Improving Child and Youth Mental Health and Addiction Services in Southland

Background for the co-design hui on Wednesday 10th May 2023

Purpose

The purpose of this document is to support a discussion about the co-design of a shared future vision for children and youth mental health and addiction services in the Southland district.

Te Tiriti o Waitangi and Equity for Māori

Child & Youth mental health services acknowledge Te Tiriti o Waitangi partnership approaches and actively apply the principles of:

- **Tino rangatiratanga**: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- **Equity**: The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection of taonga**: The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

Equity

This principle requires the crown to commit to achieving equitable health outcomes for Māori. Equity recognises different people with various levels of advantage require different approaches and resources to achieve equitable health outcomes.

Background

Infant, children, and youth in the 0–24-year-old age bracket make up 31% of the population in the **Southern district**, however C&Y attracted less than 15% of the MH&A budget for the 2020-21 financial year. With projected growth in the 0–19 segment of the population over the 2018–2028 time period is projected to be 17% (Māori), 31% (Pacific) and 24% (Asian).

Furthermore, the onset of mental illness peaks in adolescence and early adulthood, with 50% of all mental disorders developing before the age of 15, and 75% by the age of 25. New Zealand also holds the shameful record of having the highest youth suicide rate for children and youth aged 10–19 years amongst 19 developed countries (Shah, Hagell & Cheung, 2019)[1].
The 0–24-year age group is a priority because the experience and impact of trauma and mental distress during this life stage is very significant and can have lasting, negative effects as an adult. Targeted prevention measures, early intervention services and effective treatment options for this group present the best opportunity to reduce the personal, social, and economic costs of mental distress and addiction problems that are experienced by infants, children, young people, and their families/whanau.

In 2017, Alliance South undertook a process to develop a "whole of sector, systems and population approach" to child and youth mental health services called "Stepped Care"[2]. The redesign priorities and activities are described in that report.

The key recommendations in that report (page 2) are:

- Establishment of a new **Southland Child youth and Family Mental Health and Addiction Community Charter.** The Charter will be a binding agreement between services and a commitment to provide a consistently high standard of care to anyone needing it.
- Development and implementation of a new **Southland Regional Wellness Plan** which will support the prioritization and coordinate the delivery of population health and health promotion activity in the region.
- Delivery of new **professional development and training** opportunities designed to grow the capability and capacity of the current workforce and also other service providers and stakeholders in the community.

[1] Shah, R., Hagell, A., & Cheung, R. (2019) *International comparisons of health and wellbeing in adolescence and early adulthood*. Retrieved from: https://www.nuffieldtrust.org.uk/research/international-comparisons-of-health-and- wellbeing-in-adolescence-and-early-adulthood

[2] Alliance South, 2017, Southland Child, Youth and Family Stepped Care Model and Plan

- Services to adopt a **developmental approach to how services are delivered** to age groups with specialist needs including infants (0-3), children (4-11), adolescents (12-17), and young adults (18-24).
- Establishment of new **School Based Health Teams** working in partnership with Education sector for the phased implementation of a new Year 9 health and Wellbeing Assessment Programme
- Establishment of a new **Primary Mental Health and Addiction Youth Service** that supports young people with mild to moderate and severe conditions. The new service will work across primary and secondary care and will be co-existing capable. It will have the flexibility to provide early/brief interventions, consult liaison support to other services including primary care and also provide ongoing care and treatment to longer term clients.
- Service providers will **collectively renegotiate contracts**, service specifications, targets and data collection requirements with the funder to ensure consistency, continuity and a joined-up approach to service delivery.

A possible future

Active consultation and co-design with iwi, people with lived experience of mental distress and whanau where possible, to address inequity within the system. This will allow us to design a future that meets the needs of our local tamariki, rangatahi and whānau.

The expansive geography of Southland poses some unique challenges where equity of access must be considered to ensure local services are available to children and youth across the region.

We will also consider how to future proof the model of care by examining how to support and develop a resilient and responsive workforce.

The 'fix-now' priority recommended to 'Adopt a life course approach and design services responses accordingly (Pg. 39, Recommendation 10. Te Hurihanga – Time for Change).

