATIONS

- The standard population pyramid of need and service-response places those with the most severe mental wellbeing needs at the top (apex) of the triangle, with the preventive population-wide initiatives forming the broad base. This way of thinking must now be inverted to signal the fundamental change in how most stakeholders (and all members of this expert group) conceptualise mental wellbeing and the approaches required to protect and promote this at a national level. It prioritises pre-emptive, primary and secondary prevention to address 'problems of living' in the community. In doing so, it recognises the reality that many people struggle at different points in their life, and that the ongoing challenges of COVID-19 risk undermining the psychological wellbeing among many, if not all citizens.
- It also highlights the central role that communities *must* play in the design, implementation and evaluation of coal-face supports and interventions. COVID-19 appears to have led to a remarkable consensus in support of this paradigm shift – one characterised by 'equal' partnership between the Government and communities. This general idea has been discussed for some time. However, it has never been fully accepted or implemented. Now is the time to enact such an approach.
- There will be greater need for easily accessible e-mental health support and treatments, but these digital tools and services need to be evidence-based, validated and regulated to ensure safety, effectiveness and acceptability for all users. The implementation and support of strongly evidenced-based approaches must be an immediate priority.
- Rapid implementation and expansion of several key recommendations from the *He Ara Oranga* Mental Health and Addictions Inquiry report (and supported in the Government's May 2019 Wellbeing Budget in the form of 'Increased Access and Support of Primary and Community Mental Health and Addiction'). This involves the move to a more community-based model of mental health-service delivery, beginning with the integration of support services into general practice and other community settings. This laudable initiative needs to evolve further, and take the form of a high-trust, decentralised approach to protecting and promoting mental wellbeing.

- As part of this expansion, and recognising the central role of work in promoting wellness, GP practices – as well as other community settings – should have Individual Placement and Support Services (IPS) specialists attached. The transition back to work is central in the 2020 Budget and supported across the political spectrum. There is ample evidence showing the benefits of this work-placement approach. It therefore makes sense to roll this out as soon as possible.
- Māori are at high risk now and into the foreseeable future. They will likely benefit from mainstream *as well* as Māori-specific services to improve their mental wellbeing as a collective. Exploration of how te ao Māori perspectives can enhance mainstream services should be prioritised.
- The accurate, real-time data collection about levels of psychological distress in the population is urgently needed so that we can understand and respond dynamically as we enter a protracted period of psychological readjustment (e.g., until an effective vaccine is available to all New Zealanders in the first instance – generally thought to be 18–24 months away). Based on what we have seen previously, for example in the aftermath of the Christchurch earthquakes,¹ and what is known from overseas disaster experiences, we must prepare for increasing levels of disillusionment and despair in the months ahead, as the true impact and magnitude of COVID-19 takes hold. Further outbreaks and/or rapid cycling up and down security levels can be expected to compound these challenges and increase psychological distress.
- We must prepare and act now. There is a potentially eerie parallel between the lack of medical preparedness seen in some jurisdictions around the world (mainly public health capacity and basic pandemic planning) and what might occur in the psychological arena. That is, we have a reasonable understanding of what to expect in terms of psychological and social impacts (noting precise estimates are never possible). For example, Australian modelling in early May 2020 estimated “that there may be a 25 per cent increase in suicides, and it is likely that about 30 per cent of those will be among young people”.² We have the opportunity to prepare. Failure to do so will likely lead to considerable, *but avoidable* psychological damage and suffering, affecting at least three living generations. This must not occur.

1 Morgan, J., Begg, A., Beaven, S., Schluter, P., Jamieson, K., Johal, S., ... Sparrow, M. (2015). Monitoring wellbeing during recovery from the 2010–11 Canterbury earthquakes: The CERA wellbeing survey, *International Journal of Disaster Risk Reduction*. <http://dx.doi.org/10.1016/j.ijdr.2015.01.012>

2 Bartone, Hickie & McGorry, 7 May 2020, Australian Medical Association (AMA), Joint Statement: COVID-19 impact likely to lead to increase in rates of suicide and mental illness. <https://ama.com.au/media/joint-statement-covid-19-impact-likely-lead-increased-rates-suicide-and-mental-illness>

PREAMBLE

Koi Tū is a non-partisan and evidence-based think tank focused on the long-term issues affecting New Zealand and globally. It is hosted in the University of Auckland, but is engaged with associate members across New Zealand and internationally. It hosts conversation groups on specific issues.

This paper is one in a series arising from the Koi Tū conversations related to the COVID-19 pandemic and its consequences. The initial discussion paper *The Future Is Now*³ provides an overview of the issues created by the pandemic, and highlights New Zealand's opportunity to take a hard look in the mirror. Will it seek to revert to 'business as usual', despite the reality that the new normal will not be the same as that which existed before the pandemic? Or will it use this event to look to reset the way the country progresses?

The pandemic will leave a long tail of social and economic disruption as a result of the lockdown and the ongoing global disorder and likely recession. New Zealand is now entering a period of significant challenge affecting our people and the economy. Some elements of this disruption to society are discussed in the second paper in the series, *He Oranga Hou: Social Cohesion in a post-COVID world*.⁴ This current paper focuses on the effects on individuals and in particular their mental wellbeing. It was informed by extensive and iterative conversations with a diverse group of experts and practitioners who have contributed to the final report. These contributors are listed at the end of the paper (see p23).

INTRODUCTION

The traditional and rather narrow concepts of mental illness are giving way to a holistic, more contextual focus on addressing mental wellbeing. The World Health Organisation defines mental health "as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".⁵ This paradigm shift suggests that mental distress is better characterised as 'problems of living', rather than by the old lexicon of symptoms, syndromes and disorders.

Such a change in perspective is consistent with both modern research findings and the lived realities of people. More specifically, it explicitly acknowledges the relevance to the challenge of mental wellbeing of a broader set of social determinants, such as poverty, food insecurity, precarious employment, inadequate accommodation, peer and family context and developmental opportunities (e.g., education). Importantly, it accords with state-of-the-art research showing that: (i) susceptibility to mental and emotional distress exists on a continuum; (ii) the specificity implied by multiple diagnostic categories is largely spurious; and (iii) most people will at some stage of their life experience a period marked by high levels of psychological distress, tantamount to meeting criteria for diagnosis.

Mirroring this richer understanding of the nature of mental wellbeing, it is increasingly recognised that traditional forms of treatment administered by experts are no longer entirely fit for purpose (except possibly at the more severe end of the spectrum). The report from the Government Inquiry into Mental Health and Addiction, *He Ara Oranga*,⁶ encapsulated this when recommending a move to a community-based delivery model in which services and supports were provided according to need, and matched to our population's diversity.

But COVID-19 substantially changes the needs landscape. It is timely, then, to reflect on the mental wellbeing needs of the whole population and how they should be addressed. These needs extend well beyond traditional mental illness services and require a very different relationship between a broader range of interventions and individuals and between the Government and communities.

3 Gluckman & Bardsley, 2020, *The Future is Now: Implications of COVID-19 for New Zealand*, Auckland: Koi Tū: The Centre for Informed Futures, The University of Auckland. <https://informedfutures.org/wp-content/uploads/Koi-Tu-The-Future-is-Now.pdf>

4 Spoonley et al., May 2020, *He Oranga Hou: Social Cohesion in a post-COVID world*. Auckland: Koi Tū: The Centre for Informed Futures, The University of Auckland. <https://informedfutures.org/social-cohesion-in-a-post-covid-world/>

5 World Health Organisation, *Mental Health: a state of wellbeing*, August 2014. http://origin.who.int/features/factfiles/mental_health/en/

6 *He Ara Oranga: Government Inquiry into Mental Health and Addiction*, 2018. <https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/>

THE PSYCHOLOGY OF COVID-19

The COVID-19 crisis represents a pervasive challenge to our modern way of life, and to societal cohesion more generally.

⁷ Upending long-held beliefs, it has undermined fundamental notions of safety, predictability and agency (control over one's life), while challenging conventional ways of thinking and operating.

The pandemic hit at bewildering speed and brought with it enormous uncertainty. Under conditions of uncertainty, people's natural alarm system kicks in, i.e. the 'fight or flight' response. This short-term response system has helped humans survive throughout history, but quickly becomes problematic when activated for prolonged periods, and when it can't be turned off. Unfortunately, the features of COVID-19 will ensure that many people's 'fight or flight' response will remain on full alert for some time. This will elevate their risk for psychological (and physical) health damage, meaning few of us will escape completely untouched, either directly or indirectly, by COVID-19 and its flow-on effects. We can reasonably anticipate a significant increase in society's levels of psychological distress that is well beyond the accepted one-year population prevalence rate for mental morbidity of 20%.^{8,9}

Commentary to date, both here and internationally, has mainly focused on this 20%, predicting that added stress from COVID-19 could have a devastating effect on those already known to be at-risk. Less attention has been paid to a second, and potentially large cohort of newly at-risk people – those who have mainly experienced wellness in their lives, but who now confront a changed reality. For instance, airline pilots, travel agents and small business owners are now without careers, facing bankruptcy or worse. Those most heavily affected face a previously unimagined scenario. This could be even more intense among youth who are already grappling with major developmental transitions and whose ideas about their future may have been totally derailed. This new high-risk group has been catapulted into the unknown and will have to contend with sudden loss, a sense of failure, fragility, shattered confidence, ambivalence around help-seeking, *whakamā* (embarrassment), and, for some, suicidal ideas. The significance and 'deservingness' of their psychological distress might be questioned by society and indeed themselves, given their previous life advantages. As such, high levels of psychological distress can be anticipated in this group, who are unaccustomed to such feelings and may end up suffering in silence.

