



The Pathways to Resilience Project

Pathways to Youth Resilience: Youth Mental Health and Drug and Alcohol Services in New Zealand

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BACKGROUND

This paper provides an overview of policy and service delivery for youth in New Zealand in relation to mental health and drug and alcohol services. It forms part of a set of policy review documents for the Pathways to Resilience Research being conducted at Massey University. Other papers address Care and Protection, Health and Disability, Youth Justice and Educational policies and services. In New Zealand mental health and drug and alcohol services are linked in both policy and delivery, and are largely managed within the health sector. Drug and alcohol use and mental health disorders are common amongst high needs young people. This report focuses specifically on youth mental health and drug and alcohol use. Youth health and disability services are the subject of a separate report.

Overall responsibility for Mental Health in New Zealand lies with the Ministry of Health, which is the principal advisor to the Government on health and disability policy. The Ministry funds and purchases health and disability support services on behalf of the Crown, and supports District Health Boards (DHBs) which are responsible for the health of their local communities. Within the Ministry of Health, the Mental Health Group provides policy advice to the Minister of Health. It is responsible for implementation of government policy through collaborative efforts with District Health Boards, and for the administration of mental health legislation (Ministry of Health, 2007).

Youth mental health services in New Zealand operate under a number of legal and policy frameworks. Legislation primarily deals with those with serious mental health needs (see definitions below) while policy also directs services to those with lower level needs requiring mental health (including substance abuse and addiction) support.

Defining Severity

Specialist mental health services in New Zealand are directed towards children and young people who are severely affected by mental illness (New Futures 1998, Te Raukura 2007). The severity of a child or young person's mental health needs determines their access to specialist mental health services, with 'mild' and 'moderate' needs expected to be treated in less formal settings such as through families, GP, schools, NGOs, Child Youth and Family and the private sector.

The Ministry of Health's access benchmarks suggest children and young people (0-19 years) with the most severe needs comprise 3-5% of the population.

New Futures (1998) defined severe mental health problems as:

“diagnosable psychiatric conditions that undermine the psychosocial development of children and young people and cause significant difficulties in the way they interrelate” (Ministry of Health 1998:14).

This policy provided guidance around the use of the DSM-IV in combination with cultural considerations to assist in the diagnosis of severe mental health problems, and noted 'severity' should consider the type and duration of the

condition, the child's circumstances, their capacity to resolve problems, the degree of impairment/ interference with normal development and the extent to which the child is a risk to him/herself or others (New Futures 1998:14).

Te Raukura notes that while New Futures defines severity, there is no agreed definition in the Nationwide Services Framework, and there are concerns about inconsistent targetting of service delivery:

“There is concern that how severity is defined and used as an entry criterion to CAMHS is not consistent nationally, and that it may lead to discrepancies and the threshold may be too high.” (Te Raukura: 12)

There are also limitations about which disorders fall within the definition of 'severe', for example CAMHS do not provide treatment services that specifically address conduct disorder/severe antisocial behaviour where it is a sole presentation (Te Raukura: 15), although other services to address conduct disorder are now available.

Mild and moderate needs are not clearly defined in New Zealand's mental health policy, although Te Raukura (2007) notes a need to increase primary health care responses/interventions for children and youth with mild to moderate mental health and/or alcohol and drug problems (Ministry of Health 2007:20).

This report focuses on responses that address the severe end of the mental health and drug and alcohol spectrum.

LEGAL FRAMEWORKS

The Mental Health (Compulsory Assessment and Treatment) Act (1992) guides youth mental health provision in New Zealand. Several other pieces of legislation and a number of codes also have a bearing on youth mental health provisions, particularly with regard to consent and confidentiality. Key documents are discussed below.

Mental Health Act

The Mental Health (Compulsory Assessment and Treatment) Act 1992 provides a legal framework for the provision of services to those with serious mental health needs. It includes guidance on compulsory assessment and treatment, treatment orders, advice and assistance, patient rights and treatment of patients. The Act prioritises the use of community based over inpatient treatment unless a patient cannot be treated “adequately” in the community (Mental Health Act 2002, s28 (2)).

Section 8 of the Act specifically addresses special provisions for children and young people and applies to children up to the age of 17 years. It states:

- assessment of a child or young person should be by a child psychiatrist

- the consent of a parent or guardian is not deemed sufficient for a young person from age 16 (the young person's consent should be sought)
- brain surgery for a mental disorder should not be performed on anyone under the age of 17
- a patient receiving compulsory treatment and about to turn 17 must be reviewed at least a month before turning 17.

The Act largely deals with the proportion of the population exhibiting the most acute mental health needs. That is, those who have a diagnosable mental disorder and pose a risk to themselves or others.

United Nations Convention on the Rights of the Child (UNCROC)

While not legally binding, UNCROC provides some guidance regarding the rights of young people in need of mental health support:

- Article 23: "The right to special care and education for children who are mentally or physically disabled"
- Article 24: "The right to the highest attainable standard of health and to facilities for treatment and facilitation"
- Article 25: "The right for children placed away from home to have their treatment reviewed regularly"
- Article 33: "The right to be protected from dangerous drugs."

Ottawa Charter

The Ottawa Charter for Health Promotion (1986) focuses on prevention of illness, promotion of health, and empowerment of communities and individuals regarding good health. It provides guidance regarding service delivery to young people.

