SUPPORTING FAMILIES in Mental Illness New Zealand

August 2017

Update from the Chair of SFNZ

By Dick Brown

Mental health is certainly gaining much media attention as we lead up to the General Election. It has been heartening to see the interest and the Government have responded with more detail on their Mental Health Social Investment Fund (MNSIF) idea first announced in the Governments 2017 Financial Budget.

You may wonder where SFNZs influence is in all of this. It has been through the SFNZ Narrative Report to the Ministry of Health (MOH), various meetings in Wellington with the likes of Platform Central and other working groups being attended by Fiona Perry, our National Coordinator. These efforts are bearing results as evident in the detail of the MHSIF and Fiona will elaborate on this later in this newsletter.

This leads me to the concentration of effort by SFNZ National Council and the Steering Group on the reorganisation proposal. As many of you are aware, consultation on the proposal has taken place with member societies led by, members of National Council in order to gain feedback and explain to staff and members of societies that which, is proposed in this reorganisation. Valued feedback has been received and will now be fed into the final discussions forming the proposed structure including full costing. Further consultation is planned to take place with member societies over coming months on the more detailed proposal document.

I very much appreciate the time put into consultation by many. This includes member societies, members of the Steering Group responsible for the decisions, Alan Wilcox the consultant contracted for developing the proposal document and Sue Barker our legal adviser. Alan has, I understand now spoken to most member society managers and is awaiting some further detail from managers in order to draw-up the costing for the new structure. Much more work has to follow in the coming months to complete the project in time for the SFNZ AGM in early December.

In anticipation of further cooperation and efforts by all, I thank you for your persistence in working to see a final proposal for the reorganisation of SFNZ.

If you haven't already don't forget to go to our FACEBOOK page, for regular updates and other items of interest.

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https://www.facebook.com/SupportingFamiliesNZ/

You can also find us on Twitter @SFNewZealand

Pinterest https://nz.pinterest.com/sfnatcouncil/

New diagnostic model for psychiatric disorders proposed[1]

University of Otago researcher Associate Professor Martin Sellbom is part of a group of 50 leading international psychologists and psychiatrists who have put forward a new, evidence-based, system for classifying mental health disorders.

The researchers hope that their recommendations will lead to a paradigm-shift in how mental illnesses are classified and diagnosed. Their study appears in the American Psychological Association's Journal of Abnormal Psychology.

Their new Hierarchical Taxonomy of Psychopathology (HiTOP) addresses limitations to the reliability and validity of traditional models such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the American Psychiatric Association's (APA) authoritative handbook used by clinicians and researchers around the world to diagnose and treat mental disorders.

They hope HiTOP will advance research efforts and improve clinical outcomes related to the causes and treatments of mental disorders.

Associate Professor Sellbom, who is a member of Otago's Department of Psychology, says HiTOP represents a new system for the classification of mental health problems that is rooted completely in cumulative scientific knowledge, unlike the current DSM-5 and the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

"The DSM-5 relies on 'categorical' diagnoses which are assigned if a person has X out of Y symptoms, with no actual scientific basis for a qualitative change when you reach X symptoms. People with fewer symptoms are often just as impaired, but are considered to have no diagnosis," he says.

Instead, HiTOP relies on dimensional (or continuous) representations of mental health problems, which allows for a better consideration of severity, and also recognise the existence of significant problems that don't currently meet full DSM diagnostic thresholds, he says.

"HiTOP organises mental health problems hierarchically, which allows for a better understanding of which causes contribute to what these problems have in common."

A major advantage of the hierarchical model is its use of empirical evidence to classify disorders, a change from the DSM's tendency to group disorders based partly on clinical assumptions about which disorders seem to go together. For instance, several of the anxiety disorders of the DSM-5 have been grouped together based on content themes rather than their scientific associations, he says.

"For instance, Major Depressive Disorder and Generalised Anxiety Disorder have a far more significant overlap than do Generalised Anxiety Disorder and the other so-called anxiety disorders, such as social anxiety disorder or specific phobias. Such scientifically based groupings link classification to shared

[1] http://www.otago.ac.nz/news/news/otago642404.html

underlying causes and therefore better targeted treatments than the current arbitrary thematic groups."

The researchers used several large epidemiological surveys in the United States, Australia, the Netherlands, and other countries to gather data about how the most common forms of psychopathology – such as depression, anxiety, substance abuse and personality disorder – are related.

The consortium's paper is titled "The Hierarchical Taxonomy of Psychopathology (HiTOP): A Dimensional Alternative to Traditional Nosology's" and can be viewed here.

Professor Terrie Moffitt, Associate Director of the internationally renowned Dunedin Study, is also a co-author on the paper.

