



What price mental health?

The crisis and the cure

Foreword by Sarah Dalton, Executive Director, ASMS

The 2018 Mental Health and Addiction Inquiry should have been a watershed moment in our history.

Finally, as a country, we confronted the scale of a problem many decades in the making. We heard the stories of frontline workers, service users, their whānau and communities. It seemed as if the Government and the Ministry of Health were determined to bring change and provide adequate funding at long last.

For the first time the issue was high on the public radar, and the longstanding stigma around mental health seemed to lift. It was a time of great hope.

It is nearly three years since the Inquiry reported back. Not only has little changed, but key indicators are worsening; there is a tsunami of unmet need.

This Research Brief is the first of two major pieces of work ASMS is carrying out to examine the mental health crisis and canvass possible ways forward.

This document examines key indicators of stress, such as rising referrals, reduced inpatient beds per population, and a concerning increase in the practice of seclusion. It lays out the framework of the system and a longstanding failure to fund the 5% of the population experiencing the most severe mental health issues.

Later this year, ASMS will release a second piece of work closely examining the state of the specialist workforce, including a survey of our psychiatry members.

A longstanding lack of workforce planning and service investment, along with a failure to address the social determinants of mental health, have created a formidable crisis.

However, there are solutions. We must not waste another three years.

At a glance

Specialist Mental Health and Addiction (MHA) service trends

- The number of unique MHA service users, or “clients seen” in DHB and contracted (non-government organisations) NGO services grew by approximately 40% in the years 2010/11 to 2019/20.



- New self or family/whānau referrals to MHA triage teams increased by 128% from 2010/11 to 2017/18. Referrals from GPs have increased by 92%. The gap between ‘clients seen’ and ‘new referrals’ is largely due to multiple referrals for individuals. It indicates increased movement of clients between services.
- Māori comprise 34% of the number of clients seen; the Māori population comprises about 11% of the total population.
- More than a third of MHA clients are in the poorest 20% of the population.

MHA needs

- The estimated number of adults with anxiety disorder more than doubled between 2011 and 2019. The estimated number of adults with depression grew by 32% over the same period.
- The estimated number of children with anxiety disorder doubled between 2011 and 2019. In 2019, the estimated number of children with depression was 75% higher than in 2011.
- Despite the growth in service use, about 60% of the people who die by suicide in New Zealand each year are reported to have not interacted with an MHA service in the previous 12 months.

MHA service capacity

- The DHB-employed psychiatrist workforce increased by 22% between 2011 and 2020. Over the same period, MHA clients increased by an estimated 28%.
- In 2018, New Zealand had the lowest number of practising psychiatrists per capita compared with 10 other countries, including Australia, the UK, and Canada.
- The total mental health nursing workforce, including all employers and nursing scopes of practice, increased by 16% between 2011 and 2019. This is less than half of the growth in the number of clients seen by DHBs and NGOs over the same period.
- The growth of the allied health workforce employed by DHBs has similarly fallen behind the growth in workloads. While the number of clients seen by DHBs increased by 28% between 2011 and 2020, clinical psychologists grew by 16%, occupational therapists by 22%, and social workers by 2%. Psychotherapist staff fell by 34% over that period.
- DHBs frequently exceed 100% occupancy levels for MHA inpatient beds; well above the 85% occupancy considered clinically safe.
- The number of inpatient MHA beds per population has fallen by nearly 10% in the past five years. The number of psychiatric beds per head of population is among the lowest in the OECD.
- The practice of solitary confinement is an indicator of the inadequacy of resources to handle acute cases. Solitary confinement increased by 21% between 2014 and 2019. There are significant racial disparities: Māori are five times more likely to be locked up in seclusion rooms than other New Zealanders.

Funding

- For more than a quarter of a century, specialist MHA service funding has been designated to cover the 3% of the population who are deemed to have the most severe need. However, the evidence indicates that closer to 5% of the population has a severe need. This is not a new trend – the evidence for it goes back 15 years.
- The number of MHA clients, including those seen by contracted NGOs, has exceeded population growth. The average funding per client in real terms has decreased by an estimated 38% between 2008/09 and 2019/20.
- In response to the MHA Inquiry's key recommendation, funding to provide more support in the community for those with mild and moderate needs was increased significantly in 2019, although to date much of it has not been spent.
- There has been no additional funding for MHA specialist services, other than adjustment for population growth and inflation. The rationale is that improving prevention and early intervention in the community will see demand for specialist services reduce.

Conclusion

- The best available evidence indicates specialist MHA services have been substantially under-funded for many years. In the meantime, the growth in service needs is continuing to outstrip the growth in service capacity, creating cumulative pressures on services, which are unsafe and unsustainable. The government policy of supporting more prevention and early intervention measures is a positive move. However, the available evidence does not support the expectation that these measures will relieve pressures on specialist services in the short or medium terms. Information is needed urgently to assess current specialist service needs, and to match those needs with appropriate funding.

Introduction

“A consistent theme in submissions was having to fight for access to mental health care due to high thresholds of acuity, limited and non-existent services, or complex care requirements beyond current service provision. We heard that some people presenting with a high risk of suicide were deemed ineligible for help and were unable to find timely, responsive service...”

He Ara Oranga, Mental Health and Addiction Inquiry Report, 2018¹

Despite its stark finding that the shortages of staff, acute beds, and respite care in specialist services meant these services were “able to accept only the most distressed or unwell people”, the 2018 Mental Health and Addiction Inquiry made no direct recommendations to fix these problems.

Instead, the inquiry pins its hopes on prevention and early intervention: “We expect demand for specialist services will reduce as issues are dealt with earlier, before they escalate...”

The need for stronger prevention measures and early intervention is not questioned. But the nature of these measures, including building community workforce capacity and addressing the socioeconomic determinants of ill health, mean any impact they may have in reducing pressure on specialist services is a distant goal.

The newly established Mental Health and Wellbeing Commission is tasked with monitoring the implementation of the recommendations that were accepted or “accepted in principle” by the Government. The monitoring is a response to the Inquiry’s findings of a lack of progress in improving mental health services over many years, partly due to “a fundamental disconnect [that] exists between stated strategic direction, funding and operational policy and ultimately service delivery”.

