National Council of
Women of New Zealand
Te Kaunihera Wahine o Aotearoa

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Submission to the Government Inquiry into Mental Health and Addiction

Introduction

0.1. The National Council of Women of New Zealand, Te Kaunihera Wahine o Aotearoa (NCWNZ) is an umbrella group representing 245 organisations affiliated at either national level or to one of our 19 branches. In addition, about 350 people are individual members. Collectively our reach is over 350,000 with many of our membership organisations representing all genders. NCWNZ's vision is a gender equal New Zealand and research shows we will be better off socially and economically if we are gender equal. Through research, discussion and action, NCWNZ in partnership with others, seeks to realise its vision of gender equality because it is a basic human right. This submission has been prepared by the NCWNZ Education Convenor and the Parliamentary Watch Committee after consultation with the membership of NCWNZ.

1. What's currently working well?

1.1. There was an overall sense that the professionals in the mental health system were good at what they did, committed and caring, knowledgeable and competent. The proviso was that some of the worst experiences appeared to arise from professionals who did not listen or follow through. Likewise NCWNZ members acknowledged many good programmes that are operating, and were generally complimentary about the care received in these programmes and in residential facilities/ mental health wards – IF the person could gain access to these programmes or facilities.

1.2. The education system was perceived by many members as doing a good job of raising awareness of mental health issues, for example through teaching children how to share their feelings, anti-bullying programmes.

1.3. Similarly the media campaigns were mentioned as being effective in raising awareness and reducing stigma around mental illness, especially those involving high profile people.

1.4. The greater awareness arising from improved training of other service personnel such as the police was also highlighted as beneficial and useful.

1.5. Some examples from our feedback in answer to "what's currently working well?"

- The move in education towards supporting the development of emotional intelligence as opposed to traditional factual intelligence. Children are being encouraged in class sharing time to mention when they have felt sad, what they have done to overcome this, or if they have not, where they can go for help.
- The recent announcements from Government about more early assessment and intervention services, anti-bullying resource for 4-7 year olds and more funding for front line family violence services are very welcome.
- Treatment by professionals for inpatients (voluntary or compulsory) appears to be working well although there are insufficient beds to cater for numbers requiring in-patient treatment.
- Hospital inpatient care in most respects for the critically unwell. Some of the facilities are old but the professional care is very good.
- Dedication of staff and their determination to go above and beyond what they are actually salaried to do.
- The service providers are very good once you manage to get into the 'system'. This could be because of the training they have received and also because the individuals themselves really care about people. It's not just another job to them.
- For people who "know the system", know what to ask for, how to speak the right language, are confident and educated, it appears there is good service available. However, even highly educated people can struggle to be taken seriously, listened to.
- The television campaign (John Kirwen, ex All Black and other well-known personalities) talking about how to behave when relating to a mentally unwell person, is working very well and should continue. It is educating the public and reassuring them that mental illness, is like other illnesses, that there is treatment for and it is not something to shy away from or avoid contact with the person. It is making it easier for people to talk about their own unwellness or their families to talk about the nature of the illness of the family or whānau member, or the unwellness of friends. It has brought mental illness, into the light, and the campaign has meant that this is no longer a taboo subject, or something to be ashamed of.
- The current system where GP's have counselling services within their practice is working well. This is for the people experiencing mild to moderate mental health issues.
- The availability of Maternal Health Nurses in the MH services helps the women who have MH and addictions issues.
- There is a better response for people experiencing mental health and drug additions issues from the medical practitioners in our local DHB emergency department. It seems that the younger doctors and nurses have grown up with the media awareness campaigns concerning

mental health and they appear to have a higher tolerance for people presenting with possible medical issues that require investigations that also have identified mental health issues.

