

## **Submission to the Government Inquiry into Mental Health and Addiction**

Ministry of Health

May 2018

The Ministry of Health's best advice on developing a cohesive mental health, addiction and suicide prevention approach for Aotearoa, New Zealand can be summarised as:

1. Improving existing mental health and addiction services, and making them accessible and suitable for all, is important, but not enough.
2. In order to enable people and their whānau to thrive wherever they live and whatever their circumstances, we need to transform our approach to mental health and addiction.
3. There is a currently significant inequity in health and social outcomes, prevalence of mental health and addiction disorders, and service experience
4. The Ministry of Health can lead the health service response, provide national guidance to enable change, lead improvements in health policy, commissioning, workforce development and service provision (specialist, primary and community) and promote positive mental health and wellbeing through incorporating mental health promotion into our decision making.
5. A broader approach is needed across whānau, iwi, hapū, communities, social networks and agencies and across government. All government agencies must take, and be formally accountable for, action to improve mental wellbeing.
6. A reformed Mental Health Commission is well placed to be an expert advisor and a transparent independent monitor and facilitator of the necessary cross-agency work.

The current mental health and addiction system is not working well for all New Zealanders. Those most severely affected by mental illness are reasonably well served, in general, although there are areas of disparity for particular populations, especially Māori, and gaps in our approach to people's issues. The much larger number of people with lower needs are not well-served. Improvements in mental health and addiction services have been steadily made, but the issues facing us will not be solved by improvements to existing services – they require transformative change.

The key change to be made administratively is that mental health must become an actual and measured responsibility of government services in general, rather than mental health services specifically. Government agencies responsible for social and economic policy affecting the determinants of mental health must be measured and made accountable for the effect policy has on mental health. This should be given effect through the annual Budget, with performance measures in the Information Supporting the Estimates, and annual examination by Parliament.

Everyone has a role to play in promoting and maintaining their own and others mental health and wellbeing. Transforming our approach to mental health and addiction will require a whole of society effort. It will mean coordinating the efforts of government and non-government agencies, people with mental illness and people with good mental health. It will mean considering how we spend money and how we judge the results. Above all, it will mean understanding people's mental health needs, particularly the experience of people living with mental health challenges, and putting them at the heart of decision-making and planning.

A reformed mental health commission would be in an ideal position to be an independent monitor of societal efforts to protect and promote mental health. The Commission could monitor agencies' performance and report publicly, as well as providing a fair and just point from which to advise departments and ministers.

## **Mental health and substance use problems are common**

Mental illness currently accounts for 15% of the total burden of disease in the developed world and the World Health Organisation predicts that depression will be the second leading cause of disability in the world by 2020.

In New Zealand, about one in five people will have a diagnosable mental illness in any twelve month period. An estimated 12 percent of New Zealanders will experience a substance use disorder in their lifetime, of whom 70 percent will have a co-existing mental health issue. Māori make up approximately 16 percent of New Zealand's population, yet they account for 26 percent of all mental health service users. Māori experience the highest levels of mental health disorder overall, are more likely to experience serious disorders and co-morbidities and have the highest 12-month prevalence of substance disorders.

Psychological distress and substance misuse that may not develop into a diagnosable disorder, is also common. We know from the most recent New Zealand Health Survey that twenty percent of adults drink in a way that is harmful to themselves or someone else. Psychological distress was experienced by 7.6 percent of adults in the previous four weeks.

Suicidal behaviour continues to be a significant issue in New Zealand. Every year over 500 people die by suicide and it is estimated that every year around 150,000 people think about taking their own life, 50,000 make a plan to take their own life and 20,000 attempt to take their own life. Suicide rates amongst young people aged 15-24 (particularly young Māori and Pacific people) are disproportionately higher than other groups. Although over the last decade official suicide rates have decreased slightly, early indications are that official suicide rates will likely increase.

