Broadening access and ongoing support for people with mental health and addiction need – re-thinking the role of primary and community care

In February this year I released my first monitoring and advocacy report into New Zealand's mental health and addiction services. I found that while growing numbers of New Zealanders are accessing health services for mental health and addiction issues, these services are under pressure and many needs are left unmet. Often services are available to people only once their condition deteriorates, and the dominant treatment options (medication and therapy) do not address the broader social factors that help people be well and support their recovery. I found that more of the same would not deliver a wellbeing and recovery-oriented system.

The last national mental health and addiction survey indicated that one in five New Zealanders (21%) live with mental illness and/or addiction each year – that's nearly 1 million people. New Zealand's health response is set up so that DHB and NGO-provided mental health and addiction services respond to the highest and most complex needs, with a target to reach 3% of the population. In 2016/17, 173,933 New Zealanders (3.7% of the population) accessed these services, at a cost of $1.4 billion. Primary and community care is expected to respond to all other mental health and addiction need, including an estimated 17% of the population with 'mild-to-moderate' mental illness and/or addiction.

Around 2% of the total DHB mental health and addiction budget funds primary mental health services (typically extended GP consultations and packages of talk therapy). In 2016/17 130,663 New Zealanders (2.8% of the population) accessed these services, at a cost of $26 million. Generalist health services designed for delivery to the general population, including general practice, school-based services, midwifery, Well Child Tamariki Ora, and NGO primary health support are expected to respond to remaining need.

Most people seeking professional help for a mental health or addiction issue will start with their GP. GP visits are only partially subsidised for much of the population. A 2001 study suggests that 6% of GP consultations are for psychological reasons, and data provided to the HDC by Procare shows a prescribing rate of two mental health prescriptions for every five enrolled patents across their network (individuals may receive more than one prescription). A growing number of New Zealanders are also accessing support online and by telephone, with the National Telehealth Service alone receiving over 200,000 mental health and addiction-related contacts in 2016/17.

While access and prevalence numbers give a sense of service provision and unmet need, they are underpinned by medical-oriented models of care and prevalence data that is over twenty years old. My monitoring suggests that more of the same services will not bring about a people-centred system that supports wellbeing and recovery across a continuum of care. There is good evidence to support early intervention, and intervention that addresses broader social factors and supports people to manage their own wellbeing and recovery. Developing these broader approaches to care has been very difficult in a system which is under pressure.

The consumer feedback I received as part of my monitoring was that consumers want broader intervention options than medication and more time with health professionals to discuss issues they were facing. Consumers valued activities provided by services that helped them socialise or provided structure, as well as having access to professional peer support, and wanted more support to live their lives, including finding meaningful employment and transitioning from school to study. Consumers' experience of services was that they needed to be very unwell to get help and then were expected to get better, and could not access ongoing support even when they recognised their own warning signs of relapse.

There needs to be a re-think, based on current information, of how health services are designed, delivered and integrated across a range of individual, whānau, community, and social responses. There is much potential for primary and community care to provide broader, earlier and easy access support for people wanting support for a mental health or addiction issue and ongoing support to maintain wellbeing and in recovery. Seamlessness within and between health services and across other social services is an ongoing issue raised by HDC, and is vital to support the changes that are needed. Pathways need to be available for primary and community care, as the first point of access for many people, to ensure that people get help that is meaningful to them.

Some innovations in practice are already occurring, which I highlight in my report. For example, Counties Manukau DHB is developing an integrated model of care designed on a "no refusal" approach to referrals/requests for support. The model enables early intervention and a shared-care approach with primary and community care. New locally based community teams provide liaison and advice, assessment and brief interventions in primary and community care settings. The clinical and non-clinical mental health and addiction specialists within these teams will support primary and community care professionals to develop their confidence and capability in relation to mental health and addictions. DHB provided mental health and addiction community teams have been redesigned to deliver defined, purposeful, individual episodes of care. NGO mental health and addiction services will be designed to deliver a seamless and comprehensive response to consumers' clinical and non-clinical needs. Care will be shared with primary and community care for a holistic approach to well-being and recovery.

While these signs of progress are encouraging, there is a loss of traction to deliver meaningful change in the sector. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*, together with the Mental Health Commission's document that informed it, *Blueprint II: How things need to be*, set out a wellbeing and recovery vision for the mental health and addiction services. These documents identified similar challenges and actions to address them as those in my report. Primary care, and its integration with mental health and addiction services was identified as a priority. *Rising to the Challenge* has now expired. With 100 actions and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, it has been difficult to measure progress at the completion of the plan.

I have recommended to the Minister of Health an action plan to broaden the focus from mental illness and addiction to mental well-being and recovery, and to increase access to health and other support services. The terms of reference of the Ministerial Inquiry into mental health and addictions, which is now underway, enable significant decisions to improve services and regain traction in the sector to be made in a timely way.

You can find the Mental Health Commissioner's full 2018 mental health and addiction services monitoring and advocacy report here: http://www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioners-monitoring-and-advocacy-report-2018/

By Kevin Allan, Mental Health Commissioner, with assistance from Jane Carpenter, Senior Advisor, Policy and Analysis

NZ Doctor, 28 March 2018