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**RACP Submission:  
NZ Government Inquiry into Mental Health  
and Addiction  
Oranga Tāngata, Oranga Whānau**

June 2018

## Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Government Inquiry into Mental Health and Addiction.

The RACP works across more than 40 medical specialties to educate, innovate, and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients, and the broader community.

The RACP recognises the significant burden of ill-health and disability attributed to mental health conditions and addictions globally and in New Zealand, and notes the critical role of the Social Determinants of Health in mental health and addiction; notably

- housing insecurity – including homelessness, overcrowding, and poor-quality housing
- unemployment or underemployment – available incomes not enough to thrive on
- educational attainment
- racism and discrimination – particularly experienced by Māori
- unsafe neighbourhoods – neighbourhoods are not health-promoting environments
- food insecurity – proliferation of food swamps, poor access to health and nutritious diets

Mental health conditions and/or addiction (MHC&A) cause enormous distress and suffering for people living what are often long-term conditions, and this has impacts on their relationships with their whanau, their friends, work colleagues and wider communities.

Our submission addresses all four questions posed by the Inquiry. Below is an overview of the RACP's submission:

### **Global and New Zealand contexts**

- an overview of mental health conditions and addiction

#### **1. What is working well?**

- For some New Zealanders; services will be working well, some of the time.

#### **2. What isn't working well?**

- Access to services
- Communication within different areas of the health sector
- People with MHC&A having equal physical health outcomes

#### **3. What could we be doing better?**

- Updating current New Zealand guidelines
- Health equity for Māori
- Transition from Child and Adolescent to Adult services

#### **4. What sort of society would be best for the mental health of all our people?**

- A society that uses a life course approach for MHC&A
- A society which addresses the Social Determinants of Health
- A society which makes Health Equity The Norm

## Global and New Zealand contexts

Mental health conditions and addictions were the leading global cause of all non-fatal burden of disease, and account for around 7.4 per cent of the global burden of disease. Depressive disorders contributed most of the non-fatal burden, followed by anxiety disorders, substance use conditions, and schizophrenia<sup>1</sup>.

In New Zealand around one in six people will be diagnosed with a mental health condition at some point in their lives<sup>2</sup>. In any 12-month period, one in five New Zealand adults will experience MHC&A each year, and many others will experience mental distress or addictive behaviour patterns without a formal diagnosis or actively seeking help<sup>3 4</sup>. In terms of overall prevalence, 5 per cent of New Zealanders are considered to live with a severe MHC&A. 9 per cent will be considered to have a moderate condition and 7 per cent a mild condition<sup>5</sup>.

Most common conditions are related to anxiety, mood, or substance abuse<sup>6</sup>. It is important to note, however, that categorisation of mental health conditions as “mild” “moderate” or “severe”, which is frequently a reflection of levels of prescribed medication and/or therapy, is not an accurate depiction of experience, and for many people living with mental health condition, symptoms are distressing and debilitating, affecting quality of life, relationships, and participation in society.

New Zealand has a high suicide rate, and in 2016/17 the number of deaths was 606, and the third year-on-year-increase. While the rate overall (12.64 deaths per 100,000 people) is similar to the OECD median (11.8 deaths), New Zealand has the highest rate of youth suicide among the 34 OECD countries<sup>7 8</sup>.

Mental health conditions and/or addiction start at an early age, and many will have an initial onset in adolescence and young adulthood<sup>9</sup>. Coexisting issues are common if a person already has a mental health condition or addiction. Over 70 per cent of people who attend addiction services are estimated to have coexisting mental health conditions, and over 50 per cent who attend mental health services are estimated to have co-existing issues with addiction<sup>10</sup>. Māori and Pasifika peoples appear to have higher rates of MHC&A than the rest of the New Zealand population<sup>11</sup>.

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<sup>1</sup> Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, Charlson FJ et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet* 2013; 382(9904):1575-86. <https://www.ncbi.nlm.nih.gov/pubmed/23993280>

<sup>2</sup> Mental Health Foundation of New Zealand. Quick facts and stats about mental health. [Internet] Auckland: Mental Health Foundation; 2014.

<sup>3</sup> Health and Disability Commission. New Zealand's mental health and addiction services – The monitoring and advocacy report of the Mental Health Commissioner. Auckland: Health and Disability Commission 2018.

<https://www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf>.

<sup>4</sup> Ministry of Health. New Zealand Health Survey: 2012/13. Wellington: Ministry of Health; 2013.

<https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey#2012-13>.

<sup>5</sup> Health and Disability Commission. New Zealand's mental health and addiction services – The monitoring and advocacy report of the Mental Health Commissioner.

<sup>6</sup> Ministry of Health. NZ Health Survey 2016/17. Annual update of key results. Wellington: Ministry of Health; 2017:

<https://www.health.govt.nz/publication/annual-update-key-results-2016-17-new-zealand-health-survey..>

<sup>7</sup> OECD. Suicide rates. Available from <https://data.oecd.org/healthstat/suicide-rates.htm>.

<sup>8</sup> Office of the Chief Coroner. Chief Coroner releases provisional annual suicide figures. Media release 28 August 2017.

Available from <https://coronialservices.justice.govt.nz/assets/Documents/Publications/suicide-statistics-media-release-20170828.pdf>

<sup>9</sup> Office of the Prime Minister's Chief Science Advisor. Towards 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/publications/>.

<sup>10</sup> Todd FC. Te Ariari o te Oranga: The Assessment and management of people with coexisting mental health substance abuse problems. Wellington: Ministry of Health; 2010. <https://www.health.govt.nz/publication/te-ariari-o-te-oragna-assessment-and-management-people-co-existing-mental-health-and-drug-problems>

<sup>11</sup> MA Oakley Browne, JE Wells, KM Scott (eds). Te Rau Hinengaro: The New Zealand mental health survey. Wellington: Ministry of Health; 2016. Available from: <https://www.health.govt.nz/system/files/documents/publications/mental-health-survey.pdf>.

# 1. What is currently working well?

There have been some signs of progress in the field of mental health and addiction. Some innovative service delivery models are being trialled and outcome information suggests that people generally improve when they are able to access services. This will mean that for some New Zealanders, their experience of mental health services has eventuated in positive health outcomes.

Once able to access treatment services, most people and whānau report positive experiences when using those services: 80 per cent of people and their whānau stated they would recommend the service they received to others if they had a similar issue<sup>12</sup>. The RACP notes that existing mental health services will be working acceptably and adequately for some people, some of the time<sup>13</sup>.

People who have had positive experiences using existing services are more likely to already have a number of protective factors which have enabled their continuing recovery, life satisfaction and mental wellbeing<sup>14</sup>. This may include having experienced positive interactions with the health system, being health literate, having a good relationship with their General Practitioner (GP), and having access to a supportive network of whānau and friends. People who have access to resources to assist in their recovery may also report no significant issues with their experience, such as having access to ongoing psychotherapy or counselling, other self-care practices (yoga, meditation, exercise), being able to afford to visit their GP when they have needed to and pay for prescriptions to be dispensed. The annual updates to the New Zealand Health Survey show that unmet need is prevalent: around one in five children (20 per cent) and nearly one in three adults (28 per cent) have experienced at least one barrier to accessing health care in the prior 12 months<sup>15</sup>.

The People's Mental Health Report, which in part, has contributed to the establishment of the present Inquiry, has noted common threads of "frustration at being unable to access services, feelings of despair and hopelessness, and on occasion a story of tragedy"<sup>16</sup>.

