Submission on Transforming our Mental Health Law - the review of the Mental Health (Compulsory Assessment & Treatment) Act

New Zealand Psychological Society

Submission prepared by
Janet Peters - Director of Social Issues,
Kris Fernando - Director of Professional Development and Training,
Diane Bellamy - Director of Professional Issues,
Brian Dixon - Director of Scientific Issues and
Veronica Pitt - Executive Director

Contact:
Veronica Pitt, Executive Director
executivedirector@psychology.org.nz

Introduction

The New Zealand Psychological Society (NZPsS, "the Society") is the premier professional and scientific association for psychologists in Aotearoa/ New Zealand and is committed to supporting quality practice, education and research in psychology. The Society is making a submission on the Transforming our Mental Health Law due to our regular work related to mental health and its potential impact on our members.

The NZPsS represents over 2000 members and students and encompasses a broad range of practice in psychology in Aotearoa/New Zealand, including clinical, counselling, organisational and educational. We are committed to bicultural perspectives and practice and have substantial Māori representation on our decision-making bodies, including Executive, having recognised the significance of our partnership with Māori, consistent with Te Tiriti, through the establishment of a National Standing Committee on Bicultural Issues in 1991

The Society advocated for and, with other professional and regulatory bodies, established a new Code of Ethics in 2002 that strongly reflects our commitment to Te Tiriti and to principles relating to the pursuit of social justice and social wellbeing.

Overview

We support the intention of this review to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act and the focus on embedding Te Tiriti, addressing Māori needs and respecting human rights.

Key points to be included in the review of the legislation from our perspective are:

- Informed consent is integral to effective relationships which underpin all work with mental health issues.
- Legislation needs to support and enable Te Ao Māori models of care
- Concerns over a highly medicalised model being implemented when a more holistic approach is beneficial to improving outcomes.
- Resourcing for community-based initiatives to enable earlier, timely, proactive, effective care to reduce or eliminate the need for compulsory treatment.
- Patients/Clients should at all times be able to have an advocate of their choosing involved in their care – this may be whānau, friends, a therapist, or a patient advocate
- Right of individuals to continue to refuse medication or aspects of treatment, even if under a compulsory order
- Complaints – the process to raise complaints needs to be easily accessible and issues raised by patients and whānau need to be followed up by an external body.

In order to contribute the New Zealand Mental Health (Compulsory Assessment and Treatment) Act law reform we also looked at current mental health act law reform in three countries. The glaringly obvious omission in such a review is the lack of indigeneity among them; and Pasifika communities are not considered. However key issues such as human rights and what constitutes "therapeutic" are global.

Discussion points

Drawing on the Society's experience and knowledge, as well as the discussions of reform in other countries we consider the following areas to be important for inclusion in the legislation:

a) Legislation and the system following from it must acknowledge structural and institutional racism and put in place appropriate cultural supports.
    i. One example of an appropriate support would be cultural assessments for Māori which contribute to meaningful treatment plans.
    ii. Understanding and awareness of cultural norms within different cultures is imperative any assessments of capacity and/or illness.

b) The goal of any treatment, and especially compulsory treatment, needs to be well considered and clearly articulated within the legislation. Is the purpose only to maintain safety, or to improve wellbeing? Where treatments are being offered for 'therapeutic' purposes, what is the meaning of that term?

c) The Code of Ethics for psychologists in New Zealand requires that we only operate with informed consent of our clients. Whilst we recognise the need to ensure safety of individuals and others in the community we do not support compulsory treatment. If this is enabled in the act, all care should be given to minimise the situations in which it can be utilised.

