NEW ZEALAND COLLEGE OF
PUBLIC HEALTH MEDICINE

31 May 2018

Submission to the Mental Health and Addiction Inquiry

Introduction

The New Zealand College of Public Health Medicine thanks the Mental Health and Addiction Inquiry for the opportunity to make a submission.

The New Zealand College of Public Health Medicine (NZCPHM) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 236 members, all of whom are medical doctors, including 183 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.

Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM strives to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

The NZCPHM recommends:

1. Addressing current problems by:
    - Prioritising and funding mental illness prevention and mental wellbeing promotion, including addressing the determinants of mental health
    - Focusing on achieving equitable mental health outcomes
    - Improving the data collection of the Programme for the Integration of Mental Health Data (PRIMHD) to include primary care data
    - Supporting and funding a national mental health and addiction survey
2. Taking a public health approach to mental health by:

- Addressing the determinants of mental health and wellbeing
- Improving the mental health and wellbeing of Māori and eliminating inequities
- Investing in early life: infant, child and youth mental health
- Using evidence to inform policies and funding decisions

3. Building a society that:
   - Adopts a comprehensive and holistic view of health
   - Implements strong policy to reduce alcohol related harm
   - Includes mental health and wellbeing in all policies
   - Includes the wellbeing of children in all policies
   - Recognises and gives effect to Te Tiriti o Waitangi

The **Public Health Association of New Zealand** (PHANZ)and the **Health Promotion Forum of New Zealand** – Runanga Whakapiki Ake i te Hauora o Aotearoa (HPF) – endorse this submission as a carefully considered, comprehensive and constructive contribution to the Inquiry.

The PHANZ's membership is open to a wide range of professional groups from public, private and non-government occupations committed to our shared vision for equity in health and provides a collective voice for the public health sector on issues of the day.

The HPF is the umbrella organisation for all those who identify health promotion as part of their work. Membership of the Forum is made up of over 100 organisations committed to improving the health and wellbeing of New Zealanders. Founded on the principles of Te Tiriti o Waitangi and the Ottawa Charter, our non-profit organisation provides information, training and resources to build the workforce and health promotion leadership.

As organisations, we work closely with the College when speaking on behalf of the public health sector. We believe the College's work on this submission articulates the evidence, values and perspective widely shared across the public health sector.

Question 1: What's currently working well?

The NZCPHM is heartened to see signs of growing societal awareness of the importance of mental wellbeing, and the expectation that investment in prevention is necessary.

As a professional body whose Fellows are Public Health Medicine specialists, we acknowledge that there are many hard working and skilled mental health clinicians and other mental health workers who are dedicated to improving the lives of the people and communities in which they work.

There have also been effective local responses to mental health challenges, such as the response to the mental health effects of the Canterbury earthquakes, from which we can learn. In 2011, in the wake of the second Christchurch earthquake, the Chief Science Advisor called for a comprehensive and effective psychosocial recovery programme to support the Christchurch community. [1] The All Right? Campaign (www.allright.org.nz) is a population based mental health promotion campaign developed for this purpose, which has been consistently evaluated as highly successful. Some key ingredients that have contributed to the success of the campaign include having a clear mandate; ongoing funding, research and evaluation; established practice models and theories; a diverse, multidisciplinary team; a responsive, adaptable approach; community involvement and trust; and tools to promote engagement. This approach to an acute disaster could be adapted to respond to the chronic disasters right now of homelessness and abuse.

Question 2: What isn't working well at the moment?

Overwhelming demand/supply mismatch

The burden of disease from serious mental illness is large, with estimates of 95,700 disability-adjusted lives lost (DALYs) in New Zealand annually. [2] Population survey data indicate:

1. Mental distress is common: about four in five adults (aged 15 years or more) have experience of mental distress personally or among people they know.
2. Although mental distress is strongly patterned by disadvantage, anyone and everyone can experience distress.
3. There are many different ways of experiencing mental distress beyond standard diagnoses of illnesses like depression and anxiety.

4. Feeling isolated from others is strongly associated with symptoms of depression, anxiety and other forms of mental distress, and also with lower levels of life satisfaction.
5. 15 to 24-year-olds report high levels of isolation and mental distress
6. Awareness of mental distress in self or in others is associated with more positive attitudes (eg, being willing to work with someone with experience of mental distress); but people are reluctant to disclose mental distress, particularly at work. [3]

Yet mental health services in Aotearoa New Zealand are operating an 'ambulance at the bottom of the cliff' model, where they are only able to provide services for those with more severe and/or long-term conditions. This is because of overwhelming demand/supply mismatch, with current service and funding provision necessarily heavily weighted toward specialist services. There is inadequate funding of many mental health services, including early intervention, child and youth mental health, maternal mental health, and primary care mental health support and community services.

Crucially, there is also a significant lack of funding and prioritisation of mental illness prevention and support for community and whānau wellbeing.

Inequitable mental health

Unfortunately, data continue to indicate that we have significant mental illness, suicide and unmet need for mental health services.

