1. Introduction

1.1. Please find enclosed the New Zealand Society for the Study of Diabetes response to the questions proposed in the mental health and addiction inquiry consultation document. Comments regarding the technical issues indicated in the Terms of Reference have been integrated into the answers. We thank you for this opportunity.

1.2. NZSSD is an incorporated society with over 400 members including diabetes specialist physicians, diabetes specialist nurses, podiatrists, dietitians, ophthalmologists, general physicians, family doctors, psychologists, community health workers and allied industries.

NZSSD is the national advisory body on scientific and clinical diabetes care and standards. NZSSD’s objectives are to promote the study of diabetes and the best standards of care of diabetes in Aotearoa New Zealand. It also provides the national reference source in the subject.

The membership has been consulted in the development of this submission.

1.3. Diabetes mellitus is a complex metabolic condition which affects the entire body. There are three main types of diabetes including type 1 diabetes mellitus, type 2 diabetes mellitus, and gestational diabetes mellitus. It is estimated that approximately 250,000 New Zealanders have diabetes and 25% of the adult population have prediabetes.

Type 1 diabetes mellitus can affect a person of any age and can only be managed by insulin injections through the skin. Within Aotearoa New Zealand the youngest child/tamaiti diagnosed was 9 months, with most diagnoses typically occurring under the age of forty, peaking in the teenage years. For type 2 diabetes mellitus management can be a combination of lifestyle change, oral medications, or insulin injections with the age of diagnosis typically post-puberty although cases are becoming more common in children/tamariki. Type 2 diabetes disproportionately affects Māori and Pasifika people. Gestational diabetes mellitus can be diagnosed at any stage of pregnancy and is managed by lifestyle change, oral medications, or insulin injections.

All types of diabetes mellitus are serious and require daily self-management to ensure adequate blood glucose control for positive health outcomes. Diabetes mellitus affects both physical health, including an increased risk of cardiovascular disease and stroke, kidney disease, limb amputation, and blindness, and mental health, including psychological distress through to serious mental illness.

People with type 1 diabetes mellitus and type 2 diabetes mellitus are at increased risk of depression, anxiety and eating disorders. It has been estimated that more than one-quarter of those with type 2 diabetes mellitus have at any one time either a current major
depressive disorder or moderate to severe levels of depressive symptomatology (Lloyd et al., 2018). The financial cost to society and health care systems is substantial when the mental health needs of people with diabetes are not diagnosed or managed, as are the morbidity and health consequences for patients (Ducat, Philipson, & Anderson, 2014, p. 691).

Further, often the identification and appropriate care for psychological and psychiatric problems is lacking, suggesting that a comprehensive approach to diabetes management is needed to improve clinical outcomes (Lloyd et al., 2018). These concerns lead to this submission.

1.4. For the purposes of this submission the term “mental health” is used to describe the spectrum of mental health concerns including mental distress to enduring psychiatric illness unless otherwise specified.

2. Inquiry Questions

2.1. What’s Currently Working Well?

What Do You Think Is Currently Working Well? Why Do You Think It Is Working Well? Who Is It Working Well For?

Diabetes professionals are interested and motivated to help their patients who experience the spectrum of mental health issues.

For those people with diabetes who are actively engaged in primary and secondary mental health services and there is collaborative treatment planning between services, this appears to be working well.

For diabetes teams, and individuals with diabetes and his/her family/whānau, who are able to access a psychologist or mental health professional with a robust understanding of diabetes, there is better identification of mental health needs and guidance about potential treatment and intervention pathways. When mental health issues are actively addressed all aspects of diabetes management improves.

2.2. What isn’t Working Well at the Moment?

What Mental Health And Addiction Needs Are Not Currently Being Met? Who Isn’t Receiving The Support They Need And Why? What Is Not Being Done Now That Should Be?

Very few diabetes services at the primary or secondary care level within Aotearoa New Zealand have a mental health professional embedded in their clinical team. If an external mental health service is available, at either the primary or secondary care health level, a person with diabetes remains the expert in diabetes, rather than working with a clinician who has an understanding of the reciprocal nature of diabetes and mental health. This creates distrust in the mental health system and reluctance by patients to access mental health support as the clinician just “doesn’t understand”.