d) We support the use of non-medical personnel in the assessment and treatment of clients. Psychologists are under-utilised within these areas currently and offer a more holistic perspective to support clients and their health. Cultural input is also necessary when considering a clients symptoms, risk and appropriate treatment

e) Community facilities, marae, retreats, and at-home care should all be enabled to provide intensive support and care for individuals in need through this legislation.
    i. The appropriate venue will depend on the individual, and the important factors in their care and recovery will also vary. Facilities and services need the ability to be flexible to enable them to respond to these factors.
    ii. Flexibility will support Te Ao Maori models of care to be implemented.
    iii. Alternative options may also include the ability for whānau or friends to be present with the individual, for pets to be present, etc.

f) Giving individuals more control over their treatment such as

    i. the right to ask a second medical/health specialist to check their treatment plan and for this to be easily accessible;
    ii. the right to ask for a tribunal/panel to review their treatment and release including safety risk assessment to self and others; and
    iii. most importantly the right to an independent advocate unless they do not wish for such an advocate. This could be a person of their choosing such as a friend or family member, their own therapist, or a patient advocate
    iv. maintaining the right to refuse medication and other treatment options, if compulsory treatment is enacted. For example, if they are compelled to be in a treatment unit, they can still refuse a medication, or to participate in certain activities.

g) Improvements to community health services, support networks and resources to reduce the need for detention/compelling individuals to enter secure care settings
    i. Such prevention is not aspirational - it needs practical budget allocations; further staffing and more rigorous follow-up for individuals through local support networks and community mental health hubs if their mental health is deteriorating and preferably before the point at which they need to enter secure facilities to prevent significant harm to themselves or others.
    ii. Regular case reviews in community settings, as well as regular checks and reviews within any secure-care settings are essential to supporting quality services and the experience of individuals.

h) Recognising that those experiencing mental health difficulties may not have the capacity to undertake official or complex complaint processes when their rights have been disrespected or their treatment has been poor. A process for an external body to review all discharges, including any information from the individual and/or their advocate, and to proactively contact or talk to individuals receiving treatment would improve this process and make it more accessible to all.

In our appendices we have included

- Information from three other countries mental health legislation reform processes that may be useful or relevant to this discussion
- The Society's submission to the Mental Health and Addiction Inquiry in 2018, as this contains information that continues to be relevant to this process.

Appendix 1

In order to be helpful for Aotearoa's law reform, we looked BRIEFLY at current law reform activities in three countries, namely:

1. **UK**[1]
2. **Scotland**[2]
3. **Italy**[3]

Examining legislative changes in other countries is a complex undertaking as language and processes differ.

These three countries are chosen as they either are seen as innovative (e.g. Italy) or have similar processes/issues to Aotearoa (excluding indigeneity which is critical for Aotearoa).

What we have included is:

A summary of key points in each country from their Government websites.

In the UK we have added key issues from Psychology groups.

Overall, it seems there are a few factors to be taken into consideration when looking at law reform in any country:

- **The perspective** obviously people who use services and may have been under the Act, people with a disability, are key to any law change.

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[1] https://www.gov.uk/government/consultations/reforming-the-mental-health-act/outcome/reforming-the-mental-health-act-government-response

[2] https://www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-interim-report-july-2021/

[3] https://en.wikipedia.org/wiki/Basaglia_Law

- **Stigma and discrimination** is rife for mental health problems generally, and for people who have been “sectioned” particularly
- **National Policy**: National mental health Strategy- is the law clearly linked to policy?
- **The context** in which legislative changes are made**:** In every country can the mental health services, health generally, police and justice services, primary care currently available in the hospital system and community effectively support law change?
- **Human Rights:** Are human rights protected?
- **The culture** (e.g. the ideas, customs, and social behaviour of each country)
- **Indigenous peoples:** inequities and inequalities will need to be considered. A critical issue in Aotearoa for Māori
- **Other marginalised groups:** In Aotearoa, for example, Pasifika and Asian communities, other ethnic groups, LGBTQIA+.
- **The language**: for example what do the words “care” and “treatment” mean for each country? Some language is discriminatory

1. The UK model of mental health law

Following the Independent Review conducted by Simon Wessely and published in December 2018[4], the government published a White Paper in January 2021. This White Paper set out the government’s response to reform mental health legislation, responding to the Independent Review. Substantial changes to the Act were proposed based on 4 principles:

- choice and autonomy – ensuring service users’ views and choices are respected
- least restriction – ensuring the Act’s powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- the person as an individual – ensuring patients are viewed and treated as individuals.

