Aotearoa New Zealand's mental health services and addiction services

The monitoring and advocacy report of the Mental Health Commissioner

1 in 5

New Zealanders live with
mental illness and/or addiction

Contents

Overview
of findings

In my monitoring role as Mental Health Commissioner, I have found that since 2018 significant progress has been made to increase the focus on wellbeing, and to broaden support for people with mild to moderate mental distress and/or addiction need. But there is much more to be done. There is a pressing need to improve support for people with complex and enduring needs, including connections to wider social supports, to partner with Māori, tāngata whaiora and their whānau, and to engage people and communities in transformational system change.

There is significant hope for transformational system change

The hope set by *He Ara Oranga,* the report of the Independent Inquiry into Mental Health and Addiction, is nothing short of transformative. The challenge laid was for a new system with "mental health and wellbeing for all at its heart: where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience, tools and support they need to regain their wellbeing".

The Government is making a promising start

The Government's initial response is an important start — accepting or accepting in principle 38 out of 40 of *He Ara Oranga's* recommendations, and investing substantially in wellbeing through Budget 2019. Of particular note for services was a $455 million investment in primary and community care over four years to reach a further 325,000 New Zealanders experiencing mental distress and/or addiction, and the expansion of digital supports. The Ministry of Health has built its mental health and addiction sector leadership team considerably since 2019, and the Government has legislated for a Mental Health and Wellbeing Commission to contribute to better and equitable mental health and wellbeing outcomes for people in New Zealand.

The wellbeing response to the COVID-19 pandemic is also showing promise as a way forward for greater collaboration and promotion of collective action. These innovations and ways of working need to be captured, rapidly assessed and developed, and where effective, built into a new normal.

More is required to gain traction

The models of support for tāngata whaiora and their whānau within health and disability services need to be broader and joined-up within the health and disability sector, within communities, and across Government. This is as important for specialist mental health services and addiction services as it is for primary care and other health and disability services.

The scale of transformational change required by the *He Ara Oranga* agenda, however, will not happen by itself. Transformation from a service to a wellbeing oriented system requires an all-of-government, all-of-community response. This includes a shared agenda, strong collaborative leadership, partnership with Māori, tāngata whaiora and their whānau and other sector and community leaders, as well as ongoing and structured support to enable collective action. It will take time and ongoing investment.

In this report I provide areas for Government to consider in order for the transformation to succeed in these early days, as well as to improve mental health services and addiction services.

All-of-government, all-of-community plan to drive change needed

To drive transformational change, an all-of-government, all-of-community plan is needed. There needs to be clear ownership of the plan within Government, and partnership with communities, to bring the collective response to life. I acknowledge *Kia Kaha, Kia māia, Kia Ora Aotearoa*, the COVID-19 psychosocial plan, which provides a helpful starting point.

Plan for the health and disability sector also needed

The health and disability sector would also benefit from a service-level action plan that is grounded in evidence and lived experiences; a pathway to connect services and better meet the needs of tāngata whaiora and their whānau. This is an opportunity for the health and disability sector to map out what it needs to achieve and the "how" and "when", so that funding decisions can be targeted, and the wellbeing workforce developed.

While progress is being made in primary and community care, change is required across the health and disability system, including greater integration with specialist mental health services and addiction services and across other areas of health, including crisis and physical health care. More of the same will not deliver the wellbeing and recovery-oriented system that is required. Attention needs to be directed towards specialist mental health services and addiction services, which are under pressure, and need the space, support, and alliances, including partnership of Māori, tāngata whaiora, and whānau to think through these changes in order to make them happen.

As part of a health and disability sector plan, the evidence base for assessing mental distress and/or addiction need and modelling and responding to workforce requirements urgently needs to be expanded, updated, and maintained. Continued focus is also required to establish and deliver at scale what works in services for a diversity and complexity of need, and to strengthen health promotion and prevention.

Ongoing support and oversight required to gain and sustain traction

Ongoing support through dedicated resource to implement the all-of-government, all-of-community plan, and the health and disability sector contribution is required at all levels, including to:

- Enable Māori and communities to lead their own solutions;
- Share knowledge, best practice and learning across district health boards (DHBs), non-government organisations (NGOs), and social services;
- Encourage Government departments to share analyses, advice, and funding and delivery mechanisms; and
- Facilitate joint Ministerial decision-making.

Monitoring and oversight by the new Mental Health and Wellbeing Commission will be essential to track and advise on progress and ensure that collective action is improving wellbeing outcomes for New Zealanders.

Continuing areas of concern must be addressed

Many of the issues and concerns I identify in this report are stubbornly similar to those raised in my 2018 report, and reported in my 2019 indicator update, despite a range of programmes in place to address these matters. This reinforces the need for a health and disability sector plan to improve its response to mental distress and/or addiction need. Areas requiring ongoing attention and quality improvement include:

- Addressing equity of physical health, employment, and housing status for people with mental distress and/or addiction;
- Ensuring all tāngata whaiora have wellness plans and receive timely follow-up on discharge from a mental health inpatient unit or from compulsory treatment under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 into the community;

- Addressing Aotearoa New Zealand's high rates of compulsion under the Mental Health Act and rising national seclusion numbers, especially for Māori. I note that there is, however, a good evidence base for effective interventions and localised examples of successful reduction and elimination of seclusion;

- Ensuring that all services work for Māori and are culturally safe, and strengthening Māori participation and leadership in the design and delivery of services to improve outcomes and better reflect commitments under Te Tiriti o Waitangi;

- Significantly improving maternal mental health services as an integral component of the Child Wellbeing Strategy;

- Ensuring that the distinct needs of people who are experiencing harm from their substance use is not lost within a broader focus on wellbeing, and that the stigma surrounding addiction is specifically addressed to encourage help-seeking and celebrate and support recovery; and

- Addressing forensic services capacity, and developing and implementing strategies to improve forensic services, including workforce development, models of care, and access to culturally appropriate services and step-down supports.

Progress is being made in a number of areas

Importantly, some of the areas requiring quality improvement I have identified above are included in the Health Quality & Safety Commission's Mental Health and Addiction Quality Improvement Programme, which is currently undergoing a mid-point evaluation. I have also identified a number of strengths and areas of progress in relation to mental health services and addiction services:
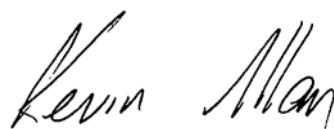
- People who use specialist mental health services and addiction services experience improvements in their mental health and wellbeing over the time of service use, and the majority would recommend their service to a friend or family member with a similar need.

- Rapid action to house people without a home and provide intensive mental health, addiction, and other support during the COVID-19 emergency pandemic response shows that homelessness can be ended where there is a

will. The integration of effective employment and mental health and addiction support will also become increasingly important as New Zealand enters into a period of recession and rising levels of joblessness following the COVID-19 pandemic emergency response.

- A focus on partnership and tāngata whaiora rights is strengthened in the Ministry of Health's proposed revisions to the Guidelines for the Mental Health (Compulsory Assessment and Treatment) Act 1992 and is signalled in the Government's commitment to repeal and replace the Mental Health Act 1992.

- Recently there has been some increase in the investment in kaupapa Māori services.

- Well-considered developments are underway by the Department of Corrections to better address the mental distress and/or addiction needs of people in prison.

Opportunity to provide global leadership in promoting wellbeing

Aotearoa New Zealand has a vital opportunity to shift from a service response to mental distress and/or addiction to a wellbeing system response, and, in doing so, provide global leadership in promoting wellbeing. In order to achieve this transformational shift, we need to be clear about what we are going to do, how we will do it and with whom, and how we will track our progress. In brief, there is an overriding need for ownership of an all-of-government, all-of-community, wellbeing agenda that delivers clarity of vision, execution, and accountability. We have shown that we can do this with our collective wellbeing response to the COVID-19 pandemic. Taking the lessons learnt from this approach to the pervasive mental health and addiction challenges our country faces can provide a way forward.

Kevin Allan
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Office of the Health and Disability Commissioner

Acknowledgements

This report, published by HDC, 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 services and addiction services.

Mental Health Commissioner's recommendations

I recommend that the Minister of Health:

1 Note this report on Aotearoa New Zealand's mental health services 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.

2 Note that the report is based on a monitoring framework developed with input from tāngata whaiora and whānau advisors, providers, and other sector leaders.

Opportunity to provide global leadership in promoting wellbeing

3 Note that the report identifies the opportunity for Aotearoa New Zealand to provide global leadership in promoting wellbeing by:

a. Partnering with people and communities in transformational change to promote wellbeing across communities, government services, and health and disability services; and

b. Honoring the principles of Te Tiriti o Waitangi by ensuring that models of care work for Māori, and enable Māori to lead solutions for Māori.

4 Note that while the COVID-19 pandemic and its emergency response has brought stress and hardship for many, and will do for some time, the collective health and social response to wellbeing has been strengthened, and provides a platform for ongoing change.

Good progress has been made towards a wellbeing approach to mental distress and/or addiction

5 Note that I commend:

a. The significant progress made by the Government since my 2018 report in increasing the focus on wellbeing and committing to implement the *He Ara Oranga* agenda.

b. Actions that are starting to be implemented to improve support for people with mild to moderate needs.

c. Completion of the suicide prevention strategy and the establishment of a Suicide Prevention Office to coordinate and support implementation of the strategy.

d. The urgent action taken to address pay issues in the NGO sector arising from pay equity settlements, to ensure that workforce capability was retained.

e. Progress by the Department of Corrections to develop mental health and addiction services since my last report.

f. Progress in establishing a Mental Health and Wellbeing Commission to strengthen independent monitoring and advocacy in relation to wellbeing, including mental health and addiction services.

g. Strengthening the Ministry of Health's stewardship and leadership of mental health and addiction service developments.

Action plan, by 31 December 2020, to implement the He Ara Oranga *agenda*

6 Work with Ministerial colleagues to:

a. Prepare an action plan, by 31 December 2020, for implementing the transformative *He Ara Oranga* agenda to improve wellbeing, including all-of-government, all-of-community and specific health and disability sector components.

b. Ensure that the plan has clarity of vision, execution, and accountability, including, as a priority, to identify which minister and Government agency will be responsible for leading the action plan and coordinating the collective effort required to implement it.

c. Develop governance arrangements for Māori, people with lived experience, providers, and other sector leaders to partner with Government in the co-creation and implementation of the action plan.

Action plan to include specific health and disability sector component

7 Direct the Ministry of Health to lead a health and disability sector plan of action to deliver transformative health and disability services that respond to mental distress and/or addiction need. This plan of action would sit within the all-of-government action plan recommended above. Attention should be given to:

a. Ensuring regular assessment of current and future population need across all age groups, including prevalence, help-seeking behaviour, and access to mental health and addiction services across the whole population;

b. The relative health and disability investment required in prevention, early intervention, primary and mental health and addiction services, alongside other sectors that contribute to wellbeing;

c. Funding models that will ensure flexibility to deliver across a continuum of care while continuing to protect mental health and addiction expenditure; and

d. Future workforce requirements — ensuring that we have a workforce equipped and supported to deliver services that best meet tāngata whaiora needs, now and in the future. We also need to build capability in our workforce to improve services continuously.

8 Develop governance arrangements for Māori, people with lived experience, DHBs, and other providers and sector leaders to partner with Government in the co-creation and implementation of the health sector action plan.

9 Ensure, as part of the plan, that there is particular focus on ensuring that mainstream services succeed for Māori, as well as enabling and strengthening kaupapa Māori services and other Māori-led responses.

10 Ensure that the plan responds to the distinct needs of people experiencing harm from their use of substances.

11 Amend the New Zealand Public Health and Disability Act 2000 to add a provision for an all-of-government New Zealand Mental Health and Wellbeing Strategy to stand alongside New Zealand's Health Strategy and Disability Strategy to ensure that there is an enduring commitment to promoting mental wellbeing beyond the initial plans detailed above to deliver the *He Ara Oranga* agenda.

Action to improve support for people with enduring and complex mental distress and/or addiction needs

12 Note that the *He Ara Oranga* agenda includes transformation of specialist mental health services and addiction services that support people with complex and enduring needs within a wellbeing system of support.

13 Support specialist mental health services and addiction services to revisit models of care to align with the *He Ara Oranga* agenda and connect with primary and other social services, including by facilitating a central or networked collection of best practice and research with easy access to information, training, support, and feedback.

14 Note my continued support of the Health Quality & Safety Commission's Mental Health and Addiction Services Quality Improvement Programme, which is supported by all DHBs. However, in relation to the zero seclusion goal, I note that important local improvements have not yet translated into nationally consistent progress. This remains an important area for collective effort to build on the gains that have been made.

15 Ensure 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 2021, on that information and actions taken to improve services as a result of the information.

16 Support the adoption of a zero tolerance approach to suicide 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.

Replace and repeal the Mental Health Act and report on prescriptions in mental health inpatient units

17 Progress the repeal and replacement of the Mental Health Act and provide more transparency about how this work will be undertaken and in what timeframe.

18 Make tangible progress to address New Zealand's high rates of compulsion under the Mental Health Act and, specifically, identify and address the factors leading to a disproportionately high use of compulsory treatment for Māori.

19 Direct Ministry of Health officials to record and, by 2021, report on prescriptions in mental health inpatient units.

Action to improve maternal mental health

20 Implement the following actions recommended by the Perinatal and Maternal Mortality Review Committee when developing a maternity whole-of-system action plan (which is part of the Government's Child Wellbeing Strategy):

a. a stocktake of current mental health services available across New Zealand for pregnant and recently pregnant women to identify both the strengths of services and gaps or inequity in current services and skills in the workforce

b. a national pathway for accessing maternal mental health services, including:

  i. cultural appropriateness to ensure service access and provision

  ii. appropriate screening

  iii. care for women with a history of mental illness

  iv. communication and coordination

  v. the need for a strategic approach to the planning of services, including the development of integrated care pathways within a stepped-care framework.

21 Ensure that substance-related and addiction issues and integration with infant services are considered as an integral component of the maternity action plan.

Action to address substance-related issues distinctly from mental health

22 Commit to and implement a public health programme aimed at promoting help-seeking, harm reduction, and de-stigmatisation for people who are experiencing harm from their use of substances. Ensure that the programme reflects current issues relating to self, social, and structural stigma, and stigma by association, and implements evidence-based strategies for mitigating these.

23 Ensure that specific measures are taken to increase the number of addiction-specific peer support workers and consumer advisors within the mental health and addiction sector, particularly in DHBs.

Forensic services

24 Note my concern that the prison population has climbed significantly (25% between 2013 and 2019) while forensic bed numbers have increased by 3% (eight beds) during a time when there has been an increase in the prevalence of serious mental illness among the prison population.

25 Note that all forensic mental health services are operating beyond capacity.

26 Ensure that urgent action is taken to develop and implement strategies to improve forensic services, including workforce development, improving models of care, and access to culturally appropriate services and step-down supports.

I recommend that the Mental Health and Wellbeing Commission take account of the findings and recommendations of this report in its work, and consider monitoring and reporting on implementation of the recommendations.

Introduction

This report provides an independent assessment of the state of mental health services and addiction services in Aotearoa New Zealand, and holds the Government to account for progress made in relation to those services, including where we are doing well, and where we need to improve.

Context

As Mental Health Commissioner, I am responsible for monitoring Aotearoa New Zealand's mental health services and addiction services and advocating for improvements to those services. In 2018, I released my first systematic assessment of the state of mental health services and addiction services using a monitoring framework developed with tāngata whaiora and family/whānau advisors, providers, and other sector leaders, and included eight recommendations to the Minister of Health for improvements to those services.

This report applies HDC's monitoring framework to the latest available evidence to assess the state of mental health services and addiction services and make new recommendations for improvement. I provide comment on the direction of change underway in response to *He Ara Oranga*, and make recommendations to strengthen the supports needed for successful transition to a wellbeing system of care. I also report back on the implementation of the eight recommendations I made to the Minister of Health in my 2018 monitoring and advocacy report.

My monitoring for this report includes engagement, research, and analysis up until the time of publication; however, the monitoring indicator set used is to 2018 and 2018/19 depending on availability. The Initial Mental Health and Wellbeing Commission, set up by the Government as part of its response to *He Ara Oranga,* includes in its terms of reference a requirement to report in detail on Government response to *He Ara Oranga* in November 2020. In June this year, the Initial Commission will also provide a targeted interim report focusing on progress of the four following *He Ara Oranga* priorities:

- Establishing a Mental Health and Wellbeing Commission

- Publishing the Suicide Prevention Strategy and establishing the Suicide Prevention Office

- Repealing and reforming the Mental Health Act

- Expanding access and increasing choice.

- The Initial Commission's reporting will complement my report.

This will be my last report on the state of services as Mental Health Commissioner before the permanent Mental Health and Wellbeing Commission takes on HDC's monitoring and advocacy role within a broader wellbeing mandate. The Health and Disability Commissioner will continue to make decisions in relation to complaints about mental health and addiction services, and to assess and respond to systemic issues that arise through complaints.

Outline of report

My main findings, commendations, and recommendations for service improvement are set out at the front of this report. The body of the report is set out in two parts.

1. Part 1 outlines the wellbeing agenda set by *He Ara Oranga* and assesses and makes recommendations for strategic settings and drivers to enable transformational change over the longer term.

2. Part 2 begins with a snapshot of mental distress and/or addiction need and the health services and health workforce that responds to those needs. It then assesses, through the application of HDC's monitoring framework, how well services are meeting the needs of tāngata whaiora. This assessment includes a focus on responsiveness to Māori, maternal mental health, alcohol and other drug treatment services, and people in prison.

Throughout the report I discuss what needs to happen to improve the quality of mental health services and addiction services and support their transformation into a wellbeing system of support. I report on Government responses to the recommendations in my 2018 report, and make new recommendations for system improvement, noting both the successes of the system and services and the challenges they face. The recommendations I made in my 2018 report and commentary on achievement of these recommendations can be found in *Appendix 1*, along with the Minister of Health's formal response to these recommendations.

Scope of services covered in 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 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 specialist mental health services and addiction services that are funded by DHBs and provided by either DHBs or NGOs. Performance is assessed at the national level. Regional or DHB variation is not illustrated.

The full range of wellbeing services and providers that respond to mental distress and/or addiction needs are not covered in this report, nor does it cover in detail prevention activity and broader community responses required to promote population wellbeing and recovery. Unfortunately, I have not been able to assess the responsiveness of services to important tāngata whaiora groups, including people with disabilities, rainbow communities, older people, and refugee, migrant, and rural communities. Each of those populations have distinct and significant experiences of mental distress and addiction, which deserve monitoring and advocacy focus. Similarly, I have not been able to consider some important specialised services, including eating disorders, transgender support services, and problem gambling services, which also deserve attention.

It is my expectation that the establishment of the Mental Health and Wellbeing Commission will enable and resource a broader and more diverse assessment of the service and system responses in place to improve the wellbeing of people living with mental distress and/or addiction and their whānau.

Methodology for assessing services

I assess service performance using a monitoring framework my team and I developed in consultation with tāngata whaiora, family and whānau, and mental health and addiction sector representatives.[1] At the heart of the framework are six monitoring questions, which form chapters in the 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 canvas service performance from the perspective of tāngata whaiora 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. The framework is set out overleaf.

To come to a view on service performance in relation to these monitoring questions, I draw on:

- Complaints made to this office about mental health services and addiction services;

- Feedback from tāngata whaiora 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, including a sub-set of measures that are replicated annually to provide consistent trend analysis over time. These measures predominantly relate to specialist DHB and NGO mental health services and addiction services because the quality of data collection is more robust than for primary care.

In the period between March 2018 and March 2020, my team and I participated in approximately 300 meetings and events with tāngata whaiora, whānau, clinical, policy, and workforce leaders, and other stakeholders in the sector, and worked closely with the Initial Mental Health and Wellbeing Commission. Te Rau Ora's Māori lived experience arm, Te Kete Pounamu, provided me with feedback from questions I posed to their networks through Survey Monkey and two regional hui. Owing to the restrictions in social contact as part of New Zealand's COVID-19 pandemic response, my team were unable to undertake the focus groups planned for this report; however, a number of people who had already been recruited to participate in these focus groups agreed to be interviewed or respond to survey questions.

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1   Refer to: Health and Disability Commissioner, *New Zealand's Mental Health and Addiction Services — The monitoring and advocacy report of the Mental Health Commissioner* (2018), Appendix 2.

Mental Health and Addiction Services Monitoring and Advocacy Framework

HDC

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

Identify successes and challenges, recommend system improvements

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

Individual

Population

TRIPLE AIM

System

Key terms and concepts used in this report

Addiction: For the purposes of this report, "addiction" has been used to refer to a wide range of harm from the misuse of substances or from gambling. "Addiction services" refers to services that support people's recovery from alcohol and other drug or gambling harm.*

Consumer: 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, including health services for mental distress and addiction need.

Family and whānau/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). Health, *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health; 2012.

Mental distress: "Mental distress" is any thoughts, feelings, and behaviours that have a negative impact on day-to-day wellbeing.*

Mental illness: A diagnostic term used to categorise people's experiences into mild, moderate, and severe conditions. The term is used in this report to describe prevalence data that is based on diagnostic tools.

Primary care/Primary health care: "Primary health care" relates to the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, nurse practitioner, pharmacist, or other health professional working within a general practice. Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention, and screening.* (For clarity, primary care includes, for example, school-based services, midwifery, Well Child Tamariki Ora, and NGO primary health support.)

Specialist mental health services and addiction services: Specialist mental health services and addiction services are services designed specifically for people with complex and/or enduring mental health and/or addiction needs. These services include NGO- and DHB-delivered community and residential services and services delivered in a hospital setting.*

Tāngata whaiora: Tāngata whaiora, literally translated, means "people seeking wellness". In this report, it refers to people from all ethnic backgrounds who experience mental health or addiction challenges and who are seeking wellness or recovery of self. It includes mental health and addiction service users and consumers of mental health and addiction services.* "Tangata whaiora" is used when referring to an individual.

Wellbeing: "Wellbeing" is when people are able to lead fulfilling lives with purpose, balance, and meaning to them.*

* These definitions are taken from Ministry of Health, *Kia Kaha, Kia māia, Kia Ora Aotearoa: COVID-19 Psychosocial and mental wellbeing recovery plan*. Wellington: Ministry of Health (2020). Note that Tāngata whai ora is also used for "people seeking wellness". See Opai, K, *Te Reo Hāpai. The language of enrichment: a Māori language glossary for use in the mental health, addiction and disability sectors*. Wellington: Te Pou o te Whakaaro Nui (2017).

Part I:
Making transformation happen

Part I of this report outlines the direction for transformational change to move from a health-service response, to a mental health and wellbeing system with people and communities at the centre. It assesses and makes recommendations to improve and enable change, including leadership, implementation support, and connection within and across services, iwi, community, and whānau.

Hope for a wellbeing oriented future

"People told us they wanted … real and enduring change — a 'paradigm shift'."
Government Inquiry into Mental Health and Addiction
He Ara Oranga

In November 2018, the independent Inquiry into Mental Health and Addiction recommended changes to improve New Zealand's approach to mental health and addiction. In developing its recommendations, the Inquiry panel heard voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems. Over 2,000 people attended public meetings across the country, over 5,200 submissions were made to the Inquiry, and over 400 targeted meetings were held with tāngata whaiora, their whānau, service providers, iwi and kaupapa Māori providers, community organisations, and others.

The Inquiry panel found a "striking degree of consensus, from most parts of New Zealand society, about the need for change and a new direction: an emphasis on wellbeing and community, with more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau- and community-based responses and cross-government action". It set a vision of a mental health and wellbeing system where "a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience, tools and support they need to regain their wellbeing".[2]

The Government formally responded in May 2019 by accepting fully or in principle 38 of the Inquiry's 40 recommendations (CABMIN-19-MIN-0182), and placing wellbeing at the centre of its 2019 Budget. As a priority, the Government committed to establishing a Mental Health and Wellbeing Commission to "provide system-level oversight of mental health and wellbeing in New Zealand and hold the government of the day and other decision makers to account for the mental health and wellbeing of people in New Zealand"[3]. The Mental Health and Wellbeing Commission Bill was before the House awaiting its Third Reading at the time this report was completed. The Government has also developed a suicide prevention strategy, established an office to coordinate that work, and addressed pay equity issues for support workers, and has committed to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992. It has also committed resources to substantially increase community support and access to primary healthcare services for people with mild-to-moderate mental distress and/or addiction needs.

The ability for New Zealanders to have a say about what they want for mental health and addiction, together with Government prioritisation of mental health and wellbeing, has brought a sense of hope for transformational change. This change will not happen by itself.

2   Government Inquiry into Mental Health and Addiction, *He Ara Oranga* (2018) 7: https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf.

3   Ministry of Health: https://www.health.govt.nz/our-work/mental-health-and-addictions/budget-2019-mental-health-wellbeing-and-addiction-initiatives.

Creating the conditions for change

In order to translate hope into action and transformational change, there is an overriding need for ownership of an all-of-government, all-of-community, wellbeing agenda that delivers clarity of vision, execution, and accountability.

Creating the conditions for a cross-sectoral, whole-of-system approach to promote mental health and wellbeing is a major challenge. Any large-scale social change requires broad cross-sector coordination, yet too often the focus can remain on the isolated intervention of individual organisations. The high level of disaggregation of leadership in the health sector alone provides added complexity, with 20 DHBs each working out, often in relative isolation, how best to support people with a diverse range of needs in relation to mental health and addiction issues. This in turn has led to each DHB creating its own support pathways and options, resulting in significant variation across geographical areas, and a "post-code" response.

We need to do better at using our collective skills, experience, and commitment to set a direction, and then implement a plan to achieve it. In doing so, the principles of Te Tiriti o Waitangi/the Treaty of Waitangi must be upheld, including through partnership with Māori, Māori-led solutions, and ensuring that all responses work for Māori. We also need to ensure that people and communities, including tāngata whaiora and their whānau, are empowered and engaged to lead and deliver change as part of a common agenda.

Many of the challenges to delivering a wellbeing system for mental health and addiction are the same challenges for the health and disability system as a whole, as set out in the *Health and Disability System Review — Interim Report*. The themes identified from their consultations and submissions were:[4]

- An overly complicated and fragmented system

- Confused accountabilities and lack of leadership at all levels

- Inconsistent implementation, despite reasonable consensus of strategies

- Concern about inequity of outcomes, particularly for Māori

- Recognition that the health and disability system alone cannot eliminate all differences in health and wellbeing outcomes, because most of the differences arise from social determinants

- Consumers want the system to respond to what they value and need, not designed around providers, and disabled people want more control, flexibility, and inclusion

- Rural communities face particular challenges and need solutions designed for them.

Addressing these challenges in relation to promoting wellbeing and improving mental health services and addiction services is an excellent place to start. Many of the directions given in the *Health and Disability System Review — Interim Report* can be delivered on now without any structural change, including embracing mātauranga Māori; values-based leadership; collaborative long-term planning; promoting wellness and having a greater focus on population health; embedding collaborative approaches into service provision; and reflecting different cultural practices in service design. Aotearoa New Zealand has the opportunity to lead change, and indeed be world leading in reorienting towards a wellbeing system response to mental distress and/or addiction.

In order to achieve the shift to a wellbeing system we need to be clear about what we are going to do, how we will do it, with whom, and how we will track our progress. While that may sound simple, it is not. And it is a global challenge we share with others. However, New Zealand — a village of five million — can provide global leadership in making this shift. We have shown that we can do this with our collective response to the COVID-19 pandemic. Taking the lessons learnt from this approach to the pervasive mental health and addiction challenges our country faces could be a way forward.

4   Health and Disability System Review. 2019. *Health and Disability System Review — Interim Report. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā*. Wellington: HDSR: 7.

Building integrated, collaborative leadership

In my 2018 report, I stated: "[T]here is a lack of integrated, collaborative leadership in the sector. This is reflected in the failure to track tangible progress against the 2012–17 [sector] plan *Rising to the Challenge*, and to develop a plan to achieve it."

Similarly, the *Health and Disability System Review — Interim Report* talks about the system needing to work in a collaborative, collective, and cooperative way, citing a need for cultural and attitudinal change. The Panel suggests that changes need "to be led from the centre and applied consistently throughout the system with a common set of values and principles guiding the behaviour of all parts of the system. Mandates need to be clarified, accountabilities clearly defined, and enforced."

However, since 2018, the Ministry of Health has invested in its mental health and addiction stewardship and leadership — a Deputy Director-General has been appointed to provide a mental health and addiction voice in the executive leadership team and the capacity of related policy and implementation, and engagement with Māori, tāngata whaiora, whānau, and providers has been expanded significantly. This is already starting to have tangible benefits with relationships in the sector and progressing Government priorities arising from *He Ara Oranga*. Sector leaders are also reporting increased collaboration across Government agencies and within communities as the Ministry of Health and DHBs led the mental health and addiction response to support people through the COVID-19 emergency pandemic response. In her evidence to the Pandemic Response Select Committee, the Joint Chief Executive of the mental health and wellbeing NGO Wise Group stated that the change with Government, DHBs, and ministries is so significant that "we don't want to go back to how it was before COVID. And why? Because now we have a new, high-trust environment. There's a new respect and collegiality. We get things done really quickly together, and all the barriers, red tape, and mindless activities have been removed."[5]

Current action to strengthen the Ministry of Health is a necessary and helpful start, with the disruption in practice brought by COVID-19 having the potential to propel development of collaborative working. What is being asked of by *He Ara Oranga* is an all-of-government, all of community, all-of-whānau approach to wellbeing — "New Zealand's mental health and addiction problems cannot be fixed by Government alone, nor solely by the health system".[6] Transformational change requires collaborative leadership across functional, organisational, cultural, and sectoral boundaries, to join up complex systems and support collective action towards a common goal. Currently it is not clear where the responsibility lies for bringing together this collective response. Without clear leadership and resourcing, the collective response is likely to be rudderless or, at best, ad hoc. I do not regard this as an onerous demand — it may be that the Ministry of Health is best placed to lead the whole-of-system change required by the *He Ara Oranga* agenda as well as the health component — but the need for a decision is now pressing.

To enable collective action, collaborative leadership needs to be strengthened across multiple levels. Support is required to build collaborative leadership capacity where things happen in local communities — for example, DHBs, health providers, iwi authorities, local authorities, social services, marae, and community organisations. In doing so, the Treaty partnership must be honoured, the voice of tāngata whaiora and their whānau in leadership needs to be protected and strengthened, and a diversity of perspectives, experiences, and expertise must be represented. There are a number of examples of where whānau, community, and population-based approaches show promise to support transformational change. These are explored further in case studies at the end of this section.

At a ministerial level, there needs to be a commitment to collaborate for shared goals, decisions on resource allocations, and priorities. Government departments need structures and processes to support shared analysis, advice, and funding and delivery mechanisms. I note that the provisions in the Public Service Legislation Bill are purpose built to help implement cross-agency action such as required by the *He Ara Oranga* agenda. Regardless of what mechanisms are decided on, the Ministry of Health will need to play a leading role on matters of policy and strategy, and act as a steward of the health system.

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5   Hansard transcript Inquiry into the Government response to COVID-19 Epidemic Response Committee 30 April 2020: https://www.parliament.nz/en/pb/sc/scl/epidemic-response/news-archive/watch-public-meetings-of-the-epidemic-response-committee/.

6   Government Inquiry into Mental Health and Addiction, *He Ara Oranga* (2018) 10: https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf.

Developing a common agenda to deliver a wellbeing system

"Mental health [including addiction], 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

Translating the hope brought by *He Ara Oranga* into collective action requires a common agenda, a joint approach to agreed actions and coordinated activities, shared measures to understand progress and hold each other to account, and ongoing communication and support for implementation.[7] While collaborative leadership is essential, Government needs to own and enable the strategic direction that will deliver on the common agenda.

There has been a high level of activity and investment by the Government and Ministry of Health to respond to *He Ara Oranga.* However, the overall direction and plan to enable both wellbeing system and mental health and addiction services transformation remains to be developed, while initial priorities were progressed. A plan should be co-created as a matter of priority, with the collective experience and commitment of Māori, tāngata whaiora and their whānau, communities, and health and social sector organisations. The plan should commit to a vision, and include goals, actions, responsibilities, and milestones to align activity and track progress.

The Ministry of Health-led COVID-19 psychosocial and mental wellbeing recovery plan *Kia Kaha, Kia māia, Kia Ora Aotearoa* includes a vision, principles, and five action areas, with recognition that mental wellbeing is reliant on social and economic foundations. It is described as a "living document" that the Ministry of Health will continue to review as the ongoing impacts of COVID-19 are assessed.[8] This recovery plan could be used as a foundation for an all-of-government, all-of-community wellbeing plan.

I also continue to recommend a statutory amendment to the New Zealand Public Health and Disability Act 2000 to add a provision for an all-of-government New Zealand Mental Health and Wellbeing Strategy to stand alongside New Zealand's Health Strategy and Disability Strategy. This would ensure that there is an enduring commitment to a long-term strategy to promote wellbeing as well as address mental distress and/or addiction, and that the strategy is not put to one side over time because of other priorities. It would also provide an anchor against which the new Mental Health and Wellbeing Commission could monitor progress once the initial response to *He Ara Oranga* is complete, and provide a framework to hold Government to account for action to improve mental health and wellbeing.

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7   Kania and Kramner cite five key conditions for large-scale change through collective impact: common agenda; shared measurement; mutually reinforcing activities; continuous communication; and backbone support. Kania, J and Kramner, M, "Embracing Emergence: How Collective Impact Addresses Complexity". *Stanford Social Innovation Review* (website) 21 Jan 2013. https://ssir.org/articles/entry/social_progress_through_collective_impact

8   Ministry of Health: https://www.health.govt.nz/publication/covid-19-psychosocial-and-mental-wellbeing-recovery-plan.

Prioritising a health and disability sector plan to support the wellbeing agenda

Sitting underneath the whole-of-government, whole-of-community wellbeing plan should be a plan to deliver transformative health and disability sector responses to mental distress and/or addiction need, connected across a continuum of care and with social services, now and into the future. The plan should also address ongoing quality improvement of services, including in relation to the areas of concern raised in this report. In my 2018 report, I recommended the development of such a plan, and I repeat this recommendation, including the need to assess:

- Current and future population need across all age groups, including a regular assessment of prevalence, help-seeking behaviour, and access to mental health services and addiction services across the whole population;

- The relative health investment required in prevention, early intervention, primary, and mental health and addiction services, alongside other sectors that contribute to wellbeing;

- 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 the needs of tāngata whaiora, now and in the future. We also need to build capability in our workforce to improve services continuously.

Responding to wellbeing challenges arising from COVID-19 has had to be a priority in recent months, and will be for some time into the future. However, I note that in December 2019 the Ministry of Health communicated that a major focus will be to "work with the sector on the long-term pathway for where the mental health and addiction system needs to head to. This will guide all of our activities over the coming years and show us where we need to put emphasis on being different."[9] I am encouraged that steps to provide a clear direction and goals for the health and disability service contribution to a wellbeing system are underway.

Collective learning and support for implementation at all levels

Plans on their own are not enough to deliver change. In the last 10 years there have been many Government documents, plans, and strategies that have talked about shifting from a service-oriented response to a people-centred wellbeing response to mental health and addiction, but have failed to get traction because not enough attention was paid to supporting implementation and tracking progress. For example, in my 2018 report I noted that the sector strategy *Rising to the Challenge* had expired, and that "100 actions and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, meant it was difficult to measure progress on completion of the plan".

Support for implementation of the *He Ara Oranga* agenda is required at all levels, including to enable Māori and communities to lead their own solutions. For complex system change, this is often described as a "backbone function" and can sit in a single organisation or multiple organisations. A backbone function supports and champions people and organisations to contribute to the shared agenda, including by ensuring clarity of purpose, creating a "partnership identity", connecting and aligning people and activities, and involving people in the process.[10]

9   Ministry of Health: https://ministryofhealthnewzealand.cmail20.com/t/ViewEmail/i/0F284427DC0B8D5A2540EF23F30FEDED/ED5B87374137D91EDCC9454293137CA2.

10   Collaborate Up, *Backbone Organizations: A Field Guide: 27 Ways to Drive Impact in Multi-Stakeholder Initiatives* (2018): https://ssir.org/pdf/Backbone_Organizations_Field_Guide.pdf.

Two examples of where a backbone-type function is operating effectively in mental health and addiction are the Aotearoa Equally Well collaborative and the HQSC's Mental Health and Addiction Quality Improvement Programme. The Aotearoa Equally Well collaborative comprises organisations that voluntarily endorse the aim of improving the physical health of people with mental health and addiction problems. The backbone team sits within the mental health and addiction workforce organisation Te Pou o te Whakaaronui, and provides overall direction, builds the evidence base, facilitates communication and action, including through Loomio and e-news, works with champions to encourage and support activities, and shares stories of good practice from around the country. The HQSC's Mental Health and Addiction Quality Improvement Programme helps to build a culture of learning and continuous quality improvement through teaching co-design and quality improvement practices, bringing together programme participants to learn and share together, and developing common measures, milestones, and timeframes to put projects into practice.

Measuring success and strengthening monitoring and oversight

The new Mental Health and Wellbeing Commission will strengthen independent monitoring and advocacy in relation to wellbeing, bringing transparency and accountability to support improvement. I welcome the Commission's establishment. Its functions include to assess and report publicly on the mental health and wellbeing of New Zealanders and make recommendations to improve the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing, and monitor mental health and addiction services and advocate for improvement. The Commission must also have effective means of seeking views, including those of Māori and people who have experienced mental distress and/or addiction, and their whānau. The new Commission, together with foundational work by the Initial Mental Health and Wellbeing Commission, will ensure that a comprehensive outcome framework is in place to measure wellbeing and track progress from Government and collective action. The Commission's measurement of outcomes needs to sit alongside the whole-of-government, whole-of-community mental health and wellbeing plan of action.

Case studies of promising whānau and community-based approaches to wellbeing

Case study 1: Whānau Ora — an integrated whānau approach supporting seamless access to health and social services[11]

Whānau Ora is an approach that puts whānau and families in control of the services they need, to work together, build on their strengths, and achieve their aspirations. Three commissioning agencies (Te Pou Matakana in the North Island, Te Pūtahitanga in the South Island, and Pasifika futures) work with their communities to determine the best ways to support their development and bring all the services a whānau may need under one umbrella. Some contract with established Whānau Ora provider collectives as well as other community providers such as iwi, marae, education providers, church groups, land trusts, or sports groups, while others invest directly with whānau or whānau collectives.