From Platform Trust:

Platform Trust is contact point for nationwide feedback on issues relating to mental health and addiction community organisations. SFNZ is a member of Platform Trust.

Pay Equity – The impact on the NGO mental health and addiction sector is substantial; our negotiation team is working hard to ensure that the critical role of mental health and addiction workers is understood. Platform will continue to advocate for a fair settlement to match the increase in pay for those working in the Disability and Aged Care sector.

Election- Platform have taken the information and evidence that members have being provided to build our election campaign, to raise the concerns of voters about mental health and addictions and to ensure that these are heard by political parties and potential candidates. With the contribution of ten members we have developed a website ItMatters.org.nz that is regularly updated as we get new information. There is a sign-up to support the campaign and they ask that you encourage as many people and organisations as possible to do that. Candidate has a profile that includes how to contact them and ask them to say how 'it matters' to them. Platform is currently seeking the political parties' mental health / addiction policies, and will follow them up post-election to see how they are doing.

Fast Track- In partnership with Te Pou Platform has developed '*Fast Track Discussion Paper- Challenges and Opportunities for the Mental Health and Addictions Community Support Workforce'.* This is now the largest part (31%) of the adult mental health and addiction workforce and this timely paper highlights some of the key issues for the further development of the community support workforce including retention and recruitment challenges for employers.

it matters!

Thinking outside the Box.

Human Rights Commission
Te Kāhui Tika Tangata

A new independent report has outlined a number of serious concerns about New Zealand's seclusion and restraint practices, says the Human Rights Commission.

The independent report, *Thinking Outside the Box? – A Review of Seclusion and Restraint Practices in New Zealand*, has been written by international expert, Dr Sharon Shalev and was released by the Commission today.

The report was commissioned to provide an independent perspective on seclusion and restraint practices in several different detention contexts and to identify areas of best practice, as well as areas that require improvement.

Chief Human Rights Commissioner David Rutherford says that while the report makes for sobering reading, the focus should now be on how the recommendations can be used to reduce the occurrence of seclusion and restraint in New Zealand and, in circumstances where it is necessary, to improve practices.

"Dr Shalev is an international expert with extensive experience in looking at detention facilities in particularly the United Kingdom and America. Her findings, and a number of other recent reports, have outlined areas of concern in relation to New Zealand's current seclusion and restraint practices.

"The report indicates that seclusion and restraint may not always be used as a last resort option, as required by international human rights law, and several of the rooms and units being used do not provide basic fixtures such as a call-bell to alert staff, a toilet, or fresh running water."

The report also highlights the over-representation of Maori in seclusion and restraint events, a small but persistent number of 'chronic' cases where solitary confinement and restraint were used for prolonged time, and systemic gaps, particularly in relation to the care of those who are mentally unwell.

"Concerns have been raised about both general seclusion and restraint practices within mental health and disability settings as well as the problems faced by corrections and police staff when dealing with detainees who are experiencing serious and acute psychiatric events, which they are not always well equipped,

or best placed, to deal with," Mr Rutherford says.

"These matters are particularly concerning, given what seems to be New Zealand's high propensity to use seclusion and restraint. The focus must now be on improving the situation. Dr Shalev's report provides an important catalyst for further discussion about these issues."

Dr Shalev has made a number of recommendations including:

- Stopping the use of equipment such as restraint chairs and restraint beds.
- Making sure that rooms and cells are of a reasonable size, are clean, safe, well-ventilated, well-lit and temperature controlled and that basic requirements around access to fresh air and exercise, food and drinking water are always be met.
- Decommissioning facilities that are not fit for purpose.
- Ensuring all cells/rooms are equipped with a means for attracting staff attention
- Thorough records and data are kept, indicating start and end times of seclusion and restraint periods and any efforts at less restrictive methods, and regularly analysed for trends in ages, ethnicities and gender.

In her report, Dr Shalev also noted the work being undertaken by Te Pou o te Whakaaro Nui ("Te Pou") to reduce the use of seclusion and restraint in the mental health, addiction and disability sectors, which could potentially be applied to other detention settings.

SFNZ AGM

Saturday 2nd December 2017

Wellington – venue to be confirmed

Updates: -

1. A strategy to prevent suicide in New Zealand 2017:

A consultation draft was released in April 2017. Comments were invited via a series of meetings or by written submission. The draft strategy attracted adverse publicity and was slated for failing to represent the views of those who had had input and for failing to determine a target or for affecting any real change.

SFNZ made a written submission, which supported the need for a target, and noted that there was little information about how family and whānau would be supported following a suicide (this has since been addressed in Governments recent announcement about new mental health initiatives).

