

Aotearoa New Zealand Association of Social Workers

Government Inquiry into Mental Health and Addiction



5 June 2018

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Submission to the Government Inquiry into Mental Health and Addiction

Government Inquiry into Mental Health and Addictions

Question 1: What's currently working well?

A highly qualified and specialist social work workforce is involved in the delivery of mental health and addiction services across the spectrum of services.

Operating from a strengths-based model, social workers consider the whole person within the context of their lives including whanau supports, environment, wider community alongside their unique challenges.

One of the strengths of social work practice is the ability to make systems responsive to people's needs and social workers' extensive knowledge of resources enables a brokerage approach.

We support the Government initiatives in mental health such as "Like Minds. Like Mine", the "Youth Mental Health Initiative" and suicide prevention initiatives, which we regard as positive moves.

An example of how first responders and mental health services have worked together is the Canterbury response to the mycoplasma bovis outbreak and confirmation of the decision to aim for eradication.

The Rural Support Trust is notified when a farm is infected or placed on movement restriction. At the next level the PHO Brief Intervention Counselling Service and Rural Community Mental Health Teams work collaboratively to provide support. If specialist psychiatric support is required appropriate referrals are made.

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

Social work skills in mental health are not always well respected, understood and utilised in formal psychiatric services.

There is insufficient focus on mental wellbeing or health promotion to ensure that accessing help early is the default position. Community based services such as the Mental Health Foundation, NGOs and some primary health care services are not well understood or easily accessible to the public.

A disproportionate number of people accessing mental health services are from lower socioeconomic groups. A 2014 study in New Zealand revealed the range of high level of psychological distress was from 34.3% in the most deprived decile of the population compare with 5.8% overall and 0.8% in the least deprived decile¹. This suggests that access to appropriate and timely services is inequitable.

Multiple barriers and criteria around restricting access psychiatric services can result in a perverse incentive where people may either present as being at risk of suicide in order to access services or actively seek a diagnosis to access some support services.

The use of language can create unintended barriers to seeking assistance and misunderstandings for all. For example, 'mental health' is often used when what we really mean is 'psychiatric'. This creates confusion and unrealistic expectations for everyone; individuals, family, whanau and clinicians,

Pathologising people and especially children and young people can lead to stigmatisation of the child / young person who is often exhibiting symptoms of family distress rather than of an individual with a mental illness and in some instances may lead to a dependence on medications. For infants, children and most young persons, the emphasis would be better placed on dealing with the causes of the family distress and supporting the caregivers in their positive parenting skills.

Failing to give young people hope and aspirational motivation can have disastrous consequences. This is well illustrated with this interview of two young people by John Campbell on Checkpoint:

<http://www.radionz.co.nz/national/programmes/checkpoint/audio/2018647194/kids-dying-in-police-pursuits-bored-reckless-and-chasing-a-thrill>

Māori and Pasifika do not have equitable access to services and are over represented in negative mental health statistics.

Part of the issue may be related to how well the practitioner can relate to Te Ao Māori. This is illustrated in the following press release in relation to training of psychologists. Social Work training programmes and our requirements for maintaining competency and an annual practicing certificate require social workers to evidence ongoing maintenance of skills demonstrating their ability to work with Maori and other cultures.

<http://www.scoop.co.nz/stories/HL1805/S00188/psychology-very-cold-robotic-for-maori.htm>

¹ Fould J, Wells JE and Mulder R (2104) The association between material living standards and psychological distress: Results from a New Zealand Population Survey. *International Journal of Psychiatry* 60: 766-771

Question 3:

What could be done better or differently to improve mental health and wellbeing in New Zealand?

The following suggestions are some ways we believe the health and wellbeing could be improved.



