16 December 2016

Simon O'Connor
Chairperson
Health Committee
House of Representatives

Dear Mr O'Connor

Petition 2014/89 of Corinda Taylor

Thank you for the opportunity to provide a written response. I will clarify why, on behalf of the Life Matters Suicide Prevention Trust (LMSPT), we have respectfully requested a comprehensive independent nationwide Inquiry into Mental Health Services to be conducted to determine if current services meet the requirements and if future planning is adequate to meet future demand.

Our Trust is a community organisation working hard to get rid of stigma and to encourage people to seek help from services, but currently the system is not coping with huge increases in demand for services. Our request is for an in depth inquiry to look urgently at how mental health services affect our suicide rates and to understand where the pressures are in our mental health system. It has been 20 years since the Mason report in 1996 and the system has reached crisis point with services having to choose who they want to help. Acute and crisis demand is growing because people are not getting early intervention in a timely fashion. Overall poor service delivery and inappropriate level of care has a direct effect on our high suicide rates. Fact is there is a burgeoning mental health crisis in NZ.

Suicide rates are a sign of the mental health and social well-being of any population. In terms of child health, New Zealand has the highest rates of suicide in the OECD for youth aged 15-19.[1] The number of people especially young people experiencing extreme depression that contacted Youthline has increased from 6909 in 2014 to 14,996 in 2015. Figures released under the Official Information Act show young people had to wait longer than eight weeks for a second appointment with a medical professional last year.

Preventing mental health issues from occurring should be the ultimate goal. Social and economic issues must also be addressed to improve health outcomes. We already know that stronger communities, education and good relationships are preventative but the capability to respond appropriately to the present mental health need is questionable. To this end, a review is necessary to reassess the delivery of services and manner of delivery of service.

A large number of New Zealanders suffer from poor mental health and there is a sense of frustration amongst mental health service users and their families around accessing appropriate services. Many people don't feel heard, understood, or taken seriously. They experience mental healthcare as superficial, beating around the bush, condescending, and sometimes disrespectful.[2]

We feel that the government is increasingly out of touch with ordinary New Zealanders who cannot go to a GP or clinical psychologist to receive affordable and accessible quality medical care. The public mental health system is failing many New Zealanders and we need to ensure that mental health systems are up to date with modern clinical practice delivery, and are provided for free. The implications of having an underfunded system has a direct effect on our suicide statistics. The public is owed a duty of care in a professional way and if that duty of care is breached, the client suffers harm and it can result in suicide.

We would like an investigation to look at the following areas of concern and to involve people with the lived experience that have suffered as a direct result:

1. **Modern integrated electronic mental health record keeping system allowing clinicians to access patient records throughout New Zealand.**
   Mental health record keeping is still paper driven and not accessible on the spot in emergency situations at some DHBs including the Southern DHB. Clinical mental health records, which are not electronic, fail our people in distress. Currently, some of the health records that are electronic do not contain treatment plans, risk assessment or care plans. The HealthOne system does not extend across the Cook Strait and therefor South Island patient records cannot be accessed electronically in the North Island. Assessments conducted without access to the clinical history, in a discipline where reviewing the clinical history is of utmost importance, is very concerning.

2. **Adequate respite care facilities for clients to be admitted under professional care.**
   There are not enough crisis beds. Many people are sent away unsupported when in crisis and told there are no beds available.
   This external public inquiry has to look at inpatient and respite facilities with peer support. People are released back into the community with little to no support and families feel overwhelmed by what they are expected to do. Moving acute care into the community is a significant problem when little or no support is available.

3. **Increased capacity particularly supporting mentally compromised people and their families in the community setting.** Many people are told they do not fit the criteria for ongoing mental health support and many families are left floundering in shock with no support or help to look after their unwell loved ones. When we turn our backs on community based mental health programs there will be a spiral towards imprisonment rather than treatment. Many end up in prisons due to lack of early intervention by mental health services.

4. **Specific funding for tertiary crisis risk assessment in suicide prevention training for clinicians, particularly frontline clinicians to be mandated.** Many people are denied crisis help. People that ask for help from emergency services are often dismissed without follow-up, referrals or support and often alone in the middle of the night. There is no mandated accredited suicide risk assessment training for all key frontline staff including Police, Ambulance workers, Victim Support, Counsellors, Nurses, Psychiatrists, Psychologists and other emergency workers. Some clinicians are lacking

knowledge, skills and expertise to provide appropriate care and treatment to psychiatric emergency patients. [3,4]

5. **More clinicians are needed and certainly an increase in clinical psychologist training and funding.** Not enough free therapy and counselling are available for suicidal people including long waiting times for people in crisis. There is a clear trend of people being unable to access services in a timely manner, and of a workforce feeling overwhelmed by demand. Ministry of Health had confirmed demand on youth and adult mental health services had grown by 70 per cent in the last 10 years. Yet these people had nowhere to turn for help. There could be better use through training and upskilling of general health services in mental health provision both at primary and secondary levels.

