Mental Health in Aotearoa New Zealand: Rising to the Challenge of the Fourth Wave?

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Over the past three decades, New Zealand's mental health system has gone through a number of significant transformations. Professor Mason Durie characterises the current stage as the fourth wave of mental health development. Increased understanding of the critical role of good mental health in the well-being and quality of life for the individual, the community, and of society have contributed to these changes. Efforts to destigmatise mental illness have reduced the barriers to seeking mental health services, and people seek care at an earlier stage, preventing deterioration into a spiral of chronicity and negative life situation. Prevention and early intervention are now one of the cornerstones of the mental health system. Yet, for those who have mild to moderate psychological conditions support services remain elusive and evidence-based interventions for high prevalence disorders in New Zealand are meagre. The demand for these services in the current mental health system is growing, yet inequity of access for certain populations is undeniable.

This article will outline the transitions that have occurred since deinstitutionalisation (between the second and fourth waves) in mental health services in New Zealand, providing a background to identifying the challenges inherent in the fourth wave of mental health services. The escalating demand for mental health and wellness throughout the continuum of the lifespan is placing considerable strain on the current model of mental health care, and this paper examines how equipped the mental health service is to meet these challenges. This article, as a companion to the previous paper documenting ways England and Scotland have responded to the social, economic, and personal burden of mental illness, addresses the sustainability of the New Zealand mental health system in the context of a greater emphasis on low intensity psychological interventions across the lifespan.

Key words: mental health; low intensity psychological interventions; high prevalence disorders; Improving Access to Psychological Therapies

The mental health system in New Zealand has undergone major transformation in the past few decades. Although these changes have followed similar events occurring overseas, the manner of the changes and the impact on the health system are unique to New Zealand. Professor Mason Durie (Mental Health Commission, 2012a) characterises the evolution of the mental health system as a number of waves; the first wave lasting more than a century treated people with mental illness in large psychiatric institutions away from the sight of the community, with psychiatry having unquestioned authority. The second wave saw the shift towards deinstitutionalisation and the closure of the large psychiatric hospitals. From being out-of-sight and now sited within the community, the care of the mentally unwell was placed on a society that was largely unprepared and apprehensive. The turmoil that eventuated proved to be a watershed in the evolution of the third wave of mental health services and continues as the existing model we have today.

The emerging literature is now shifting away from the traditional paradigm of mental disorders to one of wellness that is maintained throughout the lifespan. The Mental Health Commission in their Blueprint II (2012b, p. 10) viewed this progression as a "new wave", or as the fourth wave. Durie (Mental Health Commission, 2012a, p. 7) succinctly defined this fourth wave as:

> *"In contrast [to the previous stages] the fourth stage may not be about disorders at all but about dysfunctional relationships, maladaptive attitudes and behaviours, exaggerated responses to life crises, emotional and cognitive symptoms associated with poor physical health, and a failure to adapt to changing times and circumstances".*

The currents of change in mental health care

Second wave (1960s-1980s): Transition from deinstitutionalisation to community care

Internationally, the late 1950s saw rapid changes towards deinstitutionalisation from large psychiatric hospitals into the care of the community for people suffering mental illness (O'Brien & Kydd, 2013). It was not until 1969 that New Zealand legally ratified the move towards a community-based mental health system of care. There was an increasing awareness of the negative impact of involuntary hospitalisation and the loss of liberty faced by those committed to psychiatric care. Furthermore, the fiscal sustainability of long-term institutional care was threatened, particularly after the prohibition of peonage (Brunton, 2013).

However, discharged patients were frequently readmitted back into psychiatric hospitals after a brief period in the community (Mason, Ryan, & Bennett, 1988). As Brunton (2003) astutely noted, deinstitutionalisation was largely concerned with the "de-hospitalisation" of patients from psychiatric institutions, while "deinstitutionalisation", in the form of the long-term effects of institutionalisation, received little attention.

