



New Zealand's mental health and addiction services

The monitoring and
advocacy report of
the Mental Health
Commissioner

FEBRUARY 2018

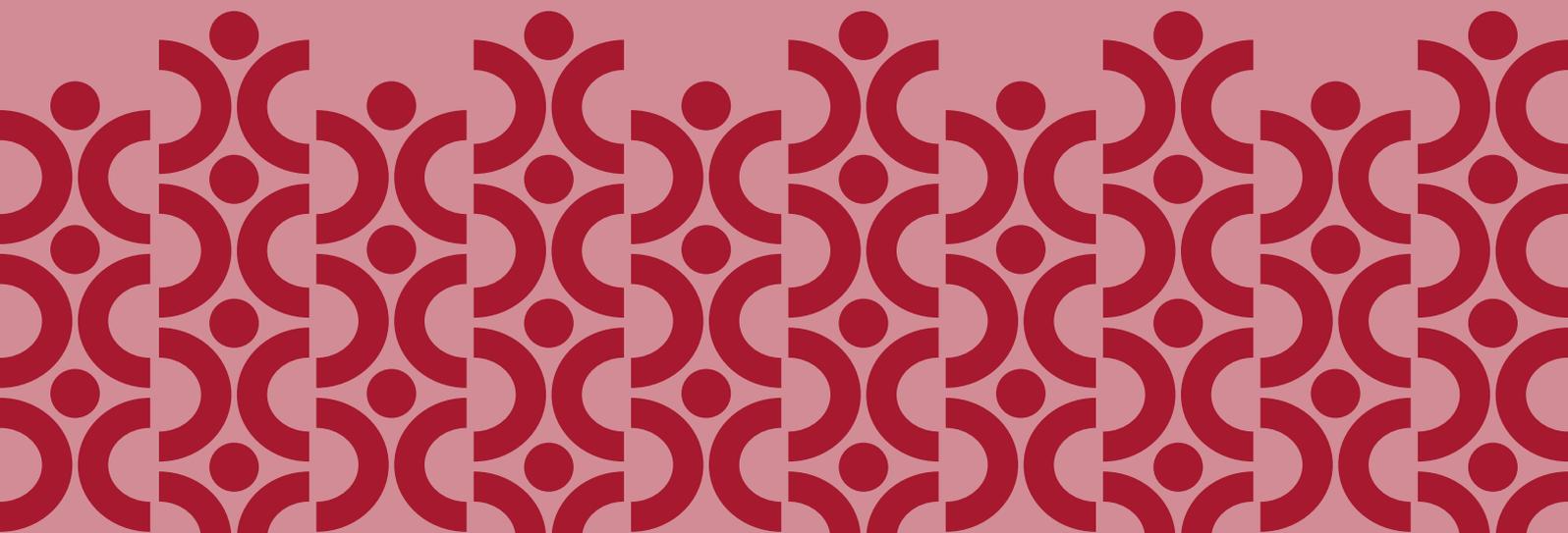




1 in 5

New Zealanders live with
mental illness and/or addiction

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Foreword





The Office of the Health and Disability Commissioner (HDC) is an independent watchdog. Its purpose is to promote and protect the rights of consumers of health and disability services. One of the Office's statutory responsibilities is to monitor and advocate for improvements to mental health and addiction services.

As Mental Health Commissioner I lead HDC's monitoring and advocacy work. This work is based on a framework I have developed over the past year, with input from consumer and whānau advisors, providers, and other sector leaders. The framework takes account of:

- Themes and trends arising from complaints to HDC
- The experience of consumers, and of families and whānau of consumers
- Information from a wide range of organisations and sector leaders; and
- Key performance information.

I am releasing this public report as part of my advocacy role to inform the public about what I believe we need to improve and where we are making progress.

While my statutory focus is on health services, I have also commented on wider issues that need to be addressed in order to achieve the changes that are required and to address the underlying factors that contribute to increased demand on specialist and other mental health services.

This report identifies a number of areas where action is required in relation to mental health and addiction services. It is increasingly obvious that the main challenge for the mental health and addiction system is to broaden the system response to ensure that support is available across a continuum of care for the one in five people who experience mental illness and/or addiction.

At the same time, we need to improve the way we provide specialist services and support to people with complex and/or enduring needs.

An action plan is needed to:

- Broaden our focus from mental illness and addiction to mental well-being and recovery. This requires increased attention to health promotion, prevention, and early intervention. This, in turn, must address factors that drive demand for health services, such as housing, income, education, and social and cultural connections.
- Increase access to health and other support services. This requires a substantial increase in support for people with mild and moderate mental health and addiction needs which, in turn, should also result in a reduction of pressure on specialist services. This does not simply mean more of the same. New approaches, informed by consumer experience and new technology, are important.
- Improve the quality of mental health and addiction services. This includes improving consumer and family and whānau engagement and service coordination, reducing restrictive practices, and improving outcomes for Māori, Pacific peoples, children and youth, and people in prison.
- Ensure we have timely information about changing levels of need, current services and support, and evidence about best practice.

“Mental health, like other aspects of health, can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach.”

World Health Organization Mental Health Action Plan 2013–2020

- Implement a workforce strategy that enables the sector to deliver better, more accessible services.
- Achieve the required changes through collaborative leadership, supported by robust structures and accountabilities to ensure successful, transparent results. This means inclusion of consumers and their whānau/family, the Ministry of Health, DHBs and other service providers, Māori and Pacific sector leaders, workforce and research organisations, as well as other sectors.

My findings and proposed action plan are not new but they do suggest a loss of traction in the sector. Issues with leadership and coordination have undoubtedly contributed to system inertia. Cohesive sector leadership is required to establish the plan of action and, just as importantly, ensure that it is delivered.

Currently there is a lack of integrated, collaborative leadership in the sector. This is reflected in the failure to track tangible progress against the 2012–17 plan *Rising to the Challenge*, and to develop a plan to succeed it. The structure of the health sector, with the Ministry, 20 DHBs, PHOs and NGOs presents inherent coordination and leadership challenges. However, for a complex area such as mental health and addiction, effective, collaborative leadership within the sector and across the broader social system is essential for success. There is, therefore, a real risk that leadership will fail when it comes to delivery. That risk must be addressed by ensuring the collective experience and commitment of the sector is harnessed to ensure the next plan of action has widespread support and, just as importantly, that there are robust leadership structures and accountabilities to implement a new action plan.

While substantial change is required, it is also important to recognise and learn from successes. Access to specialist services has grown significantly over the past 10 years and, although that has placed these services under considerable pressure, waiting times for a first appointment have not increased markedly, and four out of five consumers surveyed

would recommend their service to others. There is also an array of initiatives to improve and develop specialist and other services. Examples of these initiatives are in the report.

I release this report shortly after the election of a Government committed to having a special focus on mental health, and which has begun an inquiry into mental health and addiction.

I welcome the Government's commitment and the breadth of focus of the terms of reference of the inquiry. That breadth is necessary to ensure that we focus on promoting mental well-being and recovery while also improving services. The timeframe for the inquiry ensures that significant decisions about improving services can be made in a timely way. The inquiry will inform Government decisions about governance and leadership of the sector, which means that my concerns about leadership can be addressed. I look forward to assisting the inquiry team in whatever way I can.

The Government has also undertaken to re-establish a stand-alone mental health commission to increase monitoring and advocacy for mental health and addiction services. I welcome that decision.

In conclusion, I thank the wide range of consumers, family and whānau, sector leaders, and service providers I have had the privilege of working with in the preparation of this report. While there is room for substantial improvement to services, it is important that we recognise what has been achieved, and acknowledge the commitment of everyone who has contributed to those achievements.



Kevin Allan

Mental Health Commissioner
Office of the Health and Disability Commissioner

Acknowledgements

This report, published by HDC, and the monitoring framework underpinning it, could not have been achieved without the involvement of a wide range of individuals and groups who have contributed to our understanding of the challenges and achievements of New Zealand's mental health and addiction services.

My thanks go to:

- Consumers and family and whānau who have shared their experiences with HDC, including over 14,000 people who have now completed the Mārama Real Time Feedback survey about their experiences of mental health and addiction services, and participants at HDC forums.
- Consumer representatives and advisors, including Victoria Roberts and the members of Nga Hau e Wha; Louise Windleborn and members of the National Association of Mental Health Services Consumer Advisors; Sue Cotton and Sharon Morrison, members of the National District Health Board Family Whānau Advisors; Tui Taurua-Peihopa and members of Te Huarahi o te Kete Pounamu; Suzy Morrison and members of Matua Raki Consumer Leadership Group.
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- Dr Janice Wilson and other Health Quality & Safety Commission staff.
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- The Offices of the Children's Commissioner, Human Rights Commissioner, Independent Police Complaints Authority, and Ombudsman.

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Finally, my thanks go to Anthony Hill, the Health and Disability Commissioner, for his thoughtful advice and support, and all HDC staff who contributed to and supported our monitoring and advocacy work, particularly Jane Carpenter, who has made an outstanding contribution to the development of our monitoring framework and led the preparation of this report, Natasha Davidson, who led the analysis of complaints to HDC, which form an important part of our report, and Wendy Parker, who made a valuable contribution to the preparation of this report.

Overview of findings



In my monitoring role as Mental Health Commissioner, I found that **while growing numbers of New Zealanders are accessing health services for mental health and addiction issues, these services are under pressure and many needs are left unmet.** Often services are available to people only once their condition deteriorates, and the dominant treatment options (medication and therapy) do not address the broader social factors that help people be well and support their recovery.

There are many signs of progress in the sector.

Innovative service delivery models are being trialled; outcome information suggests that people generally improve in services; and the majority of consumers and their family and whānau report positive experiences of services. Interventions that show promise, including e-therapy and peer support, are also growing.

The sector is also working to address many of the areas I identify in this report as being of concern, including through the Mental Health and Addiction Quality Improvement Programme led by the Health Quality and Safety Commission.

Areas I am concerned about include:

- a lack of early intervention options;
- low commitment by services to shared planning with consumers and their family and whānau;
- coordination challenges within and between services;
- high uses of compulsory treatment, especially for Māori;
- stagnation in seclusion reduction;
- poorer physical health outcomes for people with serious mental health and/or addiction issues; and
- disparity in outcomes for Māori and other population groups.

I am pleased that the sector has established a programme with a goal to eliminate seclusion by 2020, and that a review is planned for the Mental Health (Compulsory Assessment and Treatment) Act 1992. I have also called for the Government to set a target for suicide reduction and for services to be more deliberate in relation to their contribution towards preventing suicide in New Zealand.

While it is positive that action is underway to improve mental health and addiction services, **more of the same will not deliver the well-being and recovery-oriented system that is required.**

A broader range of health interventions is needed, to be available earlier, and be better connected into other community and social supports. The health sector is only one part of an effective system response.

At the same time, **action is required to relieve pressure on existing mental health and addiction services.** Access to these services has grown 73% over the last decade, while funding has grown only 40%. Better information and a broader re-think of system design and financial arrangements is required to understand current and future need and plan for and deliver the right responses across a spectrum of need. New Zealand's prevalence data is over 15 years old, and does not include children, people outside of households, or less common conditions. Access targets for mental health and addiction services were set over 20 years ago and were based on assumptions of prevalence and service delivery models known at that time.

My findings are not new and suggest a loss of traction in the sector. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*, together with the Mental Health Commission's document that informed it, *Blueprint II: How things need to be*, set out a well-being and recovery vision for the mental health and addiction sector. These documents identified similar challenges to those in my report, as well as actions to address them. *Rising to the Challenge* has now expired, and there is no plan in place to replace it. With 100 actions and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, it has been difficult to measure progress at the completion of the plan.

The primary recommendation I make in this report is for a new action plan to regain traction in the sector and deliver results. This action plan needs to:

- Broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery.
- Increase access to health and other support services.
- Improve the quality of mental health and addiction services.
- Ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice.
- Implement a workforce strategy that enables the sector to deliver better, more accessible services.
- Achieve the required changes through collaborative leadership, supported by robust structures and accountabilities to ensure successful, transparent results.

Issues with leadership and coordination have undoubtedly contributed to system inertia.

There is a complex array of leadership roles within the mental health and addiction sector and across the broader social system that needs joining up. Collaborative leadership is essential. The collective experience and commitment of the sector needs to be harnessed to ensure the next plan of action has widespread support and, just as importantly, there is a robust leadership structure and transparent tracking of progress to ensure the plan gets traction and is delivered.

My findings and recommendations are underpinned by a monitoring framework developed with the sector in 2017. At the heart of the framework are six consumer-centric monitoring questions, which are assessed by drawing on HDC complaints data, consumer and family and whānau feedback, sector feedback, and key performance information.

This is my first monitoring and advocacy report in relation to mental health and addiction services. I have focussed on services that are predominantly publicly funded through Vote Health, and have taken a national rather than a regional view. I have not been able to cover a number of important consumer groups and specialised services for this first report, but I hope these populations and services will be a focus of monitoring and advocacy work in the future.

The sector is committed to a well-being and recovery-oriented system, but needs a re-think of service design, a plan of action, and strong collaborative leadership to make change happen.

Recommendations



I recommend that the Minister of Health:

- 1 Note the Mental Health Commissioner's report on New Zealand's mental health and addiction services, released as part of the Office of the Health and Disability Commissioner's statutory responsibility to independently monitor and advocate for improvements to mental health and addiction services under section 14(1)(ma) of the Health and Disability Commissioner Act 1994.
- 2 Note that the report is based on a monitoring framework developed over the past year with input from consumer and family/whānau advisors, providers, and other sector leaders.
- 3 Consider the proposal for an action plan, detailed in the report, to:
 - a. Broaden the focus from mental illness and addiction to mental well-being and recovery.
 - b. Increase access to health and other support services.
 - c. Improve the quality of mental health and addiction services.
 - d. Ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice.
 - e. Implement a workforce strategy that enables the sector to deliver better, more accessible services.
 - f. Achieve the required changes through collaborative leadership, supported by robust structures and accountabilities to ensure successful, transparent results.
- 4 Invite the Inquiry into Mental Health and Addiction to consider:
 - a. The findings of this report.
 - b. The introduction of a regular assessment of prevalence, help-seeking behaviour, and access to mental health and addiction services across the whole population, to identify and respond to changing needs.
 - c. The introduction of a requirement on DHB-funded providers to undertake comparable, representative sampling of consumer experience of mental health and addiction services, and to report annually, from 2019, on that information and actions taken to improve services as a result of the information.
 - d. The development of an action plan, in collaboration with Māori experts and leaders, and other sector leaders and providers, to reduce the exceptionally high rate of Compulsory Treatment Orders for Māori.
 - e. The adoption of a specific reduction target in the Government's suicide prevention plan (noting that the World Health Organization suggests a target of 10%, but that some countries may go further).
 - f. The adoption of a goal of zero tolerance of suicides in services, informed by the strategies adopted by Mersey Care, with support for providers to work together to develop a consistent approach in achieving it.

- g. The findings of independent agencies responsible for monitoring New Zealand's compliance with the United Nations Convention on the Rights of Persons with Disabilities (the UN Convention) and the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in relation to mental health and addiction services.

5 Note that it appears that urgent action is required to address pay issues in the NGO sector arising from pay equity settlements, to ensure that workforce capability is retained.

6 Note that this report:

- a. Supports the introduction of a population-based mental health and well-being outcome framework to provide national-level guidance on where to focus effort to support regional and local mental health and addiction service and workforce planning.
- b. Welcomes the re-introduction of collection of discharge planning information in 2018, which provides important information about continuity of care, and recommends that this information should be reported publicly.
- c. Welcomes the development of mental health and addiction services by the Department of Corrections, but expects to see evidence of early improvements, through the implementation of the Department's intervention and support model, to address concerns identified by the Ombudsman.
- d. Welcomes the Health Quality & Safety Commission mental health and addiction quality improvement programme, which focuses on improving services in areas in which this report identifies concerns about service quality, safety, and responsiveness, including:
 - i. an aspirational goal of eliminating seclusion by 2020 in a collaboration with Te Pou o te Whakaaro Nui;
 - ii. improving transition planning;
 - iii. improving medication management;
 - iv. maximising physical health of consumers with mental health and addiction problems ("Equally Well"); and
 - v. improving responses to serious adverse events and complaints.

7 Direct Ministry of Health officials to:

- a. Advise on changes required to the Mental Health (Compulsory Assessment and Treatment) Act 1992 to ensure that it aligns with current expectations about human rights, supported decision-making and best practice in the provision of therapeutic health services, and with the United Nations Convention and the Code of Health and Disability Services Consumers' Rights (the Code), so that this can be progressed quickly in any regulatory review following the Inquiry.
- b. Record and, by 2019, report on prescriptions in mental health inpatient units.

8 Note that there is strong international evidence that investing effectively in mental health and addiction services can make a positive difference, both to people's health, as well as to the economy.

Introduction



As Mental Health Commissioner I am responsible for monitoring New Zealand's mental health and addiction services and advocating for improvements to those services. I also make decisions in relation to complaints about those services. These responsibilities are delegated to me by the Health and Disability Commissioner.

Why this report?

The purpose of this report is to provide a systematic and evidence-based way of assessing the performance of mental health and addiction services and make recommendations for service and system improvement. The ultimate aim is to improve the well-being of people who need to use those services.

The structure and methodology of the report is designed to be replicated on an annual basis to identify trends over time and provide accountability for progress against recommendations and performance measures.

What services are covered in this report?

The report focuses on the performance of publicly funded health services in their response to the needs of people with mental health and addiction issues. Publicly funded health services include primary and community care services (such as a family doctor or midwife, non-governmental organisation (NGO) primary health support, and specific mental health and addiction interventions funded for delivery in primary and community care settings) and mental health and addiction services that are funded by district health boards (DHBs) and provided by either DHBs or NGOs.

The full range of services and providers that respond to mental health and addiction needs are not covered in this report, nor does it cover prevention activity and broader community responses required to promote population well-being and recovery.

This is HDC's first report based on the monitoring framework developed with the sector in 2017. Unfortunately, we have not been able to cover a number of important consumer groups, including disabled people, gay, lesbian, bisexual, transgender and intersex populations, older people, and refugee, migrant and rural communities. Each of those populations has distinct and significant mental health and addiction issues, which deserve monitoring and advocacy focus in the future. Similarly, we have not been able to consider some important specialised services, including eating disorders, transgender support services, and problem gambling services, which also deserve attention, nor consider regional as distinct from national issues.

How is service performance assessed?

I assess service performance using a monitoring framework my team and I developed over the last 18 months in consultation with consumers, family and whānau, and mental health and addiction sector representatives.

At the heart of the framework are six monitoring questions, which form chapters in this report:

- Can I get help for my needs?
- Am I helped to be well?
- Am I a partner in my care?
- Am I safe in services?
- Do services work well together for me?
- Do services work well for everyone?

These questions canvass service performance from a consumer perspective with reference to the internationally regarded dimensions of healthcare quality — access, safety, experience, equity, effectiveness, and efficiency — developed by the National Academy of Medicine (formerly the Institute of Medicine) and adopted in New Zealand by the Health Quality & Safety Commission.

To come to a view on service performance in relation to these monitoring questions, I have drawn on four sources of monitoring information, which represent a mixed qualitative and quantitative approach. These information strands are:

- Complaints made to this office about mental health and addiction services;
- Feedback from consumers and their families and whānau through HDC's Mārama Real Time Feedback Survey, specific engagement for this report, and regular meetings;
- My ongoing engagement with many different people in the sector; and
- System and service performance information from official sources, for example, national Ministry of Health data on how long people wait before receiving help from mental health and addiction services, and reports by other watchdog organisations such as the Ombudsman and Children's Commissioner.

Within the information sources I have selected a sub-set of measures that can be replicated annually to provide consistent trend analysis over time. These measures predominantly relate to DHB and NGO mental health and addiction services at this time because the quality of data collection is more robust than for primary and community care. It is my expectation that measures relating to primary and community care will be expanded on in the future.

A full methodology is set out in Appendix 2.

How is the report structured?

This report begins with an overview of the mental health and addiction system. The overview covers the big picture — the prevalence of mental health and addiction issues in the population, how services are funded and delivered in New Zealand, who delivers them, and strategic guidance and leadership for those services.

Throughout the report I discuss what needs to happen. I make recommendations for system improvements, having noted both the successes of the system and services and the challenges they face.

Key terms and concepts used in this report

Consumer: A person who accesses health services for mental health and/or addiction need. The term “consumer” is used in the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers’ Rights to describe people who access any health or disability service.

Mental health and addiction need: Mental health and addiction issues exist along a continuum. Diagnostic terminology tends to categorise people’s experiences of mental illness and addiction into sub-threshold, mild, moderate, and severe conditions. I have avoided this terminology where possible as it assumes a certain service delivery model. Instead I refer to mental health and addiction services as being designed to respond to people with “complex and/or enduring need”, and primary and community care as being designed to meet the needs of people outside of mental health and addiction services.

Family and whānau: Family and whānau is not limited to blood ties, but may include partners, friends, and others in a person’s wider support network. Definitions and understandings of family and whānau vary and are informed by different cultural backgrounds and practices. Almost always,

the most important perspective for defining family and whānau is that of the person. This definition of family and whānau is taken from: Ministry of Health, *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health; 2012.

Mental well-being and recovery: Mental well-being and recovery is more than the absence of a mental illness and/or addiction. Concepts of well-being and recovery are different for every person, and refer to living a satisfying, hopeful, and meaningful life, even where there are ongoing limitations and challenges caused by mental illness and/or addiction.

Stepped care approach: The stepped care approach is the model of care set out in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* for health services to respond to mental health and addiction need. With this approach, a person should be able to access help from health services in the least intrusive way, for just as long as the person needs, to best support his or her well-being and recovery. A person should be able to “step up” and “step down” the intensity of those services as his or her needs change.

Health services that respond to mental health and addiction need

Mental health and addiction services: Services designed specifically for people with complex and/or enduring mental health and/or addiction needs. These services are publicly funded through Vote Health, and include NGO- and DHB-delivered community and residential services, and services delivered in a hospital setting.

Primary mental health services: Services designed for people with mental health and/or addiction need who do not meet the threshold for mental health and addiction services. These services are publicly funded through Vote Health for delivery in primary and community care settings, typically involving extended consultations with general practitioners and counselling sessions.

Primary and community health care: Generalist health services designed for delivery to the general population, including to provide for need that is not met in mental health and addiction services. These services are partly funded by Vote Health, and include general practice, school-based services, midwifery, Well Child Tamariki Ora, and NGO primary health support.

Virtual and self-care services: These supports are accessed without physical contact with a service. They include helplines with trained counsellors, and websites and online communities with health promotion information, self-assessment tools, e-therapy, and recovery strategies.



Part I: System overview

The big picture



This report begins with an overview of the mental health and addiction system. The overview covers the big picture — the prevalence of mental health and addiction issues in the population, how services are funded and delivered in New Zealand, who delivers them, and strategic guidance and leadership for those services.

While a lot of valuable data is available, there are a number of limitations to it. The main prevalence data is now 15 years old, there is limited information about primary and community care access for mental health need, and the data does not cover some population and ethnic groups known to have higher need, including disabled people, gay, lesbian, bisexual, transgender and intersex populations, older people, and refugee, migrant and rural communities.

Mental health and addiction issues are common

Many New Zealanders will live with mental health and/or addiction issues in their lifetime

Te Rau Hinengaro, the national mental health survey, estimated that nearly half of New Zealanders will live with mental illness and/or addiction at some point during their lifetime.¹ Studies that regularly interview a cohort of people over time suggest an even higher lifetime prevalence: for example, in the Dunedin longitudinal study, 83% of the cohort had experienced mental illness and/or addiction by age 38.²

One in five New Zealanders live with mental illness and/or addiction each year

In any year, one in five New Zealand adults will meet the diagnostic criteria for a mental health and/or addiction condition. Nearly 5% of New Zealanders will be considered to have a severe mental health and/or addiction condition, 9% a moderate condition, and 7% a mild condition. Many other New Zealanders will experience some form of mental distress or harm from addiction issues. The most common group of disorders relate to anxiety, mood, or substance use.³

Mental distress is a risk factor for suicide. Other known risk factors include a recent relationship break-up, recent engagement with the police, and unemployment.⁴ While the rate of suicide in the general population has been declining over the last 15 years, it is still unacceptably high. The Coroner's provisional suicide figures for 2016/17 show that 606 people died by suicide in 2016/17.⁵

1 Oakley Browne, MA, Wells, JE, and Scott, KM (eds), *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health; 2006.

2 Schaefer, JD, Caspi, A, Belsky, DW, *et al.*, "Enduring mental health: Prevalence and prediction". *J Abnorm Psychol* 2017; 126(2): 212–24.

3 Similar figures are found in the NZ Health Survey conducted annually: Ministry of Health, *New Zealand Health Survey 2016/17 Update of key results*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/annual-update-key-results-2016-17-new-zealand-health-survey> (accessed 19 December 2017). (Surveyed 13,598 adults and parents or primary caregivers representing 4,668 children.)

4 Health Quality & Safety Commission, *Ngā Rāhui Hau Kura Suicide Mortality Review Committee Feasibility Study 2014–2015, Report to the Ministry of Health*. Wellington: Health Quality & Safety Commission; 2016.

5 Provisional figures, August 2017: <https://coronialservices.justice.govt.nz/assets/Documents/Publications/2016-17-annual-provisional-suicide-figures-20170828.pdf>. The mortality database is a dynamic collection, and numbers can be subject to change, even when nominally final.

Mental health and/or addiction issues start at an early age

Most adult disorders have their onset before 18 years of age.⁶ Around 4% of children aged 2–14 years have already been diagnosed with emotional and/or behavioural problems at some time in their life. One in four secondary students report poor emotional well-being, and 16% of female students and 9% of male students have clinically significant depressive symptoms. New Zealand's youth suicide rates are amongst the worst in the OECD. The suicide rate for 15–19-year-olds in 2013 was 18 per 100,000, accounting for 35% of all deaths in this age group.

Co-existing issues are common

It is not uncommon for people to have more than one mental health and/or addiction condition: over 70% of people who attend addiction services are estimated to have co-existing mental health conditions, and over 50% who attend mental health services are estimated to have co-existing substance use problems.⁷

It is also common for people to have co-existing long-term physical and mental health and/or addiction problems. Evidence demonstrates that people with a long-term condition are two or three times more likely to develop mental ill-health. People with two or more long-term conditions are seven times more likely to experience depression than those without a long-term condition.⁸

Some population groups are more at risk than others

Mental health and/or addiction issues are more common in some parts of the population than others. Māori and Pacific peoples appear to have higher rates of mental illness and/or addiction than the rest of the population. The rate of Māori who have a mental health or addiction condition over a 12-month period is 30%, compared to 21% in the general population. Māori are also more likely to have multiple and more serious conditions.⁹

The rate of Pacific peoples who have a mental illness and/or addiction over a 12-month period is 25%.¹⁰ Pacific peoples have higher rates of substance use disorders and gambling-related harm than the general population. The suicide rate for Pacific peoples is lower than the average for the general population, but youth rates are of concern.¹¹ Suicide is the leading cause of death amongst young Pacific peoples (aged 12–18 years). The *Youth '12* study found that Pacific high-school students were three times more likely to have attempted suicide than other high-school students.¹²

The majority of people in contact with the criminal justice system have substance use disorders and/or other mental health issues. Nine out of ten people in prison (91%) will meet the diagnostic criteria for a mental health or substance use disorder in their lifetime, and 62% will have experienced a diagnosable condition in the previous 12 months. This 12-month prevalence is three times that found in the general population. Prevalence is higher still for female prisoners, with 75% having had a mental

6 Copeland, WE, Adair, CE, Smetanin, P, *et al.*, “Diagnostic transitions from childhood to adolescence to early adulthood”. *J Child Psychol Psychiatry* 2013; 54(7): 791–9; Copeland, WE, Shanahan, L, Costello, EJ, and Angold, A, “Childhood and adolescent psychiatric disorders as predictors of young adult disorders”. *Arch Gen Psychiatry* 2009; 66(7): 764–72; Kim-Cohen, J, Caspi, A, Moffitt, TE, *et al.*, “Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort”. *Arch Gen Psychiatry* 2003; 60(7): 709–17.

7 Todd, FC, Te Ariari o te Oranga: *The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems*. Wellington: Ministry of Health; 2010: <https://www.health.govt.nz/publication/te-ariari-o-te-oranga-assessment-and-management-people-co-existing-mental-health-and-drug-problems> (accessed 3 July 2017).

8 Chapman, DP, Perry, GS, and Strine, TW, “The vital link between chronic disease and depressive disorders”. *Prev Chronic Dis* 2005; 2: 1–10.

9 Oakley Browne *et al.*, 2006, at note 1.

10 *Ibid.*

11 Faleafa, M and Pulotu-Endeman, FK, “Developing a culturally competent workforce that meets the needs of Pacific people living in New Zealand”. In Smith, M and Jury, AF (eds), *Workforce Development Theory and Practice in the Mental Health Sector*. Hershey, IGI Global; 2017: Chapter 8.

