ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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Submission to the Government Inquiry into Mental Health and Addiction

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Background

The Association of Salaried Medical Specialists is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent nearly 5,000 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians.

Over 90% of all DHB permanently employed senior doctors and dentists eligible to join the ASMS are in fact members. Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant and growing number work in primary care and outside DHBs. These members, many of whom are general practitioners, are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

Introduction

There has been insufficient time allowed for us to canvass our members' views and insights about the challenges in meeting mental health and addiction service needs. From the input we have received, however, the key issues identified are increased 'demand', lack of resourcing, and the need for more effective models of care. We expect these themes will be reflected in the many personal accounts from patients and their families, as well as from those providing the services, that the inquiry panel will hear through its engagement with communities throughout the country. This submission brings together the available data on mental health and addiction service provision that sits behind and, we believe, complements those accounts. We also summarise some of the evidence supporting the case for greater investment in mental health and addiction services.

Increasing service need and unmet need

Unmet health need in mental health is well acknowledged. About 60% of the people who die by suicide in New Zealand each year have not interacted with a mental health or addiction service in the previous 12 months.[1] New Zealand is not alone. A major report on mental illness from the Organisation for Economic Cooperation and Development (OECD) found mental illness is neglected "in far too many countries". It says estimates suggest up to 60% of those needing treatment don't get it.[2]

The New Zealand Health Survey Update for 2015/16 recorded 7% of adults experiencing psychological distress within the previous four weeks of the survey "indicating a high probability of the person having an anxiety or depressive disorder". An Auditor-General's report on mental health service discharge planning estimates about 20% of the population experience a mental health problem in any one year.[3] Currently, specialist mental health services are covering about 3.6% of the population. The OECD says evidence suggests that around 5% of the working-age population has a severe mental health condition.[4]

Ministry of Health figures show the growing need for mental health services is far exceeding the growth in resources. The number of unique 'clients seen' by Mental Health and Addiction (MHA) services teams grew by 50% in the seven years from 2008/09 to 2015/16 (Table 1), while funding increased by just 27%, or 16.5 percent in real terms, from $1.1b in 2008/09 to $1.4b in 2015/16, according to the former Minister of Health.[5]

Table 1: Mental Health and Addiction Service – Number of clients seen

2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	% Increase
111,734	121,196	132,682	139,389	151,374	155,956	158,670	167,840	50.2%

Source: Ministry of Health 2017

Other Ministry of Health data show new referrals to MHA triage teams increased by 62% over the five years from 2010/11 to 2015/16 (earlier data is less robust). This includes self- or relative referrals, which increased by 125%. This may be due in part to an increased awareness of mental health issues and a willingness to seek help. Referrals from sources such as GPs and adult community mental health services have also seen big increases – by 58% and 62% respectively (Table 2).

The gap between 'clients seen' and 'new referrals' is largely due to multiple referrals being counted against many individual clients in any given year. There are also variations in the 'clients seen' data compared with the 'new referrals' data. However, the growing gap between 'clients seen' and 'new referrals' indicates an increased movement of clients between services, raising questions as to whether clients are being discharged from services too early or with inadequate support, only to be referred back to an MHA service down the track. For example, discharges of clients from MHA services to 'self or relative', or the care of their GP, or adult community health services increased by 94%, 75% and 74% respectively.

After the initial referral to an MHA team, further referrals onto other MHA services are also increasing significantly. For example, 'referral discharges' from MHA teams to psychiatric inpatient services increased by 70%, and referrals to outpatients increased by 139%.