Whānau Ora Kaiārahi (or navigators) work closely with whānau to identify their specific needs and aspirations, then help to identify the services, education providers, or employment and business opportunities. Kaiārahi support whānau to plan, and then connect them with the support they need to achieve their goals. Kaiārahi have the cultural and local knowledge necessary to understand whānau situations and build relationships of trust and confidence.

A formative evaluation in 2016 found that when whānau work with Kaiārahi they experience significant benefits, including improved outcomes across education, employment, and income. The Whānau Ora Kaiārahi approach was identified by the Productivity Commission as a key example of an integrated whānau-centred approach supporting seamless access to health and social services.

A Whānau Ora Partnership Group provides strategic oversight of Whānau Ora comprising six Iwi Chairs and six Ministers (Whānau Ora (chair), Finance, Health, Education, Social Development, Business Innovation and Employment) and supported by a Strategic Advisors Group and Whānau Ora Officials Group.

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11 Independent Whānau Ora Review Panel, *Whānau Ora Review — Tipu Matoro kit e Ao Final Report to the Minister for Whānau Ora* (November 2018): https://www.tpk.govt.nz/docs/tpk-wo-review-2019.pdf; Te Puni Kōkiri — Formative Evaluation of the Whānau Ora Commissioning Agency Model, Te Puni Kōkiri (2016): https://www.tpk.govt.nz/en/a-matou-mohiotanga/whanau-ora/formative-evaluation-of-the-whanau-ora-model; The New Zealand Productivity Commission, *More Effective Social Services*, Appendix 3 (August 2015): https://www.productivity.govt.nz/assets/Documents/8981330814/Final-report-v2.pdf.

Case study 2: Inclusive cities — using community to build recovery capital and reduce stigma

The concept of inclusive cities recognises that effective community reintegration and acceptance is an integral part of recovery journeys from substance use. It reflects evidence of the "social contagion" of hope of recovery and the potential role of communities to transmit that hope and make recovery visible, thereby increasing community cohesion and challenging stigmatisation and exclusion of recovery populations.[12]

In the United Kingdom, where the concept of inclusive cities was developed, examples of the concept in action include the Serenity Café in Edinburgh, which is open to all people to come together and support each other in their recovery, and Jobs, Friends and Houses in Blackpool, which engages people in recovery through a building programme.

After volunteering, participants in Jobs, Friends and Houses complete a training programme to learn to renovate and refurbish houses, and start a paid apprenticeship. The social enterprise buys houses, renovates or refurbishes them, and either rents them as recovery housing or sells for profit, for reinvesting in the social enterprise. Not only does this model offer employment opportunities in the construction industry for people in recovery, it also gives a sense of pride and meaning.[13]

The Haven "sign of progress" outlined at the end of Part II, Question 6, of this report is an Aotearoa New Zealand example of the inclusive cities approach. At Haven — an after-hours, drop-in support space on Karangahape Road — anyone is welcome, and peer support workers from addiction, mental health, and homeless services are on hand for a chat and to help people to identify next steps if necessary.

He Hikoi Mātūtū — Aotearoa New Zealand's first addiction recovery walk held in December 2019 — is another example of a social cohesion and acceptance approach to recovery. He Hikoi Mātūtū is the start of a movement to change the conversation about addiction, treatment, and recovery by shining a light on what actually works for people.[14] Recovery walks are well established in the Northern Hemisphere, with the aim to dispel stigma around addiction, to demonstrate that recovery is possible, and to celebrate achievements.

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12   Best, D and de Alwis, S, "Community recovery as a public health intervention: The contagion of hope". *Alcoholism Treatment Quarterly* (2017) 35(3): 187–199.

13   Best, D and Colman, C, "Let's celebrate recovery. Inclusive Cities working together to support social cohesion". *Addiction Research & Theory* (2019) 27(1): 55–64. DOI: 10.1080/16066359.2018.1520223.

14   Press Release DAPAANZ: https://www.scoop.co.nz/stories/GE1911/S00082/kiwis-walk-to-celebrate-freedom-from-addiction.htm.

Case study 3: Trieste model — responding to mental distress in the community

The city of Trieste in Italy operates a network of 24-hour community mental health centres capable of responding to the most complex and enduring needs, and supporting clients in their daily life, with a view towards recovery and inclusion. The staff at the centres provide overnight hospitality, early intervention, ongoing treatment, informal support, and home-based assertive care, and link to a range of other services. The model, developed in the 1970s, replaced the use of mental health institutions, and has been recognised by the World Health Organization as one of the most progressive and people-centred mental health systems in the world.[15]

The Trieste model's values and philosophy are as important as the structure of its services. Key values include helping the person, not treating the illness; respecting the user as a citizen with rights; maintaining social roles and networks; and addressing practical needs — housing, employment, study, relationships, etc. Numerous observers have noted that Trieste's values are consistently espoused by staff and adhered to throughout the delivery of services.[16]

Case study 4: Thrive cities — building a collective response to mental health and wellbeing

The "Thrive" approach has been adopted by cities around the world, including New York City and London. The aim is to move beyond traditional mental health services and addiction services to develop collaboration across all supports that matter to their public and communities, while still providing care to those in most need.[17] Thrive takes a public and population health approach to build social capital in the community to compliment the formal mental health and addiction system, including through strategic partnerships with community organisations.

New York City introduced its Thrive programme in 2015. Comprised of 54 initiatives, its plan included training 250,000 residents in "mental health first aid" to help people to recognise symptoms, and listen to and help others. Its plan also included greater access to care, improved social and emotional education for children, and public awareness campaigns focusing on mental health promotion and early intervention.[18] Canterbury DHB expressed an interest in this model in its submission to the Inquiry into Mental Health and Addiction: "We believe a region-wide focus on supporting mental health and wellbeing could reduce and prevent mental health issues in the future and improve the wellbeing and resilience of individuals and communities."[19]

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15   Portacolone, F, Segal, S, Mezzina, R, Scheper-Hughes, N, and Okin, R, *A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Fransisco* (2015).

16   Discussion paper #1: Comparing the Trieste approach to delivering mental health services with New Zealand models: https://www.tepou.co.nz/assets/images/content/training_funding/tools-for-learning/files/applyingtriestemodeltonz.pdf.

17   International Initiative for Mental Health Leadership, *Make it So Promoting Mentally Healthy Cities across IIMHL countries: I-CIRCLE, 19 December 2017*: http://www.iimhl.com/files/docs/Make_It_So/20180116.pdf.

18   https://thrivenyc.cityofnewyork.us/.

19   Canterbury District Health Board submission into the Inquiry into Mental Health and Addiction, quoted in https://www.stuff.co.nz/national/health/109735647/quakehit-city-wants-mental-health-first-aid-plan (4 January 2019).

Part II:
Are health services meeting the needs of tāngata whaiora?

Introduction

In Part II, I provide a snapshot of mental distress and/or addiction need and the health services and health workforce that respond to these needs. I then consider how health services are performing in responding to the needs of people experiencing mental distress and/or addiction.

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. Do services support me to be safe?
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 tāngata whaiora and 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.

Mental distress and/or addiction is common in Aotearoa New Zealand and globally

1 in 5
New Zealanders live with mental illness and/or addiction each year[20]

Some population groups are more at risk than others[21]:

Almost 1 in 3
Māori

1 in 4
Pacific peoples

2 in 3
People in prison

Most people's first experience of mental distress and substance use problems is before the age of 18[22]

6%
of children aged 2–14 years have been diagnosed with an emotional or behavioural problem

1 in 4
secondary students report poor emotional well-being.

6%
of young people aged 15–17 years report drinking hazardously.

50–80%
of New Zealanders will experience mental illness and/or addiction over a lifetime.[23]

Over 70%
of people who attend addiction services have co-existing mental health conditions; between 30% and 50% of people who attend mental health services have co-existing substance use problems.[24]

12%
of all health loss in New Zealanders is attributable to mental distress and addiction, similar to the global burden of disease estimates.[25]

Personal and economic costs of mental distress and/or addiction are high

25 years
shorter life
New Zealanders with a serious mental health condition and/or addiction have a lower life expectancy, dying up to 25 years earlier.[26]

685 people
Mental distress and substance use are risk factors for suicide. Other known risk factors for suicide include a recent relationship break-up, recent engagement with the police, and unemployment.[27] In 2018/19, 685 people died by suspected suicide.[28]

$6.2bn
(2.6 percent of GDP)
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.[29]

There is a growing range of mental health services and addiction services across a continuum of need

PRIMARY HEALTHCARE SERVICES

72%

of children (0–14 years) and 78% of adults (15+ years) saw their GP in 2018/19 (the proportion of people seeking help for mental distress and/or addiction is not known).[30]

132,525

people accessed primary mental health services in 2018/19. These primarily consist of funded extended GP consultations and talk therapies.[31]

$455m

in Budget 2019 to expand access to, and choice of, primary mental health and addiction support to reach an additional 325,000 people by 2023/24.

Around
839,936

New Zealanders were dispensed a psychotic medicine in 2018, with 425,000 people receiving a psychotropic medicine regularly throughout the year.[32] There is considerable variation around the country on psychotropic prescribing in primary care, reflecting different approaches, pathways, and practices.[33]

HEALTH PROMOTION AND DESTIGMATISATION APPROACHES

Health promotion, prevention, and destigmatisation approaches are an important aspect of the health sector's response to mental distress. The "Like Minds, Like Mine" programme, the "National Depression Initiative", "All Right?" (an earthquake response initiative in Christchurch), "Getting Through Together" (a national response to COVID-19), "Farmstrong", and the HPA's "no-beersies" campaign, and regulation of alcohol licencing and purchase hours, are good examples of health promotion activity. There are no national destigmatisation campaigns to support people seeking support or people in recovery from addiction. Some more targeted activity exists — for example, Blueprint for Learning's Addiction 101 provides a one-day workshop designed to increase awareness and reduce the stigma associated with addiction — both at work and in everyday life.

SELF CARE AND DIGITAL SERVICES

For example, in 2018/19 there were:

National tele-health mental health and addiction services[34]

161,985 contacts

- **86,425** to 1,737 Need to Talk
- **52,357** to the depression helpline
- **19,022** to the alcohol and drug helpline
- **4,181** to the gambling helpline

Drughelp.org[35]

84,440 visitors

Depression.org[36]

404,201 visitors

The Lowdown[37]

98,918 visitors

MEDICATIONS

Funded mental health medication dispensings have increased in the last five years, while addiction medication dispensings have decreased.[38]

Anti depressants

16% increase

1.60M 2014/15 → 1.87M 2018/19

Anti psychotics

19% increase

534K 2014/15 → 634K 2018/19
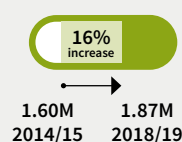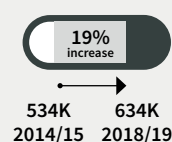
Treatments for substance dependence

7% decrease

277K 2018/19 ← 299K 2014/15
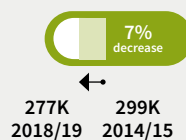
SPECIALIST MENTAL HEALTH SERVICES AND ADDICTION SERVICES

186,540

people (or 3.8% of the population) accessed specialist mental health and addiction services in 2018/19[39]

The majority of people access services in the community rather than inpatient settings[40]

1,372,193 Individual treatment sessions

481,966 coordination of care

371,496 contacts with family/whānau

Examples of mental health services and addiction services delivered (total treatment days in 2018/19)[41]

500,786 community support

204,383 group programmes

125,367 day programmes

40,541 opioid substitution treatment service

67,575 peer support contacts

59,043 Māori specific interventions

143,551 crisis attendances
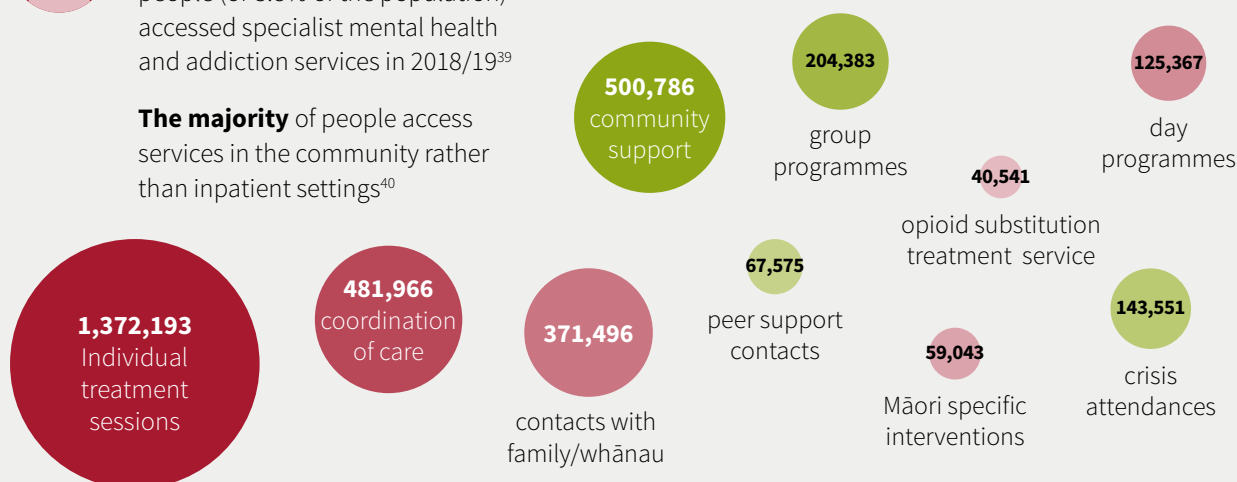
INPATIENT AND RESIDENTIAL SERVICE EXAMPLES 2018/19[42]

	People	Bed nights
Inpatient care	9,814	248,029
Rehabilitation or residential care	2,880	478,808
Planned or crisis respite care	5,668	65,924
Forensic secure inpatient	496	85,716
Substance use medical withdrawal management (detoxification)	1,685	15,474
Substance use residential treatment	2,022	121,945

ACCESS HAS INCREASED

DHB- and NGO-provided services[43]

55% increase

2009/10	2014/15	2018/19
120,293	162,213	186,540
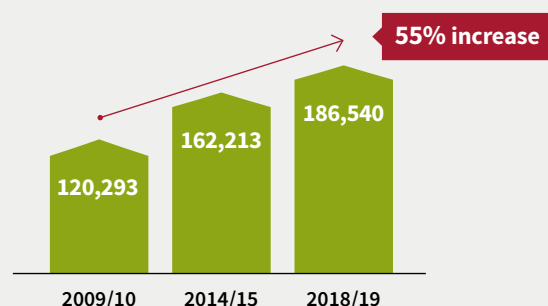
EXPENDITURE HAS INCREASED

DHB and Ministry of Health funded services[44]

24% increase

2009/10	2014/15	2018/19
$1.23b	$1.37b	$1.53b
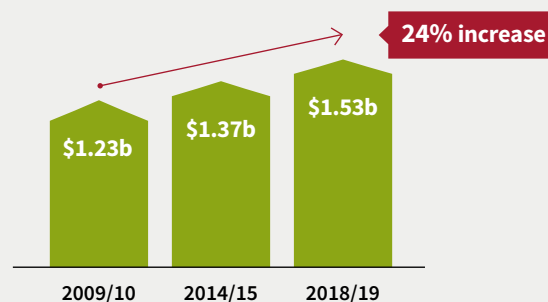
THE MAJORITY OF DHB AND MINISTRY OF HEALTH EXPENDITURE IS SPENT ON MENTAL HEALTH SERVICES

$12,968,294 (<1%) problem gambling

$162,395,702 (11%) addiction

$1,364,059,165 (89%) mental health
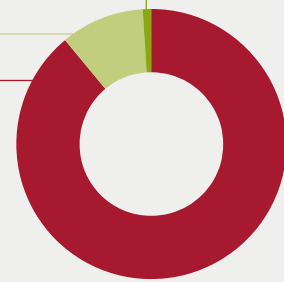
Less than a third of expenditure is on NGO services:

$477,329,989 (31%)
NGO services

$1,053,512,557 (69%)
other expenditure
(predominantly DHB)
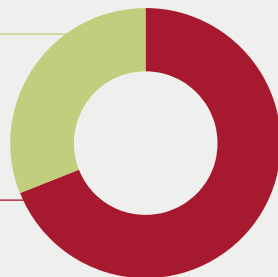
11% is spent on kaupapa Māori and Pacific services:

$15,079,501 (1%) Pacific

$151,703,880 (10%) Māori

$1,364,059,165 (89%)
mainstream
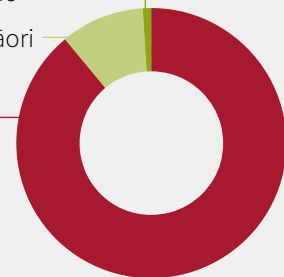
Mental health services and alcohol and other drug treatment services workforce is diverse

INFANT, CHILD AND ADOLESCENT SERVICES WORKFORCE[45]

1,866

FULL-TIME EQUIVALENT POSITIONS

as at 30 June 2018

FTEs

36% were in
NGO services

64% were in
DHB services
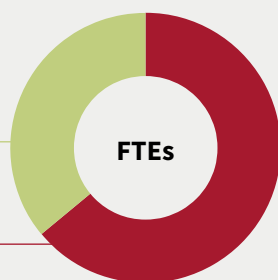
The majority of the workforce are in clinical roles:

72%	Clinical roles
18%	Non-clinical roles
10%	Administration/management
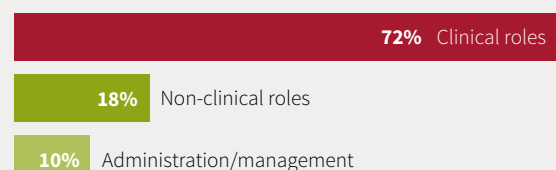
The most common clinical roles are:

27%	Mental health nurse
20%	Social worker
15%	Psychologist
10%	AOD practitioner
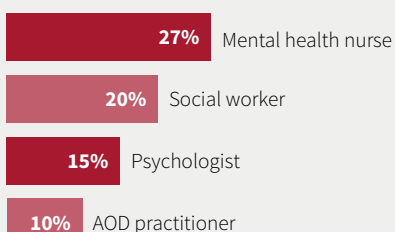
The most common non-clinical roles are:

48%	Mental health support worker
26%	Youth worker
9%	Cultural worker
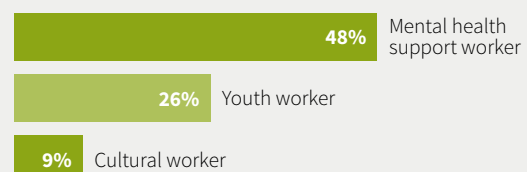
ADULT SERVICES WORKFORCE[46]

10,832
FULL-TIME EQUIVALENT POSITIONS

as at March 2018

7% were in NGO alcohol and drug treatment services

6% were in DHB alcohol and drug treatment services

46% were in DHB mental health services

FTEs

10% were in Forensic mental health services

31% were in NGO mental health services
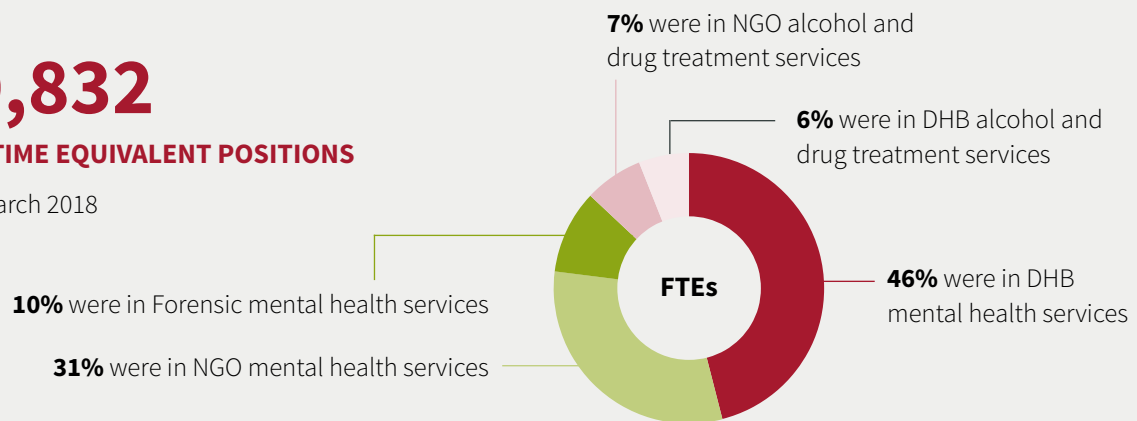
Workforce composition varies by services delivered:

- Allied health
- Nurses
- Non-clinical roles (including support and peer workers)
- Administration and management
- Medical & other clinical roles

AOD
1,434
FTEs

| 50% | 17% | 17% | 12% | 4% |
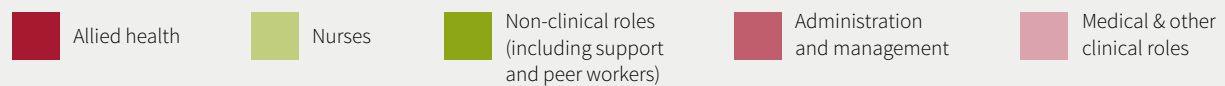
Forensic mental health
1,060
FTEs

| 11% | 48% | 23% | 10% | 8% |

Mental health
8,338
FTEs

| 11% | 30% | 38% | 14% | 7% |

Total workforce
10,832
FTEs

| 16% | 30% | 34% | 13% | 7% |

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

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

22 Ministry of Health, *New Zealand Health Survey Annual Data Explorer — November 2019*: https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/_w_34688004/#!/explore-topics (accessed 14 April 2020); Clark, TC, Fleming, T, Bullen, P, Denny, S, Crengle, S, Dyson, B, Fortune, S, Lucassen, M, Peiris-John, R, Robinson, E, Rossen, F, Sheridan, J, Teevale, T, Utter, J (2013). Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012. Auckland, New Zealand: The University of Auckland https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2012-overview.pdf; *Annual update of key results 2018/19: New Zealand Health Survey.* https://www.health.govt.nz/publication/annual-update-key-results-2018-19-new-zealand-health-survey.

23 Oakley Browne, MA, Wells, JE, and Scott, KM (eds), *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health (2006); Schaefer, JD, Caspi, A, Belsky, DW, *et al.*, "Enduring mental health: Prevalence and prediction". *J Abnorm Psychol* 2017; 126(2): 212–24.

24 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).

25 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. 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.

26 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.

27 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).

28 Annual provisional suicide statistics for deaths reported to the Coroner between 1 July 2007 and 30 June 2019: https://coronialservices.justice.govt.nz/assets/Documents/Publications/Provisional-Figures-August-2019.pdf.

29 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.

30 NZ Health Survey Annual data explorer November 2019: https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/.
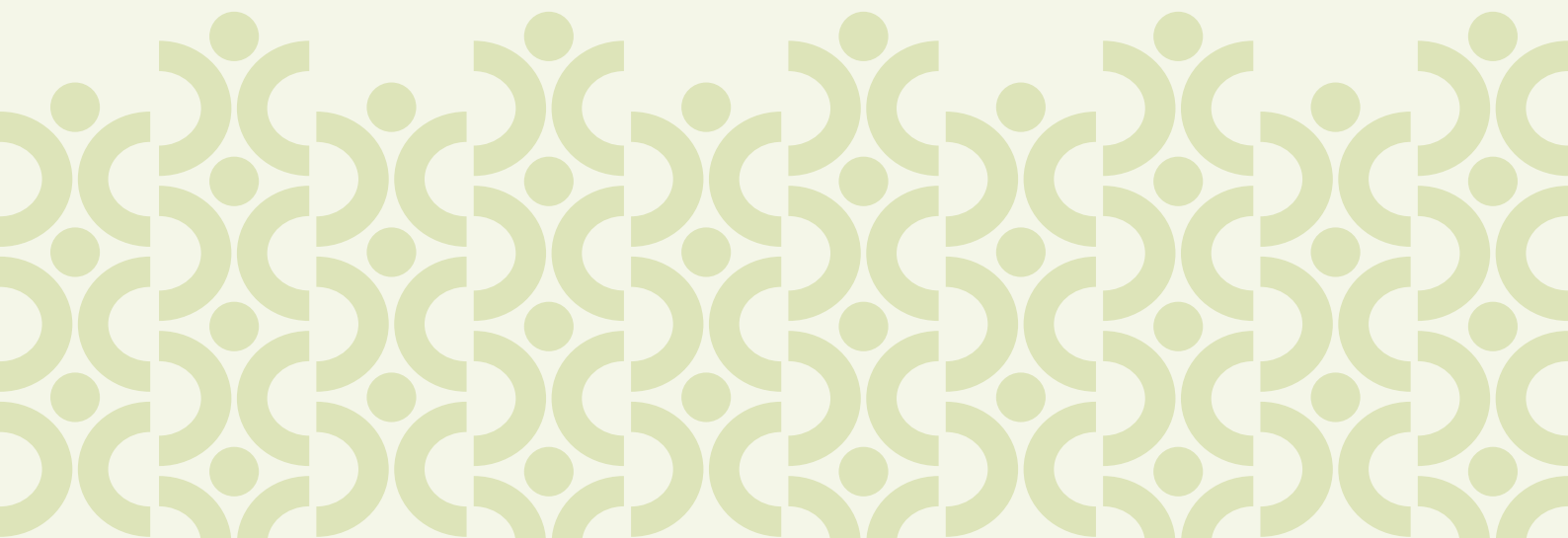
31 Supplied by the Ministry of Health February 2020. These figures relate only to the devolved primary mental health funding that DHBs report against, and are estimates only, as the unique number of clients seen in New Zealand is not reported. Clients seen by more than one DHB, and in more than one quarter of the year or more than one service are double-counted.

32 Atlas of Healthcare Variation — Mental health in primary care: https://public.tableau.com/profile/hqi2803#!/vizhome/Mentalhealthinprimarycaresinglemap/AtlasofHealthcareVariationMentalhealthinprimarycare?publish=yes. Note that only a specified list of psychotropic medicines are included in the Atlas.

33 *Ibid*.

34 Supplied by Homecare Medical, March 2020.

35 Supplied by the New Zealand Drug Foundation, April 2020.

36 Supplied by the Health Promotion Agency, March 2020.

37 Supplied by the Health Promotion Agency, March 2020.

38 Supplied by PHARMAC, March 2020.

39 Ministry of Health PRIMHD database, analysed by the Ministry of Health, February 2020. PRIMHD (*Programme for the Integration of Mental Health Data*) database is a single collection of national mental health and addiction services information, administered by the Ministry of Health.

40 In 2018, 91% of people accessed only community mental health and addiction services, 0.4% accessed only inpatient services, and the remaining 8% accessed a mixture of inpatient and community services. Data provided by the Ministry of Health, based on PRIMHD data as at 29 July 2019.

41 Ministry of Health PRIMHD database, analysed by Te Pou o Te Whakaaronui, January 2020.

42 Ministry of Health PRIMHD database, analysed by Te Pou o Te Whakaaronui, January 2020.

43 Supplied by the Ministry of Health, February and March 2020.

44 Expenditure figures supplied by the Ministry of Health, in March 2020, sourcing the DHB Price Volume Schedule, CMS, CCPS. Note that includes problem gambling services.

45 Werry Workforce Whāraurau, *2018 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: Werry Workforce Whāraurau for Infant, Child & Adolescent Mental Health Workforce Development, The University of Auckland (2019).

46 Te Pou o te Whakaaro Nui, *Adult mental health and addiction workforce: 2018 secondary care health services*. Auckland: Te Pou o te Whakaaro Nui (2019).

Question 1: Can I get help for my needs?
Key findings

- Significant investment to increase access to clinical and social support for people experiencing mild to moderate mental distress and/or addiction has been made through Budget 2019 (access and choice investment). A large portion of the investment aims for an additional 325,000 people with mild to moderate mental distress and/or addiction to be seen in primary and community settings by 2023/24. It is important that as these new services are rolled out there is a diversity of reach, including for people who do not access GPs and for people experiencing problematic substance use and gambling harm.

- Access to and the development of self-care, e-therapy and virtual services is increasing. Services have also adapted and filled the gap in face-to-face care during the COVID-19 pandemic emergency response. These innovations need to be captured, assessed, and developed, and where effective built into a new normal.

- More of the same in specialist (community and hospital-based) services will not deliver the wellbeing and recovery-oriented system that is required. Years of growing access to specialist services, combined with relative underfunding and workforce shortages, has resulted in cumulative pressure on these services, despite recent increases in funding. Specialist services need the space, time, support, alliances, and tāngata whaiora and whānau input to think through and operationalise changes in systems of care in order to make them happen.

- Ensuring people can get help for their needs requires an evidence-based assessment of need, supported by responsive models of care and workforce planning to support delivery. Consideration also needs to be given to developing and growing the support and peer worker workforce and the NGO sector in order to strengthen care in the community.

- 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?

"You have to put in a lot of work to get the help you need. It's not like you can say I'm not in a good place and you get help — you have to earn it."

– Adult tāngata whaiora interview

"Getting the help wasn't challenging, it was admitting I had a problem that was challenging … To get into the service itself was very easy."

– Youth tāngata whaiora interview

Introduction

Not every New Zealander experiencing mental distress or addiction issues needs a health-service intervention. But when people do, it is fundamental that they can get the right support, in the right way, when they need it. A well-functioning mental health and addiction system responds appropriately to a diversity of needs across a continuum of care, from help to stay well in the community to intensive support when people are most unwell. Support should be person- and whānau-centred, and relevant to life stages and cultural and social context.

This section looks at the responsiveness of the health system to mental health and addiction need by assessing access to a range of healthcare supports for people experiencing mental distress and addiction issues, and progress made to address issues identified in my 2018 report and *He Ara Oranga*. The Initial Mental Health and Wellbeing Commission has been tasked with reporting more fully on Government's response to *He Ara Oranga* by November 2020.

Monitoring indicators
2018/19

186,540
people (or 3.8% of the population) accessed mental health services and addiction services

132,525
people accessed primary mental health services

Options for early intervention support are broadening and becoming more accessible

Since 2018, early intervention responses in primary and digital care have experienced significant investment and growth. A centerpiece of the Government's 2019 Wellbeing Budget and response to *He Ara Oranga* was a $455 million investment over four years for the national roll-out of integrated primary mental health and addiction services, with the aim of an additional 325,000 people receiving primary mental health and addiction support by 2023/24 (Access and Choice investment). The annual Access and Choice investment increases over the course of the five-year rollout, and includes funding for service delivery, workforce development, and system enablers such as engagement and change support. In 2019/20, $48.1 million was available across these three areas, with funding committed to expand integrated primary mental health and addiction services to over 100 new sites in 15 DHB areas. While initial Access and Choice funding has focused on general services, money has been ring-fenced for tailored supports in relation to kaupapa Māori, Pacific, and youth settings. Design of the new kaupapa Māori and new Pacific service models were developed through a series of hui and fono in 2019, and the Request for Proposal process is now underway.

It is important to ensure that Access and Choice services in their design and roll-out are able to reach a diversity of tāngata whaiora in a variety of settings. For example, 13% of the population did not access a GP in the last year because of cost. The proportion was higher for younger adults, with 20% of 25–30-year-olds and 16% of 15–24-year-olds not accessing a GP in the last year because of cost, and for Māori, with more than one in five Māori adults (22%) not visiting a GP because of cost in the past year.[47] People with mental distress and/or addiction also experience greater challenges than others accessing primary health services — including because of transport and costs — and report less positive experiences with general practitioners. This is heightened for Māori and Pacific peoples.[48] Addiction treatment providers have also raised with me that people who use their services do not tend to seek help from general practice, and there is limited evidence that general services models work specifically for people who are experiencing harm from substance use or gambling as distinct from mental distress.[49]

The Access and Choice investment addresses a significant gap in care for people with mild to moderate need identified in both my 2018 report and *He Ara Oranga*. Both of these reports also highlighted the potential for digital technologies to provide evidence-based, convenient, affordable, and easily expandable responses for people experiencing mental distress and/or addiction. In an environment with high unmet need, virtual and digital mental health presents a wide-reaching and cost-effective approach. If delivered effectively, digital mental health can help people before their needs escalate, improve the reach and accessibility of supports and services (particularly in rural or isolated areas), and alleviate pressures in workforce capacity.[50] In November 2020, the Initial Mental Health and Wellbeing Commission is expected to report on progress towards implementing *He Ara Oranga* recommendations to expand access to, and increase choice of, services.

47   NZ Health Survey Annual Data Explorer November 2019: https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/; HQSC, "Atlas of Health Care Variation — mental health in primary care": https://public.tableau.com/profile/hqi2803#!/vizhome/MentalhealthinprimarycaresinglemapAtlasofHealthcareVariationMentalhealthinprimarycare?publish=yes.

48   Te Pou o te Whakaaronui, *Using New Zealand data to understand health inequities; The physical health of people with mental health problems*: https://www.tepou.co.nz/uploads/files/resource-assets/TP%20NZHS%20infographic-2d-Final.pdf.

49   Synergia, *Fit for the Future: Evaluating Enhanced Integrated Practice Teams. A report for the Ministry of Health* (2018): https://synergia.consulting/wp-content/uploads/2018/11/Synergia-ADHB-FtfF-Enhanced-integrated-practice-teams-evaluation-FINAL-181001.pdf. The evaluation of elements of the Fit For the Future programme that were drawn on in the design of the general settings model noted that alcohol and drugs accounted for only 1.8% of all primary presenting reasons, and so conclusions could not be extended to effectiveness for addiction.

50   Social Sector Science Advisors, *Towards an Evidence-Informed Plan of Action for Mental Health and Addiction in New Zealand: A response by the social sector science advisors to the request of the Government Inquiry into Mental Health and Addiction*. Wellington: Social Sector Science Advisors (2018).

Digital support options continue to grow and have stepped up to COVID-19 challenges

Each year, engagement with digital mental distress and/or addiction support grows. Contacts to the national telehealth mental health and addiction helplines rose 23% between 2017/18 and 2018/19. Visitors to drughelp.org increased by 35% between 2017/18 and 2018/19, and the audience for depression.org increased nearly 40% between 2017/18 and 2018/19, with a three-fold and nearly six-fold increase in engagement with the Māori and Pacific webpages.

Digital programmes have been a key component of the immediate emergency psychosocial response to COVID-19. This includes online applications that assist people to look after their mental health and wellbeing, e-therapy, and telehealth responses. Digitally enabled responses have allowed programmes and services to respond rapidly at a whole-of-population level to a significant event that has disrupted the lives of all New Zealanders, resulting in significant psychosocial impact. For example, during COVID-19 Level 4, within 10 days[51] of the launch of Sir John Kirwin's Mentemia app for people to use to monitor, manage, and improve their mental health and wellbeing by setting daily goals and tracking progress, there were 35,000 downloads (see "signs of progress" at the end of this section for more examples of COVID-19 wellbeing initiatives). During the period of lockdown and self-isolation, existing providers also had to change their model of service delivery rapidly, to include virtual consults and other service-delivery options. I have received positive feedback from tāngata whaiora and services about the transition to virtual delivery of care, with many expressing a desire to incorporate greater virtual delivery into a "new normal" alongside traditional supports. It is important, however, to acknowledge that not everybody has the ability to access virtual delivery. Inequity of access to these services needs to be addressed as part of their continued development.

Monitoring indicators
2018/19

Wait time for mental health DHB services:

47%	75%	91%
Less than 48 hours	Less than 3 weeks *(target 80%)*	Less than 8 weeks *(target 95%)*

Wait time for addiction services:

56%	85%	95%
Less than 48 hours	Less than 3 weeks *(target 80%)*	Less than 8 weeks *(target 95%)*
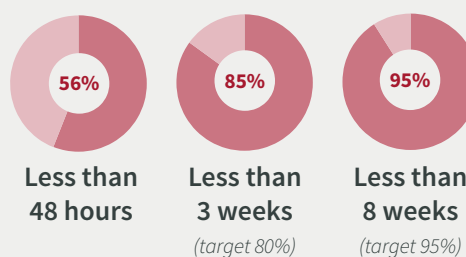
16%
of HDC mental health and addiction complaints were about access to services

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51 New Zealand Parliament, 30 April 2020. *Question No. 10 — Health*: https://www.parliament.nz/en/pb/hansard-debates/rhr/document/HansS_20200430_051000000/10-question-no-10-health.

The Ministry of Health is progressing work on telehealth and digital supports as a critical part of the Government's commitment to expand access and choice for New Zealanders. As an initial step, the Ministry has begun development of a Framework for Digital Mental Health and Addiction to ensure that tools and products are safe to use. The focus to date has been on consultation with the sector on what would be required of an assessment tool to promote clinical, digital, and cultural safety, and a roadmap for a more detailed phase of work based on the consultation findings. The framework is intended to ensure that all stakeholders understand what "good" looks like in helping people to manage their own mental health and wellbeing, and that providers recommend safe options. Development of the framework will likely be iterative, but initially will provide a set of questions that can be used to assess different aspects of digital solutions. The Ministry of Health will link into the World Economic Forum, which is also developing a Digital Mental Health Framework, to leverage material and thought leadership from this global forum.

Access to specialist services continues to rise, but without support to broaden systems of care

Over the last five years, access to mental health and addiction services has risen steadily just ahead of population growth, reaching 186,540 people in 2018/19, or just under 4% of the population. Over this time, wait times for addiction services have remained steady, just under and over national targets of seeing 80% of non-urgent cases within three weeks, and 95% within eight weeks respectively. Wait times for mental health services have lengthened. Five years ago, these services met the targets; in 2018/19, only 75% of people were seen within three weeks, and 91% were seen within eight weeks. For young people, the wait times were even longer in 2018/19, with only 65% seen within three weeks, and 86% seen within eight weeks.