The Mental Health Commission, 2012 introduced a 'life course' approach (Figure 1), which looked at the critical points in the development of mental health and addiction issues across the life span.

The benefit of adopting a life-course perspective is that it makes explicit the influence of family/whānau, community, environment, and the wider societal issues on people's lives. Such an approach implies that the development of health (and other outcomes) over a lifetime is an ongoing, interactive process

and that pathways are changeable (Fine & Kotelchuck, 2010)[3] - refer to diagram below.

It also suggests that it is possible for health and social services to work together to make a real difference in people's lives by intervening earlier and more effectively in the life course, thereby improving people's health, wellbeing, and long-term outcomes.

The possible future will align with the directions signalled in key guiding documents, including He Ara Oranga, Kia Kaha, the Long-Term Pathway, Whakamaua, and any Service Frameworks that are developed.

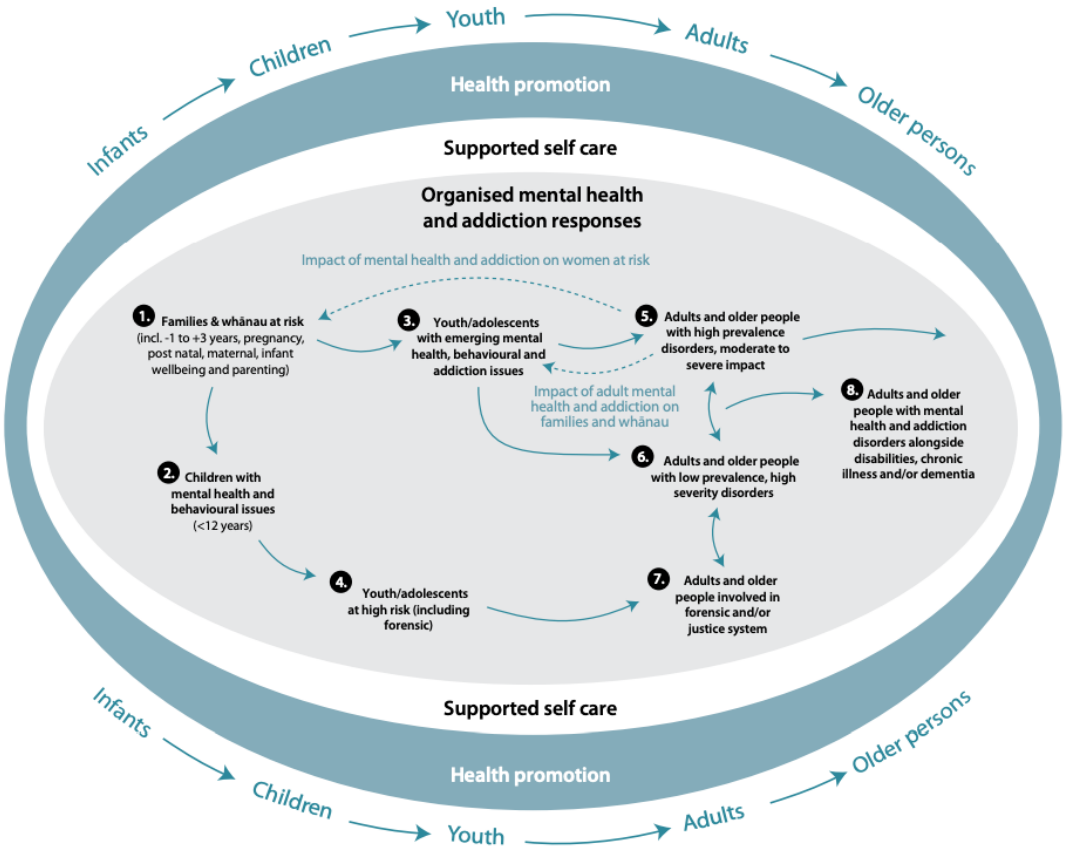

Figure 1:

[3] Fine, A. &, Kotelchuck, M. (2010). *Rethinking MCH: The MCH life course model as an organizing framework.* US DHHS, HRSA, Maternal and Child Health Bureau.