Table 2: Mental Health and Addiction Service Referral Trends, 2010/11 to 2015/16

	2010/11	2015/16	% increase 2010/11 - 2015/16
New referrals to MH&A teams*	218,884	354,399	62%
Three main sources:			
General practitioner	33,526	53,055	58%
Self or relative referral	40,519	91,249	125%
Adult community mental health services	29,169	47,279	62%
Referral 'Discharges'	201,259	348,610	73%
Destinations include:			
General Practitioner	35,203	61,622	75%
Adult community mental health services	18,418	31,965	74%
Self or relative	7,031	13,642	94%
Psychiatric inpatients	3,055	5,198	70%
Psychiatric outpatients	1,055	2,517	139%
Workforce growth			
Registered nurses**	4,293	4,482	4.4%
Psychiatrists***	477	554	14.2%
General Practitioners****	3614	3884	7.5%

Notes:

* A client may have more than one referral open at the same time, so 'new referrals' will be greater than 'clients seen'. A new referral is defined as a referral with a start date in the current year.

** Includes Addiction services, Inpatient, and Community services. Some nurses may be counted more than once where they work in more than one setting.

*** Doctors with vocational registration in psychiatry, with an Annual Practising Certificate and a NZ address.

**** Doctors self-reporting as working as general practitioners

Sources:

Ministry of Health. Mental Health and Addiction: Service Use – Series. Available:

http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/mental-health-and-addiction-service-use-series (See also Appendix 1 for latest unpublished data)

NZ Nursing Council. *The New Zealand Nursing Workforce*, 2010/11 and 2014/15 (data as at March 2015).

MCNZ: Medical Register as at June 2011 and Medical Workforce Survey 2015 (data gathered from November 2015 to August 2016).

These trends appear consistent with the Auditor-General's findings of a revolving-door effect where follow-up support after discharge from hospital was often inadequate due in part to 'high caseloads of community mental health teams', which in some DHBs led to high numbers of mental health clients being re-admitted within 28 days of being discharged.

Lack of resources

While the numbers of 'clients seen' increased by 50% in the seven years from 2008/09 to 2015/16, funding increased by just 27%, or 16.5% in real terms, from $1.1b in 2008/09 to $1.4b in 2015/16, according to the former Minister of Health.

Table 3: Mental health service funding, 2008/09 to 2015/16[6]

Former Minister says mental health funding increased as follows:	**CPI (excl GST increase)**		**In June 2016 dollars**
$1.1 billion $1.4 billion	June-09 Jun-16	1081 1181	$1.2 billion $1.4 billion
Dollar increase 27.3%	Increase in real terms - 16.5%		

The lack of funding to keep pace with growing service needs is reflected in clinical staffing trends. As indicated in Tables 1 & 2, the growth in the number of psychiatrists, GPs and registered nurses employed in MHA services is dwarfed by the growth in 'clients seen' and new referrals.

Specialist workforce shortages

Increasing the capacity of the specialist workforce must be a top priority. The need for more specialists is not only urgent for covering gaps in services but also for training supervising and supporting new specialists and other health professionals, especially when the intention is to develop a more diverse team of health professionals in a more integrated system. As the largely overlooked MH&A Workforce Service Review Report commissioned by Health Workforce New Zealand (HWNZ) explains, this will require specialists "to have reduced 'active' caseloads" but growing clinical work pressures do not allow this.[7] Nor do reduced DHB training budgets.

The ASMS supports in principle the aspirations of the MHA Workforce Action Plan 2017-2021, including empowering patients and their families, developing better coordinated and integrated approaches to care, including specialists providing more support for primary and community-based services, and better and more equitable access to services.[8] But this simply will not happen if specialists are unable to find time to train and supervise other staff and provide support to patients so they may be more involved in their mental health, or have the capacity to respond to growing clinical need.

While demand for specialist skills continues to rise, there are also increasing pressures on the supply of specialists in key roles such as psychiatry. Our specialist workforce is aging and we are dependent on imports to supply our needs. As the Workforce Action Plan acknowledges:

Among all specialty areas, psychiatry has the second highest percentage of international medical graduates, who make up 59% of the psychiatry workforce (based on registration data). This impacts on continuity of care as turnover for international medical graduates is higher than for those who are New Zealand trained.