- We understand the NZ Police now ensure all front line staff have some knowledge of mental health and addiction issues. This is a good start but much more awareness needs to be developed and far more training given.
- In Tauranga there are some programmes to help those with addictions, but long waiting lists are a barrier to those motivated to change or choose to change. Programmes appear to be working well for more adults who are highly motivated to change, but accessibility and availability is a problem for young people.
- One thing which has impressed us is the co-operation and liaison between community support services [in Hawkes Bay]. While these services are not Health Board staff, they do receive government funding and, locally at least, are doing a lot of effective work.
- Drop in Centres – they work well for those attending due to their flexibility, the companionship and support they provide, closeness to assistance if required, and an ordinary environment (not medicalised).

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

2.1. The overwhelming perception of NCWNZ members was that the current mental health service has inadequate resources to provide much more than a crisis management service, and even that service is not always sufficient or immediate enough to meet the community's needs.

2.2. In particular, members' experiences show that there are not enough resources to provide effective early intervention and prevention, or enough support for the recovery phase and reintegration back into society.

2.3. NCWNZ members had many stories concerning difficulties in accessing mental health services. Barriers included stigma around asking for help, some bias or prejudice in the system, and difficulties for some people in expressing and explaining themselves as not everyone can be articulate about their feelings and thoughts. Other barriers were a lack of knowledge of where and how to get help, the high and unaffordable costs of some professional help, and a shortage of professional staff, beds in residential care and places on programmes, all leading to long waiting lists. In some areas there was a lack of suitable facilities, therefore the travel was a barrier.

2.4. Despite many good stories about the work the education system is doing, there was also a perception that more could be done. In particular there were many comments about the lack of professional staff available to schools, such as social workers.

2.5. There were a number of other issues raised by members. One was the experience of a lack of communication between professional silos, making an already-difficult experience more difficult. Support for the family and caregivers was also seen as lacking. Gaps in services were identified, particularly mental health services for autistic people and limited services for self-referred addicts,

and after-hours services that can cater to the specific needs of youth. A question was also asked about what happens to those people who are turned away from services because of a shortage of places. Another issue was the lack of segregation in residential care, where mixing potentially violent patients with others who need a safe space for recovery can be problematic.

2.6. Further, NCWNZ is particularly concerned with the lack of support for those people who do identify easily within gender binaries or heterosexual norms, and the mental health issues that arise for them. These people are overrepresented in statistics involving suicide and self-harm – an example of how gender equality is not yet a reality in Aotearoa NZ.

2.7. Examples of feedback received:

- We need far better staffing levels for mental health units so that when a person needs mental health care they can get it straight away and not wait for weeks. Insufficient staff appears to be one, if not THE critical factor in our present mental health care system. If this was addressed, we believe we would see vast improvements in mental health care.
- It is difficult to access in-patient mental health services by phone and it is difficult to access emergency services teams. Help does depend on a person explaining their symptoms strongly and clearly enough to the doctor to enable the GP to ascertain what level of treatment is needed.
- People the mental health services view as the "worried well" don't get any help – yet many from this group go on to commit suicide. People are constantly told to seek help if they are depressed or suicidal, but there is no help for the majority.
- People with communication/access barriers and cultural differences are pretty much shut out.
- When a crisis is happening the process around this for the patient and family is very difficult. Some crisis services are inadequate.
- There are insufficient professionals working in mental health teams. Those that are, are overworked and do not appear to have sufficient time to deal in depth with mental health issues. Some people are turned away with their needs being diagnosed as not meeting the mental health team's criteria. One member said that the only way her daughter was able to have the crisis mental health team intervene when the daughter was suffering from severe postnatal depression was for the daughter's doctor to tell the mental health team that if they didn't respond by 10 pm the doctor would arrange for the daughter to be committed. The team then responded.
- Some patients are being discharged back into their GP's care far too early and this has a detrimental effect on the full recovery of the patient. The premature discharge is often done because of lack of either bed space or to make room to respond to a new patient's needs.
- I have personally been told, when acutely unwell, that I would only be admitted to hospital for 48 hours. I was told that during that time, I was to write down what I was going to do to get well. And that in 48 hours I would be discharged, whatever state I was in.