Perhaps then, what could be considered as tentatively on its way towards "working well" is that New Zealanders are increasingly engaging in an ongoing public dialogue about all aspects of mental health and addiction in Aotearoa. This conversation is not limited to service access or delivery (though these elements feature prominently); as there is an increased awareness of the impact of the Social Determinants of Health on mental health and addiction, and a recognition of the 'causes of the causes' – how governmental systems, legislation and policies, as well as widely-held attitudes, values and biases shape societal understandings and responses<sup>17</sup>.

Conversations around addiction as a health issue are continuing to evolve, particularly following the Global Commission on Drug Policy's call to end the 'War on Drugs', which found that the punitive and prohibitionist approach to policy and regulation had resulted in more harm, stigmatisation and addiction prevalence globally than it had prevented<sup>18 19</sup>. The work of organisations such as the New Zealand Drug Foundation, who are active participants in discourse on addiction as a health issue, have developed evidence-based resources to advocate for health approaches to reducing harm from alcohol and other drugs<sup>20</sup>.

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<sup>12</sup>Health and Disability Commission. New Zealand's mental health and addiction services – The monitoring and advocacy report of the Mental Health Commissioner.

<sup>13</sup> Office of the Prime Minister's Chief Science Advisor. Towards a whole of Government/Whole of nation approach to mental health

<sup>14</sup> Bellis MA, Lowey H, Hughes K, Deacon L, Stansfield J et al. Variations in risk and protective factors for life satisfaction and mental wellbeing with deprivation: a cross-sectional study. BMC Public Health. 2012; 12:492. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3432633/>.

<sup>15</sup> New Zealand Health Survey: Annual update of key results 2016/17.

<sup>16</sup> Elliott M. People's Mental Health Report: A crowd-funded, crowdsourced, story-based report. Wellington: Action Station; 2017. <https://www.peoplesmentalhealthreport.com/foreword/>.

<sup>17</sup> Compton MT, Shim RS. The social determinants of mental health. Focus. 2015;13(4):419-25. <https://focus.psychiatryonline.org/doi/abs/10.1176/appi.focus.20150017>.

<sup>18</sup> Global Commission on Drug Policy. War on Drugs. Report of the Global Commission on Drug Policy. Geneva: Global Commission on Drug Policy; 2011. <http://www.globalcommissionondrugs.org/reports/the-war-on-drugs/>.

<sup>19</sup> Hurley R. The war on drugs has failed: doctors should lead calls for drug policy reform. BMJ 2016;355. <https://www.bmj.com/content/355/bmj.i6067>.

<sup>20</sup> NZ Drug Foundation. Policy and advocacy. 2017. <https://www.drugfoundation.org.nz/policy-and-advocacy/>.

## 2. What isn't working well at the moment?

## 3. What could be done better?

The RACP has responded to Questions Two (What isn't working well at the moment?) and Three (What could be done better?) concurrently. Potential solutions and recommendations are included below the problem identification and exploration sections. This is not an exhaustive list of the issues identified through existing literature; rather the RACP has focused on aspects identified by members, and current College Policy and Advocacy priorities:

- Access to services
- New Zealand guidance for mental health conditions and addiction
- Communication within the system
- Health equity for Māori
- Service delivery

### Access to Services

The RACP recommends increased access to mental health and addiction services at all levels of the system: inpatient treatment, specialist community outpatients, crisis services, psychotherapy and counselling, peer support, and whānau support services. The RACP advocates for services which are culturally safe, accessible and equitable, particularly for communities who have specific health needs, and may be more at risk of adverse experiences in existing mental health and addiction services, including Māori; Pasifika; migrant communities; refugees and asylum seekers; people with disabilities; people in prison; and the lesbian, gay, bisexual, trans, intersex and gender diverse community.

The RACP is concerned that people are unable to access services; people experience delays in receiving care and treatment; the quality of services is variable; and following treatment, there are issues with inadequate or inappropriate follow-up<sup>21</sup>. When people are experiencing severe distress, are suicidal or at risk of self-harming, delays in assessment, diagnosis and treatment are placing people in precarious and vulnerable positions. In the People's Mental Health Report, 36 per cent of stories stated that it was hard to get help unless the person was really unwell<sup>22</sup>. The perception that people seeking support need to meet a 'threshold' of an immediate and irreversible crisis to access services could also prevent people from seeking support in the first place.

There is widespread agreement within the public, the media and in the health sector that demand is exceeding supply. The association between the increased demand for services and the inevitable delays in accessing these services is compounded by the inability of services to be funded at levels to meet demand. The Health and Disability Commission's 2018 Advocacy and Monitoring Report on Mental Health and Addiction found:

- The access target for mental health and addiction services is 3 per cent of the population (this was set in 1994 and has been exceeded each year since 2010/11).
- Demand for access to mental health and addiction services has grown at twice the rate of funding increases since 2006/07: demand has increased by 73 per cent, while funding has increased by 40 per cent.
- It is unclear whether this target is still fit for purpose, given that data and information on prevalence and service models are dated – no comprehensive national survey of MHC&A has been undertaken in New Zealand since Te Rau Hinengaro was released in 2006<sup>23</sup>.

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<sup>21</sup>Health Quality and Safety Commission. Mental Health and Addiction Quality Improvement Programme. <https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/programme/>.

<sup>22</sup> Elliott M. People's Mental Health Report: A crowd-funded, crowdsourced, story-based report.

<sup>23</sup> Health and Disability Commission. New Zealand's mental health and addiction services – The monitoring and advocacy report of the Mental Health Commissioner.

## ***Available services don't meet spectrum of need or provide the range of services required***

The RACP recommends that the system is redesigned to enable the right services and support to be offered across a continuum of care. Because the mental health and addiction system is stratified across a variety of settings and environments, a holistic, person-centred system which takes the patient journey and experience of care as a priority should be a principle of a redesigned system.

A redesign of the system for MHC&A must include acute and crisis care, specialist care in the community, primary and community care, peer support, and support for whānau who are caring for a loved one. A redesigned system should consider:

- Patient pathways
- Transitions between services
- Integrating technological solutions for transfer and referral notes
- Access points for treatment, including GP, Emergency Department presentation, and instances where other agencies are involved, such as the police.

A well-functioning health system is able to meet the requirements of people across a spectrum of need and deliver across a continuum of care, and New Zealanders with moderate mental health needs are not getting the help that they require<sup>24</sup>. People who have improved in mental health and addiction services but need support to maintain their wellness and/or recovery are reporting that they are unable to access ongoing support, meaning that opportunities for maintaining people's recovery and embedding more prevention services are being missed.

The current system of service delivery tends to focus on intensive interventions, when people are the most unwell, rather than a preventative approach. This was a major theme in the stories resulting from the People's Mental Health Report, with the many responses describing that a person had to be extremely unwell in order to access services. One participant noted that "I struggle through in a grey-zone of "too healthy to get free services, but too sick and unemployed to afford private services"; and a respondent working in the sector stated that "we need a system that is preventative, one that works for people to support them as and when bad things happen"<sup>25</sup>.

The diversity of need in mental health and addiction means that a variety of service responses are necessary in order to help people who are unwell; these services must also be connected, collaborative, flexible, respectful and culturally competent in order to ensure the system is person-centred and focused on patient experience and outcomes.

### ***Range of services needed***

During HDC consumer and whānau feedback sessions, people using services had concerns that there was a "hand over the medication mentality". People using the services noted that health practitioners did not always listen to or explore options with people or their whānau about what was going to help them to be well and stay well<sup>26</sup>.