## **People with mental health and substance use problems have poor overall outcomes**

New Zealand's experience mirrors the well-documented international trends that show people with serious mental illness and addiction have poorer outcomes than others. Neuropsychiatric disorders are the leading cause of health loss in New Zealand, accounting for 19 percent of total disability-adjusted life years (DALYs).

People with mental health and addiction issues have worse physical health overall than the general population. New Zealanders with serious mental illness and addiction have significant physical health needs and a reduced life expectancy (by up to 25 years) in comparison with the general population. The estimated annual cost of premature death from comorbid mental and physical health conditions in people with serious mental disorders or addiction is \$6.2 billion each year<sup>1</sup>.

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<sup>1</sup> The economic cost of serious mental illness and comorbidities in Australia and New Zealand: Royal Australian and New Zealand College of Psychiatrists. Retrieved from <https://www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx> 24/5/2018

In addition to these significant physical health issues, people with mental health and addiction issues experience a greater level of social issues such as homelessness, unemployment, poverty. For some, particularly for those who experience addiction, this results in interaction with the criminal justice sector. Those in prison are 30 times more likely than the general population to have an addiction issue, and 20 percent of those in prison have both a mental illness and an addiction issue. Fifty-two percent of women in prison have post-traumatic stress disorder.

Mental illness can therefore lead to compounding disadvantage for people already at risk of poor outcomes.

### **There are significant inequities and unmet needs**

Both the incidence of mental health and addiction issues, and the experience of them, differs significantly across populations. Because these issues affect, and are affected by, wider aspects of a person's life, this is an issue both for specialist health services, wider government services, and ultimately society as a whole.

One of the strongest indicators of inequity of outcome is the rate Māori are subject to compulsory treatment orders. This is 3.6 times the rate of the general population. This ratio has been increasing over recent years. There is a clear need to consider what impact service design and institutional elements have on the experience of Māori in the system, both for specialist mental health services and more general government services, given their potential to both support and impair mental health.

The last major epidemiological study of mental health and addiction in New Zealand, *Te Rau Hinengaro* was published in 2006<sup>2</sup>. It shows that:

- 50.7 percent of Māori interviewed had experienced at least one mental disorder in their life before the interview, 29.5 percent in the last 12 months (compared with 20.7 percent for non-Māori), and 18.3 percent in the last month.
- Māori male suicide rates were 19.7 per 100,000 of population compared with a non-Māori rate of 15.6, and Māori youth (aged 15-24) suicide rates are double those of non-Māori (31.8 compared with 14.4 per 100,000).
- Alcohol abuse or dependence was 7.4 percent for Māori, compared with 4.2 percent for Pacific and 2.2 percent for others.

It showed a significant unmet need for treatment for Māori with mental health and addiction disorders. Of all those with a mental disorder in the preceding 12 months, only 38.9% had a mental health visit to a health or non-healthcare provider within those 12 months. Most significantly, the study showed that even after controlling for other demographic factors, such as income and employment, Māori still had a significantly higher prevalence of mental health and addiction disorders.

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<sup>2</sup> The Ministry considers there to be a need for a further study to provide up-to-date information to inform the implementation of the Inquiry's findings.

## **What has happened in the past has been necessary, but insufficient**

Specialist mental health and addiction services have focused on the (estimated) 3 percent of the population most severely affected by mental illness. This is for sound historical reasons. This group were the worst off and were not well served following the deinstitutionalisation programme of the 1980s. In 1998 the Health Funding Authority estimated only 1.5% of adults, and about 0.7% of children and young people were being served. This has improved steadily over the past twenty years, and have now exceeded the 3% target (as set out by the Blueprint 1998) for access to adult specialist mental health and addiction services. But there is still unmet or poorly met need, particularly among Māori and low-income people.

We continue to see high and increasing demand and are now getting reports from DHB's about acute services experiencing critical occupancy issues. The workforce is under pressure and there are growing concerns about workload and conditions. There is also an increasing demand for experienced mental health practitioners in particular nurses and psychologists from both within and outside health.