The tragic failures of deinstitutionalisation highlighted in the Mason reports (Mason et al., 1988; Mason, Johnson, & Crowe, 1996) prompted the New Zealand government to develop a strategy for a community-based mental health service (Ministry of Health, 1994). It was also the beginning of an investment by the New Zealand government to ring-fence funding from the general health funds towards the mental health system.

Based on the Tolkein report (Andrews, 1991), the focus of the community mental health initiative was to treat the most severely unwell people, identified as 3% of the total population. Contrasting with the dominant psychiatric institutionalised model of care, its intent was to shift away from an illness model to that of a recovery model; defined as "when people can live well in the presence or absence of their mental illness" (Mental Health Commission, 1998, p. 1). New Zealand was the first country to articulate the principles of a recovery model of mental health care that was eventually taken up by other countries, such as England, Scotland, and the United States of America (NGOiT, 2012). Patients were placed at the forefront of mental health service delivery, and respect for their rights and dignity as service users was paramount. The right to participate in society and not to be discriminated against because of mental illness was also emphasised. The responsibility for recovery would devolve from the State to the consumer, the family, and the community (Ministry of Health, 1994). These aspirational intentions paved the way for the third wave of mental health reforms.

Third wave (mid-90s to early 2000): Development of community mental health services

The focus on community care led to the establishment of a number of community non-government organisations (NGOs; Peters, 2010). The NGOs' initially focused on providing housing and support for the patients leaving institutionalised care, but has now expanded into medical, education and employment training, provision of psychotherapy, and social and cultural support. Despite an increase in community based mental health

providers, it did not necessarily lead to improved quality of care or in quality services due to the lack of integration of services (Ministry of Health, 1997). This prompted the development of a second strategy addressing these difficulties (Ministry of Health, 1997).

The focus of the second strategy was not just to treat mental illness, but to promote good mental health and prevent mental illness. The new mental health model would continue to treat the 3% severely unwell but after Oakley-Browne, Joyce, Wells, Bushnell, and Hornblow's (1989) survey of Christchurch citizens, it would extend its services to treat the 5% with moderate to severe, and 12% of the people experiencing mild to moderate mental health disorders.

People with moderate to severe mental health disorders would be managed through the primary health care services in liaison with the specialist mental health service. Those with moderate to mild problems would be managed through informal support, counselling, and social support services. Materials on the promotion of good mental health would be available to the remaining population. This "building block" model of mental health care is very much the current mental health system operating in New Zealand; with primary, secondary, and tertiary level of care (Ministry of Health, 1997, p. 13).

Central funding for mental health services, however, was primarily targeted towards the development of specialist services at the tertiary mental health sector, and the development of kaupapa Māori and consumer/carer support services at the secondary level of care. There was little investment from central funding to support mental health care at the primary health level. (Dowell et al., 2009).

A number of factors contributed to the prominence placed on the primary health services in mental health care (these services include general practices, nursing services, mental health private practitioners, counselling services, and other support groups). These factors included: the high level of undiagnosed mental health disorders experienced in the community, that general practitioners were often the first point of contact for many people experiencing mental health difficulties rather than the mental health

sector, the findings that mental health problems contributed significantly to the overall burden of chronic health conditions, and the high rate of suicide and distress experienced by young people in New Zealand. These are discussed in more detail below.

Firstly, although the international literature had already highlighted the high levels of mental health problems, with nearly a third of the population experiencing a mental health condition at least once in their lifetime (Steel et al., 2014), research into the epidemiology of mental health disorders in a New Zealand population was limited. Although an earlier study of the prevalence rate in Christchurch found the lifetime prevalence to be high (Oakley-Browne et al., 1989), with anxiety and depression being the most prevalent (Oakley Browne, 1995), it was not until 2003-2004 that a national mental health survey of New Zealanders was undertaken (Oakley Browne, Wells, & Scott, 2006). The report confirmed the high prevalence of diagnosable disorders in the community, with 39.5% reported having experienced at least one episode of mental illness in their life and 20.7% reporting having done so in the past 12 months. The report also highlighted that mental health conditions were disproportionately distributed within the community, with higher rates found for Māori and Pasifika populations, that women experienced higher levels of mental illness, and the younger age group had higher rates for most disorders, particularly substance and major depressive disorder. The prevalence rate for serious, moderate, and mild disorders were 4.7%, 9.4% and 6.6% respectively. Nearly two out of five people with a serious mental health disorder did not seek help, and only a small percentage of those in the moderate to mild group visited a mental health service (35% and 18.5% respectively). The report highlighted the commonality of mental health disorders in the community, the disproportionate rate of mental illness within certain sectors of the population, and that very few people suffering mental distress sought help from the mental health services.