The U.K model introduces the ideas of patient/individual choice and autonomy; therapeutic benefit – that is, to get better in order to be discharged from involuntary detainment in a mental health hospital/ setting/facility and treating each patient as an individual. These are important concepts to imbed in the NZ reform system.

In terms of actual outcomes for patients/individuals there is useful and thoughtful suggestions from the U.K NGO "MIND" agency and a group representing people with disabilities.

For interest, there are two responses to the Act from Psychology in the UK:

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[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703919/The_independent_Mental_Health_Act_review__interim_report_01_05_2018.pdf

- The Association of Clinical Psychologists UK

https://acpuk.org.uk/mha_reform_consultation_response/

- The Royal College of Clinical Psychologists

https://acpuk.org.uk/wp-content/uploads/2021/04/MHA-Reform-ACP-Uk-Response-Final.pdf

2. Italian Law Reform

This law was radical at the time of reformation in 1978 as it led to much more care in the community, the notable example was the work done in Trieste.

(Note: The word "patients" is still used in Italy).

The Trieste Mental Health Department (MHD) is a public, community-based mental healthcare service of the Trieste Local Healthcare, which aims to provide resources and encourage community-based health care services. MHD is responsible for prevention, diagnosis, treatment and rehabilitation of people with mental disorders within the local population. It focuses on the elimination of discrimination, stigma and exclusion, as well as the promotion of full and complete rights of citizenship for people with mental illnesses.

> ***"Recognised for years as one of the most advanced public mental healthcare services in the world, the Trieste MHD continues to remain a leader in innovative approaches to mental healthcare aimed at the emancipation and social reintegration of persons suffering from mental disorders.***
> ***The MHD has been reconfirmed by WHO as a Collaborating Centre for Research and Training in Mental Health."***[5]

"Law 180[6]

Law 180 is the mental health law in Italy in 1978, and it was based on the following main provisions: [7]

The general objectives of Law 180/1978 included creating a decentralised community service of treating and rehabilitating mental patients (sic) and preventing mental illness and promoting comprehensive treatment, particularly through services outside a hospital network.

Law 180/1978 introduced significant change in the provision of psychiatric care:
- The emphasis has shifted from defence of society towards better meeting of patients' wants through community care.
- New hospitalizations to the "old style" mental hospitals stopped instantly.
- The law required re-hospitalizations to cease within two years.

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[5] https://www.mhinnovation.net/organisations/who-collaborating-centre-research-and-training-mental-health-trieste-italy

[6] https://en.wikipedia.org/wiki/Basaglia_Law

- Nobody was involuntarily discharged into the community.
- Psychiatric assistance was to be shifted away from mental hospitals to Community Mental Health Centres, newly organized in a sectorised or departmental manner to assure integrations and connections with services and community resources.
- Hospitalization of new patients to the existing mental hospitals was not to be allowed. The construction of new mental hospitals was also prohibited.
- Psychiatric wards were to be opened inside General Hospitals with a limited number of beds (no more than 14–16).
- Compulsory treatments were to be exceptional interventions applied only when adequate community facilities could not be accessed and when at the same time the treatment outside of the hospital was not accepted by the patient."

Dichotomy in mental health treatment

"Since the passing of Law 180 in 1978, the Italian Mental Health Act has produced serious debate, disputing its socio-political implications, appraising its positive points and criticizing its negative ones. However, the international discussion has never questioned what Law 180 has done to improve the destiny of the mentally ill who commit crimes. The Italian experience demonstrates how, when there are no convenient solutions, difficult issues may be sidestepped.