As there is no set target, we suggested that more thought is needed to determine an exact goal for the strategy, whether that is determined by having a '*Zero harm*' approach as a target, as used by ACC, or a simple statement '*to reduce….* ', might help to give the strategy a focal point. Education, we believe is crucial, both social and formal. The Ministry of Education currently has a programme for use in schools titled Positive Behaviour for Learning (PB4L), which could be adapted to include emotional intelligence, which is a key factor in learning to handle disappointment, the most common cause of suicides by young men.

The announcement on Monday this week of an increase in the numbers of those who lost their lives to suicide is devastating and highlights the need for a robust approach to suicide prevention.

2. Transforming Respite: DSS respite Strategy 2017-2022

The over-arching theme is that respite needs to be available early, to support whānau to continue to provide care. Options need to be of good quality, accessible and be flexible, by introducing a new way of thinking about respite and trust that families will access supports that meet their needs.

NASC will need to take an outcome approach when allocating respite and consider the long term goals. Families will need to be support to find and use their respite allocations.

Current respite options such as carer support, in home respite and respite in a facility (rest home or other facility), are inflexible and do not meet the needs of those who need them.

Respite for Older People, ACC and those caring for those affected by mental illness are excluded from this strategy. However, the strategy addresses some of the key issues that we identified in our report on Respite and could provide a guide for future discussion on respite in mental health services.

A copy of the strategy is available from:

http://www.health.govt.nz/system/files/documents/publications/transforming-respite-dss-respite-strategy-2017-2022.pdf

Respite continues to be an issue for many of the family and whānau supported by our organisation. We will continue to advocate for respite options that support whānau to provide care, and maintain their own wellness.

3. Summary of the Recently announced Mental Health Initiatives[2]:

In the July Budget government announced funding for a range of new initiatives. More details were released this week. The new initiatives will cover

Distance and e-therapies – particularly aimed at younger people, using CBT therapies aimed at improving anxiety and depression, including making services available to young prisoners. A package of tailored telehealth pilots aims to reach those hard to reach or not engaged. There will also be follow up for those who have attempted suicide or at risk of suicide, this may include screening for risk factors. There will be an expansion of services for primary care aimed at those who do not meet the threshold for specialist services which will included training for peer support workers etc.

Step up / step down for people experience acute and emergency services: which will include working with existing providers to support people to maintain tenancies, in both the private and public sphere. Services will be aimed at reducing the gap following discharge, responding more quickly and appropriately to changes in need. a multi-agency approach will be trialled in 3 settings for people phoning 111 but identified as needing a mental health response. A provider will be sought to pilot a programme in an Early Childhood Setting aimed at improving self-regulatory control that responds to growing development in this area aimed at improve outcomes long term.

Schools Package: including a pilot programme in 'learning centres', as part of an on-location programme to screen and support young people. Supportive housing with wrap around support is also muted including building on existing services such as the one-stop-shop. A pilot of the Canadian programme 'Strongest Families' which delivers CBT via teleconferencing is aimed at improving overall well-being of the whānau.

Enhancing mental health and neurodevelopmental capacity in Gateway assessment teams and associated service pathways: a pilot programme to be hosted by 3 DHB's alongside existing trials.

It is also proposed to trial CBT (Trauma informed care) for young children following family and/ or sexual violence.

Gathering and collating data to get a better understanding of mental health and mental disorder in NZ, and will ensure that data from those hard to reach will be included.

Many of the aspects of these initiatives have been flagged through the information shared in our narrative report, discussed at the meetings I attended last year and from intensive lobbying by a wide range of community organisations, as part of this processes there are a range of opportunities to contribute and advocate on behalf of the whānau.

4. Mental Health Commissioner

On 1 August 2017, the Mental Health Commissioner Kevin Allan, wrote to the Health Committee in support of a petition presented by Corinda Taylor (Life Matters Suicide Prevention Trust). The petition requests a review of mental health services, by the Health Committee. In his letter Kevin Allan outlines why such a review is needed based on 4 different factors:

1. Increase in access to service has put pressure on services;
2. Increase in demand;
3. Variation in service quality; and
4. International experience

An action plan is needed to respond to growing pressures, address gaps and variation in service quality. The full version of the letter can be viewed at http://www.hdc.org.nz/media/384501/letter%20to%20health%20committee%20from%20mhc%202%20august%202017.pdf

We support the need to provide adequate mental health services that are able to respond to the growing need in communities everywhere.

Lastly:

A sure sign that spring is not too far away – the Tui are having a great time in the Kowhai not far from my office window.

[2] http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/new-mental-health-care-initiatives/mental-health-initiatives-summary