Before COVID-19, New Zealand's mental health services were poorly structured and already struggling to respond to existing levels of unmet need, and these added pressures have worsened the situation. Hence a number of questions arise: What is the new level of demand likely to be, both acutely and chronically? Are the current plans for service improvement agreed pre-COVID-19 still fit for purpose? Are there opportunities to act

differently to deal with both short and longer-term threats to psychological wellbeing? How should new initiatives be integrated with 'business as usual'? What is the right balance between pre-emption, primary and secondary prevention/intervention? What are the optimal configurations for services meeting the needs of the most severely afflicted? What role do the community and local context play in this new world? What value do research and evaluation have in ensuring services and supports are effective, holistic, accessible, and sensitive to our cultural milieu? What does co-determination of the future look like in Aotearoa-New Zealand circa 2020?¹⁰

SETTING THE 'PSYCHOLOGICAL' SCENE: THE BROADER SOCIETAL CONTEXT

Dynamic social, constitutional, economic, and political factors are at play, but the full effects will not be understood for some time. We are witnessing an economic downturn, both globally and nationally, with rapidly rising unemployment a major concern. From what we have already seen, the export, tourism, and education sectors will likely experience big changes and uncertain futures. There are also emerging signs of a desire for an environmental reset. The Government is already intervening, but inevitably such intervention is developed in a hurry and at the beginning of an election season, which itself creates further uncertainty, and will be uneven. It will be important to ensure policy promotes equality during the prolonged recovery period, with resources, support and opportunities accessible to all affected groups. In this, there will be differing requirements to ensure the sustainable wellbeing of young people, women, Māori, Pacific peoples, people who live with disabilities, single parents, 'essential workers' from the lockdown period and beyond, the newly at-risk as described above, older citizens who may be more isolated and less mobile, and the mentally unwell. Further, many matters are beyond the Government's control and depend on what the virus does and what unfolds globally. Therefore, we should expect a significant overlap across these (and other) domains in terms of issues and impacts, implying the essential need for cross-sectoral approaches to recovery in all sections of society.

This pandemic has touched the lives of everyone to some extent, creating the need to support the mental wellbeing of the whole population, while also addressing the needs of those most severely affected. There must be assessments at the grassroots of society to fully understand the realities of people's lives during COVID-19 in order to better recognise and meet their mental wellbeing needs. The crisis should be seen, then, as an opportunity for the mental health sector to adapt and improve in ways that better respond to the diverse needs now evident.

⁷ *He Oranga Hou: Social Cohesion in a post-COVID world*, May 2020.

⁸ *He Ara Oranga*, 2018.

⁹ Potter et al, May 22, 2017, *Toward whole of government/whole of nation approach to mental health*: <https://www.pmcsa.org.nz/wp-content/uploads/17-08-14-Mental-health-long.pdf>

¹⁰ Co-determination refers to equal partnership between iwi and the colonial government, according to Te Tiriti o Waitangi. See Treaty of Waitangi principles as expressed by the Courts and the Waitangi Tribunal. <https://waitangitribunal.govt.nz/assets/Documents/Publications/WT-Principles-of-the-Treaty-of-Waitangi-as-expressed-by-the-Courts-and-the-Waitangi-Tribunal.pdf>

As the New Zealand Medical Association Chair, Kate Baddock, reported to the Epidemic Response Committee:

there is an underlying stress level associated with loss of jobs, loss of income, and without clear understanding of what that's going to look like going forward. We are going to see a huge amount of mental health over the next six to 12 months and beyond ... There are massive levels of suppressed mental issues in the population currently. Underlying stress levels are high, especially for those dealing with 'unknowns' around life, employment, and job security, which keeps a constant stress level present at all times. As such, mental health is going to be a big area of care over the post-lockdown months.¹¹

THE NATURE OF STRESS AND DISTRESS

Typically, the human response to high threat or stress comprises: (i) an initial reaction to the immediate threat (the acute stress response phase); followed by (ii) attempts to adapt and/or cope with the high levels of ongoing stress (the chronic stress response). With COVID-19, this chronic stress phase will be prolonged as a result of ongoing uncertainty regarding how the pandemic will unfold globally and how health and

socioeconomic events will unfold domestically. The first major de-escalation point is expected to be when an effective vaccine becomes available and when international travel without risk becomes possible, but the timeline to vaccine success and universal availability is highly uncertain. Thus, it seems that many people will face disadvantaged and unresolved circumstances and anxiety over their future, perpetuating problems of despair, anger, anxiety and depression, over an extended period.

This period of chronic stress will be both dynamic and emergent. In other words, we won't necessarily know what the problem is until it has been widely experienced. This evolving clarity is akin to driving a car at 100km/h in a Westland forest while looking out the side window at the passing surrounds. All you can see is a blur, but the forest slowly comes into relief the longer you look through your rear-view mirror.

It has long been recognised that people's responses to stress vary greatly. Science explains this 'heterogeneity in response' in terms of an interplay between a person's life experiences (nurture) and their genetic endowment (nature) as well as the influence of contextual modifying factors, either distally (e.g., poverty) or more proximally (e.g., the buffering effects of good social connections).



Photo: Perry Grone / Unsplash

11 Kate Baddock, Chair, New Zealand Medical Association – Paraphrased. Epidemic Response Committee, 22 April, 2020. Transcript and video: <https://www.parliament.nz/en/pb/sc/sc/epidemic-response/news-archive/watch-public-meetings-of-the-epidemic-response-committee/>

IDENTIFYING DIFFERENTIAL VULNERABILITY IN THE POPULATION

In the discussion that follows, we refer to two overlapping groups: those who are stress-experienced (the 'previously at-risk') and those newly stress-exposed (the 'newly at-risk'). This categorisation should be viewed simply as an organising heuristic, and thus should not be reified. There will likely be highly complex needs in both groups, but the specific aspects may differ between groups. As such, we caution against an automatic application of universal approaches as these may be less effective, especially for Māori, Pacific peoples and other minority groups. Instead, a focus on restoring and promoting wellbeing in context will be key, as will the need to restore a sense of spiritual wellbeing for those for whom this is integral.

PRE-COVID

The **Previously At-Risk** group in the general population (about 20% in any one year) have been well described in the sociological, developmental, clinical and treatment literature. We know what the ideal evidenced-based prevention and treatment looks like for this group, but also recognise that this ideal has rarely been achieved. Specifically, Māori, Pacific peoples, the economically disadvantaged, minorities, LGBTQIA+ persons, people who live with disabilities, those with diagnosed mental illness, those with substance addictions, people without

work, people who have to rely on government income support, those involved in the justice system, and single parents are over-represented in this high-risk group. In general, their mental health issues often appear in the teenage years and magnify thereafter.

POST-COVID

The **New At-Risk** group of children, adolescents, working-age adults, and older citizens facing major disruption in their lives – disruption they did not prepare for – may be, somewhat paradoxically, less resilient than the previously at-risk. This is because they are less likely to have experienced such situations of being completely overwhelmed, without hope, and without a sense of personal efficacy or agency. These newly vulnerable people may not know how to seek help, and their peers and family may not recognise their needs. They will have little or no experience of welfare and agency support. They face status degradation, which will create psychological tension impacting on their families. Existing generational tensions, such as between 'boomers' and today's youth, may be compounded given young people's already escalating rates of mental health concerns. Put simply, the new at-risk group have no playbook for this scenario and could respond in unpredictable or even catastrophic ways.



IMPACTS ON SPECIFIC POPULATION GROUPS

IMPACTS FOR MĀORI

Undoubtedly, it should be a priority to identify the pandemic's impacts on Māori, as they already carry a disproportionate load of disadvantage. However, it should also be noted that Māori elders tend to be more resilient in terms of mental wellbeing, even when disadvantaged or physically vulnerable.¹² In terms of employment impacts, whānau Māori have already been hit hard financially, with significant job losses to date and more jobs hanging in the balance for many wāhine and tāne (women and men). A Ngāti Whātua Ōrākei survey reveals sizeable impacts on their iwi respondents: 51% have had financial losses and up to 34% are facing job losses, particularly self-employed business owners and those employed in retail, tourism and hospitality sectors.¹³ In the Gisborne area, Māori have been heavily affected as the export-dependent forestry industry has estimated a loss of 1500 jobs nationwide so far, with 75% of forestry workers being Māori.¹⁴

Pre-COVID, Māori consistently had the highest addiction risk¹⁵ and worst mental health outcomes¹⁶ of all ethnic groups in New Zealand. With suicide rates higher among those who are male, Māori, and living in high deprivation,¹⁷ these recent job losses indicate an urgent need for targeted cross-sectoral support for Māori. Younger Māori generations who are already disadvantaged in terms of training and employment opportunities will face uncertain futures around employment. With rangatahi (young Māori 15–24 years) having the highest suicide mortality rates in the country, and Māori males within this group having the highest rates of suicide, significant support will be needed for this highly vulnerable group. Moving into the recovery period, appropriate services that better meet the needs of Māori will be required. Recent reports tell us the current system is too clinically focused,¹⁸ which suggests best outcomes for Māori are unlikely to result solely from e-therapy or clinical care.

In general, Māori have been badly shaken by the crisis. They feel the Government failed to consult them in the early stage of the pandemic.¹⁹ Indeed iwi (tribe) and hapū (sub-tribe) worked together to rapidly develop their own support systems and some of these efforts have been impressive²⁰ – there is much for Pākehā to learn from them.²¹ Young Māori in particular are very concerned, especially those who themselves have young children. These rangatahi are inclined to mistrust official information and therefore not engage with it,²² which in turn exacerbates their anxieties. More than half the Māori population is aged 25 years or under.²³ Tamariki and rangatahi are an especially vulnerable group, because many already experience the burden of intergenerational exposure to determinants of poor mental wellbeing: poverty, multiple disadvantages, and material hardship.²⁴ Before COVID-19, about 25% of Māori children were living in poverty and over 40% of Māori were living in areas of high deprivation.²⁵ This suggests an urgent need to reduce persistent disadvantage across this vulnerable population to alleviate further stress from COVID-19's impacts.