12 Clark, TC, Fleming, T, Bullen, P, *et al.*, *Youth '12 overview: The health and wellbeing of New Zealand secondary school students in 2012*. Auckland: The University of Auckland; 2013.

health or substance use disorder in the previous 12 months. The occurrence of substance use issues over a person's lifetime is 13 times that found in the general population. Multiple disorders (two or more diagnoses of a mental health or substance use disorder) appear in the prison population at almost four times the rate of the general population (30% compared to 8%).¹³

Physical health is poorer for people with mental illness and/or addiction

The physical health of New Zealanders with a serious mental health condition and/or addiction is poorer than the general population, with this population dying on average up to 25 years earlier.¹⁴ The reasons for this have been attributed to a range of factors, including lifestyle factors (for example, diet, exercise, or smoking), socio-economic status, adverse health-effects of some medications, issues with accessing healthcare, and a lack of clarity over roles and responsibilities of healthcare providers.¹⁵

The cost of premature deaths of people who have both physical and long-term mental health conditions has been estimated at \$3.1 billion per year, rising to \$6.2 billion (2.6% of GDP) when the impact of addiction is factored in.¹⁶

A recent New Zealand study found that mental health and addiction conditions were estimated to account for 12% of all health loss in New Zealanders.¹⁷ This is similar to the global estimate of the burden of mental illness and addiction.

50–80%

OF NEW ZEALANDERS

will live with a mental illness and/or addiction in their lifetime (figure differs depending on study)

Sources: Te Tau Hinengaro; Schaefer et al, 2017

Co-existing conditions are common:



of people who attend addiction services are likely to have co-existing mental health conditions

Source: Todd 2017



of people who attend mental health services are likely to have co-existing substance use problems

\$6.2bn

(2.6 PERCENT OF GDP)

The estimated cost of premature deaths of people with both physical and long-term mental health and/or addiction conditions

Source: Royal Australian and New Zealand College of Psychiatrists

13 Indig, D, Gear, C, and Wilhelm, K, *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*. Wellington: Department of Corrections; 2016.

14 Cunningham, R, Peterson, D, Sarfati, D, and Collings, S, "Premature mortality in adults using New Zealand Psychiatric Services". *NZ Med J* 2014; 127(1394): 31–41. These New Zealand findings are comparable to overseas findings. Higher death rates stem from a combination of factors, including higher rates of smoking, lower rates of physical activity, the effects of medication on cardiovascular health, to disparity in access to treatment and the quality of that treatment. Some access to treatment issues are based on discrimination and/or social and economic deprivation. Schaefer et al., 2017, at note 2.

15 Oakley Browne et al., 2006, at note 1; Te Pou o te Whakaaro Nui, *The physical health of people with mental health conditions and/or addiction — Summary Evidence Update: December 2017*. Auckland: Te Pou o te Whakaaro Nui; 2017.

16 The Royal Australian and New Zealand College of Psychiatrists, *The economic cost of serious mental illness and comorbidities in Australia and New Zealand*. Melbourne: RANZCP; 2016: 2017b. <https://www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx> (accessed 8 August 2017).

17 Ministry of Health, *Health loss in New Zealand 1990–2013*. Wellington: Ministry of Health; 2016: <https://www.health.govt.nz/publication/health-loss-new-zealand-1990-2013> (accessed 15 August 2017). Health loss is the gap between the population's current state of health and that of an ideal population in which everyone leads a long life free from ill health or disability.

There is a range of publicly funded health sector responses to mental health and addiction need

Health services deliver care for mental health and addiction issues across a spectrum of need

A “stepped care” approach¹⁸ guides the delivery of health services for people experiencing mental health and/or addiction issues. It sits within a broader social response to prevent mental distress and support people to be well and in recovery. The idea of the stepped care approach is that people can access help from health services in the least intrusive way to best support their well-being and recovery. Interventions should respond to a person’s life stage and what the person needs, for just as long as he or she needs, and a person should be able to “step up” and “step down” the intensity of those services as his or her needs change.¹⁹ In this report, I have categorised health services into:

- Self-care and virtual services;
- Primary and community care, including primary mental health services; and
- Mental health and addiction services.

Additionally, health promotion, prevention, and destigmatisation approaches are an important aspect of a broad approach. The “Like Minds, Like Mine” programme, the “National Depression Initiative”, “All Right?” (an earthquake response initiative in Christchurch), and “Farmstrong” are good examples of health promotion activity.

A total of \$1.43 billion was spent in relation to mental health and addiction in 2016/17 from Vote Health. The majority of this funding (95%) was allocated by 20 DHBs across New Zealand. DHBs are responsible for planning for and funding health services that meet the needs of their populations, across the stepped model of care (from primary, secondary, and tertiary care).²⁰

The mental health and addiction services DHBs fund are provided by either a DHB service or NGO provider, including community organisations, iwi providers, and primary health organisations (PHOs). DHBs provide a greater share of services overall, including all in-patient services. About half of alcohol and other drug services are provided by NGOs. The Ministry of Health funds and coordinates problem gambling services, and these services are delivered wholly by NGOs. In 2015/16, \$14.1 million was allocated to problem gambling services.

In 2015/16, community mental health services and community support²¹ together received 35% of DHB mental health and addiction funding, followed by adult inpatient services (17%), child and youth mental health services (11%), alcohol and other drug services (10%, including opioid substitution therapy), and forensic (for people in prison) services (9%). Primary mental health and mental health of older people received only 2% and 4% of DHB funding respectively.

DHB funding is ring fenced and has increased 40% over the past 10 years

A “ring fence” is in place to protect spending on mental health and addiction services within each DHB’s budget. According to the Ministry of Health’s Operational Policy Framework, DHBs cannot reduce their annual spending on mental health and addiction services unless they can show that a change in service delivery would reduce costs while keeping or improving service levels.

18 Ministry of Health, *Rising to the Challenge — the Mental Health and Addiction Service Delivery Plan 2012–2017*. Wellington: Ministry of Health; 2012: <https://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017> (accessed 17 May 2017).

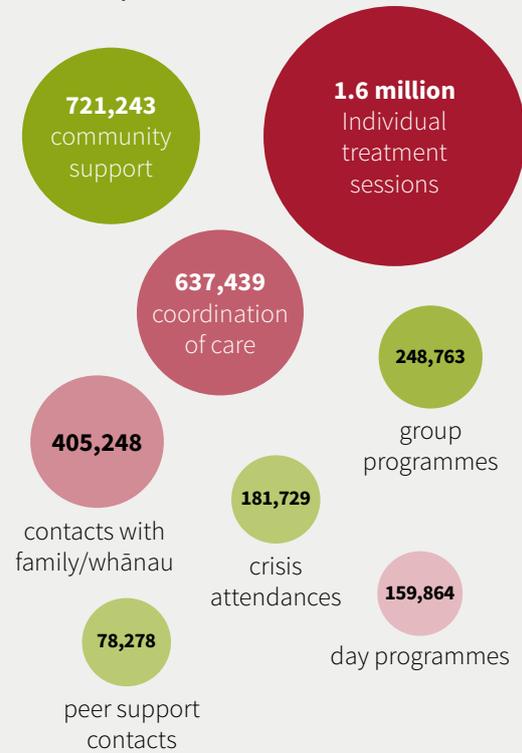
19 *Ibid.*

20 New Zealand Public Health and Disability Act, 2000, section 23. The Crown Funding Agreement sets out service specifications that DHBs are required to deliver.

21 Community support services help people to engage with their community, including accessing and maintaining accommodation, employment, and social activity.

MENTAL HEALTH AND ADDICTION SERVICES

Community care in 2016/17:



Acute, inpatient and residential care

	 People	 Bed nights
Acute inpatient care	9,528	235,973
Sub acute, rehabilitation or residential care	2,881	492,807
Planned or crisis respite care	5,469	78,127

Source: MOH

MEDICATIONS

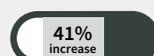
Mental health prescriptions have increased by 50% in the last 10 years and continue to grow at a rate of around 5% each year

Anti depressants



1.13M 2006 → 1.67M 2016

Anti psychotics



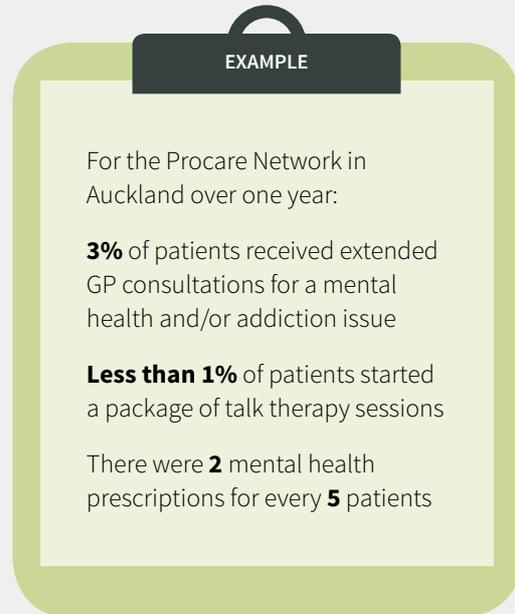
392K 2006 → 551K 2016

Source: PHARMAC

PRIMARY AND COMMUNITY CARE

73% of New Zealand children and 77% of New Zealand adults saw their GP in 2016/17

130,663 accessed primary mental health services in 2016/17



Sources: New Zealand Health Survey; MOH; Procure

SELF CARE AND SUPPORT VIA VIRTUAL SERVICES IS GROWING

For example, over one year there were:

 depression.org.nz

305,593 unique visits

 **National tele-health mental health and addiction services**

Over 200,000 contacts

 sparx.org.nz

21,227 visits to the e-therapy page

Sources: Homecare Medical; The University of Auckland

Public funding for mental health and addiction services more than doubled over the decade from 1996/97 to 2006/07 from \$430 million to \$1.02 billion, and then increased another 40% over the next decade to \$1.43 billion in 2016/17. As well as reflecting population growth, this growth includes additional funding provided to reach the 3% access target and expand the provision of services in the community.

The 3% access target was met nationally in 2010/11, and additional funding provided into the ring fence to support growth in community services ceased shortly afterwards. Growth in DHB funding for mental health and addiction services over the last five years to 2016/17 has slowed, with average increases in expenditure of approximately 2% per year.

The Ministry of Health also set an expectation that efficiencies created through improving service models would be used to implement *Rising to the Challenge — the Mental Health and Addiction Service Delivery Plan 2012–2017*.

Most people seeking professional help for a mental health and/or addiction issue will start with their general practitioner

Primary and community care provides professional generalist health care designed for delivery to the general population. Primary and community care services provide for need that is not met in mental health and addiction services, including to support people with complex and/or enduring needs alongside mental health and addiction services. Care is usually provided by a general practitioner (GP), practice nurse, pharmacist, or other health professional working within a general practice. School-based services, midwifery, and Well Child Tamariki Ora (e.g., Plunket) services are also examples of primary and community care, as is NGO primary health support.

Most people wanting professional help for a mental health and/or addiction issue will start with their GP. GPs are trained to assess, treat, and manage many mental health and addiction issues, including the prescribing of medication and providing brief interventions. Depending on the needs of the individual consumer, primary and community care services can access funded treatment options within primary and community care, or refer people to mental health and addiction services.

Seventy-three percent of New Zealand children and 77% of adults visited a GP at least once in 2016/17.²² The purpose of the visit is not reported, and therefore the proportion of people seeking help for a mental health or addiction issue in primary and community care is not known. A 2001 study to investigate prevalence of psychological problems in general practice in New Zealand suggested that 23% of patients attending their general practice had significant psychological symptoms, but only 6% of the consultations were identified as being for psychological reasons.²³

DHBs fund treatment options, known as Primary Mental Health Services, for delivery in a primary care setting to people who do not meet the threshold for mental health and addiction services. These options typically involve extended GP consultations and talk therapy sessions. In 2016/17, 16,261 young people (aged 12–19 years) and 114,402 adults (aged 20+ years) accessed these services, reaching 2.8% of the population. This compares to 17% of the population identified in Te Rau Hinengaro as living with a mild to moderate mental illness and/or addiction. In 2016/17, \$26 million, or approximately 2% of the annual DHB spend for mental health and addiction services, was allocated to these interventions.²⁴

22 Ministry of Health, *New Zealand Health Survey 2016/17 Update of key results*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/annual-update-key-results-2016-17-new-zealand-health-survey> (accessed 19 December 2017). At note 3

23 Bushnell, JA, McLeod, D, Dowell, AD, *et al.*, "Psychological problems in New Zealand primary health care: a report on the pilot phase of the Mental Health and General Practice Investigation (MaGPIe)". *NZ Med J* 2001; 114(1124): 13–16.

24 Figures supplied by the Ministry of Health, 2018.

Access to Primary Mental Health Services varies across DHB regions owing to different models of service delivery. Because services are rationed, often they are available only to specified populations (that is, to youth, Māori, Pacific peoples, and Community Services Card holders), and services offered vary across the country. GPs work within PHOs.²⁵ PHOs can also fund and deliver their own initiatives, and a number do.

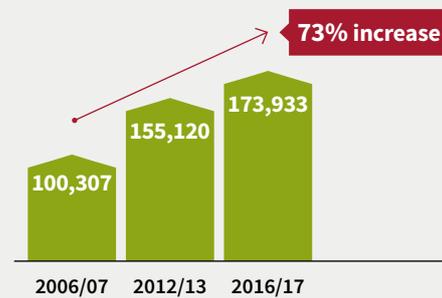
Mental health and addiction services provide care for people with complex and/or enduring mental health and addiction needs

Mental health and addiction services are designed specifically for people with complex and/or enduring mental health and addiction needs. In 1994, the Ministry of Health set a target for mental health and addiction services to reach 3% of the population,²⁶ and the Mental Health Commission's *Blueprint* set out a plan for how this would happen.²⁷ This target was based on what was known about prevalence at the time, and assumed that some people with complex and/or enduring needs would manage through self care, family, whānau and community support, and the support of primary care and other social services.²⁸ This assessment has not been updated, and may no longer be set at an appropriate level or reflect the mix or design of services needed.

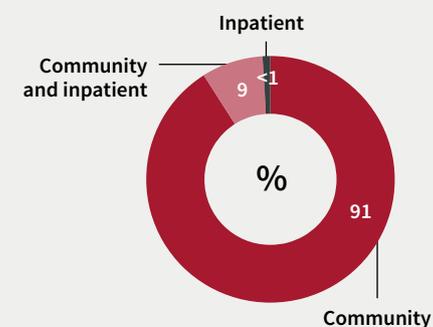
In 2016/17, 173,933 people, or 3.7% of the population, accessed mental health and addiction services. Most mental health and addiction services (91%) are delivered in the community, with only a small proportion of people receiving inpatient care each year.²⁹ There is a wide range of treatment options within mental health and addiction services,

ACCESS HAS INCREASED

Mental health and addictions services



Most people access services in the community



Source: MOH

the most common being individual treatment sessions — 1.5 million sessions were delivered in 2016/17. Other options include peer support, kaupapa Māori services, therapeutic, physical exercise, and psychoeducational groups, and community support.

25 PHOs are organisations that receive funding from DHBs to deliver primary care health services to the people enrolled with it. A PHO can deliver services directly or through providers that are members of the PHO, like a GP practice. There are 32 PHOs across New Zealand that receive government funding to subsidise the cost of primary care.

26 Ministry of Health, *Looking Forward: Strategic directions of the mental health services*. Wellington: Ministry of Health; 1994.

27 Mental Health Commission, *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission; 1998.

28 Ministry of Health, *Looking Forward: Strategic directions of the mental health services*. Wellington: Ministry of Health; 1994. This was reinforced by the target set by *Blueprint 1*, *ibid*.

29 One percent of the population access only inpatient services, while 9% access both community and inpatient services. The remaining 91% access only services in the community. Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

There is growing potential to deliver virtual mental health and/or addiction self-care support

Technology provides opportunities to increase access to support through, for example, telephone, text and online chat services with trained counsellors, online communities of peer support, and e-therapy treatments. These services are convenient, affordable, and easily expanded to be available to more people. E-therapies have been proven in some circumstances to be as effective as traditional face-to-face therapies. There is strong evidence that they work for psychiatric disorders at all levels of severity. They can also be delivered with high levels of privacy, and they can be easily scaled up as well as being cost efficient.³⁰ The examples below are of New Zealand-based services. New Zealanders can also access international websites and virtual services.

The National Telehealth Service operates helplines for depression, substance use, and gambling, and has specific lines for youth, Māori and Pacific peoples, and links with government websites, including www.alcoholdrughelp.org.nz. The National Telehealth Service was contacted more than 200,000 times in 2016/17 for mental health and addiction issues. In June 2017, the Government introduced a single telephone line, Need to Talk (1737), to make it easier for people to connect with any mental health or addiction professional in the National Telehealth Service.

New Zealand-based websites providing information and assistance for people with anxiety and depression include The Low Down (www.thelowdown.org.nz) — a site focused on young people — and www.depression.org.nz. Self tests for depression were completed 136,817 times on depression.org, and 8,732 times on The Low Down (year to 16 June 2017). Self tests for anxiety were completed 72,343 times on depression.org, and 8,099 times on The Low Down over the same period.

Pasifika health workforce agency Le Va has created an online problem solving tool, “Aunty Dee” www.auntydee.co.nz, to help people move positively forward when they are feeling overwhelmed, sad, angry, or confused. The Mental Health Foundation also provides a range of information, including self-help resources (www.mentalhealth.org.nz).

Online resources and communities are also available for people wanting to manage their substance use or support a loved one. For example, Drughelp (www.drughelp.org) is a website with information and tools for people concerned about the negative effects of their substance use. Living Sober (www.livingsober.org) provides a friendly place for people to talk with others about their relationship with alcohol, as well as stories and a sober toolbox.

Other government departments fund and/or deliver mental health and addiction services

The monitoring questions in this report assess the contribution health services make towards improving the well-being of people experiencing mental illness and/or addiction issues. However, other parts of government provide and purchase mental health and addiction services out of different (non-health) budget allocations.

For example: the Accident Compensation Corporation (ACC) purchases counselling for people who have experienced sexual trauma or have developed a mental illness as a result of injury; the Department of Corrections purchases or delivers services directly to its clients, including addiction treatment interventions within the prison and community settings; and the Ministries of Social Development and Education and Oranga Tamariki — Ministry for Children buy services where they see gaps for clients, particularly for children in care or with special education needs.

30 Gluckman, P, *Toward a Whole of Government/Whole of Nation Approach to Mental Health*. Auckland: Office of the Prime Minister's Chief Science Advisor; 2017: <http://www.pmcsa.org.nz/wp-content/uploads/17-08-14-Mental-health-long.pdf> (accessed 7 June 2017).

Individuals and employers privately fund services, as does the public through donations

As with other parts of New Zealand's health and disability system, consumers also access private mental health and addiction care through insurance or self-funding. Many workplaces also invest in employee well-being, for example, by providing access to free counselling through an Employee Assistance Programme. A number of charitable trusts also provide services that are partially or fully funded through donations, sponsors, and grants. Lifeline and Barnardos 0800 What's Up services, for example, fall into this category.

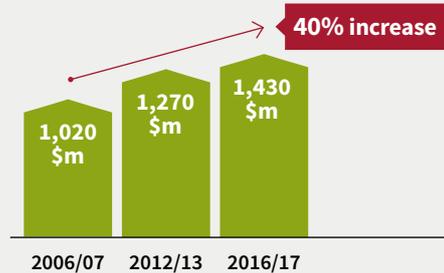
Investing in mental well-being produces significant personal and economic benefits

In addition to the large personal cost of mental illness and/or addiction, it is not surprising that an issue as prevalent as mental health and addiction has significant economic costs. The costs lie in responding to population needs by providing healthcare services, and the wider costs to the economy, such as lost productivity, social services, and income support.

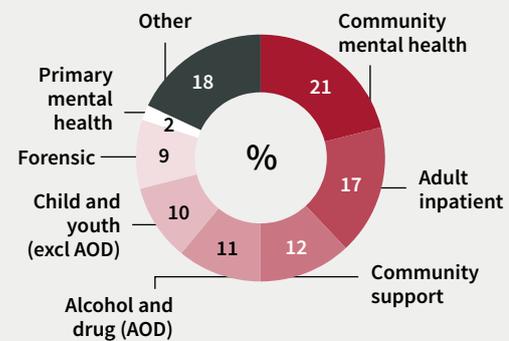
There is strong evidence that promotion, prevention, and early intervention targeted at children and families can produce significant net cost benefits. Programmes that help people to access treatment early, or help them to stay out of hospital or out of the criminal justice system, can also be very cost effective.³¹ There is also growing evidence of the size of potential returns from undertaking workplace and employment support initiatives.³²

FUNDING HAS INCREASED

DHB and Ministry of Health funded services



Funding allocations in 2015/16



The cost to the economy of the premature death of people with both long-term physical and mental health conditions alone currently is estimated at 2.6% of GDP. For example, in Canada, the cost to the country of mental health and addiction was estimated at well over C\$50 billion annually, or nearly C\$1,400 for every person living in Canada in 2016.³³

31 The Mental Health Commission of Canada analysed four major economic studies completed in the previous decade to conclude that there was a return on investment. See Mental Health Commission of Canada, *Making the Case for Investing in Mental Health in Canada*. Ottawa: Mental Health Commission of Canada; 2013: https://www.mentalhealthcommission.ca/sites/default/files/2016-06/Investing_in_Mental_Health_FINAL_Version_ENG.pdf (accessed 15 January 2018); Mental Health Commission of Canada, *Strengthening the Case for Investing in Canada's Mental Health System: Economic Considerations*. Ottawa: Mental Health Commission of Canada; 2017: https://www.mentalhealthcommission.ca/sites/default/files/2017-03/case_for_investment_eng.pdf (accessed 15 January 2018); World Health Organization, *Investing in mental health: evidence for action*. Geneva: World Health Organization; 2013.

32 OECD, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*. Paris: OECD Publishing; 2014: <http://dx.doi.org/10.1787/9789264208445-en> (accessed 21 August 2017).

33 Mental Health Commission of Canada, 2017, at note 31.

The mental health and addiction services workforce is diverse

The majority of the infant, child, and adolescent services workforce are in clinical roles

At June 2016, 1,611 full-time equivalent staff (FTEs) were working in infant, child, and adolescent mental health and alcohol and other drug services; the vacancy rate was 8%. Of these FTEs, 70% were in DHB services and the rest in NGO services.³⁴

The majority of the workforce (74%) were in clinical roles. Of the clinical workforce, the most common professions were mental health nurses (16%), social workers (13%), psychologists (12%), and alcohol and other drug practitioners (8%). Of the non-clinical workforce, the most common professions were health support workers (44%), youth workers (27%), and other non-clinical roles (14%).

The workforce broadly reflects the ethnic make-up of the general population; however, Māori and Pacific peoples are under-represented in relation to the population accessing services. The majority of staff identify as European (58%), followed by Māori (18%), other ethnicity (12%), Pacific (7%), and Asian (5%).

Recruitment and retention of specialist staff, access to specialist training, working with diverse cultures, and funding were identified in the *2016 Stocktake of Infant Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand* as the biggest workforce challenges.³⁵

Support workers and nurses make up the majority of the adult services workforce

The last adult mental health and addiction workforce stocktake was undertaken in 2014. At the time, the workforce was estimated to be just over 9,500 FTE positions.³⁶ The vacancy rate was 5%. Just over half (52%) of the workforce worked in DHB mental health services, 32% in NGO mental health services, 7% in DHB addiction services, and 9% in NGO addiction services.³⁷

The largest part of the adult services workforce was support workers (31%), followed by nurses (28%). The NGO sector had a higher proportion of non-clinical staff compared to DHB services, and this difference was more pronounced for mental health services. NGO mental health services had 73% non-clinical staff compared to 14% non-clinical staff in DHB mental health services. The most common clinical roles in mental health services were nurses, making up 61% of the clinical workforce, followed by health practitioners at 23% (including social workers, psychologists, and occupational therapists) and medical and other professions at 13% (including consultant psychiatrists).

In contrast, only 27% of the NGO addiction workforce were non-clinical, although this is significantly higher than the DHB addiction workforce, where 7% of staff were non-clinical.³⁸ Addiction services also differed from mental health services in their clinical make-up — the most common clinical profession was addiction practitioner (30%), followed by registered nurses (28%) and dual diagnosis practitioners (10%).

34 The Werry Workforce-Whāraurau, *2016 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: The Werry Workforce-Whāraurau for Infant, Child and Adolescent Mental Health Workforce Development, The University of Auckland; 2017: http://www.werryworkforce.org/sites/default/files/2016%20Stocktake%20Full%20Report%20Aug2017_0.pdf (accessed 18 September 2017). These stocktakes are undertaken every two years. Note that they do not include the primary mental health workforce.

35 *Ibid.*

36 Te Pou o te Whakaaro Nui, *DHB mental health and addiction employees: 2017 profile*. Auckland: Te Pou o te Whakaaro Nui; 2017. Note that this stocktake does not include the primary mental health workforce.

37 More information can be found in Te Pou o Te Whakaaro Nui, *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services*. Auckland: Te Pou o te Whakaaro Nui; 2015.

38 *Ibid.*

INFANT, CHILD AND ADOLESCENT

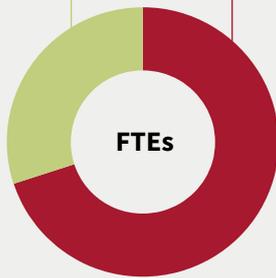
1,610

**FULL TIME
EQUIVALENT POSITIONS**

as at 30 June 2016

30% were in
NGO services

70% were in
DHB services

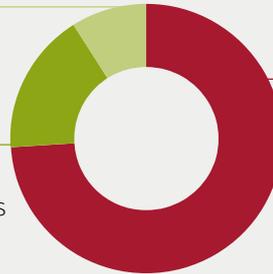


The majority of the workforce are in clinical roles

9% were in
administration/
management

17% were in
non-clinical roles

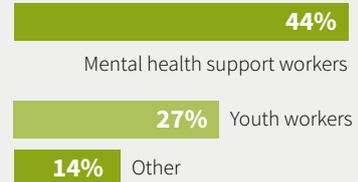
74% were in
clinical roles



The most common
clinical roles are:



The most common
non-clinical roles are:



ADULT

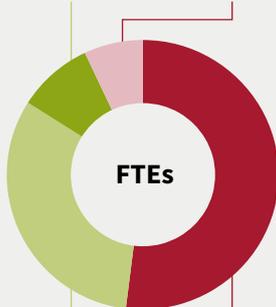
9,509

**FULL TIME
EQUIVALENT POSITIONS**

as at March 2014

9% were in
NGO addiction
services

7% were in
DHB addiction
services



32% were in
NGO mental
health services

52% were in
DHB mental
health services

The majority of the workforce are support workers (31%) or nurses (28%)

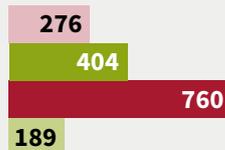
Support workers



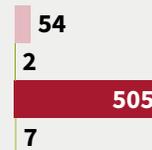
Nurses



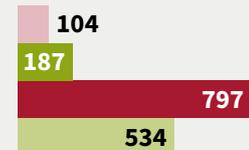
Allied health



Medical



Other



In 2014, the peer workforce made up 3% of the mental health workforce and 0.4% of the addiction workforce. NGO services had the highest peer workforce numbers, making up 5% and 6% of the NGO addiction and mental health workforce respectively.³⁹ Peer support worker is the most common peer role. In 2014, peer support workers made up 2% of the mental health and addiction workforce.

The workforce is aging. The average age of the DHB workforce is 48 years, with 51% being aged 50 years and older.⁴⁰ At last count, in 2007, the NGO workforce had an average age of 44 years, with 35% being aged 50 years and older.

As with the infant, child, and adolescent workforce, percentages of Māori and Pacific workers in the adult workforce under-represent the ethnic make-up of consumers, particularly in clinical roles, and more so in DHBs than in the NGO sector.⁴¹ Māori comprised 12% of the DHB workforce, and 27% of the NGO workforce. In the addiction workforce, Māori comprised 16% of the DHB workforce and 28% of the NGO workforce. The Pacific mental health workforce made up 3% of the DHB workforce and 8% of the NGO workforce. The Pacific addiction workforce comprised 6% of the DHB workforce and 6% of the NGO workforce.

Workforce shortages, workforce planning, and under-representation of Māori and Pacific health professionals were identified as key challenges for the sector in the Ministry of Health's *Mental Health and Addiction Workforce Action Plan 2017–2021*.⁴² Growing peer and consumer roles and family and whānau roles, as well as strengthening peer and consumer leadership, were also identified in the Ministry's workforce plan as a priority area. Managing pressure on staff, increased demand for services, recruiting, and funding were identified as the top challenges by adult mental health and addiction services as part of the 2014 *More than numbers* workforce survey.⁴³

New Zealand is moving towards a well-being and recovery-oriented health and social system

Over the last century, New Zealand's mental health and addiction system response has progressed from institutionalisation, to deinstitutionalisation in the 1970s–1990s, to the expansion of community-based mental health and addiction services in the late 1990s to early 2010s.⁴⁴ The next phase of development is a well-being and recovery-oriented system response.

39 *Ibid.*; Matua Raki, *Growing dedicated peer support and consumer roles in addiction services*. Wellington: Matua Raki; 2017: <https://www.matuaraki.org.nz/resources/growing-dedicated-peer-and-consumer-roles-in-addiction-services/731> (accessed 18 October 2017).