- Our recent experience has shown a terrible lack of an ability to keep patients a bit longer and monitor properly a patient who is unstable. Services are only able to cope with the acute crisis stage. Our daughter was just let out on the street time after time after time only to have more psychotic episodes and overdoses.
- I have met few staff who actually express love and concern for their patients. It may be an unpopular idea – but love heals. Patients need staff they can trust – and staff who have time to listen. As a patient, I saw staff spending hours writing up patient notes. I was baffled as to what they would write about me each shift, because staff seldom had a meaningful conversation with patients.
- Some feel the mental health system is prejudiced and there are barriers due to criteria for treatments.
- There also seems to be a shortage of highly trained counsellors offering services for the mentally unwell or those addicted. The number of counsellors working in this area (Tauranga and environs) seems to be very limited.
- Although there are residential in-patient and residential services for mentally unwell people at hospital, residential and community levels, there has been a shortage of beds for considerable periods of time now, so people could well be sent home 'early' to free up a bed for more acute cases. It would be of support to those discharged from hospital to be followed up by DHB Community based social workers. Currently this service by social workers is not available [in Tauranga].
- There appears to be insufficient beds available. We believe the formula itself for deciding on how many beds are required needs reviewing especially in view of the increase in the number of patients with drug related mental health issues now being accommodated in the same unit as non-drug related mental health patients.
- There is very little prevention work being undertaken. Addiction services do not have enough residential treatment services and the MH service does not have enough supported residential services. There is not enough emphasis on the need to provide immediate professional services to pregnant women experiencing intimate partner violence.
- The removal of services in a central city location. These changes now mean the mentally ill are channelled through Accident and Emergency Departments. My son and I have been twice when he was suicidal and after three hours, being seen by the psychologist on duty, finally told that there were no beds , and imagine being suicidal and having to sleep on your mother's couch… and how do I cope? How do I stop him taking his life?
- Many places where people could stay to recover or be supervised with specialised care have vanished leaving people with inadequate support in the community
- Following discharge from hospital acute care, ongoing community support is not adequate due to the under resourcing of the community mental health services. Waiting times for psychiatrist

appointments and then ongoing psychologist support are many weeks, leading to people with mental health issues, and their families, being unsupported over this time.

- Professionals working in silos, not taking a holistic approach, not listening, crisis management instead of prevention.
- There is a lack of integration between health and justice e.g. Ministry of Education reports on self-harming and suicide are only available up to 2013 but Justice has much more recent figures.
- Groups providing services don't work together. This can be because of the competitive nature of winning contracts.
- The threshold criteria for support is just too narrow for entry into the secondary services for assessments and support and going to the GP for early prevention support is just too expensive for many living on the fine line of poverty.
- GP fees are way too high for most low income people to go to their GP with mental health issues until these are quite serious.
- Registered psychologists are expensive and do not advertise through our various media outlets, such as newspapers/newsletters/radio and are not accessible to those in poverty who may not have ready access to technology.
- There needs to be more education around the signals of mental health. Teenagers may use 'copy cat' behaviour e.g. self-harming because others do it. The seriousness is not being dealt with in schools.
- In Nelson there is no segregation of people once admitted to the mental health unit. As there is a wide range of mental health issues some patients find it really uncomfortable being in close proximity to patients with vastly different mental health needs. This adds to the stress of patients.
- Inpatient hospital care is quite frightening for anyone suffering from a non-psychotic illness like PTSD. Violent patients should be kept in a separate facility.
- I am very concerned that many mentally ill patients finish up in prison when they should be in a secure mental health facility.
- In Nelson the after-hours crisis mental health youth service is being integrated with the after-hours crisis service for adults. Understanding the mental health issues of youth is a specialist field and youth need access to those specially trained in that field.
- Some rest homes admit residents with diagnosed mental health issues, and the expectation is that the staff will be able to manage these people. However often the staff lack the skill required. Support from mental care agencies is often unavailable.