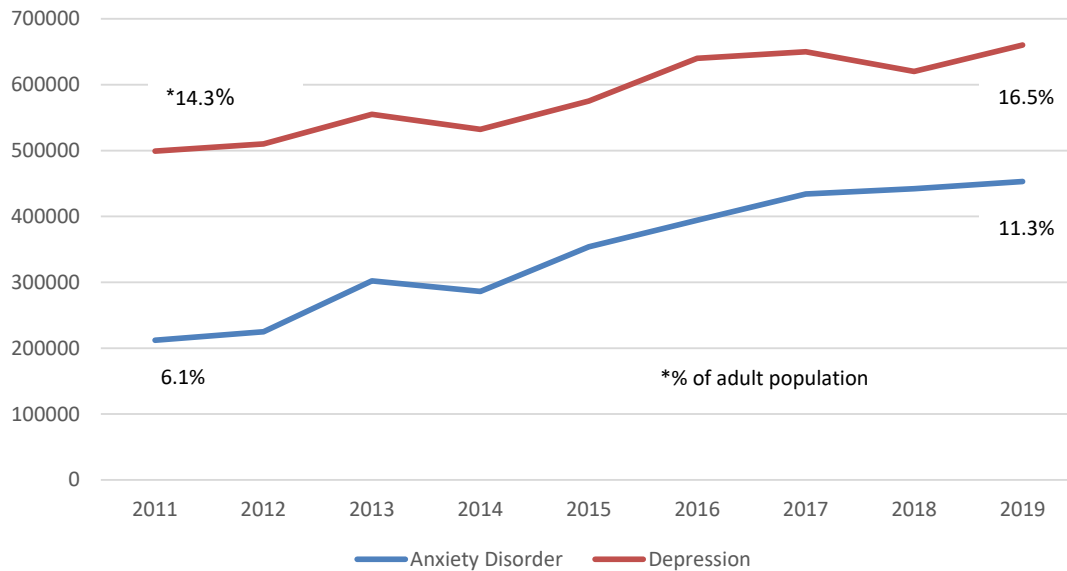
The absence of any recommendations on specialist services, compounded by an absence of up-to-date service data, points to an absence of scrutiny on how those services are managing – or not – and the consequences for service users. The purpose of this paper is to go at least some way to filling the void.

For clarification, ‘specialist services’ are not provided exclusively by specialist clinicians. They include community-based services, respite care and social support services, as well as inpatient services. They account for the vast bulk of government funding for mental health and addictions services, which is a ring-fenced portion of the overall district health board (DHB) budget allocation. Most of these services are provided by DHBs, though some are contracted by DHBs to other providers such as non-government organisations (NGOs).

Mental health needs in New Zealand

New Zealand health surveys show the prevalence of mental ill health has grown well above population growth. The estimated number of adults with anxiety disorders more than doubled between 2011 and 2019, while the adult population grew by 16%. The estimated number of adults with depression grew by 32% over the same period.

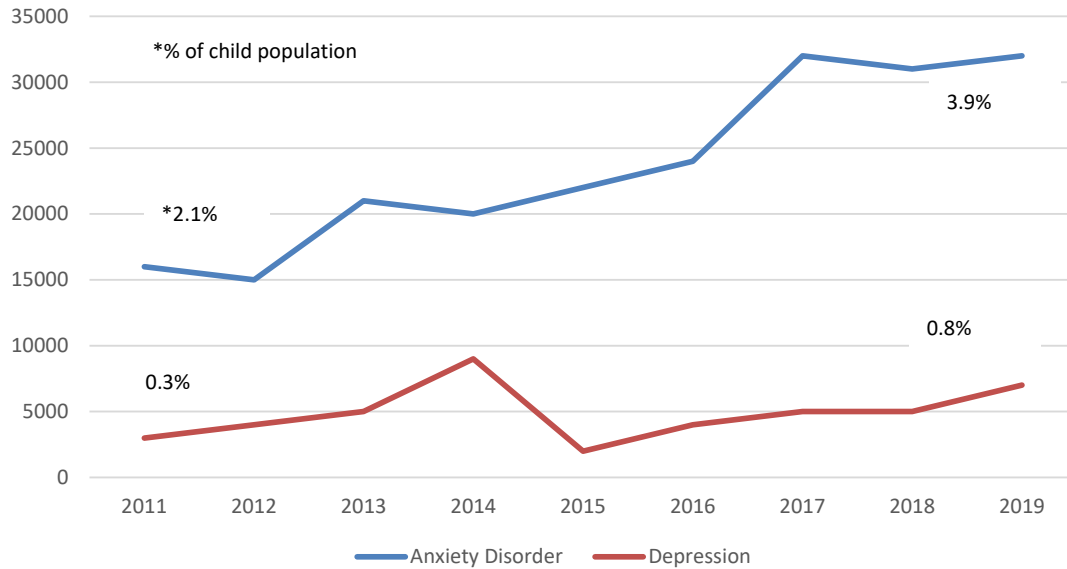
The latest figures indicate 11.3% of the adult population have been diagnosed with an anxiety disorder and 16.5% have been diagnosed with depression (Figure 1). Approximately 1% have been diagnosed with bipolar disorder. There will be overlaps in the statistics. The MHA Inquiry reports “one in five people experience mental health and addiction challenges at any given time”.



Source: New Zealand Health Survey results 2019/20

Figure 1: Estimated number of adults diagnosed with anxiety disorder, and the estimated number diagnosed with depression, 2011-2019

For children (under 15s), the prevalence of anxiety disorder is much greater than that of depression, but, like adults, both have seen substantial growth. The estimated number of children with an anxiety disorder doubled between 2011 and 2019, while the child population grew by 5%. In 2019 the estimated number of children with depression was 75% higher than in 2011. (Figure 2).



Source: New Zealand Health Survey results 2019/20

Figure 2: Estimated number of children diagnosed with anxiety disorder, and the estimated number diagnosed with depression, 2011-2019

According to the World Health Organisation (WHO), New Zealand’s level of need for mental health support is one of the highest among the 37 countries belonging to the Organisation for Economic Cooperation and Development (OECD), based on the estimated prevalence of depressive disorders and anxiety disorders.²

Depression is ranked by the WHO as the single largest contributor to global disability; anxiety disorders are ranked 6th. Depression is also the major contributor to suicide deaths, for which New Zealand’s provisional rates were the ninth highest in the OECD in 2018 (13.7 per 100,000 population).^{3 4} For Māori, the rates were much higher, at 23.7.

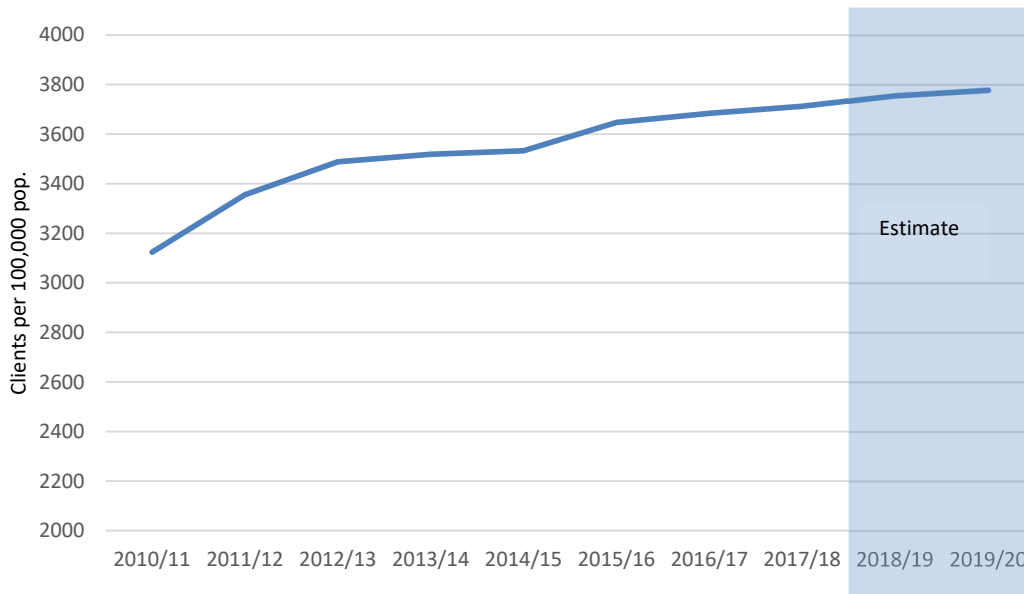
About 60% of the people who die by suicide in New Zealand each year are reported to have not interacted with a mental health or addiction service in the previous 12 months.⁵ New Zealand is not alone. A major OECD report on mental illness found mental illness is neglected “in far too many countries”. It says estimates suggest up to 60% of those needing treatment don’t get it.⁶

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.⁷ Currently, ring-fenced specialist mental health services are funded to cover 3% of the population deemed to have the most severe needs, although services are seeing about 3.7% in practice, and the evidence points to a need to cover 5%, as discussed later.