Physical health care providers do not receive appropriate levels of education and training around mental health issues to screen and assess patients. More importantly, there is not education and training around ways in which they can support and help manage their patients with mental health concerns.

Screening of mental health concerns is recommended in all patients with diabetes and occurs sporadically in primary and secondary physical health care. However, when screening identifies mental health and/or addiction difficulties there are limited resources and
services that these people can be referred to. People with diabetes very rarely meet the inclusion criteria of specialist mental health services.

Mental health services cannot exist in a vacuum. However, there is a lack of connection between mental health and physical health services; these are separate systems within individual District Health Boards and this creates barriers and confusion. Diabetes services and mental health services need to work together with integrated care pathways to best meet the needs of their clients/patients and whānau. There needs to be standardised processes and opportunities that facilitate collaboration and shared care to enable better patient outcomes.

The process of referrals to mental health services is often confusing and cumbersome with limited consistency across the country. There are often multiple services with no single point of entry and therefore patients can fall through the gaps, with diabetes teams often and inappropriately holding responsibility for a person’s mental health. Diabetes clinicians only have access to inadequate primary mental health services, as the three available funded sessions are not sufficient and referrals may be declined due to an opinion that concerns are about physical health needs. Similarly, secondary mental health services often, and at times incorrectly, attribute the mental health concerns to “poorly controlled diabetes” and decline referrals.

A diagnosis of diabetes is life-changing for any individual regardless of age. Many people describe being diagnosed with type 1 diabetes as a traumatic experience. This is often because it can result in an admission to Intensive Care to initiate insulin and stabilise blood glucose levels. Very few people diagnosed with diabetes or their whānau have access to a mental health clinician to support them with the stressors that diabetes brings, including the accompanying shock and grief, nor do they have access to mental health professionals who can assist them to make the necessary changes to their lifestyle.

Diabetes is a health condition that affects all members of a family/whānau. Many family members, particularly parents and spouses, experience vicarious anxiety due to the struggles that they see their family/whānau member going through. Parents of infants/kōhungahunga, children/tamariki, young people/rangatahi diagnosed with diabetes are also expected to take on the added responsibility of overseeing diabetes management tasks which is extremely burdensome. This is extremely stressful and psychologically draining and there is often no support for these family/whānau members.

Insulin is a life-saving medication that has the ability to kill. Many examples were provided of cases of young people and adults who have attempted to kill themselves with the use of insulin (omission or overdose). However, they are not viewed as having a mental health disorder by consult-liaison services so are usually not picked up by community mental health services until the situation is dire.

A patient had two admissions for Diabetic Ketoacidosis (insulin omission) which were self-reported as attempted suicides in three weeks before it was agreed he needed to be admitted under the Mental Health Act.

Adult in their late 20’s with limited whānau support, had repeated admissions with Diabetic Ketoacidosis (due to insulin omission) approximately every ten days; assessed regularly by inpatient mental health services. After about 10 months of similar admissions, community mental health agreed to follow-up.

Adult patient overdosed on insulin with the intent to die. Mental health “stabilised” then deteriorated quickly. Could not access mental health services directly and had to go via the GP which extended the length of time
for specialist help to make sure diabetes was “stable” and the family and diabetes team were at a loss as to how to help.

Mental health legislation says patients can be compelled to take their mental health medication but not any other medication. Therefore, patients with diabetes on insulin cannot be compelled to take insulin, even if they have psychological barriers to administering insulin which means they are unable to care for themselves and can place themselves in a life-threatening situation. These people often end up admitted to hospital in either diabetic ketoacidosis or a hyperosmolar hyperglycaemic state where they are given their insulin intravenously, and repeated hospital admissions occur as they are unable to be compelled to take their live-saving insulin.

Alcohol and illicit substances are also a major issue. The use of alcohol and illicit substances has a direct impact on blood glucose levels. The physiological impact of methamphetamine and other substances means that diabetes treatment has to be modified to account for this. This reduces the potential of achieving blood glucose control, increasing the risk of negative health outcomes including mental health. It is well recognised that hospital admissions in people with diabetes are associated with marijuana and other substance use.