Both the HDC report and the People's Mental Health Report found that service-users and health practitioners reported an over-reliance on medication and absence of a range of other treatment options, or the ability for people using the services to choose other treatment options<sup>27 28</sup>.

Current New Zealand guidance, including the Mental Health and Addiction Development Plan 2012-2017 uses the Stepped Care Approach, which is commonly applied for treatment of depressive conditions in primary care. With this approach, a person should be able to access treatment and support from health services in the least intrusive way, for just as long as the person needs, to best support their well-being and recovery. A person should be able to "step up" and "step down" the intensity of those services as their needs change. In

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<sup>24</sup> Office of the director of mental health. Annual Report 2016. Wellington: Ministry of Health; 2017. Available at: <https://www.health.govt.nz/publication/office-director-mental-health-annual-report-2016>.

<sup>25</sup> M Elliott. The People's Mental Health Report.

<sup>26</sup> Health and Disability Commissioner. New Zealand's mental health and addiction services.

<sup>27</sup> M Elliott. The People's Mental Health Report.

<sup>28</sup> Health and Disability Commissioner. New Zealand's mental health and addiction services.

terms of a reported “over-reliance” on medication, the stepped care approach has four ‘steps’ escalating from Step One to Step Four, with medication (treat depression with selective serotonin reuptake inhibitors (SSRIs)) introduced at Step Three<sup>29 30</sup>. There will be many factors at play that may have impacted on the perceptions of an over-reliance on medication, including people not seeking health services until symptoms have significantly worsened. If the Stepped Care Approach continues to operate as best practice in the assessment, treatment and management for MHC&A, the RACP recommends that equal resourcing is applied to the early intervention and preventative aspects in Steps One and Two, rather than loading resourcing to the upper (more intensive) end of treatment options. Some of these could include:

- Greater access to exercise and wellbeing interventions like the Green prescription
- Developing e-Therapy resources for specific population groups who may be more at risk, including Maori, Pasifika and the LGBTIQ+ community
- Ways for health practitioners to be knowledgeable and remain up-to-date about what resources are available for people of different ages, ethnicities, sexualities in local/regional/digital settings

## Service Delivery

The RACP notes the repeated references to high rates of compulsion in mental health and addiction services in New Zealand – most notably in the People’s Mental Health Report and the Health and Disability Commission’s Monitoring and Advocacy Report<sup>31 32</sup>. The RACP supports the aspirational goal of Te Pou o te Whakaaro nui to eliminate seclusion practices by 2020<sup>33</sup>.

### **Compulsion rates too high**

A compulsory treatment order is a court order that establishes that a person who is assessed as having a mental health condition or addiction will have to receive treatment for up to six months. For the first month, a person must accept treatment under the order; from the second month, the person is not required to accept treatment unless they give informed consent, or treatment is considered in the person’s best interests by an independent psychiatrist; or the person requires emergency treatment and informed consent is not possible. The treatment is not limited to medication but can also include programmes, counselling, and discussion groups that are related to the mental disorder<sup>34</sup>. While compulsory treatment can take place either in the community or in a hospital inpatient unit, the majority takes place in the community – in 2016, this was around 88 per cent<sup>35</sup>.

New Zealand has a high use of community treatment orders by international standards, and in 2016, 6 per cent of people who accessed mental health and addiction services were treated under the Act. The number of community treatment orders has increased since 2005, despite weak evidence in relation to their efficacy in preventing readmission to hospital and helping people manage recovery and integration into the community<sup>36 37 38</sup>.

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<sup>29</sup> New Zealand Guidelines Group. Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline. Wellington: New Zealand Guidelines Group; 2008.

<https://www.health.govt.nz/publication/identification-common-mental-disorders-and-management-depression-primary-care>.

<sup>30</sup> Ministry of Health. Rising to the Challenge: the Mental health and addiction service development plan 2012-17.

Wellington: Ministry of Health; 2012. <https://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017>.

<sup>31</sup> Health and Disability Commission. New Zealand’s mental health and addiction services – The monitoring and advocacy report.

<sup>32</sup> Elliott M. The People’s Mental Health Report.

<sup>33</sup> Te Pou o te Whakaaro Nui. Towards restraint-free mental health practice. <https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149>.

<sup>34</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 14, 59, 62.

<sup>35</sup> Ministry of Health. Office of the Director of Mental Health – Annual Report 2016

<sup>36</sup> Gordon S, O’Brien A. New Zealand’s mental health legislation needs reform to avoid discrimination. N Z Med J 2014; 123(1403).

<sup>37</sup> Health and Disability Commission. New Zealand’s mental health and addiction services – The monitoring and advocacy report.

<sup>38</sup> Heun D, Subbodh D, Rowlands P. Little evidence for community treatment orders: a battle fought with heavy weapons. BJPpsych Bulletin 2016; 40(3):115-18. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4887726/>.

In 2016, Māori were 3.6 times more likely than non-Māori to be subject to a community treatment order<sup>39</sup>. Although some people found the use of a compulsory treatment order a positive experience in relation to treatment for a MHC&A, others found the use of it harmful, as it reduced their sense of control over their life and diminished their self-esteem<sup>40</sup>.

The RACP recommends the reduction of community treatment orders and further investigation into reasons behind the disparity in use of community treatment orders between Māori and non-Māori. Māori researchers have encouraged further investigation into the disparity in use of community treatment orders between the two groups and whether the pattern indicates a need for greater cultural awareness in the workplace or greater whānau engagement<sup>41</sup>. Anecdotal reports from whānau suggest that their consultation in decision-making around their loved one's treatment continues to be suboptimal: in 2016, only 61 per cent of whānau were consulted about a whānau member's compulsory treatment order. The benefits of whānau support and connectedness may have a positive impact on a person's continued recovery under a compulsory treatment order; services and information designed to support whānau in this situation may also be beneficial and have a positive impact on health outcomes.

## New Zealand guidance for mental health conditions and addiction

In 2016, 91 per cent of specialist mental health service users accessed community mental health services only (an increase of 5 per cent since 2002); this is consistent with a study on the prevalence of mental health conditions in primary health care in New Zealand, which found that around 75 per cent of treatment for mental health conditions is delivered in the primary care context, often by General Practitioners<sup>42 43</sup>.

Given that primary care remains a key point for initial presentation, or ongoing access to health care for mental health conditions, the RACP strongly supports the diagnosis, management and treatment of people with mental health conditions to be supported and informed by up-to-date, best practice and evidence-based guidelines.

The current practice guideline available on the Ministry of Health's website is the Identification of Common Mental Disorders and Management of Depression in Primary Care, developed by the New Zealand Guidelines Group (NZGG) in 2008, and endorsed by a number of organisations including the Royal Australian and New Zealand College of Psychiatrists, the Mental Health Foundation and the Paediatric Society of New Zealand. The RACP notes the guideline is comprehensive in its coverage of common mental disorders in children/tamariki and young people/rangatahi (attention deficit hyperactivity disorder; anxiety; conduct disorder; depressive disorders; and addiction); and for adults (depression; dysthymia; and addiction)<sup>44</sup>. The RACP recommends that the guideline is reviewed and updated, with consideration to:

- New evidence that has emerged since 2008 – for example, recent Cochrane reviews on the use of antidepressants versus placebo for panic disorder in adults, and continuation and maintenance treatments for depression in older people; and the updating of the Diagnostic and Statistical Manual of

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<sup>39</sup> Health and Disability Commission. New Zealand's mental health and addiction services – The monitoring and advocacy report.