In my 2018 report I identified that specialist mental health services and addiction services were under significant pressure, with access having increased 73% over the last 10 years, compared to funding increasing by only 40%. This gap is closing. In the 10 years between 2009/10 and 2018/19, access rose 55%, with expenditure rising 25% from 1.2 billion to 1.5 billion. In the last five years, increases in funding have overtaken increases in access, with access rising 15% between 2014/15 and 2018/19, and expenditure rising 12%. Budget 2019 included a $1.9 billion mental wellbeing package over five years across a range of portfolios, $213 million of which was the ring-fenced minimum that DHBs are required to allocate to mental health and addiction services from within their total funding.[52] Budget 2020 provided an additional $3.92 billion to DHBs over four years, a portion of which will be ring-fenced for mental health services and addiction services.

Cumulative pressure from years of growing demand and periods of relative underfunding remain, however, and any impact on demand from investment in early intervention services will take time. Financial pressure is compounded by significant workforce pressures. Stressful work conditions are leading to high turnover and persistent vacancies, with most DHBs and NGO services reporting vacancies of around 10–13%.[53] Issues of staff retention and vacancies were also identified in the Ombudsman's inspections of mental health inpatient units in 2018/19, noting: "[This] was highlighted by security staff being observed in a number of inpatient units assisting with the personal restraint of patients and conducting patient searches, which I considered to be sub–optimal."[54] Attracting and maintaining staff in rural areas is a particular challenge, as is a lack of appropriately qualified specialist staff in areas such as child and youth mental health. There is also a need to increase the diversity of the workforce and strengthen peer roles at all levels, including leadership. Despite recent advances, the ethnicity profile of the workforce does not match that of the people who use services. The Pacific mental health

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52 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. This is known as the "ring fence", and sits at roughly 10% of DHBs' budgets.

53 Te Rau Ora, *Te Iti me te Rahi*: *Everyone counts. Addictions services: Supplementary report 2019*: https://terauora.com/wp-content/uploads/2019/09/TIMTR_Addictions_Supplementary_Report.pdf.

54 Office of the Ombudsman, *Annual Report 2018/19* (2019) p 34: https://www.ombudsman.parliament.nz/sites/default/files/2019-10/annualreport-20182019.PDF.

workforce needs similarly targeted development to complement the recent improvements in Māori workforce development.[55]

It is positive that in July 2018 the Government extended the Care and Support Workers (Pay Equity) Settlement Act to include mental health and addiction support workers — I called for urgent action on this matter in my 2018 report to ensure that workforce capability was retained. However, attraction into, and retention of, the support worker workforce continues to be a challenge for some services in areas of high living costs such as Auckland. Differences between DHB and NGO pay rates owing to differential funding also creates challenges for support workers, as well as the whole workforce. The support worker workforce, including peer support roles, is an area of expansion, and a dedicated approach is required to recruit, train, and upskill this workforce to meet demand now and into the future. So too is a workforce strategy that enables the sector to deliver better, more accessible services and support to deliver on a long-term plan for change.

To support effective workforce and service planning, it is critical that evidence that underpins assessment of population need is updated urgently, expanded to capture all people and experiences of mental distress and/or addiction, and then maintained. Figures from New Zealand's only national prevalence survey, undertaken in 2003 and 2004,[56] are still relied on to estimate population-level mental distress and/or addiction need and the service-level response required. While no longer a formal target, the notion that specialist mental health services and addiction services should provide care to at least 3% of the population in a given year has also not been revisited.[57] Consideration also needs to be given to strengthening the NGO sector to enable delivery of broader models of care in the community. Less than a third (31%) of expenditure on mental health and addiction services was spent on NGO services in 2018/19. In my 2018 report I stated that "more of the same will not deliver the wellbeing and

recovery-oriented system that is required". Simply increasing access to specialist services without support to change practice will not ensure that more people will get their needs met, it will deliver more of the same, spread more thinly. Access to a broader range of health and wellbeing interventions within secondary as well as primary care is needed, including addressing employment, housing, and other needs within services or in partnership with others. Specialist services need the space, time support, and alliances and partnership of Māori, tāngata whaiora, and whānau to think through these changes in order to make them happen.

55   Te Pou o te Whakaaro Nui, *Adult mental health and addiction workforce: 2018 secondary care health services*. Auckland: Te Pou o te Whakaaro Nui (2019); Te Rau Ora, *Te Iti me te Rahi: Everyone counts. Addictions services: Supplementary report. Ministry of Health (2019); Ministry of Health, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018*. Wellington: Ministry of Health (2014).

56   Oakley Browne, MA, Wells, JE, and Scott, KM (eds), *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health (2006): www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey.(external link).

57   The Ministry of Health first set a target of 3% in 1994, which has not been revisited since: Ministry of Health, *Looking Forward: Strategic directions of the mental health services*. Wellington: Ministry of Health (1994). The then Mental Health Commission set out a *Blueprint* for how the 3% would be met.

Signs of progress

Expanding access to mental health support through general practice

The Fit For the Future model of primary mental health and wellbeing care aims to provide all New Zealanders experiencing mental distress or addictions challenges with access to convenient, high quality person-centred care and support. It was developed through a co-design group that comprised ADHB, ProCare, ThinkPlace, MahiTahi Trust, and Emerge Aotearoa. Elements of this model informed the new integrated primary mental health and addictions services funded through Budget 2019 to be rolled out nationally.

The aim of this new model is to deliver just enough support flexibly to a large number of people, as opposed to a larger fixed amount of therapy to a small group of people. The programme is accessed through general practice, and is based around new roles in the primary care and community NGO workforce: the Health Improvement Practitioner, the Health Coach, and the Awhi Ora community support worker.

Operating from the practice, these new members of the team provide rapidly accessible advice and support to clients based on individualised goals, promoting self-management, and connecting people to other services within their community as they may need. The Health Improvement Practitioner and Health Coach work closely with local community NGO support workers, ensuring that people can access the full range of help they need to manage mental distress, encourage and maintain behaviour change, address social issues, and increase their wellbeing.

A preliminary evaluation of the Fit for the Future pilot showed that the model was delivering significant improvements in timely, early intervention for people across the spectrum of mental health needs. Patients and GPs have been very positive about the programme, with wait times being significantly reduced compared with referral-based services — 75% are seen within five days compared to less than 17% with conventional services.[58]

Digital mental wellbeing responses to Covid-19

The Government invested $15 million in a package of initiatives to support the psychological and social needs of New Zealanders during the COVID-19 outbreak. This includes a suite of online/app-based self-help and support options, aimed at reaching as many New Zealanders as possible. This has built on existing services and partnerships, prioritising investment readiness and ability to quickly mobilise evidence-informed interventions. It also includes approximately $3 million funding for organisations supporting the mental wellbeing of at-risk communities because of COVID-19, covering April 2020 to 30 September 2020.

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58 Synergia, *Fit for the Future: Evaluating Enhanced Integrated Practice Teams. A report for the Ministry of Health (2018)*: https://synergia.consulting/wp-content/uploads/2018/11/Synergia-ADHB-FtfF-Enhanced-integrated-practice-teams-evaluation-FINAL-181001.pdf.

Getting through together

The "Getting through together" campaign shares ways to help Kiwis to cope with the stress of COVID-19. The campaign has been developed by All Right?, which produced the world-leading disaster recovery programme following the Canterbury earthquakes, in partnership with the Mental Health Foundation. It includes tools, dubbed "Sparklers at Home", to help parents to talk with their primary-aged children about their mental health and wellbeing. It provides free activities to help children to find calmness and to feel good.

Mentemia

"Mentemia" is an app that aims to help everybody to feel better every day through improved sleep, boosting energy, reducing stress, and easing anxiety. The app allows people to build a tailored programme to improve wellbeing every day based on the areas they want to improve. Mentemia — Italian for "my mind" — was created by long-time mental health advocate John Kirwan and tech entrepreneur Adam Clark. It provides users with practical tips and techniques to help them to take control of their mental health and wellbeing. Mentemia allows users to monitor, manage, and improve their mental health, and to track their progress.

Melon

"Melon" is an app supplied by Melon Health aimed at the whole population, but with a youth-specific component. Melon provides self-awareness tools and resources to help people to manage their emotional wellbeing. It also provides an online community for New Zealanders to connect and support each other; this virtual peer support is via a 24/7 monitored chat-room function. It also offers mindfulness exercises and resources — videos, audios, articles; optional daily webinar facilitated by health coaches; general healthy lifestyle guidance; a health journal (rataka) for self-awareness, reflection and tracking progress; and triage to national or regional services (i.e., 1737), and navigation to covid19.govt.nz and other government or community services.

Staying on track

"Staying on track" is an e-therapy tool supplied by the Wise Group on the "Just a Thought" website. It is for anyone experiencing anxiety and stress. Based on cogitative behavioural therapy (CBT), it provides a free online course of practical strategies to cope with the stress and disruption of day-to-day life as an impact of COVID-19. Funding is also being provided for nationwide marketing of the tool.

Question 2: Am I helped to be well?
Key findings

- Wellbeing is a combination of our mental, physical, spiritual, and social wellbeing, conceptualised through Māori models of health such as Te Whare Tapa Whā. Measurement and reporting on wellbeing outcomes for people with mental distress and/or addiction, and all people of Aotearoa New Zealand, should improve through the work of the Initial and permanent Mental Health and Wellbeing Commissions.

- There is evidence that people who use specialist mental health and addiction services do experience improvements over the time of service use, and the majority would recommend their service to a friend or family member with a similar need. However, people who use services also experience worse outcomes than the general population in relation to their physical health, engagement in education, training or employment, and accommodation status. This continues to be of significant concern.

- Rapid action to house people without a home and provide intensive mental health, addiction, and other support during the COVID-19 emergency pandemic response shows that homelessness can be ended where there is a will. Housing provides an important step to ensure that this vulnerable population receives effective support for mental health and addiction need. As New Zealand enters into a period of recession and rising levels of joblessness following the COVID-19 pandemic emergency response, strengthening the delivery and integration of employment and mental health and addiction support will become increasingly important.

- Continued effort is needed to establish and deliver at scale what works in services for a diversity and complexity of need, and to strengthen health promotion and prevention. There needs to be a central or networked collection of best practice and research with broad and easy access, dissemination, training and support, and feedback loops to strategy, policy, and planning.

Am I helped to be well?

"Just taking the clinical point of view is not helpful. We're all individuals … We have lives and dreams and we want things for our future as well."

– Adult tāngata whaiora interview

"Having the same goal is the unity thing. Doctors are trying to get rid of the voices, actually I wanted the voices as that's what kept me sane."

– Te Kete Pounamu hui participant

Introduction

Concepts of wellbeing 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 distress and addiction. A wellbeing system response to mental distress and addiction is centred on people and what matters to them. It recognises that mental wellbeing (taha hinengaro) is intimately connected with physical (taha tinana), spiritual (taha wairua), and social (taha whānau) wellbeing.[59] The Initial Mental Health and Wellbeing Commission has been tasked with developing a draft outcomes framework for the permanent Commission to consider. The Initial Commission will also identify gaps in measures and make recommendations to Government on how to fill them.

This section assesses the responsiveness of health services to the needs of tāngata whaiora, their impact for tāngata whaiora, and tāngata whaiora outcomes compared to the general population. It also highlights gaps in wellbeing outcome measures, and evidence of effectiveness, for consideration by the Initial Mental Health and Wellbeing Commission.

Monitoring indicators
2018/19

82%
of tāngata whaiora and their whānau would recommend their service to others

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59 These four dimensions are expressed in Te Whare Tapa Whā, a Māori model of health developed by Dr Mason Durie: http://www.health.govt.nz/our-work/populations/Māori-health/Māori-health-models/Māori-health-models-te-whare-tapa-wha. See also analysis on the social determinants of mental health: 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).

Outcome measures show that people improve in mental health and addiction services

In the Mārama Real Time Feedback Survey to 2018/19, 82% of tāngata whaiora and 84% of whānau reported that they would recommend their service to others if they needed similar care or treatment, indicating that there is something about that service that worked for them or their loved one.[60] Clinical outcome measures collected by services also indicate that people generally improve during their time in contact with mental health and addiction services.

DHB mental health services are mandated to undertake a clinical rating for all tāngata whaiora in their services. The tool they use for this is called the Health of the Nation Outcome Scales (HoNOS),[61] which measures clinical symptoms of mental distress and the overall social functioning of a person. The information from these measures indicates that tāngata whaiora are admitted into both community and in-patient services seriously unwell, and by the time of discharge have been much improved.

In 2018/19, people's clinician-rated scores of mental distress and social functioning improve by around half between admission to, and discharge from, a mental health service. The greatest improvements on discharge from an inpatient unit were for Pacific adults (a 62% improvement compared to 54% for Māori and 53% for all adults accessing services) and Māori youth (a 45% improvement compared to 42% improvement for all young people accessing services). The greatest improvements on discharge from a community service were Pacific adults and youth, who saw 56% and 48% average improvements respectively, compared to an average of 48% for all adults and 43% for all children and young people. Māori improvements were at a lower level than average in community services (46% in adult services and 39% in child and youth services). While HoNOS scoring can be undertaken with tāngata whaiora, the tool is clinically led and does not always take into account distinctions between personal, functional, and clinical recovery.[62] Opportunities to expand the current suite of measures to capture different aspects of the wellbeing continuum, including outcome measures for people accessing services, should be considered by Mental Health and Wellbeing Commission tāngata whaiora. Particular consideration should be given to whether existing measures adequately appreciate Māori concepts of health and wellbeing.

Community-based alcohol and other drug outpatient services, and Ministry of Health methamphetamine contract holders 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 tangata whaiora with clinician facilitation, and tāngata whaiora 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 and employment, as well as measuring recovery progress. The improvement measure used in this report relates to a tangata whaiora's assessment of progress towards their recovery goals.

Self-rated recovery scores for people accessing alcohol and other drug services showed an average improvement of 24% in 2018/19. There was very little variation compared to previous years. A recent finding from analysis of ADOM scores is that even a small reduction in alcohol consumption can have a positive effect on a person's wellbeing, with each alcohol-free day further improving lifestyle and wellbeing.[63]

60   HDC collects the voices of tāngata whaiora and their families through Mārama Real Time Feedback mental health and addiction service tāngata whaiora and whānau experience survey. The result reported is the average score over five years of data collection through to 30 June 2019. As at 30 June 2019, the survey was used by 14 DHB providers and 5 NGOs, and 29,836 tāngata whaiora and whānau voices had been collected (18,875 and 10,961 respectively).

61   Fifteen items are used in the HoNOS scale for children and adolescents aged 4–17 years (HoNOSCA), and 12 items are used for adult tāngata whaiora, 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.

62   Health and Disability Commissioner, *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner* (2018) 48.

63   Hanton, P, Jury, A, Lai, J, Tuason, C, "Reducing days of alcohol use improves lifestyle and wellbeing: An analysis of outcomes data from New Zealand adult community alcohol and other drug services". *NZ Medical Journal* (May 2019) 132(1495) 54–64.

There are no nationally consistent outcome measures for NGO mental health services, despite a variety of individual contract requirements to report on outcomes. Similarly, there is no national outcome information for people accessing primary and community care for mental health and addiction issues. These are significant gaps that should be considered by the Commission. I have been advised by the Ministry of Health that national outcome reporting requirements have been built into contracts for the Budget 2019 primary care investment, which will build the evidence-base in this area.

Wellbeing outcomes for people with mental distress and/or addiction continue to be poorer than population wellbeing

Outcomes relating to physical health, engagement in education, training or employment, and accommodation status are worse for people with mental distress and/or addiction than the general population. Contributions to these outcomes come from many places, and emphasise the need for a whole-of-government, whole-of-community, whole-of-whānau response to support wellbeing and recovery. [64]Health services and systems (including workforce) have a role to connect into wider social responses, putting people and whānau at the centre of care.

Monitoring indicators
2018/19

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

Average HoNOS score for adults

14 Admission

7 Discharge

Average HoNOS score for children and adolescents

19 Admission

11 Discharge

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

Average HoNOS score for adults

11 Admission
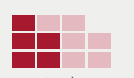
5 Discharge

Average HoNOS score for children and adolescents

15 Admission
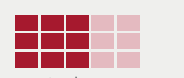
9 Discharge

24%
average increase in tāngata whaiora satisfaction towards achieving recovery goals (addiction services)

64   Indeed, the Interim Report of the Health and Disability system review noted that "mental heath outcomes are of particular concern, and the populations being underserved by the health and disability system are, in most instances, the same populations being underserved by other systems" — p 9: https://www.systemreview.health.govt.nz/assets/HDSR-interim-report/3fae23ee48/H-and-D-interim-report-August-2019-Section-A.pdf.

Achieving physical health equity

Evidence collated for the Aotearoa NZ Equally Well collaborative continues to provide the most up-to-date picture of the physical health disparities for people living with mental distress and/or addiction. While these disparities exist across the continuum of mental health and addiction needs, people experiencing serious mental distress or addiction die up to 25 years earlier than the general population. Two-thirds of this premature mortality is due to preventable and treatable physical health conditions — particularly cancers and cardiovascular disease.[65] Māori with serious mental distress have higher rates of chronic pain and respiratory conditions.[66] People with a diagnosis of a psychotic illness have an increased risk of premature death. People who use alcohol hazardously have almost double the risk of developing a wide range of cancers.[67] People with amphetamine use disorders are more likely to experience heart disease, cerebrovascular complications, oral health diseases, and increased risk of blood-borne viruses. About three-quarters of people who receive opioid substitution treatment are likely to have, or have had, Hepatitis C.[68]

The contributors to these high rates of co-occurring physical health issues include the physical impacts of psychotropic medications and some of the medication used in the treatment of substance use disorders, the effects of colonisation, poverty, nutrition, and poor housing, and past trauma, alongside, on average, higher rates of tobacco and alcohol use.

However, there is also clear evidence for a disparity in the physical health care provided to people with mental distress and addiction compared to the general population, both in terms of prevention and promotion, early intervention, and within the quality of care received in specialist and general health services.[69] In a recent HDC breach decision (19HDC00536, see case study at the end of this section), a man presented to a medical centre 24 times over a period of four years and saw six different doctors. The man, who had a long-standing diagnosis of bipolar affective disorder, was prescribed his usual lithium medication at most appointments. A side effect of this treatment is lithium toxicity, which can cause permanent kidney damage, so it is recommended that lithium levels and renal function are monitored every three months. However, each doctor failed to recognise that the man's lithium monitoring was overdue, and that his renal function was deteriorating. Subsequently, the man was admitted to hospital and diagnosed with acute kidney injury secondary to lithium toxicity. The Commissioner made a number of recommendations, including that the practice apologise and discuss the findings of the investigation with the family, and audit whether changes introduced since the events have resulted in regular monitoring of patients on medications that require regular blood tests.

A number of studies have also identified the attitudes of a range of health professionals towards people experiencing mental distress and/or addiction issues as a factor in inadequate

65 Cunningham, R, Sarfati, D, Peterson, D, Stanley, J, and Collings, S, "Premature mortality in adults using New Zealand psychiatric services". *New Zealand Medical Journal* (2014) 127(1394): 31–41. In Te Pou o Te Whakaaronui, *Equally Well Aotearoa New Zealand — some key facts*: https://www.tepou.co.nz/resources/equally-well---some-key-facts/921; 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.

66 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).

67 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.

68 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).

69 Cunningham, R, Poppe, K, Peterson, D, Every-Palmer, S, Soosay, I, and Jackson, R, "Prediction of cardiovascular disease risk among people with severe mental illness: A cohort study". PLoS ONE 14(9) e0221521: doi: 10.1371/journal.pone.0221521; Firth, J, Siddiqi, N, Koyanagi, A, Siskind, D, Rosenbaum, S, et al., "The *Lancet Psychiatry* Commission: a blueprint for protecting physical health in people with mental illness". *Lancet Psychiatry* (2019) 6(8): 675–712: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30132-4/fulltext.

preventative care or treatment.[70] 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 a diagnosis of schizophrenia. There was no difference between professionals working in primary care and in mental health services in this regard.[71]

The Aotearoa NZ Equally Well collaborative supports awareness raising, learning, and action for people and organisations, with the common goal of achieving physical health equity for people with mental health and addiction issues. To date, 126 organisations have joined the collaborative formally. Equally Well collaboratives, modelled on Aotearoa NZ Equally Well, are now well established in Australia and England, and there are collaboratives emerging in France, Canada, and Sweden. A recent Equally Well initiative led by champions *Kaikōura Health: Te Hā o Te Ora* has focused on promoting regular physical health screening, including by identifying patients seen for serious mental health and addiction issues and calling people in for funded consultations; establishing an individualised health plan; and working in a multi-disciplinary model to refer internally to social workers or community support workers and externally to a range of organisations, including dental services, nutrition services, and addiction services. While still a work in progress, *Kaikōura Health: Te Hā o Te Ora* report "improved mental health outcomes for people accessing the service in this isolated rural area with people being seen by skilled clinicians within a week of referral and subsequent interventions being delivered in or close to the person's home … As an example of the impact that is already happening, one person who is also under the care of specialist mental health services, was identified as having had no physical health checks since 2015. As a result of this initiative, this person is now receiving regular district nursing support for the identified health issues."[72]

Monitoring indicators
2018/19

49%
of tāngata whaiora are in employment, or educational training
Source: MOH

Tāngata whaiora accommodation

Homeless — 4%
In supported accommodation — 12%
Live independently — 84%
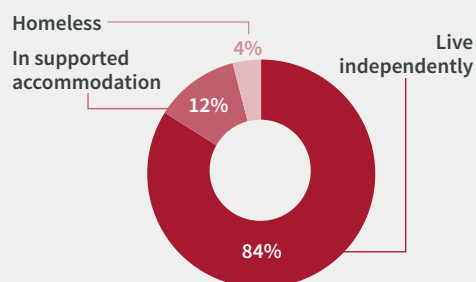
National policies are also increasingly recognising and responding to the increased physical health risks for people with mental health and addiction issues. For example, a sign of progress at the end of this section outlines how the Needle Exchange is being used to increase access to treatment for Hepatitis C for people who inject drugs. The Ministry of Health's 2018 Cardiovascular Disease Risk Assessment Guidance[73] included a specific focus on prioritising people with serious mental health conditions for cardiovascular health checks from the age of 25 years. People with mental health and addiction issues are also prioritised in the New Zealand Cancer Action Plan 2019–2029.[74] Members of the Aotearoa NZ Equally Well

70 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.

71 Corrigan et al. (2014), *ibid*.

72 Te Pou o te Whakaaro Nui, "Equally Well Kaikōura Health profile" (2020): https://www.tepou.co.nz/news/equally-well-kaikoura-health-profile/1200

73 Ministry of Health, *Cardiovascular Disease Risk Assessment and Management for Primary Care*. Wellington: Ministry of Health (2018).

74 Ministry of Health, *New Zealand Cancer Action Plan 2019–2029 — Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029* (revised January 2020). Wellington: Ministry of Health (2019).

collaborative worked with the Ministry of Health for a focus on mental health and addiction in both of these important policy and strategy documents.

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. The *Maximising physical health* project is due to commence in 2021.

Continued, sustained action is still needed until physical health equity is achieved, including routinely reportable measures of physical health equity for people with mental distress and addiction.

More is needed to help people to stay in work or find a job

Recently, the Ministry of Health started to collect data on the employment, training, education, and accommodation status of people accessing mental health services and addiction services.

In 2018/19, 49% of people accessing mental health and addiction services were in employment, education, or training. While this is an improvement on 45% in 2016/17, it means that half of people were not in work or study, suggesting that this is an area with potential for services to improve their connection with wider supports. Rates of education, training, or employment were lower for Māori (45%) in 2018/19, and slightly lower for Pacific tāngata whaiora and people accessing addiction services (47%). People accessing NGO services had the lowest rates of education, training, or employment (at 40%) compared to the total population accessing services. Young people had the highest rates (83%), which in part will reflect enrolment in schooling.

In December 2018, the OECD released a report *Mental Health and Work: New Zealand*, which reviewed New Zealand's policies against the OECD's *Council Recommendation on Integrated Mental Health, Skills and Work Policy*, endorsed by

all health and employment ministers from all OECD countries, including New Zealand, in 2016. The OECD found that people who have a mental health condition face lower rates of employment than those without such conditions, and twice the rate of unemployment (12% compared to 5%). The employment and unemployment gap is especially large for people with a severe mental health condition, who have a four-fold unemployment risk. The OECD also found that in New Zealand, mental health conditions are very prevalent among people who receive social benefits, with Māori experiencing multiple disadvantages, including the highest mental health prevalence and the largest income and employment disparities.[75]

The OECD noted that New Zealand was well placed to respond to mental health and unemployment because of high levels of awareness and openness to discussion of mental health issues. This was attributed to the success of the long-running anti-stigma and discrimination campaign "Like Minds Like Mine" (although I note that this campaign solely addresses mental health, and not addiction issues). Nonetheless, the OECD considered that awareness of the issues was yet to translate sufficiently into better policies and outcomes for people with mental health conditions. The report identified a number of reasons for this, applicable to almost any area of mental health and addiction, including an inability to scale successful pilots; fragmented and duplicate services; a lack of cross-country and cross-government leadership; a focus on severe diagnosed conditions without reach to common mental health conditions such as mood and anxiety disorders; the differential system for injury and illness; semi-private provision of primary health care; and an absence of early intervention in the welfare system.

The OECD made a number of recommendations, including to establish employment as a key target for mental health care, to focus on supporting vulnerable youth and improving workplace mental health, and prioritising support for mental health in the employment and welfare system. The OECD recommended that in order to move from policy thinking to implementation, there should be an

75   OECD, *Mental Health and Work: New Zealand*, Mental Health and Work, OECD Publishing: Paris (2018): https://doi.org/10.1787/9789264307315-en.

evidence-based, integrated mental health and employment strategy, supported by systematic collection of evidence. Pilots and trials should be evaluated and rolled out where proven effective, and the focus of intervention should be broadened to include high-prevalence common mental health conditions without the requirement for a diagnosis. These recommendations apply equally to people who experience addiction.

As New Zealand enters into a period of recession and rising levels of joblessness following the COVID-19 pandemic emergency response, strengthening the delivery and integration of work and mental health and addiction support will become increasingly important. In his submission to the Epidemic Response Select Committee, the Prime Minister's former chief science advisor, Sir Peter Gluckman, warned of a "new vulnerable" — people with an uncertain employment future who have never had to rely on the welfare system, who would join the large number of New Zealanders who were already disadvantaged.[76] The Government's COVID-19 psychosocial and mental wellbeing recovery plan *Kia Kaha, Kia Māia, Kia Ora Aotearoa* acknowledges that being out of work is associated with worse physical and mental health, and includes an action to "consider how mental health and addiction services and employment support can be linked".[77] Some work is already underway with the Aotearoa NZ Individual Placement and Support (IPS) Employment Support steering group, with representation from the Ministries of Social Development and Health, lived experience, Maōri, NGOs, and DHBs. IPS are practices that have been proven to be effective for people in contact with mental health and addiction services. One of the aims of the steering group is to increase access to high quality IPS employment programmes, and therefore it has developed an IPS employment support scale-up plan, including to fund and support service start-ups.

Homelessness, including for people with mental distress and addiction, can be eliminated where there is a will

In 2018/19, 84% of people who accessed mental health and addiction services lived in independent accommodation. A further 12% lived in supported accommodation, and the remaining 4% were without a home. While the percentage of independent and supported accommodation varied between 2016/17 and 2018/19, the proportion of homeless stayed the same. Māori (6%) and people accessing addiction services (5%) have slightly higher rates of homelessness than the general population accessing services.

In his recent evidence to the Epidemic Response Select Committee, Auckland City Missioner Chris Farrelly described the significant and rapid response to ensure that those who were homeless or in severe overcrowding, or living in situations not fit for human habitation, had somewhere safe when the COVID-19 pandemic emergency response message went out to isolate at home. Very quickly, "over a thousand motels were made available nationwide to rapidly house homeless people over the weeks. And in Auckland, the collective I just spoke about, over the last one month, has housed 495 homeless people in 415 MSD and Ministry of Housing and Urban Development provided motels."[78] Many of the people housed have significant complex issues, including in relation to mental health and addiction, and were provided wrap-around support to enable those people to stay in those motels.

The Government followed with a $107 million announcement to move people who are in this temporary accommodation into more permanent accommodation, and to fund the intensive support required to keep them in housing. I commend this investment, along with investment from the previous and current governments in the Housing First approach, which I highlighted in my 2018 report. The Housing First approach recognises that it is easier for people to address issues with their mental health and substance use, once they are housed. Following this, wrap-around services are provided to support success. What the COVID-19 pandemic emergency response has shown is that when there is a will, homelessness can and should be ended.

76   New Zealand Parliament, *Epidemic Response Committee Meeting Recording and Hansard Transcript: Thursday 30 April* (2020): https://www.parliament.nz/en/pb/sc/scl/epidemic-response/news-archive/watch-public-meetings-of-the-epidemic-response-committee/.

77   Ministry of Health, *Kia Kaha, Kia Māia, Kia Ora Aotearoa; COVID-19 Psychosocial and mental wellbeing recovery plan*. Ministry of Health (2018): 22.

78   New Zealand Parliament, *Epidemic Response Committee Meeting Recording and Hansard Transcript: Thursday 30 April (2020)*: https://www.parliament.nz/en/pb/sc/scl/epidemic-response/news-archive/watch-public-meetings-of-the-epidemic-response-committee/.

We need to ensure that people receive the earliest and most effective support

The significant gap in health, housing, and employment status for people who access mental health services and addiction services compared to the general population, and static/rising population prevalence[79] despite increasing access to services, suggests that there is significant scope for services to be more effective in providing meaningful support for the people they see. A recent analysis of several OECD countries experiencing similar increases in treatment with persistent or rising prevalence identified a "prevention gap" and a "quality gap" in the provision of care after finding that destigmatisation and increasing awareness of help-seeking and social factors did not explain the lack of impact of treatment on population outcomes.[80]

Addressing the quality gap

He Ara Oranga described "strong discontent across submissions about the ease with which help-seeking was often met with only a prescription, instead of accessible, community-based, timely, holistic options … DHB staff described a lack of 'step-down' services to help people recovering from being acutely unwell to re-establish a stable and meaningful life in the community. This need for a continuum of support and services was a constant concern among tāngata whaiora, families, members of the public, clinicians and NGOs. The lack of available services, especially talk therapies, was blamed for much of the perceived ineffectiveness and inefficiency of the current system such as an over-reliance on medication, the exhausting struggle to meet criteria for specialist services and the difficulties of discharge planning."[81]

There is strong evidence that investing effectively in mental health and addiction makes a positive difference, both to people's health, as well as to the economy.[82] For example, as highlighted in my 2018 report, growing the peer workforce is one area with evidence of benefit, including in relation to clinical outcomes (engagement, symptomatology, functioning, admission rates), subjective outcomes (hope, control, agency, empowerment), and social outcomes (friendships, community connection).[83]

Policies and responses that address inequities and make space for Māori and other world-views alongside clinical approaches, including through the expansion of kaupapa Māori services and whānau-centred approaches, should be strengthened (see Question 6 for further discussion). Where evidence is lacking, particularly for populations whose needs are not being met in generalist services, there should be support for populations and services to develop, trial, and evaluate new approaches, trusting that population groups and communities know what works best for them. Both the Te Tumu Waiora model (discussed in Question 1) and the Parenting and Pregnancy Services (discussed in Question 6) developed out of pilots to address unmet need. In order to promote diversity and inclusion of response, all populations need to be at the table and included in these developments.

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79   Note that while the national prevalence survey, *Te Rau Hinengaro*, has not been repeated (and used 2003 and 2004 data), there are some indications of a rise in mental distress and substance use for some populations. For example, the New Zealand Health Survey reports an increase in people experiencing psychological distress in the last four weeks from 5% in 2011/12 to 8% in 2018/19.

80   Jorm, A, Patten, S, Brugha, T, and Mojtabai, R, "Has increased provision of treatment reduced the prevalence of common mental disorders? Review of evidence from four countries" *World Psychiatry* (2017) 16(1): 90–99.

81   Government Inquiry into Mental Health and Addiction, *He Ara Oranga* (2018) 56: https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf.

82   See, for example, World Health Organization, *Investing in mental health: evidence for action*. Geneva: World Health Organization (2013); 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; 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; 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.

83   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.

There is a need to focus effort on identifying, sharing, and scaling what works, including to support diverse populations and needs. There is also a need for good practice to be disseminated better, to ensure that services learn from each other and avoid unnecessary duplication. Too often services are not aware of, or are not learning from, innovations happening in other DHBs or NGOs (or overseas initiatives). This is despite existing forums and programmes to encourage shared learning and quality improvement. Investing in change is often seen as risky or not feasible when services are already under pressure and there is limited support for change. Health services do not have to do it all, and they should not try to, but they need to work with others to connect people and whānau into meaningful support.

In order to reduce duplication of effort — where 20 DHBs and hundreds of NGOs are attempting to implement the same thing without reference to each other — and ensure that services and interventions are focused on the right things, there needs to be a central or networked collection of best practice and research. This needs to be supported through broad and easy access, dissemination, training and support, and feedback loops to strategy, policy, and planning. Delivery of that support may be by a range of existing or new organisations, such as current workforce organisations, an expansion of the HQSC quality improvement programme, the new Mental Health and Wellbeing Commission, or a new centre of excellence. Best practice co-design with tāngata whaiora and family/whānau should be a core component.

Addressing the prevention gap

Prevention and health promotion, including strengthening the resilience of individuals, whānau, and communities is an important aspect of a wellbeing system response. While out of the scope of my monitoring function focus on services, I will note that *He Ara Oranga* identified a broad range and growing amount of mental health promotion and prevention activity, as well as significant gaps and untapped opportunities that would benefit from more funding and investment. *He Ara Oranga* also recommended that the new Mental Health and Wellbeing Commission develop an investment and quality assurance strategy for mental health promotion and prevention, working closely with key agencies, which the Government accepted in principle.

HDC case study

Inadequate monitoring of renal function for a man taking lithium medication for bipolar affective disorder (19HDC00536)

Between 2014 and 2018, a man in his seventies with a long-standing diagnosis of bipolar affective disorder presented to a medical centre 24 times and saw a total of six different doctors. At most of these appointments, he was prescribed his usual lithium medication. A side effect of this treatment is lithium toxicity, which can cause permanent kidney damage, so it is recommended that lithium levels and renal function are monitored every three months. However, each doctor failed to recognise that the man's lithium monitoring was overdue, and that his renal function was deteriorating.

In June 2018, the man was admitted to hospital and diagnosed with acute kidney injury secondary to lithium toxicity. It was noted that his lithium levels had not been checked since May 2014.

The Health and Disability Commissioner found the medical centre in breach of Right 4(1) of the Code, owing to the repeated failure of multiple GPs to prescribe appropriately or monitor his lithium levels or renal function. He also found the practice in breach of Right 4(5), as the poor coordination of care and clinical oversight reflected poor systems for continuity of care at the medical centre.

The Commissioner was also concerned that none of the doctors at the medical centre had ever given the man any written or verbal information regarding the side effects of lithium or the recommended monitoring requirements. This removed a critical element of safety-netting around the man's care, and deprived him of the opportunity to give informed consent and participate in his own care. For these failings, the Commissioner found the medical centre in breach of Right 6(1) and Right 7(1) of the Code.

The Commissioner asked the medical centre to:

- Provide the man with an apology for its breach of the Code

- Meet with all staff involved in the man's care to discuss the findings of this investigation, including the importance of monitoring lithium, reviewing a patient's notes before prescribing medication, and following Medical Council standards for prescribing

- Audit whether changes introduced since these events have resulted in regular monitoring of patients on medications that require regular blood tests.

Signs of progress

Hepatitis C treatment Tū Ora PHO partnership with the Needle Exchange

People who inject drugs are at increased risk of Hepatitis C but are often marginalised from standard healthcare delivery models. Previous treatments have not always been pleasant for the person undergoing them, or successful in eliminating the virus, which has put others off seeking treatment. Members of this community do not always trust or want to engage with primary health services, and may face other barriers to access if they do. The Needle Exchange is a service they do tend to engage with. Peer led and with completely open access, the Needle Exchange has been leveraging its roots in this community to improve members' health and wellbeing since it first started.

Tū Ora Compass Health PHO is part of a national project to eliminate Hepatitis C. Armed with a new fully Pharmac funded, highly effective and better tolerated treatment option (Maviret), Tū Ora understood that it needed to partner with organisations like the Needle Exchange to reach the people in its region that would benefit most. This partnership has resulted in monthly drop-in clinics at Needle Exchanges throughout the Central region, with a nurse practitioner from Te Aro Health running a full One Stop Shop clinic at the Wellington Exchange — offering education, testing, and

treatment to all who want it. People can choose to undertake their whole course of treatment through either Te Aro Health as a casual client (which ensures continuity of care), or their usual practitioner. The whole process is free of charge to the patient. The same nurse practitioner also provides drop-in Hep C clinics at the Downtown Community Ministry in Wellington, and Tū Ora is keen to partner with other organisations that are well connected with communities who face barriers to engagement with mainstream health services.

> "Having the Needle Exchange at the centre has been really amazing. They have so much knowledge about their clients and so much knowledge about Hep C … If we want to see equitable outcomes for more marginalised members of our communities, we have to be creative and work in ways that clients have determined would work for them."
>
> Tū Ora

Equally Well initiative — cardiometabolic screening for people using clozapine

When the Equally Well initiative highlighted the decreased life expectancy of people with prolonged mental illness, a team in Nelson-Marlborough DHB decided to look at what was happening for tāngata whaiora in their own region. Knowing that psychiatric medication was a key contributor to poorer health outcomes, the team began investigating what was going on for people using clozapine — a drug that while effective for the treatment of schizophrenia, is known to have some unpleasant side effects. Despite the risks of clozapine to the cardiac health of those using it, the team found that only 2% of people prescribed the drug in their region had received cardiometabolic screening.

Working with tāngata whaiora and whānau, the team found that the health impacts of clozapine were a significant concern, and that there were multiple barriers to screening. These included financial barriers, health literacy challenges, a lack of trust of health services, and poor coordination and connection between primary health care and specialist mental health services.

Armed with a list of everyone in the region who was being prescribed clozapine, a registered nurse was seconded to coordinate a programme of screening and intervention. The programme takes advantage of people's existing appointments with specialist mental health services to conduct ECGs, arrange blood tests, and follow up with primary care to ensure that the components of cardiometabolic screening are taking place. Pivotal to the success of the project is having one person with the dedicated time to manage the process and to build trust and rapport between all of the stakeholders involved.