People with type 1 or type 2 diabetes mellitus can drink alcohol safely. Alcohol binges however, can result in diabetic ketoacidosis, a life-threatening condition requiring hospital admission, typically in Intensive Care or High Dependency Units, a very costly experience for the health system or alternatively alcohol excess can cause severe hypoglycaemia and coma. These people can often not readily access rehabilitation services, be it residential care or outpatient addiction services.

Diabetes management tasks bring direct attention to a person’s body and food intake. Patients are expected to inject insulin into subcutaneous “fat” and focus intently on their food intake. Many people with diabetes experience body image concerns as well as eating problems. Omitting insulin is used as a tool for weight loss, compromising a person’s physical health whilst perpetuating psychological distress. Eating disorder services or mental health services very rarely accept referrals for people using insulin for “weight loss” as this is not a mental health diagnosis, regardless that there are significant body image concerns and unhealthy relationships with food and weight. Long term omission of insulin increases a person’s risk for diabetes complications and significant health burden for individuals and the health care system.

For those with type 2 diabetes mellitus, the focus is often on reducing food intake and the messages received from society are that type 2 diabetes is cause by the person themselves, that they are “fat” and “lazy”. This can lead to unhealthy behaviours including severe food restriction. These people are not deemed to meet criteria for mental health support, regardless that their distress levels are not manageable, and they are engaging in harmful behaviours for both their physical and mental health.

Metabolic health has become a significant co-morbidity of psychiatric illness, in particular by the use of atypical antipsychotics. Appreciating that medical professionals prescribing such medication are doing this in the best interests of their patient’s mental health, the risk of medical sequelae including type 2 diabetes mellitus is typically overlooked. Antipsychotic medication adversely affects blood glucose control (hallmark of diabetes) which has a reciprocal nature with mental illness. The more “poorly controlled” a person’s diabetes is the more negatively impacted their mental health is. Additionally, monitoring of physical health is often overlooked for these people, which increases the risk of serious health complications including cardiovascular disease, another costly issue for the health system.
2.3. What could be Done Better?

What Are Your Ideas About What Could Be Done Better Or Differently To Improve Mental Health And Wellbeing In New Zealand? What Could Be Done Better Or Differently To Prevent Addiction From Occurring? What Could Be Done Better Or Differently To Prevent People Taking Their Own Lives And Support Those Affected By Suicide? How Could Support Be Better Provided To Those Who Need It?

Links between mental health and diabetes have been recognised for nearly a century (Kooy, 1919). Unfortunately, regardless of this knowledge, this link is not reflected in the provision of service for people with diabetes in Aotearoa New Zealand, as outlined in the previous section. Moreover, the “full visibility” of the impact of poor mental health is difficult to quantify unless at the extreme end. The following are recommendations about what could be done to improve the mental health and wellbeing in Aotearoa New Zealand including the prevention of addiction and prevention of suicide.

2.3.1. Specialist psychological support needs to be available nationally at the time of diagnosis of diabetes for individuals and their whānau to determine risks for mental health concerns, strengths, and to support the development of adaptive coping strategies.

Physical illness including diabetes, can have profound social and emotional consequences and can result in mental health problems which then impede management of physical health and increase mortality rates. (Royal College of Psychiatrists, 2010). There are several factors that make a person with diabetes vulnerable to developing mental health concerns, these include real or perceived threats to life, physical discomfort, reduction in quality of life, and multiple demands on the individual and their family/whānau.

The Mental Health Issues in Diabetes Conference Working Groups recommend that mental health screening be conducted as part of a programme of anticipatory guidance and a preventative mental health approach should be taken (Ducat, Rubenstein, Philipson, & Anderson, 2015).

Approximately half of all people diagnosed with diabetes are at high risk of decreased psychological wellbeing at the time of diagnosis (Rane, Wajngot, Wändell, & Gåfvels, 2011; Walker et al, 2012). Research has found that nearly 60% of parents report clinically significant depressive symptoms and 60% report clinically significant anxiety in the weeks following their child’s diagnosis of type 1 diabetes (Streisand et al., 2008). Children and young people also report high levels of psychological distress at the time of diagnosis including symptoms of depression, anxiety, and social disruptions (Grey et al., 1995).

2.3.2. Ensure that all diabetes teams and people with diabetes (regardless of age) have access to a mental health provider knowledgeable about diabetes and thus the reciprocal relationship between diabetes and mental health. All people with diabetes should have access to specialist services for psychiatric comorbidities including depression, anxiety, and eating disorders.