<sup>40</sup> Elliott M. The People's Mental Health Report.

<sup>41</sup> Elder H, Tapsell R. Māori and the Mental Health Act. In Dawson J and Giedhill K (eds.) New Zealand's Mental Health Act in Practice. Wellington: VUW Press; 2013.

<sup>42</sup> Office of the director of mental health. annual report 2016

<sup>43</sup> Hartdegen M, Gibson K, Cartwright C, Read R. Stressful events and circumstances reported by patients prior to being prescribed antidepressants. N Z Med J 2017;130(1448):45-53. <http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1448-13-january-2017/7124>.

<sup>44</sup> New Zealand Guidelines Group. Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline. Wellington: New Zealand Guidelines Group; 2008.

<https://www.health.govt.nz/publication/identification-common-mental-disorders-and-management-depression-primary-care>. The guideline includes no substantive reference to what are considered thought disorders, including schizophrenia and psychosis; while the RACP notes that would not necessarily be termed "common" conditions, a reference to guidelines on these conditions as developed by the Royal Australian and New Zealand College of Psychiatrists or the Mental Health Foundation should be included.



Mental Disorders (DSM-5), published in 2013; and updated guidelines from the National Institute of Health and Care Excellence<sup>45 46 47 48</sup>

- The incorporation of evidence and recommendations as part of the Equally Well initiative, which recognises people living with mental health conditions experience physical health disparities
- The expansion of the mediascape and digital environment (now encompassing social media and the internet, particularly in relation to children and young people)
- New or amended legislation
- Updating lists of resources listed in appendices, notably those included in the 'self-management' section, such as including the helpline for children and young people, "0800 What's Up", and removing the references to the now-defunct NZGG
- Integration of other best practice platforms, such as the best practice guidance developed by the Royal Australian and New Zealand College of Psychiatry or the Best Practice Advocacy Centre<sup>49 50</sup>
- The integration of te reo Māori throughout the guideline and the emphasis on cultural safe patient-practitioner interactions is highly relevant and should be retained (if not enhanced) by any evidence update or review process.

## Physical health disparities and Equally Well

There is a greater prevalence of physical comorbidities and premature mortality experienced by people living with chronic mental health conditions and/or addiction, compared with the general population<sup>51 52 53</sup>. Many of these diseases, such as cardiovascular disease, respiratory diseases, metabolic disorders and infections are not only preventable, but significantly affect a person's quality of life and experience in the health care system<sup>54</sup>. As the disparity with the general population continues to widen, particularly for type-2 diabetes, cardiovascular disease and some forms of cancer, it is clear people with mental health conditions experience unmet need in relation to their physical health<sup>55 56</sup>. In New Zealand, the rate of premature mortality (death from natural causes before age 65) is twice as high for people using mental health and addiction services compared to the general population. For people diagnosed with a psychotic disorder, it is three times as high<sup>57</sup>.

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<sup>45</sup> Bighelli I, Castellazzi M, Cipriani A, Giralda F, Guaiana G, Koesters M et al. Antidepressants versus placebo for panic disorder in adults. *Cochrane Database Syst Rev* [Internet] 2018;4:CD010676. <http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD010676.pub2/full>.

<sup>46</sup> Wilkinson P, Izmeth Z. Continuation and maintenance treatments for depression in older people. *Cochrane Database Syst Rev* [Internet] 2016;9:CD006727. <http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD006727.pub3/full>.

<sup>47</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.)*. Arlington, VA: American Psychiatric Association; 2013.

<sup>48</sup> National Institute for Health and Care Excellence. *Depression in adults: recognition and management CG90*. [Internet] 2009 (updated 2018). <https://www.nice.org.uk/guidance/cg90>.

<sup>49</sup> For example, Royal Australian and New Zealand College of Psychiatry. *Guidelines and resources for practice*. <https://www.ranzcp.org/Publications/Guidelines-and-resources-for-practice>.

<sup>50</sup> For example, see Best Practice Advocacy Centre. *The role of medicines in the management of depression in primary care*. <https://bpac.org.nz/2017/depression.aspx>.

<sup>51</sup> Richardson CR, Faulkner G, McDevitt J, Skrinar GS, Hutchinson DS, Piette JD. Integrating psychical activity into mental health services for persons with serious mental illness. *Psychiatr Serv* [Internet] 2005; 56(3):324-31. <https://www.ncbi.nlm.nih.gov/pubmed/15746508>.

<sup>52</sup> Osborn DPJ. The poor physical health of people with a mental illness. *West J Med* [Internet] 2001; 175(5):329-332. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071612/>.

<sup>53</sup> Brown S, Birtwistle J, Roe L, Thompson C. The unhealthy lifestyle of people with schizophrenia. *Psychol Med* [Internet] 1999; 29(3):697-701. <https://www.ncbi.nlm.nih.gov/pubmed/10405091/>.

<sup>54</sup> Liu NH, Daumit GL, Dua T, Aquila R, Carlson F, Cuijpers P et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry* [Internet] 2017;16(1):30-40. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5269481/>.

<sup>55</sup> Das Munshi J, Ashworth M, Dewey ME, Gaughran F, Hull S, Margan C et al. Type 2 diabetes mellitus in people with severe mental illness: inequalities by ethnicity and age. *Cross-sectional analysis of 588 408 records from the UK*. *Diabet Med* [Internet] 2017; 34(7):916-924. <https://www.ncbi.nlm.nih.gov/pubmed/27973692>.

<sup>56</sup> Lawrence D, Kisely S, Pais J. The epidemiology of excess mortality in people with mental illness. *Can J Psychiatry* [Internet] 2010; 55(12):752-60. <https://www.ncbi.nlm.nih.gov/pubmed/21172095>.

<sup>57</sup> Cunningham R, Peterson D, Sarfarti D, Stanley J, Collings S. Premature mortality in adults using New Zealand Psychiatric Services. *N Z Med J* [Internet] 2014; 127(1394):31-41. <http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1394/6126>.

## Diagnostic overshadowing

Diagnostic overshadowing is a significant issue, impacting the treatment and health care patients receive, their experience of the health system, and ultimately their health outcomes. Diagnostic overshadowing occurs when health practitioners may attribute signs or symptoms of illness or disease to one condition, where in fact it may be strongly associated or caused by another long-term health condition.

For people living with mental health conditions, the presentation or experience of physical symptoms is frequently misattributed by health practitioners to the person's mental health condition, rather than being investigated as signs of a physical health condition. Subsequently, as treatment may be delayed or inadequate, this diagnostic overshadowing can contribute to the higher health inequalities experienced by people with mental health conditions. While the literature has posited a range of explanations for the inequalities and greater premature mortality experienced by people with mental health conditions, these are largely focused on exploring factors related to the patient, including current medication and behavioural factors. More recently, systemic disparities, including access to screening and treatment for physical health conditions for people with mental health conditions, have been explored as contributing factors<sup>58 59</sup>.