Furthermore, data indicate that Māori, socioeconomically deprived populations and gender or sexual minorities are disproportionately affected by mental illness. [4-6] Notably, Māori males have the highest rate of death by suicide in Aotearoa, and suicide is the second leading cause of "Years of Life Lost" for Māori males in Aotearoa. [7] More mental illness and suicide are seen in Māori and among people who identify as LGBTIQA+[1], partly because both these groups suffer more discrimination, prejudice and social isolation. [3,8-12]

[1] L - lesbian; G - gay; B - bisexual; T - transexual; I - intersex; Q - queer; A - asexual, agender, aromantic; + - other diverse sexual orientations and gender identities

The physical health of people with mental illness is another area of great concern. [13] New Zealand data indicate that people with mental illness experience more ill health than their peers without mental illness and higher rates of premature morbidity. [13,14]

Māori mental health connection with colonisation

Māori mental health is strongly connected with colonisation. Colonisation is a story of "depopulation, disease and dispossession". [15] The impact of colonisation – both historic and present day – has been devastating on the mental health of many Māori in Aotearoa. [6,16,17]

Māori were viewed as a 'lesser race' by European colonisers and challenged Māori authority over political control and resources. [15] The result of this legacy has been ongoing prejudice and racism, cultural suppression and inequitable access to resources. [17] The outcomes have been devastating for Māori: the loss of resources, economic power, cultural identity, self-determination and disconnection from places of spiritual and cultural importance. [15,16]

Socioeconomic deprivation does not adequately explain the differences in rates of mental illness between Māori and non-Māori. [6,9,18] Racism, and loss of cultural identity and connection to whānau and land play critical roles in the development of mental distress, mental illness and suicide. [6] New Zealand data indicate that Māori are more likely to experience interpersonal racism than non-Māori in New Zealand. [9,18] Furthermore, a dose response relationship has been found between exposure to racism and measures of mental health[9,18] and socioeconomically deprived people have been shown to experience worse outcomes from racism. [12]

Unfortunately, Māori are frequently viewed as being the problem, as opposed to Māori inequities being viewed as a consequence of colonial systems that were set up based on a Pākehā worldview. In fact, colonisation can be seen in the establishment and maintenance of systems that privilege non-Māori across all government sectors, including education, justice, health and welfare. [16,17] Treatment of Māori by government institutions has ranged from deliberate exploitation, such as land and resource acquisition, through to neglect and more subtle breaches of the Te Tiriti o Waitangi, such as the failure of the health and education systems to support Māori.[17,19]

Mental health data collection

The national mental health dataset is called PRIMHD (Programme for the Integration of Mental Health Data). PRIMHD collects secondary service data on the diagnoses and treatment of people with the most severe mental illness in our communities. However, there is a lack of any (non-NGO) primary care mental health data. This is despite New Zealand research indicating that general practitioners identified approximately half of all their patients as having psychological problems in the past year, of which around one in ten were moderate or severe. [20]

The quality and type of data in PRIMHD is also a concern. Some important data fields are substantially missing and/or of low quality, and there is substantial variation between DHBs. For example, the proportion of clients who have a current diagnosis recorded varies between DHBs, from as low as 15% of clients to as high as 85%.[21] And while there are moves to include social outcomes data in PRIMHD, currently the information captured is of low quality.

Despite these issues, PRIMHD does have data that could provide many insights into secondary mental health services. Unfortunately, it is an under-utilised resource and there is limited reporting of the activities and outcomes of mental health services.

Te Rau Hinengaro, the most recent national mental health survey, was conducted in 2006 and used a clinical interview (CIDI 3.0) to estimate the prevalence of mental health conditions in different population groups. Mental wellbeing questions have been included in the New Zealand Health Survey, the Mental Health Monitor, and the New Zealand General Social Survey. However, these surveys do not provide sufficient information to estimate the prevalence of mental health conditions and therefore to understand the degree of unmet need. A repeat of Te Rau Hinengaro is needed, with consideration of improvements to measure the prevalence of low prevalence conditions and to more thoroughly examine differences between groups including differences by sexual orientation, gender identity and disability status.

It is also crucial that we build on current mental health surveillance in New Zealand by obtaining high quality population wellbeing data in the New Zealand Health survey. There is a need to introduce a strengths based measure (for example, the Warwick-Edinburgh mental well-being scale (WEMWBS) [22,23] or the WHO-5 Wellbeing Index[24]) to assess and monitor

population wellbeing and provide longitudinal data to inform and evaluate population mental health strategies.

Recommendations:

1. Prioritise and fund mental illness prevention and mental wellbeing promotion, including addressing the determinants of mental health
2. Focus on achieving equitable mental health outcomes
3. Improve the data collection of PRIMHD to include primary care data
4. Support and fund a national mental health and addiction survey
5. Use a strengths based measure of wellbeing in the national health survey

Question 3: What could be done better?

The NZCPHM contends that a population approach to mental wellbeing will improve the overall mental health status of the New Zealand population.

The essential elements of a population health approach to mental health and wellbeing for New Zealand are that it:[25]

- Focuses on the causes of the causes: the socioeconomic determinants of mental wellbeing and mental ill health
- Emphasises prevention
- Thinks about whole communities and population groups
- Works in partnership with populations
- Is centrally concerned with equity
- Uses evidence to inform policy development and funding
- Recognises the central importance of Te Tiriti o Waitangi for population mental health

