Barriers and drivers in mental health services in New Zealand: current status and future direction

Vidit Kulshrestha and Syed M. Shahid

Abstract: In New Zealand, mental health issues have created a 'silent epidemic' with diverse consequences in mental health outcomes. Poor mental health state along with inequities to access services are persistent. Key areas of mental health promotion in New Zealand that require constant attention are appropriate policymaking, reaching out to all communities, interventions at the individual level, and the complexity of the mental health system. This commentary evaluates the inadequacies faced by the public in accessing mental health services and the directions to improve in the future. It also reviews the New Zealand government's 'Like Mind, Like Mine' program, aiming to provide socially inclusive services to people to live a life free from mental health-related stigma or discrimination.

Keywords: mental health, barriers, drivers, New Zealand

Introduction

Mental health (MH) disorders account for around 16% of the burden of global diseases affecting 10–20% people worldwide. The World Health Organization (WHO, 2021) noticed that the promotion and protection of MH can improve quality of life, strengthen human capital, contribute to socioeconomic development and lead to a more equitable world (1). It is strange to see that MH promotion is disregarded as a part of various health promotion initiatives worldwide (2).

MH promotion has a key role in understanding and improving the determinants of MH and is also reflected in two of the five key strategic principles in the Ottawa Charter, which are 'Strengthen community action' and 'Development of personal skills' (3). The level of morbidity due to MH was 5% in 2011 and rose to 14.5% in 2018. Only 69% of people reported good emotional wellbeing, and around 23% of people reported having symptoms of depression and stress (4).

In the Mental Health and Addiction System in New Zealand (NZ), the Ministry of Health (MOH) plays a key role in strategic planning and regulation. Implementation and delivery are the functions performed by the MOH, District Health Boards (DHBs), non-governmental organizations (NGOs), community groups, primary healthcare departments and hospitals (5,6). This framework includes MH nurses, psychologists, counsellors, general practitioners, social workers, peer support workers, and youth workers (7). An annual budget of around $1.4 billion in 2016/17 is provided by the public sector. Around $30 million in services are allotted for people who experience normal levels of care termed as 'primary MH service' and comprise purchased services; and activities, like workforce, promotion, etc. are funded by MOH and receive around $100 million annually (8). The system is insufficient in its purpose and focuses on illness when it is diagnosed, but the demand is to develop a system that not only responds but helps to prevent MH and addiction, is available for early diagnosis, and helps in mental and emotional wellbeing (9). The system is

School of Health & Sport Science, Eastern Institute of Technology, New Zealand.

Correspondence to: Syed M. Shahid, School of Health & Sport Science, Eastern Institute of Technology (EIT), Auckland Campus, 238 Queen Street, Auckland 1010, New Zealand. Email: sshahid@eit.ac.nz

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complex and has various segments to it which leads to misperceptions and there lies a lack of leadership, with growing pressure of concerns about the poor funding of the system and its impact on the quality of services and inadequate workforce (10,11).

This commentary evaluates drivers and barriers to access MH services and the state of MH promotion in NZ with an emphasis on the Mental Health and Addiction Workforce Action Plan 2017–2021 and the future of MH wellbeing in NZ (12).

Barriers to access to MH services in NZ

Challenges to access MH services due to long delays, overburdened workforce, lack of information and awareness, and unusual scenarios for the mental health professionals are observed (5). Lack of timely and effective services which are appropriate due to the unavailability of a 24/7 service initiative, are evident (7). Around 40% of cases had a wait time of 0 days and were addressed on the same day, whereas around 42% cases had to face a wait time between 1 day and 3 weeks. Also, 6% of the cases had to face a wait time of 57+ days, which can prove to be fatal in some cases and is an issue of concern (2).

Patients who received medical treatment termed the services as unfit and did not consider the social determinants of mental well-being like discrimination, education, employment and housing, inequity, life condition, and violence (7). The care that was provided to them only included a prescription and poor timely options for service. People also felt the lack of counselling services, peer-services, addiction services and trauma related services (6). They had to face difficulties in making an informed choice from the complex and multifaceted services available. There has been stress in families searching for MH services for children but facing disappointments due to limited options. The percentage of services that are available to different communities are observed as significantly different and related to the psychological distress faced by the community due to lack of access (2).

A definite gap exists between the MH system for people having mild to moderate or high levels of mental illness. The general practitioners are unable to refer the patients to further diagnosis with the counselor, DHB, or social support due to unavailable levels of services (7). There is a lack of motivation amongst the workforce to help the patients recover and be mentally well in life and this has been a continuous concern raised by the whānau, general public, and NGOs. Rural residents with mental illness had to face severe challenges to reach out and access services or consultation (6).