The Quality Standards for Diabetes Care Toolkit (Ministry of Health, 2014) outline that ALL people with diabetes “should be assessed for the presence of psychological problems with expert help provided if required” (p. 1) and that “psychological services be delivered as part of the diabetes multidisciplinary team” (p. 53).

Poor mental health can impact social and cognitive function, decrease energy levels, and negatively impact the adoption of health-promoting behaviours, which are key to the safe and effective management of all types of diabetes (Royal College of
Psychiatrists, 2010). Diabetes self-management tasks have a psychological impact, and it is acknowledged by diabetes clinicians that many people with diabetes have difficulty integrating these into their lives while attempting to achieve optimal blood glucose control. Detecting and intervening with maladaptive diabetes-related cognitions and emotions can help improve confidence and the ability to self-manage. Positive emotional health can assist with long-term coping efforts and protect patients from the negative consequences of mental health concerns.

International and national research indicates that psychiatric disorders are more common in people with diabetes mellitus than those without (Anderson, Freedland, Clouse & Lustman, 2009; Oakley Browne et al., 2006; Vinogradova, Coupland, Hippisley-Cox, Whyte, & Penny, 2010). Of concern is that people with schizophrenia and bipolar disorder die approximately 25 years earlier than the general population, largely because of physical health problems including complications of diabetes (Royal College of Psychiatrists, 2010). Treatment for comorbidities needs to target both medical and psychological outcomes in people with diabetes. Alleviating mental health concerns is vital for positive diabetes self-management as the individual is likely to have more motivation and drive for better health outcomes (Petrak, Baumeister, Skinner, Brown, & Holt, 2015).

National data on psychological distress in people with diabetes is scarce. McClintock, Fraser, Lowe-Reid, Corbett & Paul (2017) reported on the psychosocial status of youth and young adults with diabetes in the Waikato. Results indicated high levels of distress with 18% indicating low mood; 9% of the teenagers and 6% of young adults’ results indicated probable depression. A third of the sample were identified to be at an increased risk of diabetes eating problems. With regards to specific diabetes distress, 16% of the sample experienced severe diabetes distress which was related to poorer blood glucose control. Additionally, half of the sample reported excessive diabetes-specific worry and over 70% engaged in an avoidance behaviour related to diabetes management. Of concern in these data are the differences between Māori and non-Māori on almost every psychosocial variable, with Māori having worse outcomes; once more highlighting inequities.

Data from Australia also indicate concerning rates of mental health concerns in both youth and adults. The Diabetes Management and Impact for Long-term Empowerment and Success-2 study (MILES; Ventura et al., 2016) looked at the emotional and behavioural health of Australian adults living with type 1 and type 2 diabetes. 17% indicated that they had been diagnosed with a mental health diagnosis in their lifetime. Moderate-to-severe depressive symptoms affected between 21% and 36% of adults with diabetes, depending on type of diabetes and treatment. Moderate-to-severe anxiety symptoms affected between 13% and 21% of adults with diabetes. Close to a quarter of respondents with type 1 diabetes experienced severe diabetes distress, as compared to between 11% and 20% with type 2 diabetes. The biggest worry for people with diabetes was the future and complications. For those with type 1 diabetes they identified emotional well-being as most negatively affected by diabetes. For those with type 2 diabetes, dietary freedom was the most significant concern.

The MILES-Youth study (Speight et al., 2015) also identified concerning rates of psychological distress in young people with diabetes and their parents. 28% of young people reported poor emotional well-being. A quarter of young people reported moderate-to-severe depressive symptoms and 23% reported moderate-to-severe anxiety symptoms. One third of parents reported their own impaired general emotional well-being and 8% of parents experienced severe anxiety symptoms. This reinforces the need for a family/whānau approach to addressing mental health concerns in diabetes.
There is an overlap of symptoms between a depressive illness and diabetes as well as anxiety and diabetes (Petrak Röhrig, & Ismail, 2018). This provides further rationale for the importance of having mental health clinicians who are cognisant of these issues.