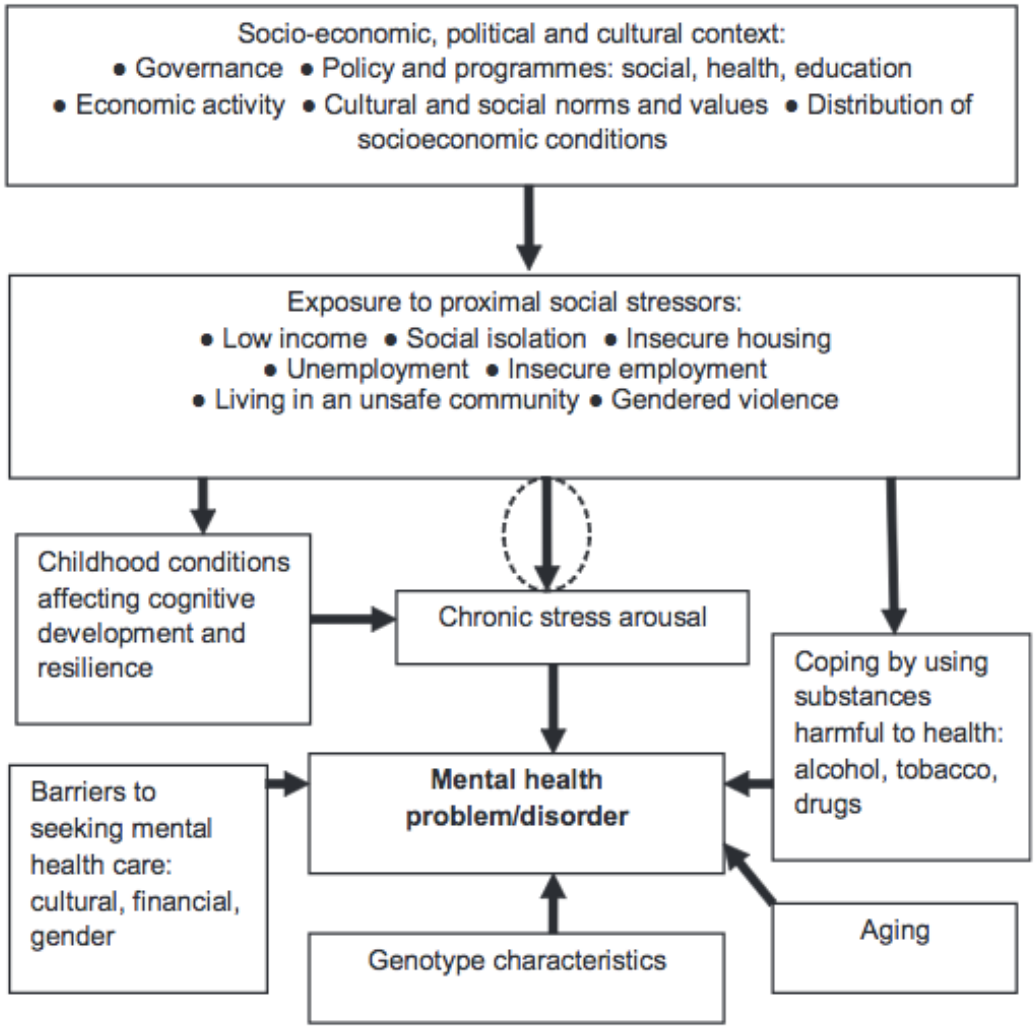
Noting these elements, our recommendations for improvement focus on three things:

- A population approach to mental wellbeing
- Prioritising health and equity
- Investment in early childhood

A population approach to mental wellbeing

A population approach lifts the gaze from the presenting clinical symptoms or illness, and deals with the 'causes of the causes'. Similar terms for this bigger picture view are 'upstream factors', 'social determinants' and 'wider determinants' of health.

Figure 1 Factors influencing individual onset of a mental health problem/disorder (adapted from Commission on the Social Determinants of Health) [26]



Common popular discourse frequently blames the development of mental illness on both 'bad genetics' and 'bad lifestyle choices' such as drug and alcohol consumption. However, neither of these 'bads' should be viewed in isolation from the environment in which a person lives and has lived in. Alcohol and drug intake are often used as coping mechanisms for significant stress and trauma such as poverty, violence and isolation. [26]

The causes of poor mental health are often intertwined and bidirectional, for example homelessness can cause or exacerbate mental illness and mental illness can contribute to homelessness. [26-28] Any type of trauma and stress, especially when chronic, increases the risk of mental distress and mental illness. [26] Figure 1 above illustrates how these factors interact and can lead to mental illness. [26]

One of the challenges for policy makers is to move away from individually focused solutions, such as funding more health services. Indeed, history shows that prevention strategies frequently move rapidly from population approaches towards victim blaming and individual interventions focused on addressing behaviour through education – a phenomenon known as 'lifestyle drift'. [29] Strategies to improve the wellbeing of our communities, reduce mental illness and reduce suicide must include solutions that sit outside of the health system and address upstream factors. [27,30] Prevention strategies must address all determinants, as shown above in the boxes of Figure 1. These determinants include poverty, employment security, safety and the impact of the socio-political landscape, needing action addressing discrimination, racism, gender norms and policy across the welfare, justice, health and education sectors.

A population approach to mental wellbeing utilises "proportionate universalism", where the aim is to move the whole population toward better mental health with greater targeting of resources for people at high risk. [31-33] This type of approach is crucial as mental distress, in the absence of a diagnosable mental illness, affects a far larger proportion of the population than clinical mental illness and collectively represents a larger burden of morbidity. [3,31] Proportionate universalism benefits the whole of society and has a greater positive impact societal mental wellbeing, mental illness and suicide prevention than purely targeted approaches.[31,33-35] Proportionate universalism includes strategies at every tier; improving the quality and access to healthcare services, early intervention supports for whānau and families needing support [44] and addressing societal determinants of mental illness. [26,28,32,36]

A focus on the 'causes of the causes' recognises that determinants of mental wellbeing are often social and economic and therefore amenable to change. [26,27,37,38] The disparities that are seen in mental health outcomes by ethnicity and by socioeconomic deprivation are also amenable to change. [5,26,27,37,38] The key message here is that the current rate of mental illness

and distress is not fixed; we can improve the situation and reduce mental health service demand and current inequities.

Mental wellbeing is not only a crucial aspect of individual health. It is also fundamental for vibrant, flourishing and resilient communities[37] and is a fundamental pillar of Māori models of health.[39]

We support the view of the Health Quality & Safety Commission's Mortality Review Committees, who state in their submission to the 2018 Mental Health Inquiry that: "It is critical that all services increase awareness of treating the whole person; the co-occurrence and interdependence of drug and alcohol abuse, mental health issues, family violence, and poverty must be factored into treatment and prevention policy and practice. Services must work together, and wraparound the individual, family and whānau. This includes extending awareness of the causes and complexities around mental health issues beyond the mental health and addictions system."