Consent and Confidentiality

For young people the legal framework that is often most concerning is around consent to treatment, inclusion of family and whānau, and confidentiality. While the various laws and codes covering the area collectively and separately suggest the starting point for the clinician should be that of family inclusion, situations do arise where a young person does not wish to have family involved in their care (Mental Health Commission, 2009). Young people 16 years of age or older can consent to treatment in the same way as an adult, but for children and young people under 16 the common law doctrine is applied, that is, that consent (or refusal to undergo treatment) can be lawful if the clinician judges the young person as having sufficient understanding and maturity (Mental Health Commission, 2009).

Codes concerning disclosure of information about the young person to their parent or guardian also depend on the extent to which the young person is deemed 'competent' and information can be withheld by clinicians if it is considered in the young person's best interests. If they are deemed competent to consent to treatment, or are over the age of 16 years, their privacy is protected

under the Health Information Privacy (HIP) Code, 1994. For a young person deemed 'incompetent', other legal considerations apply, as consent to treatment must be sought from a parent or guardian.

Other

Legislation and codes also exist regarding treatment of people with an intellectual disability and provisions concerning drivers' licences for patients under the Mental Health Act.

POLICY

The 1995 Mason Report (Mason Inquiry Report 1996) marked pivotal changes to New Zealand's mental health system. It recommended the establishment of a Mental Health Commission, the ring fencing of mental health funding separate from general health funding (Mason, Johnston & Crowe 1993), and the development of a programme to reduce discrimination against people with mental illnesses .

Established in 1996, the Mental Health Commission acts as a 'watchdog' on mental health and addiction services in New Zealand, provides independent advice to Government and leads the implementation of Te Tahuu (Ministry of Health 2005), New Zealand's current mental health strategy . The Commission has a current expiry date of 2015, by which time it is intended that mental health and/or addiction services are fully integrated into the wider health system .

The Blueprint

When it was first established one of the Mental Health Commission's first tasks was to produce the 'Blueprint for Mental Health Services in New Zealand: How Things Need to Be' (The Blueprint) (Mental Health Commission 2007). The Blueprint set strategic benchmarks for the delivery of mental health services in New Zealand. In particular it set a target for state delivery of mental health services to the three per cent of the population in most need. This target still applies today. The Blueprint suggested the remaining seventeen per cent of the population who require mental health services would access these through the private sector. The three per cent benchmark provides a useful way of assessing progress towards adequate service delivery in New Zealand. The Blueprint also endorsed a 'recovery' approach to Mental Health, with recovery defined as "happening when people can live well in the presence or absence of mental illness" (Mental Health Commission 2007). This approach embraces a move away from institutional care and toward greater social inclusion of people living with addiction and mental health disorders. The recovery approach is now official policy in New Zealand (Gawith 2006).

The Blueprint recognised that children and young people's particular and different mental health needs require specially designed services which:

- have a developmental focus

- focus on emerging psychiatric problems
- focus on disorders which are specific to children and young people
- include intensive family involvement
- give particular attention to youth suicide risks
- offer strong consultation and liaison with other health and social services
- co-ordinate well with services from other sectors such as education and social welfare
- are delivered in an environment that recognises the special physical, cultural, and emotional needs of children and young people
- are easily accessible to young people, including being mobile.

The Blueprint's development was directly influenced by the Treaty of Waitangi and continuing recognition of the poor state of Māori mental health (including that of young Māori) during the 1980s and 1990s (Kingi, 2002:12). It placed emphasis on meeting the mental health needs of and developing effective services for Māori (Mental Health Commission, 1998). It stated in particular that Māori children and young people need access to both kaupapa Māori and appropriate mainstream services (Mental Health Commission, 1997).

The Mental Health Commission is currently developing a new Blueprint that “provides guidelines to achieve a sustainable investment pathway for [Mental Health and Addiction] services”. This is in response to high levels of unmet needs in the mental health and addiction sector (particularly for those with ‘mild to moderate mental illness’, and significantly more mental health and addiction problems in Maori and Pacific populations), and increasing demand “with only a 30–40 percent increase in resources, including workforce” (Mental Health Commission 2011:9). The new Blueprint will guide the future mix of mental health and addiction services, resourcing (with constrained growth in resources) and service models (Mental Health Commission 2011:11).

Te Puāwaitanga and New Futures

In alignment with the Blueprint, the mental health strategies of the 1990s, *Looking Forward* (Ministry of Health 1994) and *Moving Forward* (Ministry of Health 1997), led to the development of *Te Puāwaitanga: Māori Mental Health National Strategic Framework* (Ministry of Health 2002b). This framework sought to provide national consistency for planning and delivery of services for tāngata whaiora (people seeking wellness, mental health service users) and their whānau. *Te Puāwaitanga* focused on “tangible mental health outputs” (Ministry of Health 2002b: 3) as stepping-stones to achieving the government’s goals. It also acknowledged the importance of non-clinical strategies and that for Māori, good mental health requires access to the “institutions of Māori society such as te reo Māori (the language), land, marae, and ready access to primary health care, education, housing and employment opportunities” (Minister of Health, 2002b: 3).

In terms of youth specific policies, New Futures (Ministry of Health, 1998) provided a strategic framework for specialist mental health services for children and young people. It outlined the functions of specialist mental health services for children and young people, and suggested that development should build on the existing core of Child and Adolescent Mental Health Services (CAMHS), Youth Speciality Services (YSS) and kaupapa Māori services . In particular, it recommended the need for flexibility and responsiveness to local needs in service provision (Minister of Health, 1998).