40 Te Pou o te Whakaaro Nui, *DHB mental health and addiction employees: 2017 profile*. Auckland: Te Pou o te Whakaaro Nui; 2017. At note 36.

41 Te Pou o te Whakaaro Nui; 2015, at note 37 — Māori make up 27% of consumers: Ministry of Health, Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

42 Ministry of Health, *Mental Health and Addiction Workforce Action Plan 2017–2021*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/mental-health-and-addiction-workforce-action-plan-2017-2021> (accessed 1 March 2017).

43 Te Pou o Te Whakaaro Nui; 2015, at note 37.

44 Collings, A, Mckenzie, S, Dowell, A, *et al.*, *Toolkit for primary mental health care development: Research report*. Wellington: University of Otago and Synergia; 2010.

A well-being and recovery-oriented system response looks beyond a diagnosis to the broader aspects of a person's life and social context to determine what will help the person to be well.⁴⁵ Developments that were instrumental in the shift towards well-being and recovery include greater understanding of:

- The influence of social determinants in affecting a person's mental health outcomes.⁴⁶
- The effectiveness of early intervention to improve individual outcomes and make economic savings.⁴⁷
- The management of long-term conditions — ongoing or recurring conditions that have a significant impact on people's lives — including the effectiveness of informed, empowered consumers with access to continuous self-management support in managing their own condition.⁴⁸

The implication for a well-being oriented system response for people with mental health and/or addiction problems is that health services provide only part of the response, and that response needs to be centred on the person and what matters to that person. An effective system response needs to be people-centred and integrated across a range of individual, whānau, community, and social responses.

- The World Health Organization *Mental Health Action Plan 2013–2020* (quoted in the Foreword) calls for a comprehensive whole-of-government approach that addresses social factors, and recent strategic government documents (referenced in Appendix 1) have taken a well-being and recovery approach.

- The *New Zealand Health Strategy: Future direction* envisages a future where “All New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system”.
- The Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19 takes a public health approach, with an overall goal for “Government, the gambling sector, communities and families/whānau working together to prevent and minimise gambling harm, and to reduce related health inequities”.
- The *National Drug Policy 2015 to 2020* sets out the Government's approach to alcohol and other drug issues, with the overarching goal of “minimising alcohol and other drug harm, and promoting and protecting health and wellbeing”.
- *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Rising to the Challenge)* sets out a vision that “All New Zealanders will have the tools to weather adversity, actively support each other's wellbeing, and attain their potential within their family and whānau and communities. Whatever our age, gender or culture, when we need support to improve our mental health and wellbeing or address addiction, we will be able to rapidly access the interventions we need from a range of effective, well-integrated services. We will have confidence that our publicly funded health and social services are working together to make the best use of public funds and to support the best possible outcomes for those who are most vulnerable.”

See Appendix 1 for a list of key government strategies and documents since 1994.

45 See, for example, Professor Durie's description of the fourth stage, in Collings *et al.*, *ibid*; Platform Trust and Te Pou o te Whakaaro Nui, *On Track: Knowing where we are going*. Auckland: Te Pou o te Whakaaro Nui; 2015.

46 Marmot, M, *Review of social determinants and the health divide in the WHO European region: executive summary*. Geneva: World Health Organization Regional Office for Europe; 2014 (report prepared by UCL Institute of Health Equity).

47 Mental Health Commission of Canada, *Making the Case for Investing in Mental Health in Canada*. Ottawa: Mental Health Commission of Canada; 2013: https://www.mentalhealthcommission.ca/sites/default/files/2016-06/Investing_in_Mental_Health_FINAL_Version_ENG.pdf (accessed 15 January 2018); OECD, 2014, at note 32; Gluckman, P, 2017, at note 30.

48 Wagner, EH, Austin, B, and Von Korff, M, “Organizing Care for Patients with Chronic Illness”. *Milbank Q* 1996; 74(4): 511–44; World Health Organization, *Innovative Care for Chronic Conditions: Building Blocks for Action*. Geneva: World Health Organization; 2002.

The vision for mental health and addiction services is failing to get traction

The most recent guiding document for mental health and addiction services is *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Rising to the Challenge)*. That plan, which expired at the end of 2017, established over 100 actions for the health sector to deliver largely through efficiencies in services.

It was intended to focus on four key areas:

- Making better use of resources.
- Improving integration between primary and secondary services.
- Cementing and building on gains for people with high needs.
- Delivering increased access for all age groups (with a focus on infants, children and youth, older people, and adults with common mental health and addiction disorders such as anxiety and depression).

The plan was informed by *Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be* (Mental Health Commission, 2012a). That document and a companion document, *Blueprint II: Improving mental health and wellbeing for all New Zealanders: Making change happen* (Mental Health Commission, 2012b), were prepared by the former Mental Health Commission to advise the Government on future directions.

As noted in *Rising to the Challenge*, the *Blueprint II* documents emphasised the need to continue to make changes in order to meet future needs. The key themes were earlier and more effective responses, improved equity of outcomes for different populations, increased access, increased system performance, effective use of resources, and improved partnerships across the whole of government. These directions were underpinned by a continued emphasis on recovery and wellness, with an additional focus on building resilience to deal with future adversity effectively.

Much of the content of *Rising to the Challenge* had broad support. However, with 100 actions and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, it has been difficult to measure progress at the completion of the plan. It was also a challenging agenda to deliver on within existing budgets and a rapid growth in the number of consumers accessing services, and the complexity of their needs.

Leadership and coordination challenges are inherent in the mental health and addiction system

Like the healthcare sector as a whole, leadership of the mental health and addiction sector sits within a complex structure. The system has many parts and many different organisations with their own leadership structures. This presents inherent coordination and leadership challenges. However, for a complex area such as mental health and addictions, effective, collaborative leadership is essential for success. We need to harness the collective experience and commitment of the sector to ensure that the next plan of action to improve mental health and addiction services has widespread support and, just as importantly, there is a leadership structure and a transparent way of tracking progress in place to ensure that the plan gets traction and is delivered.

There are numerous leadership roles, including the Minister of Health, leaders within the Ministry of Health, including the Director of Mental Health, leaders within the 20 DHBs (chief executives, planners and funders, clinical and nursing directors, and service general managers), leaders of other service providers (including NGOs and primary care providers), professional bodies, and consumer and family and whānau advisors and representative groups. ACC, MSD, Oranga Tamariki — Ministry for Children and the Department of Corrections also play significant leadership roles. Entities such as the Health Quality & Safety Commission and workforce organisations play an important role supporting quality improvement and sector development.

Additionally, there are a number of watchdog organisations that currently provide for accountability of the sector:

- The Office of the Health and Disability Commissioner promotes and protects the rights of consumers of health and disability services, and considers complaints about those services;
- The Mental Health Commissioner, a position within the Office of the Health and Disability Commissioner, is responsible for monitoring and advocating for improvements to mental health and addiction services;
- The Director of Mental Health and District Inspectors have responsibility for overseeing the implementation of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Substance Addiction (Compulsory Assessment & Treatment) Act 2017;
- The Human Rights Commission and Ombudsman have roles to ensure that human rights are upheld, especially in relation to practices that could restrict liberty and human dignity, such as seclusion and restraint;
- The Children’s Commissioner has a special interest in services provided to children, particularly those in state care; and
- The Auditor-General oversees the effective use of public funds for delivering services.

Collectively, a number of these agencies monitor New Zealand’s progress in implementing our international obligations. The monitoring undertaking in relation to the United Nations Convention on the Rights of Persons with Disabilities and the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) provides important information about our mental health and addiction services, both in progress made and in challenges faced. I draw on this work in a number of places throughout this report.

Part II: System overview

**Are health services
meeting the needs
of consumers?**



In Part II, I consider how health services are performing in responding to the needs of people experiencing mental health and/or addiction issues.

The framework for doing this consists of six questions:

1. Can I get help for my needs?
2. Am I helped to be well?
3. Am I a partner in my care?
4. Am I safe in services?
5. Do services work well together for me?
6. Do services work well for everyone?

For each question, I draw on information gathered from HDC complaints, and consultation with consumers and families/whānau, along with many other people from the sector. Those sources of information are supplemented by national data and reports. Collectively, this information has shaped my views about how we are doing and about what needs to happen next.



Question 1: Can I get help for my needs?

Key findings

- Access to mental health and addiction services has grown at twice the rate of funding increases over the last decade (73% versus 40%), putting services and the workforce under pressure.
- The access target for mental health and addiction services (3% of the population, set in 1994) has been exceeded since 2010/11. It is unclear whether the target is still appropriate as prevalence information and service models are dated. A new national survey is required to support service and workforce planning and design.
- Wait times for first appointment with a mental health and addiction service have been close to targets (80% seen within three weeks and 95% seen within eight weeks of referral) over the last five years. However, timely access to the right help is a matter of concern for consumers.
- There are limited funded or low-cost options available in primary and community care. There needs to be better, more accessible community support for people who do not meet the threshold for mental health and addiction services, as well as for people who do but want ongoing support to maintain their well-being and recovery.
- More of the same will not deliver a well-being and recovery-oriented system. A plan of action is required to ensure the right services are available across a continuum of care.





Can I get help for my needs?

“I want ongoing support for my relapse prevention plan. Because it changes.”

– Adult consumer feedback session

“You develop a sense that you’re not worth it when told you’re not sick enough.”

– Youth consumer feedback session

Introduction

A person’s well-being is greatly influenced by the social, economic, and physical environments in which they live. Income, housing status, employment status, physical wellness, and connectedness are all predictors for mental health and addiction issues.⁴⁹ Social inequality creates greater risk factors. This disadvantage starts before birth and accumulates throughout a person’s life; this is known as the social determinants of mental health.⁵⁰ Therefore, to help people be well, a broad, all-of-society, all-of-government response is needed: mental health and addiction is everybody’s business.

The health sector’s response to mental well-being and recovery must be understood and assessed as one component of a wider system response. Not every New Zealander experiencing mental distress or addiction issues needs a health service intervention, but when health care is needed, it is fundamental that people get the right support when they need it. The diversity of mental health and addiction need in the population requires a wide range of responses, from acute and crisis care, to specialist care in the community, to primary and community care, to help and support from friends and family.

Monitoring indicators



173,933

people (or 3.7% of the population) accessed mental health and addiction services in 2016/17



73%

increase in the last 10 years



130,663

people (or 2.8% of the population) accessed primary mental health and addiction services in 2016/17

Source: MOH

49 Marmot, 2014, at note 46.

50 *Ibid.*

This section looks at the health system responsiveness to need by assessing access to, and wait times for mental health and addiction services. It also reviews what is known about access to help for people in primary and community care. I focus on the healthcare services delivered through the Vote Health budget, although I note that other sectors such as ACC, Education, Social Development, Justice, and the private sector also deliver mental health and addiction services.

Access to mental health and addiction services has grown by 73% over the past 10 years

As set out earlier, community and inpatient mental health and addiction services are designed for the 3% of the population with the highest and most complex needs. This target is based on an assumption that primary and community care services will respond to the remaining population need, namely people with mild to moderate mental illness and/or addiction, or those with high need who are able to manage outside of mental health and addiction services.

In 2016/17, 173,933 people — 3.7% of the population — accessed mental health and addiction services. This represents a 73% growth in access to services over the last decade (from 100,307 people in 2006/07). Increasing access is consistent with international trends and reflects population growth, improved reporting of access to NGO services, growing social awareness, and increasingly open discussion of mental health issues.⁵¹ It may also reflect gains made through investment in community mental health and addiction services in the mid-90s to the mid-2000s.

Despite access rates exceeding the government target, there is insufficient information to assess whether the 3% rate, which was set in 1994, is still appropriate. The target was based on what was known about the prevalence of mental illness and/or addiction at the time.

We do not know what the current level of need is. The Government's Chief Science Advisors suggest that prevalence of mental illness and/or addiction is increasing,⁵² but this is yet to be confirmed through national-level surveying. The New Zealand Health Survey reports fairly static levels of psychological distress, and an increase in hazardous drinking levels in some parts of the population, over the past decade. Addiction services are also reporting more complex presentations. However, since the target was set, only one national prevalence survey of the adult population has been undertaken, in 2006, and has not been repeated.

It is possible that population need has increased since the target was set, and the access target should be increased. It is also possible that people are not getting the support they need in primary and community care, and that some presentations to mental health and addiction services could be avoided with earlier intervention. A better understanding of population need now and into the future is required to ensure that the right services, appropriately staffed, are available in a timely way. I recommend a current assessment of prevalence, help-seeking behaviour, and access to services across the whole population, and a commitment to regular updates of this information. While commissioning a large, population-level survey along the lines of Te Rau Hinengaro is a substantial undertaking, it would provide essential information, needed to identify and respond to current levels of need.

Funding has grown at a slower rate than access growth

Funding for mental health and addiction services increased by 40% from \$1.02 billion in 2006/07 to \$1.43 billion in 2016/17 compared to a 73% increase in access. During that time, services were also required to implement the 100 actions of *Rising to the Challenge* from within baseline funding. Additionally, while funding for mental health and addiction services is in theory protected, there are divergent views about the effectiveness of the ring fence in preventing funding from being reprioritised

51 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

52 Gluckman, P, *Youth Suicide in New Zealand: a Discussion Paper*. Auckland: Office of the Prime Minister's Chief Science Advisor; 2017: <http://www.pmsca.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf> (accessed 18 September 2017).

into other parts of the DHB budget. Questions were also raised about whether the ring fence now acts more as a barrier to innovation rather than protecting investment in mental well-being and recovery.

I note that the Ministerial Inquiry has been asked to consider fiscal approaches, models, and funding arrangements for the mental health and addiction system. This will ensure that there is independent consideration of the most appropriate funding models for services and, probably, an assessment of how well the ring fence is operating. I note that the Inquiry will also provide advice on governance, leadership, and accountability. That will enable consideration of future monitoring of funding, including any role for the re-established Mental Health Commission. I welcome the inclusion of these matters in the Inquiry's terms of reference.

The workforce is showing signs of strain

The workforce situation is concerning. As set out in the Ministry of Health's Mental Health and Addiction Workforce Action Plan 2017–2021, there is a continuing trend of declining numbers in the mental health and addiction workforce, which is aging. Anecdotally, there are reports of people working extra shifts, including double shifts, owing to staff shortages.

Information collected as part of the Werry Workforce Whāraurau 2016 stocktake indicates that many infant, child, and adolescent services are experiencing significant workforce stress.⁵³ Vacancy rates for these services are increasing — from 6% to 8% between 2014 and 2016 — and retention is an issue, with an annual turnover of 16%, mainly for clinicians.⁵⁴

Through my engagement with the sector, I have been told that frequent negative media reporting about mental health and addiction services is affecting staff morale and making it harder to attract new recruits. Service leaders have also advised me that the exclusion of mental health and addiction support workers from the carer pay equity settlement means that these workers are seeking roles outside of the sector. In our consumer and

Monitoring indicators

Wait time for mental health DHB services:



Wait time for addiction services:



Source: MOH



15%
of HDC mental health and addiction complaints in 2016/17 were about access to services

Source: HDC

family and whānau feedback sessions, a number of people expressed concern about the stress placed on the workforce, and the impact this has on the quality of services they or their loved one receive. Many wanted more time with their case worker or psychiatrist.

53 The Werry Workforce-Whāraurau, 2017, at note 34.

54 *Ibid.*

Despite increased pressure, wait times have remained constant

Despite pressure from slowed funding increases and more people accessing services, mental health and addiction services have managed to keep wait times for first appointments steady over the last five years. DHB mental health services have been holding just under Ministry of Health target levels for the last few years, and targets have been exceeded in addiction services. In 2016/17, in relation to DHB mental health services, 79% of people were seen for their first appointment within three weeks of referral, compared to a target of 80%, and 94% were seen within eight weeks of referral, compared to a target of 95%. For addiction services, 85% of people were seen for their first appointment within three weeks, and 95% were seen within eight weeks of referral. Waiting times are consistently lower for infant, child, and adolescent services, and this is discussed in Question 6, “Do services work well for everyone?”

The Ministry also expects all urgent referrals to be seen within 48 hours. However, it is unknown whether this occurs in practice. In 2016/17, around half of all people referred for their first appointment were seen within 48 hours.

These measures are a positive indicator of services managing entry into services under pressure of access growth. They do not provide a measure of whether appropriate prioritisation is occurring, or an indication of the wait times people experience across their journey in mental health and/or addiction services. For example, anecdotally I have heard of practices delaying follow-up appointments in order to meet the target for first appointments.

Wait times also do not provide a measure of whether the right services are available for that person’s needs. For example, in relation to acute care, in the Ombudsman’s most recent annual report, his inspectors under the United Nations Optional Protocol on the Convention against Torture observed evidence of consumers being discharged from inpatient units at short notice because their

bed was required for an acute admission, and a greater number of consumers being subject to compulsory treatment in order to secure a bed. In my conversations with the sector, I have been told of people remaining in acute inpatient care longer than necessary because there is no appropriate accommodation or support for them in the community. The growing number of children in adult inpatient units due to a lack of appropriate facilities, discussed in Question 6, is also concerning.

Complaints about access are growing

Difficulties accessing mental health and addiction services is an area of growing concern for consumers and their family and whānau. Concerns about access now feature prominently in the HDC’s complaints data. Fifteen percent of the 247 mental health complaints received by the HDC in 2016/17 were about access/prioritisation issues. These complaints reflect concerns by consumers that they either cannot access mental health and addiction services, or that there has been a delay in receiving services when they have been accepted into the service. Additionally, inadequate/inappropriate follow-up is a common issue raised by complainants in relation to mental health and addiction services, with 17% of complaints involving this issue. These complaints often relate to a delay in consumers receiving required follow-up or not receiving follow-up at all. Complaints about inadequate follow-up and difficulty accessing services can reflect a failure to prioritise patients appropriately or to communicate adequately with consumers while they are waiting for appointments.

Access was the most commonly raised issue in The People’s Mental Health Report,⁵⁵ with 36% of respondents saying that it was hard to get help unless the person concerned was really unwell.⁵⁶ This point was reiterated in HDC’s consumer and whānau feedback sessions:

“It is embedded in the psyche that you need to be sick enough — it’s preventing people from seeking help.”

(Youth consumer feedback session)

55 Elliot, M, *The People’s Mental Health Report: A crowd-funded, crowdsourced story-based report*. Wellington: ActionStation; 2017: <https://www.peoplesmentalhealthreport.com/> (accessed 6 June 2017). The report was based on over 500 stories, submitted by consumers, family and whānau and people who worked in mental health services.

56 *Ibid.*

"I was shocked at how difficult it is to get the right care."

(Family/whānau feedback session)

"I spent over 12 hours in ED with our son because there were no psychiatrists to assess him."

(Family/whānau feedback session)

Consumers and family and whānau also considered that having a knowledgeable and supportive GP was instrumental in the referral process. They experienced wide variation in relation to GPs:

"My GP knows how to access tools I need.

Really lucky to have a good GP.

She referred me straight away."

(Youth consumer feedback session)

"GPs can't direct parents on where to get help."

(Family/whānau feedback session)

"No clear pathway for where need to go to get help that you need. If start with GP and they don't really know where to go then can bounce around."

(Youth consumer feedback session)

Services are not providing for the spectrum of need

A well-functioning mental health and addiction system should be able to deliver across a continuum of care. When people do not meet the criteria for mental health and addiction services, there needs to be somewhere for them to get help. The Director of Mental Health has expressed particular concern about people at the higher end of the threshold for mental health and addiction services: "We know that there is a group of New Zealanders with moderate mental health needs who are not easily managed in primary and community care, but who do not meet the threshold for mental health and addiction service care. This can result in their needs not being fully being met."⁵⁷ *The People's Mental Health Report*⁵⁸ considered that a lack of funded or low-cost

treatment options was resulting in an over-reliance by GPs on medication. Mental health prescriptions have increased by 50% over the last five years, with the number of antidepressant prescriptions rising from 1.1 million in 2001 to 1.7 million in 2016, and the number of antipsychotics rising from 392,000 in 2006 to 551,000 in 2016.⁵⁹

Similarly, people who have improved in mental health and addiction services but need support to maintain their wellness and/or recovery are reporting that they are unable to get that support.

"I don't want to go back in [to the service] but am struggling to maintain my wellness ...

I have lots of tools in my kete and I'm using them, but I just want someone to talk to."

(Adult consumer feedback session)

"Feels like to get help you need to be 'sick' and then once receiving help you have to get 'better'.

Where is the ongoing support for people who are 'well' but still needing support?"

(Youth consumer feedback session)

*"DHB services are *\$@# at getting people better, good at getting people stably unwell."*

(Adult consumer feedback session)

"If I present to ED and leave without a referral, there is no support or follow up. Might get a letter to GP."

(Adult consumer feedback session)

These views were reinforced by feedback service providers have given me that the current contracting environment tends to focus on intensive interventions when people are most unwell, and overlook the support people need — on the pathway in and the pathway back out into their life in the community.

57 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

58 Elliot, M, 2017, at note 55.

59 See <https://www.pharmac.govt.nz/about/2016/mental-health/>. Note that some prescriptions will be off-label, that is, prescribed for a reason other than mental health

There is an expectation, first set out in the *Primary Healthcare Strategy 2001*, that care outside of mental health and addiction services happens in primary care. The OECD sees strengthening primary and community care as a way to better care for people with mild-to-moderate disorders, and providing more integrated care for people with severe mental illness.⁶⁰

In 2016/17, 130,663 people (or 2.8% of the population) accessed primary mental health services (16,261 young people and 114,402 adults).⁶¹ These services included extended GP consultations and referrals to talk therapy specifically funded by DHBs. Funding for primary mental health services has been fairly static at just under \$30 million over the last five years.

Rising to the Challenge identified primary care, and its integration with mental health and addiction services, as a priority. It included a commitment to develop and implement a primary mental health and addiction service delivery framework. The Ministry of Health led the “Fit for the Future” project to “develop system-wide solutions that address the increasing demand on the mental health system, particularly at the higher end of community and primary care”.⁶² I am told that a series of pilots to test solutions are well underway and will be reported on from September 2018.

Data relating to people accessing, or wanting to access, help for mental health or addiction issues in primary and community care is poor. I was advised by the Ministry of Health that the number of people accessing these services is no longer collected centrally following the devolution to DHBs of much of the funding in 2013/14. I recommend that this significant information gap be filled.

New Zealand is not unusual in its lack of accountability for primary and community mental health spending. The OECD has observed:

“[F]ew countries can reliably measure the resources they devote to mental health care [including addiction], in particular to primary care and other forms of community-based services, meaning that governments cannot fully quantify the cost of mental illness. The absence of comprehensive data on quality and outcomes, in turn, inhibits a full assessment of mental health system performance. The result is poor policies — in particular, an inability to focus scarce resources on those areas of care that will lead to improved functioning and better outcomes, including under-treated mild-to-moderate disorders such as depression and anxiety.”⁶³

We need to ensure that people can get the help they need across a continuum of care

It is increasingly obvious that the main access challenge for the mental health and addiction system is to broaden the system response to ensure that support is available across a continuum of care for the one in five people who live with mental illness and/or addiction. At the same time, we need to improve the vitally important services and support provided to people with complex and/or enduring needs.

We need better, more accessible community support for people with mild and moderate needs. This, in turn, should result in a reduction of pressure on mental health and addiction services.

60 OECD, 2014, at note 32.

61 Figures supplied by the Ministry of Health, 2018.

62 Ministry of Health, *Mental Health and Addiction Workforce Action Plan 2017–2021*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/mental-health-and-addiction-workforce-action-plan-2017-2021> (accessed 1 March 2017). At note 42.

63 OECD, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*. Paris: OECD Publishing; 2014: <http://dx.doi.org/10.1787/9789264208445-en> (accessed 21 August 2017).

We need a clear plan of action to ensure that the right services are available across a continuum of care, now and into the future. Underpinning this plan requires assessment of:

- Current and future population need across all age groups;
- The relative health investment required in prevention, early intervention, primary and mental health and addiction services, alongside other sectors that contribute to well-being;

- Funding models that will ensure flexibility to deliver across a continuum of care while continuing to protect mental health and addiction spend; and
- Future workforce requirements — ensuring that we have a workforce equipped and supported to deliver services that best meet consumers' needs, now and in the future. We also need to build capability in our workforce to improve services continuously.

No one part of the sector can develop or deliver an action plan in this area alone. Strong collaborative leadership is required.

Signs of progress

No refusal approach

Counties Manukau DHB is developing an integrated model of care that aims to be an effective partnership between consumers and services at all levels of the system. With a focus on equity, improved outcomes and positive consumer experience, the model is being designed on a “no refusal” approach to referrals/requests for support, enabling early intervention and a shared-care approach with primary and community care.

New locally-based community teams (Integrated Locality Care teams) provide liaison and advice, assessment, and brief interventions in primary and community care settings. The clinical and non-clinical mental health and addiction specialists within these teams will support primary and community care professionals to develop their confidence and capability in relation to mental health and addictions. DHB provided mental health and addiction community teams have been redesigned to deliver defined, purposeful, individual episodes of care. NGO mental health and addiction services will be redesigned to deliver a seamless and comprehensive response to consumers' clinical and non-clinical needs. Care will be shared with primary and community care for a holistic approach to well-being and recovery.

Integrated Locality Care teams are established in each of the four Counties Manukau DHB

localities. Primary and community care services have been positive about the benefit to consumers and to the professionals in the primary and community care teams. Work is ongoing to understand the impact of this new approach and how best to respond to the unmet need that is likely identified.

Better integration between primary care and mental health and addiction services

The Mental Health Liaison Programme, set up by the primary health organisation Compass Health, provides free mental and physical health care for people who have experienced mental illness. Referrals can be made by GPs or mental health services, and can be either full transfers or shared care arrangements. Patients meeting the criteria (assessed as having an ongoing mental illness, having a community services or high user card, having seen a psychiatrist within the last six months) get free health care, whether for mental or physical health needs. They may access up to 12 visits to a GP or nurse a year, including up to two after-hours appointments per quarter.

Patients may also access a primary mental health community navigator/coordinator, who can provide information and support on employment, benefit entitlement, budgeting and financial advice, housing, other health services, and recreational and social activities.

Question 2: Am I helped to be well?

Key findings

- Outcomes that improve people’s well-being and recovery include adequate housing, meaningful activity, and a sense of belonging. Support comes from many sectors, not just health, emphasising the need for a whole-of-system response.
- Māori models of health care, such as “Te whare tapa whā”, provide guidance on what whole-of-person care looks like. Consumers consider social interaction, establishing a routine, exercise, and relationships with people who delivered services to be important. Peer support is evidence-based and valued by consumers.
- Many consumers would recommend their service to others if they had a similar issue, and outcome measures indicate that consumers generally improve while in mental health and addiction services.
- People with serious mental illness and/or addiction, on average, experience worse outcomes than the general population in relation to their physical health, engagement in education, training or employment, and accommodation status. This is a matter of concern. I welcome the Equally Well Collaborative and HQSC initiatives to reduce this disparity.
- The Ministry of Health’s population-based mental health and well-being outcome framework needs to be completed to provide guidance on where to focus effort, and to support service development and workforce planning.





Am I helped to be well?

“Don’t say we’ll solve your problem, ask us how we want to live our lives.”

– Youth consumer feedback session

“All these years, services were trying to make me feel normal, when I just wanted to feel accepted.”

– Adult consumer feedback session

Introduction

To be effective, the mental health and addiction system must be centred on people and what matters to them. Once consumers access a service, the service needs to help those people to live their life by supporting them to get where they want to be, whatever that means for them. The New Zealand Mental Health Foundation describes well-being in terms of “flourishing”, that is, experiencing positive emotions and positive psychological and social functioning most of the time.⁶⁴

Outcomes related to a consumer’s well-being and social functioning are broader than the presence or absence of mental illness and/or addiction.⁶⁵ There is strong evidence to support addressing a person’s social context in the delivery of effective mental health and addiction care.⁶⁶ Adequate housing, meaningful activity, and a sense of belonging are all examples of outcomes that matter. Contributions to these outcomes come from many sectors, not just health, and emphasise the need for a whole-of-system response to support well-being and recovery.

This section assesses the responsiveness of health services to the needs of consumers, their impact on consumers, and consumer outcomes compared to the general population.

Monitoring indicators



80%
of consumers would
recommend their
service to others

Source: Mārama RTF

Health services often focus on medical interventions over the broader needs of consumers

In HDC consumer and family and whānau feedback sessions, participants said that services often had a “hand over the medication mentality”, and did not always listen to or explore options with consumers or their family and whānau about what was going to help them be well. Consumers wanted clinical and care approaches that treated them as a whole person, and not as a set of symptoms; this included services being equipped to talk about and respond to spirituality/purpose, physical health, and belonging.

64 The New Zealand Mental Health Foundation’s vision is for a society where all people flourish: <https://www.mentalhealth.org.nz/>

65 World Health Organization and Calouste Gulbenkian Foundation, *Social determinants of mental health*. Geneva: World Health Organization; 2014; Gluckman *et al.*, 2017, at note 30.