Prioritising Māori mental health and equity

At a population level, equity of mental health outcomes must be prioritised. Inequities arise not only through unequal determinants of health, but also through unequal access to care and quality of health care itself. [40]

Providing services according to need will mean that our most vulnerable populations are able to have a fair chance of care and recovery. High quality services must be able to adapt their care to suit the people they care for. This means a focus on co-design with consumers and families/whānau, cultural competence, and using data in service design and monitoring to be able to see what is working and what isn't working for different populations. [41] Leadership for equity is paramount; creating flexible services requires commitment and advocacy to enable 'difference' to be celebrated.

Racism and discrimination are key drivers of mental illness. Racism and the impacts of colonisation have had, and continue to have, a significant impact on the development of mental illness. Quality services must also eliminate current institutional racism. [9]

For Māori, as Treaty partners, quality service design includes the opportunity to attend kaupapa Māori services that centralise Te Ao Māori concepts.

The Puahou plan, named after the 'Five Fingers' of the Puahou tree, recommends five strategies for Māori mental health: the enhancement of a secure cultural identity, active Māori participation in society and in the economy, the alignment of health services to coincide with Māori realities, accelerated workforce development, and greater Māori autonomy and control. [42] Underlying these strategies are themes of Māori-centred values and beliefs, intersectoral collaboration, positive Māori development and the need to link health with the broader arenas of cultural enhancement and socio-economic advancement.

Prioritising infant and child mental health

Adult mental illness should be viewed as an outcome of child and adolescent mental distress and mental illness, and infant and child mental health a consequence of early childhood environment. [19,26,37,43] Epidemiologic studies indicate that approximately half of all mental illness experienced begins by the mid-teenage years and three quarters of mental illness has manifested by the mid-20s. [19] It is also important to recognise that onset of mental illness in later years is typically a secondary condition and that severe disorders usually begin with less severe presentations that go untreated, usually with an onset in childhood or adolescence.[19]

Maternal mental health is another area to invest so as to improve the health and wellbeing of young children. Maternal mental health problems are often seen as an adult mental health issue. However, given the effects poor maternal mental health can have on attachment and a mother's ability to care for and sensitively nurture a child, maternal mental health needs to be viewed as a part of the investment in infant and child mental health and as part of a focus on the first 1000 days of life. [43,44]

It is crucial that we invest in children and caregivers to build a healthy and flourishing society. There is strong evidence that deprivation and toxic stresses in early life leads to poorer physical and mental health outcomes, and that poorer mental health outcomes are linked with poorer educational attainment, poverty and material hardship – creating intergenerational cycles of ill health and deprivation. [26,27,45] It is crucial that we ensure adequate family incomes, paid parental leave and housing; prioritising, setting targets and investing in the eradication of child poverty; ensuring family-friendly working conditions and adequate pay; supporting and valuing skilled and attentive parenting; and addressing family

violence, child maltreatment and tobacco, drug and alcohol-related harm (intrauterine and in the family environment). [46]

Recommendations

The New Zealand College of Public Health Medicine advocates for a whole of government approach to mental health and wellbeing. We support a strategy for mental health that prioritises:

1. Addressing the determinants of mental health and wellbeing
2. Improving the mental health and wellbeing of Māori and eliminating inequities
3. Investing in infant, child and youth mental health, in particular the first 1000 days of life

Question 4: From your point of view, what sort of society would be best for the mental health of all our people?

An Aotearoa that supports the wellbeing of all people would be one that:

1. Adopts a comprehensive and holistic view of health
2. Implements strong policy to reduce alcohol-related harm
3. Includes mental health and wellbeing in all policies
4. Includes the wellbeing of children in all policies
5. Recognises and gives effect to Te Tiriti o Waitangi

A holistic view of health – Te Pae Mahutonga

Mental health and wellbeing cannot and should not be separated from other aspects of health, including the health of communities. Te Pae Mahutonga, a Māori model of health promotion, [47] provides a framework for considering all of the aspects that are required for a healthy, vibrant and resilient community and the strengths in our communities which we should build on. Appendix 1 lists aspects of a healthy vibrant society using this framework. To improve mental health and wellbeing, investment is required at every level.

Physical health

Physical and mental health are inextricably linked. And yet the two are treated separately in our health care system. There is a strong bidirectional relationship between physical and

mental health; poor physical health is linked to worse mental health and mental illness negatively impacts on physical health. [37,48-50]

A healthy society supports and enables people to live long and healthy lives. Our current situation is far from this, particularly for people with experience of mental illness. Serious mental illness is associated with high levels of physical morbidity and reduced life expectancy. [2,48,49] There are multiple causes of reduced life expectancy and poor health for people with mental illness – many of which are preventable. These causes are numerous and include the impact of psychiatric medication; risk factor behaviours such as smoking; poorer access to health services and 'diagnostic overshadowing' of physical health problems; higher rates of injury, violence and suicide; and the impact of socioeconomic factors that disproportionately affect people with mental illness, such as poverty and poor-quality housing or homelessness. In New Zealand, people using specialist mental health services are twice as likely to die before the age of 65 compared to the general population, and most premature deaths are due to 'natural causes', namely cancer and cardiovascular disease. [14]

Internationally there is evidence that the gap in life expectancy between those with serious mental illness and those without is increasing, as public health and clinical advances disproportionately benefit those without mental illness. [51] In New Zealand it is estimated that one third of cigarettes consumed in New Zealand in 2008 were consumed by people with mental illness, [52] indicating that public health's success in reducing smoking has not been spread equitably through the population.

