June 6, 2018

Mental Health and Addiction Inquiry
PO Box 27396
Marion Square
Wellington 6141
By email: mentalhealth@inquiry.govt.nz

Dear Professor Paterson,

Re: Mental Health and Addiction Inquiry

Thank you for the opportunity to respond to the above inquiry. The Faculty of Pain Medicine, of the Australian and New Zealand College of Anaesthetists (ANZCA), recognises the inquiry as a significant opportunity to examine the way New Zealand supports patients with mental health and addiction issues, and to identify ways to improve delivery of care.

The Faculty of Pain Medicine (the Faculty) is the professional organisation responsible for the training, examination and continuing professional development of specialist pain medicine physicians and for the standards of clinical practice in pain medicine in New Zealand and Australia. The Faculty formed in 1998, and is one of the first multidisciplinary medical academies in the world to be devoted to education and training in pain medicine. The Faculty's mission is to serve the community by fostering safety and high quality patient care in pain medicine.

The Faculty is particularly interested in the mental health and addiction inquiry, as mental health and addiction are common comorbidities for patients with chronic pain. There is a bidirectional relationship between chronic pain and mental health and addiction, meaning chronic pain and poor mental health are essentially risk factors for each other. This is recognised in the multidisciplinary model of care in which specialist pain medicine physicians work, namely a sociopsychobiomedical framework. To successfully rehabilitate patients suffering from chronic pain, the physical, psychological, and socio-environmental factors contributing to the condition must be addressed.

Below, the Faculty has provided its response to the inquiry, with an executive summary of key points, followed by more in depth responses. If you have any questions about this submission, please contact Virginia Mills (Senior Policy Adviser) in the first instance, at policy@anzca.org.nz.

Yours sincerely,

Professor Edward Shipton
Chair, New Zealand National Committee

New Zealand
National Committee
Faculty of Pain Medicine
PO Box 25506
Featherston Street
Wellington 6146
New Zealand
Level 7, EMC House
5 Willeston Street
Wellington 6011
T: +64 4 499 1213
F: +64 4 499 6013
E: fpm@anzca.org.nz
www.anzca.org.nz
www.fpm.anzca.edu.au

1. Executive Summary – the Faculty of Pain Medicine's key points in response to the Mental Health and Addiction Inquiry

It is the Faculty's position that:

- Physical health and mental health are strongly linked and have a bidirectional relationship but this is not reflected in the disconnected funding mechanisms and structure of the health system.
- Chronic pain must be recognised as a significant risk factor contributing to poor mental health and addiction in New Zealand. It is also a modifiable risk factor, meaning significant improvements could be achieved by increased support for patients with chronic pain conditions.

in New Zealand suffers from chronic pain

What's working well?

- There is growing awareness of chronic pain and the physical and mental impact it has on patients in the medical community and the general public.
- Over the past decade, access to psychology services in primary care has been supported via Ministry of Health funding.
- ACC has recognised the link between chronic pain and mental health, and its community pain contracts now enable patients to access multidisciplinary care for both physical and mental wellbeing. However, it has had significant problems in implementation due to resource limitation.
- Canterbury Health Pathways is a successful model for supporting integrated care as a web-based information portal that can be accessed by general practitioners, hospital specialists, nurses, and allied health practitioners to plan patient care.

What isn't working well?

- Mental health, addiction and chronic pain services are under resourced and over-stretched - and therefore unable to meet population needs.
- Funding and service provision are fragmented and siloed – with disconnection between treatment for somatic conditions and mental health and addiction.
- Government funding is in siloes, creating barriers to a cross-sector approach to health and wellbeing. Whole of government costs and benefits do not seem to be taken into account, such as between Health, Social Development, Oranga Tamariki and ACC.

What could be done better?

