SUBMISSION TO THE MENTAL HEALTH AND ADDICTION INQUIRY

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mentalhealth@inquiry.govt.nz

Submitted by: Cleopatra Maru Matthews

Junior Policy Analyst and Health Promotor

On behalf of Women's Health Action Trust

13 Coyle Street, Sandringham, Auckland, New Zealand

Introduction:

This submission is made on behalf of Women's Health Action Trust. Women's Health Action is a women's health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policymakers and other not for profit organisations to inform government policy and service delivery for women. Women's Health Action is in its 34th year of operation and remains at the forefront of women's health in Aotearoa New Zealand.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women's health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women's sexual and reproductive health and rights.

The following submission presents our perspectives on some of the areas discussed in the consultation paper on Mental Health and Addictions.

This submission is informed by our extensive background in women's health promotion and policy analysis.

Please note that in addition to the views of Women's Health Action, aspects of this submission represent the views of wider networks with whom we are involved including:

List:

- Mental health service users;
- Health practitioners, including midwives;
- Whānau of service users;
- Other community health providers.

General comments: Mental Health and Addiction Services in New Zealand need development. It is concerning to note that women continue to experience psychological distress at a disproportionate rate to men (Ministry of Health, 2017) and are more likely to be diagnosed with a common mental disorder than men (Ministry of Health, 2014), facing barriers to treatment and access of services across numerous areas. Some areas in which female mental health is of concern is in maternity, LGBTQIA communities, elderly care and domestic violence and alcohol addiction.

In this submission, we will primarily explore mental health in maternity, including postnatal and antenatal depression and LGBTQIA experience of mental health, with consideration to gender as a determinant of health. We will speak to experiences shared with us from our consumers and our care workers and make recommendations based on our analysis.

The right to health is a fundamental human right, recognised in numerous international treaties including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and expressed by the World Health Organisation Special Rapporteur as *"the right to the enjoyment of the highest attainable standard of physical and mental health"*. This right is also embedded in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), in Articles 11(1)(f), 12 and 14 (2)(b).

The right to health includes entitlements which Women's Health Action Trust (WHA) believe are lacking in Aotearoa New Zealand.

Question 1: What's working well?

We note, based on anecdotal evidence from a wider range of consumer experience that once identified as suffering from mental health issues, varying degrees of satisfaction and usefulness were experienced.

Maternal mental health:

In some regions, there are support programmes in existence for women who experience postnatal depression, though these are not nationwide. For example, in Taranaki, there is a 12-week group programme called 'Adjustment to Parenthood' which is run by the Maternal Mental Health team at the Taranaki District Health Board. Unfortunately, programmes like this do not widely exist and are not easily accessible or are not well-run.

Question 2: What's not working well?

Maternal mental health:

We believe maternal mental health services are falling short, particularly as a women's risk for mental illness has been shown higher around childbirth (Ministry of Health, 2011) with approximately 15% of all women who give birth affected by postnatal depression (BPJ, Special Edition, 2010). Antenatal and postnatal depression has shown a detrimental effect on the mother-infant relationship (Ministry of Health, 2011) and are associated with a range of negative outcomes including cognitive, emotional and behavioural difficulties for the child, adverse effects on the family, the child and the family's socioeconomic situation, and suicidal behaviour (BPJ, Special Edition, 2010).

The support services available for those suffering from postnatal and antenatal depression are limited and are not adequate for the vast quantity of women suffering from these mental illnesses (BPJ,

Special Edition, 2010). Maternal mental health not only affects women but can affect her family and whānau with information showing that postnatal depression may lead to depression in the woman's partner and is linked to difficulties in infants that can have ongoing negative effects through to adulthood (BPJ, Special Edition, 2010).

Low detection rates: Contributors to this submission have explained that when asked questions to do with harming themselves or their baby, they have not felt comfortable to answer honestly because of the stigma associated with infant and self-harm. Women who do not answer 'yes' to these questions are deemed not to be suffering from maternal mental health problems and so they slip through the gaps. This further compounds already low detection rates contributing to inadequate treatment and increasing the risk of long-term damage to the woman and her whānau.

Satisfaction: We note that the Maternity Consumer Survey which assesses women's perceptions of the maternity services they received, fails to ask women about their experience of maternity mental health services. There is little information about the prevalence of antenatal depression but there is the knowledge that women who have experienced depression during or after pregnancy are more likely to experience postnatal depression in future pregnancies (Ministry of Health, 2011).

Midwives have expressed frustration with the system, stating that despite referring patients for services, they are rarely taken into mental health care. Our contributors (including midwives and service users) to this submission have also expressed that once referred to mental health care, they do not receive quality care, stating that 'a one-off visit does not adequality help the whole family'.

Acceptably and accessibility: Contributor's to this submission expressed concern that maternal mental health care is not holistic and treatment that only manages the symptoms with anti-depressants does not adequately support whānau. Particularly when coming from a Māori worldview, which regards wellbeing as including spiritual, emotional, physical and social wellbeing. By excluding any area of haoura, Māori needs will not be met. Our contributors have expressed that whānau have been excluded from the conversation about maternal mental health support and care. Māori have expressed their desire to be included in the support and care for the women. Additionally, there is little research to adequately support Māori and Pacific communities who suffer from maternal mental health problems on a larger scale when compared to European women.