Secondly, although the mental health specialist sector was principally funded for the management and treatment of the

3% most chronic and serious disorders, only 1.6% of those seriously unwell were seen (Mental Health Commission, 1998). This meant that for most people the first point of contact was primarily through their general practitioner. Primary health care services generally act as gateways and gatekeepers to mental health services in the health system; whether to secondary or tertiary level of care. About half of the patients were identified by their general practitioners as having some form of mental health condition, although most were subclinical (Bushnell et al., 2003). The consultations were primarily for physical rather than psychological reasons, yet nearly three quarters of treatment for mental health problems were being provided in the primary health sector (Bushnell & MaGPIe Research Group, 2004); despite most GPs not receiving sufficient training to assess and treat mental health problems. These studies revealed the greatest need for mental health care was at the primary sector, and the inequity in the distribution of funding for mental health services.

Thirdly, 70% of the cases in general practitioners' offices are for chronic diseases, such as diabetes, cardio-vascular disease, and asthma (Veale, 2003), but significant depressive and anxiety symptoms were associated with the disease as well (Chapman, Perry, & Strine, 2005). Cassano and Fava (2002) showed that the comorbidity of depressive symptoms with chronic health conditions increased the morbidity, disability, and mortality for patients compared to their non-depressed peers. Without the recognition and treatment for the psychopathology, patients were less likely to respond to and/or adhere to the recommended care regime, showed greater severity and chronicity in their health condition, and experienced lower quality of life and general functioning. Thus there was increasing recognition that poor psychological health added to the overall burden of long term chronic health diseases, over and above that of the illness itself (Moussavi et al., 2007).

Finally, of the rates of suicide in any Organisation for Economic Co-operation and Development (OECD) countries, New Zealand was one of the highest particularly amongst young people (Ministry of Health, 2007a). Apart from motor vehicle accidents,

suicide was the leading cause of death per year. Hospitalisation from suicidal harm, however, is ten times greater than the fatality from suicidal attempts. Beautrais' (2006) study found that while suicidal ideations were common, the risk of suicide behaviours was unequally distributed in certain populations groups, with the highest risk in the most deprived areas, for young people, and for ethnicity, Māori (both male and female). Despite the morbidity and mortality from suicide, nearly half of the people did not see a specialist mental health professional and less than one-third who made a suicide attempt received treatment.

The high prevalence of mental health concerns in the community, that most people did not seek care from the mental health system, and the inextricable link between health and mental health highlighted the importance of the primary health care sector. The development of the Primary Health Care Strategy (Ministry of Health, 2001) led to the emergence of the Primary Health Organisations (PHOs) in the third wave of mental health care. The new entity was seen as the vehicle through which primary mental health care would be delivered, particularly to the 17% of people experiencing mild to moderate mental health problems (Rodenburg & Dowell, 2008), and reduce the inequities of access for high need groups. Only a few PHOs were initially funded to carry out this activity (Collings et al., 2010) but once central funding was extended through the Primary Mental Health Initiatives (PMHI) in 2004, it opened the gateway for the PHOs to develop a number of innovative mental health practices (Dowell et al., 2009). A variety of models were developed, dependent on the resources allocated and the local need (Dowell et al., 2009). For example, iwi based and Pasifika organisations developed culturally appropriate services for their local community. For some, new mental health professional positions were created or there was redesignation of roles within the existing personnel in the PHOs, or the service was contracted out (see Dath, Dong, Stewart, & Sables, 2014; Fitzgerald, Galyer, & Ryan, 2009; Lyons & Low, 2009; Wynands & Gawith, 2009 for an outline of some of the mental health initiatives in the primary health sector).