According to Ministry of Health data an estimated 675 consultant psychiatrists will be practising in New Zealand by 2026. While the number of psychiatrists per 100,000 is projected to increase from the current estimated 12.5/100,000 to 13.2/100,00 by 2026, the MHA Workforce Action Plan notes that "if current trends continue we would expect that a significant number of these will be international medical graduates. Of the 39 psychiatrists that entered (or re-entered) the workforce in 2016, 34 were international medical graduates (IMGs)."

As well as retention challenges indicated with increasing dependency on IMGs, World Health Organisation data from 2014 indicates many countries already have far greater numbers of psychiatrists per capita than is projected for New Zealand in 2026.[9]

The MHA Workforce Action Plan recognises that:

Critical specialist areas are experiencing shortages and for others shortages are anticipated in the future; some rural and provincial areas are also experiencing ongoing challenges to meet demand.

However, the Workforce Action Plan's response to meeting specialist workforce needs is vague and focuses mostly on reorganising the way services are delivered. A great deal more substance is needed to explain what these strategies must involve, and the investment needed to implement them, if the Action Plan is to realise the vision where "people [are supported] to thrive and experience wellbeing wherever they live and whatever their circumstances".

There are opportunities to invest in strategies which, international evidence shows, not only help to achieve recruitment and retention goals but also improve service quality and patient outcomes, while at the same time reduce costs. These strategies include adopting a patient centred care approach to organising and delivering services and properly implementing the government policy of clinical leadership, which are discussed further below.

A prerequisite is a workforce action plan that includes detailed psychiatrist recruitment and retention measures based on developing attractive environments and conditions in which to practise.

Workforce shortages in primary care

The ASMS recognises that to achieve high-quality patient centred care stronger collaboration and coordination of services is required at every level. That means viewing the health system not so much in terms such as 'primary care' and 'secondary care' etc, but as a single continuum, with care provided by integrated multidisciplinary teams. We also recognise, however, that like the hospital specialist workforce, the general practitioner workforce is also experiencing shortages, as acknowledged by HWNZ. At the same time, as shown in Table 2, the general practice workload involving mental health 'clients' is growing significantly.

This is not acknowledged in the Workforce Action Plan, even though a clear underlying theme is a shifting of the MH&A workload from secondary care to primary care.

Care of patients with mental illness is a significant part of the workload of primary care services. But as the MH&A Workforce Service Review working group points out, while the primary care workforce may be competently handling a wide range of MH&A issues, the general practitioner and primary nursing workforces "usually had limited mental health training/experience…[and] the current model of care and funding model for primary care is centred around brief consults that are generally too short to enable MH&A issues to be effectively assessed and plans of care to be developed".

However, focused and relevant training can provide substantial lifts in capability and confidence. New roles are developing in primary based mental health clinical support roles, which need expanding. This requires funding. Further, as mentioned above, hospital specialist staff are expected to provide significant support within primary care and community settings, which will require these staff to have reduced 'active' caseloads.

Reducing hospital specialist caseloads when there are already shortages of MH&A hospital specialists is clearly problematic and probably self-defeating. Part of the current pressure on primary care and other community-based services, which are having to manage acutely unwell patients, is due to difficulties obtaining timely referrals to specialist services. We understand that secondary mental health services are running at 100% capacity in some areas. Increasing demand on hospital in-patient beds is creating high-stress workloads and is leading to staff burnout and losses, which in turn is adding to the difficulties in accessing specialist services. There is no room for flexibility, or for developing more efficient service models.

The Workforce Action Plan's approach of shifting resources from secondary care to primary care is therefore too simplistic. There is a need to recognise that an under-resourced secondary care service will increase the workloads of the primary care services. Both sectors require adequate funding.