Specialist mental health and addictions service trends

Ministry of Health figures show the growing need for specialist mental health services is more than twice that of population growth. The number of unique “clients seen” by DHB and contracted NGO MHA service teams grew by approximately 40% in the years 2010/11 to 2019/20, while the population grew by 16%. Total clients per 100,000 population increased by 21% (Figure 3).⁸

For some specialist teams the numbers of clients seen increased substantially between 2011 and 2018, including maternity (48%), forensics (54%) and eating disorders (96%). Later figures are unavailable.



Source: Programme for the Integration of Mental Health Data (PRIMHD), Ministry of Health 2021

Note: Some clients were seen by both DHBs and NGOs.

Figure 3: Mental Health and Addiction (MHA) clients seen by district health board and contracted NGO services per 100,000 population, 2010/11 to 2019/20

Notes on the data

The Mental Health Commissioner notes the rises in the number of clients could be partly due to several variables, including greater accuracy in capturing data, improved visibility of and access to services, and stronger referral relationships between providers.

The Ministry of Health explains its mental health data is a “living data collection”, which continues to be revised and updated as data reporting processes are improved. Data for those aged 65 and over is incomplete; data for 2017/18 is incomplete. Data from NGOs is incomplete but is improving over time. This may account for the sharp rise in clients seen from 2010/11 to 2012/13, although when NGO data is excluded, a similar trend occurs from DHB-only data. The latest data available is for 2017/18. Data for subsequent years have been estimated based on recent trends.

Given the above, the Ministry’s “service use” data presented here should be seen as indicative rather than precise.

New referrals

New self or family/whānau referrals to MHA triage teams increased by 128% from 2010/11 to 2017/18 (the latest available). This may be due in part to increased awareness of mental health and a willingness to seek help. Referrals from sources such as GPs and adult community mental health services have also seen big increases – by 92% and 66% respectively (Table 1).

Table 1: Mental Health and Addiction Service Referral Trends, 2010/11 to 2017/18

| | 2010-11 | 2017-18 | % increase 2010/11 - 2017/18 |
|---|---------|---------|------------------------------|
| New referrals to MH&A teams* | 218,884 | 375,732 | 72% |
| Three main sources: | | | |
| General practitioner | 33,526 | 64,268 | 92% |
| Self or relative referral | 40,519 | 92,523 | 128% |
| Adult community mental health services | 29,169 | 48,488 | 66% |
| Referral 'Discharges' | 201,259 | 373,270 | 85% |
| Destinations include: | | | |
| General Practitioner | 35,203 | 72,002 | 105% |
| Adult community mental health services | 18,418 | 47,123 | 156% |
| Self or relative | 7,031 | 16,707 | 138% |
| Psychiatric inpatients | 3,055 | 5,433 | 78% |
| Psychiatric outpatients | 1,055 | 2,696 | 156% |

Source: Programme for the Integration of Mental Health Data (PRIMHD), Ministry of Health 2021

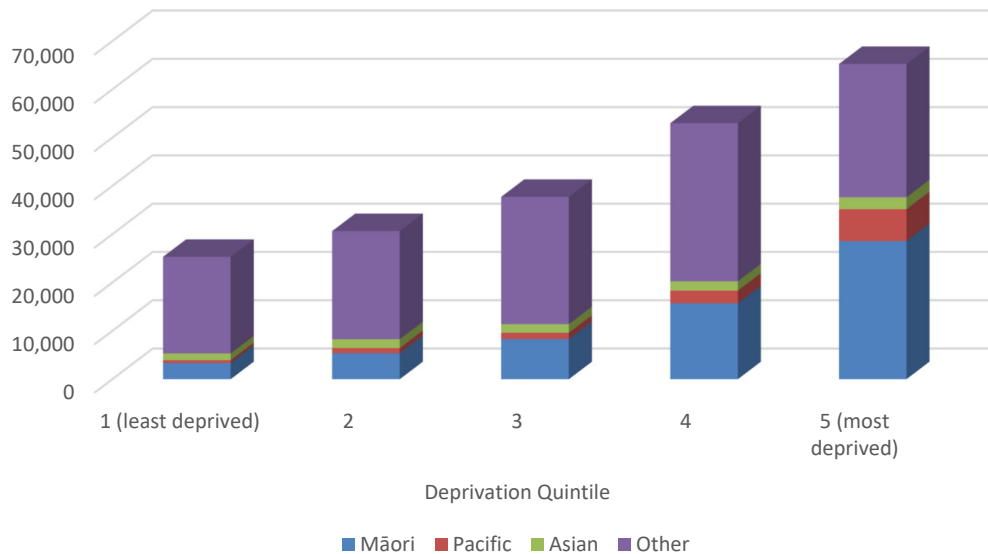
* A client may have more than one referral open at the same time, so 'new referrals' will be greater than 'clients seen'. A new referral is defined as a referral with a start date in the current year.

The gap between “clients seen” and “new referrals” is largely due to multiple referrals being counted against many individual clients in any given year. The growing gap between “clients seen” and “new referrals” indicates an increased movement of clients between services, raising questions about whether clients are being discharged from services too early, or with inadequate support, and then subsequently referred back to an MHA service. 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 138%, 105%, and 156% respectively. As outlined above, these are areas that have also seen significant increases in new referrals.

Referral discharges from MHA teams to psychiatric inpatient services increased by 78%, and referrals to outpatients increased by 156%.

These trends appear consistent with the Auditor-General’s findings of a revolving-door effect, where follow-up support after discharge was often inadequate. This was due in part to the “high caseloads of community mental health teams”, which in some DHBs led to high numbers of mental health clients being re-admitted.⁹

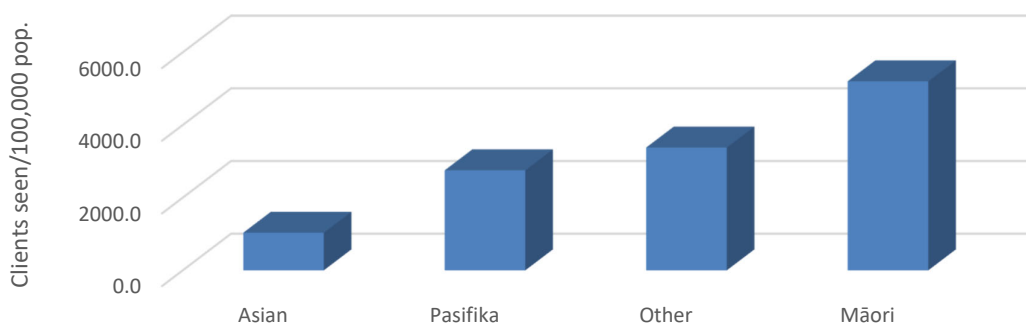
Recommendation - Develop and fund policies to promote high quality collaboration across the spectrum of MHA service providers and with the community.