### “Primary” diagnosis

Te Rau Hinengaro finds that for people who are living with comorbid mental and physical health conditions, there is no process to identify the primary diagnosis, i.e. if the physical condition can be attributed to the mental health condition and vice versa<sup>60</sup>. There are likely to be several factors contributing to comorbidity – and importantly, many of these factors are not strictly “medical” in nature. They are the systemic and societal determinants of health which are heavily stratified by socioeconomic, environmental and discriminatory risk. Liu et al have translated these relationships into the following model of risk:

#### Multilevel model of risk for excess mortality in persons with mental health conditions (adapted from Liu<sup>61</sup>)

Social determinants of Health				
<i>Discriminatory public policies</i>	<i>Socio-economic factors</i>	<i>Cultural and societal values</i>	<i>Environmental vulnerabilities</i>	<i>Lack of social support and resources</i>
Health system-level factors				
<i>Absence of relevant policies and guidelines</i>		<i>Low financial investment in quality care</i>	<i>Limited health information systems</i>	
<i>Fragmented and limited service delivery</i>		<i>Practitioner factors, including poor communication</i>	<i>Medications incl. antipsychotics, polypharmacy</i>	
Individual (person-level) factors				
<i>Condition-specific – symptoms, pathophysiology etc</i>			<i>Behaviour-specific – tobacco use, diet, substance use</i>	

<sup>58</sup> Shefer G, Henderson C, Howard LM, Murray J, Thornicroft G. Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms – A qualitative study. PLoS ONE [Internet] 2014; 9(11): e111682. <https://doi.org/10.1371/journal.pone.0111682>.

<sup>59</sup> The Royal Australasian College of Physicians. Action to prevent obesity and reduce its impact across the life course: evidence review. Sydney; Wellington: The Royal Australasian College of Physicians; 2018. <https://www.racp.edu.au/advocacy/policy-and-advocacy-priorities/obesity>.

<sup>60</sup> Oakley Browne MA, Wells JE, Scott KM (eds.) Te Rau Hinengaro: The New Zealand Mental Health Survey.

<sup>61</sup> Liu NH, Daumit GL, Dua T, Aquila R, Carlson F, Cuijpers P et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry [Internet] 2017;16(1):30-40. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5269481/>.

Issues around medication, including polypharmacy and medication not functioning at a therapeutic level (higher dosages or suboptimal dosages) may be factors in greater prevalence of comorbidity. For example, the negative side effects attributed to the use of antipsychotics are well known, such as weight gain, glucose intolerance and dyslipidaemia<sup>62 63</sup>. Nearly 14 per cent of stories received as part of the People's Mental Health Report were on issues relating to medication, including people who had concerns about the negative impacts that some psychiatric medications had on quality of life, physical and mental health and life expectancy<sup>64</sup>.

RACP members have noted that medication adherence where people have coexisting mental and physical health conditions needs remains a challenge, particularly where housing status is concerned:

- A member reported that the chaotic circumstances of people experiencing homelessness while living with a mental health condition and/or addiction made taking regular medication unfeasible – medications are lost or stolen, meaning chronic physical health conditions, including diabetes, heart failure and chronic airway disease go untreated.
- A member found it near impossible to link a person living with Human Immunodeficiency Virus with specialist mental health services because there are three District Health Boards operating in Auckland and the person was currently homeless.
- A member working in general and acute care found it distressing knowing that they were treating people with mental health conditions for acute medical reasons (pneumonia, cellulitis) who would be discharged only to return to sleeping rough.

### ***Equally Well: Working to reduce physical health disparities for people living with mental health conditions***

The Equally Well Initiative aims to improve physical health outcomes for people who live with mental health conditions and/or addiction. Signatories to the Consensus Statement, which includes many New Zealand District Health Boards, professional bodies, medical colleges, specialty societies and non-government organisations recognise there is an urgent need for coordinated action that will contribute to improved life expectancy and physical health. This must be reflected in how health care systems are designed and integrated; how services are delivered; and how policies and programmes are developed and implemented.

The Equally Well consensus statement contends that people living with mental health conditions and/or addiction need

- To be identified as a priority group at a national policy level based on significant health risks and relatively poor physical health outcomes
- To have access to the same quality of care and treatment for physical illnesses, and to have a right to assessment, screening and monitoring for physical illnesses
- To be offered support to make the connection to how they are affected physically and guidance on personal goals and changes to enhance their physical wellbeing

The RACP has recently released its position statement and evidence review on action to prevent obesity and reduce its impact across the life course. The RACP calls for people living with mental health conditions to be recognised as a priority population for urgent action for co-designed interventions which reduce the prevalence and impact of obesity, and as highlighted above, noncommunicable disease<sup>65</sup>.

There are opportunities to embed Equally Well's recommendations into models of care, quality improvement and best practice through the Health Quality and Safety Commission's (HQSC) Mental Health and Addiction Quality Improvement programme. The Initiative has included

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<sup>62</sup> Liu NH, Daumit GL, Dua T, Aquila R, Carlson F, Cuijpers P et al. Excess mortality in persons with severe mental disorders.

<sup>63</sup> Correll CU, Detraux J, De Lepeleire J, De Hert M. Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry* [Internet] 2015;14(2):119-36. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4471960/>.

<sup>64</sup> Elliot M. The People's Mental Health Report.

<sup>65</sup> The Royal Australasian College of Physicians. Action to prevent obesity and reduce its impact across the life course.

maximising physical health through the Equally Well initiative as one of its five areas of focus (the others being learning from serious adverse events and consumer experience, improving service transitions, minimising restrictive care (seclusion and restraint), and improving medication management and prescribing)<sup>66</sup>. The RACP notes that the Mental Health Commissioner's 2018 report welcomes the HQSC's programme and highlights Equally Well as a key initiative towards achieving positive health outcomes for people with mental health conditions.

## Communication within the system

People may interact with multiple health practitioners, in different health care contexts and environments, to access treatment and management of their health conditions. This includes transitioning between different layers of the health system – for example, from in-patient services to community mental health services. For people living with mental health conditions and physical comorbidity, there are additional interactions with the health system which may also traverse the layers of the system, such as from primary care referral to secondary care and then continued follow-up through primary care. The Mental Health Commissioner's monitoring report has cited examples where a lack of communication between services and practitioners; poor record-keeping and notes; and lack of clarity around roles and responsibilities have directly or indirectly contributed to an adverse event or negative outcome<sup>67</sup>.

RACP members contributing their professional experiences as part of the development of the College's submission noted:

- Communication between service providers who are contributing to management of a person's comorbid conditions remains ineffective – continuity of care is disrupted, recommended follow-ups are not scheduled
- Tensions can arise between practitioners depending on professional background and understanding of models of risk and resilience
- The extent to which services are integrated is variable; while some have established good connections, others operate separately – for example, paediatrics and child and adolescent mental health services

The RACP believes that effective communication and coordination between providers, services and practitioners is essential for patient experience, optimal health outcomes, and health equity.

Communication is part of effective collaboration and team work. The Medical Council of New Zealand's Good Practice Guide makes several references to the importance of effective communication, including the need to work collaboratively with colleagues to improve or maintain care, and to ensure continuity of care. While the Good Practice Guide notes the need to gain informed consent for information sharing, there are clear benefits for optimal patient care where information is shared between providers, and it is in the patient's best interests<sup>68</sup>.

## Health equity for Māori

The poorer health outcomes experienced by Indigenous populations globally are strongly associated with the Social Determinants of Health which encompass the conditions under which people are born, grow, live, work and age (i.e. social, economic, political, cultural and physical circumstances), and are then compounded by the traumatic effects of colonisation, and an inequitable system which perpetuates racism.

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<sup>66</sup> Health Quality and Safety Commission. Mental Health and Addiction Quality Improvement Programme.

<sup>67</sup> Health and Disability Commission. New Zealand's mental health and addiction services – The monitoring and advocacy report of the Mental Health Commissioner.