He Nuka Mo Nga Taitamariki: A national workplan for child and youth mental health services (Kia Tu Kia Puawai Mental Health Group, 2000) addressed the service gap for children and young people with severe mental health problems. It identified high priority groups to receive additional new funding in the first instance. These were firstly Māori children and young people and their whānau; secondly, Pacific children and young people and their extended families; thirdly, children and young people with severe problems and multiple needs and their families/whānau/ caregivers and fourthly, groups with other areas of high need (rural groups, those with alcohol and drug dependency, those at risk of suicide and those experiencing stigma).

Current Policy

Strategic direction in general population Mental Health is currently guided by the Ministry of Health's plan, Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005). Te Tahuhu includes a number of priorities specific to children and young people:

- to increase services that are funded for children and young people
- building a workforce to deliver services for children and young people
- improve the availability of and access to quality addiction services and strengthen the alignment between addiction services and services for people with mental illness, recognising that substance abuse and problem gambling are increasing problems for many young people.

Current priorities for youth mental health are outlined in Te Raukura – Mental Health and Alcohol and Other Drugs: Improving Outcomes for Children and Youth (Ministry of Health 2007b). Linked to Te Tāhuhu, Te Raukura widens the scope of mental health services to

- include alcohol and drug services
- include children and youth with mild to moderate needs (previous policies focussed on youth with severe mental health needs)
- take a whole of government approach to youth mental health including sectors such as primary health and education
- "... reduce inequalities and improve access for Māori and Pacific peoples (Werry Centre 2009a: 25)."

Development of the mental health and addictions workforce has been identified as needing improvement. Two specific policies have been designed to address this issue. Whakamarama te Haurahi: To Light the Pathway. A Strategic Framework for Child and Adolescent Mental Health Workforce Development 2006-2016 “outlines a national approach to tackle systemic obstacles currently limiting workforce development and a process to support regional, inter-district and local planning processes” (Wille 2006:3). Kia Puawai te Ararua: National Māori Mental Health Workforce Development Strategic Plan 2006-2010 aims to have Māori make up to 20 per cent of the mental health and primary health workforce by 2011, and to enhance the “indigenous values” and clinical standards in the workforce (Te Rau Matatini 2006).

DELIVERY

New Zealand’s youth mental health services are delivered both by the state and the non government sector (NGOs). As noted in the background to this report, specialist mental health services, particularly those provided by the State, are directed towards children and young people with severe needs. Services to address mild and moderate needs are more likely to be provided by community based services, families, GP, schools, and/or Child Youth and Family or through the private sector which requires that people have the capacity to pay on a fee for service basis.

The Ministry of Health (MoH) provides ring-fenced funding for state services and for some NGOs. The Ministry operates through 21 District Health Boards (DHBs) which in turn fund local Primary Health Organisations (PHOs). PHOs are the local structures for delivering and coordinating primary health care services .

Each DHB funds an adult mental health and Community Adolescent Mental Health Service (CAMHS). CAMHS work with children and young people up to the age of 17 and cater to the 3 per cent of the population in greatest need. It provides predominantly clinical services (assessments, referrals, medication, therapeutic treatments etc). Three DHB’s provide inpatient youth services , six fund Kaupapa Māori youth services, and two fund two Pacific youth services. Child and youth services are intended to include alcohol and other drug services for this age group, although there is considerable variation in approach by different DHBs. More than one in four young service users access general adult, alcohol and other drug, adult specialty, and forensic services. Nearly half of 15 to 19 year-olds who access services are seen by adult services rather than by child and youth teams (Mental Health Commission 2006:20). PHOs may also provide mental health services; the extent and nature of these vary.

Non government organisations, community and voluntary services play a significant role in the sector, providing both clinical and support services in mental health and drug and alcohol addiction, and in some cases residential treatment. Many cater for young people with moderate and low needs as well as

those with severe needs. In 2008 there were 100 NGO youth service providers across New Zealand, including 21 kaupapa Māori and 5 Pacific NGOs (Werry Centre 2009a: 43). NGOs' services may be based on type of diagnosis (such as eating disorder or conduct disorder); on cultural background (such as iwi-based or kaupapa Māori services or Pacific health services); or cater to a particular age group (such as youth specific services delivered by Youthline, Youth One Stop Shops or Youth Health Centres).

The first point of contact with the health service for young people with mental health or alcohol and drug problems is usually a primary health worker. This may be within a PHO, such as a general practitioner, a nurse, or a Māori community health worker, or it may be health workers from other agencies such as the school guidance counsellor or nurse, iwi-based or community youth health services such as Youth One Stop Shops (YOSS) (Minister of Health, 1998).

Other agencies likely to be involved with young people with mental health issues are specialist education services (Group Special Education) which provide psychological or other services to help teachers manage young people, and Children Young Persons and Their Families Services (CYFS) may also provide psychological services for young people with care and protection and/or offending problems.

Inpatient (Tertiary) Services

Young people who experience more serious mental health issues may have contact with specialist inpatient and outpatient services delivered by DHBs' provider arms (e.g. hospitals). Availability of these services varies regionally.

Child and youth mental health inpatient services are offered in Auckland, Wellington and Christchurch by DHB Regional Services.