Italian legislation has created a dichotomy in mental health treatment: to its credit it has given the law-abiding mentally ill the right to refuse treatment and has stopped all further admission of mental patients; at the same time, it allows the law-breaking mentally ill to be confined in special institutions on indeterminate sentences, thereby depriving them of all civil rights.

As a consequence, the approval of Law 180 led to the closure of psychiatric hospitals in Mantova, Castiglione delle Stiviere and in Mombello.

Main consequences

The main long-term consequences of implementation of Law 180 are that:

- Patients who were staying in mental hospitals before 1978 were gradually discharged into the community, and;
- The availability of psychiatric beds in Italy is lower than in other comparable countries: Italy has 46 psychiatric beds for every 100, 000 population, compared with 58 in the United Kingdom and 77 in the United States of America".

Fioritti wrote in 2018:[7]

> *"Over time, psychiatric deinstitutionalisation inspired policies in other sectors of Italian society, such as those regarding physical and intellectual disabilities, education of children with special needs, drug addictions and management of minors.*

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[7] https://pubmed.ncbi.nlm.nih.gov/29335037/

Furthermore, debate about Law 180 has reached and maintained an international dimension, becoming a term of reference for international agencies such as the World Health Organization and the European Commission, for good and for evil.

The overall balance sheet of the Reform process would seem mostly positive, though the last decade has seen many threats challenging the system".

3. The Law reform in Scotland

Introduction

Mental health legislation[8] (background information)

The main mental health legislation in Scotland is the Mental Health (Care and Treatment) (Scotland) Act 2003, as amended by the Mental Health (Scotland) Act 2015. Information for service users and whānau:
https://www.gov.scot/publications/mental-health-law-in-scotland-topic-guide/

Mental health legislation reviews

The Mental Health strategy 2017-2027 recognises the importance of human rights and as part of this various aspects of mental health and incapacity legislation use in Scotland are currently being reviewed.

Learning disabilities

- Consideration is being given to whether new legislative measures are necessary to meet the distinct needs of people with learning disabilities or autism.
- A report of their scoping exercise findings on learning disability and autism provision in the Mental Health (Scotland) Act 2003 has been produced.
- An independent review of learning disability and autism in the Mental Health Act in Scotland is expected to report to Ministers at the end of 2019.
- A review has been announced which follows on from the learning disability and autism review and reforms to the Adults with Incapacity (Scotland) Act 2000.

Recent activities: Scottish Mental Health Law Review - Interim Report - July 2021[9]

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[8] https://www.gov.scot/policies/mental-health/legislation-and-guidance/

[9] https://www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-interim-report-july-2021/

"Currently defined under section 328(1) of the 2003 Act as:
a. Mental illness;
b. Personality disorder; or
c. Learning disability.

The Act also states that certain behaviours or personal characteristics do not, in themselves, constitute mental disorder, including sexual orientation, anti-social behaviour, or acting imprudently." (P.62)

Since the last interim report, we have worked to a significant extent on five workstreams supported by Advisory Groups looking at the following areas:
(To note: each area is summarised)

- Children and Young People
- Economic, Social and Cultural Rights
- Capacity and Support for Decision-Making
- Communication and Engagement
- Compulsion

Other areas of interest:

Human Rights
The current legal framework

The purpose of the legislation we have been asked to review may be summarised as follows:

- the purpose of mental health law has historically been (at least since 1960) to authorise and regulate compulsory care and treatment for mental disorder, where the person's ability to make a treatment decision is compromised by the mental disorder.
- the purpose of capacity law is to allow people whose impairments mean they cannot safely take actions or make decisions involving their finance, welfare or medical treatment to have this done for them. 16
- and the purpose of adult support and protection law is to provide a set of short-term measures to protect people who, by reason of impairment or circumstances, may be vulnerable to abuse.