- More emphasis should be on the promotion of strategies for wellbeing and building resilience across the whole community. An example would be the promotion of the UK New economic foundation² and NZ Mental Health Foundation’s “5 ways of wellbeing”.
- Providing easier access to the first layer of mental health support – usually via the GP where a financial cost is incurred. The social work profession is ideally placed and skilled to work when someone is experiencing a health or social crisis, or social chaos emerges at this level and more social workers with mental health training in primary health care would be beneficial.
- Supporting the development and maintenance of healthy workplaces is consistent with a focus on the social determinates of health and enhancing wellbeing. Appendix 1 outlines a research project on workplace wellbeing.
- Focus prevention strategies through risk factor modification such as parenting behaviours, school and work place environments, diet and lifestyle³.
- Mental Health Services need to be nimble and *sufficiently funded* to respond to natural disasters such as the Christchurch and Kaikoura earthquakes and the Edgumbe flooding with an emphasis on developing and maintaining wellbeing.

What could be done better or differently to prevent addiction from occurring?

Addressing Social determinate of health such as good employment can provide opportunities for people to make significant positive lifestyle choices. For example, in Kaikoura, post-earthquake, access to very well-paid employment with ongoing career prospects has enabled people to make positive life choices, including for some the significant reduction in the use of alcohol and other drugs.

This strengthens the view that by addressing social determinates of health generates positive outcomes for individuals and their family whānau and ultimately the wider community.

² 5 Ways to Wellbeing, New Economics Foundation, UK, 2011

³ Mulder R, Rucklidge J & Wilkinson S; (2017) Why has the increase provision of psychiatric treatment not reduced the prevalence of mental disorder. Australian and New Zealand Journal of Psychiatry, 5 (12)

Prescribing addictive medications such as sleeping tablets or Ritalin may lead to longer term addiction problems. It can also send the message that a problem can be solved by a pill rather than a sometimes more complex but also a more sustainable and healthy response by addressing the underlying cause of the presenting chaos or crisis.

What could be done better or differently to prevent people taking their own lives and support those affected by suicide?

Destigmatise access to early intervention – people are often more likely to confide in someone in their personal network that they trust than they are to access formal mental health services. Ensuring public education campaigns provide the opportunities for people to know how to help their friend/ family member/ neighbour. Some programmes such as “Good Yarns”, ‘Psychological First Aid’ and various other similar mental health for lay persons education.

Develop different responses for following up attempted suicides and ‘self-harms’ with active follow up focussing on mental wellbeing support.

Suicide cannot be eliminated but initiatives can be taken, and social services provided to reduce risk factors. These include mental health issues, exposure to trauma (such as disaster, family violence and sexual abuse), a lack of social support (for people living alone, for example) and experience of stress from chronic pain, discrimination, bullying, relationship conflict, job or financial loss, and so on. The high prevalence of some of these issues in New Zealand suggests some underlying social culture of acceptance and ‘normalising’ of such negative behaviours. Never an easy solution to such challenging issues but as a professional group, social work is keen to be actively engaged in helping to find solutions to these issues.

Suicide prevention policy should recognise it is vital for everyone – individuals, families, whānau, communities, employers, the media and Government agencies – to work together to promote protective factors and reduce these risk factors. Access to community and health resources must be ensured and social connectedness encouraged.

How could support be better provided to those who need it?

We recognise phone help and e-support as a useful mechanism for supporting wellbeing, but it is also important that some type of ‘credentialing’ or similar process is undertaken in order for the public to have confidence in such mechanisms of support.

Access to and creative use of telemedicine for enabling improved access to support over long distances and could also be used in other instances where social issues – eg when childcare issues are barriers to accessing ongoing mental health care.

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

What would a refreshed system look like,

ANZASW would support the Allied Mental Health Forum's statement on what a refreshed system would look like:

- **Accessible** – I'm depressed and need help- I know where to go for affordable, expert help including validated e sites
- **Wraparound**-my adolescent boy is suicidal – I know where to get help and I know the whole family will be assisted and supported
- **Culturally informed**- I need a tikanga Māori approach to help me and I know where I and my family can find this
- **Coordinated**- There is violence and trauma in my family and its impacting on me and my children-I can go to the local school and tell someone, and I will get help
- **Follow-up**-I have a meth addiction- I know who can help and I know I will be followed up and supported through the journey
- **Treatment first**- I have committed a crime-I have access to mental health and addiction services that are helping me to become well
- **Wellbeing**- Thanks to the television, social media etc campaign I have a much better idea of how to manage my anxiety and avoid depression
- **Work to potential**-I am an allied mental health professional-I can use my expertise, am not overworked to the point I can't provide follow-up and I work in a supportive multidisciplinary team
- **Predictable funding**- I provide community mental health and addictions services. I can plan the services we offer as I no longer have to compete for funding each year.