Rates of depression in people with diabetes are two to three times greater than that of the general population (Ducat et al., 2014; Holt, de Groot, & Golden, 2014). This occurs across the life-span from children through to adults. Young adults with type 1 diabetes are identified as being at higher risk of poorer mental health outcomes (Ducat et al., 2014). Depression in people with diabetes is also related to poorer engagement with diabetes self-management, increased hospitalisations, micro- and macrovascular complications and increased mortality (Fisher, Chan, Nan, Sartorius, & Oldenburg, 2012; Mitchell et al., 2013). Depression also increases the risk of progression from impaired glucose tolerance to diabetes (Deschênes, Burns, Graham & Schmitz, 2016).

A bidirectional relationship between depression and diabetes also cannot be ignored, where type 2 diabetes raises the risk of depression and people with depression are at an increased risk of developing type 2 diabetes (Petrak et al., 2018), through both biological and psychosocial pathways. This provides further evidence that mental health providers and diabetes providers need to work together. More and more young people/rangatahi are being diagnosed with type 2 diabetes and there is growing evidence that they are at greater risk of mental health difficulties in subsequent years compared to their peers with type 1 diabetes (Hood et al., 2014).

Depression increases the risks of developing diabetes during pregnancy and, conversely, diabetes during pregnancy increases the risk of perinatal and postnatal depression (Hinkle et al., 2016; Silverman et al., 2017). Moreover, Māori and Pasifika women/wāhine are more at risk of developing depression (BPAC, 2010). Perinatal and postnatal depression has been clearly evidenced to affect our most vulnerable population, our– babies/pēpē (Ministry of Health, 2011; Muzik & Borovska, 2010).

Anxiety is a common presentation in people with diabetes; this is not necessarily diabetes-specific anxiety. Research has found rates of 14% of people with diabetes have diagnosable anxiety with up to 40% experiencing significant symptoms of anxiety (Grigsby et al, 2002). Common diabetes specific anxieties include fear of hypoglycaemia, resulting in missed insulin doses and running blood glucose levels high placing them at risk of diabetic ketoacidosis. Conversely, the fear of complications can lead to people with diabetes restricting carbohydrate intake and running blood glucose levels lower than safely recommended, resulting in hypoglycaemia, which can have dire consequences as well. Needle fear and phobia is a reality in diabetes care, as insulin can only be injected, and can result in missed injections or a delay in initiating an effective management option. Regardless, of whether the anxiety is generalised or diabetes specific, it can lead to non-engagement in diabetes management tasks, resulting in poor physical and mental health outcomes.

Eating disorders are very complex psychiatric conditions with high mortality rates. The link between eating disorders and diabetes was identified in the 1980’s (Rodin, Johnson, Garfinkel, Daneman, & Kenshole, 1986). A key reason for this link is that diabetes management tasks bring direct attention to a person’s body and food intake. The combination of the two conditions increases the mortality risk by three times (Arcelus, Mitchell, Wales, & Nielsen, 2011). This is made more complicated by the societal pressure through advertising, literature, and entertainment on dieting and body image for both females and males.
Colton et al. (2015) studied 126 females with type 1 diabetes over 14 years. Starting at about age 11 years they conducted interviews every 2 years. At the 14\textsuperscript{th} year, 32.4\% met criteria for a current eating disorder, and an additional 8.5\% had a subthreshold eating disorder. Similar concerns are present in children and young people. A study by Wisting, Frøisland, Skrivarhaug, Dahl-Jørgensen, and Rø (2013) identified disturbed eating problems in 18.3\% of 770 Norwegian children aged 11 – 19 years (27.7\% females and 8.6\% males). These rates were higher in the 17 – 19 year age group, with disturbed eating problems identified in half of the females and 14.5\% of the males.

Recent Aotearoa New Zealand data shows similar concerning rates. In a recent study (Edmunds et al., 2017) of 307 young people aged 12 – 20 years, 55\% of females reported significant diabetes eating related problems, and 44\% of males. Of concern were the higher rates in Māori and Pasifika young people.

2.3.3. Ensure that people with diabetes who have repeated life-threatening hospital admissions receive follow-up specialist mental health support in the community to reduce the risk of suicide.