Also key to success was the redevelopment of the clozapine initiation titration documentation in conjunction with a pharmacist, in order to capture baseline cardiometabolic screening. People who are starting on clozapine now have metabolic screening as part of standard practice, and this baseline informs the ongoing screening and interventions once the person has moved into a medication maintenance phase. Ongoing cardiometabolic screening is captured on a new form that aligns with the Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines and prompts the initiation of interventions and referrals to additional support should an issue be discovered on screening. The underpinning philosophy is "Don't just screen ... intervene". Screening opportunities are used to provide health education and to troubleshoot interventions with any tāngata whaiora who are experiencing side effects. Referrals made in response to an identified issue are then followed up by the coordinator. The aim is to make life easier for people on this medication and to utilise the opportunity of people's engagement with mental health services as a way to improve their overall health and wellbeing.

Since the team started the project, 91% of people on clozapine in the Nelson-Marlborough region have now had metabolic screening, and the majority have also had supportive intervention to improve their quality of life. The team is still aiming for 100% screening completion, and is now looking at how to expand this approach to all people on antipsychotic medications, as well as clients of alcohol and drug treatment services.

HDC case study

Inappropriate discharge and lack of respect for dignity (17HDC00497)

This case highlights the importance of compassionate, person-centred care, and comprehensive consideration of a person's needs, including accommodation requirements, on discharge from hospital.

A man with a background of depression, anxiety, and harmful alcohol use, was admitted to the gastroenterology ward of a public hospital. He was treated for alcoholic hepatitis.

Around three weeks later he was discharged, despite remaining unwell and requiring ongoing medications, and having no suitable accommodation arrangements in place. The man was considered to be deliberately engaging in behaviour intended to prevent his discharge.

The man was escorted from the hospital by security staff and taken to a nearby bus stop while wearing hospital pyjamas. He remained at the bus stop for many hours. Members of the public and security staff raised concerns about his condition with the hospital's Emergency Department (ED), but he was not reassessed by hospital staff.

Later in the day, the man was taken to the ED waiting room, and the police were called to remove the man. He was issued a trespass notice and taken to a social service agency. While there, his condition deteriorated further and he was returned to the hospital, where he died two days later.

HDC's clinical advisor noted that "all patients deserve equal care regardless of personal circumstances", and that the failure of reasonable care in this case was due to a loss of concern for basic human dignity and a duty of care for all people regardless of their behaviour or underlying reasons for their illness.

In the Commissioner's view, given the man's unresolved medical and accommodation issues and his need for ongoing compliance with medication, it was not appropriate for him to be discharged. The Commissioner noted that discharge to a bus stop should never happen, and was particularly concerned that there was a lack of effective response to the man's obvious need for help. He therefore found that the DHB failed to provide the man with services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner commented that there was a striking lack of compassion shown to the man in failing to take seriously the concerns raised by security staff and members of the public. He found the DHB in breach of Right 3 of the Code for failing to respect the man's dignity.

The Commissioner's recommendations included that the DHB apologise to the family, audit the operation of its new trespass policy, and ascertain whether staff in the gastroenterology ward feel free to raise their concerns and escalate these if necessary.

Question 3: Am I a partner in my care?
Key findings

- Tāngata whaiora have a right to be treated with respect, to receive effective communication, and to make informed choices and give informed consent, as set out in the Code of Health and Disability Services Consumers' Rights. Where a Code Right is overridden in part or in full by an Act such as the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) or the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act), all other Code Rights continue to apply.

- Supporting whānau and support networks is an important part of a system response to recovery and wellbeing. Lack of whānau involvement in risk assessments and care is a common issue raised with HDC.

- Partnership and tāngata whaiora rights can be strengthened through shared development of wellbeing plans, supported decision-making, and advance directives. I support the intention of the Ministry of Health's proposed draft revisions to the *Guidelines for the Mental Health (Compulsory Assessment and Treatment) Act 1992,* which include greater incorporation of these tools.

- Marked improvement is required in ensuring that tāngata whaiora have wellness plans on discharge. When they do, evidence indicates that their health improves, including fewer acute admissions and increased employment. No DHBs achieved the target of 95% of people having a transition plan on discharge from an inpatient unit in 2017/18. This improved to four in 2018/19.

- Tangible progress to address New Zealand's high rates of compulsion under the Mental Health Act is required, especially for Māori. There also needs to be more transparency about how the review of the Mental Health Act will be undertaken, and in what timeframes.

- To date, reasonably small numbers of people have been detained compulsorily under the Substance Addiction Act, suggesting that it is working as intended as an intervention of last resort. While the majority of people leaving compulsory treatment went on to engage in services voluntarily (36% received additional inpatient care and/or 64% attended outpatient services), only 25% are recorded as having wellness plans on discharge. A greater focus on wellness planning for people receiving compulsory substance addiction treatment is required, particularly given the complex needs of this group of people.

Am I a partner in my care?

"My key worker comes to me with everything first. Nothing is put forward without me saying it's ok."

– Youth tāngata whaiora interview

"Starts with the whānau … until my whānau can accept their part it doesn't work."

– Te Kete Pounamu hui participant

Introduction

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

In this section, indicators of partnership are considered in relation to communication, respect, and shared planning, as well as involvement of whānau, where appropriate, in a person's care. I also look at the use of compulsory assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act).

Monitoring indicators
2018/19

76%
tāngata whaiora and their whānau agree they are involved in decisions about their care

60%
of HDC mental health and addiction complaints included communication issues

75%
of tāngata whaiora and their whānau agree their plans are reviewed regularly

Consumers have a right to respect, effective communication, and to make an informed choice and give informed consent

The Code of Health and Disability Services Consumers' Rights (the Code of Rights) sets out ten rights that apply to "every consumer" of health and disability services, including the right to be treated with respect, to dignity and independence, to effective communication, and to make an informed choice and give informed consent.[84] These Rights are core underpinnings of partnership in care, and align with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), of which New Zealand is a signatory. The CRPD reflects an international movement towards greater recognition of the rights of disabled people, including people with psychosocial disabilities.

The people to whom my team and I spoke during the development of this report also highlighted the importance of a partnership relationship in the delivery of care.

> "[My caseworker's] really kind and she doesn't judge me and I feel like I can talk to her about anything — which is rare for me."
> Adult tangata whaiora interview

> "I feel able to tell my therapist if an exercise/ intervention that she suggests won't work for me/I won't do it, and then we will work together to find something else that will work."
> Youth tangata whaiora interview

> "Being able to connect with kaimahi on a deep level of knowing you have similar experiences creates a connection from the start."
> Te Kete Pounamu hui participant

> "Having a key worker who has taken the time to read my notes before engaging with me, then listening to me to understand what is going on with me. Making me feel heard."
> Te Kete Pounamu hui participant

> "The psychiatrist and psychologist respected my views and decisions. They gave me choices and didn't try to pressure me into anything I didn't want."
> Te Kete Pounamu hui participant

The majority of tāngata whaiora and whānau (76%) report in the Mārama Real Time Feedback Survey to 2018/19 that they feel involved in decisions about their, or their loved one's, care. While this is a positive result, it is the second lowest score of the seven core questions — the lowest being agreement to the statement "our plan is reviewed regularly" (75%). The measure "I feel involved" has also seen a slight decline from the previous two years (which were 77% and 78%). The biggest decline was seen in relation to whānau, where, up to 2018/19, 75% reported that they felt involved, compared to 80% up to 2016/17.

Communication issues are a common feature of complaints to HDC about mental health and addiction services. Of the 301 complaints received by HDC in 2018/19 about mental health and addiction services, 60% included concern about how the provider had communicated with them — an increase from 55% in 2016/17. Additionally, inspections of inpatient services by the Ombudsman in 2018/19 identified that "the majority of mental health units inspected did not routinely invite patients to attend their multi-disciplinary team meeting review, nor did they receive a copy of the meeting minutes. Additionally, consent for treatment was poorly documented."[85]

The Health Quality & Safety Commission's survey into staff views on mental health and addiction services, *Ngā Poutama Oranga Hinengaro: Quality in Context*, found that the highest percentage of staff (77%) agreed that tāngata whaiora were treated with respect[86] (the results of the tāngata whaiora and whānau survey are yet to be published). Similarly,

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84   Health and Disability Commissioner, *Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996* (2020): https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

85   Office of the Ombudsman, *Annual Report 2018/19* (2019): 34: https://www.ombudsman.parliament.nz/sites/default/files/2019-10/annualreport-20182019.PDF.

86   Mobius Research and Strategy Ltd for Health Quality & Safety Commission, *Ngā Poutama Oranga Hinengaro: Quality in Context survey of mental health and addiction services, National report*. Health Quality & Safety Commission (2018).

to 2018/19, the statement "I am treated with Respect" had the highest agreement by tāngata whaiora and whānau in the Mārama Realtime Feedback Survey (83%). Twelve percent of complaints about mental health and addition services included concern about providers having a disrespectful manner/attitude.

Where a Code Right (such as Right 7, to make an informed choice and give informed consent) is overridden in part or in full by an Act such as the Mental Health Act or the Substance Addiction Act, all other Code Rights continue to apply. Other Code Rights (including to dignity and independence, to be treated with respect, to effective communication, and to support) become particularly important and relevant where a Code Right has been overridden.

Opioid substitution treatment (OST) guidelines stress the need for recovery and tāngata whaiora focused care.[87] It is important that when control is exercised in OST services, it is proportionate to the risks posed in the individual instance, and that it is underpinned by tāngata whaiora and a recovery-focused model of care. Particular care should be taken to adopt a partnership approach where there is significant power imbalance, such as OST services where providers have high levels of control about whether, how much, and how medication is administered. Some tāngata whaiora spoken to in the development of this report described a coercive and disrespectful relationship with their OST clinicians:

> "You can't tell them the truth about anything or you get punished. You can't tell them what's actually going on or they'll take your takeaways away and !#@% with your life."
> Adult tangata whaiora interview

> "[T]hey treat you like a drug seeker and don't take anything you say seriously. You can see that some of the people there just hate junkies."
> Adult tangata whaiora interview

Opioid treatment services can be risk averse, and are subject to strict legislative requirements. This can influence clinical decision-making, and can be experienced by people using the service as punitive. Instances of OST clinicians using their prescribing power coercively, or to punish, have been raised with the HDC and anecdotally through engagement with tāngata whaiora and sector engagement.

Monitoring indicators
2018 AND 2018/19

4 out of 20
DHBs met the target of 95% of tāngata whaiora having a transition plan

12%
of treatment days by services included contacts involving whānau

15,026
treatment days by services included contacts to support whānau, including children

6,317
people were under Community Compulsory Treatment Orders in 2018

HDC receives few complaints about addiction services — in 2018/19, only 15 of the 301 mental health and addiction complaints received were about addiction services. I am aware of the vulnerability of this tāngata whaiora group, and have initiated a project with the National Advocacy Service to engage with people who access OST, and other tāngata whaiora with less of a voice, to ensure that they are supported to raise concerns. This project is part of my response to *He Ara Oranga's* recommendation 22 directing the HDC to undertake specific initiatives to promote respect for, and observance of, the Code of Rights by providers, and awareness of their rights on the part of tāngata whaiora, in relation to mental health and addiction services.

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87   Ministry of Health, *New Zealand Practice Guidelines for Opioid Substitution Treatment*. Wellington: Ministry of Health (2014).

Amplification of whānau voice across all aspects of the mental health and addiction system — as leaders, providers, designers, advocates, and supporters — is an important component of partnership and a mechanism to uphold consumer rights and improve services.[88] Regular sampling of tāngata whaiora and whānau experience provides an indication of quality, and highlights areas for quality improvement. In my 2018 report I recommended that there be a requirement for providers of DHB-funded mental health and addiction services to undertake comparable, representative sampling of tāngata whaiora experience, and to report annually, from 2019, on that information and actions taken to improve services as a result of the information. No decisions have been made on how best to progress this recommendation; however, I note that it is in the Initial Mental Health and Wellbeing Commission's Terms of Reference to identify any gaps in information required to monitor performance, and to make recommendations to the Minister of Health on how these could be filled and by whom. In the meantime, I have partnered with Te Pou o te Whakaaronui to improve the quality of the Mārama Realtime Feedback and better support services to utilise Mārama for quality improvement and report improvements to tāngata whaiora and whānau (see signs of progress at the end of this section).

Whānau and support networks need to be valued as an integral part of recovery and wellbeing

For many, although not all, tāngata whaiora, their whānau are a primary support and an integral part of their wellbeing and recovery journey. For many Māori, the concept of whanaungatanga (extended family and relations) is inseparable from health and wellbeing. The power of a person's support networks in building resilience and aiding recovery and wellbeing is well documented, particularly for addiction.[89] Additionally, tāngata whaiora who are parents or caregivers of dependent children often need support in their role as parents or caregivers when they are unwell or experiencing distress, and the children they care for may also need support.

Too often in complaints to HDC, whānau or support people were not engaged or consulted when they should have been. In a recently published HDC breach decision (15HDC01279), a man was referred to the Alcohol and Other Drug Service for alcohol and substance use, and a personal crisis plan was drafted. Over the course of the next two months, the man made several calls to the Mental Health and Addiction Crisis Team and was admitted to hospital twice voluntarily. During an admission, a friend offered to be his support person. The man's crisis plan was not updated during these admissions. Subsequently, a Complex Case Conference was held to discuss the man's care, and the key worker then drafted a management plan, including that if the man made any threats of self-harm, his appointment would be cancelled immediately, the police would be contacted, and he would be discharged from AOD. The case management plan was then discussed with the man and his support person. The man did make threats of self-harm, and was discharged from the Alcohol and Other Drugs Service. Some weeks later, the man was found dead.

Although the man's needs were complex and support was needed from both mental health services and addiction services, and at times police, it appears that emphasis was placed on dictating the man's behaviour, rather than supporting him, and an inappropriate management plan was developed without the man's input or reference to his support people. A more compassionate and consumer-focused approach could reasonably have been taken. I made a number of recommendations to the DHB, including that it assess its mental health and addiction services with reference to strengths-based practice, to identify service improvements, including consideration of consumer and family/whānau engagement in care planning.

In 2018/19, 12% of total treatment days involved family and whānau, slightly up from 10% five years previously in 2014/15. In 2018/19, young people had the highest percentage of treatment days involving family and whānau, at 32%. Addiction services (5%), followed by NGO services (6%), have the lowest percentage of treatment days involving family and whānau. Māori have the same proportion (12%), and Pacific peoples a slightly lower proportion (11%), of treatment

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88   Slade, M, *Implementing shared decision making in routine mental health care* (2017): https://onlinelibrary.wiley.com/doi/abs/10.1002/wps.20412.

89   Best D, Irving J, Collinson B, Andersson, C, and Edwards M, "Recovery networks and community connections: identifying connection needs and community linkage opportunities in early recovery populations". *Alcoholism Treatment Quarterly* (2017) 35(1): 2–15.

days involving family and whānau compared to the general population accessing services. The number of contacts made by services to support tāngata whaiora in their role as parents or caregivers, or to support whānau, including children, of tāngata whaiora is small (less than 1% of total treatment days). These numbers may be under-represented, as services may still be familiarising themselves with this new reporting code. The DHB and NGO provider-led Mental Health and Addictions Key Performance Indicator Programme introduced a focus on whānau involvement in 2019, in order to bring about quality and performance improvement in this area.

Partnership and consumer rights can be strengthened through shared planning, supported decision-making, and advance directives

Shared planning, supported decision-making, and advance directives are important tools to support people to make an informed choice and give informed consent (Right 7, Code of Rights). These tools also enable people to exercise some control and communicate their preferences for treatment where consent is overridden by the Mental Health Act and the Substance Addiction Act.

Between December 2019 and January 2020, the Ministry of Health consulted on proposed draft revisions to the *Guidelines for the Mental Health (Compulsory Assessment and Treatment) Act 1992*.[90] I support the direction of the proposed revisions, which include guidance on shared planning, supported decision-making, and advance directives, as well as greater incorporation of patient-centred models of care, improved whānau consultations, and greater cultural responsiveness.

When tāngata whaiora have a personal plan, their health improves, including fewer acute admissions and increased employment.[91] 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."[92]

In my 2018 report, I noted that as part of its response to an Auditor-General's report into discharge planning from inpatient units,[93] 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 and Addiction. While the 2018 Annual Report of the Office of the Director of Mental Health and Addiction is yet to be published, I have been provided with discharge planning measures that will be discussed in that report by the Ministry of Health. Four DHBs (of 20) met the target of 95% of people having a transition plan on discharge from an inpatient unit in 2018/19. This is an improvement on zero meeting the new target in 2017/18. It should be noted that not all DHBs are reporting on this measure, citing problems with information technology infrastructure. Of those DHBs that reported by the end of 2018/19, the average rate of patients with plans was 78%, with a range of 26% to 100%. DHB self-assessed quality of the plans ranged from 33% acceptable quality to 100% acceptable quality, based on sample audits.

While DHBs are showing improvement in undertaking shared planning, there is a long way to go. It remains a matter of serious concern to me. As noted above, 75% of tāngata whaiora and whānau reported that their plan was reviewed regularly — the lowest rating of seven standard questions. Inadequate involvement of tāngata whaiora and whānau in treatment plans continues to feature in complaints to HDC. The tāngata whaiora we spoke to for this report also highlighted deficiencies in their own experience — "They do a recovery plan but they don't follow it. It's more of a rubber stamping thing" (adult tangata whaiora); "They get you to write treatment goals but they don't help you to achieve it" (adult tangata whaiora).

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90   Ministry of Health, *Draft revisions to the guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (2020): https://consult.health.govt.nz/mental-health/draft-revisions-to-the-guidelines-to-the-mental-he/.

91   Ministry of Health, *Office of the Director of Mental Health Annual Report 2014*. Wellington: Ministry of Health (2015): https://www.health.govt.nz/about-ministry/corporate-publications/mental-health-annual-reports.

92   *Ibid*.

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

Supported decision-making is defined by the Ministry of Health as "the process of providing a person with the help they need to make decisions about their treatment, care or support. It comprises various informal and formal support arrangements which give priority to a person's views, will and preferences in decision-making".[94] In its proposed draft guidelines, the Ministry of Health states that "every effort should be made to take a supported decision-making approach to give the person the opportunity to determine how they would like to be cared for".[95] This aligns with both the Code of Rights and the Royal Australian and New Zealand College of Psychiatrists' Code of Ethics, which recognises the need to "support the decision-making of a patient with impaired capacity so that, where possible, a decision can be validly made" (5.6). The Code of Ethics also requires its members to "respect the rights, will and preferences of the patient, and take into account any advance directive" when seeking consent from a substitute decision-maker (5.7).[96]

Right 7(5) of the Code of Health and Disability Services Consumers' Rights states that "[e]very consumer may use an advance directive in accordance with the common law". An advance directive is a statement signed by a person setting out in advance the treatment wanted or not wanted in the event of becoming unwell in the future. An advance directive will not override the ability of a clinician to authorise compulsory treatment if a person is under the Mental Health Act. However, an advance directive gives a person more control over their treatment and care should they be unable to decide or communicate their preferences during an episode of mental distress. Advance directives and advance care plans can be modified or revoked at any time, while the person has capacity. The proposed draft guideline revisions recommend that as "a best practice, all patients should be offered the opportunity to create an advance directive as part of recovery and relapse prevention planning. The process of discussing an advance directive creates the opportunity for clinicians to understand what is important to a patient, and what they do and do not want to happen in the event that a future episode of illness affects their decision-making capacity."[97]

Southern DHB, in collaboration with the University of Auckland, has developed and trialled a new advance directive tool called "Mental Health Advance Preferences" (see signs of progress at the end of this section for further description). This trial suggests that advance care planning and advance directives can reduce the need for compulsory treatment.

An enduring power of attorney is another option for people to ensure that their wishes and interests are represented in a time of crisis or distress. An enduring power of attorney is a nominated person (such as a partner, close friend, or relative) who can make decisions for a person if they lose their capacity to make informed choices and give consent. Alternatively, if a person has lost their capacity to manage their own personal care or welfare, but has not appointed an enduring power of attorney, the Family Court can appoint a welfare guardian. It is important that clinicians ascertain the legal status of a patient and provide the person who has been nominated to speak for the patient with sufficient opportunity to provide input into their treatment plan.

More progress required to address unacceptably high rates of compulsion for Māori

Compulsory detention and treatment under the Mental Health Act overrides the Code of Rights and the Convention on the Rights of Persons with Disabilities, which emphasise the importance of consent.

In my 2018 report, I found that rates of compulsory treatment under the Mental Health Act are unacceptably high, and disproportionately high for Māori. New Zealand has a high use of community treatment orders by international standards,[98] and the evidence for their effectiveness is extremely weak

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94   Ministry of Health, *Proposed draft Mental Health Act Guidelines Revisions — clean* (2019) 8: https://consult.health.govt.nz/mental-health/draft-revisions-to-the-guidelines-to-the-mental-he/

95   *Ibid*.

96   Royal Australian & New Zealand College of Psychiatrists, *Code of Ethics* (2018): https://www.ranzcp.org/files/about_us/code-of-ethics.aspx.

97   Ministry of Health, *Proposed draft Mental Health Act Guidelines Revisions — clean* (2019) 13: https://consult.health.govt.nz/mental-health/draft-revisions-to-the-guidelines-to-the-mental-he/.

98   Gordon, S and O'Brien, A, "New Zealand's mental health legislation needs reform to avoid discrimination". *NZ Med J* (2014) 123: 1403.

in terms of preventing hospital admissions and other relevant outcomes.[99]

Rates of compulsory community treatment under the Mental Health Act have continued to climb. In 2018 (the latest available figures), 6,317 people were subject to a community treatment order. This compares with 6,127 in 2017 and 5,478 in 2014 — an increase of 3% over one year and 15% over five years. Māori rates of compulsory treatment have remained high. Thirty-eight percent of people who were subject to a compulsory treatment order in 2018 were Māori — the same as in 2017, and similar to 2014 (at 37%). Ministry of Health figures state that in 2017, Māori were 3.9 times more likely than non-Māori to be subject to a community treatment order[100] compared with being 3.6 times more likely one year previously in 2016,[101] and 2.9 times more likely four years previously in 2013.[102]

In 2018 I recommended 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 (Recommendation 4(d)). While I have been advised by the Minister of Health that this recommendation is being considered as part of the Government's commitment to review the Mental Health Act, I consider that progress to address Māori rates of compulsory treatment is too slow and requires greater urgency.

In 2018 I also recommended that the Ministry of Health prepare advice on changes required to the Mental Health Act 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 on the Rights of Persons with Disabilities and the Code of Rights, so that this can be progressed quickly in any regulatory review following the Inquiry". *He Ara Oranga* also recommended repealing and replacing the Mental Health Act (recommendation 34), which the Government accepted. While I am aware that the Ministry has begun initial conversations with stakeholders, and I note that the Initial Commission's progress report

to be published in June 2020 includes a description of progress to repeal and replace the Mental Health Act, there needs to be greater transparency from the Ministry of how it intends to deliver on this commitment. This includes its approach to, and timeframes for, engagement with Māori, tāngata whaiora and whānau, and other stakeholders, and to encourage a national discussion to reconsider beliefs, evidence, and attitudes about mental health and risk as recommended by *He Ara Oranga* and accepted by the Government.

The Ministry of Health needs to strengthen its communication in relation to the approach it intends to take to address the high rates of compulsory treatment for Māori, and to review the Mental Health Act, including in relation to stakeholder engagement and timeframes for phases of work. This will enable the Ministry of Health to be held to account for its processes and progress for these important pieces of work.

The Substance Addiction Act appears to be largely working as intended, with opportunities for improvement in post-service care

The Substance Addiction Act came into force in February 2018 and sets out the circumstances where someone who lacks the capacity to consent owing to impairment through substance use can be assessed and treated compulsorily. Unlike the Mental Health Act, if someone can show that they have the capacity to make an informed decision about their treatment, 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. The legislation includes the requirement that services should be "mana enhancing" to uphold the dignity of the person receiving services. It was too early to assess the operation of the Substance Addiction Act in my 2018 report, but I noted that it should be implemented in a way that minimises compulsion and increases access to treatment.

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99   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.

100 Ministry of Health, *Office of the Director of Mental Health and Addiction Services: Annual Report 2017*. Wellington: Ministry of Health (2019).

101 Ministry of Health, *Office of the Director of Mental Health and Addiction Services: Annual Report 2016*. Wellington: Ministry of Health (2017).

102 Ministry of Health, *Office of the Director of Mental Health and Addiction Services: Annual Report 2013*. Wellington: Ministry of Health (2014).

In 2018, 25 people were detained under the Substance Addiction Act for an average length of seven weeks and four days. The age range of people detained under the Act was between 24 and 70 years old, and approximately half (12) were women, and 13 were men. The most prevalent ethnic group was New Zealand European, and 16% were Māori. Nearly half of all patients were from the greater Auckland region.[103]

The small number of people detained under the Act in 2018 indicates that it is being used as intended as an intervention of last resort. To date one provider, NovaSTAR in Christchurch, has been approved by the Director of Mental Health and Addiction to provide compulsory treatment under the Act. However, the single location for compulsory treatment is problematic for tāngata whaiora to maintain contact with support networks, especially given that the majority of patients are coming from the Auckland region. Distance from whānau and support networks, as well as traumatic associations with the City of Christchurch, were put to the Family Court by people appealing their compulsory status.[104] I would welcome more approved facilities for providing compulsory treatment if it enabled patients to receive care closer to home; and I understand that this has been encouraged by the Ministry of Health, with all regions having the ability to apply for approved status.

It is also important that even the most complex needs can be catered for. In one case, NovaSTAR sought to refuse treatment for a person who presented with a brain injury and difficulty managing his moods. The Judge found that the Act does not allow for such selective service, and that it was clear from within the parliamentary debate that "this cohort would inevitably include people with other co-morbidities, including mental health issues, family violence, and other social harms". As this is relatively new legislation, the distinctions between having the person under the Mental Health Act or SACAT may not always be clear cut. As services become more familiar with the Act, this problem may not arise.

An important component of the Substance Addiction Act is the requirement that the "responsible clinician" in the person's home DHB must work with whānau and caregivers to prepare a suitable plan to address the person's problematic substance use following release from compulsory status. The plan should include recommendations for future treatment, continuing care, and any other action the clinician considers appropriate (section 44). In 2018, only 25% of people were recorded as having wellness plans on discharge from compulsory treatment, although 36% went on to receive additional inpatient care, and 64% engaged with individual treatments in outpatient services (numbers are not mutually exclusive and do not capture support provided outside of health services, such as through marae-based programmes and social housing providers). While there is no Ministry of Health target for wellness planning, it is reasonable to me that the target for 95% of tāngata whaiora having a transition plan on discharge from a mental health inpatient service should also apply to compulsory substance addiction treatment, especially given the high and complex needs of people likely to be subject to the Act. A greater focus on wellness planning is needed to meet this target.

The Ministry of Health must review the Substance Addiction Act within three years of the commencement of the Act, and the Minister must present the review report to Parliament (section 120). I understand that this review is intended to commence this year, and will provide a more in-depth assessment of the operation and effectiveness of the Act.

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103 Information supplied by the Ministry of Health, March 2020.

104 *McBride v BB* [2019] NZFC 2596; *Waitematā District Health Board v FP* [2019] NZFC 2830; *Shepperd v Bay of Plenty District Health Board* [2018] NZFC 2115.

HDC case study

Informed consent for dementia patient (17HDC00296)

An elderly woman with dementia was admitted to a mental health unit for assessment and treatment, as staff at her rest home were finding it increasingly difficult to manage her behaviour. The woman's daughter, who was her welfare guardian and the appropriate person to give consent on behalf of her mother, opposed the admission. The DHB, however, considered that admission was the only practicable option.

When reviewing this case, I commented that in this context, it would have been appropriate for DHB staff to consider the legal basis on which it was admitting the woman to the ward. The DHB acknowledged that the woman should have been treated under the Mental Health Act.

During her time in the unit, the woman was administered intramuscular (IM) lorazepam to restrain her without informed consent from her daughter. Additionally, there was a lack of consistent engagement and regular, timely meetings with the woman's family, and the woman's daughter was not given sufficient opportunity to provide input into the woman's treatment plan.

The woman's records frequently referred to the woman's daughter incorrectly as her enduring power of attorney, and I considered that this mistake, together with poor communication with the woman's daughter, indicated that care was not taken to ascertain and understand the daughter's legal role. It is important that providers are aware of a consumer's legal status, and that they sight and retain copies of the relevant documentation.

I found the DHB in breach of Right 7(1) of the Code for administering the woman IM lorezapam to restrain her without informed consent from her welfare guardian. I also found the DHB in breach of Right 6(2) of the Code for failing to consult the woman's welfare guardian prior to the use of IM lorazepam, and for failing to communicate with her adequately regarding the woman's care plan.

I made a number of recommendations to the DHB, including that it provide the woman's daughter with an apology for the failings identified; provide training to all staff in the mental health unit on the Code of Rights, informed consent, enduring powers of attorney, welfare guardians, the Mental Health Act, and restraint and the interaction of respective decision-making rights; conduct an audit of IM medication administration to ensure that informed consent had been obtained appropriately; and provide an update on the efficacy of the changes it made to its Older Adult Mental Health Service following the complaint.

Signs of progress

Mārama Real Time Feedback

Mārama Real Time Feedback is a satisfaction survey, designed to ensure that the voices of consumers, family, and whānau are heard and contribute to quality improvement in mental health and addiction services. At the point of care, anyone accessing a service can provide feedback on their experience, answering a series of questions co-designed with tāngata whaiora, whānau, and service providers. Mārama has seven core questions, designed to measure people's experience of the care provided, including communication, partnership, planning, and whānau engagement. There is also a free text option for people to comment on whatever they choose, and services can add two additional questions of their choice. Demographic questions also help services to ensure that what they are doing is working equally well for everyone.

As of June 2020, Mārama is being used by 14 DHBs and 5 NGOs, and has captured feedback from tāngata whaiora and their whānau on over 34,000 experiences of care. The information being provided by Mārama is helping DHBs and NGOs to monitor and improve their services, as well as allowing the Mental Health Commissioner and the Ministry of Health to monitor the performance of the mental health and addiction sector through the experience of those coming into contact with it. A reference group of Mārama users is convened by Te Pou, to ensure that the platform and the support provided around it meets current needs and priorities. Recent feedback led to the rapid development of QR codes, to ensure that Mārama could continue to be used safely during the COVID-19 pandemic.

There are some excellent examples of the feedback from Mārama being used to make changes to the way services are designed and delivered. For Odyssey, using Mārama at their services around the country helps to highlight the issues that need to be prioritised by their service improvement programme. Complaints and concerns coming out of Mārama are tested with a consumer group and presented to the Operations Managers and the Executive Leadership Team to determine the action needed to be taken in response. The real-time nature of Mārama means that issues can be acted on quickly — something that is critical when significant concerns are highlighted by the feedback received.

Recent feedback illustrated that tāngata whaiora in some services were having trouble understanding the material provided. This meant that people were graduating programmes without having really understood them. Where people may not have been comfortable expressing this within a group therapy session, Mārama gave them the opportunity to be open about how they were struggling to grasp what was being presented. In response, Odyssey is now reviewing its programme content to suit people's needs and literacy levels better.

Further information about Mārama RTF can be found at https://www.tepou.co.nz/outcomes-and-information/real-time-feedback/259 or by contacting Mark Smith at mark.smith@tepou.co.nz.

Enhancing the communication of consumer preferences in Southern DHB[105]

Southern DHB is revitalising the use of advance directives through its recently developed Mental Health Advance Preferences Statement (MAP). The MAP is designed to be easy for consumers to complete, and to support clinicians to work with consumers' preferences to the maximum extent possible, including those who are subject to compulsory treatment.

In 2015, when the project was initiated by Southern DHB Consumer Advisor Johnnie Potiki, the advance directives document was overly long and had limited staff awareness, and there was no system of signalling to clinical staff that a consumer had an advance directive. A research team was formed to design and implement a new instrument within Southern DHB mental health services, and to evaluate its effectiveness. The research team comprised Anthony O'Brien and Katey Thom from the University of Auckland, Professors John Dawson (Law) and Paul Glue (Psychiatry) and Jessie Lengah-Glue (University of Otago), Johnnie Potiki (Consumer advisor, Southern DHB), and Heather Casey (Director of Nursing, Southern DHB). The project was supported by the DHB's senior mental health leadership team, and received a grant from the Hume Foundation.

Initial work focused on a survey of clinicians and consumers, replicating an earlier national study conducted by Katey Thom. The survey, and a series of focus groups with consumers, explored perceptions and expectations of advance directives, leading to the development of a new instrument, the MAP. The term "MAP" was chosen because the instrument was intended to state consumers' preferences rather than "direct" care.

The MAP enables consumers to record preferences in a number of areas at times when they are in a mental health crisis and may be unable to express those preferences to their clinical teams. Preferences include those that are directly treatment related, and those that are more social in nature. Examples include medications preferred or not wanted, preferred place of treatment, who should be contacted in a crisis situation, who should not be contacted, and care of property and pets. The MAP was embedded in electronic clinical records so that a "flag" was raised informing clinicians that a MAP was in place. So far, around 60 consumers have completed MAPs. A future project will evaluate consumers' and clinicians' experiences of working with MAPs.

The research team's experience has shown that although advance directives are strongly supported by consumers and clinicians, implementation takes a concerted effort between consumers, clinicians, and mental health leaders. For further information about MAPs in Southern DHB, contact Johnnie Potiki: johnnie.potiki@southerndhb.govt.nz.

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105 Lenagh-Glue, J, O'Brien, A, Dawson, J, Thom, K, Potiki, J, Casey, H, and Glue, P, "A MAP to mental health: the process of creating a collaborative advance preferences instrument". *The New Zealand Medical Journal* (online) (2018): 131(1486), 18–26; Thom, K, Lenagh-Glue, J, O'Brien, A, Potiki, J, Casey, H, Dawson, J, and Glue P, "Service user, whānau and peer support workers' perceptions of advance directives for mental health". *International Journal of Mental Health Nursing* (2019) doi: 10.1111/inm.12637; Thom, K, Lenagh-Glue, J, O'Brien, A, Potiki, J, Casey, H, Dawson, J, and Glue, P, "Service user, whānau and peer support workers' perceptions of advance directives for mental health". *International Journal of Mental Health Nursing* (2019) doi: 10.1111/inm.12637.

Question 4: Am I safe in services?
Key findings

- The proportion of complaints about quality of care is increasing, but in 2019 serious adverse events remained the same, after consecutive rises in the previous four years. While each adverse event represents harm to a tāngata whaiora and their whānau, it is most likely that the previous increases in adverse event reporting represents an improvement in the ability of providers to recognise and report events. I support the HQSC Quality Improvement Programme project to learn from adverse events and tāngata whaiora, family, and whānau experience, and recommend that New Zealand adopt a zero-tolerance approach to suicide in services, as has been implemented successfully overseas.

- Despite important efforts of a national zero-seclusion project, national seclusion numbers, and the proportion of Māori being secluded, are rising. I am concerned about this. There is, however, a good evidence base for effective interventions, and localised examples of successful reduction and elimination. Support for the implementation of the "Zero seclusion" project should continue, and a mid-point evaluation should help with strengthening impact.

- Mental health services, addiction services, emergency departments, and emergency services need to work together closely to re-think how best to provide crisis support for tāngata whaiora and their whānau.

- It is encouraging that personal restraint and sedatives have been identified as balancing measures in the "Zero seclusion" project. Currently, reporting on the use of medication to sedate or chemically restrain tāngata whaiora is not collated nationally, and accessibility to this data needs to improve. It is important to ensure that increased chemical and other forms of restraint is not an unintended consequence of efforts to reduce seclusion.

Am I safe in services?

> "Places should support us in our healing and recovery, not punish and isolate us."
>
> – Tangata whaiora, "Zero seclusion" project[106]

> "My therapist … always asks me how everything has been going and checks in throughout the session to make sure I am doing okay."
>
> – Youth tangata whaiora interview

Introduction

The Code of Health and Disability Services Consumer Rights (the Code) includes a right to services being of an appropriate standard, including being delivered in a manner that minimises potential harm.[107] 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.[108] Being safe is not equivalent to being free from risk: positive risk-taking gives people freedom and supports their wellbeing and recovery.

This section looks at factors that have an impact on tāngata whaiora safety. I look at incidences of harm in relation to HDC complaints, serious adverse events, and restrictive practices, with a particular focus on the experience of people in inpatient mental health services under the Mental Health Act, because of the vulnerability of this population — only under this Act can people can be secluded legally.

Monitoring indicators
2018/19

232
serious adverse events (suspected suicide, serious self harm and serious adverse events)

23%
of HDC mental health and addiction complaints were about inadequate or inappropriate care

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106 Health Quality & Safety Commission and Te Pou o te Whakaaro Nui, "Zero seclusion: Towards eliminating seclusion by 2020": https://changingminds.org.nz/wp-content/uploads/2018/09/hqsc-zero-seclusion-consumer-family-wh%C4%81nau-leaflet.pdf.

107 Right 4(4), The Code of Health and Disability Services Consumers' Rights.

108 Mental Health Commission, *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington: Mental Health Commission (1998), Ministry of Health *Rising to the Challenge – the Mental Health and Addiction Service Delivery Plan 2012.* Wellington: Ministry of Health (2012).

The proportion of complaints about quality of care is increasing, but serious adverse events have remained the same

In 2018/19, HDC received 301 complaints about mental health services. This is an increase of 22% on the 247 complaints received in 2017/18, and a 41% increase over the last four years. In 2018/19, 23% of complaints to HDC about mental health and addiction services were about inadequate treatment. This is a consecutive increase on the percentage of complaints about inadequate treatment over the previous two years (22% in 2017/18, and 18% in 2016/17). Despite these increases, complaint profile appears no more serious than has been seen in previous years.

Similarly, the number of serious adverse events (suspected suicide, serious self-harm, serious adverse behaviour) reported in mental health and addiction services rose by 36% between 2014/15 to 2018/19, from 171 to 232, but there was no change from the previous year. For 2018/19, these events can be broken down as follows: suspected suicides, 197 (13 inpatient, 184 community); serious self-harm, 25 (10 inpatient, 15 community); serious adverse behaviour, 10 (6 inpatient, 4 community). The Health Quality & Safety Commission notes that while each adverse event represents harm to a tangata whaiora and their whānau, it is most likely that the increase in adverse event reporting represents an improvement in the ability of providers to recognise and report events.