How would it be different from what we have today,

Health, Social Service, Education and other providers focus on sustaining wellbeing, easy access and early intervention for maintaining good mental health.

Primary health and the GP represent the 'front door' to health and wellbeing services. No exclusion criteria and having a customer service approach of "How can we help" is a useful and destigmatising approach which brings in a wide range of presentations with the person being seen early and / or linked with the most appropriate service.

Shorter sessions of thirty - forty minutes, allowing time for the person to process the issues discussed and offering a follow-up session/s if required has been proven to be at least as effective and useful as the often traditional 50 – 60 minute sessions. This has positive implications for more improving access to assistance.

Integrating traditional primary and secondary mental health services into one integrated model in which the Brief Intervention Counselling / GP work as part of a combined team with the Rural Mental Health Team breaking artificial barriers between primary and secondary health services. This integrated team would be based in primary care and needs to be able to be accessed at no cost.

Question 5: Anything else you want to tell us

United Nations – Transforming Our World: The 2030 Agenda for Sustainable Development

ANZASW fully supports the United Nations 2030 Agenda for Sustainable Development and believe that this must underpin any strategy to address inequalities in Aotearoa New Zealand that contribute to the prevalence of mental health and addiction conditions.

Relevant United Nations Sustainable Development Goals

Goal 1. End poverty in all its forms everywhere

Goal 2. End hunger achieve food security and improved nutrition and promote sustainable agriculture

Goal 3. Ensure healthy lives and promote wellbeing for all at all ages

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5. Achieve gender equality and empower all women and girls

Goal 6. Ensure availability and sustainable management of water and sanitation for all

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Goal 10. Reduce inequality within and among countries

Social Determinates of Health

The determinants of health include:

- the social and economic environment,
- the physical environment, and
- the person's individual characteristics and behaviours.

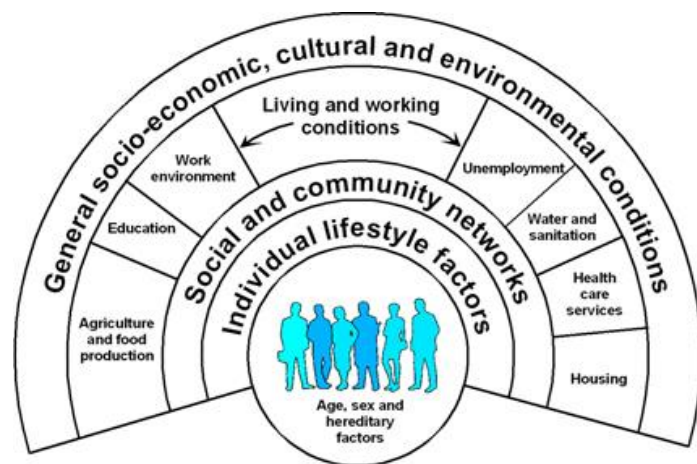
The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants—or things that make people healthy or not—include the above factors, and many others:

- **Income and social status** - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.

- **Education** – low education levels are linked with poor health, more stress and lower self-confidence.
- **Physical environment** – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- **Social support networks** – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
- **Genetics** - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life’s stresses and challenges all affect health.
- **Health services** - access and use of services that prevent and treat disease influences health
- **Gender** - Men and women suffer from different types of diseases at different ages.⁴

In the New Zealand context, the level of inequity experienced by Māori and Pasifika would suggest that being indigenous or Pasifika is an additional factor when considering social determinants of health.