<sup>68</sup> Medical Council of New Zealand. Good Practice Guide. Wellington: Medical Council of New Zealand. Available from <https://www.mcnz.org.nz/news-and-publications/good-medical-practice/>. Accessed 1 June 2018.

## **Health inequality experienced by Māori**

Māori experience the greatest level of health inequality of all peoples in New Zealand, with substantial inequalities in mortality and morbidity<sup>69</sup>. Over a 12-month period, Māori were found to have experienced a MHC&A at a rate of 30 per cent, compared to the 21 per cent of the general population, meaning that 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<sup>70</sup>. Māori are more likely to experience multiple and more serious conditions compared to the general population and have the highest rate of suicidal behaviour (including ideation, attempt and completion) of any ethnic group in New Zealand<sup>71</sup>.

Māori are also at greater likelihood to experience compulsory treatment under the Mental Health Act, and to be subject to restrictive practices (including seclusion and restraint) once they are<sup>72</sup>.

While policymakers have developed programmes and services which expand the biomedical model to a biopsychosocial model encompassing some elements of social and economic realities, these remain focused on the individual. This model has done little to achieve health equity for Māori, rather the focus on the individual/mainstream model of health and disease over the collective or whānau-based approach means the health gap between Māori and non-Māori New Zealanders has persisted. The culture, practices and world-view of Māori are marginalised and relegated within the mainstream discourse, meaning that potential solutions to many public health issues such as mental health are homogenised, and do not incorporate Māori knowledge to inform action for groups which are adversely affected.

## **Culturally safe health systems**

The RACP strongly supports the reorientation of health systems towards achieving health equity. Ensuring all aspects of the health system are culturally competent means that the whānau are more likely to have a culturally safe experience.

The RACP recommends any redesign of the mental health and addiction system is premised on the principles of partnership, protection and participation articulated in Te Tiriti o Waitangi, and incorporated into He Korowai Oranga, the Māori Health Strategy<sup>73</sup>. A system can provide effective intervention and support for Māori only when it is designed with equity of outcomes and experience at its heart. An equity-based health system:

- Has a focus on cultural identity and holistic wellbeing
- Co-designs interventions and services with Māori leaders, iwi, hapū and whānau, and Māori with lived experience of MHC&A
- Models of health should be based on te ao Māori models, and informed by Mātauranga Māori and Tikanga Māori

The RACP supports Te Whare Tapa Wha and the Meihana model being the basis for all future models developed for mental health and addiction services treatment pathways in New Zealand. Both models uphold the centrality of holistic health and wellbeing, including the importance of whānau (the collective within the narrower definition of individual health); and both models give equal weight to mental and physical wellbeing. The integral significance of whānau in the patient experience is acknowledged in both models; and in the Meihana model particularly, the influence and impact of nga hau e wha (the four winds): experiences of marginalisation, racism, the legacies of colonisation and migration – factors which may impact the journey to health and wellbeing are included<sup>74 75</sup>.

The RACP supports the recognition and acknowledgement of nga hau e wha in future treatment and management models for MHC&A – understanding how these underlying factors contribute to the development

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<sup>69</sup> M King, A Smith, M Gracey. Indigenous health part 2: the underlying causes of the health gap. *The Lancet*. 2009; 374(9683): 76-85.

<sup>70</sup> MA Oakley Browne, JE Wells, KM Scott (eds). *Te Rau Hinengaro: The New Zealand mental health survey*.

<sup>71</sup> MA Oakley Browne, JE Wells, KM Scott (eds). *Te Rau Hinengaro: The New Zealand mental health survey*.

<sup>72</sup> Ministry of Health. Office of the Director of Mental Health Annual Report 2016.

<sup>73</sup> Ministry of Health. *He Korowai Oranga: Maori Health Strategy*

<sup>74</sup> Pitama S et al. Improving Māori health through clinical assessment: Waikare o te Waka o Meihana. *N Z Med J* <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-126-no-1393/viewpoint-pitama>.

<sup>75</sup> Ministry of Health. Māori health models: Te Whare Tapa Wha. <http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha>.

and exacerbation of symptoms is essential for meaningful action towards achieving health equity for Māori. There is broad scope for these concepts to be embedded into continuing professional development for all health practitioners, and in orientation programmes for overseas-trained health practitioners and other staff entering the sector.

## Transfer from child and adolescent to adult mental health services

Many mental health conditions (anxiety disorders, attention deficit hyperactivity disorder, depressive disorders, eating disorders) have an initial onset in late childhood or during adolescence; conditions such as autism spectrum disorder, and other neurodevelopmental disorders will frequently be diagnosed in childhood<sup>76</sup>. For children living with intellectual disability, evidence shows that mental health conditions are common, with one population prevalence study reporting rates of 30-40 per cent; equally mental health conditions are common in children living with chronic physical health conditions, such as inflammatory bowel disease<sup>77 78 79</sup>.

It is acknowledged that the transition of children and young people from paediatric services to adult services requires careful planning and management in the context of any long-term condition, and mental health services are no exception<sup>80</sup>. For many children and young people using mental health services, transfer to adult services can be distressing and seem unnecessary; if poorly managed, a suboptimal transition may lead to negative health outcomes in the long term<sup>81</sup>.

Consultation with RACP members noted that transfer from paediatric and adolescent services to adult services is an area requiring additional resourcing to ensure this critical time period does not eventuate in negative health outcomes and disengagement from services in the long term. Members noted that

- High demand has created significant workforce pressures, particularly in specialist child and adolescent psychiatry
- Lack of services for children and adolescents living with mental health conditions and intellectual disability; especially in relation to dual diagnosis – this means many will leave specialist services at transition to be managed in primary care
- Many children and adolescents with mental health conditions will be using developmental paediatrics services – for example, those with autism spectrum disorder – and there is a significant gap in adult specialist services for adolescents transitioning to adult services

The RACP supports transition pathways that are flexible, responsive to the needs of the young person and their whanau, enable continuity, are comprehensive, and coordinated in order to minimise complications arising for adolescents transferring to adult services<sup>82</sup>.

Recent reports from health and disability watchdogs, evidence-based commentators and flax-roots advocacy organisations have highlighted the numerous challenges within mental health and addiction and promoted

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<sup>76</sup> Office of the Prime Minister's Chief Science Advisor. Towards a whole of government/whole of nation approach to mental health.

<sup>77</sup> Enfield S, Tonge B, Chapman L, Mohr C, Taffe J, Horstead S. Inter-rater reliability of the diagnoses of psychosis and depression in individuals with intellectual disabilities. *J Appl Res Intellect Disabil*. 2007; 20(5):384-90. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2605090/>.

<sup>78</sup> Van den Brink G, Stapersma L, El Marroun H, Henrichs J Szigethy EM, Utens EMWJ et al. Effectiveness of disease-specific cognitive-behavioural therapy on depression, anxiety, quality of life and the clinical course of disease in adolescents with inflammatory bowel disease: study protocol of a multicentre randomised controlled trial (HAPPY-IBD). *BMJ Open Gastroenterol*. 2016; 3(1):e0000071. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780038/>.

<sup>79</sup> The Royal Australasian College of Physicians.

<sup>80</sup> Colver A, Pearse R, Watson RM, Fay M, Rapley T, Mann KD et al. How well do services for young people with long term conditions deliver features proposed to improve transition? *BMC Health Serv Res* 2018; 18:337. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5941647/>.