The Health Quality & Safety Commission's quality improvement project "Learning from Serious Adverse Events and Consumer Experience" is now underway as part of its Mental Health and Addiction Quality Improvement Programme. I support the initiative. When things go wrong, it is important that good processes are in place to learn from events, so that systems can be changed to prevent them from happening again. The evidence review prepared for this work cited feedback from sector leaders[109] identifying that:

"reviews are currently far too slow and … there is significant variation in the way that the reviews are carried out. They identified a clear opportunity to support providers in their efforts to learn from and reduce serious adverse events by providing guidelines and facilitating timely, consistent reporting and review. In addition to learning from the review of serious adverse events, a well-executed review process can minimise harm to both the family and whānau of the affected consumer as well as staff members involved in the event."

In my 2018 report, I expressed concern about New Zealand's high rate of suicide, particularly amongst young people. I continue to have concern. In 2018/19, 685 people died by suspected suicide — an increase in both number and rate per 100,000 on the previous two years.[110] While the Government did not agree with my recommendation for a suicide reduction target in line with the World Health Organization guidance (a recommendation shared by the Inquiry panel), I am encouraged by the establishment of a Suicide Prevention Office, the finalisation of a suicide prevention plan, and a dedicated fund to strengthen community responses. I am also encouraged by the continued funding of the Suicide Mortality Review Committee to ensure a strong evidence base to support effective investment in prevention.

Just under half of the people who die by suicide are engaged in mental health and addiction services. I continue to recommend that we adopt a zero-tolerance approach to suicide in services, such as has been implemented in Mersey Care in the United Kingdom. Mersey Care focuses on discharge from inpatient care as a high-risk period, and has improved timeliness and processes in relation to post-suicide reviews, as its first actions to reduce suicide rates. Every tangata whaiora with a history of suicidal intent or self-harm will have a personalised safety plan, and the service will monitor tāngata whaiora at the highest risk. The HQSC project "Learning from Serious Adverse Events and Consumer Experience" provides an opportunity for DHBs, tāngata whaiora, and whānau to work together to develop a consistent joint approach to eliminate suicide of people within the care of services.

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109 Health Quality & Safety Commission, *Evidence Review to Inform Development of the Mental Health and Addiction Quality Improvement Programme 'Learning from Adverse Events and Consumer Experience' Project*, Wellington: Health Quality & Safety Commission (2019).

110 Annual provisional suicide statistics for deaths reported to the Coroner between 1 July 2007 and 30 June 2019: https://coronialservices.justice. govt.nz/assets/Documents/Publications/Provisional-Figures-August-2019.pdf. The mortality database is a dynamic collection, and numbers can be subject to change, even when nominally final.

Rising seclusion numbers, including for Māori, are concerning

Restrictive practices, such as seclusion[111] and restraint, do not have therapeutic value, are against human and disability rights, and are traumatising for tāngata whaiora and staff and re-traumatising for people who have experienced inter-personal violence and victimisation.[112]

In 2017, the "Zero seclusion" project was launched with the aim of eliminating seclusion by 2020.[113] The project is a partnership between HQSC and Te Pou o te Whakaaro Nui, working with the national mental health and addiction key performance indicator programme, teams of tāngata whaiora, their families and whānau, and service providers, to find alternatives to seclusion.

This project has seen some important wins. For example,[114] Auckland DHB (ADHB) is consistently experiencing seclusion as a very rare event. Hawke's Bay DHB is reporting its lowest seclusion rates in eight years and a significant reduction in numbers of Māori secluded. As seclusion practices reduce, some DHBs have been able to re-purpose seclusion rooms as low-stimulus or sensory-modulation rooms. Several DHBs have re-designed their welcome process to be more culturally responsive and ensure that tāngata whaiora are greeted with mana and respect, and some DHBs are changing their model of care and staff skill mix, including the introduction of cultural peer support, and "aunties" in support roles.

However, despite the collaboration and effort of many, and pockets of excellence, seclusion rates, and the proportion of Māori secluded, are rising. In 2018, 850 adults were secluded in inpatient

Monitoring indicators
2018

850
tāngata whaiora were secluded on 1,672 occasions in 2018

70%
of seclusions lasted ≤ 24 hours in 2018

units — up 10% on the previous year.[115] The number of seclusion events (an individual can have more than one seclusion event) increased by 7% in the year between 2017 and 2018 — from 1,569 to 1,672 respectively.[116] This represents three consecutive years of increasing numbers of seclusion events following nearly a decade of downward trends.

Of those who experienced seclusion in 2018, 44% were Māori — a rise from 36% in 2014. The proportion of seclusion events that apply to Māori has also increased over the last five years — from 30% in 2014 to 43% in 2018.[117] The number of Pacific peoples reported as being secluded may be artificially low because of the way ethnicity is reported, prioritising Māori ethnicity when multiple ethnicities are selected. An analysis undertaken for the "Zero seclusion" project identified that Pacific peoples had a similarly high rate of seclusion as for Māori.[118]

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111 Seclusion involves a person being placed alone in a room or area from which they cannot exit freely. Standards NZ, *Health and disability services (general) Standard 2008*. Wellington: Standards NZ (2008): NZS 8134.0:2008.

112 Ministry of Health, *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health (2018): 88 (proposed draft guidelines for consultation).

113 The "Zero seclusion" project is part of Ngā poutama oranga hinengaro-mahitahi, the Health Quality & Safety Commission's mental health and addiction quality improvement programme.

114 Health Quality & Safety Commission, *Mental health and addiction quality improvement programme Ngā poutama oranga hinengaro-mahitahi; March 2020 update* (2020).

115 Figures supplied by the Ministry of Health, February 2020.

116 *Ibid.*

117 *Ibid.*

118 Health Quality & Safety Commission, *Zero seclusion: towards eliminating seclusion by 2020; Data on seclusion of Pacific Peoples* (2018): https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Images/Pacific-seclusion-infographic-Jun-2018.pdf.

It is important that efforts to eliminate seclusion, including a particular focus on Māori and Pacific peoples, continue. Strategies for reducing seclusion are well evidenced, and include leadership, effective engagement and consultation with people accessing services and their whānau, development of the peer workforce, cultural approaches, trauma-informed care, seclusion reduction tools, de-escalation techniques, and debriefing.[119] The "Zero seclusion" project has also begun work to develop kaupapa Māori quality improvement methodology, and is testing change ideas to reduce and eliminate seclusion for Māori, including access to cultural tools, whānau involvement in care, and de-escalation techniques. The programme is also undertaking unconscious bias education and training within the sector.[120] A mid-programme evaluation of the Health Quality & Safety Commission's Mental Health and Addictions Quality Improvement Programme is currently being commissioned, and will shed light on what is required to enable and embed changes in practice.

Managing capacity is a barrier to reducing seclusion and restrictive practices in some services

The inability to shift national seclusion rates is indicative of the pressure services are under. 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 observed that services are showing a willingness to reduce seclusion and restraint, but struggle to put strategies

into action. OPCAT inspectors have identified that physical and staff capacity are common barriers to reducing seclusion and restraint.

In 2018/19, OPCAT inspectors observed a number of units using seclusion rooms as bedrooms, owing to unit capacity issues.[121] An unannounced inspection in September 2019 found occupancy at the service's mental health wards to be at 130%, with seclusion rooms, interview rooms, and whānau rooms, as well as "sleepovers" in other wards, being used to accommodate service users when the mental health wards were over-occupied. The Ombudsman considered that the "ongoing issue of over occupancy across the Wards, and the resulting impacts, is not only unsustainable, but unsafe for service users and staff", and that it is "degrading treatment and a breach of Article 16 of the Convention against Torture".[122] There is variation between services in how capacity is managed, with stakeholders reporting that capacity is being managed well in some services. DHBs would benefit from nationally coordinated guidance and monitoring, and best practice examples to support all DHBs to manage capacity well.

In my engagement with the sector across a range of settings, I repeatedly hear that mental health inpatient units are not well equipped to deliver effective responses for people experiencing agitation, aggression, substance intoxication or withdrawal, and psychosis, and that this is affecting seclusion rates. Two-thirds of seclusion episodes occur within 48 hours of admission.[123] Focusing on strategies to strengthen workforce competence and capability to respond effectively to people who are experiencing agitation, aggression, substance intoxication or withdrawal, and psychosis has the potential to divert seclusion events. More fundamentally, there is a need for mental health services, addiction services, emergency departments, and emergency services to work together closely to re-think how best to provide crisis support for tāngata whaiora and their whānau.

119 Te Pou o te Whakaaro Nui, *Reducing and eliminating seclusion in mental health inpatient services: An evidence review for the Health Quality and Safety Commission New Zealand*. Auckland: Te Pou o te Whakaaro Nui (2018): https://www.hqsc.govt.nz/.

120 Health Quality & Safety Commission, *Annual Report 2018/19* (2019) 17: https://www.hqsc.govt.nz/assets/General-PR-files-images/HQSC_AR2019_WEB_LR.pdf.

121 Office of the Ombudsman, *Annual Report 2018/19* (2019): https://www.ombudsman.parliament.nz/sites/default/files/2019-10/annualreport-20182019.PDF.

122 Office of the Ombudsman, *OPCAT Report: Report on an unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital, under the Crimes of Torture Act 1989* (2020): https://www.ombudsman.parliament.nz/sites/default/files/2020-03/report-opcat-wards343536HRBC.pdf.

123 Jury, A, Lai, J, Tuason, C, Koning, A, Smith, M, Boyd, L, Swanson, C, Fergusson, D, and Gruar, A, "People who experience seclusion in adult mental health inpatient services: An examination of health of the nation outcome scales scores". *International Journal of Mental Health Nursing* (2019) 28(1):199–208: https://doi.org/10.1111/inm.12521.

Use of restraint is common, and more transparent reporting is needed

Restraint can be mechanical, physical, environmental, and chemical. In my 2018 report, I raised the risk of incidences of restraint rising as services try to address seclusion. I am encouraged that this risk has been recognised by the "Zero seclusion" project. The use of personal restraint and sedatives (a form of chemical restraint) are included as balancing measures (physical assaults on staff and patients is the third important balancing measure).[124] However, in a recent inspection, OPCAT inspectors observed a rise in levels of restraint.[125] In the Ombudsman's 2018/19 Annual Report, he reported observing open units (those where permanently locking doors is not part of service delivery and may include voluntary patients) routinely locking their exit doors (environmental restraint),[126] restricting patients' ability to come and go freely, including access to the outdoors and fresh air. As a positive note, OPCAT inspectors reported observing a number of units providing unrestricted access to kitchen facilities, allowing patients the independence to access hot and cold drinks and snacks throughout the day.[127]

In my 2018 report, I expressed concern 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. I identified the potential for inappropriate prescriptions, and for medication to become an unintended method of control amid efforts to reduce seclusion. I recommend that work to record and report on inpatient prescriptions is progressed. The Ministry of Health advises that this work is progressing, but it has not yet found an easy way to obtain data for analysis. I recommend that this work is progressed as a matter of priority, with clear milestones and timeframes for implementation identified.

124 Health Quality & Safety Commission, *Zero Seclusion Measurement: A family of measures:* https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Resources/Zero_seclusion_measurement_Feb_2019.pdf.

125 Office of the Ombudsman, *OPCAT Report: Report on an unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital, under the Crimes of Torture Act 1989* (2020): 17.

126 Office of the Ombudsman, *Annual Report 2018/19*. Wellington: Office of the Ombudsman (2019): 29.

127 *Ibid.*

Signs of progress

Least restrictive practice journey in ADHB

In 2010, when ADHB began its least restrictive practice journey, it had seven seclusion rooms across four sites, and recorded 343 episodes of seclusion. By 2020, ADHB has reduced the number of seclusion rooms to one, in the adult in-patient unit, and records low levels of seclusion — often going months with no seclusion and some months with 2–4 seclusion events.

With the number of seclusion events so low, each individual case is able to be reviewed, including by peer advisor de-briefs with the tangata whaiora, and with multi-disciplinary teams and whānau. Areas of support for the tangata whaiora can be identified, as well as what can be done differently from pre-admission through to the seclusion event itself and after care. One example of improvement came from tāngata whaiora feedback that where they came to the inpatient unit after long periods waiting in emergency departments or police stations, often they were not only tired and grumpy, but hungry. There is now warm food available for tāngata whaiora on welcome into adult inpatient units.

Other measures ADHB has taken include:

- All staff have "Safe Practice Effective Communication" training that supports best and least restrictive practice in mental health inpatient units, and three staff are trained facilitators, meaning that they can provide refresher training.

- Weekly zero-seclusion steering group meetings, and monthly Police Liaison meetings to bring up challenges and co-develop responses.

- Engaging with the Community Alcohol and Drugs services about strategies for amphetamine intoxication.

- Having cultural support on site and on call after hours.

- Having a clinical charge nurse on site to provide after-hours monitoring of the environment, and support less senior staff with clinical decision-making.

- Regularly reviewing tāngata whaiora activities and identifying ways to improve the physical environment, including through murals and safe but attractive furniture.

The remaining challenge for ADHB is to overcome the last hurdles, to eliminate seclusion for all individuals. ADHB is participating in the HQSC "Zero seclusion" quality improvement project, and is learning from the experience of others.

Co-designing a healing environment — the Tiaho Mai story

Tiaho Mai, meaning "the light that comes from the moon and stars here" is the acute adult mental health inpatient unit within Counties Manukau DHB (CM Health). In 2013, the decision was made to redevelop and expand Tiaho Mai, as it was a dated, leaky building, and the occupancy was under extreme pressure. This began a co-design journey to discover, acknowledge, and represent what was critically important for Tiaho Mai tāngata whaiora, whānau, staff, and the wider community, both now and into the future.

The design brief for Tiaho Mai was integrally linked to the model of care that CM Health aspired to implement. Extensive input from a wide range of people involved in all elements of Tiaho Mai began with the development of the detailed Business Case. These partnerships continued throughout the project and informed the functional design brief, design principles, and evolving model of care. The design principles identified included for Tiaho Mai to be a welcoming place of healing and recovery, with lots of natural light, functional outdoor activity space, and safe spaces to sit and reflect. It should also provide for a great inpatient admission experience and promote interaction between staff and tāngata whaiora towards healing.

Global cafés enabled a broad and diverse group of people to contribute; reference groups gathered the input, views, experience, and ideas of specific stakeholders, including tāngata whaiora, staff, and whānau, as well as specific engagement opportunities with Māori and Pasifika, through a range of methods, including workshops, interviews, surveys, and hui held in Nga Whetumarama (the local whare at Tiaho Mai).

> "The aim was to give our community lots of options to participate with flexible times, venues and approaches."
> Cassandra Laskey, Professional Leader Consumer and Family, Mental Health Services, CM Health

> "At each workshop it was amazing to see the design developing and to hear the architects explain where they had used our ideas and feedback. I nearly cried … it was wonderful."
> Tangata whaiora/whānau

> "Patient stories are incredibly important and valuable and can challenge perceptions of what patients/end-users think and feel about different situations. Having some of this input prior to getting into detailed design ensured that this was integral to how the building was designed and developed."
> Klein Architects

In late 2018, phase one of the new Tiaho Mai opened, with 38 beds available and a design not seen previously in a New Zealand acute mental health facility. Design features include low-stimulus suites with access to a private courtyard; a shared "heart" space incorporating open-plan peer support; and therapy spaces, including dining and lounge areas as well as more separate art and activity rooms. The new whare provides a familiar and calm space for many people to experience a special kawa and whakawhanaungatanga during their admission, and for tāngata whaiora and whanāu to have available when they need it. Stage two, an identical 38-bed wing, is scheduled to be completed in mid-2020. When fully operational, Tiaho Mai will be the largest acute mental health unit in Aotearoa New Zealand.

One of the ongoing challenges at Tiaho Mai is changing the old-style hospital culture, and opening people's hearts to new ways of working in the new building.

> "It's a fabulous building. But the care you get is not about the building, it's about the people in the building … The challenge now will really be about the clinical practice. The facility has provided plenty of options for this."
> Dr Peter Watson, Clinical Director, Mental Health Services, CM Health during the development of Tiaho Mai

Question 5: Do services work well together for me?
Key findings

- Most tāngata whaiora and whānau report that the services they use communicate with each other when they need to.

- Issues relating to coordination of care are common in complaints to HDC, and are a common finding on HDC's assessment of a complaint, including in regard to coordination between inpatient units and community mental health teams, and between mental health services and addiction services, and communication between crisis teams and other services and within multi-disciplinary teams. The system needs to ensure that it has good processes in place that support staff to work together effectively, allowing them to foster good working relationships and clear lines of communication.

- Systems need to be in place to ensure timely follow-up for people being discharged from a mental health inpatient unit to the community. The low proportion of people receiving follow-up from a community mental health team within seven days of discharge from hospital is concerning. The HQSC's improvement project "Connecting Care" includes a focus on this and other transitions.

Do services work well together for me?

"They do a good job of communicating between each other when they need to"

– Youth tangata whaiora interview

"I've been sober and clean for 32 years. But I couldn't get a psychologist in the other system. So I got one at [Community Alcohol and Drug Services]"

– Te Kete Pounamu hui participant

Introduction

People-centred health care means delivering care that is seamless within and across services. Transitions in and out of different mental health and addiction services is a natural part of a tangata whaiora's recovery journey.

This section looks at results from HDC's tāngata whaiora and family and whānau experience survey, and complaints to HDC about coordination of care, to assess the seamlessness of services, including a particular focus on the connection between crisis response and other health services. 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
2018/19

83%
of tāngata whaiora and whānau report they were happy with the communication between the people they see

11%
of HDC mental health and addiction complaints were about coordination of care

Coordination of care issues are common in complaints to HDC

As with my 2018 report, many tāngata whaiora and whānau are happy with the way services communicate with each other. In the Mārama Real Time Feedback Survey to 2018/19, 83% of respondents agreed that the people they see do communicate with each other when needed. However, issues relating to coordination of care continue to feature in complaints to HDC, being raised by the complainant in around 11% of all complaints in 2018/19. This is similar to previous years.

Issues with 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; mental health services and addiction providers for tāngata whaiora with co-existing problems; and mental and physical health services. Failure of communication at the mental health/emergency department interface and between the multi-disciplinary team at review meetings are also recurrent themes in complaints. The HDC breach decision 15HDC01202 reflects many of the themes I see in regard to care for tāngata whaiora with co-existing problems — particularly tāngata whaiora with a primary diagnosis of addiction who are experiencing mental distress. In this case, a woman was admitted to the emergency department following an episode of self-harm. She was assessed by a psychiatrist, who documented that her mood disorder could not be seen as primary while she was using alcohol in large amounts, and that her risk of suicide was currently low but that this could change depending on her level of intoxication. The woman was referred to the Community Alcohol and Drugs Service, where the primary focus was on addressing the woman's alcohol addiction issues. The same level of attention was not being given to her mental health issues or to integrated, on-going risk assessment and, sadly, the woman died before an assessment had been organised for her (the full case study is set out at the end of this section).

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, good communication, and timely follow-up between and within healthcare providers for all needs.

The HDC breach decision 17HDC00632 highlights the importance of coordination of care between primary and secondary healthcare services and between physical and mental health service providers. In this case, a man was under the care of the DHB's Community Mental Health Service (CMHS) and also receiving services from two support organisations, which were funded by the DHB's Needs Assessment and Service Coordination service to assist him to live in the community. At a CMHS multi-disciplinary team review meeting, a decision was made to discharge the man from CMHS, as the team considered that his symptoms were stable and he had appropriate supports in place. The discharge summary was sent to the man's GP, but was not provided to the man, his family, or the support organisations. No lead organisation was appointed to oversee the man's on-going care. Subsequently, on multiple occasions, one of the support organisations advised NASC of problems with the man accepting help. Support workers reported that the man had no clean clothes or sheets, and often no food. These concerns were not addressed appropriately or escalated within the DHB. The man was admitted to hospital in a compromised physical state, and died from pneumonia secondary to malnutrition and depression. I found that the DHB failed to provide the man with services with reasonable care and skill, in breach of Right 4(1) of the Code of Rights, and made a number of recommendations for improvement including that the DHB:

- Implement robust policy documentation to ensure that when a person is to be discharged from the Mental Health and Addictions Service and there are multiple services involved, a multi-service meeting is held to determine the lead agency and confirm the support plan for the person;

- Undertake an audit of compliance with CMHS discharge documentation requirements, focusing on obstacles to future service delivery and criteria for re-referral to the service;

- Implement a clear escalation pathway for NASC staff to follow when concerns are raised by contracted providers about obstacles to service delivery; and

- Familiarise NASC staff with the Equally Well Consensus Paper, to support them to enact this in the context of needs assessment and contracting services.

The HDC breach decision where a practice failed to monitor a man's lithium levels and renal function (19HDC00536, discussed in Part II, Question 2) is an example of multiple doctors practising in a single service but failing to coordinate the care being provided. The Health and Disability Commissioner commented:

> "This case is both unremarkable and disturbing. It is unremarkable in that a patient presented to a series of different doctors and a single practice, which is becoming the norm in primary care practice in New Zealand. It is disturbing that the basics were not done … the case is a salutary reminder that the operation of medical practice means that no practitioner can operate in isolation … Care must be integrated and collaborative — particularly for patients seeing multiple GPs. Doctors and their systems must be connected with each other intentionally. Patients will receive better care as a result."

Better support for inpatient to community transitions is needed

Follow-up within seven days of discharge from inpatient services, length of inpatient of stay, and rate of re-admission within 28 days together give insight into the effectiveness of transitions between inpatient and community mental health care. Where data is available, New Zealand's performance against these three indicators can be compared with 14 countries, including Australia, Canada, England, Sweden, and Norway through an international NHS benchmarking network.

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.[128] In 2018/19, 67% of people were followed up within seven days of leaving an inpatient unit, which is similar to previous years. Pacific peoples are more likely to be followed up within seven days of discharge than others (69%), and Māori have lower than average rates of follow-up within seven days, at 62%. Young people are also less likely to be followed up within seven days of being discharged from an inpatient unit (54%). Rates of follow-up across all groups falls short of the 90–100% aspirational target set by the sector in its Key Performance Indicator Programme. However, there are high levels of variation across DHBs, with their achievement against this measure suggesting that improved performance is achievable. Community follow-up was not assessed in 2019, but in 2017, New Zealand was assessed as being fourth out of six benchmarking countries for follow-up rates within 7 or 14 days on discharge (depending on local measures). England reported the highest rate of community-based follow-up care, with 96% of tāngata whaiora followed up by a mental health practitioner within seven days of discharge.

Re-admissions may also occur if a tangata whaiora is discharged too early (although prolonged lengths of stay subject people to necessary restrictions in freedom and increased likelihood of being secluded or restrained). 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. In 2018/19, the average length of stay in an inpatient unit was 18 days, and is similar to previous years. Pacific people have longer average stays in inpatient units (26 days). Young people have the shortest length of stay at 13 days. In 2019, New Zealand was assessed as having one of the shortest lengths of stay compared to 13 benchmarking countries, with only Sweden and Australia being shorter, with an average of under two weeks. Japan and Scotland had the longest lengths of stay, both over 100 days. The report notes that the "range may owe something to the different service models in place across countries, but also to the differences in service delivery and the clinical models underpinning this".[129]

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128 Office of the Auditor-General, *Mental health: effectiveness of the planning to discharge people from hospital* Wellington: Office of the Auditor-General (2017).

129 *NHS Benchmarking Network, International Mental Health Comparisons 2019, Child and Adolescent, Adult, Older Adult services* (2019): https://www.uppdragpsykiskhalsa.se/wp-content/uploads/2019/11/International-MH-report-31-October-2019.pdf.

Re-admission rates within 28 days of discharge from an inpatient unit were 17% in 2018/19, similar to the previous five years. Pacific people have a lower rate of re-admission than other groups, at 11%. These figures are nearly double the KPI Programme "stretch-target" of 0–10%. In 2019, New Zealand was assessed as having the highest emergency re-admission rate out of seven benchmarking countries, with the Netherlands having the lowest at under 2%.

In my 2018 report I raised concern about the low rate of follow-up on discharge from inpatient services, and these rates have not improved. Systems need to be in place to support timely follow-up. Connecting care is one of five projects within the Health Quality & Safety Commission's five-year Mental Health and Addiction Services Quality Improvement Programme, and seeks to improve service transitions. This work includes a focus on the transition between inpatient and community care,[130] acknowledging the vulnerability of tāngata whaiora at that point in their journey, and the negative consequences of poor transitions for the health and wellbeing of tāngata whaiora and their whānau, as well as the impact on service providers in many ways. An example of where this programme is making a difference for people entering inpatient services for the first time is set out in the "sign of progress" at the end of this section.

Monitoring indicators
2018/19

18 days
average length of stay in an adult inpatient unit

67%
of people followed up within 7 days of discharge from an acute inpatient unit

17%
were readmitted within 28 days of being discharged

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130 Other transition areas of focus are DHB community to primary care and youth to adult.

Signs of progress

ADHB and Oranga Tamariki collaboration pilot[131]

A significant proportion of children and young people admitted to mental health inpatient units have care and protection concerns. Yet separate processes for assessment and planning, as well as different philosophies between mental health services and Oranga Tamariki, often result in a narrowly focused and fragmented approach to care, and less than ideal outcomes for children and young people with high needs. Acknowledging that this was an issue, and that relationships between staff in the two agencies were deteriorating, ADHB and Oranga Tamariki decided to pilot a different approach.

With governance provided by senior leaders at both ADHB and Oranga Tamariki, a senior Oranga Tamariki staff member was seconded to the Child and Family Unit at ADHB (CFU), to act as a programme manager and work across both organisations to manage the collaboration. Having an Oranga Tamariki staff member embedded in the CFU allowed for better information sharing between the two agencies, with mental health clinicians benefiting from an enhanced understanding of the past care and protection and trauma histories of the children and young people they were seeing. The programme manager was also able to facilitate relationships and shared understanding between the two agencies, creating opportunities and embedding processes for joint planning informed by both mental health and Oranga Tamariki expertise. Oranga Tamariki staff began to visit the CFU more frequently, increasing their understanding of how mental health issues were affecting the young person, and CFU staff were encouraged and supported to participate in Family Group Conferences.

Processes, procedures, and expectations were also developed jointly to engage key stakeholders effectively in timely admission and discharge planning. This included a process for quickly identifying young people who required a multi-agency approach; an escalation pathway for instances where a higher level of negotiation between the two agencies was required; and an MOU between ADHB and Oranga Tamariki to formalise entry and exit procedures from the CFU and how each agency would support this process.

An evaluation found that this collaboration not only led to better relationships between the two agencies and better outcomes for children and young people, but also resulted in an increased number of children and adolescents being identified as benefiting from Oranga Tamariki's services. Staff in the mental health unit were better able to recognise when young people required more support than they were able to provide.

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131 Information taken from the following document: Auckland District Health Board and Oranga Tamariki *ADHB Child and Adolescent Acute Mental Health Inpatient and Oranga Tamariki Collaboration Report* (unpublished).

Connecting people from inpatient into community care in Whanganui

As part of its "Connecting Care" project, Whanganui DHB partnered with local iwi-run kaupapa Māori service Te Oranganui to improve the transition for Māori from the inpatient unit into the community. Te Oranganui offers a range of social, health, and wellbeing services to people in the Whanganui rohe, including specific support for mental health and addiction.

Before the "Connecting Care" project, the inpatient unit often waited until after discharge and assignment to a DHB key worker, for tāngata whaiora Māori and whānau to be referred to mental health support. This delay meant that tāngata whaiora had already developed set views about mental health and addiction services, especially if the inpatient admission process was not a good experience, and were less open to engaging with services in the community following discharge.

Te Oranganui and Whanganui DHB identified this delay as a barrier to connected care, and changed their processes so that when new Māori whānau come into an inpatient unit, they are referred to Te Oranganui straight away. This enables Te Oranganui staff to develop relationships from the start with tāngata whaiora, their whānau, and key workers, and to be involved in multi-disciplinary team meetings. It has also increased awareness within the DHB of the range of services and supports that exist in the community for mental health and addiction. The project has been running since mid-2019, with this part of the project in place for only a few months, so only a small number of Māori new to services have benefited from the new approach. However, staff in both services are reporting an increase in transparency and strengthened relationships between the services. The next step is to collect feedback from tāngata whaiora and whānau on this approach.

HDC case study

Coordination of care for woman with mental health and addiction issues (15HDC01202)

A woman with a history of anxiety, depression, and daily alcohol use was admitted to the emergency department of a public hospital following an episode of self-harm. It was documented that she had suicidal intent, and she was referred to the Psychiatric Emergency Service (PES).

The woman was reviewed by a PES psychiatrist. It was documented that her mood disorder could not be seen as primary while she was using alcohol in large amounts, and that her risk of suicide was currently low, but that this could change depending on her level of intoxication.

The woman's case manager verbally consulted with a clinical nurse specialist at the Community Alcohol and Drug Service (CADS) and requested a referral to the service for the woman. CADS understood that PES would be continuing to work with the woman with regard to her mental health issues. However, after PES was unable to make further contact with the woman, she was discharged by PES.

The woman later spoke with CADS by telephone and was referred to the Alcohol and Other Drug Coordination Service (AOD). The telephone screening focused on the woman's motivation to engage in treatment pathways, and self-harm risks were not discussed. The PES referral to CADS was withdrawn. The plan was for AOD to organise an assessment for the woman in a few weeks' time. However, the woman had no further contact with DHB services before she was found to have passed away.

This case highlights the importance of an integrated system of health care for consumers with co-existing mental health and addiction disorders. Primarily, staff focused on addressing the woman's alcohol addiction issues, but the same level of attention was not given to her mental health issues or to integrated, on-going risk assessment. DHB staff separated the woman's mental health issues and her addiction issues and, as a result, the woman did not receive a coordinated and appropriate standard of care for her mental health issues.

The lack of critical thinking in relation to the co-existing disorders resulted in inadequate coordination of the woman's care by the DHB, and the DHB was found in breach of Right 4(5) of the Code. The DHB agreed to provide an apology to the woman's family for its breach of the Code.

The DHB was also asked to review and update its Service Provision Framework to ensure that it explicitly clarifies and documents the transfer process between services; the CADS criteria for acceptance; and the CADS telephone screening process.

Question 6: Do services work well for everyone?
Key findings

- Mental health and addiction services performance continues to be poorest for Māori across the monitoring questions in this report, and use of restrictive practices are increasing. Greater Māori participation and leadership in the design and delivery of services is needed to improve outcomes and better reflect commitments under Te Tiriti o Waitangi. While greater investment in kaupapa Māori services is welcomed, all services need to improve their ability to engage effectively with Māori whānau. Greater diversity and cultural competence is needed across the system, and must be championed from the top.

- Suicide is the leading cause of death for young mothers in New Zealand, and Māori whānau are affected disproportionately. Around 10–20% of women will experience mental distress during pregnancy and/or the first year following birth. Screening for these issues is currently ad hoc, and people are finding it hard to access appropriate support. Maternal mental health and substance use issues can have long-lasting effects on the healthy development of children, so better integration between maternal and infant services is essential. While it is important to improve the health response, broader approaches that address social isolation and socio-economic determinants are needed.

- Around 12.5% of people will experience a substance use disorder at some stage in their lives. Co-morbidity between mental health and addiction is common, but there are important differences in the drivers of, approach to, and experience of, people with addiction that need to be taken into account as New Zealand transforms its approach to mental health. While people benefit from addiction treatment, access is declining, and a broader approach to addressing substance-related issues is required. Stigma creates significant barriers to people seeking and receiving the help they need, and must be addressed.

- Prisoners have some of the highest mental health and addiction needs in the country. The Department of Corrections has a number of developments underway to address those needs better, and is making progress despite some continuing areas of concern. Forensic capacity has not kept up with the growing number and needs of the prison population, and urgent action is required to address this.

Do services work well for everyone?

> "There's a whole bunch of men in the justice system that have the same story or a version of the same story that could benefit from … mental health help and intervention."
>
> – Te Kete Pounamu hui participant

> "Don't put mums in mental health wards. I needed people to look after me, to help me sleep, relax, eat — but not having my baby involved meant I missed out on that early bonding time."
>
> – New mother, Whai-Ao ki te Ao Marama

Introduction

A well-functioning mental health and addiction system should provide equity of care for all populations, particularly the most vulnerable. People accessing services should be able to expect the same quality of care, experience, and outcomes as others, regardless of who they are. Services should provide a culturally safe environment by respecting and acknowledging a person's identity, values, and beliefs, including ties with family and whānau. As a Tiriti o Waitangi partner, publicly funded services have a particular responsibility to practise the principles of partnership, participation, and protection in the design and delivery of mental health and addiction care.

This section takes a focused look at the responsiveness of services to a selection of population groups with known disparities in outcomes and distinct needs: Māori; mothers and infants; people with problematic substance use; and people in prison. In this report, I have not been able to cover a number of other important populations and groups that also experience poorer outcomes. I trust that the Mental Health and Wellbeing Commission is resourced to be able to monitor outcomes for additional populations and groups in the future.

Almost

1 in 3

Māori live with mental illness and/or addiction (1 in 5 in the general population)

38%

of those under a compulsory community treatment order in 2018 were Māori

44%

of those secluded and 43% of those involved in seclusion events in 2018 were Māori

Māori

Current approaches must change to work for Māori

The special relationship between Māori and the Crown under Te Tiriti o Waitangi is recognised and expressed in a number of laws and strategies, including the New Zealand Public Health and Disability Act 2000 and He Korowai Oranga — the Māori Health Strategy. The Government's commitments under Te Tiriti are often summarised by three principles — Partnership, Participation, and Protection — although there are differing views of what these principles mean in practice. These commitments highlight the pressing need to address unacceptable inequality of outcomes for Māori generally, and in services, to enable Māori-led solutions and ensure that all services work for 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.

There are a number of well-evidenced drivers of this disparity. These include inter-generational trauma — the ongoing legacy of state policies that have led to Māori being separated from whenua and whānau through colonisation, confiscation, incarceration, and under the premise of child protection;[132] the related disproportionate experience of poverty and disadvantage, which has a particularly profound effect on mental health during childhood that then lays the foundation for wellbeing over the lifecourse;[133] and the experience by Māori of racism and discrimination, which has been found to have a significant impact on measures of mental health, self-reported health, and life satisfaction.[134] The monitoring indicators in this report highlight that while there have been some slight improvements in some areas, the mental health and addiction system continues to perform poorly for Māori.

As would be expected given higher levels of need, Māori continue to have high rates of access to mental health services and addiction services. In 2018/19, Māori made up around 16.5% of the total population but accounted for 28% of all mental health service and addiction service users. While wait times for access to DHB mental health services have decreased for Māori since 2017/18, wait times for access to addiction services have increased in the same period.

Māori account for only 17% of primary mental health service users, which is more reflective of their proportion of the overall population than their estimated level of need. Early intervention for mental health issues is critical for preventing mental distress from escalating, and lower access rates in primary care are likely to be contributing to the over-representation of Māori in specialist services. The HQSC's Atlas of Healthcare variation found that while all people with a self-reported mental health condition were more likely to experience barriers to access to primary care, this was particularly true for Māori.[135] While Māori are reported to have higher rates of depression and anxiety,[136] they are less likely to receive a diagnosis,[137] or be prescribed first-

132 Wirihana, R and Smith, C, "Historical Trauma, healing and well-being in Māori communities", in Smith C and Tinirau R (eds), *He Rau Murimuri Aroha: Wāhine Māori insights into historical trauma and wellbeing*. Te Atawhai o Te Ao: Independent Māori Institute for Environment & Health: Whanganui (2019); Pihama, L, Reynolds, P, Smith, C, Reid, J, Tuhiwai Smith, L, and Te Nana, R, "Positioning Historical Trauma Theory Within Aotearoa New Zealand". *Alternative* (2014) 10: 3: https://researchcommons.waikato.ac.nz/bitstream/handle/10289/12397/Positioning%20Historical%20 Trauma%20in%20Aotearoa%20%281%29.pdf?sequence=2&isAllowed=y.

133 Gibson, K, Abraham, Q, Asher, I, Black, R, Turner, N, Waitoki, W, and McMillan, N, *Child poverty and mental health. A literature review*. Child Poverty Action Group and the New Zealand Psychological Society (2017): https://www.cpag.org.nz/assets/170516%20CPAGChildPovertyandMentalHealthr eport-CS6_WEB.pdf.

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

135 Health Quality & Safety Commission, *Atlas of Healthcare Variation. Mental Health in primary care* (2020): https://www.hqsc.govt.nz/our-programmes/ health-quality-evaluation/projects/atlas-of-healthcare-variation/mental-health/.

136 Tapsell, R, Hallett, C, Mellsop, G, "The Rate of Mental Health Service Use in New Zealand as Analysed by Ethnicity". *Australasian Psychiatry* (2018) 26(3): 290–3.

137 Lee, CH, Duck, IM, Sibley, CG, "Ethnic inequality in diagnosis with depression and anxiety disorders". *NZMJ* (2017) 130(1454): 10–20.

line medications for these issues,[138] and are more likely to experience cost barriers to prescriptions when they are.[139] While it is not clear whether lower prescribing rates for Māori are due to clinical or client decision-making, HQSC argues that evidence that Māori are under-served and poorly served by both primary and secondary mental health services suggests that "the lower use of medication observed here is not compensated for by higher use of non-pharmacological therapies".[140]

Māori remain more likely than non-Māori to be placed under the Mental Health Act, and to be subject to restrictive practices once they are. The number of Māori under compulsory treatment orders (CTOs) has risen every year since at least 2014, climbing to 2,387 in 2018 or 38% of those under such an order. Forty-four percent of those secluded and 43% of those involved in seclusion events in 2018 were Māori — both a three percentage point increase since 2017. Evidence gathered by the Waitangi Tribunal highlights that Māori are also significantly over-represented amongst deaths in mental health inpatient units.[141]

The economic disparity among population groups continues to be evident in two of the wider wellbeing indicators considered for this report. Tāngata whaiora Māori still have lower rates of independent accommodation than other tāngata whaiora of mental health and addiction services, with 78% of Māori living in independent accommodation compared to 84% of all tāngata whaiora in 2018/19. There has been slight but unequal improvement[142] in this indicator for both Māori and the broader tāngata whaiora population. Māori continue to have a higher rate of homelessness than other tāngata whaiora, with 6% of tāngata whaiora Māori being homeless compared to 4% of all tāngata whaiora.