Priority areas:

The following areas have been identified by the reviewers of Te Hurihanga – Time for Change as areas of focus for review and improvement.

Workforce capability/capacity:

Several respondents made comments about the increased demand for both specialist MH&A interventions and community support services for expectant mothers, children, youth and their families/whānau. They were concerned about the inability of the current MH&A system to respond to the increased level of demand. This includes the **lack of services available for moderate to severe needs:** There needs to be a more supported and collaborative transition plan between services and reintegration and support within the community.

Sustainable workforce:

It was identified that the workforce is ageing, as well as losing staff from the sector due to the high demands on individuals and subsequent burnout. Consideration to how a resilient and well supported workforce that has access to professional development can be built.

Wait times to receive care:

Access to Child & Youth MH&A services can exceed ten weeks for a youth NGO service. Concern was expressed about the strain on community providers that were expected to support distressed teenagers and their families/whānau until such time as a specialist MH&A service was able to help.

Access to services:

Accessing the services that are needed can be difficult, with unclear entry criteria and obscure pathways resulting in systemic service barriers. Suggestion of a referral responsive initiative that assists in consistent and clear referral management in and out of services. Equity of access must be considered to ensure young people and their whānau, have access to appropriate services closer to home.

Access to youth appropriate services:

The time for transition from adolescence to adulthood means that some young people in the 18–24-year age group are best served by a dedicated youth MH&A service (particularly if they are already known to that service) rather than being transferred to an adult MH&A service. However, the retention of some young

people who have reached the upper age limit for access to a child and youth MH&A service does have resource implications.

Child services:

Teachers and schools need training in **Trauma Informed Practices** to enable support for children who are experiencing difficult situations. Any interventions will also need to consider the child's family and school contexts and will need to address multiple social, health, mental health, and behavioural issues.

The effects of family harm and resulting trauma and maltreatment experienced in childhood can result in long-term physical and mental health consequences, including depression, anxiety disorders, drug abuse and suicidal behaviour. The Family Harm approach aims to drive down the significant harm experienced by families through an integrated cross-agency response.

Earlier intervention and preventative approaches:

It is noted that some specialist Infant, Child, and Adolescent Mental Health Service (ICAMHS) staff expressed a desire to work more closely with local schools to help teachers address mental health issues as part of a targeted early intervention strategy but said that they were unable to do this now because of the lack of ICAMHS staff and the lack of resources. This also includes accessibility of alcohol and vapes. The youth survey identified that alcohol and vapes are very accessible and sold to minors causing stress and anxiety.

The result of the Adolescent Health survey (Clark et al., 2013)[4] indicates that efforts to support students with very high substance use will need to reach at least 11% of the high school population.

Culturally responsive services:

The Southern district has had a significant increase in refugees and migrants over the years, many of whom are living in rural areas where services are not well equipped to deal with language and cultural differences. In the Southern region, the numbers of young people identifying as being of Māori, Pacific or Asian ethnicity are predicted to increase over the next two decades. Services and workforce that reflect the culturally diverse community with specific focus on Māori contribution. Empowering Māori, Pacifica, and other ethnicities to

[4] Clark, T. C., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012. Auckland, New Zealand: The University of Auckland.

participate in their hauora (health) and oranga (wellbeing). This also means educating the workforce on te ao Māori and other worldviews to ensure a culturally safe space for people using services.

Better integration and continuity:
There is some evidence that poor integration across Te Whatu Ora Southern and Community Services, leads to poor therapeutic collaboration and results in distress and disengagement in tamariki, rangatahi and whanau. It has been suggested that shared wellbeing plans that accompany tamariki and rangatahi through the system would be helpful.

A shared understanding across the sector of practice frameworks and language:
Agreed definitions and frameworks, such as what constitutes 'need' and 'moderate-severe' are required. One solution suggested is the development of Health Hubs that are accessible to youth as well as time and effort being given to building effective practice relationships across the sector. It should be noted that in some areas within the sector shared understandings and collaborative approaches to service delivery are working well.

Include rangatahi (youth) voice in service design:
Consideration of how to facilitate rangatahi input into service design is important, for example, engaging with youth through peer support services and youth advisors to normalise regular feedback and communication with service users.