IMPACTS FOR PACIFIC PEOPLES

Nearly 40% of Pacific people²⁶ live in crowded households (compared with 4% of New Zealand Europeans).²⁷ Over a quarter of Pacific families live with other families,²⁸ and households are often multi-generational, with elderly cared for at home rather than in formal care. Pre-existing high unemployment rates will be exacerbated by the secondary stressor of job loss and contribute to already disproportionately high levels of mental distress for Pacific adults^{29,30} in particular, the 'children of the migration' generation, who may be supporting both parents and children in the same household. This psychological distress can be compounded when they are unable to contribute to family and community obligations,

12 Russell, 2018, *Te Oranga Hinengaro: Report on Māori Mental Wellbeing Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey*. Wellington: Health Promotion Agency/Te Hīringa Hauora.

13 Ngāti Whātua Ōrākei, 2020, *COVID-19 Impact report*, Whai Maia Ltd.

14 McLachlan, L., RNZ, 11 February, 2020. <https://www.rnz.co.nz/news/te-manu-korihī/409261/coronavirus-outbreak-hitting-forestry-industry-maori-families-hard>

15 WAI 2575, #B26. Gassin, August 2019. *Māori Mental Health*. A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Inquiry.

16 WAI 2575, #B30. Walker, December 2019. *Issues of Tobacco, Alcohol and other Substance Abuse for Māori*.

17 Gassin, 2019, *Māori Mental Health*, WAI 2575.

18 *He Ara Oranga*, 2018. *ibid*.

19 Menzies, 5 April, 2020, <https://informedfutures.org/inclusive-and-deliberative-decision-making-in-the-covid-19-pandemic/>

20 Menzies, 1 May, 2020, <https://informedfutures.org/a-pandemic-response-framework-for-equitable-and-inclusive-planning-and-decision-making/>

21 Kukutai, Moewaka Barnes, McCreanor & McIntosh, 19 May 2020. <https://theconversation.com/recession-hits-maori-and-pasifika-harder-they-must-be-part-of-planning-new-zealands-covid-19-recovery-137763>

22 Ngāti Whātua Ōrākei, 2020. *ibid*.

23 *Health and Disability Systems Review – Interim Report*, 2019.

24 StatsNZ, Child poverty statistics: Year ended June 2019. <https://www.stats.govt.nz/information-releases/child-poverty-statistics-year-ended-june-2019>

25 *Health and Disability Systems Review – Interim Report*, 2019.

26 'Pacific Island' or 'Pacific people' is a collective term used here to describe over 300,000 people of diverse cultures from Pacific islands nations residing in New Zealand – in the most part Polynesians from Samoa, Cook Islands, Tonga, Niue, Tokelau, Tuvalu, and also Fiji, Micronesia and Melanesia. The term does not imply homogeneity. Each nation has its own specific languages, beliefs, customs, values and traditions.

27 Ministry of Pacific Peoples. <https://www.mpp.govt.nz/assets/Uploads/Contemporary-Report-Web.pdf>

28 Pasifika futures. http://pasifikafutures.co.nz/wp-content/uploads/2015/06/PF_HowAreWeDoing-RD2-WEB2.pdf

29 Foliaki S., Kokaua J., Schaaf D., Tukuitonga C. 2006. Pacific People. In: M.A. Oakley Browne, J.E. Wells, K.M. Scott (eds). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

30 Ataera-Minster, J., & Trowland, H. (2018). *Te Kāveinga: Mental health and wellbeing of Pacific peoples. Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey*. Wellington: Health Promotion Agency.

such as religious contributions and remittances to the islands, because these commitments can be intertwined with cultural identity, assigned status in social structures, cultural values (e.g., reciprocity), and ultimately their sense of self and place within their culture.

Churches have been likened to a marae for Pacific people in New Zealand and the ripple effect of reduced donations may put this major support system at risk. The reduced remittances to the islands would have a significant impact on extended family, and also national economies, given that some South Pacific islands are among the highest remittance recipient countries in the world.³¹ Job losses for the 9,500 Pacific horticultural and viticultural workers in the Government's seasonal employment scheme will also affect Pacific nations' economies.³²

IMPACTS FOR CHILDREN AND YOUTH

Children and youth are naturally experiencing multiple transitions in development, such as from home to school, from child to teenage social roles, and biologically from pre- to post-puberty. Recently, this has been compounded by disruption to schooling, particularly during already stressful (NCEA³³) years. The rates of mental health morbidity in young people have been rising rapidly over the last decade in many countries,³⁴ including New Zealand, for reasons that have yet to be properly investigated, but clearly relate to multiple changes in the milieu of development. The effects of the COVID-19 crisis on children and youth are not well understood. For example, during lockdown, young people have reported difficulties with self-regulation in the online space; problems with motivation to complete schoolwork and study; struggles with being disconnected from friends and usual activities; and fears of 'what will the world be like?'. Schools are going to be important for identifying early intervention opportunities. Beyond being able to recognise signs of mental distress, staff need to be confident that their students will have prompt access to support, instead of having to deal with frustration around referrals to overstretched and sometimes unresponsive services. School leavers especially are going to need support dealing with (un)employment challenges. Finally, psychological science suggests children who are not showing signs of distress now may instead be 'incubating' poor mental wellbeing, only to have it spill over in later years via stress sensitisation processes.

ADULTS FACING LOSS OF JOBS AND BUSINESSES

A particularly heavy impact of job loss on adults aged 50+ years can be expected, as there will be less likelihood of new employment in a highly competitive job market. Loss of jobs as a result of closure of industries will make employment a challenge for some workers who will need to change industries or retrain. Some sectors and jobs are being hit especially hard and are unlikely to recover for many years, e.g., forestry, tourism, and the airline industries.

Household incomes will be affected, with fewer earners or members becoming benefit-dependent, even if temporarily. Reliance on benefits could have negative effects on people's identity and core values. Role changes within families or couples may also occur. As such, it will be important to consider the impact of these dynamics on families and relationships more generally, and have appropriate support readily accessible.

Extra stress and risk for women is likely. Some women may become the main income earner, in addition to being a partner and mother. Others may now be out of the workforce and suddenly reliant on partners, whānau or benefits. Women with children will need additional resources and support around childcare in order to access training and employment. Having safe, accessible, and responsive psychosocial support and services as well as retraining opportunities will be paramount to promoting wellbeing for women during the recovery phase.

For adult males, facing job loss may have an extra impact on their mental wellbeing, as role expectations may be entrenched. For many males, their sense of wellness is closely linked to gainful employment and the ability to support their family. Cultural constructs around gender roles also need to be carefully considered, especially for Māori and Pacific males. Inability to support families can be devastating for some men, and their mental wellbeing could seriously decline as a result.

Newly unemployed people may use negative coping strategies to feel better, e.g., alcohol, drugs, and tobacco. Coupled with anger and frustration, this could result in additional issues, such as relationship problems, divorce, chronic conditions, premature mortality, domestic violence and harm, suicide, mental illness, accidents, and self-harm.

31 Connell, J. & Brown, R. 2005. *Remittances in the Pacific: An overview*. Asian Development Bank.

32 Ministry of Pacific Peoples. April 2020. *COVID-19 Community Insights and Data*. Unpublished.

33 National Certificate of Educational Achievement, NZ

34 Ministry of Health. *New Zealand Health Survey Online*. 2019. <https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey>

THE ‘PSYCHOLOGICAL’ ROAD AHEAD: HOW SHOULD WE PREPARE?

As can be seen in this stylised diagram, we should expect greater psychological challenges in the months ahead, compared with those experienced during lockdown (see Figure 1.). Obviously, this is a troubling thought, as many found our first lockdown very draining as a result of the social isolation, disturbance of normal activities, and constant worry about the future. The first stage of that ‘future’ has now arrived as we have entered Level 2. Anticipation of what lies ahead provides us with a chance to mitigate the worst-case scenarios and mount pre-emptive coping strategies, for both the short and longer-term.

Here a cautionary note is appropriate: it would be prudent to acknowledge the possibility that COVID-19 will reappear, necessitating a quick upgrade in risk level at some point in the future. Given the uncertain science regarding control of the virus, the foreseen wait before a vaccine may appear and the need at some stage to reconnect New Zealand to the global community by air travel, this change in alert level may be necessary on several occasions. Hopefully, we can avoid this, because level changes will certainly exacerbate what is already a highly stressful situation. Were this possibility captured in Figure 1, it would show further dips over a longer period of time.

MĀORI PERSPECTIVES

We recognise there are different perspectives on what constitutes mental wellbeing in a culturally diverse society like ours, and that this will need to be explored further to gain a deeper understanding of commonalities and differences among groups. In particular, it is necessary to understand different cultural constructions around health and wellbeing in order to provide culturally responsive approaches and services.³⁵ In this regard, adopting a te ao Māori (Māori worldview) lens for the recovery period is crucial for supporting Māori mental wellbeing. As represented in widely-used Māori models of health, like Te Whare Tapa Whā,³⁷ holistic cultural constructs view mental wellbeing as dynamically interconnected with body, spirit, and whānau dimensions of wellbeing, meaning you cannot separate the mental dimension from other dimensions.³⁸ This further speaks to the need for extensive implementation of te ao Māori approaches for mental health and wellbeing.