Disparities for tāngata whaiora Māori in levels of engagement in education, employment, or training continue to be less pronounced, with a slight but unequal improvement[143] in this measure for both Māori and the broader tāngata whaiora population. In 2018/19, the rate of engagement in education, employment, or training for tāngata whaiora Māori was 45% compared to 49% of all tāngata whaiora.

A transforming system must do things differently to meet the needs of Māori

Efforts to improve the responsiveness and cultural capacity of mental health services and addiction services and improve outcomes for Māori have been underway for a long time. Driven largely by Māori working in the sector, and supported by a range of measures introduced by Government, these efforts have helped to create a system that is committed to respecting and incorporating Māori cultural values, and increasing the provision of culturally appropriate services and culturally competent practitioners.

However, as outlined above, Māori continue to have higher mental distress and/or addiction needs while experiencing less equitable, more restrictive care. Evidence gathered by the Waitangi Tribunal identified that "Māori have long concluded that the Western approach to mental health care has failed".[144] Major limitations include the resourcing of kaupapa Māori services; the responsiveness of mainstream services; and Māori workforce development. The current momentum around transforming our approach to mental distress and/or addiction comes with an opportunity to address these disparities — not just by building on approaches that are effective, but by being open

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138 Health Quality & Safety Commission, *Atlas of Healthcare Variation. Mental Health in primary care* (2020): https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/mental-health/.

139 *Ibid*.

140 Health Quality and Safety Commission, *Atlas of Healthcare Variation. Key findings: Mental Health in primary care* (2020): https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/mental-health/.

141 37% of those who died in the period between 1 January 2009 and 6 August 2019 identified as Māori; Gassin, T, *Maōri Mental Health. A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Enquiry* (2019) 52: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_153087514/Wai%202575%2C%20B026.pdf.

142 Rates of independent accommodation for Māori climbed by 1% between 2016/17 and 2018/19 compared to an average increase of 2%.

143 Rates of engagement in employment, education, or training for Māori climbed 2% between 2016/17 and 2018/19 compared to an average increase of 4%.

144 Gassin, T, *Maōri Mental Health. A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Enquiry* (2019) 2: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_153087514/Wai%202575%2C%20B026.pdf.

to new ways of doing things. As we work on a new system of care it will be important to ensure that any changes are having an equitable impact, and I support the new Mental Health and Wellbeing Commission having a particular responsibility for taking Māori experiences and outcomes into account as it performs its functions.

There are a number of successes we can build on. I am pleased to see more funding being allocated to kaupapa Māori services. There were strong calls made during the Inquiry into Mental Health and Addiction for kaupapa Māori services to be "prioritised, valued and appropriately resourced".[145] Support for "by Māori, for Māori" approaches to mental distress and/or addiction are an essential component of the Crown's commitments under Te Tiriti o Waitangi in regard to Māori self-determination. Māori with lived experience have also shared with me the alienation they feel when services do not feel welcoming to them, or understand their cultural perspective. They have told me that being able to access kaupapa Māori services for their mental health and addiction needs can make a huge difference.[146]

> "Having access to a Māori organisation who have kaimahi with lived experience rather than just clinical views. Being able to connect with kaimahi on a deep level of knowing you have similar experiences creates a connection from the start."
> Te Rau Ora hui participant

While there is no fixed definition for what constitutes a kaupapa Māori approach,[147] key themes that came out of a recent series of hui-Māori a motu to inform the design and development of a kaupapa Māori primary mental health and addiction model highlight the difference from the more traditional Western biomedical model of care:

- **Whānau-centred:** service design and delivery must meet the needs of whānau first and foremost and be informed and accountable to whānau aspirations.

- **Delivering "For Māori, by Māori":** meeting the needs of Māori in a uniquely Māori way. Necessitates increased Māori leadership and learning systems that support the uptake of kaupapa Māori practices.

- **Supportive of kaupapa Māori principles and practices:** legitimating and endorsing strengths-based and mana-enhancing models of care that are centred in Te Ao Māori as an asset for optimising whānau outcomes through collective action and impact.

- **Strong in Te Reo Māori:** an important tool and vehicle for engaging with, and connecting to, whānau needing support, and supporting them to heal and grow.

- **Skilled in Tikanga:** a set of Māori principles that are observed and upheld to ensure that whānau needs are met.

- **Steeped in Mātauranga Māori:** represents a significant strength and will to work in a Māori way, and a commitment to supporting Māori leadership and action across all modalities of health and wellbeing.

- **Experienced in Rongoā:** a set of Māori principles and practices that support healing within the whānau, including cultural therapies that can be complementary to others under the guidance of best practice from Rongoā leaders.[148]

While the expansion of kaupapa Māori services provides people with more options for support, most Māori will still access care through mainstream services. The ability of these services and those working in them to engage with Māori whānau effectively is essential to the achievement of equitable outcomes.

145 Inquiry into Mental Health and Addiction, *Oranga Tāngata, Oranga Whānau: A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction*. Department of Internal Affairs: Wellington (2019) 3.

146 The same themes were also shared with the Inquiry into Mental Health and Addiction.

147 Gassin, T, *Māori Mental Health. A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Enquiry* (2019) 93: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_153087514/Wai%202575%2C%20B026.pdf.

148 Awa Associates, *Ngai Maōri Insights for a Kaupapa Māori Primary Community Mental Health and Addiction Services Model: the Analysis* (2019) 2: https://www.health.govt.nz/publication/ngai-Māori-insights-kaupapa-Māori-primary-community-mental-health-and-addictions-service-model.

As Sir Mason Durie notes, "[T]he degree of comfort individuals feel with seeking health services impacts on their use of services and, in turn, health outcomes … The delivery of care in a culturally appropriate manner is an important element in determining both the willingness of people to access services and the success of any treatment or care then delivered."[149]

There are some good examples of services that are provided in a culturally appropriate manner, which have shown a positive impact on outcomes for Māori. The Te Kūwatawata pilot in Tairāwhiti is one (see signs of progress at the end of this section). By combining matauranga Māori and Western knowledge, this pilot reduced inpatient admissions and the use of CTOs — particularly for youth. Key elements included a focus on whanaungatanga, including whānau ora; culturally competent staff; and a welcoming environment with no barriers to access (manaakitanga).

In my conversations with tāngata whaiora Māori and whānau there are three inter-related issues with mainstream services that come up repeatedly — the cultural safety of services, including the cultural competence of practitioners; the importance of whanaungatanga, including the need for a broader focus on whānau ora; and the importance of taking a more holistic approach to improve people's wellbeing. Through mutual respect and an appreciation that "neither approach has all the answers",[150] a bicultural approach to care benefits from the best of both indigenous and clinical wisdom and practice, and is likely to work better for everyone.

> "[It] starts with the whānau … until my whānau can accept their part it doesn't work. Need to resource and support whānau to know what to do and to support [me].
> Te Kete Pounamu hui participant

As Durie points out, a person's comfort in a service is not just about the way that a service is delivered, but is also a product of individual attitudes. New Zealand has rightly focused on the cultural competence of health professionals in the pursuit of equity — particularly for Māori. The ability to "have effective and respectful interaction with Māori"[151] is embedded into the standards and regulations that guide and govern the professional conduct of people who work in mental health services and addiction services. Tāngata whaiora Māori have shared some positive experiences of care that reflected this ability, and particularly appreciate being treated as partners in their care, with their views and decisions respected. But I have also received complaints that highlight that this is not always happening and that sometimes even with the best intentions, "serious and unrecognised miscommunication"[152] occurs when providers allow their own cultural beliefs, including the biomedical lens, or the stereotypes they unconsciously hold, to dictate how they interact with, and make decisions about, the care of Māori. There is compelling evidence that implicit bias — the unconscious application of negative stereotypes — is affecting patient–provider relationships and contributing to inequitable outcomes for Māori.[153] This is a critical and complex aspect of transformation.

Real partnership with Māori is essential

Both the Mental Health report prepared for the Waitangi Tribunal and the final report of the Inquiry into Mental Health and Addiction expressed frustration that despite significant and long-standing consensus around the changes necessary, this had failed to translate into service delivery.[154]

In my previous report, I talked about the importance of a more substantial leadership role for Māori in both the design and delivery of services and at the highest level. Not only do I continue to advocate for this as an essential component to meaningful

149 Durie, M, *Mauri Ora: the dynamics of Māori Health*. Oxford University Press: Auckland (2001) 12.

150 Durie, M, "Foreword", in NiaNia, W, Bush, A, and Epston, D, *Collaborative and indigenous mental health therapy: tātaihono, stories of Māori healing and psychiatry*. New York: Routledge (2017).

151 Health Practitioners Competence Amendment Act 2019: 37(2).

152 Walker, R and Sonn, C, *Working as a Culturally Competent Mental Health Practitioner* (undated): https://www.tepou.co.nz/assets/images/content/training_funding/tools-for-learning/files/Chapter12.pdf.

153 Houkamau, CA, "What you can't see can hurt you. How do stereotyping, implicit bias and stereotype threat affect Māori health?" *MAI Journal* (2016) 5: 2.

154 Gassin, T, Maōri Mental Health. *A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Enquiry* (2019) 92: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_153087514/Wai%202575%2C%20B026.pdf.

change, but I note that it also reflects what was heard by the Inquiry into Mental Health and Addiction,[155] and the interim findings of the Health and Disability Sector Review.[156] In my conversations with tāngata whaiora Māori, people not only wanted to be included in decisions made about their care, but also in those relating to mental health system reform and delivery. This is an essential component of accountability.

Giving life to this will require investment in the development of a workforce that is more diverse, and culturally as well as clinically competent. I acknowledge the work already being done by Te Rau Ora, Te Pou te Whakaaro Nui, Werry Workforce Whāraurau, and others to encourage more Māori into the mental health and addiction sector, and support people already working in the sector to increase their confidence in kaupapa principles and practices and further develop their ability to provide culturally responsive and culturally safe care.

A commitment from leadership at all levels that these skills and reflective practice are important is essential. The extent to which they are embedded and applied in practice is reliant on both a willingness on the part of staff members and the "ability of the wider organisation to endorse the relationship between culture and health".[157] Shared governance systems, clinical leadership, and forums for clinical and cultural processes have been highlighted as key to increasing the respect for, and application of, cultural wisdom and practice to issues traditionally seen as sitting within the clinical domain.[158]

While increasing the investment in kaupapa Māori services is a positive step, a partnership approach that aligns with Treaty commitments also requires a closer relationship and greater trust and collaboration between mainstream and kaupapa Māori services. This should be championed from the top, and include consideration of how contracting and funding structures and processes can be best used to support this.

There is also an urgent need to consciously tackle the biases that still exist in many mental health services and addiction services. I acknowledge the work that the HQSC is doing to assist people to learn about unconscious bias and reflect on and address their own practice. I also note that the high take-up of the learning and education models the HQSC has developed on unconscious bias suggests a willingness from people working in the health sector to challenge themselves and make change. I encourage those in leadership, as well as those in frontline positions, to take advantage of these resources to reflect on their preconceptions and practice.

Maternal mental health

Maternal mental health and substance use issues are common and can have devastating consequences

During pregnancy and in the first year after birth, women are at an increased risk of developing or having a recurrence of mental health issues. Conversations with new mothers highlight how the intensity of their experiences during this period "often amplifies any existing stress or mental distress they were already experiencing, and can unearth previously undealt with grief and trauma".[159] Distress during this period can also relate to the termination or loss of a pregnancy or baby.

While New Zealand lacks robust prevalence data, it is estimated that around 10–20% of women will experience mental distress during pregnancy and/or the first year following birth — most commonly depression. The "Growing Up in New Zealand" study found that 12% of women in their cohort

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155 Inquiry into Mental Health and Addiction, *Oranga Tāngata, Oranga Whānau: A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction*. Department of Internal Affairs: Wellington (2019): 12, 18, 29–30.

156 New Zealand Health and Disability System Review, *Interim Report* (2020): 8–9: https://systemreview.health.govt.nz/assets/HDSR-interim-report/2d959670c7/HDSR-InterimReport-Executive-Overview-final.pdf.

157 Lawrence, M, "Te Hauora o Ngā Pakeke Māori: Adult Mental Health", in Kingi, TK, Durie, M, Elder, H, Tapsell, R, Lawrence, M, and Bennett, S, *Maea te Toi Ora. Māori Health Transformations*. Wellington: Huia Publishers (2018): 182.

158 Tapsell, R, "The Rehabilitation of a Māori Mentally Abnormal Offender in Te Hauora o Ngā Pakeke Māori: Adult Mental Health", in Kingi, TK, Durie, M, Elder, H, Tapsell, R, Lawrence, M, and Bennett, S, *Maea te Toi Ora. Māori Health Transformations*. Wellington: Huia Publishers (2018): 118.

159 HPA and the Innovation Unit, *Whai-Ao ki te Ao Marama. Coming into the light; Mothers' experience of distress and wellbeing during pregnancy and the first year of motherhood* (2019): 8.

had symptoms of anxiety/depression during the antenatal period.[160] A later study using the same cohort found that 16.5% of women experienced significant levels of antenatal or postnatal depression, with more women meeting the criteria for depression during pregnancy than after the birth.[161] While less common, and the subject of less research, mental distress during this period can also take the form of obsessive-compulsive disorder, post-traumatic stress disorder, anxiety, and postpartum psychosis.[162]

While there is evidence that women generally try to reduce their use of substances — at least during the early stages of pregnancy[163] — distress can also manifest in[164] or co-occur with hazardous or harmful substance use.[165] Given their potential effects on the fetus, any use of some substances during pregnancy is considered risky.[166] Some women will even stop taking mental health medication to protect the health of their baby.[167]

While any woman can experience distress in the perinatal period, some are at greater risk than others. The "Growing Up in New Zealand" study found that experiencing depression at any stage was significantly more common among Pacific[168] and Asian mothers, and slightly more common for Māori mothers.[169] Given the evidence of higher prevalence and greater severity of mental illness among the Māori and Pacific population more
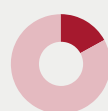
16.5%
of women experience significant levels of antenatal or postnatal depression

60%
of women who died by suicide in pregnancy or within six weeks of pregnancy between 2006 and 2017 were Māori

broadly,[170] it is likely that Māori and Pacific mothers are also at greater risk for other perinatal mental health issues.

The impact of maternal mental distress on individuals, families, and society is substantial. At the most severe end of the spectrum is self-harm, infant-harm, and suicide. I am deeply concerned that suicide is now the leading single cause of maternal death in New Zealand, and that Māori whānau are disproportionately affected. Between

160 Waldie, KE, Peterson, ER, D'Souza, S, Underwood, L, Pryor, JE, Carr, PA, and Morton, SM, "Depression symptoms during pregnancy: Evidence from Growing Up in New Zealand". *Journal of Affective Disorders* (2015) 186: 66–73.

161 Underwood, L, Waldie, KE, D'Souza, S, Peterson, ER, and Morton, SM, "A longitudinal study of pre-pregnancy and pregnancy risk factors associated with antenatal and postnatal symptoms of depression: evidence from Growing Up in New Zealand". *Maternal and Child Health Journal* (2017) 21: 915–931.

162 Ministry of Health, *Healthy Beginnings* (2012).

163 Superu, *Patterns and Dynamics of Alcohol Consumption During Pregnancy in a Recent New Zealand Cohort of Expectant Mothers*. Wellington: Superu (2015).

164 HPA and Innovation Unit (2019).

165 See, for example, Wouldes, TA, *et al*., "Comorbidity of substance use disorder and psychopathology in women who use methamphetamine during pregnancy in the US and NZ". *Drug Alcohol Depend* (2013) 127(1–3): 101–107.

166 For example, the Ministry of Health recommends that there is no safe amount of alcohol that can be used in pregnancy.

167 Ministry of Health, *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health (2011): https://www.health.govt.nz/publication/healthy-beginnings-developing-perinatal-and-infant-mental-health-services-new-zealand.

168 Using the Edinburgh Postnatal Depression Scale, Abbott and Williams (2006) assessed 16.4% of the Pacific women they interviewed as meeting the criteria for postnatal depression, with prevalence rates varying from 7.6% of Sāmoan mothers to 30.9% of Tongan mothers. Abbott, MW and Williams, MM, "Postnatal depressive symptoms among Pacific mothers in Auckland: prevalence and risk factors". *Aust N Z J Psychiatry* (2006) 40(3): 230–38.

169 Underwood, L, Waldie, KE, D'Souza, S, Peterson, ER, and Morton, SM, "A longitudinal study of pre-pregnancy and pregnancy risk factors associated with antenatal and postnatal symptoms of depression: evidence from *Growing Up in New Zealand*". *Maternal and Child Health Journal* (2017) 21: 915–31.

170 Oakley Browne, MA, Wells, JE, and Scott, KM (eds), *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health (2006): 35. Using data from PRIMHD on all referrals or admissions to mental health services for people who had not been patients in the proceeding six years, Tapsell et al. (2018) also found that Māori were disproportionately more likely to be referred to, or admitted for, schizophrenia and major depression than non-Māori, although the same was not found for bipolar disorder. Tapsell, R, Hallett, C, and Mellsop, G, "The Rate of Mental Health Service Use in New Zealand as Analysed by Ethnicity". *Australasian Psychiatry* (2018) 26(3): 290–93.

2006 and 2017, 60%[171] of the women who died by suicide in pregnancy or within six weeks of pregnancy were Māori.[172]

As the Perinatal and Maternal Mortality Review Committee's 11th report highlighted, women with a prior history of mental health issues are particularly at risk of experiencing distress during the perinatal period.[173] The speed at which issues can develop and increase in severity during this time highlights the need for rapid access to specialist services.

While there has been some progress, barriers to effective, equitable care for maternal mental health and addiction remain

In 2012, the Ministry of Health released *Healthy Beginnings*. This document laid out the case for investment in perinatal and infant mental health services, and guidelines for providing integrated services that catered to the range of need. It noted that no DHB was providing the full range of services required, and that where they did exist, these services had been developed in an "uncoordinated, ad hoc and siloed way".

Since then there have been some significant efforts made to improve the availability of support. In 2013, the Government invested $18.2 million into maternal mental health services in the North Island, including a specialist inpatient unit catering for mothers and babies at Starship Hospital and in-home and community respite for mothers and babies in Auckland. In 2016, the Government invested $12 million over four years to expand the Pregnancy and Parenting Service into three areas. This model has been operating for over a decade in Waitematā, and

provides assertive outreach and holistic support to pregnant women and parents with children up to age three who have addiction issues and are not well connected to services (see signs of progress at the end of this section). In 2019, a further $7 million was invested to expand this initiative into two further areas. $10 million was also invested into the development, testing, and evaluation of a pilot to provide enhanced support for parents and whānau with mental health or addiction needs during pregnancy, in the first two years of a child's life or following stillbirth. Those developments were encouraging.

"Maternal mental health services need to be equitable, available and accessible across the country with consistent pathways for engagement."[174] Yet the regional variability, lack of coordination, and service gaps highlighted by *Healthy Beginnings* are still apparent, and some women are having a hard time finding the support that they need.

Conversations with new mothers highlight the difficulty women have in distinguishing between the normal ups and downs associated with pregnancy and being a new parent, with more serious signs of distress. They want help to be able to understand what's normal and what isn't.[175] While mothers tend to turn to informal support networks for help first,[176] they want the opportunity to discuss mental health with professionals.[177] Those most likely to be coming into contact with women during that period are Lead Maternity Carers (LMCs), GPs, and Well Child Tamariki Ora providers. New Zealand currently lacks a formal perinatal assessment/screening programme for maternal mental health.[178] While it is clear that professionals will often check in on a mother's wellbeing, and some screening does take

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171 18 out of 30 women.

172 PMMRC, *Thirteenth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality and morbidity 2017*. Wellington: Health Quality & Safety Commission (2019): 111: https://www.hqsc.govt.nz/assets/PMMRC/Publications/12th-PMMRC-report-final.pdf.

173 PMMRC, *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015*. Wellington: Health Quality & Safety Commission (2017).

174 PMMRC (2017): 142.

175 HPA and Social Innovation Unit (2019).

176 HPA and Social Innovation Unit (2019): 12.

177 Holden *et al*. (2019).

178 Ministry of Health, *Advice regarding Perinatal and Maternal Mental Health*. Wellington: Ministry of Health (2018).

place,[179] both mothers and professionals describe current practices as ad hoc.[180]

> "No-one quantifies what normal means …
> I wanted a score — to know if I'm OK or not."
> New mother, Whai-Ao ki te Ao Marama[181]

In its review of the case histories of women who had died by suicide while pregnant or within six weeks of pregnancy the PMMRC identified "potentially delayed and/or missed diagnoses of physical and/or mental health issues" in five cases.[182] Early identification of issues is critical for ensuring timely intervention and support. If combined with good data collection and reporting, a formal screening programme would also enhance our ability to plan and deliver care in response to need. Currently, lack of data makes it difficult to quantify need or monitor the effectiveness and equity of our response.

When issues are identified, both women[183] and professionals[184] have expressed concerns about the difficulty accessing the necessary support. Common issues reported include a lack of support for mild to moderate conditions; rigid (and tightening) access criteria owing to pressure on DHB services; siloed support for those dealing with multiple issues; long wait times; barriers to access (e.g., transport or cost); fear of formal support; and not knowing where to find the right support for themselves or their clients.[185]

> "Currently the acceptance criteria for the perinatal team within our DHB has moved from moderate/severe to severe only. So, a mother must have suicidal ideas before she will be accepted."
> Plunket nurse[186]

> "I've had a couple where they're just 'No, she doesn't need it', or 'She doesn't qualify, you need to ring this person, you need to ring this person', you get a bit of a runaround. Who am I supposed to be calling about this lady?"
> Midwife[187]

PMMRC reviews of case histories also found that while almost half of the women who had died by suicide (47%) were documented as having an identified mental health issue, they were "either not referred, referred but not seen, or it was unclear if they had been referred or seen by mental health services".[188] While multiple services were often involved in the women's care, PMMRC also identified "poor communication between services, poor coordination, and inadequate follow-up".[189]

This lack of integrated care and support is unacceptable, and I note the ongoing criticisms by the PMMRC about the lack of action to address these issues. As it argues in its 13th report, there is an urgent need for investment in this area, in the areas of prevention, developing appropriate screening tools, and treatment for women and their babies.[190]

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179 For example, during pregnancy, LMCs are required to screen for alcohol and drug use, but mental health screening is not part of their current schedule. The focus of WCTO providers is more on the health and development of the child, but they provide a comprehensive assessment that includes a postnatal depression screen as part of their intake process. See also Mellor, C, Payne, D, McAra-Couper, A, "Midwives' perspectives of maternal mental health assessment and screening for risk during pregnancy". *New Zealand College of Midwives Journal* (2019) 55: 27–34.

180 Holden, G, Corter, AL, Hatters-Friedman, S, Soosay, I, "Brief Report. A qualitative study of maternal mental health services in New Zealand: Perspectives of Māori and Pacific mothers and midwives". *Asia-Pacific Psychiatry* (2019) e12369: 2; Mellor, C, Payne, D, McAra-Couper, A, "Midwives' perspectives of maternal mental health assessment and screening for risk during pregnancy". *New Zealand College of Midwives Journal* (2019) 55: 27–34.

181 HPA and Social Innovation Unit (2019): 13.

182 PMMRC, *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015*. Wellington: Health Quality & Safety Commission (2017): 159.

183 HPA and Social Innovation Unit (2019): 11.

184 Holden, G, Corter, AL, Hatters-Friedman, S, Soosay, I, "Brief Report. A qualitative study of maternal mental health services in New Zealand: Perspectives of Māori and Pacific mothers and midwives". *Asia-Pacific Psychiatry* (2019): e12369. Mellor, C, Payne, D, McAra-Couper, A, "Midwives' perspectives of maternal mental health assessment and screening for risk during pregnancy". *New Zealand College of Midwives Journal* (2019) 55: 27–34; Royal New Zealand Plunket Trust, "Submission to the Mental Health Inquiry" (2018): 5: https://www.plunket.org.nz/assets/Submissions/Mental-Health-Inquiry-Submission-FINAL.pdf.

185 HPA and Social Innovation Unit (2019): 11; Holden *et al.* (2019); Mellor *et al.* (2019).

186 Quote in Royal New Zealand Plunket Trust "Submission to the Mental Health Inquiry" (2018): 5.

187 Quote in Mellor *et al.* (2019): 30.

188 PMMRC, *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015*. Wellington: Health Quality & Safety Commission (2017): 159.

189 PMMRC, *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015*. Wellington: Health Quality & Safety Commission (2017): 159.

190 PMMRC, *Thirteenth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality and morbidity 2017*. Wellington: Health Quality & Safety Commission (2019): 111.

Improving maternal mental health requires a focus on the broader social determinants

While the health sector has a significant role to play in supporting women and their whānau to identify and address mental distress in the perinatal period, a whole-of-government, whole-of-community response will be essential. As with mental health more generally, social, economic, and individual factors also play a role in the development of distress during this period, as well as a woman's ability to access or engage in care.

In the New Mothers' Mental Health survey, respondents who met the criteria for postnatal depression[191] were more likely to give responses that indicated greater life difficulties, lower coping self-efficacy, lower social connectedness, more isolation, lower family/whānau wellbeing, and lower life satisfaction.[192] Difficult relationships (including abusive relationships[193]) and home environments (including unstable housing), and a lack of paid employment have also been associated with maternal mental distress.[194] While health professionals need to be mindful of these as risk factors for mental distress when working with women and their whānau, broader supports and well-considered social policies are also essential.

Support does not always have to be intensive. New mothers interviewed by the Health Promotion Agency (HPA) talked about how things like help with cooking, cleaning, laundry, and childcare would help them to get the time and space for self-care.

> *"Support for mental health is great — but it doesn't take away from the day-to-day stresses. I still have to eat, have a shower ..."*
> New mother, Whai-Ao ki te Ao Marama[195]

As outlined above, Māori, Pacific, and Asian women are more likely to experience mental health issues in this period, but may face additional barriers to seeking and receiving support. Interviews with Māori mothers have highlighted particular issues that are likely to be having an impact on equitable outcomes. These include a fear of stigma and discrimination; lack of cultural competency from health professionals; not feeling like they fit into either kaupapa Māori or mainstream services; not being aware of, or able to access, kaupapa Māori services (including Māori midwives); unhelpful attitudes from whānau;[196] and feeling isolated in Pākehā-centric support groups and services.[197]

There are a range of things New Zealand needs to do to address these barriers, including raising public awareness of maternal mental health issues and how common they are, increasing the availability and visibility of kaupapa Māori services and other culturally responsive support options, and increasing the cultural competence and diversity of the workforce.

An integrated approach to maternal mental health and infant health and development is essential

New Zealand's renewed focus on improving mental health and wellbeing, as well the development of a Child Wellbeing Strategy, offer a unique opportunity to improve our collective response to maternal mental health and take advantage of the life-long and inter-generational benefits of investing in the start of life. I note that a key action in the Child Wellbeing Strategy is the development of a Maternity Whole of System Action Plan. One of the components within this is the development of a specific work programme to improve maternal and infant mental health outcomes. I am encouraged to see this as a specific focus, and note that

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191 As measured by the Edinburgh Postnatal Depression Scale.

192 HPA, *Postnatal depression in NZ: Findings from the 2015 New Mothers' Mental Health Survey* (2016).

193 WHO (2008): https://www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf?ua=1. The PMMRC 11th report also found high rates of relationship stressors and exposure to family violence.

194 Underwood, L, Waldie, KE, D'Souza, S, Peterson, ER, and Morton, SM, "A longitudinal study of pre-pregnancy and pregnancy risk factors associated with antenatal and postnatal symptoms of depression: evidence from *Growing Up in New Zealand*". *Maternal and Child Health Journal* (2017) 21: 915–31.

195 HPA and Social Innovation Unit interview with new mothers.

196 Tongan women interviewed by Holden *et al*. (2019) also talked about culturally based responses from kāinga.

197 HPA and Social Innovation Unit (2019): 14.

international cost–benefit estimates highlight very good returns on investment in this area — mostly related to better outcomes for children.[198]

Better integration, communication, and collaboration between maternal mental health and addiction services and those focused on infant and child health and development is essential. The first 1,000 days of life — which includes the antenatal period — is a foundational period for future health, development, and wellbeing.[199] Prolonged stress or exposure to toxins such as alcohol during pregnancy can have a significant impact on the healthy development of the baby — particularly that of their central nervous system. Antenatal anxiety, depression, and stress, as well as exposure to alcohol in utero,[200] are key risk factors for pre-term birth and low birth weight, and are associated with delayed infant brain development, including cognitive, emotional, and behavioural development.[201]

Prolonged or severe mental illness, including substance dependence,[202] can affect attachment between the mother and infant, and diminish the level of positive interactions, including touch and play, they have together. Research has found that this can have long-lasting implications for the child, including behavioural problems and depression at age 21.[203]

At the same time, the effects on the child's mental health and neurodevelopment can manifest in ways that make parenting more stressful, and can increase any pressures the whānau may already

be experiencing. Increased irritability and tantrum throwing, difficulty settling, sleeping, or feeding, and medical issues or missed milestones in infants are common signs that something is not going right. Early intervention to address emerging issues is key to preventing them from entrenching, and effective treatments generally need to involve both the infant and the caregiver/s.

I found it difficult to assess whether we had the capacity and pathways needed to intervene effectively in issues presenting in infancy, but conversations with the sector suggest that the same issues exist in relation to the response to infant mental health as I have found in the response to these issues during maternity. I encourage the new Mental Health and Wellbeing Commission to pay particular attention to this issue.

Next steps

I welcome the Government's commitment to the development of a maternity whole-of-system action plan as part of its Child Wellbeing Strategy. I encourage Government to take account of the findings and recommendation of the reviews undertaken by the PMMRC in doing so, including the actions they proposed in their 12th report:

- A stocktake of current mental health services available across New Zealand for pregnant and recently pregnant women to identify both the strengths of services and gaps or inequity in current services and skills in the workforce; and

198 Bauer, A, Parsonage, M, Knapp, M, *et al.*, *Costs of perinatal mental health problems*. London: London School of Economics and Political Science (2014): http://eprints.lse.ac.uk/59885/ estimated that the cost to society of perinatal mental illness is about £8.1 billion for each yearly cohort of births. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother. A £400 investment per birth in universal and specialist provision for perinatal mental health problems was estimated to lead to savings to society in the region of £10,000 per birth. In 2013, the projected costs for not treating perinatal depression and anxiety in Australia were estimated at A$538M during the period from conception to the end of the first year of a child's life. If the prevalence of women affected by perinatal depression was reduced by 5% (15,500 women), total costs (direct and indirect) in the first two years could be reduced by $147M. PriceWaterhouseCoopers Australia, *Valuing Perinatal Health. Beyond Blue* (2014): https://www.cope.org.au/wp-content/uploads/2013/12/PWC-2013_Final3.pdf.

199 Potter, JD, Poulton, R, Gluckman, P, McNaughton, S, Lambie, I, *et al.*, "Towards a Whole of Government/Whole of Nation Approach to Mental Health". Presentation to the Mental Health and Addiction Inquiry by the Social Sector Science Advisors (2018): 12: https://mentalhealth.inquiry. govt.nz/assets/Summary-reports/SSSA-report-Toward-a-Whole-of-Government-Approach.pdf.

200 *Ibid.*

201 Gentile, S, "Untreated depression during pregnancy: Short- and long-term effects in offspring: A systematic review". *Neuroscience* (2017) 342: 154–166.

202 Potter, JD, Poulton, R, Gluckman, P, McNaughton, S, Lambie, I, *et al.*, "Towards a Whole of Government/Whole of Nation Approach to Mental Health". Presentation to the Mental Health and Addiction Inquiry by the Social Sector Science Advisors (2018): 12: https://mentalhealth.inquiry. govt.nz/assets/Summary-reports/SSSA-report-Toward-a-Whole-of-Government-Approach.pdf.

203 Betts, KS, Williams, GM, Najman, JM, and Alati, R, "The Relationship between Maternal Depressive, Anxious, and Stress Symptoms during Pregnancy and Adult Offspring Behavioural and Emotional Problems". *Depression & Anxiety* (2015) 32(2): 82–90. For alcohol, see also Ministry of Health, *Taking Action on Fetal Alcohol Spectrum Disorder (FASD): A discussion document*. Wellington: Ministry of Health (2015).

- A national pathway for accessing maternal mental health services, including:
  - cultural appropriateness to ensure service access and provision;
  - appropriate screening;
  - care for women with a history of mental illness; and
  - communication and coordination.

Importantly, the Committee also noted that, as a number of different agencies are involved in the provision of mental health care during the perinatal period, there is a need for a strategic approach to the planning of services, including the development of integrated care pathways within a stepped-care framework.

Addiction issues and integration with services focused on infant health and development must also be considered as an integral component of the action plan.

Alcohol and other drug addiction

It is important to keep a focus on addiction as we improve our response to mental health

When we talk about transforming the mental health system, this includes the way we respond to addiction.[204] The two issues have a lot in common. As well as being part of the same Ministry of Health funding umbrella, both the risk factors and social determinants that contribute to the development of these issues, and the experiences of distress, discrimination, and early mortality,[205] are all too often shared by people with mental health and people with addiction issues.

Co-morbidity is common, and can have negative reinforcing effects on both the health and wellbeing of, and treatment outcomes for, people.[206] Aotearoa/New Zealand has rightly emphasised the need for better integration between mental health and addiction treatment. It is essential that services are responsive to people's needs.

But being responsive requires a recognition that there are also important differences. When considering the different drivers of addiction and mental health issues, it is important to note that there are substantial commercial enterprises focused on developing and marketing legal drugs that are known to cause addiction. Use of alcohol is normalised in Aotearoa/New Zealand.[207] People in recovery have told me about how much harder it is to maintain their sobriety when there is significant social pressure and well-funded marketing campaigns promoting alcohol. While *He Ara Oranga* recommended that New Zealand make changes to the regulatory landscape governing alcohol, this was one of the few recommendations the Government did not accept.

While people with mental health issues and people with addiction issues are both likely to have had experiences of stigma and discrimination, "no medical condition is more stigmatised than addiction".[208] Even those who are dependent on legal drugs are considered more blameworthy and provoke more social rejection and negative emotions than people with mental health disorders.[209] As I discuss further on in this chapter, healthcare professionals — including those who work in mental health services — are not immune from holding negative views about people who have alcohol and drug issues. Their attitudes can have a significant impact on the care people do or do not receive.

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204 In this section, the focus is on addiction as it relates to alcohol and other drugs.

205 Te Pou o te Whakaaro Nui, *The physical health of people with mental health conditions and/or addiction (2017); Te Pou o te Whakaaro Nui, The physical health of people with a serious mental illness and/or addiction. An evidence review* (2014).

206 Todd, FC, *Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems.* Ministry of Health, Wellington (2010) 7–8.

207 New Zealand Medical Association, *Reducing alcohol-related harm* (2015): https://www.tttpho.co.nz/wp-content/uploads/2016/10/Alcohol-Briefing18.may_.FINAL_.pdf. See also, New Zealand Law Commission, *Alcohol in our lives: curbing the harm* (2010). Law Commission Report no. 114. https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R114.pdf

208 Global Commission on Drug Policy (2017): 27; See also, Corrigan, PW, Kuwabara, SA, and O'Shaughnessy J, "The Public Stigma of Mental Illness and Drug Addiction: Findings from a Stratified Random Sample". *Journal of Social Work* (2009) 9(2): 139-147

209 Shomerus, G *et al.*, "The stigma of alcohol dependence compared with other mental disorders: a review of population studies". *Alcohol and Alcoholism* (2011) 46(2): 105–112.

While people with mental health issues fare worse than the general population in terms of health outcomes,[210] the physical health needs of people with addiction issues can be more acute, owing to the accidents and injuries that can occur while people are intoxicated.[211] The often social nature of drug use, combined with the modes of ingestion, put people who use some drugs at a higher risk of blood-borne viruses.[212] Some pharmacotherapies for addiction can also cause health problems (e.g., methadone and oral health[213]), and prolonged use of some substances can cause lasting damage to physical health.[214] Alcohol and drug related illness and injury can be a catalyst for wanting to make changes, and as people reduce their use of substances in treatment, physical and mental health issues may become more pressing.

The treatment approaches used in these two fields have tended to be based on different ways of thinking about how people change. Mental health treatment "tends to focus on ways of caring for and protecting people from harm. It traditionally starts under a medical model that includes medication, hospitalisation, symptom focus, risk management and can include forced treatment and restrictive practices."[215] Addiction treatment has tended to place more emphasis on strategies that promote self-responsibility. "It rarely starts with medication and most often begins with choices to do with self-exploration within therapy and therapeutic groups and self-selected rehabilitation options for recovery."[216]

If they are to be effective, these differences need to be taken into account when developing responses that will meet the needs of all people whose issues sit under the mental health umbrella. While I support better integration between mental health and addiction treatment, I am concerned that rather than giving equal weight to the importance of both issues, attempts to create a combined approach can result in an erosion of the necessary focus on addiction. I see examples of that in complaints to HDC.
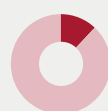
12%
of New Zealanders will experience a substance use disorder at some stage in their lives

Nearly
200,00
people will experience a substance use disorder each year (3.5% of the population)

2x
Māori are twice as likely to experience a substance use disorder in any year than non-Māori

25 years
most people who develop substance related issues will do so before age 25

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210 Te Pou o te Whakaaro Nui (2017) and (2014).

211 Hospitalisations for alcohol and drug related harm are higher by deprivation level, highest (by far) for recently released prisoners (especially for alcohol). Māori have higher rates of hospitalisation for both alcohol and drug related harm, and youth aged 13–24 years have a slightly higher rate of hospitalisation for drugs but not alcohol. Gibb, S and Cunningham, R, *Mental health and addiction in Aotearoa New Zealand. Recent trends in service use, unmet need and information gaps* (2018).