Developing effective, evidence-based models of care

Since many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live, multi-sectoral government policies to improve New Zealanders' wellbeing are critical to improving mental health. Within the health sector, a properly resourced integrated multi-disciplinary approach is also critical to ensure preventative strategies are reaching people who are exposed to the multiple risk factors such as homelessness, poverty, substance dependency and family violence, and to ensure timely access to specialist services when they are needed.

Distributive clinical leadership

The overwhelming evidence is that multi-disciplinary integrated care is not achieved by top-down directives, which negate the complexities of 'front line' services. Distributive clinical leadership is essential for achieving well-coordinated, integrated care.[10] [11] [12] There are a number of reasons for this.

The need for service-specific knowledge – understanding how clinical services work and what is required to provide high-quality care – means clinicians need to be among the people leading the change. The insights of staff, at the clinical team level, provide critical intelligence for how to foster an environment that is nurturing not only for patients and families but also for health care professionals.

Involving senior doctors directly in the design and implementation of patient centred processes is an important way to achieve engagement, improve the efficiency and quality of services, increase patient and staff satisfaction, improve safety, and reduce staff turnover.

Studies on the effects of engagement have consistently shown that improvement in health care is a cultural phenomenon that relies upon the contribution of staff who are not only individually motivated but are also provided with the appropriate time and opportunities to apply their skills, knowledge, and experience.

The benefits of engagement are mirrored in numerous studies on clinical leadership in general. There is now a strong body of evidence showing how distributed clinical leadership can achieve what New Zealand's successive attempts at health reform have failed to achieve: significantly improve the effectiveness and efficiency of our public hospitals across the whole spectrum of services (not just the selected few targeted by Government) while managing the increasing costs of health care.

Indeed, given the health indicators for the coming decade, the ability of our health system to meet the growing demands may well rest on the extent to which distributed clinical leadership is established in practice.

Quite simply, the reforms we need are only likely to be successful if clinically led.

– Professor Des Gorman, Executive Chair, HWNZ[13]

Successful clinical governance, as envisaged by the Government's *In Good Hands* policy statement and by the *Time for Quality* agreement between the ASMS and the country's DHBs, requires distributive leadership embedded at every level of the system.[14] [15]

Some of the many specific benefits of distributive clinical leadership include:

- effective and efficient development of new innovative service models
- quality training and supervision
- sustainable achievement of government health targets
- improved safety and quality of services and outcomes.

For this to succeed in any meaningful way, financial investment is needed to develop the capacity of the specialist workforce to enable 'time for quality'.

Up until recently, distributed clinical leadership was recognised as a critical part of government health policy. Inexplicably, it appears to have dropped down New Zealand's policy priorities. It is vitally important that this addressed.

Patient centred care

The evidence shows effective distributed clinical leadership is a key factor in achieving genuine patient centred care.[16] Psychiatrists, and indeed all medical specialists, need quality time to enable discussion with patients and their families about treatment options and their potential consequences, and to encourage and empower people to be more involved in their health and wellbeing.

This is especially important given our health services are facing increasing numbers of patients with chronic and complex needs. Research shows there are many benefits from patient-centred care when it is properly implemented. When health care administrators, health professionals, patients and families work in partnership, the quality and safety of care rises and provider and patient satisfaction increase. Recent research indicates that a patient-centred approach can also make health service delivery more efficient. Specific benefits include decreased mortality, decreased emergency department return visits, fewer medication errors and reductions in both underuse and overuse of medical services.[17]

In the care of patients with chronic conditions, studies indicate that patient-centred approaches can increase both patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life.

A patient-centred care approach is also seen as integral to preventative care. Further, it has been acknowledged that to succeed, a patient-centred care approach must address staff needs, as the staff's ability to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient-centred care approach is firmly established, a positive cycle emerges where increased patient satisfaction increases employee satisfaction, and this in turn improves employee retention rates and the ability to continue practising patient-centred care.