The Faculty considers:

- A national strategy for the assessment and management of people experiencing chronic pain should be developed, that recognises the social, psychological and biomedical factors that contribute to chronic pain, and addresses the issues of inappropriate opioid prescription and risk of addiction.
- Resource needs to be invested in provision of pain medicine services and training a sustainable pain medicine workforce to meet population needs.
- Resource also needs to be invested in primary and specialist mental health and addiction services.
- The per patient funding cap for ACC patients with chronic pain should be revised, to enable patients to access appropriate multidisciplinary care.
- It would be beneficial for health practitioners across medical, nursing and allied health practitioner groups to have more access to education and training in managing patients with chronic pain.
- A patient education campaign around chronic pain and addiction could also have significant benefit and increase population health literacy.
- Policy making at the government level needs to take a cross-sector approach, which recognises investment in one area may result in savings in another area.
- Collaboration between specialist services, and between primary, secondary and tertiary care needs to be fostered, to enable a patient centred approach to managing physical and mental health comorbidities.

2. Submission – the Faculty of Pain Medicine's response to the Mental Health and Addiction Inquiry

It is the Faculty's position that:

- Physical health and mental health are strongly linked and have a bidirectional relationship. However, in New Zealand, the systems and structures in place for funding and treating physical and mental conditions are often disconnected.
- Chronic pain must be recognised as a significant risk factor contributing to poor mental health and addiction in New Zealand. It must also be recognised that it is a modifiable risk factor, meaning significant improvements could be achieved by increased support for patients with chronic pain conditions.

Evidence of the relationship between mental health and chronic pain is clear in the scientific literature. Chronic pain sufferers have a higher prevalence of suicidal ideation, suicide plans, suicide attempts, and death by suicide, than those without pain, and chronic pain itself is an independent risk factor for suicidality. [i] Chronic pain sufferers also have a higher risk of developing depression than those without pain, and the risk increases as the severity of pain increases. Pain severity negatively impacts depression outcomes, and is associated with more severe depression, more frequent use of medications including opioid analgesics (which can lead to addiction), functional limitations, poorer self-rated health, higher unemployment, , and more doctors' visits for pain

related reasons. Also, patients with an increasing severity of depression, report more frequent pain complaints, [ii] reflecting that the relationship is bi-directional.

Chronic pain is highly prevalent in New Zealand, affecting more than one in five adults (21%) [iii], and having a burden of disease similar to that of anxiety and depressive disorders. [iv] The clear link between chronic pain and poor mental health, and the high prevalence of chronic pain in New Zealand, means chronic pain must be taken seriously as a risk factor for, and contributor to, poor mental health in New Zealand. As with mental health issues, chronic pain patients often suffer stigmatisation that they are work avoidant, or their chronic pain complaints are not real or valid, which can further contribute to poor mental health.

The Faculty commends the broad terms of reference of the mental health and addiction inquiry. Members of the Faculty's New Zealand National Committee have addressed the inquiry's consultation questions below, based on their experiences of working with patients who suffer from chronic pain, and mental health and addiction issues.

1. **What's currently working well?**

There are several initiatives in the health sector that show promise for supporting the mental health of patients with chronic pain, and enable a combined approach to treating physical and mental health. Significant gains could be made by expanding and supporting these promising initiatives. The Faculty would like to highlight several examples below:

Education and awareness

There is growing awareness of chronic pain and the physical and mental impact it has on patients in the medical community and in the general public. The Faculty is aware that Auckland Medical School has begun teaching aspects of pain medicine in its undergraduate programme, using the ANZCA Essential Pain Management programme. Trainee Interns at the University of Otago in Christchurch are exposed to acute and chronic pain in their anaesthetic block. Expanding education about managing patients with chronic pain would be beneficial across the medical, nursing and allied health professions.

Access to psychology services in primary care

Over the past decade, access to psychology services in primary care has been supported via Ministry of Health funding. This enables patients to be referred by their general practitioner and seen by psychology services in the community. It also enables a referral pathway, so that specialist pain medicine physicians working with patients who have chronic pain, and anxiety or depression, can refer patients to psychology services in primary care. The Faculty strongly supports access to such psychology services in primary care, but notes there are several challenges with the current model. Access to psychology services in primary care seems to be dependent on the general practice, and seems to be unavailable for patients under the age of 18 (possibly due to funding structures). It provides only a relatively low number of sessions (between two to four), which is inadequate for intervention. The Faculty considers that further resourcing is required to expand psychology services in primary care so as to ensure equitable access for patients of all age groups across New Zealand.