66 Marmot, 2014, at note 46.

“You can label me for your paperwork, but work with me how I want to be worked with.”
(Youth consumer feedback session)

“A lot of clinicians give the diagnosis and medication but don’t address the other issues.”
(Youth consumer feedback session)

“Something happened to me that took away my sense of purpose, but nobody looked at what gave me a sense of purpose.”
(Adult consumer feedback session)

“I’m interested in other ways to deal with my medication, but I’m just told I’m on a CTO [compulsory treatment order] so that’s what I need to do.”
(Adult consumer feedback session)

“My rituals and routines, to do with my OCD, help me to feel better. Doctors tell me that they can fix this, but they haven’t asked what I want.”
(Youth consumer feedback session)

“The only treatment my son has been given for schizophrenia is drugs.”
(Family/whānau feedback session)

Māori models of health care, such as Professor Sir Mason Durie’s “Te whare tapa whā”, provide guidance on what whole-of-person care looks like. Te whare tapa whā is based on four equal cornerstones, or aspects of health (represented by the symbol of the wharenuī). The model illustrates the four dimensions of Māori well-being: taha tinana (physical), taha wairua (spiritual), taha whānau (family), and taha hinengaro (the mind). If any one of the four dimensions is missing or damaged, a person or a group of people may become out of balance and subsequently become unwell.⁶⁷ Māori and Pacific models of health care are discussed further in Question 6.

Consumers consulted for this report wanted more tolerance for, and inclusion of, alternative treatments that work. The interventions that consumers said helped them were broader than medication or individual therapy sessions. Social interaction, establishing a routine, exercise, and relationships with people who delivered services were considered important.

A number of participants were interested in Open Dialogue, but did not consider that the services they were involved with were equipped to engage in this approach. The Open Dialogue approach aims to intervene early in the course of a person’s emotional distress, and uses his or her social networks (including family and whānau) to support the person as part of an integrated and individualised and therapeutic approach. The mental health service response is structured around the person’s needs. Evaluations carried out in Finland suggest that Open Dialogue, like other family therapy programmes, produces better outcomes for consumers who are experiencing psychosis than conventional treatment, including fewer relapses, less psychotic symptoms, and a better employment status.⁶⁸

Continued investment to build the peer workforce is needed

Having support from people with lived experience of mental illness and/or addiction and recovery (such as a peer support worker, or family and whānau) was raised by many participants in HDC’s consumer and family and whānau feedback session as something they valued, or wished they had access to. Participants told us of the value of feeling accepted by their peers, and of “just having someone to listen”. Family and whānau participants said that they would like the peer support concept extended to whānau peers, so that they could be supported “by people who know what it’s like”.

67 The model was developed by Dr Mason Durie: <http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha> (accessed 6 Dec 2017). The website also discusses two other models — Te Wheke and Te Pae Mahutonga.

68 Seikkula, J, Alakare, B, Aaltonen, J, et al., “Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-year Follow-up on First Episode Schizophrenia”. *Ethical Hum Sci Serv* 2003; 5(3): 163–82.

“Strengthening the participation of service users at all levels” was identified as a priority in *Rising to the Challenge*. It is not clear what actions were taken to progress this priority. Peer and consumer leadership is also a priority in the Mental Health and Addiction Workforce Action Plan 2017–2021.⁶⁹

The peer workforce makes up only a small proportion of the overall mental health and addiction services workforce — estimated to be 3% of the adult workforce in 2014 (with peer support workers comprising 2%). These roles include consumer advisors, family and whānau advisors, and peer support workers. Consumer and family and whānau advisor roles present systemic consumer and family and whānau views, needs, and rights to relevant stakeholders, and they also develop relationships and partnerships to facilitate participation in service and strategic development, planning, implementation, and evaluation. Consumer advisors are well situated to guide and support the development of peer support within mental health and addiction services, as consumer advisor roles are generally part of the management team.

Peer support workers work alongside consumers to instil empowerment and to connect consumers to communities, supports, and resources. In 2016/17, 5,217, or around 3%, of consumers received a peer support contact by mental health and addiction services, with an average of 15 contacts per consumer, suggesting a reasonable level of engagement when peer support workers are used. Participants in HDC’s family and whānau feedback sessions wanted to see the development of a dedicated workforce with lived experience of supporting family and whānau through mental distress and addiction.

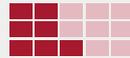
Monitoring indicators

Average improvement in the mental health of consumers when leaving an inpatient service:

Average HoNOS score for adults



15 Admission

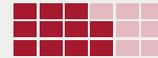


7 Discharge

Average HoNOS score for children and adolescents



18 Admission



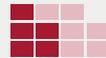
11 Discharge

Average improvement in the mental health of consumers when leaving a community service:

Average HoNOS score for adults



11 Admission



5 Discharge

Average HoNOS score for children and adolescents



14 Admission



8 Discharge

Source: MOH



24%

average increase in consumer satisfaction towards achieving recovery goals (addiction services)

Source: MOH

69 Ministry of Health, *Mental Health and Addiction Workforce Action Plan 2017–2021*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/mental-health-and-addiction-workforce-action-plan-2017-2021> (accessed 1 March 2017).

International research, including a number of randomised controlled trials, found consistent benefits and results from professional peer workers comparable with treatment by professionals in other roles.⁷⁰ Evidence of the effectiveness of peer workers includes benefits in relation to clinical outcomes (engagement, symptomatology, functioning, admission rates), subjective outcomes (hope, control, agency, empowerment), and social outcomes (friendships, community connection). There is also emerging evidence of the cost-effectiveness of peer workers compared with other professionals employed in similar roles.⁷¹ Actions to build the peer and consumer workforce should be a priority as part of the next mental health and addiction services plan.

Most people's well-being improves in services

Many consumers report favourably on services. Eighty percent of consumers and their family and whānau say they would recommend their service to others if they had a similar issue, indicating that there is something about that service that worked for them or their loved one.⁷² Outcome measures also indicate that consumers generally improve while in services.

Mental health DHB services are mandated to undertake a clinical rating for all consumers in their services. The tool they use for this is called the *Health of the Nation Outcome Scales* (HoNOS),⁷³ which measures clinical symptoms and the overall social functioning of a person. The information from these measures indicates that consumers are admitted into services seriously unwell and discharged much improved.

In 2016/17, people were admitted into adult inpatient units with an average score of 15 on HoNOS (out of a possible score of 48) and discharged with an average score of 7. For adult community services, adults began treatment with an average score of 11, and were discharged with an average score of 5.

In 2016/17, children and adolescents were admitted into inpatient services with an average score of 18 (out of a possible score of 60), and discharged with an average score of 11. For child and adolescent community services, children and young people began treatment with an average score of 14, and were discharged with an average score of 8.

The HoNOS measures are not without their critics. They are based on clinical judgement without input from consumers (although I know that some clinicians undertake the scoring with consumers). Clinical scores do not always take a person-centred recovery approach, and clinical recovery and personal recovery are not always the same thing.⁷⁴ The Auditor-General received mixed feedback from DHB staff about the value of HoNOS measures, with some describing it as a “tick-box exercise” that did not provide useful information. There was also evidence of a lack of staff training in using HoNOS.⁷⁵ These factors may explain the low use of HoNOS measures — for example, over the last four years, over 40% of discharges from mental health inpatient units have taken place without a HoNOS score being recorded.⁷⁶

70 Davidson L, Bellamy C, Guy K, and Miller R, “Peer support among persons with severe mental illnesses: a review of evidence and experience”. *World Psychiatry* 2012; 11(2): 123–8; Repper J and Carter T, “A review of the literature on peer support in mental health services”. *J Ment Health* 2011; 20: 392–411; Slade, M, Amering, M, Farkas, M, *et al.*, “Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems”. *World Psychiatry* 2014; 13: 12–20.

71 Slade, M, *ibid.*

72 HDC collects the voices of consumers and their families through Mārama Real Time Feedback mental health and addiction service consumer and family experience survey. The result reported is the average score over three years of data collection through to 30 June 2017. At that point in time, the tablet-based survey was used by 16 DHB providers and 11 NGOs and approximately 12,800 consumer and family voices had been collected.

73 Fifteen items are used in the HoNOS scale for children and adolescents aged 4–17 years (HoNOSCA) and 12 items are used for adult consumers, covering areas including mood, relationships, substance use, and housing. Each item is measured out of 4, with a score of 2 or more considered clinically significant. The maximum total score is 60 for children and adolescents and 48 for adults.

74 Slade, M, 2014, at note 70.

75 Office of the Auditor-General, *Mental health: Effectiveness of the planning to discharge people from hospital*. Wellington: Office of the Auditor-General; 2017.

76 Non-compliant discharges.

Despite these shortfalls, the HoNOS measures are important tools. They provide the only consistent mental health service outcome data recorded and reported on nationally. Unless a better alternative is put in place, the focus should be on improving practice and reporting.

Information on improvement in NGO mental health services is not available, as there is no standard tool for collecting outcome information and no requirement to report nationally. A number of NGO services use the World Health Organization Quality of Life instrument, which measures physical health, psychological health, social relationships, and environment. I understand that work is underway in the NGO sector to align outcome measures, and I expect to see progress to deliver nationally consistent measures over the coming year.

Community-based alcohol and other drug outpatient services, and Ministry of Health methamphetamine contracts have been required to collect and report outcomes using the Alcohol and Drug Outcome Measure (ADOM) to the Ministry of Health since July 2015. Scoring within ADOM is undertaken by the consumer with clinician facilitation, and consumers can decline to use it. ADOM measures include physical and mental health, and the contribution of alcohol and other drug use to issues with family and whānau or friends, and housing, as well as measuring recovery progress. The improvement measure used in this report relates to a consumer's assessment of progress towards their recovery goals. Consumers accessing alcohol and other drug services were on average 24% more satisfied with progress towards their recovery goals between treatment start and treatment end.

Monitoring indicators



10%

Consumers with 3 or more mental health conditions have a 10% lower level of GP satisfaction than the average patient

Source: HQSC

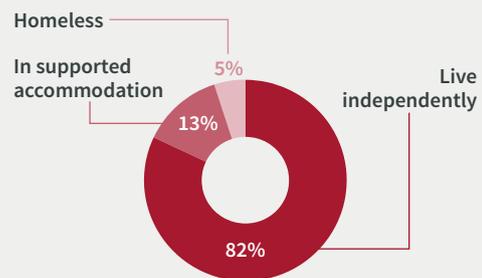


45%

of consumers are in employment, or educational training

Source: MOH

Consumer accommodation



Source: MOH

We do not have national outcome information for people accessing primary and community care for mental health and addiction issues. Outcome information recorded by the Procure Network⁷⁷ provides a representation of what improvements in outcomes may be like across the country. The Procure Network uses the 10-item Kessler Psychological Distress Scale at the start and end of packages of talk therapy sessions. In 2016/17, the average improvement between the start and the end of a package of talk therapy was 29% (scores decreased from 31 to 22, where a lower score indicates lower levels of distress).

Consumer well-being is poorer than population well-being across a range of outcomes

Despite consumers in services showing improvement, people with serious mental illness and/or addiction on average experience worse outcomes than the general population in relation to their physical health, engagement in education, training or employment, and accommodation status. These outcomes are also, in turn, social determinants of mental illness and addiction.

Physical health

People with a serious mental illness and/or addiction die up to 25 years earlier than the general population.⁷⁸ Diabetes, respiratory illness, cardiovascular disease, and cancer are the main illnesses that account for this disparity.⁷⁹ Consumers are more likely to die from cancer, despite having a similar rate of cancer to the general population.⁸⁰

There is no evidence of any reduction in this disparity. The latest evidence is that the gap is widening, owing to the impact of cardiovascular disease on people with serious mental health or addiction conditions.⁸¹

People with a psychotic illness also have an increased risk of premature death due to the damaging health effects of antipsychotic drugs. Alcohol has been causally linked to more than 60 medical conditions, including a range of gastrointestinal diseases and cancers, central nervous system effects, and heart disease.⁸² Other drivers of relatively poor health amongst people with severe mental illness and/or addiction include lower socio-economic status; reduced physical activity; poor nutrition; and high levels of tobacco use, along with reduced access to good quality physical health care.

77 The Procure Network is New Zealand's largest primary health organisation, involving 177 practices across the greater Auckland Region, with around 600 GPs and an average enrolled population of 822,736 in 2016/17.

78 Thornicroft, G, "Premature death among people with mental illness". *BMJ* 2013; 346: f2969; WHO, 2014, at note 46; Te Pou o te Whakaaro Nui, *The physical health of people with mental health conditions and/or addiction — Summary Evidence Update: December 2017*. Auckland: Te Pou o te Whakaaro Nui; 2017; Te Pou o te Whakaaro Nui, *The physical health of people with mental health conditions and/or addiction: An evidence review*. Auckland: Te Pou o te Whakaaro Nui; 2014.

79 De Hert, M, Correll, CU, Bobes, J, *et al.*, "Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care". *World Psychiatry* 2011; 10(1): 52–77; Robson, D and Gray, R, "Serious mental illness and physical health problems: A discussion paper". *Int J Nurs Stud* 2007; 44(3): 457–66.

80 Te Pou o te Whakaaro Nui, *The physical health of people with mental health conditions and/or addiction — Summary Evidence Update: December 2017*. Auckland: Te Pou o te Whakaaro Nui; 2017.

81 *Ibid.*

82 Jones, L, Bates, G, Bellis, M, *et al.*, *A summary of the health harms of drugs*. London: Department of Health; 2011: <https://www.gov.uk/government/publications/a-summary-of-the-health-harms-of-drugs> (accessed 4 September 2017); Mannelli, P and Pae, CU, "Medical comorbidity and alcohol dependence". *Curr Psychiatry Rep* 2007; 9(3): 217–224; Room, R, Babor, T, and Rehm, J, "Alcohol and Public Health". *The Lancet* 2005; 365(9458): 519–530.

Qualitative studies from New Zealand and Australia have shown dissatisfaction with primary care services, both by consumers and primary care clinicians. GPs have expressed concern about the lack of information they have, especially in supporting patients with coexisting conditions.⁸³

In contrast, a survey of consumer experience in primary care undertaken by the Health Quality & Safety Commission found that most people report positive experiences of primary care. There is little difference in satisfaction with a GP between consumers with one self-declared mental health diagnosis and those without a mental health diagnosis.⁸⁴ However, satisfaction declines for consumers with more than one mental health diagnosis. People with three such self-declared

conditions have the lowest levels of satisfaction with their GP, with the biggest differences being that cost becomes a barrier, and experiences of partnership are scored lower than for people with fewer self-declared conditions or no mental health diagnosis.⁸⁵

A job and somewhere to live

Employment, training, education, and accommodation status are examples of outcomes that matter for consumers and are social determinants of health. The Ministry of Health recently started to collect data on the employment, training, education, and accommodation status of consumers of mental health and addiction services.

Of the people using mental health and addiction services, 45% were in employment, education, or training in 2016/17, meaning that the majority of consumers were not in work or study (there was very little difference between consumers accessing mental health services and those accessing addiction services).

There are no measures that allow for a direct comparison with the general population. The national unemployment rate is 5%, but that measure counts only people who are both not in work and actively job seeking. Many consumers not in education, training, or employment may not be job-seeking (for example, they may be retired or caring for dependants) and therefore not considered unemployed. More comparable data is available for young people. Statistics New Zealand keeps data on numbers of young people aged 15–24 years not in employment, education, or training, whereas data is available for consumers aged under 20 years who are not in work or study. For the 2016/17 year, 12% of young people aged 15–24 years were not in work or study, as compared to 18% of consumers aged under 20 years.

83 Te Pou o te Whakaaro Nui, *The physical health of people with mental health conditions and/or addiction — Summary Evidence Update: December 2017*. Auckland: Te Pou o te Whakaaro Nui; 2017. At note 15.

84 Satisfaction is scored against five domains — communication, coordination, cost barriers, needs, and partnership. Health Quality & Safety Commission, *Primary Care Patient Experience Survey: results from the first year of pilots*. Wellington: Health Quality & Safety Commission; 2017: https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Primary_care_experience_survey_report_Dec_2017_final.pdf (accessed 5 February 2018).

85 *Ibid.* The rating for cost for three mental health diagnoses is 6/10, compared to 8.36/10 for people with one mental health diagnosis, and 8.55 for people with no mental health diagnosis.

In total, in 2016/17, 82% of consumers of mental health and addiction services lived in independent accommodation. A further 13% lived in supported accommodation, and the remaining 5% were without a home. New Zealand's homeless population is estimated to be just under 1% of the population, or around 41,200 people, and includes people living in cars, garages, or emergency or temporary shelters.⁸⁶

Outcomes for consumers of addiction services compared to mental health services were very similar. Addiction service consumers had slightly higher levels of education, training, and employment than mental health consumers. Mental health consumers had slightly higher levels of independent accommodation, and slightly lower levels of supported accommodation and homelessness.

Reporting of well-being measures needs to be improved

The Ministry of Health, in conjunction with the sector, developed a draft population-based mental health and well-being outcome framework, He Tāngata, as an action under *Rising to the Challenge*. He Tāngata captures a range of population health indicators, including health, disability, welfare dependence, victimisation, family violence, and education as measures of the cumulative impact of the mental health and addiction system to promote well-being and recovery. The purpose of this framework is to provide national-level guidance on where to focus effort to support regional and local mental health and addiction service and workforce planning. I understand that the framework will be finalised once a new long-term strategy for mental health and addiction is completed, so it can be aligned to it. I support the development of the framework and look forward to its completion.

Other sectors are also building outcome measures to assess population well-being. Statistics New Zealand has begun reporting on outcome measures for Māori that reflect Māori values. This will build an evidence base about the contributing factors to Māori well-being.⁸⁷ Treasury's Government Investment Statement in March 2018, its stocktake of the Government's balance sheet, will have a focus on well-being for the first time, taking into consideration the natural, social, human, and physical impacts. Collectively this growing set of outcome measures will provide valuable signs of progress and where changes are required.

86 Amore, K, *Severe Housing Deprivation in Aotearoa/New Zealand 2001–2013*. Wellington: He Kainga Oranga; 2016: <http://www.healthyhousing.org.nz/wp-content/uploads/2016/08/Severe-housing-deprivation-in-Aotearoa-2001-2013-1.pdf> (accessed 9 February 2018).

87 Stats NZ, *Te Kupenga*. Wellington: Stats NZ; 2013: <https://www.stats.govt.nz/information-releases/te-kupenga-2013-english> (accessed 13 November 2017). The main dimensions of Te Kupenga are whānau, cultural engagement, and te reo. Spiritual engagement is part of the cultural engagement dimension.

Signs of progress

Equally Well collaborative and HQSC focus on physical health

Equally Well is a group of people and organisations with the common goal of reducing physical health disparities between people with mental health and addiction issues, and people without. The Equally Well backbone team has built an evidence base of the physical health of people with a serious mental illness and/or addiction, and hundreds of activities are underway by Equally Well supporters to reduce disparities. Activities include medication reduction guides for prescribers and consumers,⁸⁸ and the introduction of a metabolic screening initiative across the three Auckland DHB inpatient mental health units to assess and modify factors causing metabolic syndrome.⁸⁹

Maximising physical health is one of five initiatives in the Health Quality & Safety Commission's five-year Mental Health and Addiction Services Quality Improvement Programme. Maximising physical health will build on the evidence-based Equally Well collaborative to improve the overall physical health of people with mental health and addiction issues.

Putting housing first for consumers

The People's Project in Hamilton is based on the "Housing First" model, where services first arrange a place to live, or a job, for a consumer, and then provide tailored support for the person's needs, including mental health and or addiction needs. Local and international Housing First initiatives are proven to be effective.⁹⁰ Since its establishment in 2014, the project has housed 844 chronically homeless people and their families in 470 tenancies. A third of the project's success stories involve housing families with children. Housing is the first step. From there, the project provides wrap-around support, based on the needs of the tenants.

Integrated employment support for mental health consumers

Employment consultants have been integrated into two medical centres in the Wellington area (Newtown Medical Centre and Waitangirua Health Centre) to support people with mental health issues to work and to stay at work. Wrap-around support is delivered by linking with GPs, employers, Work and Income, and other identified supports and services, including family and whānau, housing, and community services.

88 A guide to reducing or stopping mental health medication — notes for prescribers: <https://www.matuaraki.org.nz/resources/a-guide-to-reducing-or-stopping-mental-health-medication---notes-for-prescribers/733> and A guide to reducing or stopping mental health medication — notes for consumers: <https://www.matuaraki.org.nz/resources/a-guide-to-reducing-or-stopping-mental-health-medication/732>, (accessed 10 January 2018).

89 Celebrating Equally Well Successes of 2017: <https://www.tepou.co.nz/news/celebration-of-2017-successes/1086>, (accessed 10 January 2018).

90 Slade, M, McDaid, D, Shepherd, G, et al., *Recovery: the business case*. Nottingham: ImROC; 2017: 30; Kinoshita, Y, Furukawa, T, Kinoshita, K, et al., "Supported employment for adults with severe mental illness". *Cochrane Database of Systematic Reviews* 2013; 9: CD008297.

Question 3: Am I a partner in my care?

Key findings

- The greatest resource in supporting a person's well-being and making change is the consumer themselves, including their support network. For many consumers, their family and whānau are a primary support and an integral part of their well-being and recovery journey.
- Services need to pay more attention to building and maintaining partnerships with consumers and do more to engage with family and whānau. While most consumers and family and whānau feel involved in decisions about their or their loved one's care, communication is a common issue raised in complaints to HDC. Consumers also report an imbalance of power, a culture of control and a lack of engagement by staff, often because of time pressure.
- Many family and whānau consider that services use privacy as a way of disengaging with them. Where consultation is required (when a consumer is subject to compulsory treatment), it happens only 61% of the time. Family and whānau also told us that there are very limited supports available for them, and, when help is available, often services do not know about them.
- Consumer involvement in plans to support their well-being needs to increase. While 74% of consumers and family and whānau agree that their plan is reviewed regularly, a recent audit found that less than half of consumers leaving an inpatient unit had a discharge plan, and in 2016 only 7 out of 20 DHBs met the Ministry youth transition (discharge) plan target. These findings are a matter of concern, and youth engagement needs to be a specific focus in the HQSC Quality Improvement Programme.
- The use of compulsion in mental health services needs to be reduced, especially for Māori, for whom it is disproportionately high. I will be monitoring the review planned for the Mental Health (Compulsory Assessment and Treatment) Act 1992 in relation to human rights.





Am I a partner in my care?

“I know me better than they do, even though I may be a bit confused sometimes.”

– Adult consumer feedback session

“Being listened to, and hearing, can save lives.”

– Adult consumer feedback session

Introduction

The greatest resource in supporting a person's well-being and making change is the consumer themselves. No two people are the same, and every recovery journey is unique. Services that work from a person's strengths will increase that person's capacity to manage and improve their own health, well-being and, recovery.

For many, although not all consumers, their family and whānau are a primary support and an integral part of their well-being and recovery journey. For example, for many Māori, the concept of whanaungatanga (extended family and relations) is inseparable from their health and well-being.

The vast majority of infants, children, and young people live within families, and in many cases supporting a younger person's well-being and making change happens within the context of their family and whānau. Services that work from a family and whānau's strengths will increase their capacity to manage and improve the health of the young person.

Services can enhance the contribution of family and whānau to a consumer's care through effective engagement in appropriate cases. Consumers and family and whānau have many roles: a person who is unwell, and the people who support them, are parents, children (including adult children), siblings, and other loved ones. When family and whānau are involved with on-going care, they need information and support.

Monitoring indicators



76%

of consumers and their family/whānau agree they are involved in decisions about their care

Source: Mārama RTF



55%

of HDC mental health and addiction complaints in 2016/17 included communication issues

Source: HDC



74%

of consumers and their family/whānau agree their discharge plans are reviewed regularly

Source: Mārama RTF

Acknowledging family and whānau as an integral part of care also means recognising that many consumers are parents or caregivers of dependent children. These consumers may need support in their role as parents or caregivers, and the children they care for may also need support.

Partnership means consumers being involved and listened to at every step. “Nothing about me, without me” is how it is often expressed in the mental health and disability sectors. A partnership approach is reinforced by the Code of Health and Disability Services Consumers’ Rights (the Code). Under the Code, every person accessing a health or disability service has the right to be treated with respect, to dignity and independence, to effective communication, to be fully informed, and to make an informed choice and give informed consent. This includes the right to refuse treatment and make choices that health professionals do not support.

The United Nations Convention on the Rights of Persons with Disabilities also requires equal recognition before the law for people with disabilities (Article 12), including the right to exercise legal capacity (with support if necessary).

There are some circumstances where partnership is diminished by legislation. The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) sets out the circumstances in which consent may be overridden, and consumers may become subject to compulsory psychiatric assessment and treatment. The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act) sets out the circumstances where someone who lacks the capacity to consent due to impairment through substance use can be compulsorily assessed and treated.

In this section, indicators of partnership in relation to communication, respect, and shared planning, as well as involvement of family and whānau where appropriate in a person’s care are considered. I also look at the use of compulsory assessment and treatment under the Mental Health and Substance Addiction Acts.

Services need to foster a culture of partnership with consumers and their family and whānau

Our monitoring indicators provide a mixed picture of consumer and family and whānau partnership within services. Many people report positive experiences of communication and involvement by services. The majority of consumers and family and whānau (76%) report in the Mārama Real Time Feedback Survey that they feel involved in decisions about their, or their loved one’s, care. Positive reports of involvement and communication by services were also received in HDC’s consumer and family and whānau feedback sessions.

“I get asked to participate and am always informed of my daughter’s care. I recognise that they are wanting to help and understand her illness and look forward — they don’t want to just be giving medication.”

(Family/whānau feedback session)

“The beginning of my recovery was when I was empowered by being asked what was important to me. I was seen as a person who was able to advocate for myself.”

(Adult consumer feedback session)

“I feel incredibly supported — getting more involved and understanding the system and services has really helped.”

(Family/whānau feedback session)

Consumers and family and whānau also gave negative feedback. Consumers talked about an uneven balance of power, a culture of control, and a lack of engagement by staff. Both consumers and family and whānau members gave examples of being dismissed or labelled as “difficult” if they sought to challenge treatment options and shared experiences of feeling unsupported.

A number of stories (17%) within the *People’s Mental Health Report* raised similar issues, including about the lack of respect, dignity, choice, and control accorded to consumers. Some reported being responded to in ways that were dismissive, dehumanising, and punitive.

“Simple question of ‘how are you?’ is often missing.”

(Adult consumer feedback session)

“They didn’t ask me what I wanted.”
(Adult consumer feedback session)

“Some people don’t know they have the power to choose.”
(Youth consumer feedback session)

“The level of communication is a very one-way conversation where the professional talks in a way that is not a partnership. Partnership communication is open, two way, builds on rapport, world views and values etc, and leads towards negotiated outcomes – that remain open and negotiable.”
(Adult consumer feedback session)

“Hasn’t been an easy or well supported journey.”
(Family/whānau feedback session)

Communication issues are a prominent feature of complaints to HDC about mental health and addiction services, and were raised in just over half (55%) of all complaints received in 2016/17. A failure to communicate openly/honestly/effectively with the consumer is the most common specific communication issue complained about, and features in around a third of complaints (33%) received.

Complaints about inadequate communication with family and whānau are also common, being present for 18% of complaints received. Inadequate communication with family and whānau is also an issue often identified by HDC on our assessment of a complaint. These issues often relate to providers failing to obtain adequate information from family and whānau during risk assessments, or a lack of family and whānau involvement in discharge planning.

Greater recognition of the role of family and whānau, and consideration of the support they need, is required

Consumers have a right to privacy in relation to their health care. I acknowledge that this can be frustrating for family and whānau when they want to help their loved ones but lack information. However, there is evidence that services create unnecessary barriers to family and whānau engagement.

Monitoring indicators



7 out of 20

DHBs met the target of 95% of youth consumers having a transition plan

Source: MOH



405,248

contacts by services included family/whānau

Source: MOH



12,258

contacts by services supporting family/whānau

Source: MOH



4,085

people under Community Compulsory Treatment Orders on an average day in 2016

Source: MOH

Family and whānau consulted for this report told us that the default presumption of services was that consumers did not want them involved, and that services used privacy as a way of disengaging with family and whānau. While the right to privacy must be upheld, and consumers who do not want family involvement must have their wishes respected, services should seek engagement with family and whānau where appropriate.

Since 1999, it has been a legal requirement to consult family and whānau at particular times where a person is receiving compulsory assessment and treatment under the Mental Health Act (section 7A), unless it is deemed not reasonably practicable, or not in the interests of the person. On average, only 61% of decisions that required consultation

HDC case study

The importance of family and whānau involvement in risk assessment and crisis planning (Decision 14HDC01268)*

In this case, a young man first presented to an emergency department with his parents, complaining of testicular pain, but was assessed as “[a]nxiety and depressed mood – suicidal ideation”. He underwent an acute mental health review and an urgent psychiatric assessment for possible ward admission. His management plan was to return home with his parents, who were present at the assessment, and to come back for a further assessment the following morning. That further assessment, which his father also attended, was that the man was at no imminent risk of self-harm. The psychiatrist made the decision to discharge him with suggested follow-up with his GP for his testicular pain, and consideration of counselling in the community. The man returned home and was later involved in an incident that resulted in injuries that caused his death. The man’s parents told the HDC that the psychiatrist’s assessment of their son was

not discussed with them, their views were not sought, and they felt that they were given no choice but to have their son at home, even though they were very concerned about him.