Since then, awareness of mental health issues has increased through a number of government-led mental health campaigns that helped to reduce the stigma and discrimination of people with mental illness (i.e. Like Minds Like Mine, Ministry of Health, 2007b). Support for on-line therapy for depression/anxiety (for adults: "the Journal" fronted by Sir John Kirwan; "Beating the Blues" which require general practitioner referral; for young people SPARX; Merry et al., 2012) were also provided. The technology explosion opened up avenues of access to a number of self-help online resources and support (e.g. Common Ground, thelowdown), and more recently internet applications that offer a range of services from daily monitoring and measurement of symptoms and mental wellbeing (see Mental Health Foundation, 2017 for a list of these).

Fourth wave: Moving into the future?

Deinstitutionalisation has wrought substantial transformations in mental health care. The landscape around mental illness is rapidly shifting and changing, and the influx of new technology will escalate this trend. Since 2008, the demand for mental health services has increased nearly 60 per cent, with the biggest growing demand from those with mild to moderate mental health needs (Coleman, 2017). The biggest challenge facing the sector is the lack of a mental health workforce to service this need (Mental Health and Addiction Service Review Working Group, n.d.), and the lack of a new way of thinking around the delivery of services that would address these needs. Even at the mild to moderate levels of distress, the impact on functioning in the personal and occupational domain, and the cost to society of homelessness, poverty, crime, and unemployment when people are disabled are immense (Layard, Clark, Knapp, & Mayraz, 2007).

The first paper in this series (Haarhoff & Williams, 2017), documented fundamental changes introduced in England as part of the IAPT initiative between 2006 and the present time. The current paper has provided a context to consider the future of the New Zealand mental health service. Are there steps which can be taken to ensure a sustainable inclusive mental health service? Where

will the fourth wave take us?

The fourth wave: What are the challenges?

Before outlining a number of key recommendations regarding the question above, we summarise key differences between the English and New Zealand mental health systems.

Firstly, the IAPT service operates within an all-encompassing five tier stepped-care system which offers integrated care wherein patients can be "stepped up or down" according to need. In New Zealand there is no wrap-around stepped-care service available. The District Health Boards (DHBs) oversee tertiary services (e.g. inpatient, crisis team, early intervention and psychiatric liaison services) and secondary services (community mental health, adult, child and adolescent). Primary Health care (although funded by the DHBs) sits outside of the DHBs and consists of private practitioners (clinical psychologists, psychotherapists, counsellors etc.), General Practitioners, PHOs, and various NGOs. All but the most serious presentations are seen outside of the DHBs. The result is that many patients with complex and chronic diagnoses and problems are managed in the overpopulated primary health sector, and those with mild to moderate disorders, who cannot afford private mental health care, have to compete with those who have more severe problems, often falling by the wayside, or receiving less effective treatment.

Secondly, IAPT distinguishes High and Low Intensity practitioners in terms of competency based training which is then matched to the level of complexity of the patient. Patients with more complex and chronic difficulties are treated by High Intensity practitioners. Those with mild to moderate presentations are allocated to Low Intensity practitioners, such as the Psychological Wellbeing Practitioners (PWP: see Haarhoff & Williams, 2017). In New Zealand the workforce is professionally differentiated. However, in terms of the type of treatment delivered, specialist practitioners in the secondary sector deliver what could be characterised as brief (low intensity) and more elaborated psychological interventions (high intensity). There is no

practitioner profile similar to the PWP in New Zealand.