For Māori and the nation, the recovery will be dependent on the quality of culturally informed evidence that draws on the breadth and depth of Māori expertise. The response from Māori communities to COVID-19 has been an expression of mana motuhake (sovereignty) as well as an expression of partnership with the Crown in the face of a crisis. This has been achieved through implementing public health measures aligned with

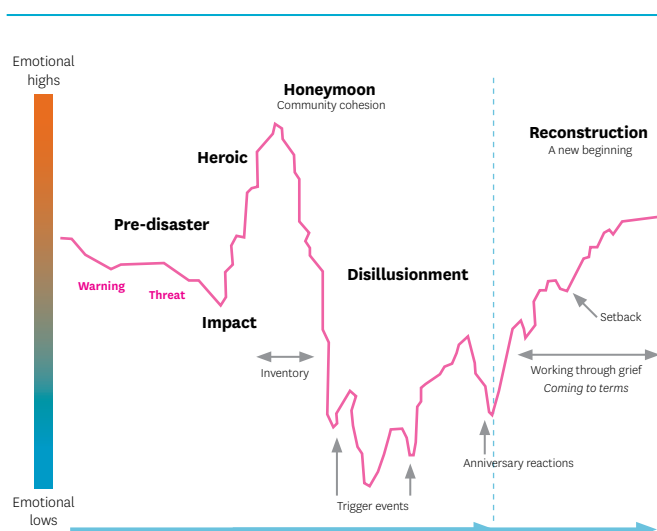


Figure 1. General phases of disasters and how they can affect survivors psychologically and socially³⁵

a tikanga (Māori customs) framework.³⁹ The commitment to ensuring collective wellbeing was most apparent in the innovative, but culturally consistent way tangihanga (funeral) have been observed. Given the centrality of tangihanga to te ao Māori, these adaptations have required a high level of sacrifice, but reinforce the commitment for Māori communities to safeguard the health of whānau Māori while meeting emotional and cultural needs.⁴⁰

As we enter the recovery phases of the pandemic,⁴¹ the need for inclusive decision-making with iwi in COVID-19 planning and response, which was largely absent in the first phase, must be urgently addressed. Inclusive and deliberative discussions and decision-making to ensure best outcomes for Māori are required, and a stronger Iwi-Crown partnership through co-determinative approaches will be key to progress issues that are fundamental to our nation’s future. So, how do we actually ‘do’ co-determination? Essentially, it revolves around collectively determining the type of future we envision and aspire for ourselves and for the generations to come. It means creating new national narratives, but also a recognition of the need for ōritetanga (equality). In this spirit, the principle of kotahitanga, that is a sense of unity based on shared vision, purpose, and expectations, would help guide the partnership and collective action. However, resourcing must follow expertise.

In this regard, tino rangatiratanga (self determination), will be paramount to promoting social wellbeing by ensuring that Māori retain and enhance their wairuatanga (spirituality). It acknowledges the need for Māori and their communities to

35 SAMHSA, 2020. <https://www.samhsa.gov/dtac/recovering-disasters/phrases-disaster>

36 Health & Disability Systems Review, 2019, Interim Report.

37 Ministry of Health, Māori models of health. <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models>

38 Te Rau Matatini, 2015, *Kaupapa Māori mental health and addiction services: Best practice framework*. Wellington: Te Rau Matatini.

39 Menzies, 1 May 2020, Koi Tū: The Centre for Informed Futures.

40 Kukutai, Moewaka Barnes, McCreanor & McIntosh, 19 May 2020. The Conversation. <https://theconversation.com/recession-hits-maori-and-pasifika-harder-they-must-be-part-of-planning-new-zealands-covid-19-recovery-137763>

41 Menzies, 5 April 2020, Koi Tū: The Centre for Informed Futures.

collectively regain their sense of agency and control, which can be lost in times of crisis. Fundamentally, it requires innovative, collaborative approaches to recovery that are culturally responsive and mandated by communities, not overbearing top-down approaches. We also need to change deficit discourse around Māori and mental health, ensuring Māori and Māori ways of knowing and being are seen as informing solutions. Exercising mana motuhake is key to overdue mental health conversations and progress towards sustainable solutions. Self-determination exercised by Māori regarding their mental wellbeing means putting power and resources in the hands of those with the greatest mental health needs.

PASIFIKA PERSPECTIVES

Traditionally, Pacific cultures are inherently collective and relational with a holistic perspective of wellbeing where cognitive, emotional, spiritual, physical, environmental, and relational dimensions of the self are required to be in harmony for positive wellbeing. The conceptualisation of balanced relationships underpins many models of Pasifika wellbeing.⁴² For most Pacific peoples, family (*āiga, kāiga, magafaoa, kōpū tangata, vuale, fāmili*) is central to wellbeing providing identity, status, honour, prescribed roles, care and support.⁴³ A major challenge to addressing Pacific peoples' high rates of mental distress, exacerbated by the secondary impacts of COVID-19, will be integrating these cultural worldviews into the delivery of support services, which are often designed based on contrasting worldviews.

Having resided in New Zealand for over 100 years, Pacific people have a unique place, with special relations through shared Polynesian whakapapa (genealogy) to Māori, as well as strong government relationships and moral obligations between New Zealand and its neighbouring countries and territories in the South Pacific. New Zealand's recruitment of a Pacific workforce to address the labour shortage in the manufacturing sector in the early 1970s saw a spike in migration. However, when recession hit not long after, Pacific people were targeted in the infamous 'dawn raids' as overstayers to be deported. Many believe this turn of racially-fuelled events laid the foundations for Pacific peoples' disproportionate representation in the social determinants today that affect wellbeing, such as low education, high unemployment, crowded households, and inequities in access and outcomes in health care.⁴⁴ The looming economic recession may give rise to anxiety and fear of history repeating itself, and the potential issues of contact tracing in this community have been highlighted.⁴⁵ It is perhaps not unanticipated to see that Pacific people now have higher rates of mental distress than the general population, and for young people, who make up over half the Pacific population, suicide is the leading cause of death.

There are, however, unique culturally based resiliencies within Pacific communities that any pandemic response or recovery plan should reinforce. Guided by Pacific leaders, including clergy, health and social-sector leaders and business leaders and supported by the Ministry for Pacific Peoples and other government agencies, Pacific communities have galvanised their collective response to the pandemic. Key messages on COVID-19 containment measures, social isolation, physical distancing, funeral and gathering protocols,⁴⁶ reducing risk for family violence,⁴⁷ wage subsidies and business support⁴⁸ have been delivered via the right channels – through church ministers, Pacific language radio stations, and Pacific organisations, and by credible Pacific leaders on TV and via social media, particularly for young people. Pacific health-care mobile units and testing stations were also established in record time, led by Pacific communities. This culminated in Pacific people having the lowest rates of COVID-19 and the highest rates of testing by ethnicity.

Pacific-led approaches to response and recovery have demonstrated how enhancing decision-making, self-efficacy and agency of Pacific communities enables them to build on the pre-existing social capital and trusted relationships, and lead solutions that protect and enhance the wellbeing of their families, and that of all New Zealanders.

42 Kingi-Uluave, D., Faleafa, M., Brown, T., Wong, E. (2016). Connecting Culture and Care: Clinical practice with Pasifika people. In *Professional Practice of Psychology in Aotearoa New Zealand* (3rd Edition). Edited by Ian M. Evans, Julia J. Rucklidge, Michael O'Driscoll. Wellington, NZ: New Zealand Psychological Society.

43 Ministry of Health. 2020. Ola Manuia. *Pacific health and Wellbeing Action Plan 2020–2025* ... in progress of publication.

44 Tukuitonga, C. (2013). Pacific people in New Zealand. In I. St George (Ed.), *Cole's medical practice in New Zealand* (12th ed.; pp. 66–73). Wellington, New Zealand: Medical Council of New Zealand.

45 Tukuitonga, C. 2020. <https://informedfutures.org/challenges-of-contact-tracing-in-pacific-communities/>

46 New Zealand Government, 2020. <https://covid19.govt.nz/communities/pacific-peoples/>

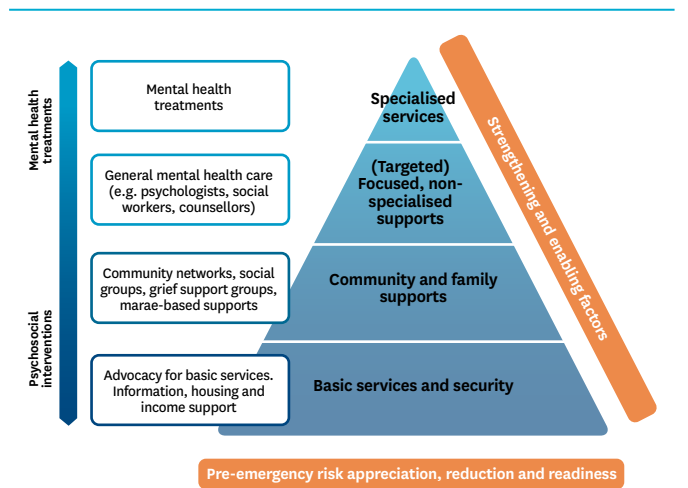
47 Le Va, 2020. <https://www.leva.co.nz/our-work/catchyourself>

48 Pacific Business Trust. 14 April, 2020. *Pasifika Business in the Midst of COVID-19: A perspective*. Unpublished paper to Treasury.

STEPPED-CARE APPROACHES TO MENTAL WELLBEING

A stepped-care model is consistent with proportionate universalism principles. That is, everybody receives some services, usually pre-emptive or preventive, so that those who need more support get it. Although there are slightly different ways of operationalising this approach, it is now widely endorsed as the best conceptually, and is widely used for service planning and delivery. Typically, this model is presented as a hierarchy of needs, using a standard pyramid to illustrate and distinguish between different levels and types of activity. The large base of the triangle denotes the community-wide prevention space that narrows through the next two layers (typically mild and moderate need) to an apex that captures a relatively small percentage of the population with complex needs, typically requiring specialist services, as shown in Figure 2. The broad base of the triangle is underpinned by a set of values, aspirations and/or principles that are intended to guide implementation of services at every level.