In Auckland, Starship Hospital's Child and Family Unit provides child and adolescent mental health inpatient services for the Auckland District Health Board. It provides all inpatient services in the North Island for children under 13 years, and inpatient services for 14-18 year olds living north of and including Taranaki.

In Wellington the Regional Rangatahi Adolescent Inpatient Service (RRAIS) is the central region's acute adolescent inpatient unit, providing services for rangatahi aged 12-17 years who are experiencing acute mental health problems (<http://www.tekorowaiwhariki.org.nz>; retrieved April 11, 2011). The Central Region also offers an Eating Disorder Service (CREDS) which is a community based organisation run by the Hutt Valley District Health Board. It provides residential and community based services (<http://www.ed.org.nz/index.asp?pageID=2145862942>; accessed April 11, 2011).

Canterbury DHB's Child, Adolescent and Family Inpatient Mental Health Services provides limited inpatient services for the Southern Region out of Princess Margaret Hospital in Christchurch. This includes

- The Child & Family Inpatient Unit and Day Programme: 8 beds for children and adolescents under 16 for assessment and treatment of "severe psychiatric, emotional behavioural or developmental disorders"
- Youth Inpatient Unit: 8 inpatient beds available for "the assessment and treatment of youth aged 16 and 17 years (or 18 if they are still at school), who have a severe mental health needs or need more specialised services than those available from other mental health services"
- Inpatient Eating Disorders Service: 6 inpatient beds operated by the Canterbury District Health Board's Eating Disorder Service, who also offer outpatient services.

(<http://canterbury.webhealth.co.nz/provider/service/view/2035281/>; retrieved 11 April 2011).

Drug and Alcohol Services

As noted above, drug and alcohol services are provided in conjunction with youth mental health services, and there is great variation across regions. For example in Auckland the Community Alcohol and Drugs Service runs a programme for youth called Altered High, and Odyssey House runs a treatment centre with a range of specialist programmes for adolescents. Raukura Hauora o Tainui is an example of an iwi charitable trust and runs the Te Oho Ake - Rangatahi (Youth) Alcohol & Other Drug Service. In Wellington, Welltrust provides regional youth drug and alcohol services. Because of the limited number of alcohol and drug treatment services for children and young people, many young people access adult drug and alcohol services. The Alcohol Drug Helpline (www.adanz.org.nz) provides information services and has an up-to-date directory of all the treatment and advice services available for youth anywhere in New Zealand.

Mild and Moderate Needs

As noted earlier, services and support for young people with mild to moderate mental health needs are largely provided by non government organisations, community and voluntary services (e.g. Youthline), the Ministry of Education, Child Youth and Family, the mainstream health sector (e.g. GPs, Youth One Stop Shops), private psychiatrists, psychologists or counsellors on a fee for service basis, or by family and friends.

There are a number of websites which provide information to young people in New Zealand about mental health or drug and alcohol use, including:

- The Lowdown: www.thelowdown.co.nz (Ministry of Health)
- Youthline: www.youthline.co.nz (Youthline)
- Urge / Whakamanawa: www.urge.co.nz; www.whakamanawa.co.nz (Youthline)
- Trippin: www.trippin.co.nz (Taranaki DHB)
- Headspace: www.headspace.org.nz (Auckland DHB)
- The Mental Health Foundation www.mentalhealth.org.nz

The Werry Centre for Child and Adolescent Mental Health maintains a comprehensive directory of all mental health services (including those provided by NGOs and within the community) available to children and young people across New Zealand (<http://www.werrycentre.org.nz/?t=214>; retrieved 11 April 2011). Youthline also has a Youth Services Directory with specific sections on mental health and drug and alcohol services available to young people: <http://www.youthline.co.nz/services-directory.html?catid=17>.

STATISTICS

Prevalence

The 2004 Mental Health Survey reported that young people aged 16-24 years have the highest twelve-month prevalence of all age groups in New Zealand of any mental health disorder, at 28.6 percent. The 16-24 year olds surveyed most commonly reported anxiety (17.7 percent), followed by mood disorders (12.7 percent), substance use disorders (9.6 percent) and eating disorders (0.6 percent) (Oakley Browne et. al., 2006). Similar results were found by the Dunedin Multidisciplinary Health and Development Study and the Christchurch Health and Development Study which conducted assessments with 15 and 18 year olds. The Youth'07 study (Adolescent Health Research Group, 2008) found that 15 per cent of female students and 7 per cent of male students reported significant symptoms of depression, although noting this study included younger students (aged 13-18 years) than the Christchurch and Dunedin studies.

In terms of gender, the Christchurch and Dunedin longitudinal studies found young females had higher rates of mood and anxiety disorders than males; males had higher rates of substance use and conduct disorders than females (Oakley Browne, et al., 2006).

Māori children and adolescents are estimated to be 1.5 to 2.0 times more likely to suffer from a mental health disorder than non-Māori, although this appears to be related to disadvantage rather than to ethnicity per se (The Werry Centre, 2009b). The Christchurch and Dunedin longitudinal studies found Māori youth had significantly higher rates than non-Māori for anxiety disorders, conduct disorders and substance use disorders. The Youth 2000 study (Adolescent Health Research Group, 2004) which included a total of 2,325 Māori students, showed that Taitamariki (Maori young people) were more likely to report significant depressive symptoms (16.2 per cent) compared with NZ European students (11.7 per cent) and that Māori females (22.7 per cent) reported significantly more symptoms of depression than males (9.9 per cent).

