

**SUBMISSION
ON THE**

**Draft Action Plan: Te Tahuu – Improving
Mental Health
2005-2015**

Prepared April 2006



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A Submission in Response to the Draft Action Plan: Te Tahuu – Improving Mental Health 2005-215

1. This Submission is from the Alcohol Drug Association New Zealand (ADANZ).
2. Cate Kearney Chief Executive Officer, Alcohol Drug Association New Zealand is the contact person. She may be contacted at the ADANZ's offices at PO Box 13-496, Armagh, Christchurch, telephone 03 3798626, fax 03 3775600, email cate.kearney@adanz.org.nz.
3. The Alcohol Drug Association New Zealand (ADANZ) is a not-for-profit organisation and has been operating in the South Island since 1982. ADANZ's statement of purpose is
“Improving the health of the community by minimising harm associated with alcohol, other drugs and gambling”.
4. Based in Christchurch, ADANZ provides coordination and information dissemination services both locally and nationally. ADANZ's core clinical service is the National Alcohol & Drug Helpline. Other services are the National Directory of Alcohol and Drug Services; Alcohol and other Drug (AOD) Consumer Advisors and local, regional and national representation on various AOD advisory committees.
5. ADANZ is presenting this submission to the Ministry of Health on behalf of our organization which is informed by research and by our AOD provider forums in the South Island and involvement in national networks. The submission is in response to the Draft Action Plan to implement Te Tahuu - Improving Mental Health 2005-2015. ADANZ would like to thank the Ministry of Health for the opportunity to make this submission.
6. ADANZ would like to receive a copy of the summary of submissions.

Consultation Questions

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

Yes✓

Comments:

Congratulations are offered for the development of the Action Plan. It is a well crafted document. It covers a wide number of areas and addresses most of the issues identified in earlier consultation. ADANZ wishes to thank the Ministry of Health for the opportunity to make this submission.

2. Are there any actions you particularly endorse?

Yes✓

Comments:

3.18 It is excellent to see that the support needs of family and whanau in their roll as care givers has been acknowledged and planned for.

7.1 – 16 Specific endorsement for the inclusion of Addictions and Gambling, both in terminology and action points.

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

Yes✓

Comments

1 **1.5 Implement the next stage of the Like Minds Like Mine Project as part of a multi-agency plan to reduce discrimination**, needs to include the addition that people with alcohol and drug and gambling addiction behaviours / diagnosis and or who are involved in treatment, are made visible in the Like Minds Like Mine so that they benefit from the investment and the success of this project.

2 Definition of Recovery on page 67 of the document (refer to question 4 below for details).

3 7.9 Change Milestone/measure/phasing to Years 1-3, it needs to happen sooner in order to align with Mental Health.

4 7.12 Add NCAT as a stakeholder.

4. Have any key actions been missed?

Yes✓

Comments:

- 1 Although it is clear that efforts have been made to clarify some of the terms and words used in the Action Plan, there is no action to clarify the language used across/throughout Mental Health.

 It is recommended that an action be added into the Workforce and Culture for Recovery section to review, compare, analyse and clarify the language used in both the mental health and addiction sectors individually and what definitions are shared.
- 2 In particular, ADANZ in accord with NCAT recommend the following **bolded changes** be made to the DEFINITION for RECOVERY

 "Living well in the presence or absence of mental illness and the losses associated with it. **The alcohol and drug sector have a similar yet different view of "recovery", one that includes both an abstinence and harm minimisation perspective that have evolved over time, allowing consumers a choice to adopt the approach that best represents their worldview.** There is long and generally held view that in the addictions field recovery involves an expectation/hope that people can and will recover from their addiction/un-wellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the widest sense) providing help. A challenge faced by both mental health and addiction sectors is the ongoing development of the concept and language of recovery
 involves an expectation/hope that people can and will recover from their addiction/un-wellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the widest sense) providing help. A challenge faced by both mental health and addiction sectors is the ongoing development of the concept and language of recovery".
- 3 There are major issues for the addiction sector in delivering alcohol and drug service to with criminality. The prison population is increasing exponentially and the growth is forecast to continue, it is well known that criminal offending is related to alcohol and drug use. **ADANZ strongly recommends this action plan provides leadership to this issue by the including the bullet point number 4 of 7.13 (work with the Department of Corrections to determine levels of need within criminal justice settings, the most effective interventions and treatment pathways, and policy to guide primary prevention, and intervention services and evaluation) as a second point to 7.1.**
 Funding actions (8.4) also need to be more explicit - to Corrections and Mental Health and Addiction so actions can be carried out.
- 4 It is difficult to identify gaps against benchmarking included in the Blueprint as ring fencing is only for Mental Health. Specific benchmarks and funding for AOD are required.
- 5 There is a need for National peer consumer advocates for AOD consumers. Consumers have traditionally been steered toward mental health advocates or health and disability advocacy services. This is not ideal as there are no trained 'peer' advocates in these services. In the words of a consumer ("I want another alcoholic/addict who is trained in advocacy to walk with me on this one.")

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

Yes✓

Comments:

- 1 Include NCAT as a key stakeholder for section 2
- 2 i How will work place skills be developed to accommodate inter-sectoral activities?
- ii Who will monitor effectiveness of these skills?
- iii Does there need to be an action to scope what will make 2.4, 2.6 and 2.7 the aim to have more inter-sectoral activity?
- iv Does Mental Health and Addictions make training available and if so, there should be some commitment expected from other relevant sectors.
The action table is lacking in direction in this section.

Although we have provided the above comments and recommendations, considering the number of public holidays and other consultations processes under way at the same time, it has been difficult to do the submission justice within the number of work days available. This submission refers mainly to the Addiction and Gambling component of the Action Plan.