   Primary health care level referral to clinical psychology services is impossible due to lack of funding. GP access, to clinical psychologists for their patients, is limited and only available to those patients who can afford the costly fees. That leaves a whole sector of the population without adequate professional support. Problems then compound and are only seen at the admission to psychiatry facility level in crisis. Referrals to DHB mental health services primarily consists of medication and a push for early discharge, and that clients have access to psychotherapy privately. Research shows that psychotherapy is consistently the treatment that most clients are seeking and that it works. ACC funds therapy for people who have suffered sexual abuse and assaults and there are ample funds to do so for the client to achieve wellness again. However, those clients suffering from severe anxiety, depression and trauma, other than sexual abuse and assaults, are not entitled to the same level of treatment.

6. **Include families and whanau in all areas of care.** Families and whānau are still actively excluded from the care of their loved ones. Failing to take parental concerns on board have failed many suicide victims. Dr Lynn Lane's Blueprint II [5] recommends that patient confidentiality concerns must be overcome to engage families in suicide prevention yet the Privacy Act is often used incorrectly with people who are most at risk of taking their own lives. Families and whānau need to be informed when their loved ones are suicidal in order to provide better support. Ensure a collaborative approach is used, with note taking including the person involved with their family/whānau. In 1999 Parliament made an amendment to the Mental Health Act that required clinicians to consult family/ whānau at particular junctures of a person's compulsory assessment and treatment under the Mental Health Act [6] (section 7A). However, this is rarely implemented.

7. **Postvention support after a suicide.** Families, whānau and friends that are bereaved by suicide and attempt survivors need good support. Currently, there is no funding for support available for people bereaved by suicide. Families of homicide victims receive 30 free counselling sessions, compared to none for suicide bereaved families. LMSPT provides free support to people bereaved by suicide.

8. **No smoking policies.** No smoking policies on mental health wards need to be reviewed. Suicidal people are not allowed to smoke inside, yet they often still smoke on hospital grounds unsupervised, which gives them an opportunity to take their own lives. Many wards have courtyards that could be used effectively as smoking areas. To stop people from smoking when they are in crisis is cruel, unrealistic and inhuman.

9. **Lack of support for families wanting to address failings.** Families are unable to advocate for changes when a serious breach occurs of any of the Health and Disability Commissioner rights. There is no legal support for families and whānau making a complaint after a serious adverse event regarding poor service delivery and systems in the mental health system. Very few serious mental health complaints are upheld in comparison to other general health complaints as a result.
   Coronial inquiries and investigations re-traumatise families. There is no support in place for those families who may have serious concerns about the system that failed their loved ones. There is no follow up on recommendations made and therefore no positive changes follow to ensure that it never happens again, resulting in Coroners making the same recommendations repeatedly since there is no national data base. The lack of a nationwide database means that coronial investigations happen in isolation with nationwide inconsistencies.

10. **Transparency is needed for suicides and mental health Serious Adverse Events**

- Serious Adverse Events (SAEs) reporting regarding mental health from the DHBs to Health Quality and Safety Commission are no longer visible to the public since 2012, even though general health reports are. The public deserve to see these reports.
- Reporting of suicides are voluntary to the Health Quality and Safety Commission NZ; it should be compulsory.
- We would like an audit done on how many services are available or delivered to people experiencing or displaying “suicidal behaviour” or to people bereaved by suicide, including making information available to the public to see how effectively any suicide prevention plans have been implemented, including an evaluation of the Ministry of Health New Zealand Suicide Prevention Action Plan 2013 – 2016 to see if it was implemented by DHBs.
- We need transparent statistics on the amount of people having contact with Mental Health services in the last year before suicide.
- We need statistics on people bereaved by suicide to see how little support they have had.

11. **The Mental Health Commission needs to be reinstated with a Mental Health Commissioner who can act as a watchdog to access solid information.**

12. **Electroconvulsive therapy (ECT):** The total number of ECT treatments not able to be consented to increased from 259 treatments in 2014 to 576 treatments in 2015. [6]

13. **Seclusion:** Number of seclusions that are reported on are only in seclusion designated areas which are locked rooms (otherwise known as solitary confinement). People are also ordered to stay in bedrooms for a period of time and not free to come and go, which is also seclusion but it is not accounted for in the reporting. This is isolating people and not a therapeutic environment. We need clear guidelines on seclusions and reporting. Seclusion is inhuman, cruel and degrading treatment and often used as punishment, as a mean of coping with staff shortages or where there is a risk of suicide or self-harm.

Terms of reference:

- The factors that contribute to suicide and suicide attempts.
- The effectiveness of services and support available to those who attempt suicide or the victims of suicide.
- The attitudes of New Zealanders towards the care they receive from mental health services.
- To consider the social, legal, medical, cultural, financial, ethical and philosophical implications of victims of suicide and people bereaved by suicide.

Imagine a world where we can talk about suicide openly, honestly, empathetically and directly where not one patient in healthcare dies by suicide. Let's adopt a ZERO SUICIDE policy where we don't tolerate mistakes in our healthcare systems. [2]

Yours sincerely
Corinda Taylor

References:

1. http://www.oecd.org/newzealand/43589854.pdf
2. http://www.slideshare.net/davidwcovington/zero-suicide-international-declaration-draft-01-september-2015
3. https://www.ena.org/practice-research/research/Documents/WhitePaperCareofPsych.pdf
4. http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf
5. https://www.mentalhealth.org.nz/assets/ResourceFinder/mhc3722-making-change-happen-web-pdf.pdf
6. http://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-annual-report-2015-nov16.pdf