MH promotion trends and shortcomings

Health promotion is important and includes strategies to support people, help them adopt healthy ways of life, and create an atmosphere around them to foster the best MH status (13). Gender and ethnic inequalities in MH issues are not new when we talk about NZ. Between 2002–2019, studies reveal that mental illness has doubled in females as compared to males and holds true for Māori and Pacific females. Collectively, depression and psychological distress in people has increased with a sharp increase in female rates of 37% compared to a 15% rate in males (1). Reports also suggest that a social gradient is present within people from high areas of deprivation having 30% mental illness as compared to 23% in medium and 17% in low deprived areas. In ethnic groups, Māori people have higher case levels reported for mental illness and related disorders with 30% and 24% for the Pacific population (9,10).

Various strategies have been developed in order to address these persistent inequalities and poor state of MH in the country by the NZ government. These policies include the National Mental Health Strategy (2016), National Mental Health and Addiction Workforce Action Plan (2017), Kia Tu Kia Puawai (Health Funding Authority), and other associated action strategies (10).

There is an ongoing debate within the healthcare sector regarding the sudden rise in mental illness and the inadequate potential of the MH services to meet the needs. Public health approaches that revolve around the NZ population are urgently needed and remain the key area that has been untouched in order to provide mental wellbeing. In the past, funding and other resources for MH services have been overburdened, to which the newly developed NZ Health and Addiction Wellness Action Plan (NHAWAP) 2017 brought a new ray of hope (14).

'Like minds, like mine': facts and evaluation

To encounter the challenges in accessing the MH services, the government is working towards health promotion, prevention, and destigmatization of MH (10). Various programs, such as the 'Like Minds, Like Mine' program, 'National Depression Initiative', 'All Right NZ?', and 'Getting Through Together' (for Covid-19 related response) are conducted. With the 'Mental Health and Addiction Service Development Plan 2012–2017' as the base, the Mental Health Department is putting efforts to consistently provide MH services across the nation and to all communities (14). It includes mass media promotion and community action support, which sets guidelines for the delivery of MH services and directs the fight against mental illness (15).

The 'Like Mind, Like Mine' program promotes the wellbeing of NZ people who face issues of MH-related human rights and inclusion issues. This program revolves around three key MH promotion initiatives of NZ, the NZ Suicide Prevention Action Plan 2013–2019, the PM's Youth Mental Health Project and the National Depression Initiative (14). These programs aim at the communities acquiring better results for people facing mental illness, but the 'Like Mind, Like Mine' program is distinguished from them because its main aim is social inclusion, not just prevention, promotion, or treatment (15). This program has been working to involve and promote attitudes and strong structure in NZ's MH environment. The 'Like Mind, Like Mine' program also includes 'Think Differently' which is a movement to provide fundamental support for better attitudes and behavioral change in people coping with mental illness issues. This plan also had significant economic benefits for the country's economy and around $720 million has been spent annually for its implementation (15).

There is currently no major evidence to show that people with mental illness are socially included everywhere and that there is an increased rate of social inclusion (16). The biggest barriers in the implementation of the 'Like Mind, Like Mine' program include social stigma and discrimination for people who face mental illness (17). Data shows that individuals having symptoms of mental illness have had to face severe economic issues, social inclusion, and income issues. Adding to this, younger people facing mental illness were severely affected in comparison to older adults (16).

The 'Like Mind, Like Mine' program will have to work towards MH services to attain the leadership goal, services for affected individuals, and flexible MH system (10). This would be a move towards changing the MH wellbeing for all communities and change the NZ society in an innovative manner ensuring wider access (18).

Conclusion & recommendations

Visible gaps in NZ's MH promotion initiatives requiring hard work and strategic planning are identified. The effectiveness of the 'Like Mind, Like Mine' program must fill the gaps to improve its impact. The MOH has developed strategies to a considerable level contributing to MH and wellbeing, which clearly reflects the response to counter the Covid-19 pandemic. Upgrading of the support and services for people with severe MH issues is urgently needed to engage all communities. An action plan towards equitable, timely, and appropriate treatment for all, urban and rural populations, removing the stigma and discrimination related to MH, and development of workforce, models, and service delivery, is suggested.

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ORCID iD

Syed M. Shahid https://orcid.org/0000-0003-0185-9362

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