The psychiatrist was found in breach of the Code for carrying out an inadequate risk assessment and formulating an inadequate management plan for a man presenting with suicidal ideation, including for failing to ascertain adequately, and take into account, the man’s parents’ opinions on risk and their views of the proposed management plan at the initial assessment. The psychiatrist was also found in breach of the Code for failing to provide sufficient information to the man’s father about the man’s condition, and for not discussing the proposed management plan adequately or providing clear information about the plan to the man’s father at the second assessment. In relation to this case, the HDC’s expert advisor stated: *“It would be widely clinically accepted that in the assessment of suicidal patients the views of the families/ carers [should] be sought and documented.”*

*See <http://www.hdc.org.nz/decisions/search-decisions/2016/14hdc01268/>

included family and whānau consultation in 2016.⁹¹ “Not practicable” was the main reason cited for not consulting with family and whānau.

Family and whānau also told us that there are very limited supports available for them, and, when help is available, often services do not know about them. The Ministry of Health has recently started recording the contacts that service providers have with family and whānau, either with or without the consumer present. The Ministry of Health has also recently started reporting on contacts to support consumers in their role as parents or caregivers.

In 2016/17, services had contact with family and whānau in relation to 39% of consumers to discuss issues relating to the consumer’s treatment and care (either with or without the consumer present).

The number of contacts made to support family and whānau is much smaller. In 2016/17, services recorded 12,258 contacts to support to family and whānau of consumers (including children), and 1,882 contacts to support consumers in their role as parents or caregivers. It is likely that the numbers are under-represented, as services may not be familiar with these new reporting codes.

91 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

Consumer involvement in care planning needs to increase

When consumers have a personal plan, their health improves, including fewer acute admissions and increased employment.⁹² The Ministry of Health describes a personal plan as one that “identifies a person’s early warning signs of relapse of their condition. It identifies what the person can do for themselves and what their service will do to support them. Ideally, the person will develop their own plan with support from their clinician and their family/whānau.”⁹³ These plans are often referred to by different names, including “relapse prevention”, “wellness recovery action plan”, and “discharge plan” or “youth transition plan”, depending on the circumstances. For younger children, clinicians have to be creative in how children contribute to their own “just in case” plans. A plan for an 8-year-old looks very different from that of a 28-year-old.

Seventy-four percent of Mārama Real Time Feedback consumers and family and whānau agree or strongly agree that their plan is reviewed regularly. While this is positive, it is the lowest rating of the core real time feedback survey questions, and other information suggests a low commitment by services to shared planning. Consumers and family and whānau described their plan template, if they had one or were given a copy of a clinician written one, as not being user-friendly.

“The format of the plan wasn’t very easy to read, not very user-friendly, not very hopeful.”

(Adult consumer feedback session)

“Need to be much better involved in care planning. Don’t usually get a copy, need to so everyone’s on the same page.”

(Family/whānau feedback session)

“We found our relapse plan on a website, we didn’t have one from the service.”

(Family/whānau feedback session)

A recent audit of discharge planning by the Office of the Auditor-General⁹⁴ found that 42% of people leaving an inpatient unit did not have a discharge plan. For those who did, it often started late in the process or was not comprehensive. Family and whānau input was sometimes limited when meetings were changed at short notice. The Auditor-General found that stretched staff and high occupancy rates in inpatient units contributed to poor discharge planning and instances where discharge was made with no formal handover to the community mental health team. Staff attitudes and behaviour in relation to discharge planning were also concerning. Copies of discharge plans were rarely given to the person being discharged or their family and whānau.

Some staff were not aware that the person and, where appropriate, family and whānau, should have a copy, or believed the consumer would be overwhelmed by it, or didn’t need to know. Inadequate discharge planning is also commonly identified as an issue in complaints about mental health and addiction services, especially for those consumers moving between inpatient units and community mental health teams.

As part of its response to the Auditor-General’s report, the Ministry of Health committed to include a section on the discharge planning key performance indicator as part of the Annual Report of the Office of the Director of Mental Health. No such section was included in the 2016 Annual Report released in December 2017.

I am advised by the Ministry of Health that collection and reporting of discharge planning information is being reintroduced in 2018 (information on relapse prevention plans was collected from 2007 to 2013 and, during that time, the percentage of consumers with a relapse prevention plan increased from 59% to 91%). This shows the power reporting has to change practice.

92 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

93 *Ibid.*

94 Office of the Auditor-General, 2017, at note 75.

The Ministry of Health currently reports on youth transition plans, with a target of 95% of young people who have used a mental health and/or addiction service to have one. In 2016/17, seven out of 20 DHBs met the target, two DHBs did not report, and three DHBs reported 0%.⁹⁵ This is a matter of concern, and needs to be a specific focus in the Health Quality & Safety Commission Quality Improvement Programme.

Rates of compulsion under the Mental Health Act are unacceptably high, particularly for Māori

A person can become subject to the Mental Health Act if they are assessed as being “mentally disordered”. A “mentally disordered” person has (a) an “abnormal state of mind”, and (b) to such a degree that it “poses a serious danger to the health or safety of others; or seriously diminishes the capacity of that person to take care of him or herself” (section 2). A person is obliged to accept treatment during the first month of a compulsory treatment order (section 59). In 2016, 11,311 people, or 6% of people who accessed mental health and addiction services, were treated under the Act.

Compulsory detention and treatment currently overrides the Code and the Convention on the Rights of Persons with Disabilities, which emphasise the importance of consent. Compulsory treatment can take place either in the community or in a hospital inpatient unit. The majority of compulsory treatment (88%) takes place in the community.

New Zealand has a high use of community treatment orders by international standards.⁹⁶ In 2016, just over 4,000 people on average were subject to a community compulsory treatment order at any given point in time.⁹⁷ The number of community treatment orders is increasing over time, despite the evidence for the effectiveness of community treatment orders being extremely weak in terms of preventing hospital admissions and other relevant outcomes.⁹⁸

Reducing community treatment orders for Māori is an action in *Rising to the Challenge*, and has been an indicator in DHB plans since 2014/15. Despite this, the number of community treatment orders is increasing for Māori. In 2016, Māori were 3.6 times more likely than non-Māori to be subject to a community treatment order, which was the same as the previous year and up from 3.5 and 2.9 for the previous two years.

The use of compulsion needs to be reduced, especially for Māori, for whom it is disproportionately high. Researchers have speculated whether New Zealand’s high rates of community treatment orders are being appropriately targeted, or whether they have become a default option.⁹⁹ There have also been anecdotal reports that compulsory orders have been used in reaction to criticism from the media and others about consumers self-harming while in the care of services.

There is large variation in the numbers of orders across the country.¹⁰⁰ The fact that some regions show relatively low rates suggests that there is scope to reduce the overall use of compulsory treatment. Māori researchers have highlighted the need to understand what lies behind these patterns, and, in particular, whether Māori receive differential treatment, and whether the patterns reflect the need for greater cultural awareness in the workforce and/or greater whānau engagement.¹⁰¹

95 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

96 Gordon, S and O'Brien, A, “New Zealand’s mental health legislation needs reform to avoid discrimination”. *NZ Med J* 2014; 123: 1403.

97 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

98 Heun, D, Subbodh, D, and Rowlands P, “Little evidence for community treatment orders: a battle fought with heavy weapons”. *BJPsych Bulletin* 2016; 40(3): 115–18.

99 O'Brien A, “Community treatment orders in New Zealand: regional variability and international comparisons”. *Australasian Psychiatry* 2014; 22(4): 352–6.

100 Gordon, S and O'Brien, A, “New Zealand’s mental health legislation needs reform to avoid discrimination”. *NZ Med J* 2014; 123: 1403.

101 Elder, H and Tapsell, R, “Māori and the Mental Health Act”. In Dawson, J and Gledhill, K, *New Zealand’s Mental Health Act in Practice*. Wellington: VUW Press; 2013: Chapter 14.

The Substance Addiction Act should be implemented in a way that minimises compulsion and increases access to treatment

The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (Substance Addiction Act) came into force in February 2018. It replaces the Alcoholism and Drug Addiction Act 1966. Forty-five people were subject to that Act in 2016.

The Substance Addiction Act provides a mechanism for compulsory assessment and treatment, but has narrower grounds for compulsion than the Mental Health Act. A compulsory treatment order under the Substance Addiction Act is intended as a measure of last resort for the treatment of people who are severely unwell owing to problematic substance use and lack capacity to make decisions about their treatment. If someone can show they have the capacity to make an informed decision about treatment, then they cannot be committed under the Act, even if the family or health professionals disagree with the decision the person makes, including the decision not to be treated. This legislation

includes the requirement that services should be “mana enhancing” to uphold the dignity of the person receiving services. I will be monitoring the application of compulsion under the Substance Addiction Act.

The Ministry of Health and workforce agencies Matua Raki and Te Pou o Te Whakaaro Nui have been working with services to develop models of care that will support people who come into contact with services because of the legislation.

There is a requirement for services to continue to engage with people who do not come under the Substance Addiction Act and seek to assist the person to engage with services voluntarily. Services must also work with family and whānau and caregivers to consider a suitable plan to address the person’s problematic substance use.

Preparing for the Substance Addiction Act to come into force provided the addiction sector with the opportunity to review how it is currently delivering services, and implement improvements. I am told that some services were more prepared than others for the legislation to come into force. It is too early to assess the effectiveness of the changes at this stage. However, this Act is likely to be a focus of my monitoring role in the future.

Signs of progress

Family-focussed guidance and initiatives

The Supporting Parents Healthy Children Guidelines (Ministry of Health, 2015) have been written for adult and child mental health and addiction services. They give services the mandate to work in a family-focused way to support parents with mental health and/or addiction issues. Individual treatment of parents in isolation is not usually as effective as a family-focused approach into which the parent has input. The guidelines have a focus on children’s support and needs.

Examples of these guidelines in action include: Stepping Stone Trust in Christchurch providing education, support and fun activities for children and young people whose parents experience mental illness, intensive services to support at-risk pregnant women and young mothers,

and the Waitemata DHB Community Alcohol and Drug Pregnancy and Parenting Service. The Service provides an intensive outreach and case coordination service for parents of children aged under three years, and pregnant women who are experiencing problems with alcohol and other drugs, who are poorly connected to health and social services.

Accessible recovery planning guidance

The Auckland Opioid Treatment Service has developed accessible information sheets to support consumers to develop their recovery plan. The Service describes recovery planning as follows: “[T]hink of Martin Luther King’s famous speech. He didn’t say ‘I have a plan’; he said ‘I have a dream’. And that’s what recovery planning is — putting a plan in place so you can achieve your hopes, dreams and aspirations to make your future a better one whatever that looks like for you.”

Question 4: Am I safe in services?

Key findings

- Services should be provided in a way that minimises potential harm, including not adding to a person's trauma. Minimising harm is not the same as being free from risk: positive risk-taking gives people freedom and supports their recovery.
- Inadequate/inappropriate care is a common issue in complaints to HDC about mental health and addiction services, especially in relation to crisis services, and risk assessments.
- Serious adverse events (suspected suicide and serious self-harm) have increased. This may be due to a better culture of reporting and greater transparency. Services need to work together to improve their response to consumers in distress. The HQSC Quality Improvement Programme includes a focus on learning from adverse events and consumer experience. I recommend New Zealand commit to a suicide reduction target.
- New Zealand has high rates of compulsion, seclusion, and restraint. These practices are not therapeutic. Seclusion has been reducing over time but is now steady, and Māori continue to experience seclusion at higher rates. A renewed emphasis on its reduction and eventual elimination is required. I welcome the joint HQSC/Te Pou initiative Pathways to Eliminate Seclusion by 2020.
- Reporting on the use of medication to sedate or chemically restrain consumers needs to improve. It is important to ensure that increased chemical restraint is not an unintended consequence of efforts to reduce seclusion.





Am I safe in services?

“There was a time when I was in hospital unwell, and I was bashing my head, and a nurse sat down next to me and sang songs with me. She still took me to isolation, but was nice about it, and it was a very different experience to other occasions.”

– Adult consumer feedback session

Introduction

This section looks at factors that impact on consumer safety. I look at incidences of harm in relation to HDC complaints, serious adverse events, and restrictive practices.

The Code includes a right to services being of an appropriate standard, including being delivered in a manner that minimises potential harm.¹⁰² For mental health and addiction services, minimising harm includes a balance of risk between keeping a person safe and supporting recovery in the least restrictive way possible.¹⁰³ Being safe is not equivalent to being free from risk: positive risk-taking gives people freedom and supports their recovery.

Restrictive practices, such as seclusion and restraint, can be highly traumatising for consumers (and staff) and re-traumatising for people who have experienced inter-personal violence and victimisation.¹⁰⁴ Minimising potential harm includes recognising that many people accessing services have experienced trauma, that is, violence or victimisation of some kind, and ensuring that their experience of services is not re-traumatising.

Monitoring indicators



180
suspected suicides



13
serious self harm incidents



13
serious adverse events

Source: HQSC

102 Right 4(4) of the Code.

103 Mental Health Commission, *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission; 1998; Ministry of Health, 2012, at note 18.

104 Happell, B and Harrow, A, “Nurses’ attitudes to the use of seclusion: A review of the literature”. *Int J Ment Health Nurs* 2010; 19(3): 162–8; Taylor, TL, Killaspy, H, Wright, C, *et al.*, “A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems”. *BMC Psychiatry* 2009; 9(1): 55; Bonner, G, Lowe, T, Rawcliffe, D, and Wellman, N, “Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK”. *J Psychiatr Ment Health Nurs* 2002; 9(4): 465–73; Brophy, LM, Roper, CE, Hamilton, BE, Tellez, JJ, and McSherry, BM, “Consumers’ and their supporters’ perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings”. *Aust Health Rev* 2016; 4: 599–604.

Studies (both in New Zealand and internationally) consistently find a 50–80% prevalence rate of physical and/or sexual abuse among people who later acquire a mental illness diagnosis.¹⁰⁵ This prevalence is high enough that trauma should inform the care of all consumers of mental health and addictions services.¹⁰⁶

This report has a particular focus on the experience of consumers in inpatient mental health services under the Mental Health Act due to the vulnerability of this population — only people under the Mental Health Act can be legally secluded.¹⁰⁷

Harmful events in services are infrequent, but have major impact when they do occur

A common issue complained about in relation to mental health and addiction services is that of inadequate/inappropriate examinations/assessments, with this issue being raised in 18% of complaints to HDC about mental health services. In relation to crisis services, issues relating to examinations/assessments made up 54% of complaints received about those services. Almost all of these complaints related to risk assessments. Additionally, inadequate risk assessment is an issue often found by HDC on assessment of a complaint, and a number of recent decisions have found a provider in breach of the Code in relation to this. An appropriate assessment of risk is essential to ensuring the safety of consumers.

Complaints to the HDC about consumer safety in inpatient units rose in 2016/17, with 27% of complaints about inpatient units relating to a general safety issue for the consumer in the facility (up from 16% the previous year). These issues often related to seclusion and restraint, consumers self-harming within units, or to consumers under the Mental Health Act leaving facilities without permission.

Continued focus on suicide reduction is needed

A serious adverse event is an event within the DHB service environment resulting in serious harm (including self-harm) or death, including those events that are suspected suicide. In 2016/17, DHBs reported 206 serious adverse events to the Health Quality & Safety Commission related to mental health and addiction services. Of these, 180 involved suspected suicide, 13 related to serious self-harm incidents, and 13 to serious adverse behaviour. The numbers of reported serious adverse events has increased by 23% since 2012/13. The Director of Mental Health considers that some of this increase can be attributed to improved reporting and a stronger commitment to a culture of transparency.¹⁰⁸ Learning from serious adverse events and consumer experience is one of five initiatives in the Health Quality & Safety Commission's five-year quality improvement programme. I support the initiative. When things go wrong, it is important to learn from events so that systems can be changed to prevent them from happening again.

105 Wells, D, *Disturbing the Sound of Silence: Mental health services' responsiveness to people with trauma histories*. Wellington: Mental Health Commission, Occasional Paper No. 6; 2004: <http://www.hdc.org.nz/media/199681/disturbing%20the%20sounds%20of%20silence.%20mental%20health%20services%20responsiveness%20to%20people%20with%20trauma%20histories.doc> (accessed 4 September 2007); Beitchman, JH, Zucker, KJ, Hood, JE, *et al.*, "A review of the long-term effects of child sexual abuse". *Child Abuse Negl* 1992; 16: 101–18; Briere, J, Woo, R, McRae, B, *et al.*, "Lifetime victimization history, demographics, and clinical status in female psychiatric emergency room patients". *J Nerv Ment Dis* 1997; 185: 95–101; Goodman, L, Rosenburg, S, Mueser, T, and Drake, R, "Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment and future research directions". *Schizophr Bull* 1997; 23: 685–96.

106 Mueser, KT, Salyers, MP, Rosenberg, SD, *et al.*, "Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: demographic, clinical, and health correlates". *Schizophr Bull* 2004; 30(1): 45–57.

107 The UN Committee on the Rights of Persons with Disabilities has criticised the lack of human rights principles in the Act. The Ministry is currently considering the Act in the light of our international obligations and legislative framework, including the NZ Bill of Rights Act; Ministry of Health, *The Mental Health Act and human rights: A discussion document*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment> (accessed 12 June 2017).

108 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

Of the 510 confirmed suicides in New Zealand in 2014, 46% of people aged between 10 and 64 years had been in contact with a mental health or addiction service within the previous 12 months.¹⁰⁹ This figure is consistent with help-seeking behaviour reported in the 2006 population survey: almost half of people with suicidal behaviour in the previous 12 months did not report making any health visits — either to mental health and addiction services or to other health professionals.¹¹⁰

I consider that mental health and addiction services can improve their response to people experiencing distress, in order to prevent the suicide of people in contact with a service. This includes greater involvement of consumers and, where appropriate, family and whānau, in wellness and recovery planning, and improving rates of follow-up following discharge from inpatient into community care.

In North West England, work led by Joe Rafferty resulted in an adult mental health, addiction and disability service, Mersey Care, adopting a zero tolerance approach to suicide, with the aim of eliminating suicide for people in their care. They have focussed on discharge from inpatient care as a high-risk period, and improved timeliness and processes in relation to post-suicide reviews, as the first actions undertaken to reduce their suicide rates. Every consumer with a history of suicidal intent or self-harm will have a personalised safety plan, and the service will monitor the consumers at the highest risk.

A number of New Zealand services are undertaking initiatives to reduce suicide; however, these initiatives are often taken in isolation. The strategies of Mersey Care are all areas that have been identified in this report as areas for improvement, and provide a sound place for New Zealand services to start from if they have not done so already. In particular, I recommend that we adopt a goal of zero tolerance of suicide in services, and that DHBs work together to develop a consistent joint approach to reduce suicides. This is preferable to developing local initiatives, which can often be done in isolation. Suicide rates in New Zealand have not reduced in recent years and are, internationally, very high for young people. We now need to move to collaborative efforts amongst mental health and addiction services, to learn and act to together to reduce suicides.

¹⁰⁹ *Ibid.*

¹¹⁰ Oakley Browne, 2006, at note 1, p 99. The percentage of people who made contact with a health professional was 43% of those who had suicidal ideation, 45% of those with a plan, and 45% of those who had attempted suicide.

Monitoring indicators



18%
of HDC mental health
and addiction complaints
in 2016/17 were
about inadequate or
inappropriate care

Source: HDC



802
consumers were secluded
on 1,485 occasions in 2016

Source: MOH



74%
of seclusions lasted
≤ 24 hours in 2016

Source: MOH

More broadly, beyond services, my recommendation is that New Zealand commit to a firm suicide reduction target in its next suicide prevention strategy, and include specific initiatives to be delivered on by service providers. I understand why some people are concerned about the Government being held to account for something beyond its control. However, a target can be seen as our collective responsibility as a society. Therefore, while any target and its time for implementation must be set after careful consideration, one should be set. I also recommend that the draft suicide prevention strategy, consulted on last year, is finalised, and actions progressed as a high priority.

Restrictive practices are common in services, particularly in inpatient settings

Approximately 10,000 people a year are subject to the Mental Health Act,¹¹¹ which means they are under some form of compulsion to have an assessment and/or treatment. Within that, a number of people are subject to restraint and seclusion. Seclusion involves a person being placed alone in a room or area from which they cannot exit freely.¹¹² Under section 71 of the Mental Health Act, seclusion can be used only where it is necessary for the care and treatment of the person being secluded, or for the protection of other people. Supporting operational standards¹¹³ state that seclusion “should be used for as short a time as possible and is best conceived as a safety mechanism rather than a therapeutic intervention or treatment”.

Eleven percent of the 7,411 people who spent time in an adult inpatient unit in 2016 were placed in seclusion. Many of those people were placed in seclusion more than once (on average 1.8 times), with the majority of events lasting less than 24 hours.¹¹⁴ Seclusion rates are higher for males than females (72% for males compared to 28% for females), for people aged 20–24 years, and for Māori and Pacific consumers. A total of 102 young people (aged 19 years and under) were secluded during the 2016 year.

The use of environmental restraint is not limited to people under the Mental Health Act. In his National Preventative Mechanism role under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), the Ombudsman monitors and inspects places of detention, including mental health inpatient and forensic facilities. OPCAT puts international obligations on New Zealand to ensure that people held in detention are treated humanely and with decency and dignity. OPCAT inspectors have reported that informal mental health consumers who voluntarily agree to receive mental health services in an in-patient setting have been forced to comply with treatment and unable to leave the unit owing to it being a locked facility.¹¹⁵

In our consumer and whānau feedback sessions, and in conversations with other stakeholders, HDC has also been told of instances where medication was used to control or chemically restrain consumers. This included community as well as inpatient settings. Consumers used the term “zombie shuffle” to describe the indignity of inpatient field trips, due to the high levels of medication the group would be on collectively. I was advised by the Ministry of Health that there is no national record of prescriptions in inpatient settings, and, accordingly, no accessible record of prescribing practices, including the use of chemical restraint and high dosage prescriptions in these settings. This lack of information is concerning, both because of the potential for inappropriate prescriptions, and the potential for medication becoming an unintended method of control amid efforts to reduce seclusion. Accordingly, I recommend that work to record and report on inpatient prescriptions is progressed.

111 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

112 Standards NZ, *Health and disability services (general) Standard 2008*. Wellington: Standards NZ; 2008: NZS 8134.0:2008.

113 Standards NZ, *Health and disability services Standards — Health and disability services (restraint minimisation and safe practice) Standards 2008*. Wellington: Standards NZ; 2008: NZS 8134.2:200.

114 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29

115 Office of the Ombudsman, *Annual report 2016/17*. Wellington: Office of the Ombudsman; 2017.

The use of seclusion has been reducing over time, but is steady

Reducing and eventually eliminating seclusion is one of the goals of the Ministry of Health's mental health and addiction services development plan *Rising to the Challenge*. The United Nations Committee on the Rights of Persons with Disabilities, and the UN Working Group on Arbitrary Detention have also urged New Zealand authorities to eliminate the use of seclusion in medical facilities.

Since the introduction of a policy to reduce seclusion in 2009, the total number of people secluded has decreased by 25%, and the total number of seclusion hours has decreased by 62% (adult inpatient services).¹¹⁶ However, in the last three years the use of seclusion has steadied, and some measures are increasing. The number of hours spent in seclusion decreased by 11% between 2015 and 2016, but the total number of people secluded increased by 6% during this period.

The Ministry of Health has anticipated this steady, noting that “most services have employed best practice strategies to reduce their use of seclusion, and are now entering a preplanning phase in which they are refining and re-focusing their seclusion initiatives”. Revised guidelines have been in place since 2010, and Te Pou works with DHBs to support local initiatives, including implementing the “Six Core Strategies” of seclusion reduction.¹¹⁷ The Ministry considers that “the continued reduction (and eventual elimination) of seclusion will require strong local leadership, evidence-based seclusion reduction initiatives, ongoing workforce development and significant organisational commitment”.¹¹⁸

The high use of seclusion for Māori

Māori secluded as a percentage of the total population of people who were secluded has not changed appreciably, even while overall seclusion rates decreased. Total seclusion numbers have declined by 30% since 2007, but the number of Māori secluded has declined by only 9%. During 2016, 44% of consumers secluded in adult inpatient services were Māori. The rate of seclusion for non-Māori was 19 people per 100,000, compared to 91.7 people per 100,000 for Māori.¹¹⁹ The relatively high rate of seclusion of Māori is a matter of concern.

While there are undoubtedly a variety of factors involved, it is apparent that the implementation of culturally appropriate and inclusive approaches should be more widely practised. This should influence the incidences of seclusion for Māori. Through the work of Te Rau Matatini, Māori have identified a number of solutions for a holistic approach to service provision, incorporating tikanga Māori (Māori customs), te reo Māori (Māori language), mātauranga Māori (Māori knowledge), and increased whānau involvement, in addition to the provision of acute mental health care in alternative, less restrictive environments.

Te Huarahi o te kete Pounamu is the national body of Māori with lived experience to improve advocacy for Māori and to increase representation of Māori service user perspectives in mental health services to influence policy and decision-making. Te Huarahi o te kete Pounamu is leading a programme in mental health services to improve practice with Māori (and to reduce restrictive practice¹²⁰).

116 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

117 See: <https://www.tepou.co.nz/resources/six-core-strategies-for-reducing-seclusion-and-restraint-checklist/464>.

118 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

119 *Ibid.*

120 Baker, M, *He Kai i nga Rangatira: He korero o nga whānau whaiora*. Wellington: Te Rau Matatini Ltd; 2015.

Workforce organisations Te Rau Matatini and Te Pou work with DHBs and publish a range of tools and guidance to support the reduction in the use of seclusion for Māori. There will also be a strong focus in the Pathways to Eliminate Seclusion by 2020 collaborative work on ensuring culturally safe approaches with Māori mental health consumers and their whānau.

Staff culture is instrumental to reducing restrictive practices

There are large variations in seclusion rates across DHBs. High secluding DHBs have rates of seclusion almost 11 times higher than the low secluding DHBs.¹²¹ Research indicates that variation between DHBs' seclusion use is due to differences in organisational culture and practice, not due to differences in populations. This is supported by observations in an independent report conducted for the Human Rights Commission on seclusion that objectives to reduce and eliminate seclusion in mental health settings are not always accepted by frontline staff.¹²²

In the HDC's consumer and family and whānau feedback sessions, participants gave examples of how staff culture and practices could have provided a less restrictive, and more human, experience of care.

"Both the police intervention and my stay in ED [when I was unwell] were unnecessary. The right person could've talked me down."
(Adult consumer feedback session)

"Instead of saying 'you're attention seeking', ask why attention seeking. Looking back, I think the reason for self-harming was to make a connection."
(Adult consumer feedback session)

There is also evidence that alternatives to seclusion and restraint are not being used as well as they could be. A recent stocktake was undertaken

by Te Pou on the use of sensory modulation as a strategy for reducing seclusion and restraint. Sensory modulation is an approach involving learning to understand and use sense (sight, sound, smell, touch, and taste) in a new way to self-calm and alleviate distress.

Both consumers and staff reported that sensory modulation had a positive impact on consumers, and had an effective role as a seclusion and restraint reduction tool. However, the report also found that sensory modulation is not included in all DHB strategic work plans, funding for sensory equipment is not always prioritised, and staff training is limited by a need for updated resources, dedicated time, and dedicated trainers. Leadership was identified as a key factor for supporting the implementation of sensory modulation.

OPCAT inspectors have also observed variation in practices around sensory modulation and, in some sites, a lack of understanding from staff about the benefits of sensory modulation as a self-management tool for de-escalation and regulating stress levels. For example, some services locked their sensory modulation rooms, meaning that consumers could access them only with the assistance of staff.

While eliminating seclusion is an important goal, OPCAT inspectors are also observing signs of other forms of restrictive practices being used as an alternative. For example, people subject to Ministry of Health night safety orders can be placed in a locked room overnight — this is not recorded as a seclusion. OPCAT inspectors are concerned that night safety orders could be used in place of seclusion without the appropriate safeguards and checks.

Eliminating seclusion is a challenging goal, but it is an important goal to strive for. Recent initiatives show that great reductions are possible with appropriate staff training, but it is also essential that staff are appropriately supported and guided through the process of changing practices.

121 Te Pou o te Whakaaro Nui, *Variation in DHB seclusion rates: mental health services*. Auckland: Te Pou o te Whakaaro Nui; 2017: https://www.tepou.co.nz/uploads/files/Variation%20in%20DHB%20seclusion%20rates_web%20version.pdf (accessed 16 October 2017); Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017). At note 29.

122 Shalev, S, *Thinking Outside the Box? A review of seclusion and restraint practices in New Zealand*. Auckland: New Zealand Human Rights Commission; 2017: <http://www.seclusionandrestraint.co.nz/> (accessed 5 July 2017).

Signs of progress

Pasifika interventions for preventing suicide

The FLO: Pasifika for Life suicide prevention programme aims to engage and empower Pasifika families and communities in a sustainable way to ensure that they know how to prevent suicide, and to respond safely and effectively when and if suicide intention occurs. The programme encourages five tactics for preventing suicide:

- Talk about issues
- Use culture to strengthen mental well-being
- Connect through relationships and experiences
- Strengthen family (including extended family)
- Use spirituality to support personal journeys of transformation, hope, and courage.

Reducing detention of people with mental health needs in police cells

Police, mental health, and ambulance services are on track to more than halve the number of non-offenders with mental health needs detained in police cells within three years — down from 4,995 in 2014 to 2,756 in 2016, and forecast to drop further to 2,324 in 2017 — which would be a 54% reduction in three years.