Over the last few decades, the mental health and addiction sector has moved from an institutional base to more of a community base. There have been a wide range of community services developed, as well as further development of specialist and acute services.

Various integrated and innovative approaches have been developed in pockets across the country and there is an opportunity to build on these. There is also an opportunity to work closely with primary care so that New Zealanders can experience a joined up and integrated response that makes a real difference to their mental health and wellbeing.

There is scope for far more preventative activity and support for those suffering psychological distress that does not constitute a mental illness. There is also scope for far more promotion of mental health to support people to develop and maintain mental wellbeing and to build their ability to deal with life stresses. We need to intervene early in the life course, early in the illness course and at key transition points across the life course. Early and practical support can make a real difference and is currently not available in all areas, to all New Zealanders.

## **This is not just about health services**

Public expectation of mental health and addiction services has changed, with more people seeking help for mental health and addiction issues. This is a positive thing: there is reduced stigma about mental illness, though less so for addictions partially due to the use of illicit substances. With the increasing awareness and decreased stigma, there is an increasing demand for services and a perception that every mental health concern is amenable to medical intervention. This reflects a medical rather than societal view of mental health in which problems have a discrete cause, and treatment has an obvious end. We need to be clear that for some people, their mental illness will require life-long management however for many, their needs will be episodic and will change over the course of their lives. People need to be active participants in their own recovery and services need to facilitate this. The goal is to enable people to thrive and experience wellbeing even when they are experiencing persistent symptoms.

It is also important to think carefully about the nature of the problems to which we respond. The factors that influence mental health and addictions are complex. They are far wider than the health sector. Poor mental health or problematic substance use can be influenced by, and can influence, almost any area of someone's life. Similarly, we should not be thinking in terms solely of diagnosable mental health or substance use disorders. Those seeking help may be experiencing stress from a traumatic life event, a major transition or may be lonely or isolated. These are issues that cause real distress and should not be ignored, but are not necessarily best addressed by specialist mental health services.

The evidence shows people's mental health and wellbeing is influenced by experiences earlier in life. It is now clear that early childhood is the critical period. Half of all lifetime cases of mental illness start by age 14 and three quarters start by age 24. Adverse prenatal, infant and childhood experiences contribute to a diverse range of poor health outcomes in adolescence and adulthood, including elevated rates of depression and conduct disorders.

Professionals such as midwives, Well Child/Tamariki Ora nurses (Plunket nurses), early childhood teachers and others have an important role in supporting parents, infants and children to live, learn and play in environments that promote mental health and wellbeing.

Experiencing poor mental health early in life can have lifelong negative consequences, including reduced participation in the future workforce, enduring disability and/or poor family and social functioning. Intervening effectively from the perinatal period through to childhood, adolescence and early adulthood can significantly improve long-term outcomes and reduce future dependence on the health and social system.

There is potential benefit in an approach similar to that taken for some physical health issues. For example, cardiovascular mortality declined globally by 16 percent between 2000 and 2012, building on previous reductions. A small amount of the reduction is attributable to specialist medical services; a larger amount is attributable to primary care advice and intervention; and the majority is attributable to preventative activity, such as lifestyle changes by individuals. Change was the result of activity across a range of areas, by a wide range of actors, from governments to hospitals, general practitioners and schools, to non-governmental and community organisations, to gaining a better understanding through talking and supporting each other<sup>3</sup>.

### **Cross-government work is happening, but needs to be better**

It is important for government agencies to work together to meet people's mental health needs – this is not merely a health, or housing, or justice issue for the citizens, and should not be approached in that way by government agencies. This was made very clear in the Office of the Auditor-General's report last year which discussed discharge planning. The report recommended urgent improvements to ensure people's wider social needs were addressed to enable better outcomes.