Given Aotearoa New Zealand has one of the highest rates of suicide in the OECD (Ministry of Health, 2017\textsuperscript{a}), this is an important consideration in the care of people with diabetes. Suicidal ideation is a key risk factor for a suicide or a suicide attempt. Therefore, although people with diabetes might not meet diagnostic criteria for a depressive illness they remain at higher risk of suicide than the general population, particularly if experiencing significant psychological distress related to their diabetes.

In a recent Australian study, Handley et al. (2016) reported that the rate people with diabetes (type 1 and type 2), aged between 18 and 70 years, who had suicidal thoughts was seven times higher than people without diabetes. More concerning was that 14\% of people with diabetes reported suicidal ideation in the previous two weeks. This compares to the Australian general population where 2.3\% report suicidal ideation. Diabetes-specific distress, independent of depression increased the risk of suicidal ideation.

In a review of the literature, Pompili et al. (2014) identified that patients with type 1 diabetes were three to four times more likely to attempt suicide than the general population. Furthermore, young men (aged 15 – 29 years) with type 1 diabetes were identified as being at higher risk for suicide.

Wang, An, Shi, and Zhang (2017) carried out a systematic review and meta-analysis and identified that the pooled proportion of deaths in type 1 diabetes attributable to suicide was 7.7\%; with 94 000 completed suicides worldwide. Wang et al. caution that these numbers may be an underestimation due to inaccurate classifications in medical records.

2.3.4. Children and young people with diabetes require specialist mental health support to ensure healthy physical and psychosocial development.

A diagnosis of diabetes during infancy, childhood, and adolescence can cause significant disruption to normal developmental processes which in turn increase the risk of mental health concerns. The Quality Standards for Diabetes Care Toolkit (Ministry of Health, 2014) state that young people with diabetes should have access to multidisciplinary care with expertise in development, youth health, and psychology. Diabetes teams should deliver individualised and family/whānau centred care that is accessible to all, including those who are vulnerable.

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Jeffries et al. (2015), looked at clinical resourcing for children and youth with diabetes younger than 18 years of age and identified that psychological and social support for patients was difficult to quantify due to no such dedicated resource in the majority of Aotearoa New Zealand diabetes centres. It was also and importantly noted that Full Time Equivalent of all disciplines were well below the international recommendations.

There is international consensus that youth and young adults with diabetes deserve access to multi-disciplinary health care teams with expertise in diabetes. The International Society in Paediatric and Adolescent Diabetes (Cameron, Amin, de Beaufort, Codner, & Acerini, 2014) state that care for young people with diabetes should focus on their normal growth and development, a high quality of life and the lowest risk of acute and chronic diabetes complications. With regards to mental health professionals, the ISPAD guidelines suggest expert diabetes teams should include 0.3 psychologists, social, and or youth workers/specialists per 100 patients.

The transition process for children/tamariki to adult/pakeke health services is a challenging one, particularly as young people are often additionally facing moves from education to employment and from the family environment to independent living. Many diabetes health services transition their children/tamariki or young people/rangatahi at different ages dependent on the services available locally. Despite most diabetes services aiming for a smooth transition, the child/tamaiti or young person/rangatahi can be lost to follow up, which increases the risk of mortality (Cameron et al., 2014).

2.3.5. Ensure that culturally appropriate models of care are implemented for Māori and Pasifika people with diabetes that take a holistic view of health, thus incorporating Taha Hinengaro, Taha Whānau, and Taha Wairua.

Mental health disorders are more common in Māori and Pasifika people (Oakley Browne, 2006). Type 2 diabetes disproportionately affects Māori and Pasifika people. It stands to reason then that Māori and Pasifika people with diabetes are even more at risk of mental health concerns.

Most of the current health system focuses on the individual, which is a Pākehā/Western model of health and increases the inequities that we see in health. This does not necessarily work for Māori or Pasifika cultures. Research clearly indicates that Māori need services that are holistic in nature, come from a Māori world view, and particularly include whānau (Durie, 2001; Rochford and Signal, 2009).

2.3.6. Instigation of nationally driven processes for the screening and monitoring of the metabolic status for people with mental health concerns, particularly those prescribed antipsychotic medication.