Source: Programme for the Integration of Mental Health Data (PRIMHD), Ministry of Health, 2021

Figure 4: Number of MHA clients seen by deprivation quintile and ethnicity, 2017/18

More than a third (36%) of MHA clients seen were in the most deprived quintile in 2017/18 and nearly two-thirds were in the two most deprived quintiles. (Figure 4). Despite the Māori population comprising an estimated 11% of the total population in 2018, Māori comprised 34% of the number of clients seen. The disproportionate need for services by Māori is illustrated in Figure 5, giving an ethnic breakdown of the number of clients seen by DHBs per 100,000 population.



Source: Programme for the Integration of Mental Health Data (PRIMHD). Ministry of Health, 2021

Note: Some clients were seen by both DHBs and NGOs

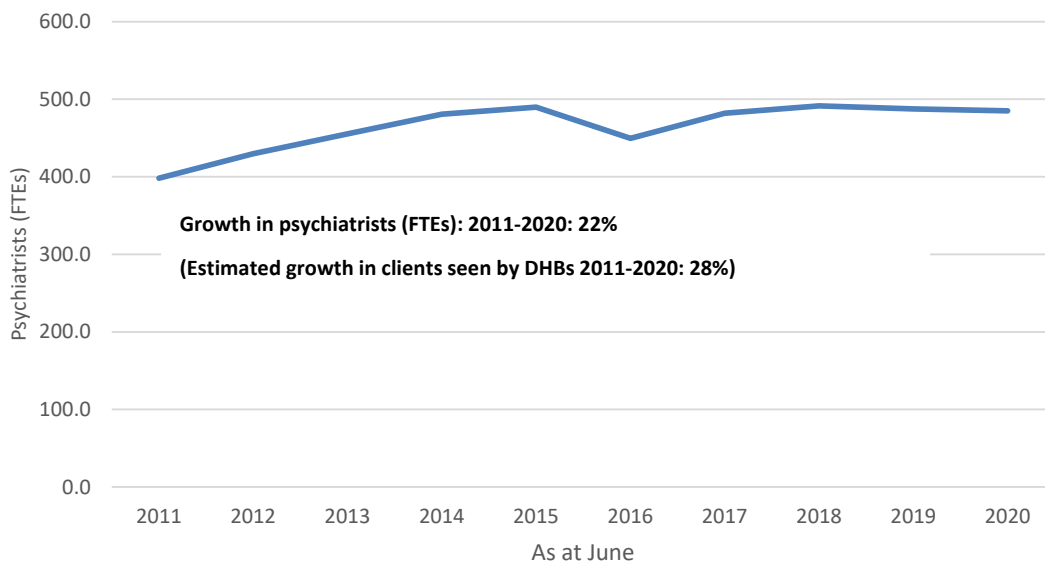
Figure 5: Clients seen per 100,000 population (age-standardised) by ethnic group, 2017/18

Mental Health and Addiction service capacity

Workforce: Psychiatrists

DHB data show the DHB-employed psychiatrist workforce (full-time equivalents, FTEs) increased by 22% between 2011 and 2020.¹⁰ Over the same period, there was an estimated 28% growth in service users. In both 2019 and 2020, the FTE workforce dropped slightly (Figure 6). Data from the medical register suggest the DHB FTEs may drop further in the year to June 2021 as there are fewer doctors practising in New Zealand with a vocational registration in psychiatry than in 2020. This may be in part due to Covid-19 travel restrictions and quarantine requirements in a workforce that heavily relies on overseas-trained doctors, or “international medical graduates” (IMGs)ⁱ.

Recommendation - Co-ordinate, publish and maintain a workforce census, sufficient to support high-quality independent expert advice to the Ministry on all aspects of MHA workforce policy, education, training and development, planning, and purchasing.



Source: Health Workforce Information Programme, TAS 2021; Programme for the Integration of Mental Health Data (PRIMHD), Ministry of Health 2021

Figure 6: DHB-employed psychiatrist workforce (FTEs) 2011 to 2020

ⁱ An international medical graduate (IMG) is a doctor who obtained their primary medical qualification overseas. This includes specialists who also obtained their vocational qualification overseas, and specialists who gained vocational qualification in New Zealand.

Sixty percent of psychiatrists practising in New Zealand are IMGs, and current indicators suggest that proportion could grow further. In the five years from 2015-2019, 78% of new psychiatrist vocational registrations were doctors from overseas.^{11 12}

While IMGs are critical to the New Zealand medical workforce – without them the system would not function – many do not stay long. Medical Council data show about a quarter are lost within three years of gaining vocational registration, rising to almost a third by the fifth year post-registration. However, there has been no evident attempt nationally to develop strategies or policies to improve retention.¹³

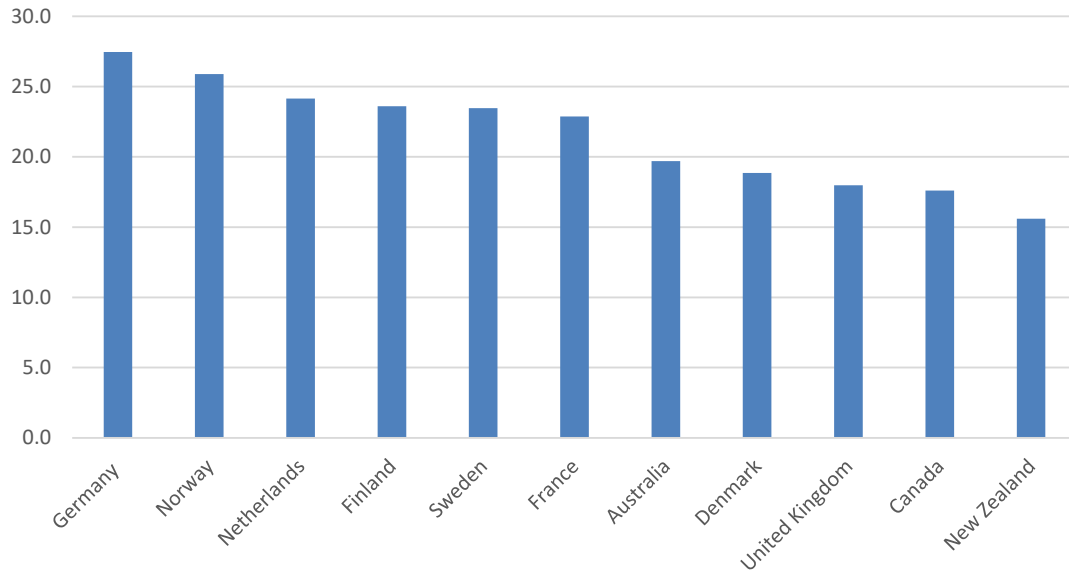
Recommendation - Urgently undertake more New Zealand specific research to understand the poor retention rates of IMG psychiatrists and to inform better retention policies and practices.