Here we recommend that a similar triangular model be used, but that it be inverted. In this way, the previously broad base, comprising population-wide prevention efforts, now sits at the top. Above this whole-of-population layer sit the principles that should guide implementation at all levels below. These guiding principles must respect the diversity within our community. For Māori, it must include key concepts, such as tino rangatiratanga and honouring of Te Tiriti, thus ensuring co-determination approaches, which are critical in promoting mental wellbeing. This proposed inversion is not trivial by any means, as it lies at the very heart of what we believe is needed. Primarily, it values



Source: adapted from IASC (2007)

Figure 2. Tiered model of psychosocial interventions and mental health treatments⁴⁹

and privileges community-led delivery, particularly in the form of place-based initiatives. Further, it supports localised initiatives, like community hubs and marae, locating them front and centre within a new fit-for-purpose system aimed at protecting and promoting population mental wellbeing. We are not alone in our thinking, as can be seen in the recently published Ministry of Health Psychosocial Recovery plan⁵⁰ in Figure 3. The fact that this report adopted the same approach speaks to an unusually strong consensus across the sector regarding the necessary changes.

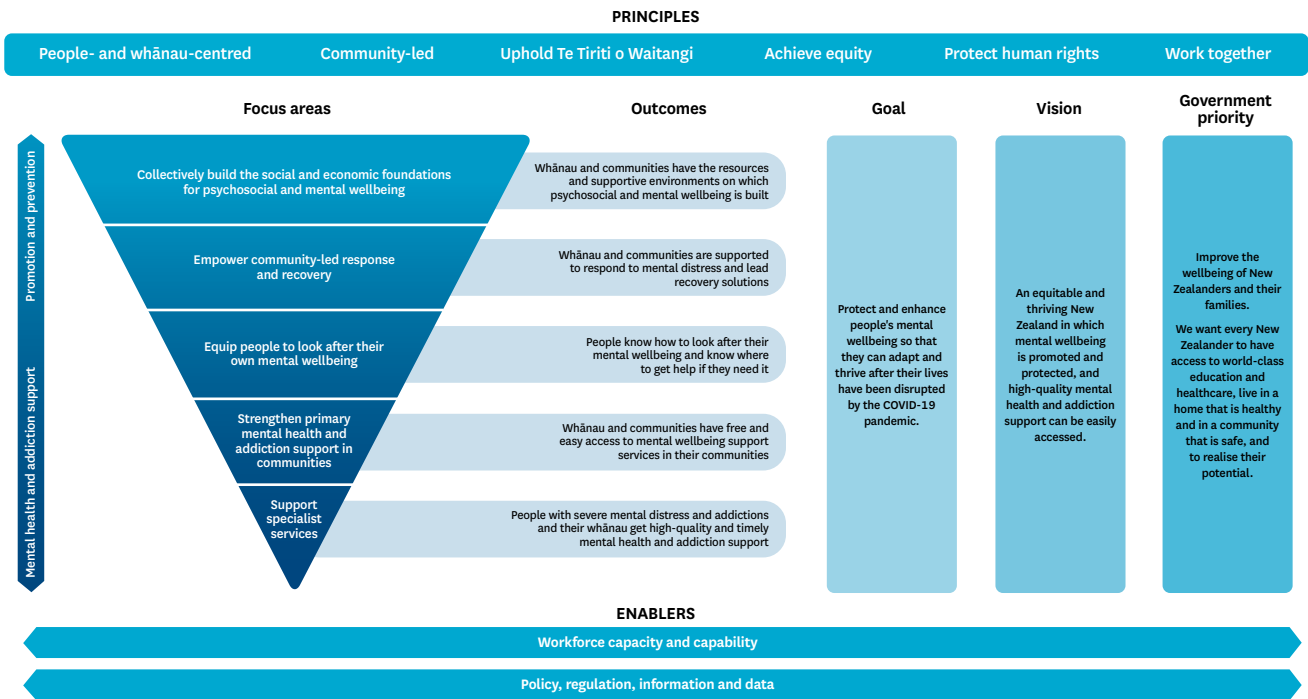


Figure 3. COVID-19 Psychosocial and Mental Wellbeing Recovery Framework⁵⁰

49 Ministry of Health. 2016. *Framework for Psychosocial Support in Emergencies*. Wellington: Ministry of Health.

50 Ministry of Health. 2020. *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Recovery Plan*. Wellington: Ministry of Health.

51 *ibid.*

The model shown in Figure 3 implies greater sharing of resources and equal decision-making between the Government, the NGO sector and communities. As such, it relies on high trust, much like that on display over the last two months, as a fundamental component of a new approach. Importantly, it addresses a sensitive issue, and one that has existed for a long time in the mental health arena: the need for greater autonomy for communities in terms of how they support their own. This approach requires meaningful recognition by the Government and agencies that communities have wisdom and capacity. Under such a model, the Government's primary role would be to gradually move from delivery and commissioning of services to that of supporter and facilitator, particularly for the top three levels of the inverted pyramid. The smallest group with high and complex needs and the structural determinants of mental wellbeing would become the primary focus of direct government intervention.

ADDRESSING STRUCTURAL DETERMINANTS OF MENTAL WELLBEING (HIGHEST LEVEL OF THE INVERSE PYRAMID)

Poverty and multiple disadvantage

Compelling data show that economic deprivation is strongly associated with psychological distress in the community. For instance, analyses from the New Zealand Health survey showed, pre-COVID, that while the overall prevalence of 'high psychological distress' was 5.8%, it was 24.3% among the most deprived decile and 0.8% in the least deprived, evidencing a 30-fold difference in outcomes.⁵² Additionally, there are numerous international studies linking income deprivation with levels of community distress. Therefore, policy and strategies for reducing population deprivation should be prioritised for the protection of collective mental wellbeing.

Unemployment

Unemployment is another major structural determinant of poor mental wellbeing. There is robust literature about the benefits of employment for those with a mental illness, including New Zealand data, particularly among young people. The good news is that there are proven interventions for getting the previously at-risk group or people with mental illness back into work sustainably. Collectively, these evidence-based practices are known as the Individual Placement and Support (IPS) employment support approach. Twenty-seven randomised control trials (RCTs) worldwide over the last 30 years have demonstrated that programmes following IPS employment support principles and practices are two to three times more

likely than traditional services to successfully support someone back into employment.^{53,54,55}

Traditional employment support services focus on lengthy training and preparation before commencing job search, often waiting for mental health symptoms to be 'cured' first. In these services, employment support is separate to health services. This follows the now discredited practice across all fields of vocational rehabilitation wherein someone receives medical treatment, 'recovers', and then is discharged. In these traditional employment programmes, it is only then that the person is considered ready to find employment, with or without support. In contrast, IPS employment support programmes consistently help people find jobs faster, hold down the jobs longer, work more hours a week and earn more. There is also a valid and reliable measure of IPS employment support programmes, which allows us to evaluate the quality of implementation. In this regard, the science is highly advanced relative to other practices we currently use in mental health.

The effectiveness of IPS employment support in primary care settings

What is particularly important at this time of increasing unemployment and rising levels of anxiety and depression is the emerging body of evidence, which includes a recent systematic review by researchers at Auckland University of Technology and University of Otago (Wellington)⁵⁶ that demonstrates these IPS employment support principles and practices are the most effective approach for supporting people whose mental health and addiction needs are concurrently being met in primary care.

Internationally, governments are recognising and responding to the evidence. For example, the Australian Government is systematically scaling up access to IPS employment support programmes through its youth mental health services, Headspace,⁵⁷ and the Australian Productivity Commission is recommending scale-up of IPS employment support programmes in adult mental health and addiction services.⁵⁸ Similarly, the UK Government has been increasingly investing in IPS employment support programmes, led by Public Health England and aptly named IPS Grow, while also investing in large-scale RCTs of IPS employment support in primary care and community-based alcohol and drug treatment services.^{59,60} Furthermore, the NHS⁶¹ Increasing Access to Psychological Therapies manual has a whole chapter on the importance of specialist employment support and how to implement this in the primary-care system.⁶²

52 Foulds, Wells, & Mulder. 2014. The association between material living standard and psychological distress: Results from a population survey. *International Journal of Social Psychiatry*, 60(8), pp 766-771.

53 Drake, 2020. Introduction to the special edition on Individual Placement and Support, 43(1), 1. DOI: doi.org/10.1037/prj0000401

54 Frederick & VanderWheel, 2019, Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support, *PLoS ONE*, 14(2). doi.org/10.1371/journal.pone.0212208

55 Kinoshita, Furukawa, Kinoshita, Honyashiki, Omori, Marshall, ... Kingdon, 2013, Supported employment for adults with severe mental illness. *Cochrane Database of Systematic Reviews*, 2013(9), 1-102. DOI: 10.1002/14651858.CD008297.pub2

56 Joanna K. Fadyl, Gail Teachman & Yani Hamdani (2019): Problematizing 'productive citizenship' within rehabilitation services: insights from three studies, *Disability and Rehabilitation*, DOI: 10.1080/09638288.2019.1573935

57 See recent evaluation: https://www.dss.gov.au/sites/default/files/documents/08_2019/individual-placement-and-support-trial-evaluation-report-june-2019.pdf

58 Productivity Commission 2019, Mental Health, Draft Report, Canberra. <https://www.pc.gov.au/inquiries/current/mental-health/draft> Final mental health report due in June 2020.

59 <https://www.gov.uk/government/news/phe-announces-areas-for-ips-alcohol-and-drug-dependency-trial>

60 <http://www.isrctn.com/ISRCTN17267942>

61 National Health Service, UK.

62 <https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/>

Successful implementation of IPS Employment Support in Aotearoa-New Zealand for over 15 years, but still no scale-up?