ANZASW argues that the wellbeing of all New Zealanders would be enhanced by addressing inequity.



5

The Global Agenda for Social Work

The International Federation of Social Workers (IFSW), the International Association of Schools of Social Work (IASSW) and International Council on Social Welfare (ICSW) developed the Global Agenda for Social Work in recognition that the past and present political, economic, cultural and social orders, shaped in specific contexts, have unequal

⁴ WHO <http://www.who.int/hia/evidence/doh/en/> accessed 1 June 2018

⁵ WHO http://www.who.int/social_determinants/final_report/media/csdh_report_wrs_en.pdf accessed 1 June 2018

consequences for global, national and local communities and have negative impacts on people.

The four Pillars of the Agenda are:

1. Promoting social and economic equalities
2. Ensuring the dignity and worth of the person
3. Promoting sustainable communities and environmentally sensitive development
4. Promoting wellbeing through sustainable human relationships

ANZASW is therefore committed to working within the Association to promote education and practice standards in social work and social development that enable workers to facilitate sustainable social development outcomes which have a positive contribution to sustainable wellbeing for all.

Aotearoa New Zealand Association of Social Workers

Aotearoa New Zealand Association of Social Workers (ANZASW) is the professional body for a national collective of more than 3,300 social workers, who have day-to-day involvement with the most vulnerable people in our society. Our work is guided by a Code of Ethics that is aligned with the International Federation of Social Workers (IFSW) Statement of Ethical Principles.

Our members are employed in a wide variety of organisations across the social services sector including health, education, welfare, justice and social advocacy.

Members work across government and non-government settings including community organisations, iwi agencies, youth justice, child protection, mental health, addictions, disability and private practice. We are involved in research, training, education, professional development, competency assessment, data gathering, risk assessment, structural analysis, interagency protocols and the improvement of social policy.

ANZASW members are responding to the consequences of poverty on an almost daily basis.

The international definition of social work mandates the profession to engage in advocacy for social justice and human rights:

“Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.”

Social work is founded on principles of human rights and social justice and, in Aotearoa New Zealand, is guided by the Treaty of Waitangi and respects the equality, worth and dignity of all people. In accordance with the March 2012 IFSW Global Agenda⁶ “we commit ourselves to supporting influencing and enabling structures and systems that positively address the root causes of oppression and inequality.

“We commit ourselves wholeheartedly and urgently to work together with people who use services and with others who share our objectives and aspirations, to create a more socially-just and fair world. We believe the overarching principles of social work are respect for the inherent worth and dignity of human beings, doing no harm, respect for diversity and upholding human rights and social justice.”

Our mission is to enable people to develop their full potential; our skill-set is problem solving and facilitation of positive change in individuals, organisations, whānau and communities. We recognise people in our society can be both agents of change and victims of factors beyond their control. As a profession, we strive to alleviate poverty, foster social inclusion and liberate those who are vulnerable or oppressed. Our interventions involve the development of coping strategies, one-on-one counselling and therapy, family and group work, agency administration, community organisation, social action and social change and helping people to access services, resources and support systems within their community.

Social workers respond to crises and emergencies along with the personal or social problems that arise from experience of barriers, inequities and injustices within our society. We are also involved in statutory intervention when vulnerable children and adults are at risk of harm.

⁶ International Federation of Social Workers, International Association of Schools of Social Work and International Council on Social Welfare (2012). ‘The Global Agenda for Social Work and Social Development Commitment to Action’. Available at isw.sagepub.com (accessed 13 June 2012)

Appendix 1

Workplace Issues

Leadership for workplace wellbeing – Research being led by Michael Webster, University of Auckland

I would like to bring to the attention of the enquiry to a major research project for which I am the principal investigator, *Leadership for workplace wellbeing*.

The abstract for the project reads:

In recent years, evidence has emerged of excessive stress on human service workers to which organisational factors have contributed or even caused. These factors include organisational restructuring change programmes; the drive towards greater efficiencies, effectiveness and economies; and workplace bullying. These stressors may produce mental distress among workers and a dysfunctional or even toxic environment.