<sup>81</sup> Broad KL, Sandhu VK, Sunderji N, Charach A, Youth experiences of transition from child mental health services to adult mental health services: a qualitative thematic synthesis. *BMC Psychiatry* 2017; 17:380. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5706294/>.

<sup>82</sup> The Royal Australasian College of Physicians. Transition to adult health services for adolescents with chronic conditions. Sydney: The Royal Australasian College of Physicians; 2014. <https://www.racp.edu.au/docs/default-source/advocacy-library/transition-to-adult-health-services-for-adolescents-with-chronic-conditions.pdf>

many of the solutions among their recommendations<sup>83 84 85</sup>. While the RACP recognises that many changes can be made within the health system to improve health outcomes, there are fundamental changes to how society supports our children, whanau and communities to promote hauora and wellbeing as the foundation of an equitable society.

## 4. What sort of society would be best for the mental health of all our people?

### ***Mental health across the life course***

Life course epidemiology understands human development through biological, psychosocial and behavioural processes, examining and tracking the impact of risk factors and protective factors on the development of chronic disease. The life course is a trajectory from conception through to death and is sensitive to socioeconomic systems and social determinants. Factors affecting development can build up (accumulated risk); be time based (critical periods, latency periods); or relate to different biopsychosocial mechanisms (mediating and modifying factors)<sup>86 87</sup>. Time-based critical periods within the life course posit that disease causation can be traced to exposures at specific time periods in development, “altering structures or functions of biological systems that without mediation or modification may precipitate disease later in life”<sup>88</sup>.

A life course approach to mental health conditions and addiction understands that there are sensitive periods of life where people may be more at risk of experiencing symptoms: social determinants as stressors (including unemployment, homelessness, family violence); biological life stage transitions (adolescence, pregnancy and birth, old age). A life course approach recognises that as people grow and develop, their resilience and coping abilities may change as their needs and environment change: resilience is not necessarily accumulative, and people may seek help at different times for different reasons. To this end, society must be enabling of good mental health and wellbeing, not just the absence of mental health conditions and/or addiction: as noted by Sir Peter Gluckman, “many who do not suffer from mental illness do not possess good mental health and may be in a vulnerable state if put under stress”<sup>89</sup>. When people require support, they should have many non-medical options within their reach as a first line of treatment, rather than more intensive interventions.

### ***Reducing harm from alcohol***

Alcohol is an undeniable part of the social fabric, and it the most widely-used drug in New Zealand – 93 per cent of New Zealanders will try alcohol at some point in their lives<sup>90</sup>. However, the many harms of alcohol addiction and its costs to individuals are substantial and indisputable:

- Consumption is higher per capita in New Zealand than in the United States or Canada
- Up to 25 per cent of New Zealand alcohol consumers are classified as heavy drinkers
- 50,000 people receive support to reduce their alcohol and drug use each year, though this is estimated to be only one third of those who are experiencing problems with their use<sup>91</sup>.

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<sup>83</sup> Health and Disability Commission.

<sup>84</sup> Office of the Prime Minister’s Chief Science Advisor.

<sup>85</sup> Elliott M. The People’s Mental Health Report.

<sup>86</sup> Kuh D, Ben-Shlomo Y, Lynch J, Hallqvist J, Power C. Glossary: Life course epidemiology. J Epidemiol Community Health [Internet] 2003; 57:778-83. <http://jech.bmj.com/content/57/10/778>.

<sup>87</sup> Hertzman C, Power C, Matthews S, Manor O. Using an interactive framework of society and life course to explain self-rated health in early adulthood. So Sci Med [Internet] 2001; 53(12):1575-1585.

<http://www.sciencedirect.com/science/article/pii/S0277953600004378>.

<sup>88</sup> Kuh D, Ben-Shlomo Y, Lynch J, Hallqvist J, Power C. Glossary: Life course epidemiology.

<sup>89</sup> Office of the Prime Minister’s Chief Science Advisor. Towards a whole of government/whole of nation approach to mental health.

<sup>90</sup> New Zealand Drug Foundation. Drug use in New Zealand. <https://www.drugfoundation.org.nz/policy-and-advocacy/drugs-in-nz>.

<sup>91</sup> New Zealand Drug Foundation. Drug use in New Zealand

Alcohol is the world's third largest risk factor for disease burden, accounting for 4.5 per cent of all Disability Adjusted Life Years globally<sup>92</sup>. Alcohol use is the eighth largest risk factor for mortality, accounting for 3.8 per cent of global deaths<sup>93</sup>.

In New Zealand, alcohol consumption has been identified as one of the most significant risk factors for avoidable mortality and disease in early and middle adulthood and contributes substantially to loss of good health across the life course. It has been estimated that 5.4 per cent of deaths under 80 years of age were attributable to alcohol, with alcohol-related injuries accounting for 43 per cent of these deaths, alcohol-attributable cancer for 30 per cent and other alcohol-attributable chronic disease for 27 per cent of these deaths<sup>94</sup>.

There is a well-documented relationship between alcohol abuse and mental health issue, with alcohol use increasing the risk or promoting the development of many mental health conditions including depression and/or anxiety. People with pre-existing mental health conditions are more likely to use alcohol, suggesting a bidirectional relationship between substance use and addiction and mental health conditions<sup>95</sup> <sup>96</sup>. Sir Peter Gluckman cites alcohol as a "cause and a consequence": there are links between alcohol addiction, interpersonal violence, and risk-taking behaviour, as well as result of other mental health conditions where self-medicating take precedence<sup>97</sup> <sup>98</sup>. Alcohol contributes to violence, suicide, injuries, approximately 60 medical conditions, and is responsible for over 1000 deaths and 12,000 years of life lost each year in New Zealand, and alcohol is believed to have a significant impact on the New Zealand health system, especially on New Zealand emergency departments<sup>99</sup>.

A life course approach to reduce harm from alcohol seeks to intervene at the very beginning – reducing use of alcohol among women who may be or wish to be pregnant – thereby reducing the risk of fetal alcohol spectrum disorder and other conditions, which are estimated to affect around 1 in every 1000 people (though likely under-diagnosed) in New Zealand<sup>100</sup>. Harm reduction initiatives can also be effective during adolescence, when most young people will try alcohol: The New Zealand Youth 12 survey found that 80 per cent of high school students had tried alcohol by age seventeen; and 70 per cent of these students were current drinkers. Significantly, the study noted that many students who were using alcohol at levels likely to cause harm were not worried about their substance use. This means that young people who may be at increased risk need to be identified early to prevent long-term addiction and because they are unlikely to proactively seek support<sup>101</sup>.

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<sup>92</sup> World Health Organization. Global health risks: mortality and burden of disease attributable to selected major risks; 2009. [http://www.who.int/healthinfo/global\\_burden\\_disease/GlobalHealthRisks\\_report\\_full.pdf](http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf).

<sup>93</sup> World Health Organization. Global health risks: mortality and burden of disease attributable to selected major risks

<sup>94</sup> Connor J, Kydd R, Sheild K, Rehm J. The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex. *N Z Med J* 2015;128(1409) <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1409/6435>.

<sup>95</sup> Brown S, Tapert S. Adolescence and the trajectory of alcohol use: basic to clinical studies. *Annals NY Acad Sci* 2004; 1021: 234-244.

<sup>96</sup> Kessler RC et al. Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Study. *Arch Gen Psych* 1997; 54:313-321.