Antipsychotic medication increases the risk of obesity, metabolic syndrome, and type 2 diabetes and adversely affects blood glucose control (hallmark of diabetes) which has a reciprocal nature with mental illness (Whicher, Price, & Holt, 2018). As mentioned above, the life expectancy of those with persistent and severe mental illness is 25 years shorter than their peers, primarily because of physical illness (Royal College of Psychiatrists, 2010). The higher mortality seen in people with psychotic disorders is also posited to be partially caused by the metabolic effects of antipsychotic medications (Cunningham, Peterson, Sarfati, Stanley, & Collings, 2014).

International research indicates that there are inequities in terms of diagnosis, monitoring and provision of treatment of physical health concerns for people with mental health diagnoses as well as higher mortality rates (Baxter et al., 2016). This has also
been evidenced in Aotearoa New Zealand (Cunningham et al. 2014) and the impact on Māori is also worse.

Te Pou o te Whakaaro Nui’s 2017 Equally Well evidence update recommends that people with mental health concerns, particularly those on antipsychotic medication, need routine screening and monitoring of physical health problems including metabolic monitoring. Stavely et al. (2017) audited New Zealand District Health Boards metabolic monitoring policies. Disappointingly, not all District Health Boards had such a policy and the use of monitoring is low regardless of the presence of a policy.

2.3.7. Ensure that physical health providers receive appropriate training and education about mental health and addiction issues that may be affecting their patients with diabetes. This should include signs, symptoms, and treatment approaches.

Quality Standards for Diabetes Care Toolkit (Ministry of Health, 2014) recommends that health care professionals should have skills to assess, manage or know how and where to refer for psychological problems. The toolkit also indicates that having psychologists as part of diabetes teams can help with the training and supervision of the wider diabetes team, research, audit and service development, thus helping to address the educational needs of diabetes healthcare providers.

Depression is often overlooked by non-mental health clinicians and thus is not treated appropriately. The interactions between diabetes and neglect of depression highlights the importance of training physical healthcare providers about the signs of symptoms of mental health disorders (Petrak et al., 2018). Sevilla-González, Quintana-Mendoza, & Aguilar-Salinas (2017) note that health care providers should be trained to “systematically search for depression-related symptoms” (p. 586), particularly for those who have a suboptimal response to diabetes and obesity treatment and who present with new diabetes-related complications.

There also needs to be increased awareness of the suicide risk in people with diabetes, which exists independently of depression (Wang et al., 2017).

2.3.8. Ensure consistency of care across the country for mild to moderate mental health and addiction issues at the primary care level, with clinical governance and transparent reporting and accountability requirements.

Providers of primary mental health services in all regions should be made readily available with clear and transparent referral processes.

The Primary Mental Health Care (PMHC) initiative was introduced over 10 years ago for adults in Aotearoa New Zealand (Ministry of Health, 2004), yet there continue to be inconsistencies across the country about access and quality. It is commonly recognised, from international and national research, that the majority of mental health presentations are ‘missed’ by primary care practitioners. Those in rural and more socially deprived areas continue to have a reduced level of care (Ministry of Health, 2017b).

There was an expectation that PMHC would integrate mental health or psychosocial interventions into the management of physical health problems as appropriate (Collings et al. 2010). However, this does not appear to have clearly translated into practice and access to services differ depending on where you live.
Whānau Ora models of health practice strongly support Māori and Pasifika cultural values. This model of practice has been implemented in some primary care services, where health care is coordinated to comprehensively address the health and wellbeing needs. Given the success of this approach (Te Puni Kōkiri, 2017), Whānau Ora should be applied across all primary care practices rather than carrying out further pilot projects.

Collings (2010) highlights that District Health Board’s and PHO’s should critically reflect within their own organizations and among primary care teams the effectiveness of primary mental health care.

### 2.3.9. Free health care for those people with both diabetes and mental health concerns.

Accessing health care is a requirement for people with diabetes and even more so for people with diabetes who have mental health concerns. A significant proportion of people with diabetes as well as those with mental health difficulties are prescribed medication to improve their health. The 2016/2017 National Health Survey (Ministry of Health, 2017b) identified several barriers to accessing health care and thus impacting on their personal health. One recognised barrier was the cost of collecting prescriptions, which was more likely to impact Māori and Pasifika adults and children.

### 2.3.10 Ensure schools are providing evidence-based resiliency programmes and introducing a skills-based approach to emotion regulation and suicide prevention.