The proposed research is designed to understand how two organisations have addressed these factors. A research team that I have formed will conduct interviews and focus groups with staff members in those organisations: a district school and a health provider for children. Participants will be drawn from governance, senior and middle management and frontline staff levels. The study will focus on how participants understand workplace wellbeing and the leadership needed to create or contribute to such wellbeing. The project builds on my doctoral thesis which developed a model for social work leadership in Aotearoa New Zealand.

Data from this project will inform leadership studies, organisational cultural analysis and wellbeing in the workplace. While building on social work research, it is equally applicable to the wider organisational development field and will in turn make a significant contribution to New Zealand-specific and transnational research and organisational practice.

Overarching goals for the research include

Workplace wellbeing: How do professionals with diverse functions, responsibilities, and levels of power and authority in these two organisations conceptualise workplace wellbeing? What do the understandings of those professionals create or contribute to the development of an underpinning model of wellbeing to inform future research?

Leadership for wellbeing: How do those same professionals conceptualise leadership values and leadership actions informed by those values? How do diverse contexts influence those values and actions? What do the understandings of those professionals create or contribute to the development of an underpinning leadership model to inform future research?

Fleshing out the two models of healthy workplaces: How and in what ways will the understandings of participants add substance to the existing WHO and Riegen⁷ models of healthy workplaces? What added value will insights from project findings contribute to an overall model for wellbeing and the leadership required to achieve wellbeing?

Specific objectives of the project are to identify and devise leadership actions which will address these three psychosocial hazards and thus contribute to healthy organisational functionality:

1. **Poor work organisation:**

Work demands, time pressures, decision latitude, reward and recognition, workloads, supervisor support, job clarity/design/training, poor communication

2. **Organisational culture:**

Lack of policies and practice relating to dignity and respect for all workers; harassment and bullying; intolerance for diversity

3. **Command and control management:**

Lack of consultation, negotiation, two-way communication, constructive feedback, respectful performance management (WHO, 2010, p.85⁸)

My comments are made in the context of mental health and wellbeing in the workplace. Up to a third of our lives is spent in the workplace. In recent years, human service organisational leaders and managers have increasingly focused on wellbeing in the workplace. The thinking which informed the Health and Safety at Work Act (HSWA) 2015 which came into force in April 2016 was a prime factor in this escalated focus. WorkSafe New Zealand (2017) notes that the HSWA “shifts the focus from monitoring and recording health and safety incidents to proactively identifying and managing risks so everyone is safe and healthy,” thus moving from a management to a proactive leadership approach to wellbeing in the workplace.

Workplace wellbeing is underpinned by the commitment of the new Labour-led coalition government to a “wellbeing” target for the 2019 Budget and beyond by applying the work of the Treasury since 2011 on a Living Standards Framework (LSF). The LSF measures four interdependent capitals: Natural, Social, Human and Financial/Physical. The human capital dimension encompasses people’s skills, knowledge and physical and mental health enabling their full participation in work, study, recreation and society (emphasis added). The new Government budget has a distinct focus on

⁷ Riegen, J. (2013). *Examining healthy workplaces*. (Unpublished master’s thesis.) The University of Auckland, New Zealand.

⁸ Burton, J. (2010). World Health Organization Healthy Workplace Framework and Model: Background and Supporting Literature and Practices. World Health Organization: Geneva, Switzerland.

wellbeing (social, natural and human, in addition to financial), rather than just raw economic numbers. This focus is to be applauded.

Again, these comments are made in the context of the workplace. Although the intentions of the HSWA (2015) were admirable, issues associated with excessive workloads and workplace bullying remain. Legislative intentions and organisational policies must be embedded into workplace culture. Evidence has emerged of excessive stress on human service workers to which organisational factors have contributed or even caused. These factors include organisational restructuring; the drive towards greater efficiencies (achieving greater productivity with the same level of budget and staffing resources or the same productivity with reduced budgets and staffing); an expectation of greater effectiveness (in which the organisation and its workers are deemed to be responsible for achieving organisational mission or purpose); and workplace bullying. These stressors may result in mental distress among workers and a dysfunctional or even toxic environment, running counter to recognised elements of a healthy workplace and healthy workers.

