NEEDS ANALYSIS

The overall situation in Northland (and New Zealand) has been well documented via the He Ara Oranga report of the Government Inquiry into Mental Health and Addiction which was released to the Minister of Health on 04 December 2018.

https://www.mentalhealth.inquiry.govt.nz/inquiry-report/

Highlights from this report that are relevant to the needs in Northland, and to some of the solutions that the Wild Side Charitable Trust is hoping to offer.

Executive Summary: (p8-9)

- Any one of us can be affected: over 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. But some people are more at risk. A range of social determinants are risk factors for poor mental health: poverty, lack of affordable housing, unemployment and low-paid work, **abuse and neglect, family violence and other trauma, loneliness and social isolation (especially in the elderly and rural populations) and, for Māori, deprivation and cultural alienation.**

- Addiction to alcohol and other drugs is causing widespread harm in New Zealand communities…

  Over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems.

  From P9 Executive Summary.

- This report records the main themes from the voices of the people: a call for **wellbeing and community solutions** – for help through the storms of life, to be seen as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self. For **Māori health and wellbeing**, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and Iwi.

- **Addictions** are recognised as a serious public health issue in New Zealand. Alcohol and other drugs are tearing families and communities apart.

- Problems of **access, wait times and quality** were reported all over the country – having to fight and beg for services, not meeting the threshold for treatment, and the cruelty of being encouraged to seek help from unavailable or severely rationed services. Gaps in services,

limited therapies, a system that is hard to navigate, variable quality and shabby facilities added up to a gloomy picture of a system failing to meet the needs of many people.

- New Zealand's mental health and addiction problems cannot be fixed by government alone, nor solely by the health system. **We can't medicate or treat our way out of the epidemic of mental distress and addiction affecting all layers of our society.**
- Wellbeing has been a theme during this Inquiry and in national conversation in recent years. It's hard for people struggling with poverty, abuse and deprivation to take steps to become well – yet, every day, people recover from distress, overcome addictions and find strength in their lives. **Sleep, nutrition, exercise and time outdoors help recovery. So too does strengthening one's cultural identity and helping others.**
- Our mental health system is set up to respond to people with a diagnosed mental illness. **It does not respond well to other people who are seriously distressed.** Even when it responds to people with a mental illness, it does so through too narrow a lens. **People may be offered medication, but not other appropriate support and therapies to recover.** The quality of services and facilities is variable. Too many people are treated with a lack of dignity, respect and empathy.
- We do not have a continuum of care – key components of the system are missing. The system does not respond adequately to people in serious distress, to prevent them from 'tipping over' into crisis situations. **Many people with common, disabling problems such as stress, depression, anxiety, trauma and substance abuse have few options available through the public system.** By failing to provide support early to people under the current threshold for specialist services, we're losing opportunities to improve outcomes for individuals, communities and the country.
- We also fail to address people's wider social needs. Initial expansion of culturally appropriate services has stalled, and there has been **little investment in respite and crisis support options, forensic step-down services in the community, and earlier access to a broader range of peer, cultural and talk therapies.**

What the Commission heard –the voices of the people (p36)

- We heard that our mental health and addiction system is not fit for purpose. We have a health system that focuses on *responding* to psychiatric illness, but people want a system that *prevents* mental distress and addiction, *intervenes early* when problems start to develop, and *promotes* wellbeing.

People called for transformation in our approach to mental health and addiction, with a focus on wellbeing and community solutions.

- New Zealanders of diverse backgrounds asked for **a more values-based and holistic approach to promoting the wellbeing of individuals, families and communities**.
- The strong consensus among Māori was that Te Ao Māori, mātauranga Māori, whānau, and te reo me ona tikanga are essential aspects of wellbeing for Māori.
- Pacific peoples called for Pacific ways and world views of knowing and doing, where connection is paramount through relationships with family, community and the environment, to be honoured.

- **All around the country, people advocated for Te Whare Tapa Whā, the concept that health and wellbeing are underpinned by four cornerstones: taha tinana (physical health), taha hinengaro (mental health), taha wairua (spiritual health) and taha whānau (family health).**
- **Help through the storms of life**

"I think there are messages we are supposed to learn through this storm and medication is only a temporary fix, but most importantly is exercise, healthy eating, sleeping … the spiritual side … Feeding my mind with positives ie. reading my spiritual devotions, shopping, only connecting with positive friends/family" (Service user)

- **Seeing the whole person**

People complained that the biomedical approach fails to see the whole person, so provides only part of the answer (and sometimes no answer at all) to restoring and maintaining wellbeing.

"The ideal system would acknowledge and attend to the whole person in the one facility. An overall positive transformation would take place without compromising other aspects of health and wellbeing as a result of service delivery". (NGO provider of Kaupapa Māori services)

Workers at all levels of the system questioned the effectiveness of current clinical practice models. We were told that medical science is only part of the answer and that the health system alone cannot solve the crisis in mental health and addiction.