Our contributors have expressed experiencing varying degrees of shame and stigma when accessing support services which are often perceived as coming from attitudes of whānau and health workers. Have expressed a lack of understanding and knowledge of mental health and the referral process, which effects their access to services.

Recommendations:

- We recommend that a review of the threshold for care be undertaken and criteria for treatment be lowered so that help services can be accessed in the intervention stages. We note that despite training regarding maternal mental health being undertaken by those involved in a pregnant women's care, the threshold to meet criteria to access care is high. This means that women are not getting the care they need before their illness progresses to severe cases. Thus, we recommend:
  - access and referral for women experiencing antenatal or postnatal depression be straightforward and equitable for all women;
  - early intervention and treatment when depression is low to moderate as intervention has been highlighted as key to combating the negative effects mental health can have on mothers and infants (Ministry of Health, 2011);
  - that perinatal and infant mental health, antenatal and postnatal mental health be delivered in collaboration with maternal, child and family health social services. Treatments will not be effective unless this is achieved (Ministry of Health, 2011);
  - that more support be made available to women who are suffering from antenatal and postnatal depression before medication is prescribed.
- We recommend there be a question in future 'Maternity Consumer Surveys' that inquiries about women's experiences with mental health care, during and after pregnancy, in addition to recommending that the following research be undertaken regarding:
  - the range of experience of women who have suffered from postnatal and antenatal depression;
  - maternal mental health services; including a stock take and gaps analysis;
  - the impacts, short and long-term that taking anti-depressants and other medications can have on infant development;
  - the prevalence of postnatal depression in Māori and Pacific communities.
- We recommend programmes be developed that enable participants to develop a support group of women experiencing similar challenges and introduce skills that are transferable to other areas of the participants' lives (Phillips & Pitt, 2011).
- We recommend increasing diversity among staff employed in mental health and addiction as Māori, Pacific and Asian peoples are under-represented among addiction and mental health workers (MOH, 2005).
- We recommend that all maternal mental health services have their own antenatal information or Hapū Wānanga available for the group or individual. Our contributors to

this submission have expressed their view that this would speed the knowledge base for the group whilst having their own workers with them for support (whakawhanaunga).

LGBTQIA mental health:

LGBTQIA women have unique mental health needs that are often not met by existing mental health services (Stevens, 2013) and are at increased risk for a variety of health problems (particularly mental health problems) and health risk behaviours (Adams et al., 2012). The LGBTQIA community has been excluded from data collection which has continued the invisibility of this population and increased the suffering of the community who have not been given an opportunity to share their thoughts on matters concerning them (Stevens, 2013). Sexual and gender minority status are associated with mental health disparities among women (Adams et al., 2012) and these services are overloaded and under-funded and do not cater well for women with children or lesbian and queer women (Adams et al., 2012).

Recommendations:

- We recommend mental health services change to address accessibility to and appropriateness for LGBTQ people. To achieve this, we recommend:
  - representative or large-scale data on lesbian and queer women's mental health and addictions;
  - additional services and more funding to better support these at-risk groups;
  - training in LGBTQIA issues for all providers (curriculum and continuing education);
  - removing barriers to appropriate healthcare, for example, GPs and counsellors need to be competent in their knowledge of LGBTQIA people and their increased risk for mental health concerns;
  - education-focused initiatives be made available to raise awareness of mental health issues and where to access support.
- We recommend changes to mental health treatment for queer women, considering the diversity of the LGBTQIA group and that their needs may not be the same as the general population. To achieve this, we strongly recommend LGBTQIA communities be actively involved and consulted about the development and delivery of programmes, policies and services regarding their mental health and wellbeing.

Alcohol addiction:

Alcohol has a negative impact on mental health which not only affects the drinker but those around them. Alcohol consumption contributes to poor mental health and well-being and can create harm in our communities with alcohol dependence being a cause for moderate to severe depression (Samokhvalov et al.,2010). People with substance use disorders in Te Rau Hinengaro, the New Zealand Mental Health Survey, had higher rates of other chronic conditions than those without any disorder (Wells et al., 2007a). In the previous year, 57% of women with any substance abuse disorder experienced chronic pain, 28% had respiratory conditions, 16% had high blood pressure, 12% had cardiovascular disease, 6% had diabetes and 6% had cancer.

Women are more likely to have alcohol problems and depression at the same time (Lejoyeux & Lehert, 2011; Brown & Stewart, 2008; Nolen-Hoeksema, 2004), and to (say they) have developed depression first and the link between depression and alcohol problems is stronger for women than men (Ibid). In New Zealand, about one in five women who drank hazardously also experienced mood, anxiety or other mental disorders (Oakley Browne et al., 2006).

The differences in mental health and well-being between Māori and non-Māori are unjust and must be urgently remedied, when discussing barriers to care for patients with mental health and AOD problems, Maori expressed wanting control over the process (Todd et al., 2002). Our contributors to this submission have said they feel the distribution of alcohol being so rampant in lower socio-economic areas and advertising to minority groups make it more difficult for Māori and others to drink responsibly.