Action on the physical health of people with serious mental illness needs to build on the successes of the Equally Well collaboration. [53]

Whānau and community

The health of the individual cannot be separated from the health of the whānau/family. For mental health in particular, connectedness is vital. Isolation and loneliness are known to both cause, and be exacerbated by mental ill health.[54,55] Whereas, connected whānau/families are protective and support positive mental health outcomes.

People with mental illness and mental distress frequently face stigma and discrimination. [11,56,57] Discrimination of people with mental illness can have multiple detrimental effects,

including unemployment, poor educational attainment, poverty, homelessness and social isolation. [5,11,56-58] These outcomes, and the effects of stigma and discrimination alone, can exacerbate symptoms of mental illness. [56-58] A healthy society accepts mental distress and grief as a normal part of the human experience and supports those with mental illness to return to wellness and to remain connected and included.

A healthy society supports, nurtures and accepts diversity and is built on a foundation of human rights and equity. A healthy society promotes, supports and legislates for policies that support whānau/families to remain connected. Examples include affordable access to reliable public and active transport networks, access to community and recreation spaces, accessibility of contact with whānau/family members who are incarcerated, and income adequacy (particularly for families and the elderly). Multigenerational relationships are also crucial to societal wellbeing; healthy societies value their members across all ages and promote and support multigenerational relationships. A healthy society also acknowledges the rights of its members to health, education, employment and participation in society.

Reducing alcohol related harm

Alcohol is a major contributor to the harm caused by mental illness, addiction, and suicide in New Zealand. Heavy alcohol use increases the risk of depressive disorders, is common among people who have mental health problems, and is strongly associated with suicide. [59,60] Alcohol was the most common substance of abuse and dependence in the 2006 mental health survey Te Rau Hinengaro, and commonly co-occurs with use of other substances and mental health problems. [4] Alcohol was also a contributing factor in the majority of suicides in New Zealand.

Policies to reduce the availability of alcohol, including increasing the price and increasing the purchase age, have been linked to reductions in suicide rates. [61]

We recommend that the Inquiry endorse the recommendations of the 2010 Law Commission Review of Alcohol Policy[62] including increasing the price of alcohol through minimum pricing, reducing the density of alcohol outlets, increasing the purchase age, and restricting alcohol advertising and sponsorship. These approaches appear to have worked well for tobacco and are needed to reduce the harm of alcohol in our society.

Mental health and wellbeing in all policies

Mental health is affected by a broad range of factors outside the health sector, including education, housing, employment, income, transport, and others, needing action across sectors and in all policies to prioritise mental health and wellbeing.

For example, poverty is significantly associated with the development of mental illness – both as a cause of mental illness and because of mental illness. [27,37] A key driver of this is the impact of financial debt. [63,64] There is also evidence to suggest that inequality itself may contribute to mental illness through the mechanisms of stigma and social exclusion, [65,66] and residing in an area of high social deprivation is strongly associated with mental ill health, even after adjusting for household measures of deprivation.[45] New Zealand data from Te Rau Hinengaro show a strong gradient between mental illness and increasing social deprivation. [4] However, strong social welfare supports are reported to be protective [67] against unemployment and poverty.

'Health in All Policies' (HiAP) is about promoting healthy public policy. HiAP is a structured approach to working across sectors and with communities on public policies. It promotes trusting relationships and engages stakeholders to systematically take into account the implications of decisions. HiAP seeks synergies to improve societal goals, population health and equity. [68] It is an approach that aims to "improve the health of the population through increasing the positive impacts of policy initiatives across all sectors of government and at the same time contributing to the achievement of other sectors' core goals". [69]

'Mental health in all policies' approaches aim to promote population mental health and wellbeing by initiating and facilitating action within different non-health public policy areas. The European Commission Framework for Action on Mental Health and Wellbeing includes mental health in all policies as a priority area and the incorporating of mental health into policies at all levels as a specific action.

Tools for a 'mental health in all policies' approach are 'Health Impact Assessments' and the 'Health Equity Assessment Tool' (HEAT). Health Impact Assessments are a vital for assessing the intended and unintended consequences of policy on health and wellbeing outcomes. However, there is a lack of guidance for mental health impact assessments that incorporate the New Zealand context; namely the importance of Te Tiriti o Waitangi and the impact of

colonisation in our history. Furthermore, the HEAT tool is a useful and practical tool that needs to be routinely used by policy makers to ensure health equity is a key focus of health policies. The UK Mental Well-being Impact Assessment toolkit could be useful model to adapt to the New Zealand context.[70]

The WHO and the international health promotion movement provide important approaches and tools to help embed a wellbeing and equity focus throughout public policy. [67,71,72]

Children in all policies

The first 1000 days of life (from conception until approximately two years old) is a crucial period of development. [43,73] Toxic stress during the first 1000 days of life, such as neglect, abuse, or caregivers who are unable to be emotionally available or nurturing, is associated with worse mental health outcomes throughout life. [26,27,43,73] A growing body of literature links exposure to adverse events in early childhood with increasing vulnerability to mental illness, more than when exposed to the same adverse events at older ages. [45,73]

For emotional and cognitive development children require "warm, reliable and appropriately responsive care".[44] Toxic stress as a young child impacts one's ability to regulate behaviour and emotions, [43] and someone's emotional health as a child is one of the strongest predictors of mental wellbeing in adulthood. [36] The presence of attentive and caring parents is protective against other forms of stress for young children. [44] New Zealand data indicate that connection to whānau and the belief that one's family are caring and supportive is a protective factor against suicidality for Māori rangatahi. [74] Social and economic stresses, including poverty and housing insecurity, and their own mental health concerns, pose barriers to nurturing and responsive parenting. [26-28,44,73] Exposure to high levels of prenatal alcohol is another cause of toxic stress on early development. High foetal alcohol exposure is associated with high levels of impulsivity and increased levels of comorbid mental illness. [75-77]