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<sup>3</sup> Shanthi Mendis. *Global progress in prevention of cardiovascular disease*, [Cardiovasc Diagn Ther.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5418214/) 2017 Apr; 7(Suppl 1): S32–S38. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5418214/> 22/5/2018



The Government has indicated that child well-being is a top cross-agency priority. The health sector contribution includes a focus on child mental health. The Ministry's child health team has given this work top priority so that mental health is viewed across the life course.

Government agencies are increasingly recognising this, and working together on these issues. Appendix one sets out agencies' initial thinking on cross-agency issues. We need to ensure coordination and governance arrangements better support and enable agencies to respond to people's mental health needs.

A cross-agency approach could also be applied to reducing the harm from alcohol (building on the recommendations of the Law Commission report in 2011) and other addictions including new psychoactive drugs.

Local government also has an important role to play and should be supported to assist their local communities to strengthen resilience and address mental health issues with a local focus, for example those arising from natural disasters, suicide clusters, and or localised patterns of alcohol and other drug abuse.

We consider a reformed mental health commission has a key part to play in a transforming environment. An autonomous Crown Entity could monitor efforts across government agencies and wider organisations, and serve a coordinating purpose. Additionally, it would be able to become an expert, independent advisor on improving mental health and wellbeing. We would be pleased to discuss this issue further with the Inquiry.

## **Transforming our approach to mental health and addiction**

Meeting people's mental health needs is not primarily a question of the availability of mental health services. Positive mental health is not an absence of mental illness or addiction but the ability to thrive and experience wellbeing. Like physical health, it is a continuum. And like physical health, there is a lot that can be done to support and promote mental health and wellbeing over the course of our lives.

Mental health and addiction are complex social issues rather than medical ones. Solutions need to look to the wider environment, as well as wider government services. There are lessons about approaches to meeting people's needs to be drawn from other areas, particularly disability services, but also public health, social services, community groups, iwi organisations, and many others.

## **We know what a transformed approach looks like**

A transformative approach must be built on trust and be fair to all people. There is a broad consensus about what should happen: a much greater emphasis on promoting mental health and preventing mental illness and addiction, starting with preconception and maternity care and proceeding throughout the life-course. Where issues arise, they should be addressed in accordance with the person's needs, rather than being dependent on a diagnosis, taking into account their particular experience, circumstances, cultural background, and their wishes. Where people are in need, services should be provided according to those needs, without being impaired by agency or service borders.

Over the last few years, the Ministry of Health has been developing an outcomes approach. This approach focuses on reshaping our system to centre on people and what matters to

them. The Commissioning Framework for Mental Health and Addiction (MoH, 2016) and He Tangata (draft Mental Health and Wellbeing Outcome Framework) are central to this approach. The Mental Health and Addiction Workforce Action Plan 2017-2021 (MoH, 2017) also sets out how we can build capacity and capability to support this approach. An outcomes approach can be part of a step change to support further transformation.

The Fit for the Future initiative challenged current approaches to primary and community mental health. Through the initiative there was a common consensus that people need to be able to access a range of responses through their community when they need it, including through primary and community care.

Transformation will take time, it cannot be done overnight, and there is much to be gained by improving existing services and thinking in the interim. We consider the best way forward to be a stepped approach, with significant improvements to existing services and improved interagency cooperation in the medium term, working toward a transformed approach in the longer term. More detail of our reasoning is in appendix two.

Workforce development will be needed to transform the system and build the necessary capacity and capability to respond effectively to population need, in particular Māori, Pacific and youth. Workforce is also key in providing leadership for change in the desired transformation of the mental health and addictions system and this will require significant investment.

Supporting existing mental health and addictions services while implementing systems transformation is a challenge. There is a national shortage of mental health professionals in New Zealand and current demand is already exceeding capacity. The success of new or different approaches will require a workforce focused on improved outcomes, that is integrated, competent, capable and the right size and skill mix.