Most women presenting for alcohol treatment have other mental health conditions and have experienced violence and there is a pressing unmet need for a specialised refuge service for women who need integrated substance abuse, mental health and domestic violence support. More than 525 women who had mental health and substance abuse problems tried to get into a women's refuge to escape domestic violence in 2006 (Hager, 2007). A total of 447 children were with them. Refuges accepted 347 of these women; 79, with 81 children, were later moved out because they were considered a threat to other residents or because staff did not have the skills to work with them. Addiction, mental health and domestic violence services that act independently, and do not collaborate, do not result in best outcomes for women.

Recommendations:

- We recommend research be carried out regarding:
  - alcohol consumption by women with intellectual and other disabilities and their access to AOD services;
  - why more women remain non-drinkers than men;
  - how women sustain non- or occasional drinking; and
  - how non-drinking can be supported;
- We recommend that (more) opportunity to Pacific and Māori communities to seek support need to be made.
- We recommend services available to Māori be based on whānau ora and include:
  - kaupapa Māori frameworks (Todd et al., 2002).
- We recommend reducing the availability of alcohol, particularly the prevalence of liquor stores in lower socio-economic areas.
- we recommend mental health training to all care workers and more facilities and funding to care for women with 'special needs' and that these services collaborate more effectively and share information to better meet the needs of their clients.
- We recommend talking therapy in Māori communities. Our contributors expressed that whānauwhānau are more likely to engage with people who have time to sit and talk with them.

Question 3: What sort of society would be best for the mental health of all our people?

- A society that removes the punitive measures and stigma attached to accessing mental health and addiction services in New Zealand.
- One that provides access to mental health and addiction services for those with mild to moderate needs, before the need becomes severe.
- A society in which prevention and intervention services are easily accessible and effective so there is less need for treatment for severe mental health problems.
- A society in which access is equal and equitable for all members, regardless of age, gender or sexual identity[1].

[1] Or any differentiating factors

Conclusion

We are pleased to see the Government has undertaken this inquiry into mental health and addiction in New Zealand. We thank you for the opportunity to comment on this and are happy to provide further information or clarification of issues discussed in this submission should that be helpful.

References

Adams, J., Dickinson, P., Asiasiga, L. (2012). Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: Needs assessment report. Auckland: Te Pou o Te Whakaaro Nui: The National Centre of Mental Health Research, Information and Workforce Development.

BPJ, Special Edition. (2010). Depression in the Antenatal and Postnatal Periods. *Best Practice Journal*, 1-21.

Brown, C.G., & Stewart, S.H. (2008). Exploring perceptions of alcohol use as self-medication for depression among women receiving community-based treatment for alcohol problems. Journal of Prevention & Intervention in the Community, 35(2), 33-47.

Hager, D. (2007). Domestic violence and mental illness/substance abuse - A survey of 39 refuges. Auckland: Homeworks Trust.

Lejoyeux, M., & Lehert, P. (2011). Alcohol-use disorders and depression: Results from individual patient data meta-analysis of the acamprosate-controlled studies. Alcohol & Alcoholism, 46(1), 61–67.

Ministry of Health. 2017. Annual Data Explorer 2016/17: New Zealand Health Survey [Data File]. URL: https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-update

Ministry of Health. 2014. Annual Update of Key Results 2013/14: New Zealand Health Survey. Wellington: Ministry of Health.

Ministry of Health. 2011. Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand. Wellington: Ministry of Health

MOH. (2005). Tauawhitia te Wero – Embracing the Challenge: National mental health and addiction workforce development plan 2006–2009. Wellington: Ministry of Health.

Nolen-Hoeksema, S. (2004). Gender differences in risk factors and consequences for alcohol use and problems. Clinical Psychology,24, 981-1010. doi: 10.1016/j.cpr.2004.08.003

Oakley Browne, M.A., Wells, J.E., & Scott, K.M. (Eds.). (2006). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.

Phillips, S., & Pitt, L. (2011). Maternal mental health: Making a difference. Aotearoa New Zealand Social Work, 31-37.

Rehm, J., Baliunas, D., Borges, G.L.G., Graham, K., Irving, H., Kehoe, T., Parry, C.D., Patra, J., Popova, S., Poznyak, V., Roerecke, M., Room, R., Samokhvalov, A.V., & Taylor, B. (2010). The relation between different dimensions of alcohol consumption and burden of disease: An overview. Addiction, 105, 817–843. doi: 10.1111/j.1360-0443.2010.02899.x

Stevens, M.W (2013). Rainbow Health: The Public Health Needs of LGBTTI Communities in Aotearoa New Zealand. Auckland: Affinity Services.

Todd, F.C., Sellman, J.D., & Robertson, P.J. (2002). Barriers to optimal care for patients with coexisting substance use and mental health disorders. Australian & NZ Journal of Psychiatry, 36, 792-799.

Wells, J.E., Baxter, J., & Schaaf, D. (Eds.). (2007a). Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Alcohol Advisory Council of NZ.