An example from my own research⁹ is given here:

A professional working in an interdisciplinary context:

“One staff member is quite a bully. When I started [3 years ago] I became aware of this person *ignoring me. I thought it was strange that out of all the staff there was one person who ignored me.*” “I didn’t worry too much about it [be]cause it [was] a [professional from another discipline] so I didn’t deal with them too much. After about 6 months I started to feel *really uncomfortable.*” “There was *direct nastiness* coming out like *comments about obesity* or about *my parenting—really mean.* If I walked into the room *the conversation would stop.*”

The emotional impact of the bullying—which at the time of the interviews had occurred over three years—was illustrated in the participant’s twice repeated comment that *‘it [bullying] is horrible’*. In an evocative statement the informant said that because the bullying was *‘eat[ing] me up inside’* she had thought of leaving and in fact had successfully applied for another position. For compelling organisational reasons, this course of action could not be followed. (Webster, 2016, p.10)

The victim confronted agency management and asked:

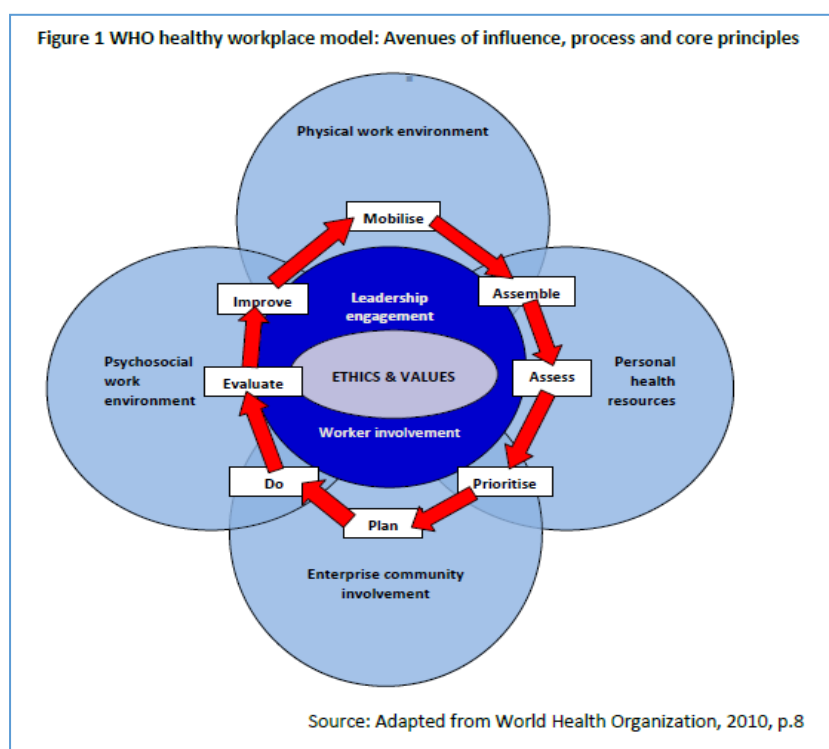
“Why is this allowed to go on?”

Their response: “Unless you can give us really specific examples we can’t do anything about it.”

This amounts to collusion with bullying

⁹ Webster, M. (2016). Challenging workplace bullying: The role of social work leadership integrity. *Ethics and Social Welfare* 10(4), 316-332. 10.1080/17496535.2016.115563

I have a formative view that in many instances workplaces are psychologically unhealthy, so much so that self-harm and tragically even suicide have taken place. I suggest that leadership for healthy workplaces is critically needed, utilising such existing models as the World Health Organization’s Healthy Workplace Model in which leadership ethics, values, and actions are applied in particular to the psychosocial work environment (figure 1) and Janice Riegen’s¹⁰ Healthy Workplaces Action Model (figure 2). Organisational leaders and managers need to establish trust and respect in the organisation, viewing employees as assets and values their contributions, communicating regularly with employees, and taking employee needs into consideration when designing new initiatives (Grawitch et al., 2009¹¹). Graham Lowe¹² (2012) proposes that the “building blocks of a healthy organization” are “positive culture, inclusive leadership, vibrant workplaces [and] inspired employees ... *two critical enablers* of a vibrant workplace are culture and leadership” (p.22, emphasis added.)