Despite this robust evidence base, and the successful implementation of IPS employment support programmes in mental health and addiction speciality teams in some District Health Board (DHB) regions for more than 15 years – with employment outcomes that are in line with and above international benchmarks – access to programmes has not been scaled up accordingly. Possible roadblocks include the current policy and contracting environment, both within and across the Ministry of Health and the Ministry of Social Development, which is acting as a barrier despite recommendations about what needs to change;⁶³ and the ad hoc, rather than systematic, manner in which the support needed to return to employment or retain employment is considered within mental health and addiction services. Employment support should be routinely available alongside all other health treatments, i.e., talking therapies and medications, with employment status used as a performance indicator for mental health and addiction services. This is not happening and there is a need to refocus and retrain the employment support workforce.^{64,65}

To illustrate, Work and Income case managers typically have a caseload of 80–200 people (depending on the type of case manager), whereas IPS employment support specialists manage a caseload of 20–25. Not everyone needs this intense level of support, but most people who have mental health and addiction issues need more support than is possible from a case manager working with 80 or more people and operating separately to health services.

For too long the number of people with mental health conditions who are unemployed has continued to rise. The 2018 OECD mental health and work report showed this, and explained why and what we needed to change in policy and practice.⁶⁶ Cabinet agreed to these OECD recommendations at the same time as it reviewed the recommendations in *He Ara Oranga*.⁶⁷ Sadly, little progress has been made to date, and with COVID-19 we are now facing an even bigger rise in unemployment and mental health and addiction issues. As the Wise Group's Joint Chief Executive, Jacqui Graham, reported to the Epidemic Response Committee: "... whilst we applaud the new employment centres being set up, there must also be an investment in having employment support attached to GP clinics and mental health centres, because the evidence shows us that we need to provide employment support integrated with care and treatment. That's how we get the best results".⁶⁸

Alcohol

A third, somewhat controversial structural determinant, despite considerable data, relates to alcohol use and abuse.⁶⁹ The Social Sector Science Advisors, supported by the then Chief Science Advisor to the Prime Minister, prepared two reports to the Mental Health and Addiction Inquiry, *He Ara Oranga*.⁷⁰ Both emphasised the damage done to mental wellbeing through abuse of both licit and illicit substances. Almost a decade prior, the Law Commission report on Alcohol in our Lives, led by Sir Geoffrey Palmer, made a series of policy recommendations to minimise harm associated with misuse.⁷¹ The current laws pertaining to the sale and use of alcohol sadly create additional structural determinants of poor mental wellbeing. At some stage, this issue needs to be reconsidered through the wider lens of societal mental wellbeing.

ADDRESSING SPECIFIC NEEDS (LEVELS 2, 3 AND 4 OF THE INVERTED PYRAMID)

These levels of the pyramid should include general education about managing stress during a pandemic as well as more specific advice and/or intervention for managing anxiety, fear and depression. Ideally, this would include messages about exposure to media and other general measures. Here the advent of strongly evidenced e-therapies is a distinct advantage. It is imperative that the best of these e-therapies become widely promoted, by both authorities and health-care practitioners. Before COVID-19, this was one of the ways the significant gap between established annual levels of mental health need (20%) and the current service capacity (3%) was going to be bridged. It was generally accepted that it is impossible to train and equip an expanded workforce quickly enough to deal with this current high level of unmet need, even with augmentation via peer support and retraining. Te Pou o Te Whakaaro Nui, the National Mental Health workforce agency, reinforced this point in its submission to the Mental Health and Addictions Inquiry.⁷²

One note of caution is warranted here. Online, digital forms of claimed support have proliferated during COVID-19, with many programmes appearing in the last few months. It is highly unlikely that any of the new entrants have had standard trialling, i.e., well conducted RCTs of efficacy and effectiveness, to prove (i) they do no harm, and (ii) they have benefits comparable to or better than 'business as usual' treatment. Obviously, this would not be expected for providers of lifestyle advice, generic support and encouragement, but should be expected for

63 Lockett, H. Waghorn, G & Kydd, R. Policy barriers to evidence-based practices in vocational rehabilitation for people with psychiatric disabilities in New Zealand. *Work*. 2018;60(3):421–435. DOI: 10.3233/WOR-182752.

64 Organisation for Economic Co-operation and Development (OECD). (2015). *Mental Health and Work Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*. Paris, France: OECD Publishing.

65 Organisation for Economic Co-operation and Development OECD. (2018). *Mental health and work: Aotearoa/NZ*. Paris, France: OECD Publishing.

66 *ibid*.

67 *He Ara Oranga: Government Inquiry into Mental Health and Addiction*, 2018.

68 Jacqui Graham (Joint Chief Executive, Wise Group), Epidemic Response Committee, 30 April, 2020, transcript and video: <https://www.parliament.nz/en/pb/sc/scl/epidemic-response/news-archive/watch-public-meetings-of-the-epidemic-response-committee/>

69 For examples see J Potter et al, May 22, 2017.

70 Social Sector Science Advisors. 2018. *Towards an Evidence-Informed Plan of Action for Mental Health and Addiction in New Zealand: A response by the social sector science advisors to the request of the Government Inquiry into Mental Health and Addiction*. Wellington: Social Sector Science Advisors.

71 Law Commission. April 2010. *Alcohol in Our Lives: Curbing the Harm*. A report on the review of the regulatory framework for the sale and supply of liquor, 114. Wellington.

72 Te Pou o Te Whakaaro Nui. 2014. *The Physical Health of People with a Serious Mental Illness and/or Addiction: An evidence review*. Auckland: Te Pou o Te Whakaaro Nui. <https://www.tepou.co.nz/resources/the-physical-health-of-people-with-a-serious-mental-illness-and-or-addiction-an-evidence-review/515>

programmes promising benefits to those with clinical levels of psychological distress. Indeed, at this time when psychological stress is at its zenith, it seems essential that some form of quality assurance or certification be required for e-based programmes aimed at improving clinical levels of distress – just as professional accreditation is required to administer face-to-face Cognitive Behavioural Therapy (CBT). The best programmes have many years of development and rigorous trialling behind them, consumers like them, they are easily scaled, and low cost. Although they are particularly effective for those who complete the whole programme, research is ongoing to enhance compliance. Finally, e-therapies for use in Aotearoa-New Zealand must be culturally informed and available to all (noting ongoing concerns about a ‘digital divide’).

ADDRESSING SEVERE AND COMPLEX NEEDS (LEVEL 5 OF THE INVERTED PYRAMID)

The next step down would be specific interventions for those with significant levels of distress. Evidence shows this group comprises 3–4% of the population who will continue to require specialist services, along with acutely unwell people.⁷³ The main issue is how to ensure timely access to such treatments. There are advantages to using existing structures to avoid duplication, but with more attention to issues of access and equity. It is critical we do not end up marginalising those who have already been severely compromised, such as those with a chronic mental or physical illness, as they are particularly vulnerable to job loss.



⁷³ He Ara Oranga: Government Inquiry into Mental Health and Addiction, 2018.

SHIFTING TO COMMUNITY-LED INTERVENTIONS – THE KEY STEP NEEDED

The experts and practitioners who contributed to the report were unanimous in their view that much of the problem lay in the desire of agencies to retain top-down control of details of service delivery (i.e., the agency knows best) rather than empowering those in communities to make judgements. Paradoxically, in the pressures of the lockdown, much of that top-down control was relaxed and a higher-trust relationship was created. This needs to be retained. Sadly, there are already suggestions that agencies are seeking a return to a centralised form of control.

Recent reports have acknowledged the need for more culturally aligned, self-determined approaches that normalise natural ways for Māori to promote their mental wellbeing.^{74,75} One report by Te Rau Matatini provides one practice framework that has been utilised in guiding services by Māori, for Māori.⁷⁶ These services are grounded in Māori holistic perspectives on health, are whānau-centred, and incorporate key cultural values and practices. To better meet the needs of Māori, these services prioritise access and utilise locally-led solutions, including community outreach, home and marae visits, free or low-cost care, local clinics and programmes. During the Level 3 and 4 lockdown period, these approaches were successfully demonstrated by iwi, hapū, and Māori health providers as they implemented extensive pandemic responses within tribal regions, including provision of influenza vaccinations and testing, distribution of care and food packages, and support visits to kaumātua and others at high risk.⁷⁷ Iwi organisations, such as Ngāti Whātua Ōrākei, are now focusing on the recovery period by assessing the needs of their tribal communities, to inform development of services, and ongoing practical and psychosocial support for their most vulnerable members.⁷⁸

One of the contributors to this report has worked with Pasifika Futures for some time and has formed the view that it is much better to allocate resources to be used by those communities in the way that they see as most efficient and useful, rather than imposing treatment models.⁷⁹ For example, during Levels 3 and 4 of the lockdown, the Pasifika Futures Whānau Ora programme has delivered packages of support to 10,326 families, reaching 56,521 individuals.⁸⁰ They also noted that half these families had experienced a loss of income and over three-quarters were unable to meet basic needs.⁸¹

The Wise Group is one of the largest NGOs in New Zealand, partnering with government agencies, other NGOs and communities to promote and support the wellbeing of community members across a range of services.⁸² For instance, Wise Group and Le Va assist Pacific families to flourish through culturally responsive approaches to mental health and addiction, disability, suicide prevention and education. The Pathways Initiative provides community-based mental health, addiction and wellbeing services that support youth and adults with their mental health needs as well as daily living, employment, and housing requirements. Another joint initiative, LinkPeople, helps individuals, families and the homeless to secure safe, healthy, affordable housing for greater wellbeing.⁸³

Clearly, we need to continue building community capacity by taking localised approaches to services and support. To do this, we must ensure the removal of unnecessary red tape and redundant financial compliance reporting so that providers can get on with their work.⁸⁴ Jacqui Graham explains:

The community works best when it's free to respond to need. But what happens in dealings with Government is that it's like a hose, where there's a kink in the hose, and between the tap and the kink is Government and all the processes and systems and contracts. And then after that, a trickle gets out to the community ... But, actually, we've seen what happens – that if we can just let the community get on with it, then you will also have collaboration between providers in an unprecedented way.⁸⁵

74 *ibid.*

75 *Health and Disability Systems Review*, 2019: *ibid.*

76 Te Rau Matatini, 2015, *Kaupapa Māori mental health and addiction services: Best practice framework*. Wellington: Te Rau Matatini.

