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Rethinking New Zealand's Approach to Mental Health and Mental Disorder: a whole-of-government, whole-of-nation long-term commitment

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This is a shorter form of the narrative provided to Ministers in late May 2017. Both this and the longer form of the discussion on mental health were prepared at the request of Government by Professor John D. Potter (Department Science Advisor, Ministry of Health), Sir Peter Gluckman (Chief Science Advisor to the Prime Minister), Professor Richie Poulton (Departmental Science Advisor, Ministry of Social Development), Professor Stuart McNaughton (Departmental Science Advisor, Ministry of Education), and Associate Professor Ian Lambie (Departmental Science Advisor, Ministry of Justice). A separate paper on youth suicide developed from the same project was released as a discussion paper on the 26 July 2017 and can be found at <http://www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf>.

The Challenge We Face

1. In New Zealand every year, one in five of us experiences some form of psychological distress or develops a diagnosable mental disorder. These numbers are increasing and will continue to do so.
2. Many people in psychological distress fail to recognise this for themselves and fail to be identified by others as needing assistance. Often mental disorders are recognised only after they become severe and consequently harder to treat. Indeed, half of all lifetime cases of mental illness begin by age 14 and three-quarters by 24.
3. The current system does not work well because there are not enough services for those of us in need and they do not necessarily work for all of us who need them. And the system will not, as it is now, prevent these numbers from increasing. We need new thinking and new organisation around mental health and mental disorder
4. The numbers are increasing because the lives of many of us are becoming more stressful as a result of very rapid changes in the way we live our lives, including urbanisation, demographic change, and digitalisation. For too many of us, urbanisation means a greater risk of isolation. Increasing reliance on digital media and communication systems often results in less human contact and, perhaps paradoxically, greater vulnerability to bullying and shaming by others – a particular problem among children and adolescents. At the same

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time, there have been major changes in the structure of society that also create adjustment stresses.

5. As a nation, we need to understand much better that psychological health is not just the absence of mental disorder. Rather, mental health is a robust state to be grown and nurtured in children – even from the time of conception – by parents, whānau, schools, and the community. Then it needs to be sustained in adults by our own practices and capacities, by the nature of our community and society, and by the support of those whom we love and cherish.
6. We need to understand that although apparently different kinds of mental disorder have different names, the nature of the disruption of our psychological wellbeing and mental health is not as different as official diagnostic manuals suggest, although it certainly can present as a mild, moderate, or severe disorder. It has become clear that, across the human population, there is a core underlying variation in our resilience and vulnerability to stresses.
7. Within that overall vulnerability some of us show a tendency to become depressed and anxious (called ‘internalising’ disorders). Others of us show a tendency to act out (substance abuse problems, attention deficit hyperactivity disorder, conduct disorder – collectively called ‘externalising’ disorders). Still others of us show a tendency to thought disorder (psychosis, bipolar disorder). This last group is the smallest but it is the one often associated with the greatest individual need and the greatest distress for the affected individuals themselves and their families and whānau. What this underlying vulnerability means is that we must pay much greater attention to an overall human-centred approach to treatment rather than simply push people into specific categories and give them specific labels. It also reinforces the need for early detection and early intervention.
8. All of this represents a huge burden in human suffering and financial cost. Ultimately it touches and affects everyone.

An Effective Response

9. There will always be stresses in our lives and some of us will be at greater risk of succumbing to these than others. What we need is a three-fold approach that involves:
 - a. working to reduce those stresses across the community;
 - b. working to increase the psychological and emotional resilience of individuals, family, whānau, and community; and
 - c. revitalising and upgrading therapeutic services so that they match the needs of those with mental disorder, both mild and more severe.