A commitment to transformational change requires the means necessary to make the change happen. Organisationally, the Ministry will need to enable change to support the management and delivery of priority and emerging needs in addition to business as usual delivery.

Effective management and delivery must blend transformational leadership and mental health and addiction subject matter expertise with consumer, policy, commissioning and performance, workforce and technology knowledge. People may be based within the Ministry; but, will have considerable connection across the sector in terms of project co-design and participation and programme governance.

The current work the Ministry is undertaking to transform disability support services has given the Ministry useful experience. The key shift is from a system where an assessment agency determines a person's needs based on a judgement of what's wrong with them, to one in which the first question asked is "what is a good life for you"? This is a long term approach that may take a decade to fully implement, but offers the greatest rewards. The key differences between this approach and transforming the mental health and addiction system is the scale and level of control that the Ministry has. More detail on this approach is in appendix three.

The following table sets out our initial thinking on an approach to transformation.



## Stepped transformation

Current system emphasis	Improved system response	Transformed experience
Mental health is misunderstood and considered solely a health problem	Mental health is understood as a complex problem and a critical component of personal, cultural, and societal wellbeing	<b>Values personal experience</b> of mental health and wellbeing factors and supports and responds to people's varied needs
The focus is on those most severely affected by mental health and addiction issues, with limited prevention or early intervention	All needs are responded to regardless of severity, with improved promotion and early intervention	<b>People are supported to live well, stay well and get well</b> throughout their lives
Treatment is medical and controlled by the system based on what is 'wrong' with the individual	Provide a collective health and social and cultural response to identified needs, to support recovery	<b>Responsive to the complex needs and wants</b> of a person and their family / whānau from the first contact
Funding and commissioning of mental health and addiction services is primarily seen as a health sector responsibility	Funding and commissioning of mental health and addiction services is seen as all-of-government responsibility	Support for people's needs is funded and commissioned in a way that reflects <b>shared responsibility for outcomes</b>
Decisions made for people, with overuse of compulsion	People are empowered to make their own decision as much as possible	<b>People make their own decisions</b> about their lives, including their care, and are supported as necessary to do so
System needs are put first and supported by business models. This is about central planning restriction but also flag some absence of necessary guidance	System is able to be flexible and innovative in its response, while still having suitable central guidance	<b>Compassionate care and support</b> based on benefit to the person and their whanau, across all areas of need designed around the person and their whānau
Response, choice and experience is different for different populations. Treatment is variable across services and regions	Deliver equitable outcomes that make a real difference for people, based on up to date evidence about effectiveness	<b>Trustworthy performance</b> based on being dependable, reliable, responsible, effective, and equitable
A focus on specialist mental health and addiction workforce, in which there are shortages	A focus on the broad and diverse range of people working in a number of different settings	<b>Everybody understands and has the ability to respond</b> to people's needs
Individual service providers are accountable for a narrow set of outputs which are not necessarily monitored	Individual providers are monitored on measurable and attributable outcomes, including cross-sectoral outcomes. System as a whole is monitored according to how well it meets the needs of the people, and whole of societal outcomes are monitored and measured	Whole of society understands what influences mental wellbeing, which is a <b>routine part of decision-making and standard measure of societal welfare</b> . Everyone understands and contributes
Society sees addiction as a moral failing, and takes a legal approach	Issues understood as complex health and social ones, with reduced stigma and law changes supporting health approach	<b>Addiction regarded and responded to as health and social issue</b> . Issues reduce as other changes towards a more supportive and free society made
No overall societal monitor, limited coordination or central consideration of interventions and models of care	Reformed mental health commission monitors all of government and reports publicly. Coordinates cross-government approaches. Considers interventions and models of care and advises	<b>Mental Health Commission ongoing monitor of mental wellbeing across society</b> . Trusted as an independent advisor on improving mental health and wellbeing as well as treatment approaches and service design