We feel that these purposes are too narrow. Our Terms of Reference push us in a more ambitious direction, suggesting a wider focus on securing human rights for all people who may currently fall within the category of 'mental disorder'. We agree with this, and we believe our reform agenda should aim high.

Who should be covered by mental health law?

Our preliminary view is that this new, human rights based legal framework should apply to persons with mental illness, learning disability, personality disorder, dementia, autism and other types of neurodiversity. It may also apply in relevant circumstances to other conditions which may impair a person's decision-making ability. In general, these groups would currently be covered by the definition of 'mental disorder' in the 2003 Act.

We are aware that ‘mental disorder’ is regarded by many as a stigmatising and offensive term, and we intend to suggest alternative terminology in our recommendations. We have been discussing the possibility of using the term ‘mental and intellectual disabilities’, but we wish to engage further with people, particularly those with lived experience, before making our final recommendations……

We are considering whether, and how far, a mental health diagnosis should be necessary as a pre-condition for compulsory treatment; how far other tests based on, for example, impaired decision making and risk, could replace this; and what might be the implications for other groups, such as people with addictions, of removing a diagnostic threshold.

In line with this, the Mental Health 2003 Act aligns very strongly with the medical model in terms of psychiatry being the clinical discipline which contributes to the decision making regarding non-consensual assessment and intervention. It is considered that the contributions of a wider group of mental health clinicians could contribute to this decision-making process which in turn would place less pressure on the psychiatry profession. Additionally, cultural input needs to be considered when interpreting the nature of a client’s symptoms, risk and most appropriate treatment.

What should mental health law be for?

We considered several options as to what, in addition to the current purposes, should be part of the purpose of mental health law, including:
- to ensure that people who are subject to non-consensual interventions receive proper support during and after the period of the intervention
- to provide greater protection for all people with mental disabilities against neglect, abuse, unjustified coercion, etc.
- to ensure that health and care services for people with mental disabilities are of a sufficiently high standard (whether they are voluntary or compulsory). Current mental health law contains some provisions which relate to these broader aims, but these are limited.

However, we feel there is a simpler and more inclusive framework for the Review. We believe the purpose of the law should be to ensure that all the human rights of people with mental disabilities are respected

We are aiming for a small set of core principles (between 4-6) which can be expanded upon in the legislation itself and in guidance. That implies some streamlining of the eight principles in Article 3. Our initial suggestion for those principles is:
- Respect for dignity
- Respect for autonomy
- Non-discrimination and equality
- Inclusion.

Appendix 2

The New Zealand Psychological Society
Te Rōpū Mātai Hinengaro o Aotearoa

New Zealand Psychological Society
Level 5 - 90 The Terrace
PO Box 25 271
Wellington

Submission to the Mental Health & Addictions Inquiry

(4 June 2018)

The New Zealand Psychological Society (NZPsS) is the national, professional association that serves psychologists from all areas of psychological practice in New Zealand. Our collective aim is to improve individual and community wellbeing by disseminating and advancing rigorous practice of psychology.

The NZPsS has over 1200 members working in a wide range of health, education, justice, corrections, children and young people's services, academic and NGO settings. We also have over 600 post graduate psychology student members.

The New Zealand Psychological Society (NZPsS) is pleased to have the opportunity to contribute to the Mental Health & Addictions Inquiry[1]. In making this submission we want to be clear that some aspects of our current mental health system work well. We acknowledge the hard work and dedication of those working within the sector who knowingly expose themselves to the distress, sadness, fear and confusion of others on a day-to-day basis. However, it is our view that some practices are outdated. Continuing to view the difficulties we all have with psychological, emotional and social functioning as a medical issue, which should be assessed and treated primarily as such, is not helpful in the long run for most people.

Internationally, mental health is increasingly being seen as an integrated part of the health and well-being of individuals and groups, rather than being adjunctive to it. The interaction between physical and mental (psychological, emotional, spiritual, social) health is progressively more accepted. This allows us to appreciate that health, including mental health, is (a) more than the absence of disease/illness, and (b) broader in focus than a 'medical' conceptualisation allows.