A focus on mental health and wellbeing in all policies therefore requires a focus on children in all policies. There is currently a growing focus on children at the policy level in New Zealand, with a Minister for Children, a child poverty reduction unit and a child wellbeing unit within the Department of Prime Minister and Cabinet, and a child wellbeing strategy being developed. And there have been improvements in primary care affordability, paid parental leave, Whānau Ora services, and the legal protections from assault. However, Aotearoa New

Zealand still fares worse in child wellbeing compared to most other advanced economies, and continues to have high rates of childhood poverty, housing problems, preventable diseases, youth suicide, mental health disorders, and violence to children.[78]

An approach such as that taken in Sweden, where a system of child-friendly public policy has been created and a "children in all policies" approach structurally embedded, offers a practical example of what is possible. Crucial elements will be to build a culture of prioritising children throughout the policy development and decision-making process, and to ingrain in society the idea that it is important for a country to prioritise the care of its children.

Te Tiriti o Waitangi

Colonisation has led to poor mental health outcomes for Māori in Aotearoa.[16,17,79] Māori experience worse mental health than non-Māori populations through multiple mechanisms, including racism,[6,9,18,40] loss of cultural identity and access to language and cultural heritage [16] and the impacts of poverty and social deprivation.[16,40,79,80]

To ensure a healthy and vibrant society we firstly need to acknowledge the disparities in mental health outcomes for Māori as unjust and amenable to change.[17] Improving Māori mental health outcomes and eliminated inequities requires an approach that addresses these drivers of poor mental health for Māori, supports the development of strengths and capacity building in Māori communities and engages Māori communities to co-design services across the health, social, education and justice sectors.

Key areas for action include:

- Integrating physical and mental health care
- Policy action to increase the price and reduce the availability of alcohol
- Ensuring that the clinical and public health sectors are monitoring equity of outcomes for people with serious mental illness
- The development of a New Zealand based guidance document for mental wellbeing impact assessments
- Prioritising children and in particular the first 1000 days of life
- Supporting Māori communities: social connection, cultural identity, eliminating material poverty and institutional racism

Appendix 1. Te Pae Mahutonga: a health promotion framework[47]

Ngā Manukura (community leadership)

Te Mana Whakahaere (autonomy)

Mauriora (cultural identity)

- Tikanga and Māori culture embraced and celebrated
- Purpose and hope
- Culture and identity

Waiora (physical environment)

- Safety
- Warm, dry, safe housing
- The natural environment is flourishing
- The natural environment is nurtured and accessible

Toiora (healthy lifestyles)

- Good physical health
- Safe and satisfying employment and education
- No reliance on or hazardous use of alcohol and drugs

Te Oranga (participation in society)

- Adequate income and no debt
- Secure housing tenure and employment
- Access to employment, education
- Celebration of diversity
- Acceptance and belonging
- Community and connectedness
- Gender equity

References:

(1) Gluckman P. The psychosocial consequences of the Canterbury earthquakes A briefing paper. 2011. Available at: https://www.cph.co.nz/wp-content/uploads/chcheqbriefingpsychosocialeffects.pdf

(2) Royal Australian and New Zealand College of Psychiatrists. The economic cost of serious mental illness and comorbidities in Australia and New Zealand. 2016. Available at: https://www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx

(3) Kvalsvig A. Wellbeing and mental distress in Aotearoa New Zealand: Snapshot 2016. 2018. Available at:https://www.hpa.org.nz/sites/default/files/Wellbeing-And-Mental-Distress-Snapshot-2016-Final-FEB2018.PDF

(4) Oakley Browne MA, Wells JE, Scott KM, (eds). Te Rau Hinengaro - The New Zealand Mental Health Survey. 2006. Available at: https://www.health.govt.nz/system/files/documents/publications/mental-health-survey.pdf

(5) Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rüsch N. Challenging the public stigma of mental illness: a meta-analysis of outcome studies. Psychiatr Serv. 2012;63(10):963-973.

(6) Harris RB, Stanley J, Cormack DM. Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. PLOS ONE. 2018;13(5):e0196476.

(7) Ministry of Health. Major Causes of Death. 2015; Available at: https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/major-causes-death.

(8) Meyer IH. Prejudice and discrimination as social stressors. In: Meyer I.H., Northridge M.E. (eds) The health of sexual minorities: Prejudice and discrimination as social stressors. Springer; 2007. pp. 242-267.

(9) Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Racism and health: the relationship between experience of racial discrimination and health in New Zealand. Soc Sci Med. 2006;63(6):1428-1441.

(10) Peterson D, Pere L, Sheehan N, Surgenor G. Experiences of mental health discrimination in New Zealand. Health Soc Care Community. 2007;15(1):18-25.

(11) Sharac J, Mccrone P, Clement S, Thornicroft G. The economic impact of mental health stigma and discrimination: a systematic review. Epidemiol Psichiatr Soc. 2010;19(03):223-232.

(12) Schmitt MT, Branscombe NR, Postmes T, Garcia A. The consequences of perceived discrimination for psychological well-being: A meta-analytic review. Psychol Bull. 2014;140(4):921-948.

(13) Te Pou o Te Whakaaro Nui. Equally Well: Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction. A consensus position paper. 2014.

Available at: https://www.tepou.co.nz/uploads/files/resource-assets/equally-well-consensus-position-paper-september-2014.pdf

(14) Cunningham R, Sarfati D, Peterson D, Stanley J, Collings S. Premature mortality in adults using New Zealand psychiatric services. N Z Med J. 2014;127(1394):31-41.