<sup>97</sup> Laslett A et al. The range and magnitude of alcohol's harm to others. AER Centre for Alcohol Policy Research, Turning point alcohol and drug centre, eastern health; 2010. Based on police records of assaults collated for 2005 from Western Australia and New South Wales.

<sup>98</sup> Office of the Prime Minister's Chief Science Advisor. Towards a whole of government/whole of nation approach to mental health.

<sup>99</sup> R Stewart, D Manidipa, M Ardagh, JM Deely, S Dodd, N Bartholomew, S Pearson, R Spearing. The Impact of Alcohol-related presentations on a New Zealand hospital emergency department. *NZMJ*. Vol 127 No 1401; 29 Aug 2014. Available at <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no-1401/6272>.

<sup>100</sup> Easton B, Burd L, Rehm J, Popova S. Productivity losses associated with fetal alcohol spectrum disorder in New Zealand. *N Z Med J* 2016;129(1440). <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1440/6974>.

<sup>101</sup> Fleming, T. Lee, A.C., Moselen, E., Clark, T.C., Dixon, R. & The Adolescent Health Research Group (2014). Problem substance use among New Zealand secondary school students: Findings from the Youth'12 national youth health and wellbeing survey. Auckland, New Zealand: The University of Auckland. <https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/Final%20Substance%20Abuse%20Report%2016.9.14.pdf>



Although around 50,000 New Zealanders receive support to reduce their alcohol or drug use each year, around 50,000 more want help but don't receive it<sup>102</sup> <sup>103</sup>. Services are overextended and underfunded, and people struggle to find the help they need at the time they need it<sup>104</sup>. Reducing harm from alcohol, such as hazardous use or addiction, requires substantial reductions in alcohol availability. The RACP call on the New Zealand government to increase support for local authorities and communities to work to reduce the presence of alcohol off-licences<sup>105</sup>.

The RACP recommend that the Government works in partnership with communities, health professionals and consumer groups to address harm from alcohol. We recommend that the Government:

- Resources timely and equitable access to appropriate treatment
- Learns from novel interventions in the community, including looking at the Wellington City Council wet house initiative
- Continues to roll out Housing First, particularly to provincial centres experiencing harm from high levels of addiction.

Due to an obvious conflict of interest, the alcohol industry must be precluded from having any place at the table in policy development. Political parties and government should reconsider accepting financial contributions from the alcohol industry<sup>106</sup>.

### **Health equity**

Where people live, how they spend their time, and who they live with and support shapes people's health. The RACP recognises health as multidimensional, encompassing more than just the treatment of illness and disease, and that health equity is achieved when the conditions in which people grow, live, work and age support health and wellbeing<sup>107</sup>.

Systems, structures, policies and programmes may be organised and designed to enable health and wellbeing, but this is only possible when people do not experience barriers to access which in turn are the result of compounded systematic injustice which is, simply put, unfair. The evidence overwhelmingly supports action on the social determinants of health through a whole-of-society response: central and local government, communities, non-government organisations and industry can work together to support health and wellbeing for all members of our society<sup>108</sup>.

The RACP notes that New Zealand has already made a commitment to a society that supports mental health and wellbeing by being a signatory to the United Nations' 17 Sustainable Development Goals – which include a call to “ensure healthy lives and promote wellbeing for all at all ages”. Actions to address the social determinants of health at the micro-, meso-, and macro-levels will make a real difference to New Zealand achieving equity for people, their whānau and their communities.

The RACP shared its vision for what a wellbeing society would look like in its election statement “Make it the Norm: Equity through the Social Determinants of Health” in 2017. New Zealand has become an increasingly unequal society: healthy housing, good work and whānau wellbeing are not the Norm for many New Zealand children and adults.

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<sup>102</sup> NZ Drug Foundation. Briefing to the Incoming Parliament-NZ Drug Foundation Policy Briefing 2017-2020. Available from: <https://www.drugfoundation.org.nz/assets/uploads/2017-uploads/nzdrug-parliamentary-briefing-dec-2017.pdf>.

<sup>103</sup> Mental Health Commission. (2011). National Indicators 2011. Measuring mental health and addiction in New Zealand. Mental Health Commission: Wellington. Retrieved from <http://www.hdc.org.nz/media/199059/national%20indicators%202011%20measuring%20mental%20health%20and%20addiction%20in%20new%20zealand.pdf>

<sup>104</sup> NZ Drug Foundation. Briefing to the Incoming Parliament-NZ Drug Foundation Policy Briefing 2017-2020. Available from: <https://www.drugfoundation.org.nz/assets/uploads/2017-uploads/nzdrug-parliamentary-briefing-dec-2017.pdf>.

<sup>105</sup> RACP. Make it the Norm (Election Statement). August 2017. Available at: <https://www.racp.edu.au/news-and-events/media-releases/racp-make-health-equity-the-norm>.

<sup>106</sup> The Royal Australasian College of Physicians and The Royal Australian and New Zealand College of Psychiatrists. Alcohol Policy. March 2016. Australia. Available at: <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcoh9ol-policy.pdf>

<sup>107</sup> RACP. Make it the Norm: Equity through the social determinants of Health. August 2017. <https://www.racp.edu.au/fellows/resources/new-zealand-resources/new-zealand-election-statement-2017>.

<sup>108</sup> RACP. Make it the Norm: Equity through the social determinants of Health.

The RACP calls for all policymakers to make health equity the norm to improve health outcomes for the most vulnerable people in our communities. We call for immediate actions, which include:

- **Making Healthy Housing the norm** by introducing a regulation to mandate a warrant of fitness and health for residential dwellings;
- **Making Good Work the norm** by promoting the living wage to support the health and wellness of employees and their whānau; and
- **Making Whānau Wellbeing the norm** by taking a child-centred approach to all legislation, policy and regulation<sup>109</sup>.

## Summary

A society which places health equity at its heart; which works actively to reduce the impact of the social determinants of health; that designs systems which seek to emphasise protective and preventative factors will be the best for the mental health of the people of Aotearoa New Zealand. Approaches that focus on the life course, reduce harm from substances like alcohol, and addresses the social determinants of health to achieve health equity are evidence-informed, whole-of-society methodologies which can address the systemic inequities.

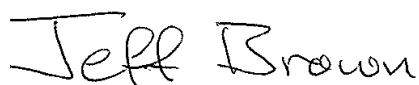
Our submission identifies a number of potential areas in where changes could result in more positive health gains and outcomes for New Zealanders living with MHC&A – and these are not bound to the health system. As identified by the Prime Minister's Chief Science Advisor's report, a whole of government and whole of nation approach is required to make real, positive change to improve the health outcomes and quality of life of people living with mental health conditions and addiction, but to also move towards a society that centralises preventative, protective approaches so that all New Zealanders can live, work and grow in a society that values mental wellbeing.

The RACP's Make Health Equity the Norm was inspired by Norman Kirk's quote, that

*People don't want much – somewhere to live, someone to love, something to do and something to hope for."*

It seems appropriate to reaffirm this perspective. The RACP thanks Mental Health and Addiction Inquiry panel for the opportunity to provide feedback on the Government Inquiry into Mental Health and Addiction, and is available to meet with the Panel to discuss this submission further. Please contact the NZ Policy and Advocacy Unit at [policy@racp.org.nz](mailto:policy@racp.org.nz).

Yours sincerely



Dr Jeff Brown  
New Zealand President  
**The Royal Australasian College of Physician**

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<sup>109</sup> RACP. Make it the Norm: Equity through the social determinants of Health.