special articles

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An experience of New Zealand psychiatry

New Zealand, an outstandingly beautiful country, offers an opportunity for the psychiatrist from the UK to work in an alternative environment. There is currently a shortage of trained psychiatrists to fill the available posts. The experience of a locum consultant post in adult mental health in the Nelson Marlborough Mental Health Service at the top of the South Island, at the beginning of the new millennium, forms the basis of observations made in this article, the purpose of which is to describe points of interest in the similarities and differences in psychiatric practice between the UK and New Zealand.

The Nelson Marlborough service

The Nelson Marlborough service provides a psychiatric service to a geographical area stretching from the Marlborough Sounds in the east to the Golden Bay area in the west. Nelson is one of the main towns in the area and is in the middle of the catchment area. It is the main site of the psychiatric service. During the 1990s the service has been transformed from a residential-based to community-style service. The large mental hospital, Ngawhatu, just outside Nelson has been run down and now closed and a new purpose-built acute unit of 32 beds opened in June 2000. The mobile community nursing teams, developed from Australian methods and who have won an Australian New Zealand Mental Health Service achievement award for excellence, play a central role in the provision of the psychiatric service. One team based in Nelson and another in Blenheim to the east give 24-hour emergency cover to the whole catchment area of approximately 110 000 people. The population is widely dispersed and considerable distances frequently have to be travelled to bring patients to the acute unit, over mountainous roads. The roads can seem alarming to the uninitiated but are treated as a matter of course by the local population. The use of teleconferencing is well developed, particularly to discuss forensic issues with the forensic service based in Christchurch. The benefit of such communication, where distance makes immediate consultation difficult, was clear.

Accommodation and support services for patients with high levels of need have been devolved to independently contracted services, although a unit for 10 patients with the highest levels of need based in the community remains managed by the mental health service. Day centre provision has been developed in both of the two major towns, and in Nelson Nikau House, a facility based on the Fountain House model in the USA, works extremely successfully.

Mental Health Act

The present form of the Mental Health Act has been in operation since November 1992 (Mental Health (Compulsory Assessment and Treatment) Act, 1992). A patient is usually admitted initially after a formal application for admission is made by a general practitioner and a duly authorised officer, who in the Nelson Marlborough service is normally a community psychiatric nurse. The application then is completed at the hospital after assessment by a medical practitioner who is recognised as having special experience in psychiatry. The initial assessment period is for 5 days and this can be extended for a further 14 days. However, to detain the patient further a formal application has to be made to a Judge for conversion of the order to a Compulsory Treatment Order. Court hearings are held at the hospital on a weekly basis and the consultant, known as the 'responsible clinician', appears regularly before the Judge, with the patient present, to make such an application.

A District Inspector – a lawyer who has a supervisory role of all procedures relating to formally detained patients – appears on behalf of the patient at the court. The patient also can be represented by a lawyer appointed by him-/herself. Presenting evidence to the court to substantiate the imposition of an order and maintaining a therapeutic alliance with the patient can be a delicate matter. The Compulsory Treatment Order, which remains in force for 6 months, can be renewed upon application or converted at an appropriate time to a Community Treatment Order. This gives authority for the continued administration of treatment within the community and can be renewed after 6 months. If re-admission is warranted, a further application for assessment has to be made. There were approximately 60 Community Treatment Orders in force within the service during my stay. There are mechanisms of appeal for the patient to a mental health tribunal. Separate provision is made under the Criminal Justice System to place offenders with mental illness under a Compulsory Treatment Order.

New Zealand mental health standards

The Ministry of Health has issued a booklet outlining quality standards in mental health (Ministry of Health, 1997). The aim is to provide a uniformity of standards in mental health care within the country. There are 20 main headings under which the standards expected in each category are listed. An audit tool accompanies the standards and each service has to audit implementation of the standards in their own district. The implementation process was still underway during my stay and compliance with the standards will shortly be part of the quality standards expected by the funding authority. The

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standards are not formidable and reflect what a good mental health service should be attaining.

Bi-culturalism

The standards indicate specific targets for services relating to Maori and Pacific people, who represent approximately 10% of the total population. The emphasis is on treatment and support in a manner sensitive to cultural and social beliefs. The place of the family and the wider grouping or 'whanau' within the area is particularly recognised. In the Nelson Marlborough service there is a specific Maori mental health service. The basic treatment for the Pakeha or New Zealander of European descent does not differ from a Maori patient. However, the Maori mental health team will befriend the patient and help to allay his/her fears. They will have a greater understanding of the cultural background of the patient and advise on how best to meet the needs of the patient.

The spiritual basis of the Maori world outlook is given due recognition. The role of the ancestors is particularly felt and, as one of the Maori team said to me, 'it is now necessary sometimes for people to face backwards to move forward'. Maori spirituality has had an influence on the local service and new staff are welcomed in a modified 'powhiri' or formal welcome, which is a moving experience that is finally completed with the 'hongi' – the pressing of noses. The foundations of the new acute unit were blessed in a ceremony that combined Christianity and Maori beliefs. Stones from the local environment were handled and meditated upon by the assembled company before being buried where the entrance to the unit would be built. The Service endeavours to represent the place of Maori culture in New Zealand society (Durie, 1999).

Pharmac

In New Zealand, as in the UK, prescriptions for drugs are only partially free, patients pay a proportion of the cost of their drugs. There is a standard charge for prescriptions and there is a lower rate for those on benefits. An organisation known as Pharmac (The Pharmaceutical Management Agency Ltd), set up by the Government, evaluates medicines and subsidises those drugs considered essential to the running of the health service. However, not all drugs are given the subsidy and where this is absent the patient must pay the full cost of the drug.

In the case of the new atypical antipsychotics, risperidone is fully funded but olanzapine, during my stay, could be prescribed only if there had been an initial trial on risperidone that was found to be unsuitable. A patient then is given a licence number that must be written on all prescriptions. Clozapine is fully subsidised but there must be a clear indication that it is prescribed appropriately. A clozapine out-patient clinic eased the monitoring of patients receiving this drug in the community.

Occasionally, drugs not funded by Pharmac can be funded by the local funding authority if there are exceptional reasons why they should be prescribed. There was a more limited choice of drugs available to prescribe than in the UK and it was necessary to be aware of the status of the drug with regard to funding by Pharmac.

Institute of Australasian Psychiatrists, New Zealand (IAPNZ)

The travelling psychiatrist will find support from the above organisation, which has a membership from those psychiatrists in New Zealand who are outside the membership of the Royal Australian and New Zealand College of Psychiatrists. It has set up a formal method of accrediting continuing professional development and can be contacted via e-mail (iapnz@uhug.co.nz). It publishes a regular newsletter that encourages the publication of matters of clinical and administrative interest.

It is stimulating to have the chance to practise psychiatry in another country. The similarities of practice are greater than the differences between cultures, but it is the social aspects of each presentation and the style of service that give great interest. The memories of the friendliness and the high quality of the multi-disciplinary team remain a source of pleasure.

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References

DURIE, M. (1999) Mental health and Maori development. *Australian and New Zealand Journal of Psychiatry*, **33**, 5–12.

MINISTRY OF HEALTH (1997) *The National Mental Health Standards*. New Zealand: Ministry of Health.

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