10. The social investment approach has considerable potential to assist with all three approaches. Combining science with citizen-based analytics allows us to better identify those factors in the environment that play a major role in driving stress and this may vary greatly across our diverse communities. Firstly, the social-investment model allows consideration of multiple dimensions, including socioeconomic, housing, and demographic factors, education, physical health, employment, physical location, ethnic and migrant status, and interaction with the justice sector. All of these have a part to play in the context of mental health and coping with stress. The social investment strategy can also, over time, allow us to consider and evaluate strategies that will promote psychological and emotional resilience (e.g., establishing what kind of early childhood and school programmes have the greatest benefit – and for whom). Finally, this approach will allow us to better evaluate what services are most effective and under what situations, for those with mild, moderate and severe disorders.
11. We need to deliberately plan for and have distinct programmes to promote mental health and individual psychological resilience on the one hand and to enhance the early identification and treatment of mental disorders on the other. These two aspects operate on distinct time frames (the former over decades, the latter over weeks and months) and need quite distinct strategies. However, if they are not developed together, the burden of mental disorder will become overwhelming, not only for the affected individuals but for the population of New Zealand as a whole. We need to build a holistic, people-centred resource and service. We cannot focus only on treatment.
12. The rethink/revitalisation will need to involve not just the Ministry of Health but also the Ministries of Social Development, Education, Oranga Tamariki, Social Housing, and the Police, Ministry of Justice, and Department of Corrections, among other agencies. It will involve not just government but also the complete range of relevant resources across the community: iwi, non-government organisations, volunteers, churches, community groups, etc.
13. We must markedly increase our ability to identify early and treat early mental illness in adults, adolescents, and children. Treatment should be recovery-focused, non-stigmatising, community-based, and flexible.
14. At the same time, we must focus on reducing this burden for future generations by instituting a completely integrated, evidenced-based, wrap-around mental-health promotion and mental-disorder prevention programme from conception to early adulthood.
15. The most useful way to build a new, functioning system is to start with the notion of the 'life-course'. The life-course considers that the development of each of us has stages and mileposts: from conception to adulthood and then further through adult life.

16. What using the life-course as a framework allows us to do is:
- a. understand that what happens early in our life has an impact – for both good and ill – on our future mental (and physical) health;
 - b. appreciate that there is an optimal time for each mental and physical developmental period for at least the first two decades of life (as well as, in a less marked way, for the rest of life);
 - c. acquire early evidence when expected and optimal development – mental and emotional, as well as physical – does not occur;
 - d. intervene early to support, nurture, and encourage those different aspects of development;
 - e. understand that transition points (early childhood education to primary school, primary to secondary school, school to the workforce, etc.) can be particularly stressful and need careful navigation and support;
 - f. appreciate that, although on-time development and early intervention are more effective, any time is appropriate for the alleviation of emotional pain and the acquisition of new life skills.
17. Starting in the preschool and primary years, developing resilience in the face of the inevitable stresses of growing up and promoting development of impulse control is important not only for maintaining an even keel through childhood and adolescence but have broader benefits for educational achievement, employment, family stability, and quality of life generally. Early childhood is an important opportunity for beginning the acquisition and practice of these skills and should be an evaluable focus of all early childhood and primary-school education. There needs to be the most intense engagement among the most vulnerable families in the first years of their children's life. Well-defined activities in the primary years contribute to enhancing self-control and resilience and reducing later adolescent suicidality as well as other unwanted behaviours.
18. Suicide among young people often has drivers that are often different from those that provoke suicide at older ages. Māori youth appear to be particularly at risk. Many young people have suicidal thoughts and some commit self-harm. Among young people, although there can be an underlying mental disorder, suicidality more often represents a lack of resilience, diminished self-control, increased impulsivity, and exaggerated emotional responses in the face of inevitable stressors. For young people right now, the world is very different from even a generation ago and continues to rapidly change. Steps to remediate New Zealand's high rate of youth suicide must include an emphasis on primary prevention and in particular improving emotional and resilience skills starting from very early in life. It means promoting mental health awareness and ensuring that there are competent, well-trained, and fully functional adult- and peer-support systems in

secondary schools. Another key aspect of primary prevention is reducing access of adolescents to alcohol, a cause of depression and an aid to suicide. Deprivation, social disintegration, and family violence create environments in which juvenile suicidal and self-harm behaviours are more likely.