In addition, psychiatry is among the medical specialties where there are fewer registrar trainees to replace older specialists approaching retirement.¹⁴ Ministry of Health data show there were an estimated 308 psychiatrists aged 55 and over practising in New Zealand in 2020, compared with 188 registrars in training programmes (as at June 2020).

The international shortage of psychiatrists is well recognised, as are the common causes – under-investment in mental health services, growing service needs, an ageing workforce, high rates of burnout, and difficulties attracting young doctors into the psychiatric specialties.

A 2019 survey by the Royal College of Psychiatrists in the United Kingdom found one in 10 consultant psychiatrist posts were unfilled, leading to increasingly lengthy waiting times for treatment. Pre-Covid reports from Australia describe psychiatry as in crisis and “under siege”. And in Canada, again pre-Covid, the “critical shortage” of psychiatrists has led to “jam-packed emergency departments, long wait lists, stressed-out families, and burned-out doctors”.^{15 16 17}

While caution is always needed interpreting international comparisons, on the available evidence New Zealanders face even tougher barriers accessing psychiatrist services. Matched with 10 comparable countries, including the above, New Zealand has the lowest number of practising psychiatrists per capita (Figure 7).



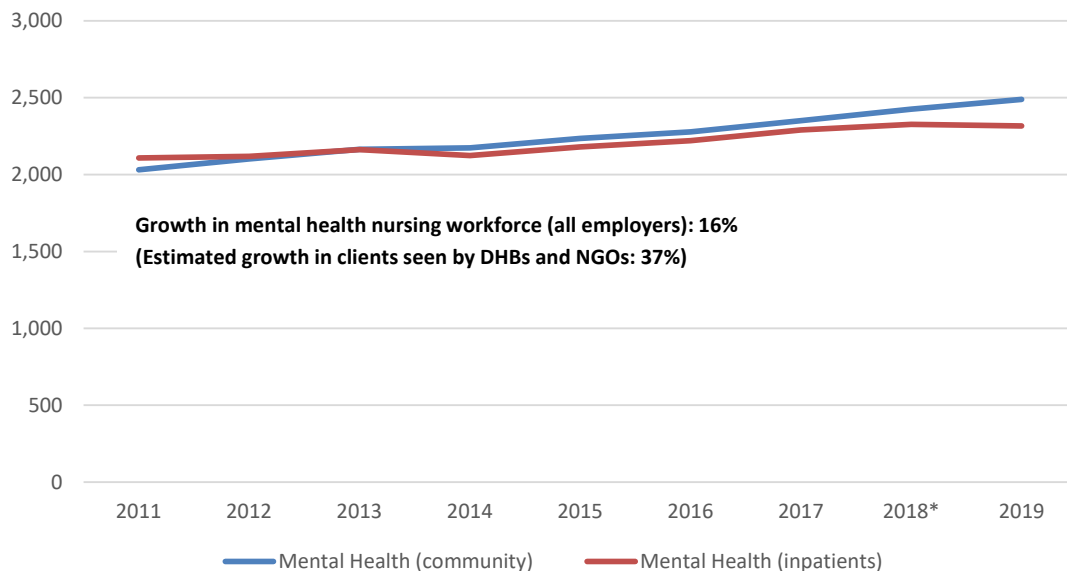
Source: Eurostat 2021; Australian Institute of Health & Welfare 2021; Canadian Institute for Health Information 2020; Canadian Post-Education Registry 2017-18; MCNZ 2018; Ministry of Health 2018

Figure 7: Practising psychiatrists (including trainees) per 100,000 population in 11 comparable countries

Workforce: mental health nurses

New Zealand Nursing Council data show the total mental health nursing workforce, including all employers and nursing scopes of practice, increased by 16% between 2011 and 2019 (Figure 8).¹⁸ The community mental health nurse workforce increased by 23%, and the inpatient workforce by 10%. This compares with an estimated 37% increase in the number of service users seen by DHBs and NGOs over the same period, though part of this growth may be due to improvements in NGO data collection.

Data (by occupational code) for DHB-employed nurses working in mental health is more limited. There appears to have been a change in data coding in 2015, but since then the growth in registered mental health nurses appears to have kept pace with the growth in clients seen by DHBs.¹⁹ However, other DHB data listing mental health and addiction nurses by “primary area of work” (PAOW), between 2017 and 2019, indicates the growth of total DHB FTE nursing workforce involved with mental health and addiction services over that two years has fallen behind estimated growth in service users.²⁰



Source: NZ Nursing Council Workforce Statistics, 2011-2019

Figure 8: Total nursing workforce (all scopes, all employers) working in community and inpatient mental health services, 2011-2019

Workforce: allied health practitioners

The FTE growth of the DHB-employed allied health workforce has similarly fallen behind the growth in workload. While the number of clients seen by DHBs increased by 28% between 2011 and 2020, clinical psychologists grew by 16%, occupational therapists (22%), and social workers (2%). Psychotherapist staff fell by 34% over that period.²¹

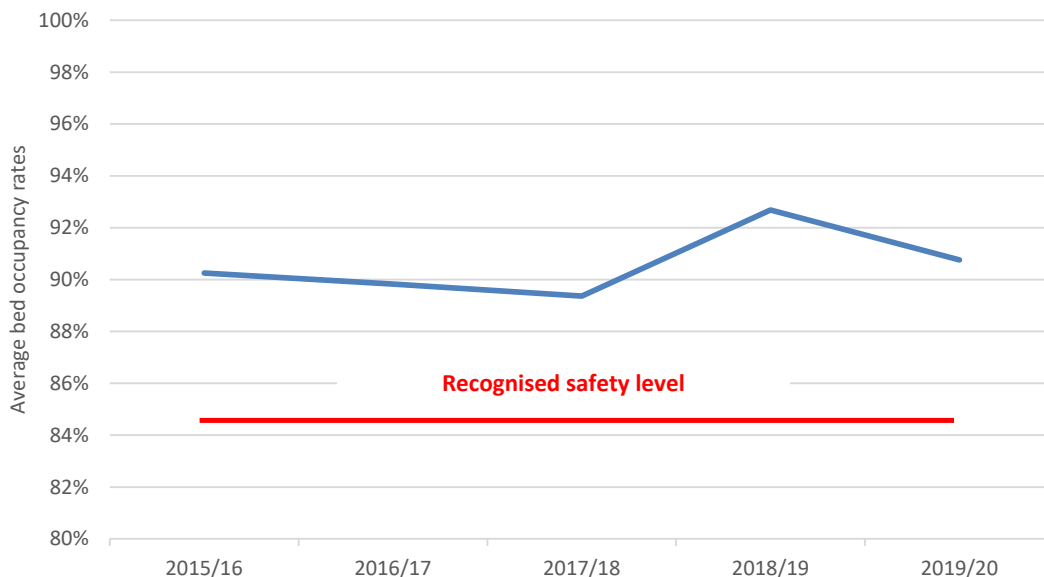
Inpatient bed capacity

Bed occupancy rates

The pressure on MHA DHB inpatient beds across New Zealand has led to average annual bed occupancy rates trending well above recognised safety levels (Figure 9). Average quarterly figures show DHBs frequently exceed 100% occupancy levels in any one year. A figure of 85% occupancy for acute hospital beds in general is often quoted as the ideal in balancing clinical safety and cost-efficiency, though the 82% to 85% range is considered by some to be the “absolute maximum occupancy” to maintain patient safety. The national average figure for Europe is around 77%.²²