This reduction is supported by a Mental Health Response Triage Line that takes non-critical mental health calls from police and ambulance communication centres and connects the caller to registered nurses with specialist health knowledge.

Seclusion-free unit following seclusion reduction programme

The 32-bed inpatient unit at Waitakere Hospital has implemented a whole of unit, structured approach to reducing the use of seclusion. The approach includes refreshing de-escalation and other techniques, providing positive feedback, and displaying progress on user-friendly graphs. The unit found that involving service users is pivotal. As at 12 December 2017, the unit had been seclusion free for 20 weeks. An 82% reduction in the use of seclusion had been achieved, and a 75% reduction in the average duration of seclusion events.

HQSC focus on medication management and prescribing

Improving medication management and prescribing is one of five initiatives in the Health Quality & Safety Commission's five-year Mental Health and Addiction Services Quality Improvement Programme. Currently there is significant variation in prescribing and managing medications for people with mental health and addiction problems, which may worsen their physical health issues. This initiative will support standardised, evidence-based processes and practices for prescribing and management.

HQSC and Te Pou focus on eliminating seclusion

The Health Quality & Safety Commission and Te Pou are leading a national collaborative project, Pathways to Eliminate Seclusion by 2020, as one of five initiatives of the Health Quality and Safety Commission Mental Health and Addiction Quality Improvement Programme. The project will involve the National Key Performance Indicator Programme, service providers, and consumers and their whānau/families, to focus effort and accelerate progress towards eliminating the need for seclusion. Work is expected to begin in March 2018.

Question 5: Do services work well together for me?

Key findings

- Transitions within and between services are a natural part of mental health and addiction care but they also carry risk. Most consumers and family and whānau are happy with the way services communicate with each other. However, consumers and family and whānau also see a need for more coordinated services between primary and community care, secondary care, and other health providers.
- Issues relating to coordination of care are common in complaints to HDC and a common finding on HDC's assessment of a complaint, particularly in regard to coordination between inpatient units and community mental health teams, and between mental health services and addiction providers.
- Services overlooking or not taking physical health needs seriously were raised in HDC's consumer and family and whānau feedback sessions. The attitude of health professionals has been identified in studies as a factor in inadequate preventative care or treatment for people with serious mental illness and/or addiction.
- Systems need to be in place to ensure timely follow-up. The low proportion of people receiving follow-up from a community mental health team within seven days of discharge from hospital is concerning.





Do services work well together for me?

“I started having multi-disciplinary team meetings and I found them really helpful.”

– Adult consumer feedback session

“You have to keep re-telling your stories.”

– Youth consumer feedback session

Introduction

People-centred health care means delivering care that is seamless within and across services. New Zealand’s stepped care model means that transitioning in and out of different mental health and addiction services is a natural part of a consumer’s recovery journey. As outlined earlier in this report, many people with mental illness and/or addiction also have co-existing physical illnesses and/or multiple conditions, including co-existing substance use and mental health conditions. Many people with co-existing mental health and/or addiction and physical health needs present with complex conditions that can be difficult to manage. Robust systems should be in place to manage complexity and ensure continuity of care and timely follow-up within and between the healthcare providers for all needs.

This section looks at how different parts of the health system coordinate care so that health services are “seamless” for mental health and/or addiction consumers. Results from HDC’s consumer and family and whānau experience survey, and complaints to HDC about coordination of care, are used to provide an indication of “seamlessness”. This section also draws attention to service transitions for people moving from an inpatient to a community setting by looking at measures relating to follow-up by services following discharge, and the rate of re-admission within a 28-day period.

Monitoring indicators



81%

of consumers and family/whānau report they were happy with the communication between the people they see

Source: Mārama RTF



13%

of HDC mental health and addiction complaints in 2016/17 were about co-ordination of care

Source: HDC

Better coordination is needed between services

Many consumers and family and whānau are happy with the way services communicate with each other. Eighty-one percent of respondents to HDC's Real Time Feedback Survey agree that the people they see do communicate with each other when needed. However, many consumers and family and whānau in the HDC's feedback sessions talked about the need to have better, unseparated care, and more coordinated services between primary and community care, secondary care, and other health providers. Examples provided by participants included:

- The team responsible for a consumer's community care not knowing that the consumer was in an inpatient unit, or the GP not knowing;
- GPs not knowing the services available in the community; and
- Coordination between mental health and addiction services lacking.

Issues relating to coordination of care are common in complaints to HDC about mental health and addiction services, with it being raised by the complainant in 13% of all complaints in 2016/17, and 20% of complaints about inpatient services. Inadequate coordination of care is also a common finding on HDC's assessment of a complaint, particularly in regard to coordination between inpatient units and community mental health teams, and between mental health services and addiction providers for consumers with co-existing problems.

Issues I see commonly in relation to coordination of care include: deficiencies in handover; inadequate escalation of care to senior staff; deficiencies in documentation hindering continuity of care; a failure to read the notes; inadequate referral management processes; and a lack of clarity around roles and responsibilities. This emphasises the need for individual providers to pay attention to

the basics — to read the notes, ask the questions, talk to the patient — and for the system to ensure that it supports staff to work together effectively, allowing them to foster good working relationships and clear lines of communication.

Two recent Coroners' decisions highlight the importance of role clarity, clear documentation, and information sharing between primary and secondary care to prevent consumers falling through the gaps:

- The first decision relates to the suicide of a man who had been seeing a GP for depression, and a relationship counsellor to support him through a separation. The man's GP prescribed him antidepressants and believed that the man's counselling was not only for relationship issues, but also for his depression. That assumption was incorrect. The man's mental health issues, depression, and thoughts of suicide were not the subject of the sessions. The coroner said that it is important that health professionals understand and clearly identify their areas of expertise. He recommended that counsellors undertake training in suicide risk assessment and when to refer someone to a specialist. He also recommended information sharing between specialists and GPs, in the best interests of the patient.¹²³
- The second decision relates to the death of a man due to "slow-gut", which was a side-effect of his psychiatric medication clozapine.¹²⁴ In that case, there was no agreed plan between the psychiatrist and GP related to the monitoring of side-effects. The coroner recommended that DHBs ensure that there are effective mechanisms and processes in operation, so that GPs of patients who are taking clozapine are aware of the GP's clinical responsibility to undertake regular physical health monitoring of those patients. The coroner also recommended that DHBs ensure adequate and ongoing education for people taking clozapine, and all those involved in their care, of the risks of slow-gut and ways to manage symptoms.

123 See: <http://www.radionz.co.nz/news/national/347702/suicide-spurs-call-for-more-sharing-of-information> (accessed 12 January 2018).

124 Warburton [2017] NZCorC 4 (26 January 2017).

In a recent HDC breach decision, I found that a man who had been under the care of addiction services was denied pain relief for what transpired to be a terminal illness, in part because the service considered that the man could be drug-seeking, and did not coordinate with the hospital service.¹²⁵ In that case, there were a number of missed opportunities for communication about the man's situation, his condition, and his pain relief requirements, as a result of service based failures attributable to the DHB. I made a number of recommendations, including that the DHB develop a process for formal handover of clients when they move from an outpatient addiction service to inpatient services, and vice versa. I also recommended that the DHB conduct an audit to ensure that all interactions with clients are recorded in addictions service records and/or clinical records if relevant, and review and revise as necessary the position descriptions for addiction service staff, to ensure clarity of role expectations, professional development, and support. Refresher training for staff and an apology to the man's family were also recommended.

Another recent breach decision of the HDC highlights the importance of monitoring the side-effects of mental-health-related medication, and ensuring appropriate follow-up and continuity of care despite staffing changes (see case study on page 74), and another breach decision provides an example of where coordination of care has failed and HDC recommendations for improvement (see case study on page 77).

Gaps in responses also exist for people with co-existing mental health and addiction problems, and those with co-existing mental health issues and disabilities. This is a common issue in complaints to HDC, especially in regard to the crisis care of patients whose main diagnosis relates to addiction. This issue was identified in *Rising to the Challenge*, but progress to address the issue appears to be slow. Issues relating to inadequate service response for people with co-existing mental health and addiction conditions continues to be raised by consumers and providers with whom I speak. Any door should be the right door when someone wants help.

Monitoring indicators



16.7 days

average length of stay in an adult inpatient unit in 2016/17



65%

of people followed up within 7 days of discharge from an acute inpatient unit in 2016/17



15%

of people who were readmitted within 28 days of being discharged

Source: KPI Programme

125 See: <http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2017/15hdc00563>.

HDC case study

Failure of GP to address side-effects of mental health medication in a timely manner, and of the GP practice to ensure continuity of care (Decision 15HDC00196)¹²⁶

Over a period of six years, a man was prescribed lithium by his GP without regular reviews of his serum lithium levels. The man's drug regimen, which also included high doses of diazepam, paroxetine, and codeine, had been established by psychiatrists in both New Zealand and overseas before he became the patient of the GP.

The man's blood tests began to indicate deterioration in his renal function, and the man reported a hand tremor (a common side-effect of lithium toxicity). On two occasions the man was reviewed by specialists — a consultant psychiatrist and an endocrinologist — who both recommended changes to the man's medication regimen. However, the changes were not implemented in a timely manner.

Although HDC acknowledged that the man's conditions and management were complex and a mitigating factor when considering the failure in care, the Commissioner remained critical of the care provider. HDC found that the GP failed to assess the man's serum lithium levels adequately, did not document any consideration that the man might be suffering side-effects from lithium toxicity, took no action to assess whether the lithium might be causing the man's tremor, and failed to ensure that specialist-ordered changes to the man's medication regimen were made in a timely manner.

HDC also found that the GP's medical practice did not have systems in place to facilitate co-operation between providers to ensure that quality care and continuity of services were provided to the man. In relation to the failures by the medical practice, HDC's expert clinical advisor stated:

“[The man] saw multiple providers and had multiple prescribers and I feel this situation may have contributed to some of the suboptimal aspects of his management . . . While staffing at [the medical centre] may have made such continuity of care difficult, this situation necessitated effective communication between providers and robust processes particularly around review and actioning of reports and results, and repeat prescribing, and I feel there were significant deficiencies in these areas.”

HDC recommended that the GP provide a written apology to the man and undertake training on the prescribing of psychotropic medication. It was recommended that the Medical Council of New Zealand consider whether a review of the GP's competence was warranted. With regard to the GP's medical practice, HDC recommended that it put in place and finalise a repeat prescribing policy, with information on patient review timeframes; and a policy for the robust filing of reviews and reports, including specialist advice, received by the practice and requiring action. The recommendations were met by both the GP and the practice.

126 See: <http://www.hdc.org.nz/decisions/search-decisions/2016/15hdc00196/>.

Consumers need appropriate recognition of all their health needs

It is also important that providers are aware of the potential for “diagnostic overshadowing” — that is, where clinicians treating a patient with mental health and/or addiction issues may attribute symptoms to the mental illness or addiction, rather than the physical injury or illness. Services overlooking physical health needs, or not taking physical health needs seriously, was mentioned by many in our consumer and family and whānau feedback sessions. For example:

“My son was in residential care and is now in my care. He was experiencing lots of discomfort and the psychiatrist kept on prescribing more meds — only looking at medication — turns out he was having trouble with his teeth and what he needed was a dentist.”

(Family and whānau feedback session)

A number of studies have identified the attitudes of health professionals towards people with mental health and addiction problems as a factor in inadequate preventative care or treatment for people with serious mental illness and/or addiction.¹²⁷ One study found that the views of health professionals affected patients’ provision of care. In that study, professionals with stigmatising views about mental health were less likely to take clinical actions to address complaints of back pain in a patient with schizophrenia. There was no difference between professionals working in primary care and in mental health services in this regard.¹²⁸

Consumers need adequate follow-up

As noted in Question 1, inadequate follow-up is a common issue seen in complaints about mental health services, and often reflects issues of timeliness.

People who receive timely follow-up care in the community following discharge from inpatient care are less likely to be re-admitted within 28 days. Re-admissions may also occur if a consumer is discharged too early. New Zealand is part of an international benchmarking network with Australia, Canada, England, Wales, Scotland, Sweden, the Netherlands, and Norway. Indicators for average length of inpatient stay, follow-up from services within 7 or 14 days of discharge from hospital, and emergency re-admission can be compared with these countries where data is available.

The low proportion of people receiving follow-up from a community mental health team within seven days of discharge from hospital is concerning. Timeliness of follow-up is important, as half of re-admissions to inpatient care occur within the first nine days of discharge.¹²⁹ In 2016/17, only 65% of consumers leaving inpatient care received follow-up within seven days. This is well below the target set by the KPI Programme of 90–100%. Progress has not been made over recent years.

New Zealand was ranked fourth out of six benchmarking countries for follow-up rates within 7 or 14 days on discharge (depending on local measures). England reports the highest rate of community-based follow-up care, with 96% of consumers followed up by a mental health practitioner within seven days of discharge.

127 Lawrence, D and Kisely, S, “Review: Inequalities in healthcare provision for people with severe mental illness”. *J psychopharmacol* 2010; 24(4 suppl): 61–8; Cunningham, R, Sarfati, D, Peterson, D, *et al.*, “Premature mortality in adults using New Zealand psychiatric services”. *NZ Med J* 2014; 127(1394): 31–41; Corrigan, PW, Mittal, D, Reaves, CM, *et al.*, “Mental health stigma and primary health care decisions”. *Psychiatry res* 2014; 218(1): 35–8; Reavley, NJ, Mackinnon, AJ, Morgan, AJ, and Jorm, AF, “Stigmatising attitudes towards people with mental disorders: A comparison of Australian health professionals with the general community”. *Aust N Z J Psychiatry* 2014; 48(5): 433–41.

128 Corrigan *et al.*, 2014, *ibid.*

129 Office of the Auditor-General, 2017, at note 75.

There are numerous factors that determine the length of stay in inpatient settings. If the stay is too short, the person may not be well in the community — too long and the person is subject to unnecessary restrictions on freedom (including increased likelihood of being secluded or restrained), and delayed recovery in the community. A number of factors can influence length of stay, including clinical practice, bed availability, how unwell a person is, and the model of community care to support a person on discharge. There are alternatives to hospitalisation, such as intensive community-based management or home-based treatment teams, allowing people to be managed closer to their homes and communities. However, my discussions with consumers and providers indicates that the availability of community options is limited, and varies markedly between regions.

The average length of an inpatient mental health stay has been relatively steady over the last four years, and was 17 days in 2016/17. Pacific peoples had the longest average stay in inpatient care (20 days in 2016/17), while young people (0–19-year-olds) had the steepest decline in length of stay over the last four years (a 20% decrease from 14 days in 2013/14 to 11 days in 2016/17). New Zealand has the fifth longest length of stay out of eight benchmarking countries.

The rate of re-admission within 28 days of being discharged from inpatient care has been steady at 15–16% for the last four years. These figures are approximately 50% over the KPI Programme “stretch-target” of 0–10%. New Zealand has the second highest rate of re-admissions within 28 or 30 days (depending on local measure) out of eight benchmarking countries, with the average re-admission rate being 12%, and the lowest reported rate, from the Netherlands, being 6%.

An HDC case illustrates the need to have systems in place to ensure timely follow-up following discharge from hospital care. The case concerned a young man who received hospital care from a number of services and providers following a suicide attempt.¹³⁰ On leaving the inpatient unit, he did not receive follow-up from the community mental health team. While a referral had been sent, it had not been received by the team. The DHB was found in breach of the Code for failing to ensure continuity of care for the man throughout his time in hospital and as he transitioned from the inpatient unit to community services.

Signs of progress

HQSC focus on improving service transitions

Reducing risk when consumers transition within or between services (for example, from inpatient to community care) is one of five initiatives in the Health Quality & Safety Commission’s five-year Mental Health and Addiction Services Quality Improvement Programme. Some serious adverse events are thought to be linked to a failed service transition. The “improving service transitions” project will begin in June 2018 to address the current variation of service transitions across the country. The HQSC will work with stakeholders from across the wider mental health and addiction sector to support a quality improvement approach to improving service transitions. An evidence review is already underway to confirm what is known nationally and internationally on improving service transitions.

130 <http://www.hdc.org.nz/decisions/search-decisions/2015/13hdc00199/>.

HDC case study

Failure to provide continuity of care between an inpatient unit and community mental health team (Decision 13HDC00199)*

A man attempted suicide and, in doing so, sustained a head injury. The man was taken to a public hospital and admitted for observation. Following a 24-hour period of observation, the man was discharged. Due to staff and family concerns for his safety, the man was then assessed by a psychiatry registrar and a Crisis Assessment Treatment Team registered nurse. Following the assessment, the man was admitted to the psychiatric inpatient unit.

The following day, the man had his first meeting with the consultant psychiatrist at the inpatient unit at the hospital. The man, his family and the consultant psychiatrist agreed that the man's status be changed to "inpatient on leave", and the man went home with his family.

The man returned to the inpatient unit the following day for an appointment with the consultant psychiatrist, who was at that time concerned about ongoing symptoms of a head injury. The man underwent follow-up and was again admitted to hospital where he remained for two nights before being discharged. For the next week the man was an "inpatient on leave". The man had two appointments with the consultant psychiatrist and was contacted each day by the psychiatric inpatient unit's transition liaison service.

Later that week a member of the man's family contacted the inpatient unit as they were concerned for the man's safety. The next day the man had an appointment with a different consultant psychiatrist, who was on-call. At that appointment, the man denied suicidal

intention. However, that evening, the man, while under the influence of alcohol and cannabis, again attempted suicide.

The man was then admitted to the inpatient unit and remained as an inpatient for a few days. Following discharge, a referral for community services through the Community Mental Health Team (CMHT) was sent, but was not received. Over a month later, the man's family raised concern with the consultant psychiatrist that they had not heard from CMHT. The consultant psychiatrist then raised concern with CMHT, who advised they did not have a referral form on file.

It was held that the consultant psychiatrist provided services of an appropriate standard to the man during his time as a patient of the psychiatric inpatient unit, and did not breach the Code.

It was also held that the district health board failed to ensure continuity of care for the man throughout his time at the hospital and as he transitioned from the inpatient unit to community services, breaching Right 4(5) of the Code.

The HDC made a number of recommendations, including that the DHB: put processes in place to alert the Inpatient Unit when patients with a high risk of self-harm are admitted into other clinical units; consider a single repository of clinical notes so that all patient notes (electronic and handwritten) are in one location for each Inpatient Unit patient; audit the effectiveness of its electronic referral process; and introduce the family meeting model at the Inpatient Unit. These recommendations have been complied with.

*See <http://www.hdc.org.nz/media/1657/13hdc00199.pdf>

Question 6: Do services work well for everyone?

Key findings

- Consumers should be able to expect the same quality of care, experience, and outcomes as others regardless of who they are. Culturally competent services respond to the distinct values and needs of different population groups, including recognising the special relationship between Māori and the Crown under the Treaty of Waitangi.
- There are a growing number of kaupapa Māori mental health and addiction services. However, greater Māori participation and leadership in the design and delivery of services is needed to improve outcomes for Māori. Mental health and addiction service performance is poorest for Māori across the monitoring questions in this report.
- Cultural alienation and contrasting world views can affect a Pacific consumer's experience of mental health and addiction services, and the ability to improve outcomes. A number of projects are underway to increase the Pacific workforce and improve cultural awareness across the whole workforce. For Pacific youth, strengthening family relationships and increasing communication within the family are essential components to support well-being.
- Most mental health and/or addiction problems have origins in childhood, and there is evidence that the most effective time for intervention is in the first four years of life. Access rates for the 0–19 age group have been increasing, partly due to specific interventions such as the Youth Mental Health Project. However, services for young people are under pressure, access for young people in care is variable, and some young people may be missing out on early intervention because of overly restrictive criteria to access services. Services need to be centred on young people.
- Every person in prison is entitled to the same health care as they would receive in the community. A number of recent reports have criticised the care of people with mental health and addiction needs in prison, including the use of tie-down beds in at-risk units, regional variation in the provision of services, and stretched forensic care. The Department of Corrections is investing in a range of new services and facilities to better meet the mental health and addiction needs of people in prison. I welcome those initiatives and will monitor progress, especially in light of rapidly growing prison numbers.





Do services work well for everyone?

Introduction

A well-functioning mental health and addiction system should provide equity of care for all populations. Consumers should be able to expect the same quality of care, experience, and outcomes as others regardless of who they are.

An important part of equitable care is cultural competence. Culturally competent services provide a safe environment by respecting and acknowledging a consumer’s identity, values, and beliefs, including his or her ties with family and whānau. This includes not assuming which cultural world views are meaningful for that person. A requirement for services to be culturally competent has both a basis in law¹³¹ and a recent strategic focus. For example, in 2008 the Ministry of Health released Let’s get real — a foundation framework with the expectation that the mental health and addiction workforce will have a degree of cultural fluency. The framework has been further developed by workforce agencies Te Pou o te Whakaaro Nui, Te Rau Matatini (for Māori), and Le Va (for Pacific peoples) in a series of resources.¹³²

This section looks at performance indicators across the other five sections of this report for three population groups who experience disparity in services: Māori, Pacific peoples, and children and youth. It also focuses on people in prison, due to the high incidence of mental health and addiction issues in that population, and the role of the Department of Corrections as a significant provider of mental health and addiction services.

Other populations and groups also experience differences in outcomes that are not covered here. I welcome the terms of reference of the Inquiry recognising the special relationship between Māori and the Crown, and recognising and respecting the needs of different population groups, including



1 in 5

New Zealanders live with mental illness and/or addiction in a given year

Some population groups are more at risk than others:



Almost 1 in 3

Māori

Source: Te Rau Hinengaro, 2006



1 in 4

Pacific peoples

Source: Te Rau Hinengaro, 2006



2 in 3

People in prison

Source: Indig et al: 2016

people with disabilities, Pacific peoples, refugees, migrants, LGBTIQ, prison inmates, youth, the elderly, and rural populations. I also welcome the breadth of the Inquiry covering mental health and addiction service providers and purchasers outside of the Health Sector, including ACC, Corrections, Ministry of Education, and Ministry of Social Development.

131 Cultural competency has been a requirement of all health workers since the introduction of the Health Practitioners Competence Assurance Act 2003, and is included in the Mental Health Act, Substance Addiction Act, and Ministry of Health strategies and workforce documents.

132 <https://www.tepou.co.nz/>; <http://teraumatatini.com/>; <https://www.leva.co.nz/>.

Māori

Mental illness and/or addiction issues are more prevalent and outcomes worse for Māori than for other ethnic groups

The special relationship between Māori and the Crown under the Treaty of Waitangi is recognised and expressed in a number of laws and strategies. Improving outcomes for Māori has been a focus for the Ministry of Health and the sector for some time.¹³³ The evidence of poorer outcomes for Māori compels all of us to redouble our efforts to ensure that services are responsive to the needs of Māori.

Māori experience the highest levels of mental illness and/or addiction of any ethnic group in New Zealand — almost one in three Māori will experience mental illness and/or addiction in a given year, compared to one in five in the general population. Māori are also more likely than non-Māori to access services later, and to experience serious disorders and/or co-existing conditions, and have the highest rate of suicide of any ethnic group.

Māori experience the greatest level of health inequality of all peoples in New Zealand, with substantial inequalities in mortality and morbidity even after controlling for deprivation, their access to care, and health needs.¹³⁴ Prevalence of child poverty and mental health issues are high amongst Māori. When controlling for childhood poverty reduces differences in psychosocial outcomes, it does not fully explain why the differences between Māori and non-Māori remain.¹³⁵

Māori youth experience high rates of self-harm, suicide, addiction, and mental health issues. This has implications for a greater rate of adverse mental health and psychosocial outcomes that carry on into adulthood¹³⁶ if early intervention, prevention,

and treatment are ineffective. Effective intervention and support are imperative, including a focus on cultural identity and holistic well-being.

The experience of mental health and addiction for Māori, and appropriate responses that work for Māori consumers and their whānau require careful attention. For example, the Māori experience of trauma is distinct in ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty, and ill health.¹³⁷

Service performance is poorest for Māori across the monitoring questions in this report

Within the monitoring indicators used in this report, there is compelling evidence of disparity for Māori, with Māori experiencing poorer well-being outcomes and quality of care than other population groups.

Māori access mental health and addiction services at a higher rate than the overall population, reflecting higher population need. In 2016/17, Māori made up approximately 16% of New Zealand's population, and accounted for 27% of all mental health service users.¹³⁸ The ratio for Māori accessing services was 6.2% compared to an overall population access rate of 3.7%.

In recognition of higher need, Māori, Pacific peoples, young people, and people with a community service card are prioritised to access primary mental health services at no cost (although access to a GP in order to get those services still comes at a cost for adult consumers). While reducing barriers to access is important, the experience of consumers within services matters too.

133 The New Zealand Public Health and Disability Act 2000 requires the health system to recognise and respect the principles of the Treaty of Waitangi. This is acknowledged in the New Zealand Health Strategy, which notes the special relationship between Māori and the Crown created by the Treaty of Waitangi and aims to reinforce the protections in the Act.

134 King, M, Smith, A, and Gracey, M, "Indigenous health part 2: the underlying causes of the health gap". *The Lancet* 2009; 374(9683): 76–85.

135 Marie, D, Fergusson, D, and Boden, J, "Childhood socio-economic status and ethnic disparities in psychosocial outcomes in New Zealand". *Aust N Z J Psychiatry* 2014; 48(7): 1–9.

136 Gibson, K, Abraham, Q, Asher, I, et al., *Child poverty and mental health: A literature review*. Auckland: New Zealand Psychological Society and Child Poverty Action Group; 2017: <https://researchcommons.waikato.ac.nz/handle/10289/11484> (accessed 12 February 2018).

137 Pihama, L, Tuhiwai Smith, L, Evans-Campbell, T, et al., "Investigating Māori approaches to trauma informed care". *Journal of Indigenous Wellbeing* 2017; 2(3) 18–31: <https://journalindigenousewellbeing.com/media/2017/12/84.81.Investigating-M%C4%81ori-approaches-to-trauma-informed-care.pdf> (accessed 23 January 2018).

138 Data supplied by the Ministry of Health, 2017.

Māori are more likely than others to come under the Mental Health Act, and to be subject to restrictive practices once they are.¹³⁹ I expressed my concern about this in Question 4. While this difference may be partly due to a greater prevalence of serious mental illness among Māori, other factors are also likely to be at play.

Māori experience similar lengths of stay and 28-day readmission rates for acute inpatient units compared to the total inpatient population. However, Māori are less likely to receive a follow-up community mental health contact within seven days following release from an acute inpatient unit than other population groups — in 2016/17, 62% of Māori received seven-day follow-up, compared to 66% of Europeans, 71% Pacific, and 67% other. Further research into why Māori have the lowest level of post-discharge community care of any group is needed.

The economic disparity among our population groups is evident in two of the wider well-being indicators considered for this report. Māori consumers have lower rates of independent accommodation than other consumers of mental health and addiction services, with 77% of Māori living in independent accommodation compared to 82% of all consumers. Māori have a higher rate of homelessness than other consumers, with 7% of Māori consumers being homeless compared to 5% of all consumers.

Disparities for Māori consumers are less pronounced for employment, education, or training, with Māori only slightly more likely than other consumers not to be in employment, education, or training. This is pleasing, given that Māori have a higher rate of unemployment among the general (non-consumer) population.¹⁴⁰



1 in 4

secondary students report poor emotional well-being

Source: Youth '12



5%

of children aged 2–14 years have already been diagnosed with emotional and/or behavioural problems

Source: NZ Health Survey

Kaupapa Māori values and mental health and addiction services promote well-being and recovery for Māori consumers

A Māori view of health is holistic and centred on whānau health and well-being rather than on the health of the individual alone. Māori health perspectives and the relevance of culture to health emphasise the importance of *taha wairua* (spiritual health), *taha hinengaro* (emotional/mental health), *taha tinana* (physical health), and *taha whānau* (family health). Health is also contextualised within *te whenua* (land providing a sense of identity and belonging), *te reo* (the language of communication), *te ao turoa* (environment), and *whanaungatanga* (extended family and relations).¹⁴¹

139 Ministry of Health, *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports> (accessed 4 December 2017).

140 Twice the New Zealand rate. Statistics New Zealand: www.stats.govt.nz/news/maori-unemployment-rate-at-nine-year-low-but-twice-new-zealand-rate (accessed 18 February 2018).

141 Durie, MH, "Māori cultural identity and its implications for mental health services". *Int J Ment Health* 1997; 26(3): 23–5.

Previous studies alongside Māori with lived experience also endorse the importance of Māori culture, language, and customary practice in recovery. Aspects promoted in the delivery of mental health services include:

- Acknowledging the importance of whānau (extended whānau relationships and members who play a major support role for Māori);
- Understanding Māori cultural perspectives to influence how Māori perceive the cause of signs and symptoms, and whether diagnoses are accepted; and
- Preferences for te reo me ona tikanga, karakia, traditional healing practices, whānau hui — overall approaches that respect customary practices in the engagement and healing of Māori.¹⁴²

National policy, various mental health and addiction service contract specifications, health professional groups, and Māori demonstrate expectations to advocate for and apply a holistic approach when working with Māori.