Accident Compensation Corporation (ACC) community pain contracts

The ACC has recognised the link between chronic pain and mental health, and its community pain contracts now enable patients to access multidisciplinary care for both physical and mental wellbeing. For example, ACC contracts enable patients to access services from psychologists, physiotherapists, and doctors, among other health practitioner groups. The intent of the ACC model is good. However, it has had significant problems in implementation due to resource limitations. The ACC has introduced a funding cap per patient, which means patients suffering from both chronic pain and mental health issues cannot access the multidisciplinary care they need. For example, patients can only access a limited number of medical and allied health professionals before their funding allocation is used. This can mean that a patient may be able to access both psychology and physiotherapy services, but their funding allocation would then be used and they could not consult a doctor, such as a specialist pain medicine physician as well. The Faculty considers that revising the "per patient" funding cap would allow patients to access the spectrum of care required for rehabilitating their physical and mental health conditions.

Areas of integrated care

Good integration between primary, secondary and tertiary care is essential for patients experiencing chronic pain, mental health, and / or addiction issues. Faculty members cited Canterbury Health Pathways as a successful model for supporting integrated care in Canterbury. Health Pathways is a web-based information portal that can be accessed by general practitioners, hospital specialists, nurses, and allied health practitioners to plan patient care. For example, if a clinician had a chronic pain patient also suffering from addiction issues, Health Pathways would provide information on the resources available to support the patient, the referral pathway to follow, and what sorts of patients are likely to be seen. The success of Health Pathways in Canterbury has largely been due to collaboration between primary, secondary and tertiary care services to establish referral pathways.

2. What isn't working well at the moment?

Faculty members regularly witness gaps and problems in the health sector that result in the mental health needs of chronic pain patients being unmet and large proportions of the population missing out on the support they need from chronic pain, mental health, and addiction perspectives. Two themes emerge for the majority of these issues:

- Services are under resourced and over-stretched - and therefore unable to meet population needs.
- Funding and service provision are fragmented and in siloes – with disconnection between treatment for physical conditions and mental health and addiction.

Further detail is provided below.

Under-resourced health services

The under resourcing applies to mental health services, chronic pain services and addiction services alike. Examples of the impact on services and patients are provided below.

Lack of resourcing for mental health services

Specialist pain medicine physicians in New Zealand witness the impact on patients of under-resourced and over-stretched mental health services. It is a common scenario in chronic pain services to identify patients who are suffering from mild to moderate depression or anxiety, but are not suicidal. However, the under-resourcing of the mental health sector means mental health specialist services are unable to support patients with mild to moderate depression or anxiety, resulting in a significant proportion of patients not meeting the referral criteria, and thus being unable to access the care they need.

Children and adolescents are also severely impacted by lack of resourcing in the mental health sector. As mentioned above, there is some access to psychology services for adults in primary care. However, funding to access psychology services in the community does not seem to be available for patients who are under 18 years of age. This means there are no referral pathways for children and adolescents with mild to moderate depression. Pain services can refer these patients to specialist mental health services, but as with adults suffering from mild to moderate depression, they are unlikely to meet the referral criteria. From there, pain services may choose to devote clinical resources to treating the patients for depression and anxiety. However, as these teams are already stretched, this will mean diverting resource that was dedicated to treating chronic pain.

Lack of resourcing for chronic pain services

New Zealand has a shortage of specialist pain medicine physicians, with approximately twelve FTE nationally. Internationally, it is recommended that there should be one specialist pain medicine physician per 100,000 people, which would equate to approximately 47 FTE in New Zealand. The shortage of specialists and limited number of training positions means patients with complex chronic pain issues can face significant waiting lists, or not be referred for specialist services at all. As an example of unmet need and late intervention, the Auckland Regional Pain Service has found that patients, who are referred to its three-week pain programme, have on average already been living with chronic pain for 8.5 years.

The shortage of specialists and lack of funding for services also means access to chronic pain services is inequitable across the country. Larger centres such as Auckland, Wellington and Christchurch have chronic pain services, and there are some smaller services elsewhere. However, many regional DHBs have no pain services, meaning proportions of the population have no access to pain medicine services at all. Unrelieved chronic pain in these communities will be a contributing factor to mental health and addiction issues. It is worth noting that DHBs with pain services also tend to have lower opioid prescribing. [v]

Children and adolescents are also significantly impacted by the lack of resource for chronic pain services. In Auckland, Starship Hospital has some limited pain services for children, but there are no dedicated paediatric pain services across the country. Unrelieved pain in childhood can progress to chronic pain in adulthood, poor mental health, and increased risk of addiction. The difference in services available to adults and children with chronic pain in New Zealand is highly inequitable.