3. What could be done better?

3.1. Most of the feedback from members was around continuing and extending the things that were going well, or fixing the things that were not going well, for example more facilities, better training, the flexibility to stay longer in residential care if needed.

3.2. One theme that came out of the feedback was the need to listen more to the families. Sometimes families feel that they have a lot of information about the patient and ideas of what could help, but this is disregarded by the 'experts'. Further, their jobs as advocates are made harder by the lack of coordination within the system, and they are often left with no option but to look after their ill whānau member because there is no professional help. This leaves them scared, worried and angry. The message was to pay more attention to listening to, involving and supporting the families.

3.3. Another common suggestion was to make more use of 'Green' prescriptions and alternative therapies. The use of medication is often necessary but should not be seen as the only answer.

3.4. Some specific suggestions are listed here:

- A 'child policy' (e.g. Sweden) needs to be developed by the government, to ensure that children's needs are put before economic considerations and policy directives and their well-being is given greater emphasis. Every government policy needs to be assessed as to how it will affect the well-being and lives of children.
- As well as quality, adequate clinical and community-based services we need to look at the cultural, socio-economic factors that are the underlying causes of our mental health issues- e.g. why our young people are depressed and anxious; the mental health issues caused by poverty, family violence.
- The WINZ current system of financial support for psychologist appointments is good. There is a cap on the amount and the number of weeks' assistance is given. An increase in the amount of money given would be helpful as it only pays for half a session.
- A living wage benefit that allows them to have an income WHILE IN A PARTNERSHIP, so that they can contribute when they are unable to work, and have a chance at keeping their relationship viable.
- A different benefit structure or department with staff who are linked with the mentally ill who are receiving benefits, so that ill people don't have to negotiate constant doctor certificates to prove they are still ill.
- Early intervention at first signs of mental health issues with support for the person affected and family. Ongoing support with gradual reduction as independence recovers should be considered as a medical issue by professionals in charge rather than a funding issue.
- With regard to alcohol addiction the placement of alcohol in supermarkets is of concern – the addict often has to walk past alcohol each time they enter a supermarket.

- Schools are encouraged to 'round the person' - socially, mentally, physically with 'caring' attributes, where personal worth and self-esteem is developed, and this is rewarded – with less emphasis on academic achievement and rating value for the school Board/Principal/staff. No doubt many schools are doing this already, but it must be maintained.
- The roll-out of social workers in all schools, and even early childhood centres and kōhanga reo, regardless of the 'decile rating' of the school.
- School needs to be a positive experience which for some will require more teacher support/aids.
- Work out a better strategy for schools to deal with 'bullies.' At present, it seems that their practise is to only focus just on keeping the victims safe, for example - restricting their freedom of movement to teacher monitored areas of the school. More needs to be done to challenge and change the behaviour of the bullies. [NB: NCWNZ is also concerned about cyber-bullying, which particularly affects girls and LGBT+ people. This comment could equally apply to that specific situation]
- Removal of student loan debt for those who are mentally ill and will never be able to complete their studies.
- Support for a gradual return to work, through having carers who specialise in gaining access to and supporting the mentally ill, and employers with taking on and facilitating a person with mental illness. Many employers are mis- or uninformed and totally fail to provide training or basic support.
- Suicide prevention - Suicide prevention strategies of government made known to the public.
- More specialist people need to be readily available to assist suicidal people seeking help. We hear from time to time of suicidal people seeking help but being turned away often because of staff shortages. The results are often drastic.
- Help needs to be available in consumer-friendly centres, where those at risk can go without an appointment. The wait between asking for help and getting it (if you get any help at all) is way too long.
- Hospital services are only provided for acutely unwell people, yet there are many who are overwhelmed. Just not coping at all. There need to be respite centres where people can get help and time out.
- Residential facilities for women and their babies who are identified with Mental Health and Addiction issues to learn how to cope with the illness/addition and their child. Plunket nurses to be able to home visit for a longer period such as the first 6 months. More support for whānau who have their adult children who experience MH and/or addiction issues who are living in their parents' home with their own offspring.
- Hospital facilities need to be seriously upgraded.