Thirdly, the IAPT service follows NICE guidelines (National Institute for Clinical Excellence, 2004). These guidelines specify the most appropriate evidence-based psychological interventions for specific diagnostic presentations. For most diagnostic presentations, CBT interventions are the primary recommendation. Outcomes are also measured using a consistent set of measures. In New Zealand there is no unified set of clinical guidelines specifying what psychological intervention should be delivered to which patient, and there is no standardised routine collection and evaluation of outcome related data. Practitioners use a variety of psychological interventions which may or may not be evidence based.

Fourthly, in New Zealand specialist training is professionally based, for example nursing, social work, clinical psychology and social work. In contrast, IAPT services support competency based training (for example the adherent delivery of particular treatment protocols), Within this system clinical psychologists and mental health nurses can both be trained to deliver High Intensity psychological interventions and psychologists sometimes work as Low Intensity therapists. In New Zealand, once professional training is complete ongoing professional development is generally left up to the individual practitioner, The IAPT service however, actively encourages and supports ongoing competency-based professional development.

Finally, and most importantly and uniquely, New Zealand is a bi-cultural country and psychological interventions have to reflect and adequately accommodate Māori perspectives. The cultural and bi-cultural status quo has wide ramifications for the sustainable development of mental health services.

Recommendations

From our perspective, three recommendations emerge from the points of differentiation outlined above:

1. The reduction of scarce and expensive specialised time at the primary level of mental health service delivery.

We suggest this could be achieved by augmenting the mental health workforce by introducing a new kind of mental health service practitioner trained to competently deliver evidence-based low intensity CBT psychological interventions.

2. Employ standardised evidence-based psychological interventions shown to be effective in primary mental health service delivery. This would mean a greater emphasis on models of intervention with a proven evidence-based track record such as CBT.

3. A greater emphasis on utilising alternative methods for the delivery of psychological interventions, for example workbooks and the internet. These alternative modes of delivery can be utilised by the patient in both a supported and unsupported context.

Each of these recommendations is elaborated below.

Reducing specialist intervention at the primary level

General practitioners (GPs) who shoulder the bulk of responsibility for referring patients with mental health difficulties to appropriate services (e.g. PHOs, NGOs and private practitioners) also receive some funding to support the delivery of psychological interventions as part of general practice. There are several problems inherent in this system. First, GPs are the most expensive of the professionalised services available. Secondly, the funding the GPs receive from the government is variable and depends on the area of practice as determined by generalised socioeconomic and demographic information. This means that some individuals are compromised by their area of residence. Thirdly, GPs are widely accepted to be a scarce resource, and lastly they have very little training in the delivery of specific and targeted psychological interventions for people with mild to moderate mental health needs. Developing a non-specialist workforce similar to that of the PWP would be a pragmatic solution to some of the problems enumerated (see Haarhoff & Williams, 2017 in this special section). Of particular relevance regarding the introduction of a new kind of practitioner is that New Zealand is becoming increasingly multi-cultural. Auckland is ranked fourth in the world in terms of

cultural diversity (ahead of New York and London) with 39% of the population born overseas (Peacock, 2016). Migrants arriving from South East Asia, China, and the Pacific Islands have traditions, practices, religious, and spiritual beliefs very different from those espoused by mainstream New Zealand culture, and this will influence the way in which the different cultural groups will interact with mental health services. A new type of practitioner more reflective of these diverse cultures is urgently needed. It could be speculated that accelerated training opportunities for practitioners that reflect this diversity is becoming a priority.