Lack of resourcing for addiction services

Chronic pain patients are at high risk of addiction from prescription and non-prescription drugs, as many people self-medicate to deal with poorly managed chronic pain. It can be a common scenario for specialist pain medicine physicians to identify chronic pain patients with addiction issues (for example to cannabis, benzodiazepines, alcohol and opioids), and it is critical to be able to refer these patients to alcohol and drug rehabilitation services. However, addiction services also tend to be underfunded, and experience significant challenges coping with their volume of referrals. Better resourcing would enable these services to better cope with referrals.

The chronic under-resourcing of mental health, addiction, and pain services impacts not only patients, but also on the ability of these services to collaborate and develop links. When services become stretched, all clinician time may need to be directed towards service delivery. This makes it challenging to find time for collaborating with other services. Under-resourcing also takes a toll on clinicians themselves, with heavy workloads and frustration about inadequate delivery of services to patients, contributing to burn out.

The fragmented nature of health funding and service provision

Funding at the government and DHB level is in siloes, contributing to fragmented service provision, which in turn impacts upon patients. Below, examples of the siloed system and fragmented care are provided.

Government funding sits in siloes

Government funding sits in siloes, creating barriers to a cross sector approach to health and wellbeing. There appears to be little recognition that costs incurred (or saved) in one area of government funding can have significant impacts on costs and savings in other areas. For example, a major function of chronic pain services is to rehabilitate patients and help them return to work. Investment in pain medicine services may come at a cost for the health sector, but is a benefit for the social development sector due to fewer people needing long term benefits, and increased contributions to the economy. However, as these factors are not seen to directly offset the health budget, they are not valued as outcomes for the health sector.

DHB funding sits in siloes

Funding for physical health and mental health within DHBs also sits in siloes. For example, mental health and addiction funding is ring fenced, and comes from a different budget than funding for conditions such as chronic pain. As well as being funded separately, services for mental and somatic health have different key performance indicators. The disjointed nature of funding and performance measurement makes collaboration between services difficult. As described throughout this document, mental health and physical health are strongly linked and strengthened collaboration and common goals between services would foster a more patient-centred approach.

Care is fragmented between primary, secondary and tertiary care

Different funding and service structures also contribute to fragmented care between the primary, secondary and tertiary sectors, directly impacting on patients. Addiction to prescription opioids is one area that could be better addressed with collaborative approaches to care. A common scenario that pain medicine specialists are aware of, is patients being admitted to hospital for trauma (e.g. a leg fracture) for which they require surgery. After surgery, patients may be prescribed strong opioids for this episode of acute pain. As hospitals are under-resourced and always under pressure, patients are often discharged with a prescription of strong opioids in order to continue managing their acute pain. This is often inadvertently continued in primary care, creating a risk not only of ineffective management of pain, but of addiction as well.

This is an issue that needs to be tackled in the tertiary, secondary, and primary care sectors. At the secondary and tertiary care level, better patient information and written material needs to be available for patients who are discharged on opioids, emphasising that they are for short term use only and outlining a withdrawal plan. At the primary care level, there may need to be more education for clinicians about how to withdraw patients from opioids, and also recognition of when to refer patients to specialist pain medicine services if they continue to experience severe, ongoing pain.

3. What could be done better?

This section about what could be done better provides brief suggestions to address some of the problems identified in questions one and two. As the inquiry's terms of reference are broad, the Faculty is pleased to make the following suggestions:

- A national strategy for the assessment and management of people experiencing chronic pain should be developed, that recognises the social, psychological and biomedical factors that contribute to chronic pain, and addresses the issues of inappropriate opioid prescription and risk of addiction.