(15) Durie M. Nga Tau Hekenga: Depopulation, Disease and Dispossesion. Whaiora: Maōri health development. 2nd ed.: Oxford University Press; 1998. pp.26-40.

(16) Reid P, Robson B. Understanding Health Inequities. In: Robson B, Harris R, editors. Maori Standards of Health IV: A study of the years 2000-2005. 1st ed. Wellington, NZ: Te Röpü Rangahau Hauora a Eru Pömare. 2007; pp. 3-10.

(17) New Zealand College of Public Health Medicine. Māori Health Policy. 2015. Available at: https://www.nzcphm.org.nz/media/89786/2015_11_30_m_ori_health_policy_statement.pdf

(18) Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: cross-sectional study. Lancet. 2006;367(9527):2005-2009.

(19) Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry. 2007 Jul;20(4):359-364.

(20) Bushnell J, McLeod D, Dowell A, Salmond C, Ramage S, Collings S, et al. The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). NZ Med J. 2003; 116(1171): U379.

(21) Stace H. PRIMHD Classification – Summary and Metadata. Commissioned by the Ministry of Health. 2017.

(22) Stewart-Brown SL, Platt S, Tennant A, Maheswaran H, Parkinson J, Weich S, et al. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a valid and reliable tool for measuring mental well-being in diverse populations and projects. J Epidemiol Community Health. 2011;65(Suppl 2):A38-A39.

(23) Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, et al. The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation. Health Qual Life Outcomes. 2007;5(1):63.

(24) Topp CW, Ostergaard SD, Sondergaard S, Bech P. The WHO-5 Well-Being Index: a systematic review of the literature. Psychother Psychosom. 2015;84(3):167-176.

(25) The Perth Charter for the Promotion of Mental Health and Wellbeing: An outcome of the Seventh World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders. 2012. Available at: https://www.cph.co.nz/wp-content/uploads/tcd0006.pdf

(26) Fisher M, Baum F. The social determinants of mental health: implications for research and health promotion. Aust N Z J Psychiatry. 2010;44(12):1057-1063.

(27) Allen J, Balfour R, Bell R, Marmot M. Social determinants of mental health. International Review of Psychiatry. 2014;26(4):392-407.

(28) Sederer LI. The Social Determinants of Mental Health. Psychiatr Serv. 2016;67(2):234-235.

(29) Carey G, Malbon E, Crammond B, Pescud M, Baker P. Can the sociology of social problems help us to understand and manage 'lifestyle drift'? Health Promot Int. 2017;32(4):755-761.

(30) Ryan CJ. Suicide explained! Aust N Z J Psychiatry. 2015;49(1):83-84.

(31) Pitman A, Caine E. The role of the high-risk approach in suicide prevention. Br J Psychiatry. 2012 Sep;201(3):175-177.

(32) The World Health Organization. Preventing suicide: A global imperative. Geneva, Switzerland: The World Health Organization; 2014. Available at: http://www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1

(33) New Zealand College of Public Health Medicine. Health Equity: New Zealand College of Public Health Medicine Policy Statement. 2016. Available at: https://www.nzcphm.org.nz/media/58923/2016_11_17_nzcphm_health_equity_policy_statement.pdf

(34) Sara GE. Mental disorder and suicide: a faulty connection, or a faulty argument? Aust N Z J Psychiatry. 2015 Jan;49(1):84-86.

(35) Li Z, Page A, Martin G, Taylor R. Attributable risk of psychiatric and socio-economic factors for suicide from individual-level, population-based studies: a systematic review. Soc Sci Med. 2011;72(4):608-616.

(36) Layard R, Clark AE, Cornaglia F, Powdthavee N, Vernoit J. What predicts a successful life? A life-course model of well-being. Econ J (London). 2014;124(580):F720-F738.

(37) Faculty of Public Health and Mental Health Foundation,. Better Mental Health for All: A Public Health Approach to Mental Health Improvement. 2016. Available at: https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement

(38) Barry MM. Addressing the determinants of positive mental health: concepts, evidence and practice. Int J Ment Health Promot. 2009;11(3):4-17.

(39) Durie M. Whaiora: Māori health development. Auckland: Oxford University Press; 1994.

(40) Jones CP. Systems of power, axes of inequity: parallels, intersections, braiding the strands. Med Care. 2014;52(10 Suppl 3):S71-5.

(41) Poynter M, Hamblin R, Shuker C, Cincotta J. Quality improvement: no quality without equity? 2017. Available at: https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf

(42) Durie M. Puahou: A five part plan for improving Maori mental health. He Pukenga Korero. 1998;3:61-70.

(43) Mark T. Infant Mental Health in the next decade: A call for action. Infant Ment Health J 2015 11/01; 2018/05;36(6):538-541.

(44) Thompson RA. Social-Emotional Development in the First Three Years. 2018. Available at: https://www.rwjf.org/en/library/research/2018/04/social-emotional-development-in-the-first-three-years.html

(45) Manseau MW. Economic Inequality and Poverty as Social Determinants of Mental Health. Psychiatr Ann. 2014;44(1):32-38.

(46) New Zealand College of Public Health Medicine. First 1000 Days of Life Policy. 2017. Available at: https://www.nzcphm.org.nz/media/64578/2017_11_15_nzcphm_first_1000_days_of_life__reviewed_2017_.pdf

(47) Te Pae Mahutonga: A model for Maori health promotion. Health Promotion Forum of New Zealand Newsletter. 1999; 49. Available at: http://hauora.co.nz/resources/tepaemahutongatxtvers.pdf

(48) Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ. 2013;346:f2539.

(49) Chang C, Hayes RD, Perera G, Broadbent MT, Fernandes AC, Lee WE, et al. Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. PloS One. 2011;6(5):e19590.