*"**Although medication can often be necessary and life-saving, we also need comprehensive services that mean people's mental health can be looked after fully – this would involve root causes of issues being explored**". (Service user)*

People noted that, although many service providers aspire to a more holistic model, it's often not evident in their practices and 15-minute general practitioner (GP) consultations don't allow it. The Wellbeing Manifesto listed 12 aspects of a holistic model, with psychiatric treatment being only one aspect alongside advocacy and navigation services, education and employment support, and whānau and parenting support.

"In my experience, the patient is not treated as a whole, but a fragment of the area of expertise the particular doctor is trained in … A band aid will eventually wear off, fix the wound and there will no longer be a need for the plaster". (Family member caring for service user)

People criticised current services for failing to acknowledge how much mental wellbeing is a function of meaningful work, healthy relationships with family, whānau and community, good physical health, and strong connection to land, culture and history.

"Employment is a huge part of recovery. It is important for self-esteem, routine, social connectedness, physical health, and of course it helps to relieve the poverty that is very often part of the lives of someone with poor mental health". (Service provider)

Māori health and wellbeing (p39)

Overwhelmingly, submissions from Māori said that the health and wellbeing of Māori requires recognition of indigeneity and affirmation of indigenous rights. They argued that our approach to mental health needs to acknowledge the Tāngata Whenua status of Māori under Te Tiriti o

Waitangi. In addition to more Kaupapa Māori services and a strong Māori mental health workforce, many Māori want to determine how services are commissioned, delivered and evaluated**.**

We were told that the Western model of mental health, enshrined in the health system and legislation, is based on beliefs that are not shared by all Māori and are not always helpful – for example, the separation of mental health from oranga (health and wellbeing) is **contradictory to holistic understandings of health**.

We heard that recognition of the importance and significance of ties to whānau, hapū, iwi and family group, including the contribution those ties make to wellbeing, and proper respect for cultural and ethnic identity and language[29] rarely form part of psychiatric assessments. They are routinely not addressed by courts, tribunals or others when making decisions about compulsory assessment and treatment. We also heard that patients are denied their entitlement to be dealt with in a manner that accords with the spirit of proper respect for cultural identity.[30]

2.5.1 Local communities want more control (p43)

We repeatedly heard how poor mental health outcomes can become endemic within communities. We met leaders in communities devastated by the impact of easy access to alcohol and other drugs. People told us how whole communities, not just individuals, can become depressed or anxious, disconnect from each other, and lose the sense of trust and the ability to work together. They expressed dismay at their limited influence over important decisions that affect community wellbeing, such as the number and placement of liquor or gambling outlets and access to addiction detoxification (detox) facilities.

.5.4 Trauma is a key factor in mental distress and addiction (p44)

Many submissions highlighted trauma in childhood as the origin of mental distress and the trigger for counterproductive coping mechanisms such as addiction. People noted that steps to prevent or reduce the trauma of childhood abuse and neglect, sexual abuse and sexual violence, adult partner violence and bullying at school and work should be recognised as strategies for preventing future distress and investing in the wellbeing of future generations.

We were told that health services responding to mental distress need to get better at acknowledging and responding to the trauma that underpins 'symptoms', rather than merely offering ways to 'dull the pain'.

A repeated theme was that intergenerational trauma can affect families and whānau and that understanding mental health through the lens of trauma requires a change in mind-set and different approaches to healing for individuals, families and whānau.

Unless we provide trauma informed services the system will remain broken. (Parent supporting service user)

2.5.5 Alcohol and other drugs and addictions are tearing families and communities apart (p45)

People demanded action to reduce the harmful effects of drugs (especially methamphetamine or 'P') and alcohol, particularly among young people and during pregnancy. We heard from communities being torn apart by the P epidemic.

2.6 Addictions (p45)

Many people identified addiction as a serious public health issue. People criticised the subtle normalisation of alcohol, other drugs and gambling within our society over past decades, with much easier access to all three. They pointed to the increasing number of liquor and gambling outlets, their placement near schools and in poorer communities, and the failure of 'tough on drugs' policies to restrict availability.

We were told that addiction is the opposite of connection, a taniwha that isolates users and holds them in its grip. They spoke of the high social costs of not addressing addictions: harm to families, children and communities. People saw an urgent need to prevent harmful addictions and provide pathways to recovery.

2.6.1 More treatment and rehabilitation services (p45)

We heard that when people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options within their communities. People called for rehabilitation (rehab) services such as detox facilities and counselling to be much more widely available. They wanted residential and other services to keep people safe during drug withdrawal and to aid their recovery with professional help, peer-support programmes and strengths-based approaches to healing.

When a person is ready to change the treatment needs to be available then. Not one hundred placements down the line.