- Resource needs to be invested in provision of pain medicine services, and training a sustainable pain medicine workforce to meet population needs. Resource investment in pain medicine services would allow earlier intervention for chronic pain patients as well as more equitable access to pain medicine care across the country. This is critical, considering 21% of the population suffers from chronic pain, which is a contributing factor to depression and an independent risk factor for suicidality. Resource also needs to be dedicated to establishing paediatric pain services, so that children and adolescents have equitable access to care, and their chronic pain can be managed early and its progression prevented.

- Resources also need to be invested in primary and specialist mental health and addiction services. In primary care, access to psychology services needs to be available for adults, adolescents and children to enable treatment of mild to moderate depression and anxiety, and provide referral pathways for specialist services that identify patients with mild to moderate depression and anxiety. Intervention at this stage is important for preventing

progress to more severe mental health concerns, and for supporting improved physical rehabilitation for conditions such as chronic pain. Investment in specialist mental health and addiction services is also crucial, to enable these services to cope with the referral and treatment of patients with more severe mental health and addiction issues.

- The per patient funding cap for ACC patients with chronic pain should be revised, to enable patients to access appropriate multidisciplinary care and have treatment for all dimensions of their injury, and therefore improved rehabilitation.

- It would be beneficial for health practitioners across medical, nursing and allied health practitioner groups to have more access to education and training in managing patients with chronic pain. This would enable improved support of chronic pain patients in the community, and increased awareness of when to refer patients to specialist services. It could also support improved awareness that opioids are not suitable for treating chronic pain.

- A patient education campaign around chronic pain and addiction could also have significant benefit and increase population health literacy. Elements of such a campaign could be the understanding of the difference between acute and chronic pain; that medications such as opioids and cannabinoids are not useful in managing chronic pain and pose a risk of addiction; that chronic pain needs to be managed like other chronic diseases; and support de-stigmatisation of chronic pain. As with mental health issues, chronic pain patients often suffer stigmatisation that they are work avoidant, or their chronic pain complaints are not real or valid, which can further contribute to poor mental health.

- Policy making at the government level needs to take a cross-sector approach, which recognises investment in one area may result in savings in another area. This is particularly the case for conditions such as chronic pain, mental health and addiction, where health service investment can support patients to stay in or return to work, therefore decreasing reliance on social welfare and contributing to the economy. The wider benefits of having a healthy, well, society need to be factored into health policy.

- Collaboration between specialist services, and between primary, secondary and tertiary care needs to be fostered, to enable a patient centred approach to managing physical and mental health comorbidities. This may mean examining different funding structures and key performance indicators across services, to incentivise collaboration.

4. **From your point of view, what sort of society would be best for the mental health of all our people?**

The Faculty supports a public health approach for fostering a society that is best for the mental health of all New Zealanders. This includes focus on equitable health outcomes for Māori and Pacific populations, a strong public health system with accessible mental health and addiction services, strong local communities, and a focus on the social determinants of health such as housing, education, employment, nutrition, and physical activity.

5. Anything else you want to tell us?

For the purposes of this submission, the Faculty has focussed on patients with the comorbidities of chronic pain, mental health and addiction issues. The Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine also highlight to the inquiry that doctors themselves are at high risk of depression and poor mental health. The health and wellbeing of the workforce is a key focus in ANZCA's strategic plan for 2018-2021, and ANZCA has a Welfare of Anaesthetists Special Interest Group that promotes the personal and psychological well-being of anaesthetists and specialist pain medicine physicians and provides resources to support wellbeing.

We are aware that the New Zealand Society of Anaesthetists (NZSA) has provided a submission to the inquiry focussed on the mental health and wellbeing of medical practitioners, and we support the content of the NZSA's submission.

[i] Racine, M. Chronic Pain and suicide risk: A comprehensive review. Progress in Neuropsychopharmacology & Biological Psychiatry 2017.

[ii] Bair M, Robinson R, Katon W, Kroenke K. Depression and pain comorbidity: A literature review. Arch intern med (2003): 163

[iii] Ministry of Health. Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health 2016. From: https://www.health.govt.nz/publication/annual-update-key-results-2015-16-new-zealand-health-survey

[iv] Ministry of Health. *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016*. Wellington: Ministry of Health 2013.

[v] Health Quality and Safety Commission. Atlas of Healthcare Variation: Opioids [internet]. 2018. From https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/opioids/ . Accessed 5 June 2018.