77 Menzies, 1 May 2020, Koi Tū: The Centre for Informed Futures. <https://informedfutures.org/a-pandemic-response-framework-for-equitable-and-inclusive-planning-and-decision-making/>

78 Ngāti Whātua Ōrākei, 2020, Whai Maia Ltd. *ibid.*

79 Pasifika Futures, 2017, *The First Three Years – Whanau Ora in Action: Prosperous Pacific Families*. <http://pasifikafutures.co.nz/wp-content/uploads/2017/10/Pasifika-Futures-Whanau-Ora-3-Years-On-Digital-Copy.pdf>

80 Pasifika Medical Association, 2020. <http://pacifichealth.org.nz/pma-funds-covid-19-packages-of-support-to-be-distributed-to-vulnerable-pasifika-families/>

81 Pasifika Futures, 1 May 2020. <http://pasifikafutures.co.nz/seasonal-and-forestry-workers-amongst-56000-individuals-receiving-covid-19-support-packages-while-pma-transitions-to-new-ways-of-supporting-the-community/>

82 Wise Group, 2014, *More Effective Social Services: The Wise Group's submission to the New Zealand Productivity Commission*.

83 Wise Group, 2019. *What we do*. <https://www.wisegroup.co.nz/what-we-do/>

84 Wise Group, 30 April 2020. *Please Press Pause*. A letter to the government. <https://www.wisegroup.co.nz/creating-change/change-for-good/>

85 Epidemic Response Committee, 30 April 2020.

A RAPPROCHEMENT AND WAY AHEAD

Pre-COVID discussions regarding the balance between prevention and treatment (i.e., the proverbial ‘fence at the top of the cliff versus the ambulance at the bottom’) have gone in rather unproductive circles for many years. This has recently become entwined with conversations around centralised versus devolved models of service delivery. Arguments for centralising cite the importance and uniformity of basic competencies, quality of service delivery (postcode lotteries), and accountability for taxpayer spending. However, arguments for more flaxroots leadership and control emphasise greater sensitivity to, and a better understanding of, local need and the ability to more precisely match to specific needs. Both sides of this discussion have merit, but flexibility is needed rather than continuing with a somewhat polarised discourse that may relate more to perceptions of where authority should lie rather than meeting need.

We see a way through that ensures we get the best of both worlds. Fundamentally, this involves a move towards a community-led model. To ensure all needs (as above) are met and maximum benefits accrue in the community, good, culturally informed and appropriate evaluation practices will be necessary. Implemented well, this should provide evidence of accessibility, quality, effectiveness, and accountability but also allow for creative community-driven solutions. The Government can facilitate and support such an approach while addressing the many structural determinants threatening mental wellbeing, including poverty, employment, and homelessness. In addition, within this paradigm, there is a natural fit with a life-course approach, because it reinforces the continuum of need and prevention opportunities, identifiable from pregnancy on through life.

WEAVING THE THREADS TOGETHER

There was a consensus among the expert and practitioner group regarding the many challenges to mental wellbeing posed by COVID-19, and the opportunity to chart a new course for the mental health sector. What would we want the new world to look like? The group agreed we have the chance to change some fundamentals at the heart of societal wellbeing, and mental wellbeing specifically, but that it will require courageous, collective effort. In this context, enhancing people’s sense of agency by empowering them was considered key to promoting and sustaining recovery from the COVID-19 effects on society.

There was also a consensus that te ao Māori and collective values should feature strongly in a new approach to mental wellbeing. The opportunity to address embedded inequities and structural problems, both historic and current, is essential for improving Māori lives and mental wellbeing. This will have positive spill-over effects that benefit other usually at-risk groups. It was agreed that it is now time to transform the mental health sector to better support people to achieve what they need to feel well. Fluidity exists in what is possible, therefore it is an opportune time for new approaches, real creativity and adaptation in response to this crisis.

Recognising that many micro actions accumulate into greater action, there is a need to identify some key actions that can be taken over the next 12 months. Key principles for guiding our response include taking collective knowledge and applying it to the current set of challenges to produce practical steps, beginning immediately. Ideally, this should start by taking a community-based approach to engaging with communities (broadly defined to also include communities of, for example, shared interests, age group, lifestyle) to find out what they need to make their lives easier and better, then taking practical steps to meet those needs. In doing so, secondary stressors can be eased and mental wellbeing protected. Initially, the focus should be on those communities identified as having the greatest needs.

REFLECTIONS ON THE PATH AHEAD

Although New Zealand may achieve ‘elimination’ of the coronavirus at least in the short-term, we do not yet know how the pandemic will run its course. The potential for ongoing domestic constraints remains. Irrespective of the economic realities of a global recession, high unemployment and continued effects of the pandemic on our international trading partners will mean that the health protection measures and secondary economic and other policy impacts will continue to affect those living and working in New Zealand. To this extent, we should be preparing ourselves for several years of disruption rather than months, and the consequent impact of this on our mental wellbeing. The nature of this impact is likely to be profound, resulting in significant and transformative changes in how we live and how we see our trajectories in life: as individuals, as communities, and as a nation.

The question is, are we prepared to respond to these big changes in how we live our lives by embracing equally disruptive and large changes in how the state seeks to protect and support our health and wellbeing?

If the appetite is there, then the required change is to clearly recognise the impact of secondary stressors on New Zealanders’ wellbeing. However, this means systemic change in recognising the impact of the social determinants of wellbeing: the wider and directly experienced effects of inequality of access to services, to educational and economic opportunities, to good food, to necessary heating, and to safe and healthy housing. Building a better mental health response will mean next to nothing, and will be a poor investment, unless these issues are addressed at the same time. Otherwise, all we are building is a better conveyor belt to patch people up and send them out into the same problematic environment that caused them to seek help in the first place. By all means, improve access, create new touch-points, and make it easier for people to access the mental health and wellbeing help they need, but take the opportunity to fix all the causes.

With so much uncertainty, we need to be alert and ready for emergent needs. Many more people are at home, so what are the risks in our new ways of working? With many job descriptions changing, both informally and formally, what are the new

physical risks at home? How is ACC involved in this?⁸⁶ How are workplaces going to adapt? What will the new workplaces look like? Offices? Are there places for people to come together and socialise if canteens are going to disappear? How are people going to eat in their lunch breaks if the queue to get food takes much longer than it used to? Although these may seem minor points, they provide an apt illustration of how day-to-day living might change and have knock-on psychosocial consequences.

DATA AND RESEARCH

We live in a world where data can inform policy. As this report makes clear, data on wellbeing is not just about health, but also many other subjects, including housing, welfare, justice, employment and so on. By linking them, we can reach far better understandings of our future needs. Further, by appropriate data collection and monitoring, early signs of risk and compromise are more likely to be identified. The need for

public health intelligence is growing. This should be separated from the ordinary business of the Ministry and with appropriate governance made available to interested parties. Mental wellbeing surveys need to be more frequent, and targeted at both new and old groups of vulnerable people. All of this requires a focus on data governance, ethics, and oversight and, in the case of Māori, processes that reflect their authority. New Zealand remains slow in addressing many issues in the use of data by the Government.⁸⁷

There is much we do not know. For example: Why is youth mental health morbidity rapidly increasing around the world? Which aspects of e-mental health services are most effective? What are the best services for individuals in different contexts? Can we predict which groups of newly vulnerable people are most at risk? These concerns require a more strategic and integrated focus on research in mental wellbeing in our country.



86 Accident Compensation Corporation, NZ

87 <https://www.pmcasa.org.nz/wp-content/uploads/17-06-19-Citizen-based-analytics.pdf>

SUMMARY – GO EARLY, GO HARD, GO LOCAL

Aotearoa New Zealand cannot rely on overseas experiences and data to guide its psychosocial response. Our approach needs to be fit for purpose and informed by our unique characteristics as a country and our history. With significant events ranging from the signing of Te Tiriti in 1840 to more recent experiences that can only be described as unpredictable, catastrophic, gut-wrenching, and tragic (e.g., the Pike River mine disaster, the Christchurch earthquakes and mosque shootings, and the Whakaari volcanic eruption). With impacts felt across the nation, these events have elicited New Zealanders' collective ability to demonstrate high levels of social cohesion at times of extreme stress. Let's build on this collective accountability and sense of community by facilitating what communities need to feel safe and be well.

It has also been instructive that when faced with the COVID-19 challenge, other countries have chosen to apply their own solutions regarding the timing of lockdowns, tracing approaches, personal protective equipment availability and use, community testing strategies, and coherence of communication. This is all the more remarkable given that essentially the same data has been available to all nations around the same time. Unsurprisingly, the result is quite different profiles of infection and impact, both up and down the infection curve, with this first wave process still far from over in many countries.

Subsequently, challenges faced by each country can therefore be expected to differ, especially in terms of the ongoing social and psychological challenges.

Realistically, this means we need to fashion our own systemic and community response. To our credit, Aotearoa New Zealand's high level of social cohesion during the acute stage of the pandemic has been praised internationally. However, we are now entering the second, more complex stage of the COVID-19 story, one in which we will be forced to live with high levels of uncertainty and stress on a daily basis, perhaps for several years.⁸⁸ Arguably, this insidious background context could become increasingly toxic for many. To prevent this from happening, promoting greater self-determination and resilience within communities towards sustainable wellbeing will be key.