2.6.2 A mature drug policy (p46)

People called for addiction to be de-stigmatised and recognised as a maladaptive response to stress, anxiety and trauma. People spoke of the harmful perverse effects of 'tough on drugs' policies, such as encouraging gang control of drug supplies and pushing addicts and their families into the margins of society. We were told that our largely punitive criminal justice response to drug use fails to acknowledge **the root causes of drug addiction (trauma, abuse, anxiety and isolation) or the frequent connection between intergenerational abuse, addiction, mental distress, unemployment, poverty and homelessness.**

2.7. Families and whānau (p46)

We heard that mental health services often make it difficult for individuals to stay connected to their families and communities. They acknowledged that mental distress can put immense pressure on an individual's relationships with family and other networks, sometimes to the point of breakdown, and that family can generate and exacerbate distress. But relationships with family, whānau and community give lives meaning and provide a potential path back to wholeness. Many people described how mental health services have severed or jeopardised these relationships.

2.7.2 Support for families (p47)

Families spoke of the difficulty of accessing advice, respite care or other forms of assistance to help them support their family member through mental distress and during recovery. They spoke of overloaded crisis services, a lack of integration and continuity of care, and having loved ones returned to their care with little information or support.

We are winging it. We are winging it. (Whānau Māori)

Some families said they were dealing with multiple intergenerational disadvantages, layers of trauma, limited skills and ongoing addiction. They asked for help to address their own wellbeing challenges.

2.7.4 Cultural support (p48)

Māori and Pacific peoples pointed to evidence that treating the mental health of an individual in isolation from family and community is ineffective and inappropriate for cultures that value collectivism. They argued that cultural approaches are vital to recovery and get much better outcomes – so should be funded and supported. Many Pākehā and other ethnic communities voiced similar concerns about treatment models that do not sufficiently acknowledge family, whānau and social context.

People were dismayed that many clinicians working from a biomedical model were reluctant to recognise cultural evidence and failed to appreciate the value of staff and support people from the individual's own culture. Culturally appropriate services were described as rare and poorly resourced.

Communities need the opportunity to shape models of care so that they fit the needs (cultural and social) of the communities they serve. (Community advocate)

2.9.1 People want access to an expanded range of therapies (53)

Many people expressed frustration at the **lack of a holistic response from mental health services.** They wanted a choice of therapies, including more counselling, rongoā Māori, talk therapies and online therapies, Pacific healing, spiritual healing and mind–body practices such as mindfulness, "rather than a reliance on pharmacology" (provider). People also wanted services that address broader health and social problems such as chronic pain, physical conditions, addictions, age-related disabilities, trauma, violence, relationship issues and nutrition.

2.9.2 Support to return to work

People told us that mental distress or psychiatric illness can compromise a person's ability to continue full-time work, leaving them socially isolated and lacking a sense of purpose. Meaningful work was described as essential for healing, and long-term dependence on sickness benefits was seen as impeding recovery. Work of any kind – paid or voluntary – was said to give a sense of purpose, a reason to get out of bed in the morning.

We were told that mental health services rarely extend to assisting people to maintain work or return to work.

2.9.3 Shift resources from DHBs to NGO providers in the community

We heard calls to shift resources from DHBs to NGO providers, which are closer to the community and better equipped to provide the services and supports that people need. People saw DHB-provided services as institutional and bureaucratic, driven by rules that reflect the priorities of the organisation such as fixed budgets, deficits and competing health services rather than the priorities of individuals and families in need. Many feared that mental health services have a permanent Cinderella status among other DHB services and that addiction services are Cinderella's poor cousin.

People saw NGOs as embedded in communities – more responsive and innovative, more likely to use peer-support workers and volunteers, more oriented towards achieving outcomes instead of 'ticking boxes'. They voiced a perception that DHBs, with their dual funder–provider roles, will often favour their own DHB-provided services rather than those delivered by NGOs.

2.10.1 Fighting for access (p54)

In rural New Zealand, people find it difficult to find the services that they need with any sense of anonymity. (Service provider)

We heard about general difficulties accessing detox, rehab, and other alcohol and other drug services due to long waitlists, a lack of culturally appropriate options and limited service locations. This was exacerbated by complexities of addiction and mental health challenges, fear of accessing services due to repercussions, and under-resourcing. People talked of being told to 'keep using' while they sat on waiting lists.

2.10.2 Limited options (p55)

Many people referred to over-medicalisation or, simply, medicalisation of mental health responses as inappropriate, inconsistent with holistic world views (particularly Te Ao Māori and Pacific world views), and dismissive of the broad array of social determinants of mental distress. These social determinants include trauma, inequity, early life conditions, discrimination, education, employment,

housing, financial stress, violence, social isolation, and bullying. Pacific and Māori submissions spoke of the need for culturally embedded solutions for their communities, given the inequitable distribution of social determinants and high rate of mental health challenges. People also sought early life-course intervention solutions that placed children and their whānau and extended whānau at the centre.