- Should there be special hospitals (not just units as part of a hospital) for the care of mental health and addiction patients? Such hospitals could have a range of recreation facilities such as gym, swimming pool etc. It is a pity that Hanmer Hospital which was used for addiction treatment and care lies empty today.
- Prisons need specific addiction units, run as a therapeutic community which take an Alcoholics Anonymous & Narcotics Anonymous approach.
- Encourage the person to allow close family members to be notified when the person is displaying mental health difficulties.
- Increase the involvement of family in the assessment and development of ongoing treatment and care. The help determined should not just be based just on the assessment of the person suffering. The family need to be consulted as well. One respondent said. 'The hospital constantly refused to help my ... until he attempted suicide three time. They kept saying he had passed their assessment so no further action was necessary'.
- Those treating mental patients must start to listen to families. There is a desperate need for monitoring a patient until they are stable and able to be safe in the community. These things are not happening. And we have become so tired in trying to get out message across to those who have treated her.
- Some cognizance should be given to grandparents and other older members of the community who look after grandchildren or other children. Sometimes these older people find it rather difficult to grasp all that is going on with young people particularly in relation to looking out for signs of possible mental and addiction issues.
- Follow up from treatments for major treatments such as cancer. I know of several people who have suffered from depression in such instances. They were told they had mild depression and given medication from a specialist, but not referred to mental health professionals. Such a referral should be a given if depression medication has been prescribed.
- More psychological help as well as psychiatric. Less emphasis on medication.
- Articles on television and radio and in the newspapers need to be balanced so that positive good news is included, currently it is all bad news.
- Corporate sponsorships readily available to students and academics to research into strategies that work in Aotearoa New Zealand, especially for Māori but not exclusively.
- An amendment to the Health Practitioners Act, such as a Limited Registration for Volunteers, IF work alongside GP, NGO staff, Health staff, and, who take overall responsibility as Supervisors, with a written contract with all agreements defined.
- TV and computer programmes have the ability to encourage people to accept bullying, particularly subtle forms of bullying, as acceptable. This can lead to suicide issues and mental health issues for the victim.

4. From your point of view, what sort of society would be best for the mental health of all our people?

4.1. Members often listed the values that they would like to see prevalent in society, especially kindness, respect, equity and acceptance. These were seen as fundamental values that needed to underpin our society to promote mental health.

4.2. A society that would be good for mental health was seen as one where there was acceptance of mental illness, and no more stigma attached to mental illness than to physical illness.

4.3. A collective approach to mental health was advocated. Members talked about helping and supporting each other in society, being inclusive and creating sense of belonging, so that no-one needed to feel isolated and alone.

4.4. Working through whānau and families was seen as a basic approach to good mental health. Within this approach, there was a very strong message that NCWNZ members felt that a society that wanted mentally health adults needed to ensure that children were cared for and nurtured properly.

4.5. Some examples:

- Our society's **principles** ideally should be caring for each other, adults taking responsibility for our own actions as is possible, respectfulness (e.g. modelled in Parliament and by civic leaders), fair and just use of power and social justice (equality, equity, justice, fairness and equal distribution of resources).
- We would start with fundamental human values of respect, equality and acceptance. This would be best reached to everyone through education.
- We need to be more kind, compassionate and stop blaming others for their predicaments.
- Emphasis on kindness, fairness and appreciation.
- A society that views mental health issues as just another health issue like high blood pressure.
- Inclusive. A society that accepts, acknowledges and values mentally ill people as people first. A society that understands that this is a period of someone's life where they need love, practical support, and most importantly … a society that believes that we are not defined by what goes wrong… with our minds and emotions, but that we are bigger than the illnesses and that we are valuable and contributing even when ill.
- Everyone living in a situation where they are valued and have a sense of belonging. People naturally want to be part of a group but many of our organisations and institutions particularly homes for elderly are very large and don't engender a sense of belonging. Instead people feel isolated, lonely and lack companionship.
- Volunteering needs to be encouraged by the local and central government, as helping others can support 'good' mental health for those volunteering and contribution to society.