A safe physical and emotional environment in schools is expected within Aotearoa New Zealand (Te Pou o Te Whakaaro Nui, 2013) and a protective school environment a recognised as a protective factor against suicide. The Health curriculum is also based on Durie’s (1994) Te Whare Tapa Whā model of health including taha wairua, taha hinengaro, taha tinana, and taha whānau; thus, incorporating mental health (Ministry of Education, n.d.).

Health education is only compulsory in the Aotearoa New Zealand curriculum up till Year 10; however, mental health challenges continue well after this. Mental health education and skills for mental health improvement needs to be explicit in the school curriculum at all levels. Senior students facing formal examinations and social pressures, including transition to employment or tertiary education, may not receive appropriate support about emotional wellbeing and mental health. There needs to be readily accessible mental health support within all schools.

A number of programmes have been piloted or implemented in some schools within Aotearoa New Zealand through the Positive Behaviour for Learning initiative by the Ministry of Education (Ministry of Education, 2015) and some are also supported by the Youth Primary Care Mental Health programme. Core principles of the initiative are that positive behaviour can be learnt and that environments can be changed to foster learning and increase student well-being.

One evaluated example of a resiliency programme is My FRIENDS Youth (Barrett, 2012a; 2012b) which has been available in some Aotearoa New Zealand schools since 2013 as a pilot programme (MacDonald, Bourke, Berg & Burgon, 2015). The focus on the programme is to build resilience and help young people/rangatahi cope with difficult and challenging situations. The My FRIENDS Youth is part of a suite of programmes endorsed by the World Health Organisation (2004). Originally developed in Australia, it has been introduced and positively evaluated in Australian schools.
In the evaluation of the Aotearoa New Zealand pilot, MacDonald et al. (2015) state that the My FRIENDS Youth can be successfully implemented within Aotearoa New Zealand secondary schools. The programme was perceived as being positive by both students and teachers. Additionally, Māori and Pasifika students also supported the use of the programme and reported using strategies from the programme.

The fact that well evaluated and effective programs have only been offered as pilots without national roll out further creates disparities. These programmes need to be made available nationwide.

2.4. **From Your Point of View, What Sort of Society Would Be Best for the Mental Health of All Our People?**

*If You Could Refresh How The System In Aotearoa Promotes Positive Mental Wellbeing, And Prevents, Identifies And Responds To Mental Health And Addiction Challenges, Including Suicide, What Would That System Look Like, How Would It Be Different From What We Have Today, Where Would You Start, And Where Would You Focus Your Efforts?*

Within Aotearoa New Zealand specialist medical and mental health services function largely independently of each other and there are 20 District Health Board’s setting their own funding priorities. This underpins the challenges of providing concurrent mental health and physical health care (Oakley Browne et al., 2006). Closer alignment of physical and mental health services with clear accountabilities is required at a national level. This is to address the issue of physical health care being overlooked in mental health services and mental health needs not adequately being managed in physical health services.

Poor mental health affects cognitive processes including problem-solving, setting goals, memory, and executive functioning skills. These are all core skills required for the management of diabetes. Therefore, without good collaborative care, the physical and mental health outcomes for our people are compromised.

The high rates of mental health concerns in people with diabetes (and their often poor diabetes outcomes) highlight the urgent need for collaborative care including shared record keeping systems. Better care and treatment outcomes for a person’s physical and mental health can be achieved by bringing together primary and secondary care from physical and mental health to form integrated teams. This would allow people with both diabetes and mental health challenges to be supported effectively in the community. Integrated care is based on the belief that improved health gain will occur if people with mental health concerns can have their care delivered by both physical and mental health providers, complementing rather than competing with each other.

Without addressing mental health issues in people with diabetes the implications will continue to be significant. These will include increased physical and mental health care use as well as individual, family/whānau, and societal costs.

2.5. **Anything Else You Want to Tell Us**

*Is There Anything Else You Want The Inquiry To Know?*

Thank you for this opportunity to provide feedback in meeting the mental health needs of our people with diabetes. We are happy to provide any further information and to work together in improving the mental health care of our patients.

**Naku te rourou nau te rourou ka ora ai te iwi**

*With your basket and my basket, the people will live*
REFERENCES


Royal College of Psychiatrists (2010). *No health without public mental health, the case for action*. Royal College of Psychiatrists: London.