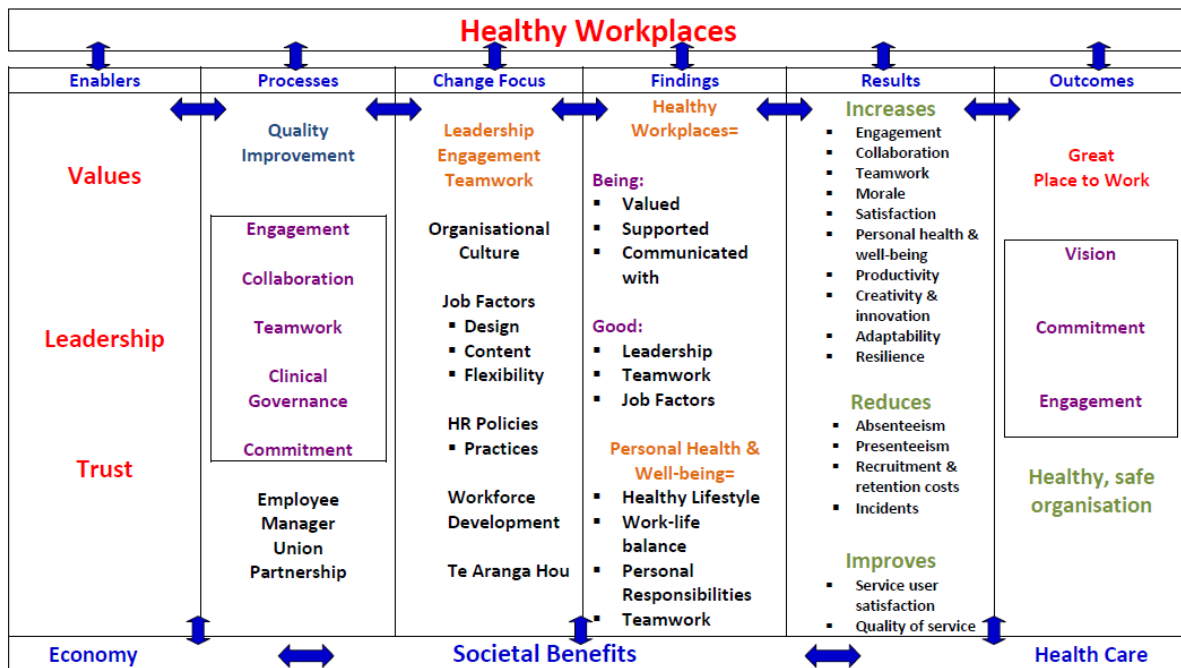


¹⁰ Riegen, J. (2013). *Examining healthy workplaces*. (Unpublished master’s thesis.) The University of Auckland, New Zealand.

¹¹ Grawitch, M. J., Ledford, G. E., Ballard, D. W., & Barber, L. K. (2009). Leading the healthy workforce: The integral role of employee involvement. *Consulting Psychology Journal: Practice and Research*, 61(2), 122-135.

¹² Lowe, G. (2012). *Creating healthy organizations: How vibrant workplaces inspire employees to achieve sustainable success*. Toronto, Canada: University of Toronto Press.

Figure 2 Healthy Workplaces Action Model (Riegen, 2013), developed from Lowe (2012).



From the workplace perspective, one in which the Living Standards Framework (LSF) as mentioned earlier becomes a major factor in people’s working lives, and in particular the human capital dimension focusing on people’s *physical and mental health enabling their full participation in work, study, recreation and society* (emphasis added).