Mental health and addiction services are significantly influenced by Māori cultural values. Health services based upon Māori models of practice have been operational in New Zealand since the 1980s. There are now a large number of services that reflect kaupapa Māori, Māori centred or culturally responsive approaches across mainstream, NGO, PHO, and iwi contexts. These services have incorporated te reo (Māori language), Māori health perspectives, and Māori frameworks in the assessment, treatment, and care of consumers and their whānau. There has also been a growth in Māori provider networks, Māori mental health and addiction programmes, an expanded Māori health workforce, and Māori leadership. These elements will continue to be crucial catalysts for the transformation of health services.¹⁴³

Greater Māori participation and leadership in the design and delivery of services is needed to address disparity

A strong theme from my conversations with Māori sector leaders, consumers, and family and whānau is a call for a more substantial leadership role for Māori in the design and delivery of services. This will help to ensure that services meet the needs of Māori consumers better in the future.

The need for Māori engagement at the highest level is also a consistent theme. Māori consumers have told me about the alienation they feel when services do not feel welcoming to them, or understand their cultural perspective. Some people wanted to see accountability and performance measures added to lift service performance, for example in staff knowledge of the Treaty of Waitangi, or cultural assessment as part of the assessment process.

Rising to the Challenge included a number of priority actions in regard to outcomes for Māori, including evaluating the effectiveness of services for Māori, improving health literacy, and more actively involving Māori in service planning.

Cultural responsiveness can be improved in services — in particular, by involving whānau and through workforce recruitment and training, but also in examining whether models of care are unhelpfully narrow.

A focus on diagnosis comes at the expense of considering a person's broader context. For Māori, it has been argued that unless cultural factors are formally considered during assessment and diagnosis, the gap between the mental health status for Māori and other consumers will never reduce.¹⁴⁴ In relation to Māori youth and their whānau, research has identified the need to improve the delivery of child and adolescent mental health services through respectful partnerships, cultural support, and Māori workforce development.¹⁴⁵

142 Fenton, L and Te Koutua, TW, *Four Māori korero about their experience of mental illness*. Wellington: Mental Health Commission; 2000; Lapsley, H, Nikora, LW, and Black, RM, "*Kia Mauri Tau!*" *Narratives of recovery from disabling mental health problems*. Wellington: Mental Health Commission; 2002; Cram, F, Smith, L, and Johnstone, W, "Mapping the themes of Māori talk about health". *NZ Med J* 2003; 116(1170): 1–7.

143 Durie, M, "Indigenizing mental health services: New Zealand experience". *Transcultural Psychiatry* 2011; 48(1–2): 24–36; Wirihana, R, "Utilising matauranga Māori to improve the social functioning of tangata whaiora in Māori mental health services". In Levy, M, Nikora, LW, Masters-Awatere, B, et al. (eds), *Claiming Spaces: Proceedings of the 2007 National Maori and Pacific Psychologies Symposium 23rd–24th November 2007*. Hamilton: Māori and Psychology Research Unit, University of Waikato; 2008: 103–4.

144 Elder and Tapsell, 2013, at note 101.

145 McClintock, K, Tauroa, R, and Mellsop, G, "An examination of child and adolescent mental health services for Māori rangatahi [youth]". *Int J Adolesc Youth* 2016; 21(1): 56–63; McClintock, K, Moeke-Maxwell, T, and Mellsop, G, "Appropriate child and adolescent mental health service (CAMHS): Māori Caregiver's perspectives". *Pimatisiwin: J of Aboriginal and Indigenous Community Health* 2011; 9: 387–98.

The Ministry of Health's targeted consultation on New Zealand's compliance with the UN Convention on the Rights of People with Disabilities indicates a number of ways services could improve experiences and outcomes for Māori consumers.¹⁴⁶ Submitters called for a more holistic, person-centred approach to treatment that includes greater acceptance of spiritual concerns and beliefs. These comments are similar to the feedback I received from HDC's consumer and family and whānau feedback forums.

Submitters to the Ministry of Health considered that more culturally sensitive service provision could be delivered through the routine use of cultural assessment for Māori consumers.¹⁴⁷ Earlier intervention, based on open, honest, and inclusive conversations, was considered critical, but required a strong relationship base. Expanding the availability of cultural leaders, advisors, and healers to all services was suggested, as was prioritising services that are culturally relevant, and dedicating funding to develop the Māori workforce. In general, while many consumers felt alienated and disempowered by their experience under the Mental Health Act, this was exacerbated for Māori, who also experienced a powerful sense of cultural alienation in the delivery of mental health services.

Pacific peoples

Pacific peoples also experience mental illness and/or addiction at higher rates than others, with 25% experiencing a disorder within the previous 12 months (compared to 21% overall).¹⁴⁸ Pacific peoples have higher rates of substance abuse and gambling-related harm. Gambling-related harm is four times higher for Pacific peoples than for the general population. The prevalence of mental illness and/or addiction is higher for New Zealand-born Pacific peoples than for those who migrated to New Zealand aged 18 years or older.¹⁴⁹

Pacific peoples have lower rates of access to health services than other population groups,¹⁵⁰ and socio-economic disadvantage plays a key part in the disparity in health outcomes. There is a link between low access to services, and barriers to access for Pacific peoples, which include discomfort, lack of awareness, cost, transport, language and communication difficulties, cultural norms, stigma, beliefs, and a preference for traditional healers.¹⁵¹

The Pacific population has the highest rate of children and young people of any ethnic group in New Zealand, with just under half of this population (46.5%) aged under 20 years old.¹⁵² Young Pacific peoples are showing a reduction in addiction-related issues, and in the use of alcohol and other drugs.¹⁵³ The suicide rate for Pacific peoples is lower than the average for the general population, but youth rates are of concern. Suicide is the leading cause of death amongst young Pacific peoples (aged 12–18 years). The *Youth '12* study found that Pacific high-school students were three times more likely to have attempted suicide than other high-school students.

146 Ministry of Health, *Submissions on the Mental Health Act and Human Rights discussion document — An analysis*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment> (accessed 16 January 2018).

147 Mental Health Commission, *Cultural assessment processes for Māori: Guidance for mainstream mental health services*. Wellington: Mental Health Commission; 2001: <http://www.hdc.org.nz/media/200434/cultural%20assessment%20processes%20for%20maori-%20guidance%20for%20mainstream%20health%20services%20sept%202001.pdf> (accessed 12 February 2018).

148 Oakley Browne, 2006, at note 1.

149 *Ibid.*

150 *Ibid.*

151 Southwick, M, Kenealy, T, and Ryan, D, *Primary care for Pacific People: A Pacific and health systems approach*. Wellington: Pacific Perspectives; 2012.

152 Stats NZ, *Census 2013*. Wellington: Stats NZ; 2013: <http://archive.stats.govt.nz/Census/2013-census.aspx> (accessed 20 December 2017).

153 Clark, TC, Fleming, T, Bullen, P, et al., *Youth '12 overview: The health and wellbeing of New Zealand secondary school students in 2012*. Auckland: The University of Auckland; 2013.

Pacific peoples are diverse and have their own models for well-being

It is important to acknowledge the cultural diversity within Pacific peoples. A third of Pacific peoples in New Zealand are of mixed ancestry, and this number is expected to grow. This group is more likely to experience lower well-being and increased identity tension.¹⁵⁴

There are a number of models of well-being that express the diverse cultures of the Pacific.¹⁵⁵ The models have elements in common, both with each other, and with Māori world views, in that they are collective and relational. Six core values have been identified as being common to Pacific peoples: *tapu* (sacred bonds), *alofa* (love and compassion), *fa'aaloalo* (respect and deference), *fa'amaualalo* (humility), *tautua* (reciprocal service), and *aiga* (family).¹⁵⁶

Well-being is attained when all relational aspects are in balance. A lack of balance between or within a domain creates stress, and may result in a person becoming unwell.¹⁵⁷

Identity, culture, and spirituality are vital to the well-being of Pacific peoples. Engaging effectively with Pacific peoples involves appropriate pre-engagement and engagement processes in order to create a safe space. It can also involve more indirect methods of communication, including the use of allegory and metaphor, as direct questioning can be considered rude.¹⁵⁸

Strengthening family relationships and increasing communication within the family are essential components of suicide prevention strategies for Pacific youth.¹⁵⁹

It is difficult to get an accurate picture of service performance for Pacific peoples

It is difficult to get an accurate picture of mental health and addiction services for Pacific peoples because of the way ethnicity is recorded.¹⁶⁰ Self-identified ethnicity tends to be categorised into Māori, Pacific, Asian, European, and Other ethnic groupings against pre-determined prioritisation protocol. Māori ethnicity has first priority when multiple ethnicities are selected, to ensure representation of individuals who identify as Māori within analysis outcomes. Pacific peoples tend to be grouped into one grouping with little appreciation for their diverse identities and populations.

Service performance indicators in relation to Pacific peoples show areas that need to be addressed, as well as signs of services responding well to the needs of Pacific peoples. The consumers of mental health and addiction services who are recorded as Pacific had higher levels of accommodation need in 2016/17 than average, but not as high as for Māori. Pacific mental health consumers also had the lowest proportion of people in employment, education, and training.¹⁶¹

154 Manuela, S and Sibley, CG, "Why do Pacific people with multiple ethnic affiliations have poorer subjective wellbeing? Negative ingroup affect mediates the identity tension effect". *Soc Indic Res* 2014; 115: 319–36.

155 Models and frameworks cited in Kingi-Ulu'ave, D, Faleafa, M, Brown, T, and Daniela-Wong, E, "Connecting culture and care: Clinical practice with Pasifika people". In Waitoki, WW, Feather, JS, Robertson, NR, Rucklidge, JJ (eds), *Professional Practice of Psychology in Aotearoa New Zealand* (3rd ed). Wellington: NZ Psychological Society; 2016.

156 Agnew, F, Pulotu-Endemann, FK, Robinson, G, et al., *Pacific models of mental health service delivery in New Zealand*. Auckland: Health Research Council; 2004.

157 Tamasese, K, Peteru, C, Waldergrave, C, and Bush, A, "Ole taeao afua, the new morning: A qualitative investigation into Samoan perspectives of mental health and culturally appropriate services". *Aust NZ J Psychiatry* 2005; 39: 300–309.

158 Kingi-Ulu'ave et al., 2016, at note 155.

159 Many references are cited in Kingi-Ulu'ave, *ibid*, p 69.

160 Ministry of Health, *Ethnicity data protocols for the health and disability sector*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols> (accessed 12 February 2018).

161 8% of Pacific peoples, compared to 45% overall and 43% Māori accessing mental health services. However, Pacific consumers of addiction services had a similar percentage in employment, or education and training, to 'other' consumers, at 50% (compared to 40% for Māori and 46% overall).

In relation to inpatient experience, Pacific peoples had the longest average length of stay in inpatient units, and the highest rate of post-discharge community care. Seventy-one percent of Pacific consumers received a contact within seven days of discharge in 2016/17, compared to 62% of Māori and 67% for all consumers. Re-admission to inpatient units was also lower for Pacific peoples than for Māori or other consumers. Assessing seclusion rates for Pacific consumers is unreliable, as the small numbers can influence variation between years. However, against a declining trend in seclusion hours and events, rates have risen consecutively over the last three years for Pacific consumers, from significantly below average rates of seclusion to slightly above average. This is a trend that requires further exploration and monitoring.

Cultural alienation and contrasting world views affect consumers' experiences of mental health and addiction services, and the ability to improve outcomes.¹⁶² Le Va has a strong focus on improving the number of Pacific peoples in the mental health and addiction workforce, and improving cultural awareness across the whole workforce, to improve consumer engagement and outcomes. The Pacific workforce makes up 5% of the workforce.¹⁶³

Infants, children, and young people

Investing in prevention and early intervention has strong returns

Early events and experiences, both positive and negative, have a major impact on a person's future health.¹⁶⁴ Many mental health and/or addiction problems that become apparent in adulthood have origins in childhood, with 50% becoming apparent by the age of 18 years.¹⁶⁵

In 2016/17, 5% of children aged 2–14 years were estimated to have emotional and/or behavioural problems.¹⁶⁶ Depression usually starts in adolescence, with a steep rise between ages 15 to 18 years, from 5% to 17%.¹⁶⁷ Depression in young people is the leading risk factor for suicide, and New Zealand has the highest youth suicide rate in the OECD, with suicide accounting for 35% of deaths for the 15–19-year-old age group.¹⁶⁸

Evidence suggests that early intervention to address problems arising in the 0–4-year-old group is more cost-effective than later intervention, and is effective in preventing mental health and/or addiction problems in the long term.¹⁶⁹ Exposure to adverse childhood experiences has a strong relationship to poor outcomes in early adulthood, including mental health and substance use issues. Prolonged exposure to adversity and trauma can affect the development of the brain and the foundations for good mental health. If these issues remain unidentified and unaddressed they can increase in severity.

162 Faleafa, M and Pulotu-Endeman, FK, 2017, at note 11.

163 *Ibid*; Te Pou o te Whakaaro Nui, 2015, at note 37.

164 Gluckman, P *et al.*, 2017, at note 30. See also Gluckman, P and Haine H, *Improving the Transition: reducing social and psychological morbidity during adolescence*. Auckland: Office of the Prime Minister's Science Advisory Committee; 2011: <http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf> (accessed 15 April 2017).

165 Oakley Browne, MA *et al.*, 2006, at note 1; Gluckman, P *et al.*, 2017, at note 30.

166 Ministry of Health, *New Zealand Health Survey 2016/17 Update of key results*. Wellington: Ministry of Health; 2017: <https://www.health.govt.nz/publication/annual-update-key-results-2016-17-new-zealand-health-survey> (accessed 19 December 2017).

167 Merry, S and Stasiak, K, "Depression in young people". In Gluckman, P, *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. Auckland: Office of the Prime Minister's Science Advisory Committee; 2011: Chapter 15.

168 *Ibid*.

169 Knudsen, EI, Heckman, JJ, Cameron, JL, and Shonkoff, JP, "Economic, neurobiological, and behavioral perspectives on building America's future workforce". *Proceedings of the National Academy of Sciences of the United States of America*. 2006; 103: 10155–10162; Olds, DL and Kitzman, H, "Review of the research on home visiting for pregnant women and parents of young children". *The Future of Children* 1993; 3(3): 53–92; Wouldes, T, Merry, S, and Guy, D, "Social and emotional competence: intervening in infancy". In Gluckman, P, 2011, at note 167.

While prevention activity is outside of the scope of this report, I am pleased that it is a focus of the Inquiry. Investing in prevention and early intervention is compassionate, and brings a strong lifetime return.¹⁷⁰ Continued investment in prevention across government and at grass roots level is necessary to reduce trauma-related mental illness and/or addiction, and build resilience across the population to cope with life's stresses.

The transition to adulthood is also recognised as a risky time for young people, reflected in a higher access target to mental health and addiction services for this group.

Access rates to services for infants, children, and adolescents are increasing

In 2016/17, the access rate for infant, child, and adolescent mental health and alcohol and other drug services was 3.9%, above the 3% target for the 0–19-year-old population group, and has been increasing at a faster rate than the adult population. The 15–19-year-old age group has a higher target of 5.5%, which was also exceeded. Access rates are also increasing for Māori, Pacific, and Asian young people, but continue to remain below the rates recommended for the needs of these populations.¹⁷¹

Primary care services for infants and children are generally available at no cost. Midwives and Well Child Tamariki Ora nurses screen carers and their children for potential mental health and/or addiction needs and refer consumers to support when required. Additionally, most general practices provide free health care until a child turns 13 years old. As with the adult population, extended GP consultations and talk-therapy sessions — known as primary mental health services — are also available to young people. In 2015/16, 15,800 young people aged 12–19 years accessed primary mental health services.

The current Government has committed to further reducing barriers to primary care for young people aged 13 years and over, including reduced GP fees and increased investment in mental health services in schools, on the basis that there is strong evidence to support them. Students will be able to go to a health professional in their school, and either have all their needs met on site, or be referred to youth health services, child and youth mental health services, or their own doctor. The school-based services will be provided by nurses, with GP back-up.

Funding for infant, child, and adolescent mental health and alcohol and drug services has also been increasing. Between 2012 and 2014, funding for these services increased by 14%, and increased a further 7% between 2014 and 2016.¹⁷² Much of the new funding has been allocated to specific projects, rather than existing services, including:

- The Youth Mental Health Project — this project, consisting of 26 initiatives across government agencies, was established in 2012 to address concerns about mental health vulnerability in young people.
- Perinatal (the period immediately before and after birth) and infant mental health services — additional funding of \$18.2 million has been allocated to address the needs of pregnant women and new mothers who are acutely unwell, and their infants. The objective of the funding is to increase timely access to effective acute treatment options that ensure a speedy return to wellness for mothers in the perinatal period, and protect and preserve the mother–infant relationship, averting future negative health and social outcomes for infants that result from disruption to the mother–infant relationship.
- Youth forensic services — the capacity of these services has been increased with 40 new FTE positions being filled in regional youth forensic community services in recent years. In addition, the national youth forensic mental health inpatient unit Nga Taiohi was opened at Kenepuru Hospital in Porirua in April 2016.

170 Gluckman, P *et al.*, 2017, at note 30; Gluckman, P *et al.*, 2011, at note 167.

171 Werry Workforce-Whāraurau, 2017, at note 34.

172 Werry Workforce-Whāraurau, 2017, at note 34; The Werry Workforce, 2014 *Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: The Werry Workforce for Child and Adolescent Mental Health Workforce Development, The University of Auckland; 2015: <http://www.werryworkforce.org/professionals/publications-and-resources/2014-stocktake-infant-child-and-adolescent-mental-health> (accessed 15 August 2017).

More can be done to strengthen services for young people

Pressure on mental health and addiction services and difficulties in accessing help, as outlined in Question 1 of this report, includes infant, child, and adolescent services. Information collected as part of the Werry Workforce Whāraurau 2016 stocktake indicates that many infant, child, and adolescent services are experiencing significant workforce stress.¹⁷³ Vacancy rates for these services are increasing — from 6% to 8% between 2014 and 2016 — and retention is an issue, with an annual turnover of 16%, mainly for clinicians.¹⁷⁴

Young people aged 0–19 years experience longer wait times than all other age groups for mental health and addiction services. The government target to be seen for a first appointment within three weeks is 80%, but fewer than 70% in the 0–19 age group are being seen in that time. The other age groups have been at 78% for several years. The small number of DHBs that meet the youth transition plan target is also concerning. In conversations with the sector, I have been told that many young people who leave services just stop coming, and there is no discharge plan.

I am also concerned about reports of variation in access criteria to infant, child, and adolescent mental health and alcohol and other drug services, including over-reliance on a diagnosis as a requirement for receiving help. Many diagnoses, while having their origin in childhood, are not apparent until people near adulthood.

Overly restrictive criteria for acceptance into services will mean that many young people will miss out on early intervention. Distinctions between behavioural and mental health needs, in particular, are often artificial. The Children’s Commissioner monitors the policies and practices of Oranga Tamariki — Ministry for Children (previously CYF) and seeks feedback from children and young people about their experiences in the system. The Commissioner has observed that many of the behaviours young people in contact with Oranga Tamariki exhibit are driven by a young person’s inability to regulate their emotions, and are often the result of unresolved trauma the person experienced earlier in life. This can undermine the ability of Oranga Tamariki to find placements for children.

Shortages in child and adolescent inpatient facilities and suitable alternative options (such as foster placement) have seen mentally unwell children being admitted into adult inpatient units more than 1,300 times from 2012 to 2016.¹⁷⁵ The United Nations Convention on the Rights of the Child and Ministry of Health guidelines state that children deprived of their liberty — including mental health consumers — should be treated alongside adults only as a last resort and for the shortest period possible, because detainment in an adult facility could be detrimental to their well-being.

Regions with little access to child mental health beds have some of the highest rates of admission of children to adult facilities — of the 48 adolescent inpatient beds in New Zealand’s public health system, 41 are in main centres. High numbers in the regions also reflects a weighing up by these services of the interests of the child in staying close to their family versus being in an adult unit. Addressing these challenges calls for innovative solutions across health providers and Oranga Tamariki, as the numbers of children needing intensive mental health support are low and fluctuate. I will be monitoring progress to address the needs of infants, children, and youth to ensure that the desired improvements are happening.

173 Werry Workforce-Whāraurau, 2017, at note 34.

174 *Ibid.*

175 http://www.nzherald.co.nz/health/news/article.cfm?c_id=204&objectid=11944708, based on 18 OIA requests to the Ministry of Health (accessed 12 January 2018).

Services need to be centred on young people and their family/whānau

Earlier sections emphasise the need for services to focus on what matters to the consumer, involve consumers in managing their care, and involve their family/whānau where appropriate, particularly where the family/whānau is responsible for the care of a child or young person. The young people in the HDC's consumer and family/whānau feedback sessions spoke of the benefits gained when their parents were involved appropriately, as well as the support they wished they had from services in relation to their parents.

“My parents sit in on sessions with my psychologist which helps them to understand my mental health better and also provides a backup for storing the information the psychologist provides. The stigma that my parents had attached to my mental health differences has now disappeared, partly as a result of this and the amount of knowledge obtained from other sources, including myself.”

(Youth consumer feedback session)

“Should be more support for families to be a support — and how to manage anger, frustration so we can as a family move forward.”

(Youth consumer feedback session)

“When I was receiving help, my parents were much more active in asking for support. So all their attention went on them not me. The workers seemed to think that would be the best way to help me but never checking with me as to whether this was helpful.”

(Youth consumer feedback session)

“There is a gap between parent and child — need strategies to understand each other and have conversations.”

(Youth consumer feedback session)

The young people in the HDC's feedback sessions also identified a number of areas where services operated with a different (“adult”) culture to themselves, which could sometimes make services difficult to deal with. They noted that young people don't talk about mental illness and diagnosis, they talk about how they feel, and services pathologise these feelings. They considered that marketing of what help is available needs to improve, especially what is available via the internet.

Youth consumers also talked about the value of youth peer support — having someone they could talk to outside of their friend group who knew their stuff, and considered that it wasn't always helpful for clinicians to be talking to them about self-care when they have “nice shoes” and a secure, well-paid job. Some consumers also talked about how it can be difficult to speak up, especially if it is not part of their culture to do so, and it is important that services are aware of and responsive to this. This is especially so for young Pacific people who may be speaking up against their parents (which may be considered “shameful”).

Access to mental health and alcohol and other drug services for children and young people in state care needs to be improved

In his annual State of Care reports, the Children's Commissioner has found good levels of access to nurses and visiting GPs for children in care and protection residences, but high variability in access to mental health and addiction services.¹⁷⁶

In many places, access to mental health and alcohol and drug services for children in care was dependent on local relationships between Oranga Tamariki — Ministry for Children sites or secure residences and child and adolescent mental health services. I agree with the Children's Commissioner that variable access for these children and young people is a significant area of concern because of the over-representation of serious and complex mental health problems, including issues of suicidality and self-harm in this population.¹⁷⁷

176 Office of the Children's Commissioner, *The State of Care 2017*. Wellington: Office of the Children's Commissioner; 2017: 32; Office of the Children's Commissioner, *The State of Care 2016*. Wellington: Office of the Children's Commissioner; 2016: 30.

177 *Ibid.*

Conversely, the Children's Commissioner has found that children and young people in youth justice residences have reasonably good access to mental health and alcohol and other drug services through regional youth forensic services.¹⁷⁸ While this is positive, young people often stay only short durations in these residences, and maintaining continuity of care with DHB services is often a challenge. I have also heard reports of variability in levels of effectiveness of advocacy for children and young people in the criminal justice system to access alcohol and other drug treatment programmes as an alternative to a youth justice residence.

The prison population

The prison population has the highest mental health and addiction needs of any population group

People in prison have the highest prevalence of mental health and addiction issues of any part of our population. Nine out of ten people in prison (91%) have a lifetime diagnosis of a mental health or substance use disorder. The 12-month prevalence (62%) is three times that found in the general population.¹⁷⁹

Substance use disorders are 13 times that of the general population, and one in five people in prison had both a mental disorder and a substance use disorder within the last 12 months.¹⁸⁰

The presentation of more serious conditions is also more prevalent among people in prison, including conditions such as post-traumatic stress disorder and bipolar disorder associated with high levels of distress and disability, especially in acute phases.¹⁸¹ Levels of distress can be affected by the contained environment of the prison.

People in prison access services across a spectrum of need

Every person in prison is entitled to the same health care as they would receive in the community.¹⁸² For the three out of five people in prison who will have a mental illness and/or addiction in any one year, this means access that reflects the stepped care model for mental health and addiction services.

Mild to moderate mental health and addiction needs are the responsibility of Corrections' health services, and include medication, one-to-one or group therapy, alcohol and other drug programmes, drug treatment units, and health education. People in prison with moderate to severe mental health needs are referred to forensic mental health services for assessment and treatment. This is generally managed within the prison environment, but individuals may also be admitted to secure inpatient forensic facilities if they require a high level of monitoring and care.

Additionally, "at-risk" units within prisons house people with increased risk of self-harm to protect their mental or physical health. The largest proportion of stays in an at-risk unit are for one day, as a result of prisoners newly coming into custody, or when staff are concerned about a prisoner's safety and well-being.

178 Office of the Children's Commissioner, 2017, at note 176.

179 Indig, D, *et al.*, 2016, at note 13.

180 *Ibid.*

181 Human Rights Commission, *Report Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention Against Torture 2016*. Wellington: Human Rights Commission; 2016.

182 The rights of people in prison are protected by the Human Rights Act 1993, the NZ Bill of Rights Act 1990, and the Crimes of Torture Act 1989, as well as by the Mental Health (Compulsory Assessment and Treatment Act) 1992, and by a number of United Nations conventions, including OPCAT. Section 75 of the Corrections Act 2004 provides that a prisoner is entitled to receive reasonably necessary medical treatment, of a standard reasonably equivalent to the standard of health care available to the public.

Some people in prison are not receiving the care and treatment they need, but this is improving

There is some evidence that, like the population generally, there is a level of unmet need for people in prison. A 2016 study found that less than half (46%) of people in prison with a mental health and/or addiction diagnosis in the past 12 months received treatment during that time (whether in the community prior to sentencing or in prison).¹⁸³

The Ombudsman monitors the treatment of people detained by the State in New Zealand prisons under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT puts international obligations on New Zealand to ensure that people held in detention are treated humanely and with decency and dignity. The Ombudsman in its monitoring in relation to OPCAT has also found that prison facilities are often insufficiently responsive to the mental health and addiction needs of people in prison, and that service provision is variable from prison to prison.¹⁸⁴ The Ombudsman also found that forensic specialists are stretched across a complex and diverse range of mental health and addiction need, and they are not able to fully exercise their expertise, considerably diluting this resource.¹⁸⁵ Gaps in service provision between Corrections and regional forensic psychiatric services were also evident, particularly for people exhibiting a personality disorder.¹⁸⁶ Forensic bed numbers have not increased in line with increased prison numbers, limiting their availability.

The Department of Corrections is undertaking action to address these issues. \$11.6 million is being invested over the next four years to develop a new prison-wide model of care to better meet the mental health and addiction needs of people in prison. The model of care will initially be piloted in three prison sites. Corrections staff will receive extra training and support to further develop their skills in managing people in prison with mental health and addiction needs. This initiative is in addition to Corrections' Investing in Better Mental Health for Offenders strategy, which includes a \$13.8 million investment to pilot mental health services to better address the mental health needs of people based in the community.¹⁸⁷

In 2016/17, Corrections spent nearly \$16 million to address substance use and dependency issues. Services range from low intensity (alcohol and other drug (AOD) brief and intermediate programmes) to medium and high intensity (intensive treatment programmes and drug treatment programmes available to prisoners, and residential AOD treatment and intensive outpatient AOD programmes available to community-based offenders). Corrections also focuses on providing aftercare support for people in the community — this includes 0800 support lines and programmes, and methamphetamine screening.

In addition, a \$300 million redevelopment of Auckland Prison's maximum security facility is due to open this year. A key component of this redevelopment is to better support people's mental health needs. Maximum security facilities often house high numbers of people with serious mental health and/or complex behavioural issues. Where possible, people with mild to moderate mental health needs will be managed in standard accommodation and supported by health staff on the unit. For those with a higher level of need, a multidisciplinary team will provide timely, on-site support, in a purpose-built therapeutic environment.

183 Indig, D, *et al.*, 2016, at note 13.

184 Human Rights Commission, *2015/16 Monitoring Places of Detention*. Wellington: New Zealand Human Rights Commission; 2017. Note that these reports have been made annually from 2008.

185 Office of the Ombudsman, *Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prison Health Services*. Wellington: Office of the Ombudsman; 2012.

186 Human Rights Commission, 2017, at note 184.

187 Department of Corrections, *Change Lives Shape Futures: Investing in better mental health for offenders*, Wellington: Department of Corrections; 2017: http://www.corrections.govt.nz/resources/strategic_reports/investing_in_better_mental_health_for_offenders.html (accessed 22 December 2017).

The aim is to assess and intervene early before behaviour escalates (or deteriorates), and reduce the demand for more acute mental health services within prison and in secure forensic facilities.

As discussed in Question 2, a person's environmental context contributes to their well-being.

The Ombudsman's inspectors have reported that the prison environment has high instances of bullying and assault. This would contribute to and exacerbate mental unwellness. Corrections needs to address these behaviours alongside mental health and addiction assessment and treatment if it is to keep up with demand for services. I understand that Corrections is making progress to improve other aspects of the prison environment to improve well-being. This includes providing more things for people to do, introducing colour, and improving concrete-dominated outside spaces with plants and murals.