Spare bed capacity is needed to accommodate variations in demand and ensure that patients can flow through the system. The UK’s National Audit Office has suggested that hospitals with average bed occupancy levels above 85% “can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections”.²³ One study identified that above 85% occupancy the probability of not being able to accommodate a patient increased considerably, rising by up to 19% probability at 100%.²⁴

Bed availability is closely linked to staffing, as well as funding, as beds cannot be safely filled without appropriate staffing levels.²⁵



Source: DHB Price Volume Schedules, 2021

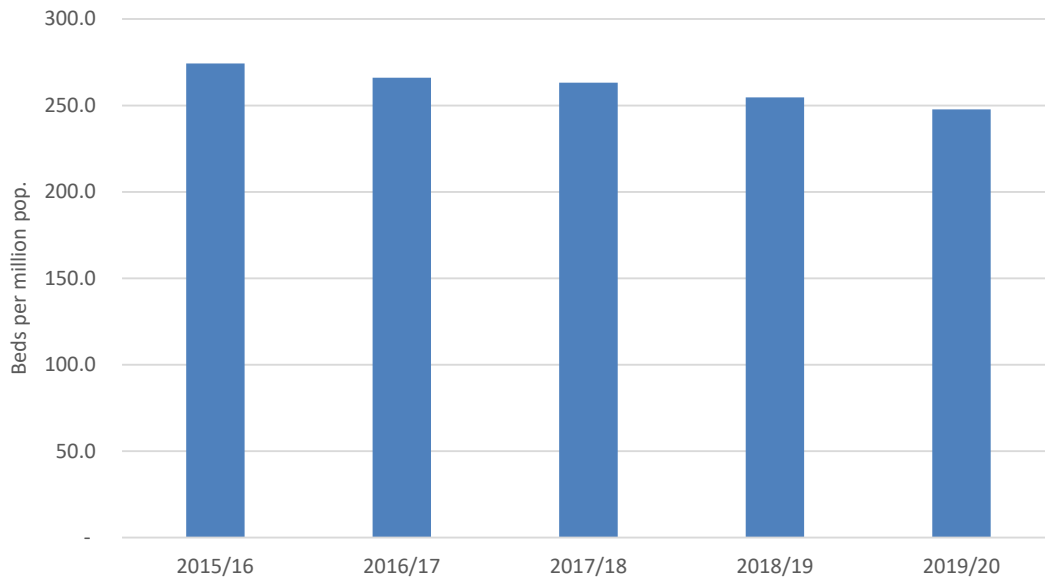
Note: Includes adult, child and youth, older people, forensic, inpatient beds; excludes community and residential beds

Figure 9: DHB mental health and addiction inpatient bed occupancy rates, 2015/16 to 2019/20

Bed numbers

Despite the overall number of MHA clients seen by DHBs growing well above population growth, and inpatient bed occupancy rates trending consistently above accepted safety levels, the number of available inpatient MHA beds per population has fallen by nearly 10% in the last five years. (Figure 10).

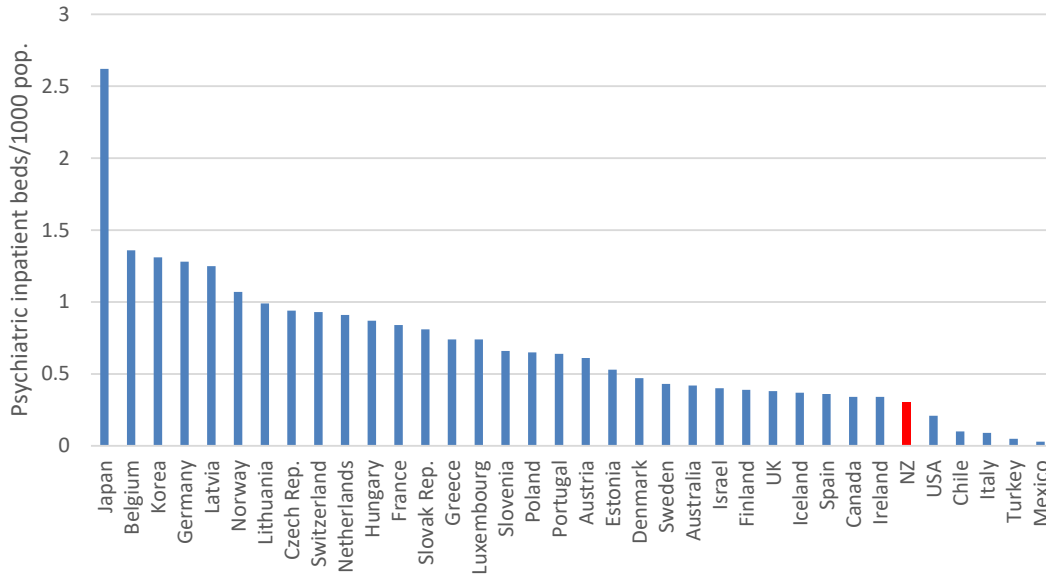
The number of psychiatric beds per head of population is among the lowest in the OECD. (Figure 11).



Source: Source: DHB Price Volume Schedules.

Note: 'Available' beds are beds that are funded.

Figure 10: MHA inpatient beds available per million population, 2015/16 to 2019/20



Source: OECD Health Data 2021

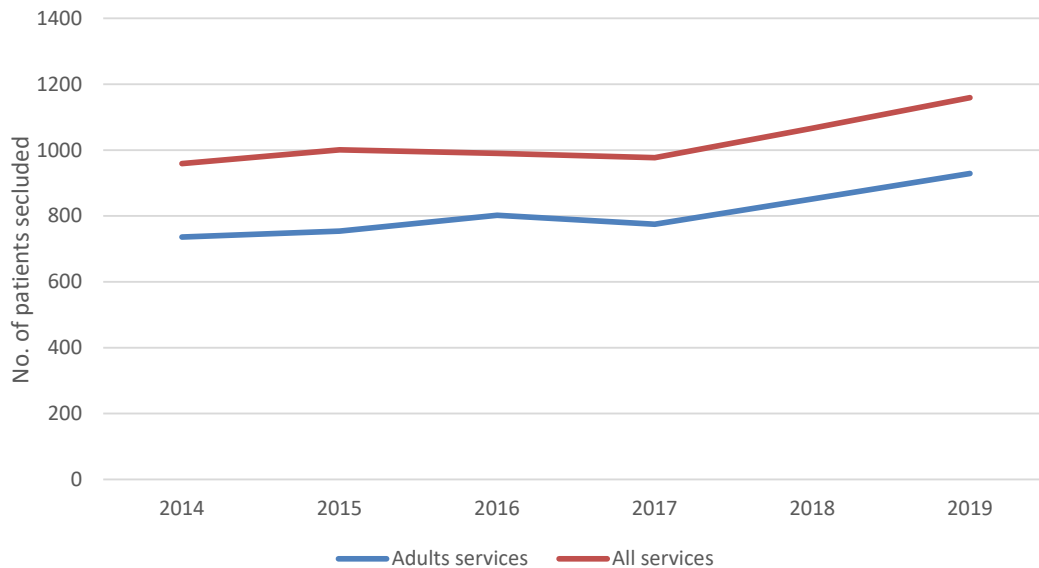
Figure 11: Psychiatric inpatient beds/1000 population, 2018 or nearest year