19. There is a special need to focus on Māori resilience and vulnerability and a special opportunity to learn and use insights from mātauranga Māori more widely.
20. There is a pressing need for us to reorder our thinking about alcohol use – because excessive and inappropriate use are both symptoms of and causes of mental disorder – as well as illicit drug use for the same reasons. We need to re-evaluate all aspects of how these are viewed and handled in our society including availability, social acceptability, behaviour, social licence, and price: all are central to any rethink/revitalisation of mental-health policy.
21. There is an acute unmet need for help, support, identification, and treatment of mental disorder. We do not have a large enough workforce to deal with the current need. This requires urgent attention. Extensive training and retraining are essential to bring the workforce up to the relevant level of skill in the relevant numbers. Further, therapy and support can often be provided by a broader range of professionals than is the case now but these individuals need to be well trained and supervised to enable them to deal with the complexities involved in helping those in need – particularly those at the severe end of the continuum of mental disorder.
22. We need to take advantage of major developments in the effectiveness of therapy. Firstly, in considering the best choices among face-to-face therapies, what is called cognitive behaviour therapy has become increasingly fine-tuned. It involves helping those in need not only to understand (the cognitive bit) their disorder, but also to make and practise changes (the behaviour bit) in how they relate to the world and to those around them. We can expect about half of mental disorders to be resolved and the particular individuals never to need further treatment after a single course of cognitive behaviour therapy. Secondly, computer-assisted therapy (called e-therapy) has been shown to be as effective as face-to-face cognitive behaviour therapy – it has the same success rate. In this case, therapy is delivered via electronic means, with the patient/client in full control of its timing. We must establish and facilitate the appropriate and widespread use of these effective evidence-based approaches to treatment.

Time Scale

23. Getting the over-arching plan right is critical. The revitalisation is a long-term strategy that may take a generation or more to be fully realised – social investment at its very best.
24. Nonetheless, some of the work can begin immediately, such as:

- a. establishing the quality and competence of our early childhood education workforce to build mental health;
 - b. beginning to strengthen our early childhood education workforce to better understand and support early childhood development and acquisition of basic skills: brain development, language and vocabulary, self-control, and motor skills;
 - c. building resilience and self-control during the primary and intermediate school years, by extending and refining whole school programmes, like the PB4L programme, with formalised components: this will particularly help in reducing impulsivity in adolescence and helping them cope with the inevitable pressures of transitioning from childhood to adulthood.
 - d. beginning to work on ensuring that vulnerable children are better supported across the transition into secondary education;
 - e. establishing the size and quality of the therapeutic workforce for all age groups and beginning to expand its size and skills;
 - f. beginning to introduce e-therapy into communities and groups with a great need and a desire to be involved in understanding how this might be made available nationwide;
 - g. getting a better understanding of the needs for mental-health resources in the justice sector and how to most effectively address the current gap in services.
25. We need better information on those at risk and those in mental distress across New Zealand, and we need to use science and data to guide decisions on service development and implementation. We therefore need more comprehensive mental health data within the IDI and this will require specific effort. We need to build and maintain an appropriately robust and sophisticated data system to manage data on mental health and disorder for the benefit of the whole population.. The evidence we have already requires careful analysis and interpretation; we then need to establish programmes aimed at promoting resilience for all New Zealanders, based on understanding what works best for each of us.
26. Substantial attention to prevention and full and supportive treatment of mental illness will, in many cases, pay for itself in the form of productivity that is not lost and benefits that are not claimed.
27. This narrative provides a template upon which government can develop short- and long-term strategies to ensure that both the provision of services to those with mental disorder and the challenge of promoting mental wellness and resilience for us all in a rapidly changing world are addressed. Over time, the social investment approach will provide data on health outcomes and on the effectiveness of services in promoting the wellbeing of

those who use them; this, in turn will allow the further refinement of the strategies chosen.

28. This overall approach and its successful implementation will help transform New Zealand in many ways: reducing pain, distress, and misery and freeing us all to achieve and be more.