As already noted, specific communities can also be expected to differ in how they respond to this type of grinding, chronic stress. Left to their own devices, some will do well over time, but some will not. Leaving this to chance will only further entrench pernicious inequalities. Ensuring everyone can come out of this dark period psychologically intact and hopeful will depend upon our ability to maintain social cohesion and commitment to a whole-of-population mental wellbeing kaupapa. This cannot be achieved without addressing upstream risk factors and inequities that already exist.



88 *He Oranga Hou: Social Cohesion in a post-COVID world, May 2020.*

We can also learn something from what was observed in the aftermath the Christchurch earthquakes. Initial euphoria (paradoxically) due to high levels of social cohesion was followed by a plunge in mood over the years following in which increasing despair and disillusionment became the norm. Notwithstanding differences between this natural-environmental disaster and COVID-19, it seems reasonable to expect similar (or perhaps worse) social and psychological repercussions ahead.

“So we’ve heard every community saying, ‘Please do not lose this, the sense of community.’ We need to grow it, not stop it.”

– Jacqui Graham, Wise Group

Over the past two months we have seen many inspiring examples of how to deal with immediate threat. Until a vaccine becomes available, and without continuing high levels of social cohesion, we are less likely to emerge long-term from this crisis mentally strong, resilient, socially-attuned and compassionate. In turn, this may decrease our appetite for risk, and trying new ways of living and working. Planning for further risk-taking may seem counterintuitive, if not slightly unhinged, when we are still struggling with such an uncertain, high-risk situation. However, we beg to differ. The world is changing at such a rapid rate, with pandemics only one source of existential threat (e.g., climate change). Clinging to the status quo will no longer suffice. We need to be creative and adaptable, using our time to best effect, but also being prepared to act at short notice. With its global shockwaves heavily felt, COVID-19 has been a brutal introduction to this new reality.

Social cohesion and mental health are intimately linked. Social cohesion will be threatened in coming months and years by the economic and social aftermath of the pandemic.⁸⁹ Different groups will feel their interests have not been supported adequately or that the priorities are wrong. Anger, frustration, anxiety and fear will be common and normal emotions. The election is unfortunately timed so the normal and healthy democratic contesting of ideas may polarise some of us and undermine cohesion. Yet we do need a more open discussion of our future direction given this inflection point in our history, and as we have suggested in other papers in this series, the more bipartisan the approach, the healthier New Zealand will be.

READY, STEADY, GO!

Much of what we have considered here – prevention and a broader focus on wellbeing – has been debated previously, but rarely fully acted on. The zeitgeist pre-pandemic was gradually moving in this direction as a result of the *He Ara Oranga* report and the Government’s response. We see COVID-19 as an opportunity to act with agility, foresight and courage, because

we must confront a number of uncomfortable realities. We now know more about the nature of mental wellbeing, its antecedents, and its maintaining factors than at any other time in history. We must seize this chance to make the necessary change.

A mass of scientific evidence has been around for a long time, but is not well incorporated into practice. In particular, the criticality of adopting a life-course preventive approach to mental wellbeing. In the last decade, the flow of data supporting this proposition has become an avalanche. In particular, we know much about how psychological resilience develops and the education system has a major role to play – both in early childhood education and in the compulsory school years.⁹⁰ Such resilience is a bedrock of maintaining wellbeing under stress. Preschool experiences provide the basics of developing healthy emotional regulation and there is much evidence on how an appropriate focus on early childhood education promotes that. The compulsory school years are critical and the skills needed then require an evolution in teaching in many ways to promote critical thinking and emotional resilience. A separate report in this series will address the future of education in more detail.

It is a well-recognised phenomenon that research takes about 15 years to make its way into useful policy or practice.⁹¹ We should no longer indulge this delay by failing to apply what we have learned from academia, consumers and communities. If anything, COVID-19 has shown that things can happen at pace when there is motivation and permission. Ironically, then, one of the greatest threats to our ability to prevent compromised mental wellbeing might be a return to the former style of operating.

IMMEDIATE ACTIONS REQUIRED

COVID-19 brings new challenges, such as an unknown, but potentially significant portion of the population facing adversity of a magnitude never previously experienced. Coping skills will be tested to their limits. The following should be acted on with urgency over the next 6 months:

- Basic human needs that underpin good mental wellbeing must be met (e.g., food, shelter, adequate income, social connection).
- Promotion of the most strongly evidenced e-based psychological therapies to the whole population. This strategy also needs to address the roughly 16% of New Zealanders who do not have access to digital platforms.⁹² There is an urgent need to develop new versions of proven e-therapies that are acceptable to groups that don’t respond well to standard approaches, including different cultural groups, those who don’t like learning via reading, or those for whom literacy is a barrier. Finally, there needs to be a process of formal and expert certification for the plethora of ‘products’ now available, so consumers know which offering will best meet their needs.

89 *ibid.*

90 See Gluckman P. et al 2017 for review of the role of education: <https://www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf>

91 Morris, Wooding & Grant, 2011, The answer is 17 years, what is the question: understanding time lags in translational research. *Journal of the Royal Society of Medicine*, 104, 510–520. DOI: 10.1258/jrsm.2011.110180

92 StatsNZ, 2018 Census. https://www.stats.govt.nz/2018-census/?gclid=EAlaIqobChMInfi8qibE6QIVCwRgCh1DfAvOEAAAYASABEgIQTPD_BwE

- Accurate information gathering about the level of need and for monitoring change is urgently required. It should have capability at three levels: national, regional and community. This will require linking of current resources such as the Integrated Data Infrastructure and community data via mechanisms such as the data exchange developed by the Social Wellbeing Agency. Priority should be given to developing well-trusted and independent oversight mechanisms so that data can be used more effectively. It will also involve using different approaches to relevant data collection that are acceptable to and work with groups of high priority, e.g., Māori youth, those not in employment education or training (NEET). Long standardised questionnaires about mental illness, developed on foreign populations, simply do not connect with most marginalised people, so are of no value. Alternative approaches can gather good-quality data in shorter and more appealing ways.⁹³ Their development needs to be prioritised.
- The pace of the “Increased Access and Support of Primary and Community Mental Health and Addiction” services rollout – both the integrated primary-care model, and the Māori, Pacific and Youth initiatives – should be accelerated.
- IPS employment support programmes should be attached to all GP clinics and primary-level mental health services, as well as to other community providers where appropriate.

That said, it is important to recognise that ‘readiness’ to act locally varies greatly across the many communities that make up Aotearoa New Zealand. It is essential, then, that appropriate supports are provided to ensure *all* communities have a chance to contribute and feel a sense of agency.

WHAT MUST HAPPEN FROM 2021?

We should embrace and expand on the recommendations of the Mental Health and Addiction Inquiry, and the Government’s initial response, to dramatically strengthen the role of communities in developing, planning and delivering mental wellbeing supports and services at the local level. Central government could then be freed up to take on the deep-rooted structural determinants of inequality in mental wellbeing.

This report is intended to open up the conversation. Thus we have elected not to make specific recommendations about how best to achieve this rebalancing because (i) it requires further, more inclusive consultation and co-deliberative examination; (ii) it would be premature to do so until all stakeholders (including the Government and its agencies) are committed to this approach; (iii) there are already examples/models of how this type of shared partnership approach might work which need to be learnt from, and (iv) the recently introduced Public Service Legislation Bill is a backdrop against which reports such as ours will inevitably be discussed. In this regard, we note some positive signs. For example, the recent establishment of 16 regional hubs focused on psychosocial wellbeing. But continuing further down this path to the truly local, community level ‘coalface’ is likely to significantly enhance the overall benefits for mental wellbeing in our country.

⁹³ Atawhai Tibble, Chief Maori Advisor, Social Wellbeing Agency – personal communication

Venturing into the unknown requires a compass, in the form of regular data gathering, interpretation and feedback into the system. Additionally, it requires a set of rules for engagement that are supported by accepted core principles. These include the importance of localism, with community as the new centre of gravity for service development, planning and delivery, and a changing focus of central government, ministries and agencies towards mitigation of structural drivers. The principle of co-determination – towards our shared future psychological wellbeing – should be the philosophical bedrock on which this new approach is built. The demand is upon us now, and the response is needed tomorrow, not months or years down the track.

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The views expressed in this paper are those of the individuals who took part and contributed to the paper rather than necessarily representing any organisational perspective or that of employers.

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Aotearoa	North Island – now used as the Māori name for New Zealand
hapū	kinship group, clan, tribe, subtribe – section of a large kinship group and the primary political unit in traditional Māori society.
iwi	tribe, extended kinship group – often refers to a large group of people descended from a common ancestor and associated with a distinct territory.
kaupapa Māori	a Māori approach, topic, customary practice, institution, agenda, principles, or ideology – a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society.
kotahitanga	unity, togetherness, solidarity, or collective action
mana motuhake	separate identity, autonomy, self-government, self-determination, sovereignty, independence, and authority
Māori	an indigenous person of Aotearoa New Zealand
marae	a complex of buildings used as a formal meeting place by Māori
Ngāti Whātua	tribal group of the area from Kaipara to Tāmaki-makau-rau (Auckland)
ōritetanga	equality, equal opportunity
Pākehā	a New Zealander of European descent
tangihanga	traditional Māori funeral process
te ao Māori	a Māori worldview
Te Tiriti o Waitangi	the Treaty of Waitangi
tikanga	correct procedures according to Māori custom
tino rangatiratanga	self-determination, sovereignty, autonomy, self-government, domination, rule, control, power.
wairuatanga	spirituality
whānau	extended family

94 The Māori Dictionary. <https://maoridictionary.co.nz/>



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