- Ideally **value systems** should centre around the early lives of our children and working to ensure their stable attachments to family, whānau and community in which they live. Value systems must include protection for the most vulnerable groups of being hurt, in society.
- My ideal New Zealand would start with children being kept safe. Most adult mental health issues have their roots in childhood. Schools need nurses and counsellors. Behaviour problems need to be taken seriously from pre-school. Families need support.
- Start with the tamariki of the whānau. The preschool children need to begin their life journey with support and with the ability to experience opportunities as they grow up into adult hood. The whānau's wellbeing strategies or lack of need to be recognised and the children need support have their self-worth lifted through their schooling. The children need to have opportunities to experience life changing events such as sport, art and drama, IT and travel, free subs for all of these.
- Acknowledge that people thrive best in a functional family environment, whatever form that takes, supported by a close community of family and friends and living in a community which has sufficient resources to support the family in all of the areas noted in the first point. Encourage a 'collective responsibility' mentality to pervade all of the community systems in order to ensure that families can thrive, belong and contribute to their community, and every person is able to develop to their full potential.
- There is not enough support for families of the ill person. Family therapy can be very useful and needs to be more available. Support needs to be more ongoing. Families are not always listened to.
- In all of the numerous stays, visits, appointments… only two carers have ever asked me how I was coping… a full time job… a son out of his mind… a divorced spouse who made things worse… a Nurse at Wakari actually spoke to me, as a person who's insight she valued, she and the Staff at Aspiring House, I felt they were on my side, but there have been and are some really terrible experiences with the professionals in this field.
- An ideal healthy Aotearoa New Zealand society will sanction extensive education systems in prisons focusing on education and counselling for addictions, depression and countering anxieties that are out of control or irrational. Our society would move away from the punitive model of punishment for crime, which research suggests does not work and never has. There are people who need to be in prison for the safety of the community, but far too many young men and women are there and exposed to new learning from some other prisoners. The criminal justice system needs an overhaul and greater use needs to be made of mediation and restorative justice systems.
- Spiritual needs need to be catered for. There need to be Bibles and Christian books available. The patients need to have visits from the chaplain and be able to attend church services in hospital.

5. Anything else you want to tell us

- The Inquiry needs to listen to patients. The professionals are equipped to make submissions, but patients are the ones who can tell you the real state of services.
- I hope the professionals are listened to as they certainly need a great deal of support and more resources to cope with an ever increasing demand for their services.
- Stop calling places of recovery 'institutions.' Yes, places are required for a healthy recovery process but an appropriate name for such a place needs to be selected with care and consideration of the people who will need this help.
- I think there is confusion about the connections – if any – between mental health and addictions.

6. Services specifically named as effective

- It is believed that there is a programme on "How to be happy" available for those suffering from or feeling depressed but promoting such a programme for those with ready access to on-line technology, would be a worthwhile exercise.
- The rural networks and support systems available through Federated Farmers appears to be working well, but greater promotion may also benefit those who are socially and geographically isolated.
- Workbridge is an organisation which supports people into employment and follows up with support for both the employer and the employee.
- Early Intervention Psychosis Services, such as Aspiring House, under the leadership of Jackie Lodge. Losing the counselling Jackie Lodge provided continues to take its toll… we have no money to pay for a weekly or fortnightly counselling session… he now only sees Dr Adams for 30 minutes twice a year…
- Addiction services CADS in Auckland have been marvellous over many years with treating and supporting our daughter. I would dearly like them to have the resources to help more people.

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