212 Seventy percent of people who receive opioid substitution treatment are likely to have Hepatitis C. Te Pou o te Whakaaro Nui (2014): 37.

213 Te Pou (2014): 38.

214 Te Pou (2017) and (2014).

215 Swanson, C, *The role of the Peer Workforce* (2019): https://www.tepou.co.nz/news/the-role-of-the-peer-workforce/1178.

216 *Ibid*.

In submissions to the mental health inquiry, those working in the addiction treatment sector noted that addiction is "often an add-on to mental health services", and that seeing it as a mental health challenge "pushed people into boxes they don't fit".[217] Recent research (based on 2014 prescribing data) highlights an over-reliance on the mental health toolkit for addiction issues. It found that rather than utilising Medsafe-approved, evidence-based pharamacotherapies for alcohol dependence, clinicians were instead more likely to prescribe medication for depression and anxiety — despite the evidence that this is not effective. The authors found that "the majority of the sample are either not receiving pharmacological treatment for alcohol use disorder or are receiving treatment for which the evidence base is limited."[218]

Attempts to create a combined approach has also led to confusion about who is responsible for someone's care. People submitting to the Inquiry into Mental Health and Addictions expressed frustration that mental health teams were not always responsive to those whose issues include alcohol and drug problems. They felt that a lack of clear accountability meant that people with addiction issues were not receiving appropriate follow-up and support, and were falling between the cracks.[219] The HDC case study at the end of Part II, Question 5 illustrates this issue well.

> "This melding of two models makes it difficult at times to decipher what is intended: with mental health dominating it can be impossible to know whether addictions is implicitly included or explicitly excluded — and often nobody has an answer because the nuances of the addictions aspect have not been considered — and that

is because there is often no one with indepth addictions knowledge and experience involved in these processes and making these decisions (like the Inquiry panel)."
DHB consumer group[220]

> "In my 40 years of involvement with both fields, I have been dismayed to watch planning for addictions being repeatedly tacked on to, and then wrapped up in, what are essentially plans for what is required in mental health."
Dr Peter Adams[221]

A range of services are available but access rates have declined

While it does not account for the high needs of populations such as prisoners, or any increase in demand driven by the changing availability and use of illicit drugs, the best data available suggests that around 12.3% of the population[222] will experience a substance use disorder at some stage in their lives.[223] About 3.5% of the population (168,581 people) will do so in any given year.[224] Even when adjusting for age, gender, and education and income levels, Māori are twice as likely to experience a substance use disorder in any year as non-Māori.[225] Most people who develop problems will do so before age 25.[226]

Not everyone who develops problems with their substance use needs treatment. Many people will make changes on their own or with help from whānau and/or peers. Those who do seek help for their substance use tend to take quite a while to do so, and are not always those with the most severe issues.[227] Motivations to seek treatment will vary by individual. Willingness to make change can

217 Government Inquiry into Mental Health and Addiction, *Summary Submissions Report* (2018): 203.

218 Beaglehole, B *et al.*, "Dispensing of medication for alcohol use disorder; an examination of large databases in a New Zealand context". *NZMJ* (2019) 132(1495): 48–53.

219 Government Inquiry into Mental Health and Addiction, *Summary Submissions Report* (2018): 203.

220 *Ibid.*

221 National Committee for Addiction Treatment, "Submission to the Mental Health and Addictions Inquiry Panel" (2018): https://www.matuaraki.org.nz/uploads/files/resource-assets/NCAT%20Submission%20to%20Mental%20Health%20and%20Addiction%20Inquiry.pdf.

222 Aged 16–64 years.

223 Oakley Brown, MA, Wells, E, and Scott, KM (eds.), *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health (2006).

224 *Ibid*: 39.

225 *Ibid*: 53.

226 Rapsey, CM, Wells, JE, Bharat, C, Gantz, M, Kessler, RC, and Scott, KM, "Transitions through stages of alcohol use, use disorder and remission: Findings from Te Rau Hinengaro, The New Zealand Mental Health Survey". *Alcohol and Alcoholism* (2019) 54(1): 87–96.

227 Kessler, RC, Aguilar-Gaxiolar, S, Berglund, PA, *et al.*, "Patterns and predictors of treatment seeking after onset of substance use disorder". *Arch Gen Psychiatry* (2001) 58(11): 1065–71.

build up over time or can be sudden and externally motivated.[228] This highlights the need for a variety of options and timely access to services when windows of opportunity present.

A wide range of services are available to support people who are experiencing problems with their substance use. These include resources for people who may be thinking about or wanting to make changes but may not be ready for or require treatment. This ranges from online information and self-help websites, to phone-based counselling and helplines. Services are also available to support those who need more support, such as in-person counselling, outpatient programmes, detoxification services, and residential treatment programmes. Supports are sometimes targeted to those who have problems with particular substances (such as Opioid Substitution Treatment) or those who have specific needs (e.g., NovaStar). Where people do need more help, they can either self-refer to services or be referred by a health professional.

In 2018/19, $162 million was spent on addiction treatment services. This equates to 10.6% of the total mental health spend in that financial year. During that period, the number of people accessing addiction services declined from 52,544 in 2017/18 to 51,877 in 2018/19. While not a marked decrease, I find this surprising given what I am hearing from the sector and consumers about growing demand, although this may be the result of more people being treated in mental health services.

In general, wait time for access to addiction services improved between 2017/18 and 2018/19, with particular improvement for Pacific consumers. However, wait times for young people increased somewhat with 12% fewer referrals being seen within 48 hours.

While treatment is helping people, the status quo does not work well for everyone

As addiction is often characterised by its chronic relapsing nature,[229] rather than focusing on reduction of drug use as a measure of successful treatment, there has been a shift towards thinking about recovery in terms of improvement to quality of life. As previously mentioned in Question 2, Aotearoa/New Zealand uses the ADOM tool in community-based settings to quantify the difference treatment is having on people's lives.

In 2018/19, self-rated recovery scores for people accessing alcohol and other drug services showed an average improvement of 24%. That means that in general, people felt that their involvement in treatment was having a positive effect on their lives, including things like their wellbeing and relationships with friends and whānau.

Unfortunately, not everyone who wants it can access treatment. Comparing current levels of access to alcohol and drug treatment services to the best estimate we have of need suggests that only about a third of those who could benefit from treatment are accessing it. While some of that is likely to be due to people not wanting or seeking help, or seeking help through less formal avenues, the New Zealand Health Survey found that for people who had used an illicit drug in the past year, slightly more people had wanted help for their substance use than had received it.[230] In a more recent survey of New Zealand high-school students, without prompting, 3% of those who drank alcohol reported difficulty accessing alcohol and drug services. Those who were particularly concerned about their drinking were more likely to report access issues.[231] The Inquiry into Mental Health and Addiction also uncovered significant frustration with the lack of access to services, with some submitters noting that even when services were available, long waiting lists meant that windows of opportunity for change were being missed.[232]

228 Roper, L, McGuire, J, Salmon, P, and Booth PG, "Treatment seeking for alcohol problems: The influence of mirroring events and windows of opportunity". *Addiction Research and Theory* (2012) 21(6).

229 McLellan, AT, Lewis, DC, O'Brien, CP, Kleber, HD, "Drug dependence, a chronic medical illness — implications for treatment, insurance and outcomes evaluation". *JAMA* (2000) 284: 1689–95; Koob, GF, Volkow, ND, "Neurocircuitry of addiction". *Neuropsychoparmacology* (2010) 35: 217–38.

230 Ministry of Health, *Drug use in New Zealand: Key Results of the 2001/08 NZ Alcohol and Drug Use Survey*. Wellington: Ministry of Health (2010): xxii — 3.2% of past year illicit drug users had received help for their substance use compared to 3.6% who had wanted help but not received it.

231 Ameratunga, A, Jackson, N, Peiris-John, R, Sheridan J, Moselen, E, and Clark T, "New Zealand adolescents' concerns about their alcohol use and access to services: Associations with ethnicity and other factors". *Journal of Ethnicity and Substance Abuse* (2018) 18(4): 634–53.

232 Government Inquiry into Mental Health and Addiction, *Summary Submissions Report* (2018): 201.

Regional variation in what is available is one issue. DHBs are largely responsible for procuring alcohol and drug treatment services that meet the needs of their communities, and some are investing more than others. In 2017, the Midlands region spent $37.67 per adult[233] on alcohol and drug treatment services compared to $27.61 per adult in the Central region.[234] Submitters to the Inquiry from more rural areas were particularly concerned about local service availability, noting that in order to access more specialist treatment they often had to travel significant distances and be far from support networks. Some noted that this could result in people not completing their treatment.[235] "A recurring theme in statements of claim submitted to the Health Outcomes Kaupapa Inquiry (Wai 2575) is the lack of provision of alcohol and other drug treatment services in the geographic locations where Māori reside."[236]

Key frustrations identified by the Inquiry, and reflected in my conversations with the sector, tāngata whaiora, and whānau, include the limited availability of residential and detoxification services.[237] This level of service is not necessary for everyone with a substance use disorder, and there can be difficulties determining the effectiveness of residential treatment compared to other treatment options,[238] but people with lived experience and those working in the sector have stressed how important these services can be in supporting recovery.[239] This is acknowledged in the Government's recent $44 million investment[240] into residential services, although this was aimed at sustainability rather than expansion. We do not have a good understanding of what demand looks like currently, so it is difficult to know whether or by how much such services need to expand, or if the percentage of the mental health spend allocated to addiction treatment is proportionate. As well as concerns from the public, the number of people with substance-related issues ending up in mental health inpatient units, and the lack of options for women with children, would suggest that there is a gap. However, more of the same is not enough. People's substance use can cause problems without them being dependent, people in recovery often relapse, and others may never achieve or even desire abstinence. This means that we need to broaden our focus and investment from interventions designed to respond to more acute and crisis-driven needs to those with a greater focus on continuing care, harm reduction, and prevention/early intervention.

I welcome the recent investment in expanding the support available for people with mild to moderate substance issues. As this work is implemented, care must be taken to ensure that these services are accessible to and able to support those who are more marginalised and often less trusting of mainstream services. Haven in Auckland (see signs of progress at the end of this section) and the partnership between Tū Ora PHO and the Needle Exchange (see signs of progress at the end of Part II, Question 2) are good examples of innovative approaches that are successfully engaging people who face barriers, and/or may be less inclined to engage with mainstream services. While the cultural appropriateness of services is important, consideration also needs to be given to the fact that the culture with which people identify can sometimes be more strongly related to the drugs they use or the associated lifestyles and behaviours. Ensuring the provision of culturally safe alcohol and drug treatment requires New Zealand to accommodate for substantial diversity — particularly when group settings remain the predominant medium for treatment.

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233 Over 20 years of age.

234 Te Pou o te Whakaaro Nui, *Adult mental health and addiction workforce: 2018 secondary care health services*. Auckland: Te Pou o te Whakaaro Nui (2019): 22.

235 Government Inquiry into Mental Health and Addiction, *Summary Submissions Report* (2018): 64.

236 Walker, K, *Issues of Tobacco, Alcohol and other Substances Abuse for Māori*. Report commissioned by the Waitangi Tribunal for Stage 2 of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575) (2019): 105.

237 Government Inquiry into Mental Health and Addiction, *Submissions Summary Report* (2018): 13–14.

238 For example, the different modalities used and client groups they serve. See Reif, S, George, P, Braude, L, Doughtery, RH, Daniels, AS, Ghose, SS, and Delphin-Rittmon, "Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence". Psychiatric Services (2014) 65(3): 301–12.

239 Dapaanz, "Submission to the Inquiry into Mental Health and Addiction" (2018): 9.

240 This is over four years.

I understand that the four DHB regions have already commenced work on regional models of care and are working in partnership with the Ministry of Health to develop a new model of care for the addiction sector. I expect to see a significant broadening of the continuum of care, including an increased focus on the provision of continuing care, prevention/early intervention, and harm-reduction services, as well as more targeted options for populations not currently well served by existing treatment options, such as women,[241] young people, and the Rainbow community. I strongly encourage DHBs and the Ministry to work in partnership with people with lived experience of addiction and whānau to co-create new models of care.

Aotearoa/New Zealand needs to do something about stigma

As outlined earlier, stigma is a significant issue for people with substance use disorders. Addressing it frequently comes out as the top priority in my conversations with people with lived experience of addiction and those working in the sector.

> *"In my circles at least when people find out you have addiction problems or substance issues if they're not part of that they don't want anything to do with you. I've had people say they don't want to associate with me because of that. That includes people in my own family — my family has almost split up about this. My brother also had addiction issues and he is an outcast in our family now. Makes it difficult to come forward to say I need help because people think it's contagious or … something like that. The way in society it's criminalised means you have to hide it to a degree so you bottle it up. It's a big problem."*
> Youth tangata whaiora interview

Stigma is well recognised in research as a significant barrier to care and people's wellbeing.[242] There are three key forms of stigma — personal or self-stigma,

social stigma, and structural stigma. These different forms can have a combined impact or may come into play at different times or in different settings. They can also exacerbate issues faced by people who may already be experiencing social isolation and/or discrimination owing to factors such as their age, ability, ethnicity, sexual identity, or gender. The Drug Foundation defines the different categories of stigma in the following way:

Personal Stigma: the internalisation of negative attitudes and stereotypes. This leads to shame and the expectation of negative social reactions. This is a barrier to seeking help, with people believing they are not worthy of receiving support or that their drug dependence is a personal failing.

Structural Stigma: created by policies and practices of organisations and institutions towards stigmatised groups that restrict their rights or opportunities. This reduces the likelihood of these groups receiving quality non-judgemental services or having access to the same treatment and opportunities that non-stigmatised groups receive.

Social Stigma: caused by the attitudes and beliefs of the general public, family, and friends based on negative stereotypes. These are communicated through inter-personal relationships, and often reinforced in social interactions, news, and popular media. This can result in social exclusion and isolation from communities.[243]

All three forms of stigma are currently an issue for people in New Zealand who are experiencing issues with substance use. Self-stigma has been found to have a robust negative relationship with a person's feeling of hope, self-esteem, and empowerment,[244] which as the Drug Foundation points out can be a barrier to people seeking treatment when they need it. Social stigma can also be a barrier to help-seeking in that it can prevent people from recognising that they have an issue in the first place, as admitting to having a problem would mean accepting membership into a stigmatised group.[245]

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241 Research shows that fear of losing their children and a lack of childcare options are key barriers to women accessing care. See, for example, Brogly, SB, Link, K, and Newman, A, *Canadian Journal of Addiction* (2018). At present, there is only one publicly funded residential treatment option that accommodates children, and this is based in Auckland.

242 Te Pou o te Whakaaro Nui (2014): 31.

243 New Zealand Drug Foundation, *Scoping Up a Destigmatisation Campaign on Drug Use and Drug Dependence* (2015): 4.

244 Livingston, JD and Boyd, JE, "Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis". *Soc Sci Med* (2010) 71(12): 2150–61.

245 See Livingston, JD and Boyd, JE, "Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis". *Soc Sci Med* (2010) 71(12): 2150–61 for a summary of the evidence.

Social attitudes to people who use or are dependent on substances can also have an impact on the quality of care that people receive when they do seek help — including from health professionals.[246] Interviews with clients of Opioid Substitution Treatment (OST) services have highlighted that some tāngata whaiora are feeling prejudged, distrusted, and controlled, and that this is having an impact on their ability to share important health information with their health providers.[247]

> "There is a perception that addicts cannot solve their own problems and 'once an addict, always an addict.'"
> OST client[248]

While there is significant variation in people's experience depending on where in the country they are based, similar sentiments were expressed by one of the people accessing OST services to whom my team talked, who reported impacts to their physical and mental health as a result of unhelpful attitudes and/or policies.

> "I was on a good amount of something that's known to work (for a neurological issue) and they didn't care — when I tried to tell them it was helping me they didn't listen. They just took me off and started counting me down off another medication without anything else. So without any other wraparound services or supports to help me for the issue they took me off something I had been prescribed by two doctors … I was stable but that destabilised me."
> Adult tangata whaiora interview

Stigma can also have an impact on people's recovery. In a workshop the Drug Foundation hosted with people with lived experience of addiction, people shared experiences of losing out on employment opportunities and being excluded from social events owing to their previous issues with drugs.[249] Although less well studied, stigma by association can also have an impact on the whānau of people who use drugs. As well as contributing to increased distress and social isolation for the whānau, this can affect their ability or willingness to provide support towards a person's recovery.[250]

In my view, a concerted and multi-faceted effort is required to address these issues. Alongside efforts to bolster prevention efforts and support barrier-free access to the right treatment, this is an essential component of shifting to a health-based response to drug use — especially as New Zealand considers changes to the legal framework. I note that "shifting thinking and behaviour", including in relation to stigma and help-seeking, is a priority in the National Drug Policy 2015–2020. The initial action in this area (to be undertaken by 2017/18) was to "build on existing AOD related public education campaigns to shift AOD culture, promote help-seeking and address stigma". To date, activities have focused primarily on messages to reduce alcohol-related harm.

I note that a destigmatisation campaign aimed at substance use and dependence was previously scoped, but its findings and proposals were not implemented. I recommend that this is updated to ensure that it reflects current issues relating to self, social, and structural stigma, as well as stigma by association, and evidenced-based strategies for mitigating these. This should be done in partnership with people with lived experience, and then resourced and implemented appropriately.

I also consider that those with lived experience are well suited to helping people who are struggling with substance issues to overcome internalised stigma, as well as challenging any negative perceptions that may be held by health professionals, and others involved in the design and delivery of care. I recommend that specific measures to increase the number of addiction-specific peer support workers and consumer advisors within the mental health and addiction sector — particularly in DHBs[251] — are also implemented.

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246 *Ibid.*

247 Allen and Clarke, The consumer experience of Opioid Substitution Treatment (OST) services (2018).

248 *Ibid*: 6.

249 New Zealand Drug Foundation, *Scoping Up a Destigmatisation Campaign on Drug Use and Drug Dependence* (2015): 10.

250 *Ibid*: 7.

251 There is significant disparity between the number of mental health and addiction peer and consumer roles in both DHBs and NGOs. This is more striking in DHBs, with only two addiction peer or consumer roles nationally compared to 13.7 mental health peer or consumer roles. Matua Raki, *Growing dedicated peer and consumer roles in addiction services* (undated): https://www.tepou.co.nz/uploads/files/AOD%20Brochure%20(Web).pdf

People in prison

People in prison have the highest mental health and addiction needs of any population group

Most people in prison have a significant history of trauma.[252] Over half of prisoners have experienced sexual and/or family violence,[253] and 91% of the people who arrive in prison by age 20 have spent time in the care of Oranga Tamariki.[254] Rates of neurodisability are also far higher in prison than they are in the community.

Unsurprisingly, 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.[255]

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. These are associated with high levels of distress and disability, especially in acute phases.[256] 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.[257]

The most recent research suggests that mental health and addiction issues are now more prevalent in the prison population than they were when the last major benchmarking study was conducted in 1999.[258]

2 in 3
people in prison live with mental illness and/or addiction (1 in 5 in the general population)

Almost
1 in 2
women in prison have experienced psychological distress in the past 30 days

Almost
24% increase
in prison population between 2013 and 2019, 3% increase in forensic bed numbers

252 Bevan, M, "New Zealand prisoners' prior exposure to trauma". *Practice: The New Zealand Corrections Journal* (2017) 5 (1): https://www.corrections.govt.nz/resources/research_and_statistics/journal/volume_5_issue_1_july_2017/new_zealand_prisoners_prior_exposure_to_trauma

253 *Ibid.*

254 Ministry of Social Development Centre for Social Research and Evaluation, *Crossover between child protection and youth justice, and transition to the adult system* (2010): 40.

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

256 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).

257 *Ibid.*

258 Simpson, AIF, Brinded, PMJ, Laidlaw, TM, Fairley, N, and Malcolm F, *The National Study of Psychiatric Morbidity in New Zealand Prisons.* Wellington: Department of Corrections (1999).

While Māori are significantly over-represented in the prison population,[259] the high prevalence of mental health and addiction issues among prisoners means there is very little difference between rates for those of different ethnicities. Māori in prison are around 2.4 times as likely to have experienced a mental health and/or addiction issue in the past 12 months as Māori in the community. Pacific prisoners had around 2.8 times the rate of mental health and/or addiction issues as Pacific people in the community.

Female prisoners have particularly high mental distress and/or addiction needs, and had been a rapidly growing part of the prison population until a recent decline. Women in prison are more likely to have a 12-month diagnosis of any mental health or substance use disorder (75% compared to 61% for men) or to have both a mental health and a substance use disorder than male prisoners (62% compared to 42%).[260] Almost one in two women in prison (47%) had experienced psychological distress in the past 30 days.[261]

Existing mental health and substance use issues can be exacerbated by incarceration, and some people may develop problems in prison.[262] This is particularly an issue in overcrowded prisons, which can increase pressures on both staff and prisoners and the likelihood of deviation from procedure,[263] which prisoners find "frustrating and unsettling".[264] The prison population grew significantly between 2013 and 2019, but has since decreased slightly and stabilised.

Signs of progress although areas of concern remain

Prisoners are entitled to the same level of health care that they would receive in the community. The high needs of the prison population combined with the restriction that comes with confinement places a significant duty of care on the Department of Corrections/Ara Poutama Aotearoa (Corrections).

Corrections is responsible for providing treatment for those with mild to moderate mental health and substance related issues, and does this through a combination of in-house and external clinical support. Nurses tend to screen for these issues upon arrival to prison, but are often doing so in areas that afford little privacy to those who may be disclosing sensitive issues.[265] I am concerned that systems are not always in place to ensure the privacy of[266] prisoners or to support prisoners' understanding of how to make health-related complaints,[267] and I will work with Corrections to address this.

Despite Corrections' efforts to improve its capacity to support those with mental health and addiction issues, prisoners do not always seem to be getting the help that they need. In many of the prisons visited by the Ombudsman over the period covered by this report, a significant number of prisoners surveyed reported that they had emotional/mental health issues, and the majority of respondents felt that they were not being supported with those needs.[268]

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259 53% of the prison population at 30 March 2020: https://www.corrections.govt.nz/resources/research_and_statistics/quarterly_prison_statistics/prison_stats_march_2020.

260 Indig, D, Gear, C, and Wilhelm, K, *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*. Wellington: Department of Corrections (2016): v-vi.

261 *Ibid*: 63.

262 13% of people surveyed by the Ombudsman in Northland Prison, 12% of people surveyed in Whanganui Prison, and 8% of prisoners surveyed in Auckland South Corrections Facility reported developing a drug problem since entering prison. Several prisoners in Whanganui Prison reported that their mental health had deteriorated significantly since entering prison.

263 National Health Committee, *Health in Justice: Kia Piki te Ora, Kia Tika! — Improving the health of prisoners and their families and whānau: He whakapiki i te ora o ngā mauhere me ō rātou whānau*. Wellington: Ministry of Health (2010).

264 Human Rights Commission, *2017/18 Monitoring Places of Detention. Annual report of activities under the Optional Protocol to the Convention Against Torture* (2019): 26.

265 See, for, example Ombudsman, *Report on an announced inspection of Auckland South Corrections Facility — 20 Feb 2019* (2019) 32: https://www.ombudsman.parliament.nz/sites/default/files/2019-03/Final_OPCAT_Prison_Report_-_ASCF_-_PDF_online_.pdf.

266 *Ibid.*

267 See, for, example, Ombudsman, *Report on an unannounced inspection of Northland Regional Corrections Facility — August 2019* (2019): 25: https://www.ombudsman.parliament.nz/sites/default/files/2019-09/final_opcat_report_2019_-_nrcf_-_pdf_.pdf

268 *Ibid*: 28; Ombudsman, *Report on an unannounced inspection of Tongariro Prison under the Crimes of Torture Act 1989* (2019): 25: https://www.ombudsman.parliament.nz/sites/default/files/2019-11/opcat-report-tongariroprison2019.pdf and Ombudsman, *Report on an announced inspection of Auckland South Corrections Facility* (2019): 35.

This may relate to broader issues than the care provided. As well as being responsible for providing care, Corrections is also responsible for developing environments, cultures, policies, and programmes that support people's mental health and wellbeing. Although I recognise that there are constraints within a custodial context, I share the Ombudsman's concerns about the level of violence and assaults, long periods of lockdown, and significant barriers to keeping connected to, and communicating with, whānau.[269] Corrections must address these issues alongside the work they are doing to improve access to treatment, if they want to make a difference to people's mental health. I am pleased to see under Corrections' *Hōkai Rangi* Strategy 2019–2024[270] a commitment to keeping people as close as possible to whānau and supporting communication with whānau.

In my 2018 monitoring and advocacy report I outlined a range of Corrections' initiatives underway to improve the care and treatment of prisoners with mental health and addiction issues. I noted that I expected to see evidence of ongoing improvements given my concerns with unaddressed needs, long waits for forensic beds, long periods of containment, and concerning practices relating to restraint.

Corrections' initiatives at the time included development of a new prison-wide model of care to better meet the mental health and addiction needs of people in prison; investment in programmes to address substance use and dependency issues; incorporating a purpose-built therapeutic environment into the redevelopment of Auckland prison; and the introduction of a new approach to managing at-risk units, re-named "Intervention and Support" units (ISUs), to make them more therapeutic.

Reports from the Ombudsman have highlighted slow progress to date in some areas, with signs that pressures from what had been a rapidly growing prison population have somewhat hindered progress, as has the difficulty recruiting and retaining health staff. While I understand the pressures Corrections are under, I am concerned that not enough has changed, and there is still significant variability around the country.

Although I am pleased to note the formal removal of tie-down beds, the Ombudsman found that restraints are still being used to manage self-harming behaviour in some prisons,[271] and that people are still spending too long in ISUs without access to therapeutic support.[272] As prisons have struggled to accommodate a significantly increasing number of people, ISUs are being used for overflow, including managing other vulnerable clients such as youth[273] and people with disabilities.[274] This is not what these facilities are designed for, and limits their availability to those who are in significant mental distress. While Corrections has invested in improving the physical environment, in some prisons, physical facilities have still not improved significantly, the use of dry rooms is still occurring, and privacy remains a major concern.[275] Although it is obvious that important progress has been made, there is still a considerable way to go. The people in ISUs are some of the most vulnerable in the country, and they have the right to treatment with an appropriate level of care and dignity.

269 Human Rights Commission, *2017/18 Monitoring Places of Detention. Annual report of activities under the Optional Protocol to the Convention Against Torture* (2019): 19.

270 Ara Poutama Aotearoa/Department of Corrections, *Hōkai Rangi Ara Poutama Aotearoa Strategy 2019–2024* (2019) 24: https://www.corrections.govt.nz/__data/assets/pdf_file/0003/38244/Hokai_Rangi_Strategy.pdf.

271 Ombudsman, *Report on an unannounced follow up inspection of Otago Corrections Facility — June 2019 Follow up* (2019) 3: https://www.ombudsman.parliament.nz/sites/default/files/2019-07/otagocorrectionsfacility-opcat-followup.pdf.

272 Ombudsman, *Report on an announced inspection of Auckland South Corrections Facility — 20 Feb 2019* (2019): 35. It needs to be noted that this prisoner was waiting to be admitted to a Forensic facility.

273 Ombudsman, *Report on an unannounced follow up inspection of Otago Corrections Facility — June 2019 Follow up* (2019): 2.

274 Ombudsman, *Report on an unannounced inspection of Whanganui Prison — 4 September 2018* (2018): 7, 14.

275 See, for example, Ombudsman, *Report on an unannounced follow up inspection of Hawke's Bay Regional Prison — 30 April 2019* (2019): 12: https://www.ombudsman.parliament.nz/resources/report-unannounced-follow-inspection-hawkes-bay-regional-prison-30-april-2019.

However, I recognise that it will take time to implement the planned changes fully and to embed the new models of care. I also note the use of Service Development Leads to help support practice change, the work that Corrections has been doing to increase the capability of all staff to respond therapeutically to mental health issues, and the introduction of supported decision-making tools and multi-disciplinary practice guidance for those working in ISUs. I am encouraged by the continuing commitment and investment of Corrections to improve mental health and addiction care, and by the tangible signs of improvement. The numbers of unnatural deaths in Corrections custody declined from seven to one between 2017/18 and 2018/19, despite incidents of self-harm increasing.[276] A review of at-risk units and separates cells, led by the Chief Custodial Officer, also aims to identify options for enhancing privacy for prisoners.

Corrections continues to make progress in providing better support for addiction. In 2018/19, 884 prisoners commenced a drug treatment unit programme. Corrections has also launched two new alcohol and other drug treatment programmes — Te Ira Wahine, which is designed specially to engage women, and Tāmaua te Koronga, which is designed for young men[277] — and expects to add another five programmes by 2022. The addiction aftercare programme initiated in 2017 has also been shown to be valuable to people returning to the community after undergoing drug treatment in prison (see signs of progress at the end of this section). In 2019, a further $127.5 million over four years has been committed to expanding addiction and aftercare services, as well as employing more mental health clinicians. Returning back into the community is a particularly vulnerable time for people,[278] so I am pleased to see Corrections investing resources to support people during that transition. Improving treatment for addiction is important for health gains, as well as the potential impact on reducing reoffending.

I am particularly encouraged by the efforts Corrections has made to improve the mental health and addiction needs of female prisoners. As outlined above, women in prison have particularly high needs and tend to have significant histories of trauma and abuse.[279] The majority are also Māori. In 2017, Corrections developed a new strategy for managing women prisoners — Wahine E rere ana ki te pae hou 2017–2021. It focuses on providing women with interventions and services that meet unique risks and needs; managing women in ways that are trauma-informed and empowering; and managing women in a way that reflects the importance of relationships to women.[280] The Te Ira Wahine programme is a kaupapa Māori intensive alcohol and other drugs programme designed specifically to meet the needs of women in prison. It provides a trauma-informed approach to addressing substance use problems, and is responsive to the mental health needs of women in prison. Corrections needs to be acknowledged for the particular attention it has paid to developing culturally appropriate programmes, and its partnership with mana whenua as new initiatives and approaches are developed.

People in prison have some of the highest mental health and addiction needs in the country, but very limited capacity to self-advocate. It is important, therefore, for those who have a watchdog role to provide oversight of how well the needs of prisoners are being met. I encourage the new Mental Health and Wellbeing Commission to maintain an active overview of Corrections' progress in this regard, and note that efforts underway by the Department to improve the way it collects health data and measures addiction needs will support robust monitoring.

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276 Department of Corrections, *2018/19 Annual Report* (2019): 32. There were 52 self-harm incidents of a level of seriousness that they posed a threat to life in 2018/19, up from 30 the year before.

277 *Ibid*: 57.

278 Zlodre, J and Fazel, S, "All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis". *American Journal of Public Health* (2012) 102 (12): e67–e75. In their meta-analysis, they found drug-related mortality to be one of the highest unnatural causes of death for recently released prisoners.

279 Bevan, M, "New Zealand prisoners' prior exposure to trauma". *Practice: The New Zealand Corrections Journal* (2017) 5: https://www.corrections.govt.nz/resources/research_and_statistics/journal/volume_5_issue_1_july_2017/new_zealand_prisoners_prior_exposure_to_trauma.

280 Department of Corrections, *Wahine E rere ana ki te pae hou: Women's Strategy 2017–2021* (2017): https://www.corrections.govt.nz/__data/assets/pdf_file/0018/30528/Corrections_Womens_Strategy_August_2017_web.pdf.

Urgent increase in forensic capacity is required

People in prison with moderate to severe mental health needs are referred to forensic mental health services for assessment and treatment. Generally this is 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.

In my 2018 report, I noted gaps in service provision in the forensic–prison interface. These related to a lack of service provision for people exhibiting a personality disorder (conduct disorders are explicitly excluded from the Vote Health Service Coverage Schedule); the limited availability of forensic beds; and the fact that specialist forensic resource is stretched too thinly over a prison population with such complex and significant need. These problems are of considerable and growing concern to me. I fear that services will be close to failure unless urgent action is taken to address capacity and other issues.

While I note that an investment of $15 million over four years was made into forensic services in Budget 2019, an internal Ministry of Health memorandum from November 2019 identified that these services are stretched beyond capacity.[281] As the prison population experienced a period of rapid growth — between 2013 and 2019 the prison population went up by 24% (from 8,153 to 10,057 people) — forensic bed numbers have increased by only 3% (8 beds). As noted above, there also appears to have been an increase in the prevalence of serious mental illness among the prison population since the last significant study. All five forensic mental health services are operating beyond capacity in their inpatient units and are carrying considerable waitlists. The Ministry of Health notes that pressure on forensic services has led to a narrowing of support to focus on psychosis rather than broader mental health issues.[282] The Ministry also refers to incidences where forensic services have been unable to admit people referred to them by Corrections owing to capacity.

People's issues worsen without appropriate intervention, and distress can become contagious in a setting where people live in close quarters and are already under stress. Lack of capacity to attend to those with the highest needs has a flow-on effect throughout the system, and results in others not receiving the level of care that they require — and are entitled to, under both local and international convention. Without additional capacity, options for managing demand can put those who are seriously unwell and others at increased risk, as well as opening up organisations to legal challenges. It is already difficult to find people who are willing to, and capable of, working with this population, and increasing pressure and risk is likely to make that harder. Work must be undertaken urgently to address capacity issues. This includes improving the use of current resources, as well as investing in both step-up and step-down capacity to alleviate pressure and support better flow throughout the system. Given the predominance of Māori among the forensic population, particular attention needs to be taken to ensure that models of care support whānau ora and prevent issues from being passed through generations, as well as stopping tāngata whaiora from cycling through the system.

I note that the Ministry of Health is collaborating with Regional Forensics Services and the Department of Corrections to address these matters. Recent developments include:

- Looking at models of care and how these influence the types of forensic services required, including in relation to beds — for instance, type of bed (acute versus rehabilitation), levels of security, and whether some are dedicated to female prisoners.

- Commissioning independent modelling of service needs based on future predictions for the prison population, noting that the prison population has changed — for instance, increased remandees and female prisoners.

- Reviewing all facilities in each forensic service to determine the fitness of buildings. This was scheduled to commence in April 2020, but has been delayed temporarily owing to COVID-19 restrictions.

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281 Ministry of Health, "Internal memo to the Director-General of Health: Capacity Issues within the Forensic Mental Health Services and High and Complex Framework" (27 November 2019).

282 Ministry of Health, *Health report to the Minister of Health: Increased Prison Muster and the Impact on Regional Forensic Mental Health Services* (2018).

- Developing short- and medium-term strategies to improve access to services for people in prison with severe mental health and/or intellectual disabilities, including service continuity during COVID-19 levels three and two.

- Funding forensic practice and clinical leadership training for 30 staff working with forensic clients in prison or in mental health services. [283]

Increasing the prison network's capacity to respond to emerging and worsening mental health issues may also help to reduce pressures on the forensic system. As well as the work Corrections has been doing as part of its Intervention and Support Project, Corrections is purpose building a 100-bed unit dedicated to mental health as part of the new 600-bed development at Waikeria Prison. I understand that there has been significant collaboration between Corrections, the Ministry of Health, and Waikato DHB on the design of the operating model for this unit. This is due to be completed in 2022.

While I am pleased to see Corrections and the Ministry working together to address these issues, I note that capacity issues have been building for a significant period of time. People who require forensic mental health services are some of the most vulnerable and high-needs people in the country, and I encourage the new Mental Health and Wellbeing Commission to pay attention to whether these efforts are successful and sustained. I welcome the news that a new KPI programme for adult forensic services is about to be re-established, and consider this an important mechanism for improving quality and monitoring how well this part of the system is performing.

283 Ministry of Health, *Boost for Forensic Mental Health and Addiction specialist training* (2020): https://www.health.govt.nz/news-media/media-releases/boost-forensic-mental-health-and-addiction-specialist-training.

Signs of progress

Te Kūwatatwata

With one of the highest levels of mental distress in the country and evidence of high need and poorer outcomes for Māori accessing mental health services, Hauora Tairāwhiti, in conjunction with community partners, wanted to take a different approach to serve the community better.

Te Kūwatawata is a pilot that trialled an innovative bicultural kaupapa Māori response for Tairāwhiti people in distress. It applied indigenous mātauranga to reframe people's distress and find a way forward in their journey to wellness. The pilot started in September 2017 and finished in June 2019.

The pilot was (part) funded by the Ministry of Health's "Fit for the Future" fund. This funding, combined with clinical services, formed the basis of the bicultural service.

Multi-disciplinary teams were formed comprising clinically and culturally competent people with recognised expertise as tohunga, cultural experts, clinicians, and administrators. While not abandoning Western psychiatric approaches to mental health treatment, aspects such as diagnosis and medication were not the only response options available.

Te Kūwatawata's provision of a more holistic response to the needs of people and their whānau was supported by the service's core principles: immediate response; whanaungatanga (meaningful relationships); flexibility and mobility; tolerance of uncertainty; and a culture of feedback — using therapist performance and a whānau outcomes measurement system to inform future treatment.

A formal evaluation of the pilot was completed in early 2019,[284] and included recommendations for the ongoing development as part of the suite of Mental Health and Addiction Services offered in Tairāwhiti.

Feedback received as part of the evaluation showed that tāngata whaiora and whānau felt respected, validated, heard, and empowered, and that they valued the service. Feedback also showed that the new approach had enhanced staff relationships, increased cultural competency, and improved overall confidence in the system. Delays and transition times decreased, there was a reduction in admissions to inpatient wards, and the use of compulsory treatment orders, particularly for youth (under 18 years), also declined.

Post-pilot, there is widespread support for the kaupapa. Reframing how people talk and think about distress while applying a Te Ao Māori approach has proven successful for Tairāwhiti people. Other features considered to be contributing to the success of this approach include:

- Easy access from the city centre for all people in distress. The door is open to everyone — they can just walk in.

- Timely response/no entry criteria.

- Friendly, culturally resonant, non-clinical environment.

So while the pilot may be complete, the kaupapa is here to stay. Te Kūwatawata partners — Te Kupenga Net Trust and Hauora Tairāwhiti — are continuing to build on the success outlined in the evaluation report, and strengthen service delivery. The service remains a key access point for those in distress and needing assistance to access the right support.