The Youth 2000 study also indicated more Pacific students reported depressive symptoms than New Zealand Europeans (18 per cent Pacific compared with 11 per cent NZ European) and significantly more Pacific students had attempted suicide in the previous year. More Asian (a diverse population with Chinese and Indians making up the largest groups) than NZ European students in this study

showed depressive symptoms (16.8 per cent compared with 11.7 per cent) and Asian female students reported significantly higher prevalence than Asian males for depressive symptoms (21.6 per cent girls compared with 11.1 per cent boys), suicidal thoughts (27.5 per cent girls compared with 16.7 per cent boys), and suicide attempts (11.7 per cent girls compared with 4.1 per cent boys) (The Werry Centre, 2009b).

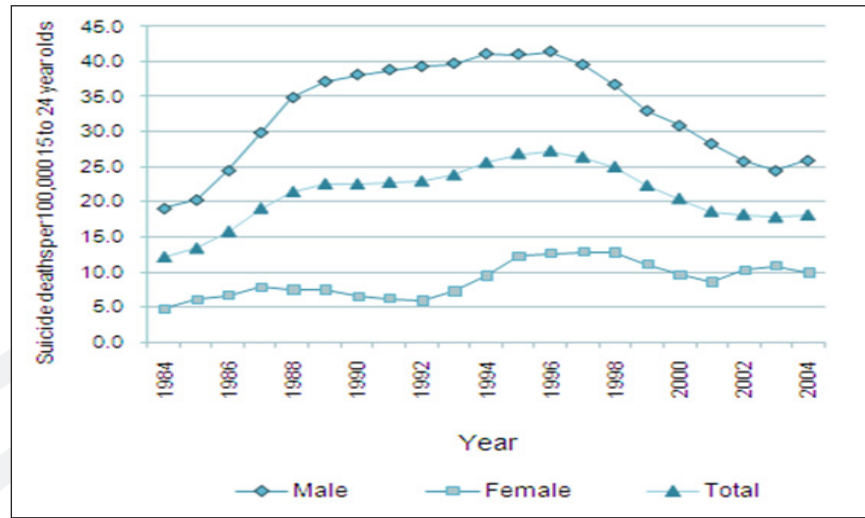
The literature suggests youth offenders and young people who attend Alternative Education schools (Denny et. al., 2004) are more likely to experience mental health and drug and alcohol issues. The international literature consistently finds the prevalence of mental health disorders with youth who offend is significantly higher than the general population. Rates of mental health and alcohol or drug issues between 65 per cent and 75 per cent highlight that mental health and alcohol or drug issues are more pronounced in the youth offender than the general population, particularly those who are detained (The Werry Centre, 2009b). There is little New Zealand specific data on mental health disorders within the youth justice population, but one study has found that among offenders under 18 years at one youth residential unit, 56 per cent of young people (73 per cent of the girls) had emerging diagnosable mental health disorders (National Health Committee, 2007).

Suicide and Self-harm

New Zealand's youth suicide rates are of concern, and in 2009 the OECD reported New Zealand had the highest rates of youth suicide by 15-19 year olds of all its member countries, at a rate of 15.9 suicides per 100,000 population (OECD 2009).

Younger people in New Zealand have higher rates of suicide than the general population. In 2006, 119 young people aged 15 to 24 died from suicide; 61 in the 15 to 19 age group (a rate of 19.4 deaths per 100,000 population) and 58 in the 20 to 24 age group (a rate of 19.9 deaths per 100,000 population) . While rates for 15–24 year olds have decreased since 1995 (having reached a peak of 28.7 per 100,000) they are still higher than the 1986 rate of 15.6 per 100,000 (MSD 2009: 24). These trends are depicted below.

Figure 1: Suicide death rate per 100,000 young people aged 15 to 24 years, by sex, selected years 1983-2005



Source: Ministry of Health, New Zealand Health Information Service.

Note: Data presented is the mid-point of a three-year moving average. 2005 data is provisional.

(From <http://www.youthstats.mhd.govt.nz>; 1 Feb 2010)

Despite the decrease in youth suicide rates in the general population, rates for Māori show no obvious trend and are higher than the general youth population. In 2006 the suicide death rate for Māori youth (15–24 year olds) was 31.8 per 100,000, compared with the non-Māori rate of 16.8 per 100,000 (MSD 2009: 25). The Youth 2000 survey (Adolescent Health Research Group 2002) found Māori students were twice as likely to attempt suicide (11.5 per cent) than New Zealand Europeans (5.7 per cent) and that suicidal thoughts and attempts were significantly higher for Māori girls (33.4 per cent and 15.3 per cent respectively) than for boys (18.3 per cent and 8.0 per cent respectively).

Male youth suicide rates are higher than female, however the number of hospitalisations for intentional self-harm is higher for females than for males.

Table 1: Hospitalisations for Intentional Self Harm 2007 (MSD 2009)

Age Group	Male	Female	Total
10-14	22	89	111
15-19	105	300	405

The Youth'07 survey (Adolescent Health Research Group 2008) found one quarter of female and 16 per cent of male secondary school students (13-18 years) had deliberately harmed themselves in the last 12 months. Despite these high rates of mental illness in its various forms, approximately 1 in 4 female students but only 1 in 10 male students had seen a health professional for emotional worries in the last 12 months.