(50) Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. Br J Psychiatry. 2011 Dec;199(6):441-442.

(51) Doherty AM, Gaughran F. The interface of physical and mental health. Soc Psychiatry Psychiatr Epidemiol. 2014;49(5):673-682.

(52) Tobias M, Templeton R, Collings S. How much do mental disorders contribute to New Zealand's tobacco epidemic? Tob Control. 2008 Oct;17(5):347-350.

(53) Te Pou o Te Whakaaro Nui. Equally Well: Physical Health. May 2018; Available at: https://www.tepou.co.nz/initiatives/equally-well-physical-health/37.

(54) Courtin E, Knapp M. Social isolation, loneliness and health in old age: a scoping review. Health Soc Care Community. 2017;25(3):799-812

(55) Huxley P, Thornicroft G. Social inclusion, social quality and mental illness. Br J Psychiatry. 2003;182:289-290.

(56) Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. World Psychiatry. 2002;1(1):16-20.

(57) El-Badri S, Mellsop G. Stigma and quality of life as experienced by people with mental illness. Australas Psychiatry. 2007;15(3):195-200.

(58) Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health. 2013;103(5):813-821.

(59) Borges G, Bagge C, Cherpitel CJ, Conner K, Orozco R, Rossow I. A meta-analysis of acute use of alcohol and the risk of suicide attempt. Psychol Med. 2017;47(5):949-957.

(60) Bell S, Britton A. An exploration of the dynamic longitudinal relationship between mental health and alcohol consumption: a prospective cohort study. BMC Med. 2014;12(1):91.

(61) Xuan Z, Naimi TS, Kaplan MS, Bagge CL, Few LR, Maisto S, et al. Alcohol policies and suicide: a review of the literature. Alcohol Clin Exp Res. 2016;40(10):2043-2055.

(62) New Zealand Law Commission. Alcohol in our lives: curbing the harm. 2010;114. Available at: http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R114.pdf

(63) Jenkins R, Bhugra D, Bebbington P, Brugha T, Farrell M, Coid J, et al. Debt, income and mental disorder in the general population. Psychol Med. 2008;38(10):1485-1493.

(64) Jenkins R, Bebbington P, Brugha T, Bhugra D, Farrell M, Coid J, et al. Mental disorder in people with debt in the general population. Public Health Medicine. 2009;6(3):88-92.

(65) Pickett KE, Wilkinson RG. Inequality: an underacknowledged source of mental illness and distress. Br J Psychiatry. 2010;197(6):426-428.

(66) Murali V, Oyebode F. Poverty, social inequality and mental health. Advances in psychiatric treatment. Cambridge University Press. 2004; 10(3):216-224.

(67) WHO and the Government of South Australia. The Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being 2010. Available at: http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf

(68) World Health Organization. Health in All Policies (HiAP) Framework for Country Action. 2014. Available at: http://www.who.int/healthpromotion/frameworkforcountryaction/en/

(69) Department of Health South Australia. The South Australian Approach to Health in All Policies: background and practical guide. 2011;Version 2. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/cb6fa18043aece9fb510fded1a914d95/HiAPBackgroundPracticalGuide-v2.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-cb6fa18043aece9fb510fded1a914d95-lY.85aS

(70) Cooke, A., Friedli, L., Coggins, T., Edmonds, N., O'Hara, K., Snowden, L., Stansfield, J., Steuer, N. and Scott-Samuel, A. The Mental Well-being Impact Assessment Toolkit. 2nd ed. 2010; Available at: https://www.liverpool.ac.uk/media/livacuk/instituteofpsychology/researchgroups/impact/MentalWellbeingImpactAssessmentToolkit2010.pdf

(71) Kickbusch I, McCann W, Sherbon T. Adelaide revisited: from healthy public policy to Health in All Policies. Health Promot Int. 2008; 23(1): 1-4

(72) Leppo K, Ollila E, Peña S, Wismar M, Cook S. Lessons for policy-makers. In Leppo K, Ollila E, Peña S, Wismar M, Cook S. (eds) Health in all policies: Seizing opportunities, implementing policies, 2013. Available at: http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

(73) Moore T, West S. Early intervention and the first thousand days of child development. Developing Practice: The Child, Youth and Family Work Journal. 2016;44:16-24.

(74) Clark TC, Robinson E, Crengle S, Fleming T, Ameratunga S, Denny SJ, et al. Risk and protective factors for suicide attempt among indigenous Maori youth in New Zealand: The role of family connection. International Journal of Indigenous Health. 2011;7(1):16.

(75) Clarke ME, Gibbard WB. Overview of fetal alcohol spectrum disorders for mental health professionals. Can Child Adolesc Psychiatr Rev. 2003;12(3):57-63.

(76) Mattson SN, Crocker N, Nguyen TT. Fetal alcohol spectrum disorders: neuropsychological and behavioral features. Neuropsychol Rev. 2011;21(2):81-101.

(77) Rangmar J, Hjern A, Vinnerljung B, Stromland K, Aronson M, Fahlke C. Psychosocial outcomes of fetal alcohol syndrome in adulthood. Pediatrics. 2015;135(1):e52-8.

(78) UNICEF Office of Research. Building the Future: Children and the Sustainable Development Goals in Rich Countries', 2017;Innocenti Report Card 14. Available at: https://www.unicef-irc.org/publications/890-building-the-future-children-and-the-sustainable-development-goals-in-rich-countries.html

(79) King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. Lancet. 2009;374(9683):76-85.

(80) Berg LD, Kearns RA. Naming as Norming: 'Race', Gender, and the Identity Politics of Naming Places in Aotearoa/New Zealand. Environ Plan D. 1996;14(1):99-122.