Limited resources in the form of underfunding, low staffing levels and low morale in already overstretched systems are a perceived barrier to the practice of patient-centred care. An underlying reason why a comprehensive patient-centred care approach has not been well established in New Zealand's District Health Boards (DHBs), despite all of these benefits and more, is that it requires an upfront investment in services, especially in the medical specialist workforce.

While patient-centred care is mentioned briefly in the MHA Workforce Action Plan, it requires much greater emphasis and detail on implementation if it is to become more than a feel-good slogan.

In summary, the psychiatrist workforce capacity needs to be as such to enable psychiatrists to provide the most effective and cost-efficient service. In this respect it is vital that psychiatrist staffing levels are sufficient to enable them to have time for distributive clinical leadership and to provide patient-centred care, including time for discussion with patients and their families about treatment options and their potential consequences and to encourage and empower people to be more involved in their health and wellbeing. Research shows that these measures not only improve patient outcomes and improve cost-efficiency but also have a positive flow-on for recruitment and retention of staff.

Evidence supporting investment in mental health and addiction services produce economic gains

Good mental health and wellbeing have been shown to result in health, social and economic benefits for individuals, communities and populations, including:[18]

- better physical health;
- reduction in health-damaging behaviour;
- greater educational achievement;
- improved productivity;
- higher incomes;
- reduced absenteeism;
- less crime;
- more participation in community life;
- improved overall functioning; and
- reduced mortality.

The Department of Health in the United Kingdom provides an example of how to produce a 'business case' for investing in MH&A services.[19] To reinforce the British Government's mental health services strategy in England, the Department commissioned supporting research from the London School of Economics (LSE) to make an economic case for the actions contained in the strategy. Their economic modelling includes details on the costs of upfront investments to implement specific actions in the strategy along with evidence-based estimates of consequent substantial savings to the National Health Service (NHS) and wider economic benefits over the medium to longer term.

The Department of Health recognised that the wider economic costs of mental ill health outweigh the direct costs of health services (and that both are increasing). In England, for example, total mental health service costs, including NHS costs and social and informal care costs, amounted to £22.5 billion in 2007, but the wider economic costs were estimated at £105.2 billion each year. (The OECD estimates the direct and indirect [wider economic] cost of mental illness can exceed 4% of GDP.)

The Department acknowledged the wealth of research showing there is potential for substantially reducing the indirect costs of mental ill health by investing more in mental health services. A range of innovative and preventative approaches can reduce services costs by improving outcomes and increasing quality. This can be achieved not just for mental health and addiction services but also for other health services, since mental illness is associated with significant morbidity.

This is reinforced by the HWNZ-sponsored MHA Workforce Service Review of 2011, which reported that people are presenting with increasing complexity, mental health issues, physical health issues, addictions, and stress, and that "the health outcomes for people with combinations of mental health and long-term physical conditions are substantially worse than either mental or physical conditions in isolation".

The Department of Health in England has found different types of intervention can promote benefits over the short, medium and longer term and often in areas other than health. For instance, the majority of economic savings from investment in mental health promotion for children and families often accrue through reductions in crime and improved earnings. By contrast, reducing the number of people who miss their appointments may decrease immediate costs to the NHS.

The LSE's modelling shows, for example, that an additional investment of £327 million over 10 years for early detection services for people with prodromal symptoms of psychosis (At Risk Mental State - ARMS) can create savings of £653 million for the NHS alone, plus £142 million for other public services, and benefits of more than £1.2 billion for the wider economy. The additional investment includes funding for contacts with psychiatrists, use of medication and provision of cognitive therapy. Similarly, an additional investment of £57 million over 10 years in multidisciplinary teams (eg, psychiatrists, psychologists, occupational therapists, community support workers, etc) providing early intervention services for people with psychosis can save the NHS £348 million, plus wider public sector and economic savings of £257 million.

It makes financial sense to invest in building and maintaining good mental health and resilience for communities, families and individuals and to provide the most effective and affordable services at times when they are needed.

– UK Department of Health

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