Youth Drinking and Drug Use

Compared with other age groups, young people in New Zealand have higher rates of alcohol and other drug use and abuse.

(<http://www.youthstats.myd.govt.nz/indicator/healthy/index.html>: 1 Feb 2010).

The New Zealand Health Survey (Ministry of Health 2008) found that young people aged 15–24 year olds comprise the largest group of the population with a potentially hazardous drinking pattern . In 2006/07, 49.2 per cent of males and 32.6 per cent of females aged 15-24 reported potentially dangerous drinking habits. Male drinkers (29.2 per cent) were significantly more likely than female drinkers (13.0 per cent) to have a potentially hazardous drinking pattern. The pattern of heavier drinking by males was consistent across age groups and for each survey year.

In the 2004 "New Zealand Health Behaviours Survey – Alcohol Use" (Ministry of Health 2007), 6.8 percent of young people aged 12 to 17 and 29.6 percent aged 18 to 24 reported drinking at least six standard drinks (men) or four standard drinks (women) one or more times a week. Young people aged 18 to 24 years were more than twice as likely as those in any other age group to engage in weekly heavy drinking.

Results from the Youth2000 study (Adolescent Health Research Group 2002) showed that alcohol use (weekly and binge drinking) was higher in Māori students (50.9 per cent for binge drinking) compared with NZ European (41.1 per cent) and regular use of marijuana was almost three times higher in Māori students (12.9 per cent) than New Zealand Europeans (4.7 per cent).

The Youth'07 study (Adolescent Health Research Group, 2008) reported that substantial numbers of students reported problems from drinking alcohol such as unsafe sex (14 per cent), unwanted sex (7 per cent), or injuries (22 per cent) and that 16 per cent of students who currently drink alcohol had been told by friends or family that they needed to cut down their drinking. It also found that approximately 5 per cent of students use marijuana weekly or more often, and among those currently using about 1 in 4 use it before or during school.

Partially in response to concerns about youth alcohol consumption, the Law Commission (2010) made substantial recommendations about amending current legislation (including raising the age at which a person can purchase alcohol and strengthening parental responsibilities) which resulted in the introduction of the Alcohol Reform Bill 2010. This Bill has had its first reading and submissions have been made. A report back on these submissions is due in June 2011 .

Access to Services

While young people have high rates of mental health disorders, they tend not to access mental health services as frequently as older people (Oakley Browne, Wells, & Scott, 2006:31). This may be at least in part attributable to the

unavailability of services for young people. Despite this, youth access rates increased 13 per cent between 2004 and 2008. The table below depicts young people's use of DHB mental health services in 2006/07.

Table 2: Clients seen by team type 2006/07

Age group (years)	Inpatient	Community	Alcohol and drug	Child, adolescent and family	Forensic	Kaupapa Māori
0-19	381	4359	1443	11,428	513	539
% of all clients	5.1	8.3	7.2	74.8	12.1	15.7
Total all ages	7,781	49,941	18,853	14,626	3,671	3,608
%	100	100	100	100	100	100

Source: Ministry of Health 2009

Note: The child and adolescent population, ages 0-19 years, comprised about 29 per cent of the total population in 2006.

Despite an increased use, access to Child and Adolescent Health Services (CAMHS) for young people aged 0-19 years remains substantially below the equivalent figure for adults and rates of access for young people ranged from 0.9 to 1.6 per cent, depending on region. These rates are substantially below the Blueprint's access target of 3 per cent (Eggleston & Watkins, 2008).

Table 3: Percentage of children and young people who accessed mental health services, over the six-month period ending 30 June 2008 compared with the Blueprint target.

	0-9 years	10-14 years	15-19 years	0-19 years
Jan – Jun 2008	0.44%	1.6%	2.49%	1.28%
National Target	1.00%	3.90%	5.50%	3.00%

Source: The Werry Centre 2009a

As the table above shows, access levels for those in the 15-19 year age group were less than half the Blueprint target. In exploring whether young people who require services are receiving them, it is interesting to note the findings from the Christchurch Health and Development study that less than a quarter of those in the study that met criteria for a mental disorder had sought treatment, with the most common source of treatment being general practitioners and counsellors (Oakley Browne, et al., 2006).

Of those young people who did access child and adolescent mental health and alcohol and addiction services:

- the majority were male
- the age group most likely to access services were 15-19 year olds
- the number of male clients under 15 years (0-14 years) was slightly larger than the number in the 15-19 year age group; however, for female clients, the number under 15 years was only about half the number in the 15-19 year age group (The Werry Centre, 2009a:39).

Interestingly, the Youth'07 study found more female than male students had seen a health professional for emotional worries in the last 12 months. This suggests while young females may be more likely to seek treatment, treatment is more frequently delivered to young males.

The Werry Centre data for 2008 (Table 4 below) shows small ethnic differences in young people's access to services. Between January and June 2008, the access rate for rangatahi Māori (1.27) was just below the national rate (1.28), although the access rates for 15-19 year olds was higher (2.94) than the national rate (2.49).

The access rates for all Pacific Peoples 0-19 years were below the national rates.