Social determinants of health and well-being are more visible than ever before. This is in part due to our greater awareness of these, but is also due to the increasingly stark separation between those people who have easier access to resources and opportunities associated

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[1] While this submission is supported with footnotes these are far from comprehensive. We are happy to provide additional supporting documentation if this would be helpful to the Inquiry. The New Zealand Psychological Society is available to engage in a face-to-face meeting if required.

with good health and well-being (e.g., adequate housing, nutrition, stable employment, financial resources, safety from trauma), and those who do not.

There remains, in our view, an over-reliance on bio-medical conceptualisation of mental health that is both inconsistent with current literature about the origins of mental health problems, and their assessment and amelioration. This is reinforced by the pathways that many seeking help must often walk before they are able to access expert evidence-based support. For example, for many the only way to access specialist services is via a medical gatekeeper. This pathway requires those with a mental health problem to conceptualise their difficulties as a health deficit and present their problem in terms of a series of apparently discrete physical signs and symptoms. Within this context it is unsurprising that a medical intervention is invariably offered first, and almost exclusively.

It is against this background that we strongly advocate for:

- broader psychological understandings of health, mental health, addictions and disability within service provision (and the community);
- improved and earlier access to psychological informed assessment and intervention options for those who are psychologically distressed;
- a quick, but considered and purposeful, expansion of the psychological workforce. This will include both qualified registered psychologists and psychologically informed practitioners who are able to skilfully implement psychological interventions, and more dedicated senior and clinical leadership positions in psychology supporting and directing the provision of psychological therapies;
- greater recognition and adherence to best-practice models of care, with resourcing priority given to services that are evidence-based, responsive to community needs, and accountable;
- resource allocation that is consistent with a more ecological model of care, rather than following traditional lines of resourcing. That is, fund what we want to have in the future, not just what we have had in the past.

Expanding the Model of Care

Our existing mental health services are based largely on a biological understanding of mental health and mental illness. That is, mental illness is viewed as a disturbance of biological/neurological systems as a result of genetic, medical, social, environmental or other factors. Whatever the cause, the remedy most commonly offered is to restore biological/neurological balance of the individual by chemical means; that is, the prescribing of medication. The most obvious difficulty with this approach is that it treats symptoms not causes. While providing medication to help a person sleep more soundly, or feel more alert or less anxious may be useful in the short-term, such interventions are unlikely to help a person to be less afraid of public speaking, improve the quality of their relationships, or give them strategies to cope with traumatic memories.

The *Diagnostic and Statistical Manual of Mental Disorders* (5th edition)[2] specifies the signs and symptoms that must be present for each disorder to be diagnosed. Using this system as the benchmark for entering and exiting the mental health system unhelpfully focuses attention on the presence/absence of symptoms, and makes symptom removal a core task on mental health services. While this is an important function of mental health intervention, it is seldom an adequate solution to mental health problems.

To place mental health challenges in context and address all determinants of fragile mental health we must adopt a bio-psycho-social-spiritual model which acknowledges the important role played by the broader ecological system, such as that detailed by Bronfenbrenner[3] or Durie[4]. The implications of this are that the allocation of resource must also be more rationally allocated to respond to ecological system needs, rather than restricting the focus almost entirely to a single facet of mental health.

The prevailing organisational processes within health services - specifically those within DHB funding and provider arm services - have been largely shaped by the biomedical approach. This has produced excellent outcomes for physical health services in many instances. However, because this approach has not generated effective mental health services, mindful and deliberate change at all levels of service development and delivery will be required. In the past lip-service has been paid to the substantial evidence-base supporting the application of psychological interventions – an acknowledgement of their importance, but a failure to adequately resource them. The development of effective comprehensive (holistic) mental health services will require individuals with sufficient expert psychological knowledge and skill to be placed at all levels of strategic service development/management. The development and management of robust, evidence-informed and sustainable psychological health services is a complex and multidimensional endeavour for which the required experience and knowledge is consistently underestimated.