I will be monitoring progress, alongside the Ombudsman and the Human Rights Commission (which coordinates OPCAT monitoring across places of detention), to ensure that the desired improvements are happening and keep up with growing need. The number of people in prison has increased by 20% in the last two years,¹⁸⁸ and more growth is expected, which will put pressure on service delivery and living conditions within the prison environment. I also recommend that the Ministerial Inquiry hear from the Ombudsman in relation to its prison visits as part of the implementation of OPCAT.

At-risk units have failed to protect the rights of people in prison with increased risk of self-harm, but this too is improving

As noted above, separate facilities, called "at-risk units", have been set up within prisons to manage people in prison considered to be at an increased risk of self-harm, and to protect their mental or physical health. These units have been of concern to me and to other watchdog organisations for some time.¹⁸⁹ At-risk units allow for increased monitoring, but are not therapeutic in their design, and clinical staff are not available 24/7 to provide support where needed. People in prison with more serious mental health and addiction conditions should be accessing forensic care, rather than custodial containment without therapeutic support.

The Ombudsman has found that the pressure on forensic beds can lead to people in prison spending lengthy periods of time in at-risk units.¹⁹⁰ Some people in at-risk units had been waiting several months for forensic beds, with little to no therapeutic interaction.¹⁹¹ In addition, a number of practices within at-risk units are of concern, including the concerning use of tie-down beds as a form of mechanical restraint.¹⁹² In 2016, an international human rights expert, Dr Sharon Shalev, considered seclusion and restraint practices in New Zealand at the request of the Human Rights Commission. Dr Shalev's report, *Outside the Box?*, recommended that New Zealand eliminate the use of mechanical restraints altogether.¹⁹³

188 Department of Corrections, *Briefing to the Incoming Minister*. Wellington: Department of Corrections; 2017: http://www.corrections.govt.nz/resources/strategic_reports/briefing_to_the_incoming_minister/briefing_to_the_incoming_minister_december_2017.html (accessed 12 December 2017).

189 Office of the Ombudsman, *A Question of Restraint: Care and management for prisoners considered to be at risk of suicide and self-harm; observations and findings from OPCAT inspectors*. Wellington: Office of the Ombudsman; 2017; Human Rights Commission, 2017, at note 184.

190 Shalev, S, *Outside the Box? A review of seclusion and restraint practices in New Zealand*. Auckland: New Zealand Human Rights Commission; 2017: <http://www.seclusionandrestraint.co.nz/> (accessed 5 July 2017).

191 Human Rights Commission, 2017, at note 184.

192 Office of the Ombudsman, 2017, at note 189.

193 Shalev, S, 2017, at note 190.

The Department of Corrections has acknowledged in its Briefing to the Incoming Minister that policies and processes for at-risk units, including the use of tie-down beds, needed changing. The Department has reaffirmed that the use of tie-down beds is a measure of last resort, and has introduced other changes, including reducing the availability of tie-down beds to four prisons, and clarifying processes for the use of tie-down beds. It is introducing a new approach to managing its at-risk units, which it is re-naming “Intervention and Support” units, as part of its new prison-wide model of care.

This work involves more effective screening and assessment processes to identify people earlier in their pathway; treating more people earlier, so that they may not need removal to an at-risk unit; improving the care in those units by providing more specialist care delivered by multidisciplinary teams; allowing more time out of the cells; and improving the physical facilities, with the intention of making them more therapeutic.

I am advised that early progress has already been made, and the full package of changes will be implemented in three sites over the next six months. One area of focus has been individualised care planning. Staff are now being supported to make individualised and safe decisions about whether a person can wear his or her own clothes, can eat with cutlery, and can socialise with others in the unit. Staff are also being encouraged to find alternative ways to minimise negative impacts. For example, if a person is at risk of self-harming, he or she could have a staff member present while the person is eating, rather than having to eat without utensils.

I expect to see evidence of ongoing improvements through the Ombudsman’s monitoring of prisons.

Signs of progress

Using waka ama as a mechanism to deliver an impaired driver treatment programme

The Manaaki Ora Trust Tipu Ora Impaired Driver Treatment Programme in Lakes DHB is linked to waka ama, comparing the waka to a vehicle and its journey. Māori models of health and wellness are used as a basis for the programme, and whānau are encouraged to participate. Whether it is through shared kai or other group activities, participants openly share stories and experiences, and gain confidence through teamwork.

Strengths of services for rangatahi

In 2014, HDC, in partnership with Te Rau Matatini, reported on the strengths and challenges facing 21 services engaging with rangatahi (Māori children and young people). *Hikaka te Manawa: Making a Difference* found that key strengths of these services included those that were grounded in the community, a single, easy access point of entry, and a philosophy based on Māori values. Service strengths also included whānau engagement on their own terms, committed, compassionate, and well supported staff and inclusive practices for working with rangatahi and their whānau on discharge, and relapse prevention planning.

The services shared common challenges, including a lack of support for rangatahi with conduct disorders; complex, inflexible funding models and contracts; difficulties collaborating with other services; difficulties in recruiting the right staff; and logistical and economic factors that impeded engagement by whānau.

Pasifika cultural competency programme

Le Va is leading a number of Pacific workforce development initiatives:

- The *Engaging Pasifika* cultural competency programme was completed by over 3,500 health workers between 2010 and 2015. The programme is supported by cultural competency guidelines for organisations.
- *Futures that Work* supports and guides Pacific peoples working in mental health and addiction services. It includes scholarships, pastoral care, coaching, and mentoring.
- *Le Tautua* aims to equip emerging leaders with knowledge, skills, and resources to support their leadership. The programme is based on the contemporary execution of traditional values and knowledge in practice.

Youth Mental Health Project

Evaluations of the Youth Mental Health Project show a return on investment, with more young people receiving services and receiving them earlier (Social Policy Evaluation and Research Unit, 2017). Initiatives include:

- SPARX, a self-help e-therapy tool specifically designed for adolescents experiencing mild to moderate depression. The tool showed effectiveness in encouraging positive changes in mental health among those who complete sufficient modules. In the year to 30 September 2017, there were 21,227 visits to the e-therapy page. A telephone line, staffed by counsellors, provides clinical support. The website, which also has a mood quiz to help young people to identify depression, and information on where to get help, had 29,801 unique visits between September 2016 and September 2017. The tool is available at www.sparx.org.nz.
- Youth One Stop Shops, offering general health care as well as social services and youth mental health services on site, e.g., psychiatric registrars visiting from hospitals, short-term drug and alcohol counselling, mental health packages of care. There are a significant number of high needs, high service using

young people who do not attend schools. Youth One Stop Shops often see a large number of transient young people who have dropped out of school and are homeless or nearly so.

- Positive Behaviour for Learning — a whānau centred pilot aimed at improving resilience and well-being in low decile schools with high Māori and Pacific populations — showed improved school cultures and more inclusive school environments.

The Alcohol and Other Drug Treatment Court (AODTC) Pilot

The Alcohol and Other Drug Treatment Court (AODTC) Pilot is a cross-agency initiative working with Health, Justice, Police, and Corrections Departments. It is the first example in New Zealand of criminal justice agencies and the alcohol and other drugs treatment sectors working together on the treatment needs of offenders.

The Ministry funds the appointment of a Māori Cultural Advisor (Pou Oranga) for the AODTC, recognising the large number of Māori participants in the programme. The Pou Oranga plays a key role in weaving Māori cultural pathways within the AODTC services, supporting participants and their whānau, AODTC judges, team members, and court staff. The Pou Oranga's collaboration with kaupapa Māori agencies and each of the main marae within the AODTC rohe (region) has strengthened relationships between these key groups and the AODTC. This has benefited the Māori participants by offering additional support in their recovery.

The pilot currently runs in two district courts in Waitakere and Auckland Central. Evaluations in 2016 indicated that the initiative could deliver considerable benefits. As of May 2017, a total of 109 participants have graduated from the programme. Some participants have undergone treatment, transformed their lives, graduated, and gained employment. An extension of the pilot will enable its impact on behaviours such as re-offending and substance use to be evaluated longer term.

Appendix 1

**Major government
documents
since 1994**



- Ministry of Health, Mental Health and Addiction Workforce Action Plan 2017–2021. Wellington: Ministry of Health; 2017.
- Ministry of Health, *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*. Wellington: Ministry of Health; 2017.
- Ministry of Health, *The Mental Health Act and human rights: A discussion document*. Ministry of Health; 2016.
- Ministry of Health, *New Zealand Health Strategy: Future direction*. Wellington: Ministry of Health; 2016.
- Ministry of Health, *New Zealand Health Strategy: Roadmap of Actions*. Wellington: Ministry of Health; 2016.
- Ministry of Health, *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19*. Wellington: Ministry of Health; 2016.
- Ministry of Health, *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*. Wellington: Ministry of Health; 2016.
- Office for Disability Issues, *New Zealand Disability Strategy 2016–2026*. Wellington: Ministry of Social Development, 2016.
- Ministry of Health, *Supporting Parents, Healthy Children*. Wellington: Ministry of Health; 2015.
- Inter-Agency Committee on Drugs, *National Drug Policy 2015–2020*. Wellington: Ministry of Health; 2015.
- Ministry of Health and Health Promotion Agency, *Like Minds, Like Mine National Plan 2014–2019: Programme to Increase Social Inclusion and Reduce Stigma and Discrimination for People with Experience of Mental Illness*. Wellington: Ministry of Health; 2014.
- Ministry of Health and Le Va, *Taeao o Tautai: Pacific Public Health Workforce Development Implementation Plan 2012–2017*. Auckland: Le Va; 2013.
- World Health Organization, *Mental Health Action Plan 2013–2020*. Geneva: World Health Organization; 2013.
- Ministry of Health, *New Zealand Suicide Prevention Action Plan 2013–2016*. Wellington: Ministry of Health; 2013.
- Ministry of Health, *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health; 2012.
- Ministry of Health, *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health; 2012.
- Mental Health Commission, *Blueprint II: How things need to be*. Wellington: Mental Health Commission; 2012.
- Mental Health Commission, *Blueprint II: Making change happen*. Wellington: Mental Health Commission; 2012.
- Ministry of Health, *Youth Forensic Services Development: Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug and intellectual disability services for young people involved in New Zealand's justice system*. Wellington: Ministry of Health; 2011.
- Ministry of Health, *Service Delivery for People with Co-existing Mental Health and Addiction Problems — Integrated Solutions*. Wellington: Ministry of Health; 2010.
- Ministry of Health, *Mental Health and Addiction Action Plan*. Wellington: Ministry of Health; 2010.
- Ministry of Health, *Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11–2015/16*. Wellington: Ministry of Health; 2010.
- National Health Board, *Faiva Ora National Pasifika Disability Plan 2010–2013*. Wellington: Ministry of Health; 2010.
- Minister of Health and Minister of Pacific Island Affairs, *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014*. Wellington: Ministry of Health; 2010.
- Ministry of Health, *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework, 2008–2015*. Wellington: Ministry of Health; 2008.
- Ministry of Health, *He Tipu Harakeke: Recruitment of Māori in the Health and Disability Workforce*. Wellington: Ministry of Health; 2008.
- Ministry of Health, *He Rito Harakeke: Retention of Māori in the Health and Disability Workforce*. Wellington: Ministry of Health; 2008.
- Ministry of Health, *Let's get real: Real Skills for people working in mental health and addiction*. Wellington: Ministry of Health; 2008.

Ministerial Committee on Drug Policy, *National Drug Policy 2007–2012*. Wellington: Ministry of Health; 2007.

Ministry of Health, *Te Raukura: Mental Health and Alcohol and Other Drugs: Improving outcomes for children and youth*. Wellington: Ministry of Health; 2007.

Ministry of Social Development, *Inter-agency Plan for Conduct Disorder/Severe Antisocial Behaviour 2007–2012*. Wellington: Ministry of Social Development; 2007.

Ministry of Health, *Like Minds, Like Mine National Plan 2007–2013: Programme to Counter Stigma and Discrimination Associated with Mental Illness*. Wellington: Ministry of Health; 2007.

Ministry of Social Development, *The Social Report: Indicators of Social Wellbeing in New Zealand*. Wellington: Ministry of Social Development; 2006.

Ministry of Health, *New Zealand Suicide Prevention Strategy*. Wellington: Ministry of Health; 2006.

Oakley Browne M, Wells J, and Scott K, *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health; 2006.

Ministry of Health, *Review of the Application of Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health; 2006.

Minister of Health, *Te Kōkiri: Mental Health and Addiction Plan 2006–2015*. Wellington: Ministry of Health; 2006.

Mental Health Commission, *Reducing Discrimination against People with Experience of Mental Illness — Te Hekenga: Whakamana/Te Tāngata Whaiora Multi-Agency Plan 2005–2007*. Wellington: Mental Health Commission; 2005.

Minister of Health, *Te Tāhuhu — Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health; 2005.

Ministry of Health, *Tauawhitia te Wero — Embracing the Challenge: National mental health and addiction workforce development plan 2006–2009*. Wellington: Ministry of Health; 2005.

Ministry of Health, *Pacific Health and Disability Workforce Development Plan*. Wellington: Ministry of Health; 2004.

Ministry of Health, *Like Minds, Like Mine: National Plan 2003–2005*. Wellington: Ministry of Health; 2003.

Ministry of Health, *He Korowai Oranga, Māori Health Strategy*. Wellington: Ministry of Health; 2002.

Ministry of Health, *Te Puāwaitanga: Māori Mental Health National Strategic Framework*. Wellington: Ministry of Health; 2002.

Ministry of Health, *Building on Strengths: A Guide for Action. A new approach to promoting mental health in New Zealand/Aotearoa*. Wellington: Ministry of Health; 2002.

Ministry of Health, *A National Strategic Framework for Alcohol and Drug Services*. Wellington: Ministry of Health; 2001.

Ministry of Health, *The New Zealand Disability Strategy: Making a world of difference; Whakanui Oranga*. Wellington: Ministry of Health; 2001.

Mental Health Commission, *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission; 1998.

Ministry of Health, *New Futures: A Strategic Framework for Specialist Mental Health Services for Children and Young People in New Zealand*. Wellington: Ministry of Health; 1998.

Ministry of Health, *A National Drug Policy for New Zealand 1998–2003*. Wellington: Ministry of Health; 1998.

Ministry of Health, *Moving Forward: The National Mental Health Plan for More and Better Services*. Wellington: Ministry of Health; 1997.

Ministry of Health, *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (The Mason Report)*. Wellington: Ministry of Health; 1996.

Ministry of Health, *Strategic Directions for the Mental Health Services for Pacific Islands People*. Wellington: Ministry of Health; 1995.

Ministry of Health, *Looking Forward: Strategic directions for the mental health services*. Wellington: Ministry of Health; 1994.

Please note: While this list includes a number of major government reports and strategic documents it is not an exhaustive list.

Appendix 2

Methodology



The monitoring framework for this report consists of four information sources to answer six monitoring questions.

The four information sources are:

- HDC's complaints data;
- Selected service performance information;
- Consumer feedback; and
- Insights gained from HDC's sector engagement.

The six monitoring questions were designed to assess important aspects of the mental health and addictions system. They were developed in consultation with a range of people, including consumers, providers, and the Ministry of Health. The Mental Health Commissioner and his staff attended over 95 meetings over the course of 2016/17 with a wide range of stakeholders, including consumer groups and individuals, family/whānau members and groups, the Ministry of Health, the Health Quality & Safety Commission (HQSC), other government departments, independent Crown monitoring agencies, District Health Board staff, non-government organisations, workforce development organisations, and professional leadership forums.

The questions are based on HQSC's quality measures, which were in turn derived from New Zealand's Triple Aim (the simultaneous pursuit of improvement across three dimensions — the individual (improved quality, safety, and experience of care), population (improved health and equity for all populations), and system (best value for public health system resources)). The Triple Aim maps against the US Institute of Medicine's six quality dimensions (an internationally well-accepted framework).

The monitoring questions are:

1. Can I get help for my needs?
2. Am I helped to be well?
3. Am I a partner in my care?
4. Am I safe in services?
5. Do services work well together for me?
6. Do services work well for everyone?

A range of data was identified to monitor and answer these questions, but not all was suitable for inclusion as annual progress measures. Selection criteria for a dataset to monitor progress in each identified domain were that the data must:

- Capture the continuum of care, including transition points, from the perspective of consumers;
- Provide insight into service performance, stress points, and areas for improvement;
- Be able to be cross-checked and compared with other information;
- Be easily obtained and able to be monitored over time; and
- Be easily interpreted and communicated.

Data that met the criteria and could be used as indicators of progress in each domain was then considered. It was obvious early on that the data set was not complete, but that there was sufficient data to use as an adequate first set that could be improved on over time. Any gaps in data could be highlighted as an area to monitor for future development. It was also clear that the data alone could not provide a full answer to the six questions posed, but that in combination with the other sources of information available to the Commissioner (complaints data, consumer feedback, and information from sector engagement) the data could usefully add to the picture.

Many data sets were available to highlight aspects of system performance. While all could be used for the full context, a smaller number of data sets were identified for use as markers. The criteria for these marker indicators were that they were measurable, replicable, relevant, and defensible.

We tested our initial findings in a series of consumer and whānau workshops. These were held in an urban and a provincial centre. Three workshops were held in each location — one for adult consumers, a youth workshop for consumers aged 18–24 years, and one for family and whānau of consumers. Local family and consumer advisors in each location helped with local knowledge and contacts, and arranged for invitations to be sent. Advisors and kaumātua were present during the sessions to ensure participant safety. An HDC advisor attended to outline the report, its six consumer-focused questions, and listen to the views of consumers and whānau. Participants were assured of confidentiality and anonymity.

Over 60 people provided input across the two locations. Their views were invaluable, both in testing our thinking, and providing rich insights into the lived experiences of consumers.

The first draft of the full report, or sections of it, were sent to a small group of peer reviewers, and the report was refined based on their feedback.

**HDC
Complaints**

**Consumer
and whānau
feedback**

**Sector
engagement**

**System
and service
performance
information**

System overview

The big picture: Population needs, services and funding landscape, workforce, leadership and strategy

Services: Are we meeting the needs of consumers?

Assessed by answering:



**Can I get help
for my needs?**



**Am I helped
to be well?**



**Am I a partner
in my care?**



**Am I safe
in services?**



**Do services work well
together for me?**



**Do services work well
for everyone?**

Areas for improvement

Identifying successes and challenges, recommend system improvements

HEALTH QUALITY MEASURES – Safety – Patient experience – Effectiveness – Equity – Timeliness/Access – Efficiency



System

By the numbers: Annual system performance indicators, trends, and sources

Indicator		2016/17	2015/16	2014/15	2013/14	2012/13
Can I get help for my needs?						
How many New Zealanders access mental health and addiction services (% population)?		173,933 (3.7%)	170,980 (3.7%)	162,213 (3.5%)	158,597 (3.5%)	155,120 (3.5%)
<i>Source: Ministry of Health PRIMHD database (MOH),¹⁹⁴ extracted 30 January 2018, analysed by MOH.</i>						
How long do people wait for mental health and addiction services from first referral to being seen? (mental health DHB services/addiction services)?	48 hours	47/50%	47/51%	48/49%	48/46%	49/41%
	3 weeks (target 80%)	79/85%	79/84%	80/84%	79/81%	79/77%
	8 weeks (target 95%)	94/95%	94/95%	94/95%	93/94%	93/92%
<i>Source: MOH, supplied 2017 and 2018</i>						
What percent of complaints about mental health and addiction services are about access to those services?		15%	-	-	-	-
<i>Source: HDC¹⁹⁵</i>						
Am I helped to be well?						
What percent of consumers and their families report they would recommend their service to friends or family if they needed similar care or treatment?		80%	-	-	-	-
<i>Source: Mārama Real Time Feedback Consumer and Family Experience Survey (Mārama RTF)¹⁹⁶</i>						
Average improvement in clinician-rated scores for the mental health of adult consumers ¹⁹⁷ (admission/discharge)	(inpatient)	15/7	14/7	14/7	14/7	14/7
	(community)	11/5	11/5	11/5	11/5	11/5
<i>Source: MOH, extracted 4 October, analysed by Te Pou</i>						
Average improvement in clinician-rated scores for the mental health of child and youth consumers ¹⁹⁸ (admission/discharge)	(inpatient)	18/11	17/11	18/11	17/10	17/11
	(community)	14/8	14/7	14/7	14/7	14/7
<i>Source: MOH, extracted 4 October, analysed by Te Pou</i>						
<p>194 The <i>Programme for the Integration of Mental Health Data (PRIMHD)</i> database is a single collection of national mental health and addiction services information, administered by the Ministry of Health.</p> <p>195 Due to changes in coding for complaints about mental health and addiction services, data cannot be compared for previous years.</p> <p>196 HDC collects the voices of consumers and their families through Mārama Real Time Feedback mental health and addiction service consumer and family experience survey. The result reported is the average score over three years of data collection through to 30 June 2017. At that point in time, the tablet-based survey was used by 16 DHB providers and 11 NGOs and approximately 12,800 consumer and family voices had been collected.</p> <p>197 The measure used is the Health of the Nation Outcome Scale for adults (HONOS). Twelve items are used for HONOS, covering areas including mood, relationships, substance use, and housing. Each item is measured out of 4, with a score of 2 or more considered clinically significant. The maximum total score is 48 for adults. Mainly collected by DHB mental health services with very few collections in clinical NGO services. Generally rated over the last two weeks. A person could have more than one collection.</p> <p>198 The measure used are the Health of the Nation Outcome Scale for children and adolescents aged 4–17 years (HONOSCA), although a few collections outside of these age ranges may occur. Fifteen items are used for HONOSCA, covering areas including mood, relationships, substance use, and housing. Each item is measured out of 4, with a score of 2 or more considered clinically significant. The maximum total score is 60 for children and adolescents. Mainly collected by DHB mental health services with very few collections in clinical NGO services. Generally rated over the last two weeks. A person could have more than one collection.</p>						

Indicator	2016/17	2015/16	2014/15	2013/14	2012/13
Average self-rated increase in consumer satisfaction towards achieving recovery goals (addiction services) ¹⁹⁹ <i>Source: MOH, extracted 4 October 2017, analysed by Te Pou.</i>	24%	-	-	-	-
What percent of consumers have independent/ supported/no accommodation? ²⁰⁰ <i>Source: MOH (new collection — only one year of data)</i>	82/13/ 5%	-	-	-	-
What percent of consumers are in employment or in education or in training? ²⁰¹ <i>Source: MOH (new collection — only 1 year of data)</i>	45%	-	-	-	-
Am I a partner in my care?					
What percent of consumers and family and whānau report they feel involved in decisions about their care? <i>Source: Mārama RTF</i>	76%	-	-	-	-
What percent of complaints about mental health and addiction services include issues with communication? <i>Source: HDC</i>	55%	-	-	-	-
What percent of consumers and family and whānau report that their plan is reviewed regularly? <i>Source: MOH</i>	74%	-	-	-	-
How many DHBs (out of 20) meet the youth transition plan targets? (95%) ²⁰² <i>Source: Ministry of Health, Office of the Director of Mental Health Annual Reports (ODMH), note calendar year not financial year</i>	7	5	-	-	-
How many contacts involving family and whānau were made by services? <i>Source: MOH, PRIMHD, extracted 4 October 2017, analysed and formatted by Te Pou</i> ²⁰³	405,248	-	-	-	-
How many contacts were made by services to support family and whānau, including children? <i>Source: MOH, PRIMHD, extracted 4 October 2017, analysed and formatted by Te Pou</i> ²⁰⁴	12,258	-	-	-	-

199 The measure used is from the Alcohol and Drug Outcome Measure (ADOM). Collecting and reporting of ADOM has been mandatory since July 2015, although consumer use of ADOM is voluntary. ADOM includes only people seen in community Alcohol and Other Drug Services. The measures analysed are only for people with ADOM matched pairs of treatment start and treatment end, includes consumers aged 18 and over, and excludes ADOM collections with five or more missing items. The measure uses the date of end collection — start collection can be outside the period, but after 1 July 2015.

200 This data is available only for the year 2016/17 as the collection commenced only on 1 July 2016. Includes only consumers who have a supplementary consumer record.

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202 In 2014, the Ministry introduced a target that at least 95% of young people who have used mental health and addiction services have a transition (discharge) plan. Several DHBs do not report or provide a zero return.

203 Codes T32 “Contact with family/whānau, consumer not present” and T36 “Contact with family/whānau, tangata whaiora/consumer present” combined.

204 Codes T47 “Support for family/ whānau” and T49 “Support for Children of Parents with Mental Illness and Addictions” combined.

Indicator	2016/17	2015/16	2014/15	2013/14	2012/13
How many contacts were made to support consumers in their role as parents or caregivers? <i>Source: MOH, PRIMHD, extracted 4 October 2017, analysed and formatted by Te Pou²⁰⁵</i>	1882	-	-	-	-
On an average day, how many people were subject to a compulsory community treatment order under the Mental Health Act? <i>Source: ODMH, note calendar year not financial year</i>	4085	3970	3841	3569	-
Am I safe in services?					
What percent of complaints about mental health and addiction services were about inadequate or inappropriate care? <i>Source: HDC</i>	18%	-	-	-	-
How many serious adverse events (suspected suicide and serious self harm) happen in mental health and addiction services? <i>Source: Serious Adverse Event database, HQSC</i>	206	178	171	165	167
How many people in inpatient units were secluded?	802	754	736	768	882
How many times was seclusion used (some people have more than one period of seclusion)?	1483	1668	1804	1851	2259
What proportion of seclusion events last less than 24 hours? <i>Source: ODMH, note calendar year</i>	74%	72%	74%	74%	77%
Do services work well together for me?					
What percent of consumers and family and whānau report that the people they see communicate with each other when they need them to? <i>Source: Mārama RTF</i>	81%	-	-	-	-
What percent of complaints were about coordination of care between different service providers? <i>Source: HDC</i>	13%	-	-	-	-
Average length of stay in an inpatient unit	17 days	18 days	18 days	18 days	-
How many people were followed up within 7 days of leaving hospital?	65%	66%	66%	67%	-
How many people went back into hospital within 28 days of being discharged? <i>Source: KPI Programme Interactive Report²⁰⁶</i>	15%	16%	17%	16%	-
Do services work well for everyone?					
HDC was supplied data from PRIMHD broken down by age, service type (AOD/Mental Health/NGO/DHB), and for Māori. Additionally, some of the ODMH reporting includes relevant breakdowns. They contributed to the analysis undertaken for this monitoring question.					

205 Code T50 "Support for Parents with Mental Illness and Addictions". Note this code has been collected only since 1 July 2016. This code is not embedded into services. It will take a while for people to know this code is available and to use it properly. Only 13 DHBs and 23 NGOs are collecting this code so far.

206 The KPI Programme Interactive Report sources data from the MOH PRIMHD database. Issued date of the latest interactive report is 19 September 2017 for PRIMHD, data extracted 4 September 2017. It includes activities up to 30 June 2017 and any historical change or resubmission to PRIMHD up to 1 September 2017.

Appendix 3

**Where to find help
and support**



In an emergency

If it is an emergency and you feel that you or someone else is at risk:

- Call 111 or
- Go to your nearest hospital emergency department (ED) or
- Call your local DHB Mental Health Crisis Team (CATT) 0800 611 116 and stay until help arrives.

If someone is unconscious, call an ambulance (111).

Helplines and e-support

If you need to talk to someone, you can free call or text any of these services at any time:

- **Need to talk?** 1737 or text 1737 for support from a trained counsellor
- **The Depression Helpline:** 0800 111 757 or free text 4202
- **Healthline:** 0800 611 116
- **Lifeline:** 0800 543 354
- **Samaritans:** 0800 726 666
- **Youthline:** 0800 376 633 or free text 234 (8am–12am), or email talk@youthline.co.nz
- **The Lowdown:** www.thelowdown.co.nz or free text 5626
- **Kidsline** (ages 5–18 years): 0800 543 754
- **OUTline NZ:** 0800 688 5463 for confidential telephone support for the LGBTQI+ family, as well as their friends and families
- **Alcohol Drug Helpline:** 0800 787 797 or free text 8681
- **Gambling Helpline:** 0800 654 655 or free text 8006

You can also access free online support resources and communities:

- **depression.org:** how to recognise depression, find a way through, and stay well; includes e-therapy tool The Journal
- **SPARX.org.nz:** online e-therapy tool for youth
- **auntydee.co.nz:** online tool for anyone who needs some help working through a problem or problems
- **Mentalhealth.org.nz:** advice if you or someone you know are depressed, anxious, or stressed
- **whaioraonline.org.nz:** online community focusing on service user's experience transitioning from treatment to supported independence to independence
- **alcoholdrughelp.org.nz** and **drughelp.org.nz:** information and help for people assessing their relationship with alcohol and other drugs and deciding whether it is time for change
- **livingsober.org.nz:** online community for people wishing to “free themselves from the clutches of alcohol”



Accessing mental health and addiction services

If you feel unwell, or want help for a mental health or addiction need, your best starting point is usually your GP (family doctor). GPs are trained to assess, treat, and manage many mental health issues. Your GP can refer you to your local community mental health or addiction service or elsewhere if needed, or your GP may be able to help you to manage your illness.



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