Table 4: Total Clients of mental health services by ethnicity for Jan- Jun 2008; 0-19 year olds

	0-9	10-14	15-19	0-19
Māori	0.39	1.53	2.94	1.27
Pacific	0.16	0.85	1.63	0.68
National	0.44	1.60	2.49	1.28
National Target	1.00	3.90	5.50	3.00

Based on data from The Werry Centre, 2009a)

In 2008, Māori children and adolescents 0-19 years made up 24 per cent of clients accessing mental health services, consistent with their 24 per cent composition of New Zealand's total 0-19 population. More Māori males accessed services than Māori females. Pacific children and adolescents 0-19 years made up 5 per cent of clients accessing mental health services, less than their 9 per cent composition of New Zealand's total 0-19 population. More Pacific males accessed services than Pacific females (The Werry Centre, 2009a).

COSTS AND WORKFORCE

Funding

Mental Health receives 10-15 per cent of the total health budget and child and youth mental health and addiction services receive about 10-12 per cent of that. In 2007/08 Child and Adolescent Mental Health Services received \$124,934,700, 11.4 per cent of the overall mental health funding. The Werry Centre suggests this spending "is currently not reflective of the population as 29 per cent of the population is 0-19 years old" (Werry Centre 2009a:43).

Since 2004/05 the total funding for youth mental health has increased 30 per cent (26 per cent in DHB provider funding and 45 per cent in NGO provider funding). This equates to a 29 per cent funding increase per head of child or adolescent, up to an average funding of \$90.73 (excluding inpatient) (Werry Centre 2009a:33).

Workforce

In 2008 the workforce equated to 1268.79 FTE's and 111.73 vacant FTE's. This is an increase of 16 per cent FTE's from 2004-2008 and a decrease of 25 per cent in vacancies (Werry Centre 2009a:35).

Despite this increase, the number of community clinical employees (DHB & NGO, excluding inpatient) is 51 per cent below the target set by the Blueprint Guidelines, and the psychiatry workforce needs to increase by 70 per cent to meet levels recommended by the World Health Organisation (Werry Centre 2009a:38-39).

SUMMARY

New Zealand's youth mental health and drug and alcohol services are linked in both policy and delivery and are largely managed through the health sector. Legislation, policy and government-funded delivery tends to focus on young people with severe mental health needs (3-5% of the population). Services for moderate to low needs are less comprehensive and largely provided by other sectors (education, welfare), NGOs, other community organisations or private providers. The Mental Health Act (1992) provides some specific guidance on youth mental health and current priorities for youth mental health are outlined in Te Raukura (Ministry of Health 2007b), including reducing inequalities for Maori and Pacific young people.

Mental health and drug and alcohol services are delivered by the state, the non government sector (NGOs) and private providers. Specialist Community Adolescent Mental Health Service (CAMHS) are state funded to provide clinical services to 3% of children and young people up to the age of 17. Inpatient youth services are available in Auckland, Wellington and Christchurch. Specialist Kaupapa Māori and Pacific youth services are available in some areas. Child and youth services are intended to include alcohol and other drug services, although many young people access adult services because specifically focused youth services are not available. Non government and local community organisations (e.g. Youthline, Richmond Fellowship, Te Runanga o Kirikiriroa, Youth Horizons Trust) provide clinical and support services in mental health and drug and alcohol addiction, and in some cases residential treatment.

Young people 16-24 years have the highest prevalence of mental health disorders for all age groups in New Zealand (Mental Health Survey 2004) with anxiety, mood disorders, substance use and eating disorders featuring most highly. Rates

for Māori are higher than for non-Māori (The Werry Centre, 2009b). Young people are less likely to access mental health services than other age groups and in 2008 only 2.49% of 15-19 year olds accessed mental health services. Treatment was most frequently delivered to males.

Youth suicide rates are the highest in the OECD (OECD 2009) although these have been decreasing since 1995. Maori youth and male suicide rates are higher than for the population as a whole.

Young people aged 15-24 make up the largest group reporting potentially dangerous drinking habits (Ministry of Health 2008) with young males reporting heavier drinking patterns than young females. Alcohol and marijuana use was higher in Maori than NZ European students (Adolescent Health Research Group 2002). The Alcohol Reform Bill which is currently before Parliament makes substantial recommendation about amending legislation in order to reduce hazardous drinking patterns by youth.

In 2007/08 Child and Adolescent Mental Health Services received \$124,934,700, 11.4 per cent of the overall mental health funding. The Werry Centre suggests this spending “is currently not reflective of the population as 29 per cent of the population is 0-19 years old” (Werry Centre 2009a:43).

In 2008 the number of community clinical employees was 51 per cent below target, and the psychiatry workforce needed to increase by 70 per cent to meet levels recommended by the World Health Organisation (Werry Centre 2009a:38-39).

ENDNOTES

¹ These pieces of legislation and standards include the Children, Young Persons and their Families Act (1989); the Care of Children Act (2004); the Ministry of Health, Involving Families: Guidance Notes; UNCROC; the Code of Consumer Rights (1996); the Medical Council of New Zealand's Statement on best practice when providing care to Maori patients and their whānau (2006); the New Zealand Medical Association Code of Ethics (2002) and the Health Information Privacy Code (1994) (Mental Health Commission 2009).

² The Mental Health Act (1992), s2(1) outlines the following definition of mental disorder, to which the Act applies: "mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it— (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself".