Seclusion

The practice of locking mental health clients alone in rooms – known as seclusion – is meant to be used only as a last resort to avoid clients harming themselves or others. The extent of the practice is an indicator of the adequacy of resources to handle acute cases. In 2015 its widespread use in New Zealand was condemned by the United Nations committee against torture and commission on human rights. However, despite the Government announcing a plan to eliminate the practice by 2020, it has continued to grow significantly.

Ministry reports show the number of people secluded – many of them more than once – increased by 21% between 2014 and 2019 (Figure 12). For adult mental health services, there was a 26% growth. The reports also reveal significant racial disparities: Māori are five times more likely to be locked up in seclusion rooms than other New Zealanders.²⁶

In August 2020 the Chief Ombudsman called for action to address serious and persistent issues at some of the country’s mental health units, including overcrowding, unduly restrictive practices, low-staff morale, and having people sleep in seclusion rooms due to a shortage of beds.²⁷



Source: Ministry of Health: *Office of the Director of Mental Health Annual Reports 2014 to 2019*.
 Note: All services include adults services, forensic, intellectual disability (ID) and youth services

Figure 12: Mental health patients secluded at least once, 2014-2019

Funding

DHB ring-fenced funding

The bulk of MHA funding is a ring-fenced portion of the overall DHB appropriation and is not included as a separate line item in the Budget documents. This funding is for specialist servicesⁱⁱ to meet the needs of people facing the most severe challenges, and is targeted to 3% of the population in a given year.

The Mental Health Commissioner has commented that the 3% target, set in the mid-1990s, was based on what was known about prevalence at the time.²⁸ In fact it was based on international studies, in particular a New South Wales estimate that services needed to cover 2.6% of the population, but that excluded forensic services, alcohol and drug treatment, and services for older people. A Ministry of Health report of 1994 noted: “Benchmarks would need to be reviewed as more information becomes available on where mental health services are needed”.

Four years later another Ministry report suggested an overall 5% access target for children and young people “in the light of new and better evidence of appropriate service provision”.²⁹ And an extensive national survey published by the Ministry of Health in 2006, using data collected in 2003 and 2004, found 4.7% of the adult population had severe mental health needs in any one year.³⁰ This is consistent with OECD estimates that around 5% of working-age populations has a severe

ⁱⁱAlthough these services are called ‘specialist services’, they are not provided exclusively by specialist clinicians, but include services such as community-based and respite care, as well as social support services. More than 90% of specialist services are provided in the community, either by DHBs or by other providers (especially NGOs) contracted by DHBs.

mental health condition.³¹ The New Zealand survey also found 42% of adults with severe mental health needs “did not make any mental health visits to the health sector”.

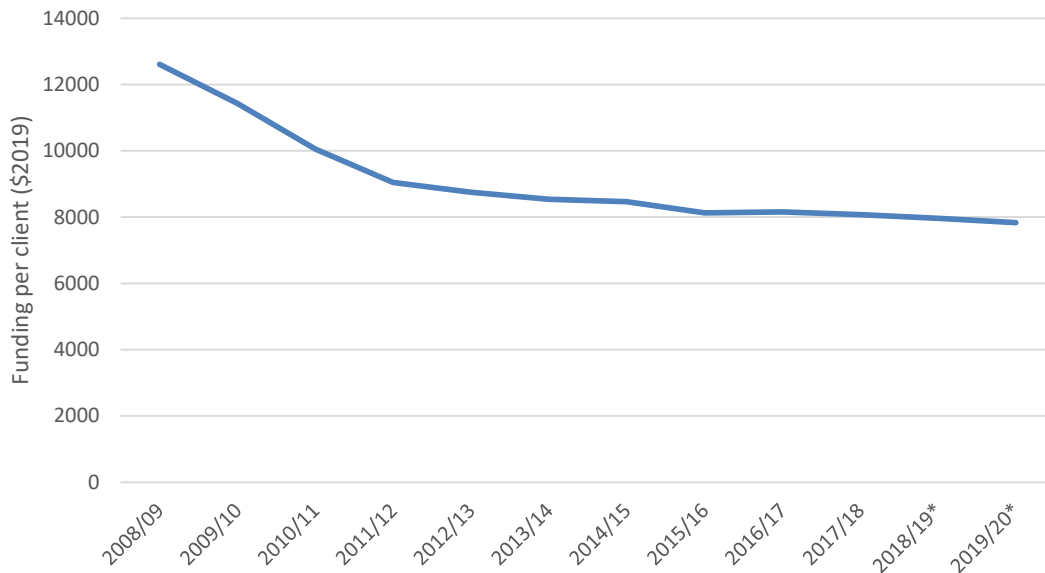
Recommendation - Urgently lift funding for specialist MHA services to cover 5% of the population and continue to ring-fence it.

Despite the new evidence that the funding benchmark targeting 3% of the population fell well short of meeting the needs, the benchmark has remained virtually unchanged.

The Ministry of Health’s submission to MHA Inquiry points out, “What the ring fence doesn’t do is ensure that the existing expenditure is sufficient. If the current expenditure is insufficient and it is scaled for population growth [as is the current practice], it would still remain insufficient. While the ring fence does mean there is a minimum investment (expenditure expectation), it may also have the unintended consequence of normalising or providing justification for an insufficient level of funding.”³²

When the Government announced new funding increases in the 2019 budget, mostly for community based services for those with mild to moderate needs, discussed below, it also announced a ring-fenced increase of \$213 million over four years (ie, an increase of \$53 million in the first year, which remained in place in the following years). However, figures provided to ASMS, which Treasury later advised in retrospect should have been withheld, indicate the increase (3.7%) amounted to only the usual annual adjustment for cost increases and population growth to maintain the 3% population target in real terms.

Given that the number of clients seen – including clients seen by NGOs contracted by DHBs – has grown well above population growth, the average funding per client in real terms has decreased by an estimated 38% between 2008/09 and 2019/20. (Figure 13). DHBs and NGOs will have also received a relatively small amount of additional annual funding from the “National Mental Health Services” budget appropriation, managed by the Ministry of Health, which will have had only a very marginal effect on the overall trend in funding per clients seen.