Increased utilisation of standardised evidence-based treatment protocols

In New Zealand the "brief therapy" or "time sensitive" model of psychological intervention is the model of choice, supported by the primary workforce development agency, Te Pou (2016). The brief therapy model was conceived in the context of managed care in North America, and was presented as emancipating the therapist and client from the strait-jacket of 'established therapy practice' (Bor, Gill, Millar, & Parrott, 2004). A parsimonious definition of "brief therapy" is difficult to find and the model is characterised as "any therapy in which the time allotted to therapy is rationed" (Bor et al., 2004, p. 15). Brief therapy is reliant on the therapist's ability to be creative, collaborative, active, and flexible in accessing the client's strengths, resilience and personal resources within a very limited period of time. The client's coping resources are then channelled towards a solution to the client's most pressing problem. Much emphasis is placed on the therapist's skill and experience to engage the client and mobilise change rapidly. The delivery of brief therapy rests on skilful use of the "miracle" question. While we have no dispute with this approach, however, it would appear that much depends on the skill of the practitioner, and in fact it is recommended that a high level of skill is necessary for success using this mode of therapy. Finally, tangible outcomes and mechanisms for change are difficult to quantify using this model.

Te Pou (2016) has taken the lead in providing recommendations in their "Let's get talking" document on what may be suitable for working with people with low-moderate mental health conditions. It provides a list of brief interventions for primary care as follows: giving people feedback and raising awareness, building positive options to enhance resilience and wellbeing, assessment of motivation and readiness for change, problem solving and goal setting, advice about addressing lifestyle issues, CBT based self-help resources, behavioural activation techniques, symptom monitoring, and short courses of talking therapy. These recommendations, however, conclude that the evidence for the effectiveness of these interventions are yet to emerge, although there is some evidence for alcohol dependence. No published research has been conducted thus far, and so to some extent the "evidence" may simply rest on the anecdotal accounts of practitioners. The problems we further identify are that the interventions listed are numerous, and there is no indication of priority or matching of specific intervention in terms of the client's diagnosis or presenting issue. We recommend that attention should be given to evidence-based psychological interventions (of which CBT is one). Further, it is very often the case that "less" done well is far more useful than "more", when it is executed poorly.

Utilising alternative methods and modes for the delivery of psychological interventions for mild to moderate mental health conditions.

One of the cornerstones of the Low Intensity Cognitive Behavioural Therapy (LICBT) arm of the IAPT service is the utilisation of simplified manualised treatment protocols. These protocols are evidence-based and designed to be accessible and easy to understand. Some examples are Living Life to the Full (Williams, 2007) and the Five Areas approach (Williams, & Chellingsworth, 2010) (see Lee & Williams 2017, and Montagu & Williams, 2017 articles in this Special Section). These manualised programmes contain targeted psychological interventions, and the role of the PWP is to maximise the impact of these materials by offering support in their use. There is also increasing evidence showing that many of these programmes can also be almost as effective when used independently by the patient (Andersson & Cuijpers, 2009; Berger, Hämmerli, Guber, Anderson, & Caspar , 2011). As previously mentioned these interventions can also be delivered in a variety of digitally supported contexts.

Conclusions

New Zealand is not unique in trying to find sustainable solutions to maintaining and improving the mental health of its citizens. The biggest challenge to the sustainability of the mental health system in New Zealand are services that can deliver treatment for the high prevalence disorders (defined as mild to moderate disorders and medically unexplained conditions; Ministry of Health, 2012), particularly at the early intervention primary level of care. With a growing and ageing population, and the success of de-stigmatisation programmes reducing the barriers to help-seeking, the demand for mental health services will increase (Mental Health Commission, 2012a). As discussed there is a shortage of a trained workforce that not only represents the cultural diversity of New Zealand but can meet the growing demand for mental health services if the objective of well-being across the lifespan is to be achieved (Mental Health and Addiction Service Review Working Group, n.d.). Furthermore, there is a fundamental lack of research of interventions that are evidence based for mild to moderate mental health conditions in New Zealand (Ministry of Health, 2017).

As psychological practitioners we can contribute our knowledge and expertise to this rising challenge; in having a mental health system that permits equity of access for all people at all stages of their life, and not one that caters just for the severely unwell or the privileged. This will mean developing evidence based interventions that are culturally appropriate for the high prevalence disorders, and to consider new methods of delivery and practice that can service this need. There are experiences we can learn from overseas to support a mental health system that is sustainable for the current and future generations; one that can take mental health into a future of recovery, well-being, and resilience.

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