³ For the purposes of diagnosis, clinicians within New Zealand (and internationally) commonly use DSM-IV criteria. The DSM-IV (Diagnostic and Statistical Manual) is a manual published by the American Psychiatric Association which provides specific criteria for assessing mental disorders. The DSM-IV has been both criticised and praised, and has had a number of revisions to include new and exclude outdated mental health disorders. The current version is the DSM-IV-TR.

⁴ This recommendation eventually led to the establishment of the Like Minds Like Mine public education campaign.

⁵ <http://www.mhc.govt.nz/Content/About%20Us/Information>; 13 July 2010.

⁶ Currently government is proposing to close the Mental Health Commission prior to its 2015 expiry date and place a Mental Health Commissioner within the Health and Disability Commission to complete any remaining work (www.stuff.co.nz/national/politics/5080909/Pain-but-no-gain-in-reshuffles-Labour; 31 May 2011).

⁷ The Treaty of Waitangi is the founding document of New Zealand for relationships between Māori and the Crown and is acknowledged in all aspects of health services provision, including in mental health.

⁸ DHB funded child and adolescent mental health services known as CAMHS are for children and young people up to 20 years old with moderate to severe emotional, behavioural or psychological problems. The Youth Specialty Service (YSS) helps young people aged 13-20 years old with serious mental health problems. Kaupapa Māori Services are specialist Māori mental health services available to Māori young people (and others). These are holistic services that respect, value and include whānau beliefs, customs, language and culture.

⁹ Te Tahuu was developed in response to a number of changes that had taken place in society since the 1990s. These changes included greater emphasis on primary health care delivery, changed perceptions of mental health users' healthcare and service delivery needs, the growth of a strong consumer voice and the development of a recovery philosophy, and the greater involvement of Mental Health service users' families and whānau in the delivery of services (Minister of Health, 2005).

¹⁰ Current until 2012.

¹¹ See definitions of mild, moderate and severe needs, page 2.

¹² Primary health organisations (PHOs) bring together doctors, nurses and other health professionals (such as Māori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives) in the community to serve the health needs of their enrolled populations. PHOs vary widely in size and structure, are not-for-profit, and provide services either directly by employing staff or through provider members.

¹³ DHBs can collaborate to provide regional services e.g. inpatient services.

¹⁴ There are several non-government organisations which provide useful information services in addition to or rather than direct service delivery. The Mental Health Foundation is a not for profit charitable trust, which provides funds to organisations for mental health education, prevention and research as well as producing its own information and resources on a wide range of mental health-related issues. Suicide Prevention Information New Zealand (SPINZ) was developed in response to 1990 data showing that New Zealand had the highest youth suicide rate in the developed world. From 2004 the service broadened to an all-ages brief rather than its initial youth-focused one. SPINZ focuses on collecting, managing and disseminating information,

and on translating high-level research into more easily accessible formats. The Werry Centre for Child and Adolescent Mental Health is a national centre that is based at the Department of Psychological Medicine at the University of Auckland and is involved in training and supporting mental health professionals, advocating for the mental health needs of children and adolescents and promoting research in child and adolescent mental health.

¹⁵ Group Special Education (GSE) is a group in the Ministry of Education focused on providing services - directly and indirectly – to children and young people with special education needs.

¹⁶ Child Youth and Family Services (CYFS) is the statutory child protection agency in New Zealand.

¹⁷ Mental health disorder as measured by CIDI 3.0 meeting criteria for DSM-IV disorder.

¹⁸ Similar results were found by two longitudinal studies. The Dunedin Multidisciplinary Health and Development Study (DMHDS) (following 1,237 children) and the Christchurch Health and Development Study (CHDS) (following a cohort of 1,265 children), have found the following rates of mental health disorders amongst their cohorts: prevalence rates of any disorder of 22 and 24 percent respectively at age 15 years, and 36.6 and 35 percent respectively at age 18 years (Minister of Health, 2002a). The DMHDS assessments at age 18 years found that the most prevalent disorders were major depressive disorder (16.7 per cent), alcohol dependence (10.4 per cent) and social phobia (11.1 per cent). The CHDS study interviews of participants at 18 years found the most common disorders were substance use (24 per cent), mood disorders (22 per cent) and anxiety disorders (17 per cent).

¹⁹ Suicide statistics at the time of writing were only available up until 2006.

²⁰ www.youthstats.mxd.govt.nz; February 2010.

²¹ Noting the small number of Maori youth suicide deaths make it hard to ascertain trends.

²² The proportion of the population aged 15 years and over who drink alcohol, who scored eight or more on the Alcohol Use Disorders Identification Test (AUDIT), as measured in the New Zealand Health Surveys conducted by the Ministry of Health in 1996/1997, 2002/2003 and 2006/2007. The AUDIT is a 10-item questionnaire covering alcohol consumption, alcohol-related problems and abnormal drinking behaviour.

²³ A summary of information about this bill can be found at Parliament's website: <http://www.parliament.nz/en-NZ/PB/Legislation/Bills/BillsDigests/b/5/c/49PLLawBD18141-Alcohol-Reform-Bill-2010-Bills-Digest-1814.htm>.

²⁴ Includes services provided by government and NGO provided services.

²⁵ This number includes DHB, community and NGO employees, including social workers, nurses, occupational therapists, alcohol & drug workers, youth workers, psychiatrists, psychologists, counsellors, family/whanau advisors, family therapists, cultural advisors and community support workers.

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