Source: Ministry of Health submission to the MHA Inquiry, 2018. Treasury (for 2018/19 and 2019/20 figures)

Figure 13: Ring-fenced funding per DHB & NGO clients seen, 2008/09 to 2019/20 (\$ 2019)

National Mental Health Services

Funding for “National Mental Health Services”, managed by the Ministry of Health, was the equivalent of approximately 8% of DHB ring-fenced funding in 2008/09 but was decreasing until 2019/20, when it more than doubled the previous year’s budget, and was restored to the equivalent of 9% of the ring-fenced budget. Much of this was in response to the MHA Inquiry’s key recommendation to provide more support in the community for those with mild and moderate needs. It included new funding to expand access to primary MHA services, and additional funding for specialist alcohol and drug services, suicide prevention, telehealth services, forensic mental health services and school-based services, among others. However, when assessing the cost of new or expanded services, the rising cost of existing services and population growth, the additional funding was estimated to be \$7.7 million short of what was needed.³³ While more funding was added in the 2020 budget, actual spending on mental health initiatives is falling well short of what was originally planned, with \$67.4 million spent by March 2021 – less than half of the \$145.3 million due to be spent by July 2021.^{34 35}

Recommendation - Continue the incremental development of services to extend coverage to people with mild to moderate needs, as recommended by the MHA inquiry.

Discussion/comment

It is well recognised that mental health and mental illness are largely societal and cultural issues and are not something for which health systems alone are responsible. While certain conditions may not be preventable, mental health issues are for many brought on by their environment, with the Covid pandemic an example.

Nevertheless, as one commentator put it, the common approach is to put mental health and mental illness into separate boxes and attempt to address mental wellbeing from the “disease end” rather than through the determinants of good mental health.

The point is emphasised in the 2018 MHA Inquiry:

People are unlikely to experience wellbeing if their basic needs – adequate food, safe environments free from abuse and violence, warm and secure homes, jobs and income – are not met. The stress and trauma that people experience from lack of appropriate housing, poverty, cultural alienation, family violence, racism and the impact of colonisation cannot, and should not, be addressed by mental health and addiction interventions alone.

The Inquiry report acknowledges these issues are not short-term or medium-term fixes, and so pose a political disincentive for investment. It observed: “The issue has always been that when resources are constrained, any changes in priority might result in a reduction of access to services for people with severe needs”. This has led to “focusing almost entirely on specialist services” while neglecting those with mild and moderate needs, referred to as the “missing middle”.

It overlooked a significant other issue, however. The evidence outlined in this paper strongly suggests there is another, even more serious, “missing middle”. These are the people who fall through the gap in specialist services because of funding aimed at covering 3%, when the evidence suggests it needs to be 5% of the population. It amounts to a 40% shortfall.

It is unclear why the findings of a major study in the early 2000s was not acted upon by any government since. The study found that under the 3% funding target, 42% of adults with severe mental health needs could not access MHA services.

The escalation in the number of clients seen by DHBs and NGOs since then may be partly a result of stretching the funding for 3% of the population to cover 3.7% of the population (as currently). That comes at a cost in the quality of care and a demoralised and burnt out workforce, as evidenced in many reports. And it still leaves significant unmet need.

While the Inquiry acknowledged specialist services were under “severe pressure and is unsustainable” it did not press for more funding for those services. The expectation was that with investment in prevention and early intervention, “demand for specialist services will reduce as issues are dealt with earlier, before they escalate...”

That comes with some ifs and buts, however. The issues around prevention are complex, benefits can take many years to be realised, and much more research and service development is needed to identify what works and what doesn't, especially for those with disproportionate needs, such as Māori, Pasifika and others in poverty or with low incomes. The Inquiry found that strategic leadership and coordination for mental health promotion and prevention are absent, as is the case for initiatives to improve wider social wellbeing. However, the Government rejected the Inquiry's recommendation to establish a new agency to take responsibility for social wellbeing within central government to provide strategic and policy advice and to oversee and coordinate cross-government action.

David Clark, then health minister, said the Government ruled out setting up a separate social wellbeing agency because that was a job for "all of government" ³⁶ which appears to miss the Inquiry's point that efforts to date have been fragmented and uneven. Prevention and early intervention activity can get crowded out by more urgent needs, especially in sectors with large operational delivery roles, and "clear strategic leadership is lacking in central government on wellbeing, prevention and tackling social determinants that impact on multiple outcomes".

Out of the 44 Inquiry recommendations and sub-recommendations, just 20 were fully accepted by the Government. Eighteen were "accepted in principle", so their implementation is open to interpretation; four were put aside for "further consideration", and two were rejected. Which raises the question of whether the Government's response ever matched the Inquiry's ambition.

The 2019 funding increase mostly aimed at improving services for the estimated 17% of the population with mild to moderate needs was widely lauded, including by the ASMS, though in perspective it means those services got about 0.8% of the health operational budget in 2019/20, rising to an estimated 1.2% by 2022/23. And as discussed above, actual spending has been falling well short of what has been budgeted. Not all of this can be attributed to delays caused by the Covid pandemic.

Perhaps the most important Inquiry recommendation, which was accepted by the Government, is to: "Agree that access to mental health and addiction services should be based on need". To do this requires gathering and regularly updating comprehensive information on need and on the extent to which the need is being met. The Inquiry's recommendation to that effect was agreed only in principle by the Government.

Given the last time such information was gathered, nearly two decades ago, showed almost 5% of the population had severe needs, and the prevalence of mental illness has continued to grow, updated information of need would most likely underline the inadequacy of current spending on MHA specialist services. It would also enable assessments of how well prevention and early intervention measures were working, and where further improvements – and funding – may be needed.

How the Government responds to this recommendation therefore could be a key litmus test of how much it is "Taking Mental Health Seriously", as it announced in its 2019 "Wellbeing Budget". It may also be a test of the Government's commitment to ensuring its planned new health and disability system works as intended. A critical component will be supporting communities, iwi and those working in the system to have a meaningful voice in the way services are planned and delivered. Up-to-date and freely available information on local health and service needs will be fundamental.

Conclusion

The best available evidence indicates specialist MHA services have been substantially under-funded for many years. In the meantime, the growth in service needs is continuing to outstrip the growth in service capacity, creating cumulative pressures on services which are unsafe and unsustainable. The government policy of supporting more prevention and early intervention measures is a positive move. However, the available evidence does not support the expectation that these measures will

relieve pressures on specialist services any time soon. Information is needed urgently to assess current specialist service needs, and to match those needs with appropriate funding.

Recommendations

- Urgently lift funding for specialist MHA services to cover 5% of the population and continue to ring-fence it.
- Continue the incremental development of services to extend coverage to people with mild to moderate needs, as recommended by the MHA inquiry.
- Develop and fund policies to promote high quality collaboration across the spectrum of MHA service providers and with the community.
- Regularly collect and report publicly on comprehensive local and national MHA service needs and the extent to which the need is being met. This should include a repeat of the Ministry of Health’s survey, Te Rau Hinengaro.
- Invest in research to acquire New Zealand specific data to inform cost effective policies and interventions.
- Co-ordinate, publish and maintain a workforce census, sufficient to support high-quality independent expert advice to the Ministry on all aspects of MHA workforce policy, education, training and development, planning, and purchasing.
- Urgently undertake more New Zealand specific research to understand the poor retention rates of IMG psychiatrists and to inform better retention policies and practices.

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