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284 Māori and Indigenous Research/Research and Innovation Centre Eastern Institute of Technology, Hawke's Bay, Tipene-Leach, D, Abel, S, Hiha, AA, Morris Matthews, K, *Rangahaua Te Kūwatawata! The Te Kūwatawata Evaluation: Final Report* (2019): https://www.hauoratairawhiti.org.nz/assets/Uploads/Te-Kuwatawata-Evaluation-FINAL-Report.pdf.

Pregnancy and Parenting Service (PPS)

Recognising the impact that parental addiction can have on children, the Ministry of Health funded the expansion of the Pregnancy and Parenting Service to three additional regions (Northland, Hawke's Bay, and Tairāwhiti) in Budget 2016. This model has been operating successfully in Waitematā DHB for over a decade, working with pregnant women and parents of children up to age three who have addiction issues but are not well connected to health and social services.

These whānau tend to be dealing with multiple and complex issues, including addiction, mental health issues, poverty, and family violence. Involvement with the Justice Sector and Oranga Tamariki is common. Despite high needs, they face significant barriers to accessing services, including a lack of trust. People working in the Hawke's Bay PPS, Te Ara Manapou, note that a lack of trust often stems from traumatising experiences with services that often are too siloed to meet their needs, and tend to see them as too hard and not engaging, making them easy clients to exit when services are under pressure.

Although each region runs its service slightly differently, each PPS has a capped caseload of up to 100 whānau a year, which allows the service to work intensively with clients. "Our first few visits are always about building the relationship, getting them to trust us enough. They're scared to talk about things that might result in them losing their babies." The approach is non-judgemental and focused on improving things for the whole whānau. If someone does not turn up for an appointment, a key worker will find the person and reconnect.

The service takes a harm-reduction approach — often addressing immediate needs such as housing, income, and safety before addiction issues. "It's all about engagement so whatever they need is what we do. Usually by the time they get to us they are pretty desperate — often addiction is not the last thing they need to deal with but it's down the list." While the PPS provides some services itself, it also coordinates access to any other services the whānau need — advocating on their behalf to support a more flexible approach. In the Hawke's Bay, the PPS is focusing on building up its in-house capacity to respond to trauma, and improve the support it can provide to the wider whānau, as well as increasing connections to broader community supports. "We're looking outside of mainstream services to what works for our whānau. We have to build up community and natural connections because we're not there after five or on the weekend."

In recognition of the complexity and inter-generational nature of these issues, the PPS is designed for long-term work, with some whānau staying in the service for a couple of years. In the Hawke's Bay, women have left the service, only to come back once they are ready to accept support. The number of self-referrals to the service — particularly from whānau who have been referred by others with whom they have worked — is a testament to the service working. As are the success stories. "I have known people for 15 years through other services and now that we have been working with them they're not using and have their kids back and that's so huge." Clients also speak to the fact that this different approach is working for them. As one client puts it: "This is the only service that actually listens to what I am saying, is honest with me and doesn't judge me for my past. I am really grateful for the support."

The success of the PPS approach continues to be recognised by Government, with funding allocated in Budget 19 for the expansion of this service into two new regions.

Haven

Haven is an after-hours, drop-in support space on Karangahape Road for people experiencing distress from substance use, who may need a safe, warm space to reduce an immediate crisis, or to feel less isolated. Since opening its doors in October 2019, Haven has had over 3,700 visitors — an average of over 100 a week.

Run along the lines of a crisis café, the initiative is led by Odyssey in collaboration with Lifewise, Mind & Body, and ADHB. It is the first step in a programme of work designed to meet the needs of vulnerable populations in the ADHB catchment who use synthetic drugs, methamphetamine, and/or emerging substances. The project is made possible by the Ministry of Health's Acute Drug Harm Response Discretionary Fund.

At Haven, anyone is welcome, and peer support workers from addiction, mental health, and homeless services are on hand for a chat and to help people to identify next steps if necessary.

Odyssey Programme Manager Rachel Scaife has been encouraged by the response from the Haven visitors. "We've had really positive feedback from the community, and our team is already working together really well. The numbers show we're a welcome addition to the neighbourhood." The positive feedback received highlights the importance of this space to the community, as well as the difference it makes to have such strong involvement of peer support workers.

"Here they listen, I've been needing to let it out, I've had a lot of anger and stress. I've needed advice and to explain how I'm feeling."

"Well for me personally, its calming for me. Like I know none of the outside stuff is going to come through the door … Yeah, it's a safe Haven."

"I don't think hospitals are what I needed it was somewhere exactly like this."

"It's what the word peer represents. They're people that you know well that you can talk to in confidence without it leaking out. It feels like someone I have known for years who I have confidence in the fact they will just listen."

Ms Scaife noted how valuable it is to have the three organisations working together, each bringing peers with critical experience and insights to the table: "There's a lot of knowledge in the room and it's been a real pleasure to watch the team in action, to stand back and let peers do what peers do best."

The Alcohol and Other Drugs Aftercare Worker Service[285]

To help people to embed the gains they have made during alcohol and drug treatment in prison, and support them to achieve long-term recovery, in 2016 the Department of Corrections introduced an aftercare service that is now available across 13 prisons. Once people have completed treatment, aftercare workers support them to develop, improve, and adhere to their relapse prevention plans as they work towards their release. They do this through the provision of one-on-one support, the facilitation of group maintenance sessions, and liaison with people's case managers.

This support continues as people transition to community settings. Aftercare workers provide individual and group maintenance sessions, and connect people to agencies that can respond to their broader reintegration needs, such as benefits and housing. They also help people to re-connect with their whānau and other recovery support networks.

Aftercare is available for 6 to 12 months after the treatment has been completed, depending on each service user's level of need. For those with more than 12 months on their sentence after completing an alcohol or drug programme, this support may be provided exclusively in prison.

After this service had been running for two years, an evaluation found that all stakeholders really valued the aftercare support, with those using it viewing it as essential to maintaining the gains that they had made in their treatment programmes, including the use of recovery strategies and prosocial connections, which supported their overall recovery. Service users, Corrections' staff, and aftercare workers believed that the service helped people to maintain treatment gains, reduce relapses and their reliance on alcohol and drugs, and increase adherence to relapse prevention plans.

"Being able to talk to people when we're all moving forward in the same way and if someone has a hiccup, then we can help that person. If I had never had the aftercare, then my hiccups would have just broke out … It's a lot of what has kept me out of going back to jail or re-offending."

Key aspects that people considered contributed to the value of the service included:

- The continuation of the therapeutic relationship from prison to the community;

- Support to practise the tools and strategies learned in alcohol and other drug treatment programmes; and

- a kaupapa Māori approach to service delivery, including a focus on whānau ora.

Following Budget 2019, 20 aftercare support positions were made permanent, with a further 35 positions being made available by 2023.

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285 Bevan M, Thompson A, Smith L, Grootveld C, Brown T, and Gormley R, "The Alcohol and Other Drugs Aftercare Worker Service: Process evaluation findings" (2019). *Practice: The New Zealand Corrections Journal* 7(1) https://www.corrections.govt.nz/resources/research_and_statistics/journal/volume_7_issue_1_july_2019/the_alcohol_and_other_drugs_aftercare_worker_service_process_evaluation_findings

Appendix 1
2018 recommendations and Ministerial response

2018 Recommendations to the Minister of Health

	Recommendation	Comment
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.	Achieved
2	Note that the report is based on a monitoring framework developed over the past year with input from tāngata whaiora and whānau advisors, providers, and other sector leaders.	Achieved
3	Consider the proposal for an action plan, detailed in the report, to: a. Broaden the focus of service delivery from mental illness and addiction to mental wellbeing 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.	Partially achieved. Government has progressed important individual projects to broaden the focus of service delivery, increase access, and improve quality. This response is not comprehensive, however, and there is no clear long-term plan for delivery of system change in the health sector, other sectors, and the wider community. The development of an action plan is a repeat recommendation in my 2020 report. I note that the development of a long-term pathway by the Ministry of Health is underway, but progress has been slowed owing to the COVID-19 response, and will now need to be adjusted for the post-COVID-19 context. The COVID-19 psychosocial and mental wellbeing recovery plan identifies focus areas and actions over the coming 12–18 months, which will set the direction for the start of a longer-term pathway.

	Recommendation	Comment
4	Invite the Inquiry into Mental Health and Addiction to consider:	Achieved, noting high levels of concordance with the recommendations of my report and those of *He Ara Oranga*. Several of my recommendations have not been picked up by Government, however, and are repeated in the 2020 report.
	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 tāngata whaiora 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.	Achieved. The Government extended the Care and Support Workers (Pay Equity) Settlement Act in 2018 to include mental health and addiction support workers.

	Recommendation	Comment

6	Note that this report:
	
	a. Supports the introduction of a population-based mental health and wellbeing 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.
		Achieved.
		
		The Initial Mental Health Commission Terms of Reference includes developing a draft outcomes framework for the permanent Commission to consider. The Mental Health and Wellbeing Commission Bill includes a function to assess and report publicly on the mental health and wellbeing of people in New Zealand (clause 11(1)).
		
		The Ministry of Health advises that discharge planning information will be included in the yet-to-be-published 2018 Annual Report of the Director of Mental Health and Addiction.
		
		Progress by the Department of Corrections to develop mental health and addiction services is noted in my 2020 report.
		
		Progress by the sector in implementing the Health Quality & Safety Commission mental health and addiction quality improvement programme is noted in my 2020 report.

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.	Partially achieved. Government agreed to repeal and replace the Mental Health Act in its response to *He Ara Oranga*. Government officials are also working through options to report on prescriptions within mental health inpatient units. It is important to progress both recommendations, and they are repeated in my 2020 report.
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.	Achieved. I recommend in my 2020 report that there be continued investment in strengthening and diversifying the evidence base of the effectiveness and benefit of investing in mental health, addiction, and wellbeing.

Hon Dr David Clark

MP for Dunedin North

Minister of Health   Associate Minister of Finance

Mr Kevin Allan
Mental Health Commissioner
Office of the Health and Disability Commissioner

1 9 DEC 2019

Dear Mr Allan

Thank you for your letter dated 23 October 2019 inviting me to respond to the recommendations you made in the February 2018 report, *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. I welcome the opportunity to outline the work this Government has undertaken that relates to those recommendations.

Transforming our approach to mental health, addiction and wellbeing

You recommended taking actions to focus on mental wellbeing and recovery. Taking mental health and wellbeing seriously is a top priority for this Government and will be an enduring focus of our agenda. We are committed to changing our approach so we can deliver better mental health and wellbeing outcomes for all.

As you noted in your report, we must adopt a broader understanding of wellbeing and recovery. This requires an overarching shift to recognise that mental wellbeing is not merely the absence of mental illness or addiction; it is a state of wellbeing, even with the presence of mental illness or addiction, and should be attainable for all. We see this as a critical change in our approach.

I agree with you 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. This evidence base underpins our approach and will continue to inform it.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction addresses many of the issues that you raised in your 2018 monitoring report. The Government's response and actions relevant to these are as follows.

Establishing a Mental Health and Wellbeing Commission

You recommended achieving changes through collaborative leadership, supported by robust structures and accountabilities to ensure successful, transparent results. The Government is establishing an independent Mental Health and Wellbeing Commission to support this aim.

The Mental Health and Wellbeing Commission will have an important leadership role and will provide oversight of activities across the mental health and wellbeing system. As a watchdog for the system, the Commission will maintain pressure on decision-makers to increase accountability, help ensure transparency of the system, and influence better and more equitable outcomes.

1

You also recommended the introduction of a population-based mental health and wellbeing outcome framework.

The Initial Commission has been tasked to develop a draft outcomes and monitoring framework for mental health and wellbeing that would be suitable for the permanent Commission to consider adopting. I expect the Initial Commission to ensure a wide range of perspectives inform the draft framework, and appreciate you sharing your expertise with the Initial Commission in this area.

As you are aware, the Mental Health and Wellbeing Commission Bill to establish the permanent Commission is currently at the Select Committee stage of the legislative process. The Health Committee will report back to the House on 30 March 2020. The Bill is anticipated to be enacted by May 2020 with a commencement date of 9 February 2021.

The Initial Commission has been established to provide independent scrutiny of the Government's progress in improving New Zealand's mental health and wellbeing. Specifically, it will monitor the Government's response to *He Ara Oranga* to provide additional accountability, while legislation establishing the permanent Commission progresses. I acknowledge your work alongside the Initial Commission to continue to improve mental wellbeing in New Zealand.

Reforming the Mental Health Act and improving practice

You recommended that I direct Ministry of Health officials to advise on changes required to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) to ensure that it aligns with upholding 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. You also recommended 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.

He Ara Oranga highlights the inequities experienced by Māori within the mental health and addiction sector broadly, including overrepresentation under the Mental Health Act. It recommended a full repeal and replacement of the Mental Health Act with new legislation designed to minimise the use of compulsion, seclusion and restraint.

As you know, the Government accepted this recommendation, and the Ministry has been directed to commence this work. I have received advice about the need to ensure new legislation is aligned to the obligations under the Convention on the Rights of Persons with Disabilities (CRPD). This is reflected in the new Disability Action Plan 2019–23, which commits to repealing and replacing the Mental Health Act with legislation aligned to the CRPD. The Ministry will continue to progress this programme of work while engaging with key stakeholders, including Māori stakeholders.

The Ministry is also progressing revisions to the Guidelines for the Mental Health Act. I have been advised the proposed changes seek to encourage application of the current Act in a manner as closely aligned to the CRPD as possible. Additionally, the use of supported decision-making is encouraged. It is my understanding that these proposed revisions are intended to signal the expected direction of change new legislation will bring and to prepare providers and statutory officials for future changes.

2

You also recommended that I direct Ministry officials to record and report on prescriptions in mental health inpatient units. The Ministry has done some preliminary investigations into the logistics and feasibility of this work.

There are challenges to implementing a reporting mechanism to track the dispensation of prescriptions in mental health inpatient units. For example, district health boards (DHBs) have different record-keeping systems for capturing this information that would make it difficult to collate the required data to give a consistent and accurate national picture. The Ministry is giving further consideration to this recommendation and will provide me with further advice.

Preventing suicide

You recommended the adoption of a reduction target in the Government's suicide prevention plan and a goal of zero tolerance of suicides in services.

The Government released *Every Life Matters – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand* on 10 September 2019. As stated in the strategy, we believe that every life matters, and by working together, we can achieve a future where there is no suicide in Aotearoa New Zealand. While the Government decided not to accept recommendation 31 of *He Ara Oranga* to set a 20 percent reduction in suicide rates by 2030, the overall strategy of the Government is to reduce suicide. We believe that one death by suicide is too many.

Every Life Matters has a number of key actions which focus on promoting wellbeing, improving responses to suicidal distress and behaviour, and supporting people bereaved by suicide. The action plan includes the development of an evaluation and monitoring framework, and a focus on measuring progress towards the goal of no suicide. This goal applies across settings, including mental health and addiction services, and population groups. This work will be led by the recently established Suicide Prevention Office.

Additionally, the Suicide Prevention Office will maintain oversight of DHBs' suicide prevention and postvention plans, which are now required to provide evidence of the programme of actions being taken within mental health and addiction services to prevent suicide. The Government invested $40 million over four years into suicide prevention and postvention services to provide support for those who need it.

Increasing access to and choice of services

You recommended increasing access to health and other support services and improving the quality of mental health and addiction services. This is a key theme in *He Ara Oranga* and a priority for this Government.

Budget 2019 included substantial investment in increasing access to, and choice of, primary mental health and addiction support. The intent of this initiative is to ensure New Zealanders will be able to access free advice and quality support that most suits their needs, where they live and at a time and place that suits them. This initiative will make support available across an expanded range of settings, including general practices, community settings, kaupapa Māori organisations, Pacific organisations and youth settings. Investment will include dedicated services for Māori, Pacific peoples and young people, as well as services tailored for people living in rural settings, Rainbow communities and other population groups who experience disproportionately poor mental wellbeing outcomes.

3

The initiative to expand access and choice of primary mental health and addiction support sits within a total investment of $1.9 billion through the 2019 Wellbeing Budget into mental wellbeing initiatives and mental health and addiction facilities. This includes investment in addiction treatment services, suicide prevention, school-based support, parenting support, crisis responses, housing support, employment support and support for people interacting with the justice system.

Our Wellbeing Budget and future Budgets will provide crucial new investment for mental wellbeing; however, we must also make the most of our existing spend to ensure access to high-quality services across the continuum of care. I have directed my officials to review options and propose enhancements to the current funding and monitoring arrangements for mental health and addiction services, with the aim of aligning arrangements to support improved access, choice and quality.

The Ministry also continues to work with the Health Quality and Safety Commission to support its mental health and addiction quality improvement programme.

Developing a diverse and skilled workforce

You recommended implementing a workforce strategy that enables the sector to deliver better, more accessible services.

Central to the transformation of our approach to mental health and addiction is the development of a diverse and skilled workforce. Ministry officials are working with other agencies and sector stakeholders to implement a strategic approach to workforce development and expansion.

Budget 2019 includes a major focus on workforce development across the health sector, and investment to upskill and grow our workforces is underway. Initial investment will focus on:
- increasing mental health and addiction literacy and the cultural competency of frontline workforces
- growing and upskilling the Māori and Pacific mental health and addiction workforce
- expanding existing workforces and supporting health practitioners to develop their skills and knowledge in the areas of mental health, addiction and wellbeing
- building new workforces to deliver a transformed approach.

You also noted that action is needed to address pay equity issues in the NGO sector arising from pay equity settlements, to ensure workforce capability is retained.

The Support Workers (Pay Equity) Settlement Amendment Bill is currently due for its second reading. The Bill formalises the 2018 mental health and addiction support worker pay equity settlement, agreeing to increase pay rates for the approximately 5,000 mental health and addiction support workers from 1 July 2017 (the same date as care and support workers in aged care, disability, and home and community support sectors). It also ensures that these support workers receive the same support for training and guarantees funding for their employers. All eligible mental health and addiction support workers also received back pay to 1 July 2017 in late 2018. Furthermore, the 2019/20 annual plan guidance has a requirement for DHBs to identify how they will ensure NGO sustainability in their regions.

4

Improving data, evidence and reporting

You made recommendations to:

- ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice
- introduce regular assessment of prevalence, help-seeking behaviour, and access to services across the population
- improve DHB and DHB-funded providers' reporting on consumer experience of services.

Improving data and information on needs and services, and supporting evidence-based practice, is a strong focus for the Ministry of Health.

The Programme for the Integration of Mental Health Data (PRIMHD) is the single national mental health and addiction information collection of service activity and outcomes data for health consumers. The Ministry will continue to improve this data collection and its accessibility. For example, the Ministry has recently rolled out the Qlik Sense application to all DHBs. The Qlik Sense application brings mental health and addiction pharmaceutical and PRIMHD data together to provide a more comprehensive picture of those having an indicator of a mental health and/or addiction condition.

The 2019/20 Operational Policy Framework requires DHBs to undertake and report the results of a mental health patient survey. The Ministry is aware that at least two DHBs are not currently using the Marama Real Time Survey, and the Ministry will consider how best to respond to this situation. The New Zealand Health Survey also includes mental health and addiction components. The mental health and addiction module that formed part of the 2016/17 Health Survey is currently being analysed and will provide more detailed information than is currently available from the main Health Survey.

I note you welcomed the re-introduction of the collection of discharge planning information in 2018. You also suggested the information should be reported publicly. Discharge and wellness planning has previously been reported in the Office of the Director of Mental Health and Addiction Services Annual Report. The Ministry is considering incorporation of in-patient discharge planning data into the Director's report in the future.

In addition to enhancing current information, efforts are underway to expand the mental health and addiction data landscape. For example:

- the evaluation of, and new data collected through, the rollout of Budget 2019 initiatives will provide a fuller picture of service access and effectiveness, demand and consumer experience
- the Government also accepted in principle the recommendation in *He Ara Oranga* to undertake and regularly update a comprehensive mental health and addiction survey. Officials are working through the implementation of this recommendation
- the Initial Commission will identify any gaps in information required to monitor performance under its draft outcomes and monitoring framework and make recommendations on how these could be filled and by whom.

I thank you for the opportunity to share some of the work this Government has undertaken to improve the mental wellbeing of New Zealanders. This letter provides an overview of our initial priorities. If you would like further information in relation to responses to specific recommendations from your 2018 monitoring report, please do not hesitate to contact Ministry of Health officials, who will provide more detail.

5

I acknowledge your significant contributions to the mental health and addiction sector, and appreciate your collaboration with the Initial Commission and ongoing advice. While we have made substantive progress towards transforming our approach to mental health and addiction, this is a long-term commitment and there is more to be done. I look forward to continuing to work together to improve the mental health and wellbeing of all New Zealanders.

Yours sincerely

Hon Dr David Clark
Minister of Health

6

Appendix 2
By the numbers: Annual system performance indicators, trends, and sources

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

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
Can I get help for my needs?					
How many New Zealanders access mental health and addiction services (% population)?[286]	186,540 (3.8%)	181,643 (3.7%)	173,933 (3.7%)	170,980 (3.7%)	162,213 (3.5%)
Māori (% of total access)	53,140 (28%)	51,614 (28%)	50,059 (29%)	48,177 (28%)	44,845 (28%)
Pacific (% of total access)	11,153 (6%)	10,737 (6%)	10,390 (6%)	10,198 (6%)	9,690 (6%)
Addiction services (% of total access)	51,877 (28%)	52,544 (29%)	51,735 (30%)	50,355 (29%)	47,583 (29%)
Young people (0–19)	51,838	51,080	49,830	48,368	44,969
What proportion was with an NGO service? (includes people who saw both an NGO and DHB)[287]	40%	39%	39%	38%	36%
How many New Zealanders access primary mental health services? (estimated, see notes)[288]	132,525	136,674	130,663	121,791	190,222
Māori (% of total access)	17%	17%	18%	19%	N/A
Pacific (% of total access)	8%	9%	8%	9%	N/A
Young people (0–19)	19,844	18,922	16,261	15,882	N/A

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286 Ministry of Health PRIMHD database, analysed by the Ministry of Health, February 2020. PRIMHD (*Programme for the Integration of Mental Health Data*) database is a single collection of national mental health and addiction services information, administered by the Ministry of Health.

287 *Ibid*.

288 Supplied by the Ministry of Health February 2020. These figures relate only to the devolved primary mental health funding that DHBs report against, and are estimates only, as the unique number of clients seen in New Zealand is not reported. Clients seen by more than one DHB, and in more than one quarter of the year or more than one service are double-counted.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
How much was spent on mental health and addiction services (DHB and Ministry of Health expenditure)?[289]	$1.53b	$1.47b	$1.44b	$1.39b	$1.37b
Kaupapa Māori services	$152m	$150m	$145m	$110m	$109m
Pacific services	$15m	$14m	$14m	$13m	$13m
Addiction services	$162m	$161m	$158m	$152m	$150m
Infant, child, and youth services	$194m	$184m	$184m	$176m	$172m
NGO services	$477m	$457m	$450m	$418m	$400m
How long do people wait to access DHB mental health services following first referral? (%)[290] ≤48 hours/≤3 weeks/≤8 weeks* *Targets are for 80% to be seen within 3 weeks and 95% within 8 weeks. All urgent presentations are to be seen within 48 hours.	47/75/91	46/77/93	47/79/94	47/79/94	48/80/95
Māori	54/79/91	51/79/93	52/80/94	52/80/94	52/81/95
Pacific	55/80/90	56/85/95	55/86/95	55/85/95	58/86/96
Young people (0–19)	34/65/86	34/70/90	32/70/92	31/70/92	31/71/93
How long do people wait to access addiction services following first referral? (%)[291] ≤48 hours/≤3 weeks/≤8 weeks* *Targets are for 80% to be seen within 3 weeks and 95% within 8 weeks. All urgent presentations are to be seen within 48 hours.	56/85/95	49/82/94	49/82/94	51/84/95	50/85/95
Māori	52/81/94	50/80/93	52/80/94	51/82/94	50/83/95
Pacific	70/94/99	63/92/98	55/86/95	63/91/97	65/92/97
Young people (0–19)	39/87/96	51/84/95	52/85/96	57/87/96	58/88/96
What percent of complaints about mental health and addiction services are about access to those services?[292]	16%	18%	15%	-	-

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289 Ministry of Health DHB Price Volume Schedule, CMS, CCPS, Supplied by the Ministry of Health March 2020. Note that includes problem gambling services – $12,968,294m was spent on problem gambling services in 2018/19. $1,364,059,164 was spent on mainstream mental health services in 2018/19. Note that child and youth addiction services are included in both addiction services and infant, child, and youth services; NGO addiction services are included in both addiction services and NGO services; NGO child and youth services are included in both NGO services and infant, child, and youth services; infant, child, and youth services include youth forensic services.

290 Ministry of Health PRIMHD database, analysed by the Ministry of Health, February 2020.

291 *Ibid*.

292 Office of the Health and Disability Commissioner. Owing to changes in coding for complaints about mental health and addiction services, data cannot be compared prior to 2016/17.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
Am I helped to be well?					
What percent of tāngata whaiora and their whānau report they would recommend their service to friends or family if they needed similar care or treatment?[293]	82%	82%	82%	-	-
Tāngata whaiora	82%	82%	82%	-	-
Māori	84%	83%	84%	-	-
Pacific	85%	85%	86%	-	-
Whānau	84%	83%	83%	-	-
NGO average	84%	85%	89%		
Average improvement in clinician-rated scores for the mental health of adult tāngata whaiora of inpatient, community services (admission/discharge) [294]	14/7 (53%↑), 11/5 (48%↑)	14/7 (54%↑), 11/5 (50%↑)	14/7 (51%↑), 11/5 (49%↑)	14/7 (51%↑), 11/5 (49%↑)	14/7 (50%↑), 11/5 (50%↑)
Māori	15/7 (54%↑), 11/6 (46%↑)	15/7 (54%↑), 11/6 (46%↑)	15/7 (53%↑), 11/6 (48%↑)	15/7 (52%↑), 11/6 (46%↑)	15/7 (51%↑), 11/6 (47%↑)
Pacific	13/5 (62%↑), 10/4 (56%↑)	14/5 (62%↑), 9/5 (48%↑)	13/6 (54%↑), 9/5 (48%↑)	13/6 (53%↑), 10/5 (51%↑)	13/6 (56%↑), 10/5 (52%↑)

293 Mārama Real Time Feedback Tāngata whaiora and Family Experience Survey (Mārama RTF), extracted by HDC, December 2019. HDC collects the voices of tāngata whaiora and their families through Mārama RTF. The results reported are the cumulative average scores over three years of data collection through to 30 June 2017, four years of data collection through to 30 June 2018, and five years of data collection through to 30 June 2019. As at 30 June 2019, the tablet-based survey was used by 14 DHBs and 5 NGOs, and 29,836 tāngata whaiora and whānau voices had been collected (18,875 and 10,961 respectively).

294 Ministry of Health PRIMHD database 15 January 2020, analysed by Te Pou o Te Whakaaro Nui. 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.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
Average improvement in clinician-rated scores for the mental health of child and youth tāngata whaiora of inpatient, community services (admission/discharge)[295]	19/11 (42%↑), 15/9 (43%↑)	19/12 (39%↑), 15/8 (45%↑)	18/11 (37%↑), 14/8 (47%↑)	17/11 (36%), 14/7 (49%↑)	17/11 (36%↑), 14/7 (49%↑)
Māori	22/12 (45%↑), 16/10 (39%↑)	21/12 (45%↑), 15/9 (40%↑)	20/13 (35%↑), 15/9 (43%↑)	19/12 (34%↑), 15/8 (42%↑)	19/12 (36%↑), 15/8 (44%↑)
Pacific	SN[296], 16/8 (48%↑)	SN, 15/8 (46%↑)	SN, 15/7 (55%↑)	SN, 14/6 (62%↑)	SN, 13/6 (56%↑)
Average self-rated increase in tāngata whaiora satisfaction towards achieving recovery goals (addiction services)[297]	24%	23%	25%	-	-
Māori	23%	24%	27%	-	-
Pacific	22%	15%	20%	-	-
Young people (18–24)	25%	28%	20%	-	-
What percent of tāngata whaiora have independent/supported/no accommodation?[298]	84/12/4%	83/13/4%	82/14/4%	-	-
Māori	78/15/6%	78/16/6%	77/17/6%	-	-
Pacific	80/15/4%	78/17/5%	77/18/5%	-	-
Addiction services	81/14/5%	80/15/5%	81/14/4%	-	-
Young people (0–19)	87/11/2%	85/13/1%	83/15/2%	-	-
NGO services	81/14/5%	79/15/6%	79/15/6%		

295 Ministry of Health PRIMHD database 15 January 2020, analysed by Te Pou o Te Whakaaro Nui. The measure used is 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.

296 Small number. Where numbers are under 50 need to suppress to protect the privacy of individuals.

297 Ministry of Health PRIMHD database 15 January 2020, analysed by Te Pou o Te Whakaaro Nui. The measure used is from the Alcohol and Drug Outcome Measure (ADOM). Collecting and reporting of ADOM has been mandatory since July 2015, although tāngata whaiora 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, and includes tāngata whaiora 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. The small numbers and short period of time ADOM has been collected may explain the variation between years.

298 Ministry of Health PRIMHD database 15 January 2020, analysed by Te Pou o Te Whakaaro Nui. This data is available only from the year 2016/17, as the collection commenced only on 1 July 2016. Includes only tāngata whaiora who have a supplementary tāngata whaiora record.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
What percent of tāngata whaiora are in employment or in education or in training[299]	49%	48%	45%	-	-
Māori	45%	45%	43%	-	-
Pacific	47%	41%	40%	-	-
Addiction services	47%	46%	46%	-	-
Young people (0–19)	83%	82%	81%	-	-
NGO services	40%	38%	36%		
Am I a partner in my care?					
What percent of tāngata whaiora and whānau report they feel involved in decisions about their care?[300]	76%	77%	78%	-	-
Tāngata whaiora	77%	77%	77%	-	-
Māori	77%	79%	79%	-	-
Pacific	79%	81%	81%	-	-
Whānau	75%	79%	80%	-	-
NGO average	77%	78%	82%		
What percent of complaints about mental health and addiction services include issues with communication?[301]	60%	57%	55%	-	-
What percent of tāngata whaiora and whānau report that their plan is reviewed regularly?[302]	75%	75%	76%	-	-
Tāngata whaiora	75%	75%	76%		
Māori	76%	77%	77%	-	-
Pacific	80%	82%	82%		
Whānau	75%	76%	77%	-	-
NGO average	75%	75%	78%		

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299 *Ibid*.

300 Mārama RTF, extracted by HDC, December 2019.

301 Office of the Health and Disability Commissioner.

302 Mārama RTF, extracted by HDC, December 2019.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
How many DHBs (out of 20) meet or exceed the Ministry of Health target of 95% of service users having a transition plan on discharge from an inpatient service?[303]	4 DHBs (78% discharged with a plan)[304]	0 DHBs (2017)	7 DHBs (youth only, 2016)	5 DHBs (youth only, 2016)	-
How many treatment days involving family and whānau were provided by services? (percentage of total treatment days)[305]	371,496 (12%)	372,323 (12%)	356,787 (11%)	340,159 (11%)	317,375 (10%)
Māori	111,488 (12%)	106,425 (11%)	100,236 (10%)	97,380 (10%)	89,943 (10%)
Pacific	24,748 (11%)	26,823 (12%)	25,047 (11%)	23,013 (10%)	21,797 (10%)
Young people (0–19)	192,321 (32%)	197,817 (33%)	190,810 (32%)	183,721 (32%)	168,577 (30%)
Addiction services	27,930 (5%)	26,635 (4%)	25,156 (4%)	25,762 (4%)	24,466 (4%)
NGO services	85,928 (6%)	79,866 (6%)	71,961 (5%)	67,938 (5%)	58,145 (5%)
How many treatment days were provided by services to support family and whānau, including children?[306]	15,026	13,760	11,979	-	-
Māori	4,773	3,925	3,173	-	-
Pacific	425	473	267	-	-
Young people (0–19)	4,856	4,789	4,676	-	-
Addiction services	2,074	1,978	2,327	-	-
NGO services	13,907	12,843	11,391		

303 Ministry of Health, supplied March 2020. Note calendar year not financial year.

304 At the end of 2018/19, 4 DHBs had not reported on the percentage of patients with transition/discharge plans. The main reason for non-reporting was a lack of IT infrastructure. Of those DHBs that reported, the average rate of patients with plans was 78%, with a range of 26% to 100%. DHB self-assessed quality of the plans ranged from 33% acceptable quality to 100% acceptable quality, based on sample audits.

305 Ministry of Health PRIMHD database 15 January 2020, analysed by Te Pou o Te Whakaaro Nui. Codes T32 "Contact with family/whānau, tāngata whaiora not present" and T36 "Contact with family/whānau, tangata whaiora/tāngata whaiora present" combined. Percentage is calculated out of total treatment days including "did not attend".

306 Ministry of Health PRIMHD database 15 January 2020 analysed by Te Pou o Te Whakaaro Nui. Codes T47 "Support for family/whānau" and T49 "Support for Children of Parents with Mental Illness and Addictions" combined. This information is not well reported and likely to be underestimated.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
How many treatment days were provided to support tāngata whaiora in their role as parents or caregivers?[307]	1,852	1,759	1,664	-	-
Māori	539	401	443	-	-
Pacific	137	231	136	-	-
Young people (0–19)	168	217	269	-	-
Addiction services	363	226	464	-	-
NGO services	953	1,195	1,098		
How many people were subject to a compulsory community treatment order under the Mental Health Act?[308] (calendar year)	6,317	6,127	5,931	5,685	5,478
Māori	2,387	2,318	2,203	2,113	2,013
Pacific	598	593	575	530	537
Young people (0–19)	255	249	229	239	225
Am I safe in services?					
What percent of complaints about mental health and addiction services were about inadequate or inappropriate care?[309]	23%	22%	18%	-	-
How many serious adverse events (suspected suicide and serious self harm) happen in mental health and addiction services?[310]	232	232	206	178	171
How many people in inpatient units were secluded? (calendar year)[311]	850 adults	775 adults	802 adults	754 adults	736 adults
Māori	375 (44%)	321 (41%)	352 (44%)	329 (44%)	264 (36%)
Pacific	66 (8 %)	63 (8%)	48 (6%)	Unable to provide*	Unable to provide*
Young people (0–19)	110	98	104	121	111

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307 Ministry of Health PRIMHD database, 15 January 2020, analysed by Te Pou o Te Whakaaro Nui. Code T50 "Support for Parents with Mental Illness and Addictions". Note that 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 14 DHBs and 30 NGOs are collecting this code so far.

308 Ministry of Health, supplied March 2020. Note calendar year not financial year. Note also that this indicator measure has been changed from CTOs in an "average day" as reported in my 2018 and 2019 monitoring reports, to total in a year, to enable splits by ethnicity.

309 Office of the Health and Disability Commissioner.

310 Health Quality & Safety Commission, *Serious Adverse Event database* and Health Quality and Safety Commission, *Learning from adverse events: Adverse events reported to the Health Quality and Safety Commission 1 July 2018 to 30 June 2019*. Wellington: Health Quality & Safety Commission (2019).

311 Ministry of Health, supplied February 2020.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
How many times was seclusion used (some people have more than one period of seclusion)? (calendar year)[312]	1,672 adult events	1,569 adult events	1,483 adult events	1,668 adult events	1,804 adult events
Māori	722 (43%)	635 (40%)	598 (40%)	692 (41%)	546 (30%)
Pacific	109 (7%)	129 (8%)	74 (5%)	Unable to provide*	Unable to provide*
Young people (0–19)	294	285	323	289	339
What proportion of seclusion events last less than 24 hours? (calendar year)[313]	70%	76%	75%	72%	74%
Māori	62%	75%	69%	Unable to provide*	Unable to provide*
Pacific	22%	74%	81%	Unable to provide*	Unable to provide*
Young people (0–19)	71%	83%	87%	Unable to provide*	Unable to provide*

Do services work well together for me?

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
What percent of tāngata whaiora and family and whānau report that the people they see communicate with each other when they need them to?[314]	83%	82%	83%	-	-
Tāngata whaiora	82%	82%	82%	-	-
Māori	83%	83%	83%	-	-
Pacific	85%	85%	86%		
Whānau	85%	83%	84%	-	-
NGO average	83%	84%	87%		
What percent of complaints were about coordination of care between different service providers?[315]	11%	11%	13%	-	-

* Data for the Director of Mental Health and Addiction annual reporting is a combination of PRIMHD data and manual reporting. Ethnicity splits were not provided with manual data for those years.

312 *Ibid.*

313 *Ibid.*

314 Mārama RTF, extracted by HDC, December 2019.

315 Office of the Health and Disability Commissioner.

Indicator	2018/19	2017/18	2016/17	2015/16	2014/15
Average length of stay in an inpatient unit[316]	18 days	19 days	17 days	18 days	18 days
Māori	18 days	18 days	16 days	17 days	-
Pacific	26 days	22 days	21 days	24 days	-
Young people (0–19)	13 days	12 days	11 days	12 days	-
How many people were followed up within 7 days of leaving hospital? (same DHB only)[317]	67%	68%	68%	67%	66%
Māori	62%	64%	63%	63%	-
Pacific	69%	72%	74%	70%	-
Young people (0–19)	54%	54%	50%	43%	-
How many people went back into hospital within 28 days of being discharged?[318]	17%	16%	15%	16%	17%
Māori	16%	15%	15%	17%	-
Pacific	11%	15%	12%	12%	-
Young people (0–19)	18%	19%	20%	17%	-

Do services work well for everyone?

HDC was supplied data from PRIMHD and from the Ministry of Health broken down for Māori and Pacific people, young people, and by service type (AOD/Mental Health/NGO/DHB). These data contributed to the analysis undertaken for this monitoring question.

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316 The Key Performance Indicator (KPI) Programme Interactive Report. The KPI Programme Interactive Report sources data from the Ministry of Health PRIMHD database. Issued date of the latest interactive report is 25 November 2019 for PRIMHD, data extracted 2 December 2019.

317 *Ibid*.

318 *Ibid*.

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

A helpful collection of links to a wide range of services and supports available can be found at: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-health-advice-general-public/covid-19-mental-health-and-wellbeing-resources.

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

- **Need to talk?** Call 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

Accessing mental health and addiction services

If you feel unwell, or want help for mental distress and/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 service or addiction service or elsewhere if needed, or your GP may be able to help you to manage your mental health and wellbeing.