There are likely multiple factors contributing to this lack of practitioners with adequate knowledge and skill at the level of strategic service development. These include the prioritising of medical professionals when appointing clinicians to such roles, and the perennial difficulty of providing adequate career pathways within the allied health professions. Presumably the thinking has been that psychologists and other allied health practitioners are technicians to be used by other professional groups, and therefore have no need to develop management and leaderships skills for themselves.

A practical vision of a (mental) health service that has the ability to provide psychological resources of the quality and quantity indicated in best practice guidelines would be of one that is resourced to implement service development and quality assurance initiatives at the

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[2] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. Washington, DC: Author.

[3] Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husen & T. N. Postlethwaite (Eds.), *International Encyclopedia of Education* (2nd ed., Vol. 3, pp. 1643–1647). Oxford: Pergamon Press/Elsevier Science.

[4] Durie, M. (1994). *Whaiora: Māori Health Development*. Auckland: Oxford University Press.

same level of detailed consideration and specialist guidance that would be typically applied to surgical or pharmacological based service development.

Better access to psychological services

Psychological services should not be seen as either a luxury or as the service of last resort, but recognised as the preferred service model for many and potentially beneficial for most.

The previous and current governments have committed to increasing access to 'talking therapies'. [5,6] It is a misnomer to refer to psychological therapies as 'talking therapies' as psychological interventions can also be behavioural in orientation and these approaches more activity based ('doing therapies'). Behaviour therapies can be highly effective with a range of problems and where the service users are less able to engage in a conversation oriented therapy due to, for example, intellectual incapacity or acute intrusive symptoms. It must also be noted that the complexity of theoretical and practice foundations which underpin therapeutic conversations are not adequately communicated when referring to these interventions as 'talking therapy'. What is happening is much more sophisticated than just talking!

There is conclusive evidence that psychological interventions can be highly effective and efficient in addressing mental health and addiction problems. [7,8,9] In some cases this is enhanced when medication is used in combination with psychological interventions.

Psychological services must be made available to those seeking help at an earlier stage in their help-seeking journey, rather than being offered only after 'all else has failed'. If service users are going to benefit from psychological assessment and intervention, and this is their preferred intervention modality, there are likely to be benefits from resourcing them to access such services quickly to both mitigate the chance for problems to become more entrenched, further impacting their quality of life, and lengthening the duration of any subsequent intervention.

Earlier psychological intervention is the rationale behind the well-resourced implementation of the *Improved Access to Psychological Therapies* (IAPT) programme in UK [10], and the less

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[5] Ministry of Health (2012). *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017.* Wellington: Ministry of Health.

[6] https://www.tepou.co.nz/initiatives/talking-therapies/54

[7] Australian Psychological Society (2010). Evidence-based Psychological Interventions: A Literature Review (3rd Edition). Melbourne: Author

[8] McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist*, *65*(2), 73.

[9] Shawyer, F., Enticott, J. C., Özmen, M., Inder, B., & Meadows, G. N. (2016). Mindfulness-based cognitive therapy for recurrent major depression: A 'best buy'for health care?. *Australian & New Zealand Journal of Psychiatry, 50*(10), 1001-1013.

[10] Clark, D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Programme. *Annual Review of Clinical Psychology, 14*, 159-183.

effective *Better Access to Mental Health Care* initiative in Australia [11]. Research shows us that most mental health difficulties are managed within primary care settings. [12] While General Practitioners may recognise the need for mental health care, their training is not in providing psychologically therapeutic intervention. Those seeking assistance will often not communicate their needs openly to medical staff because they believe the doctors/nurses are not trained to respond to their needs, or they do not want the intervention they are likely to be offered, that is, medicalisation of their problem. [13,14] It is recommended that a system which provides easier access to expert psychological evaluation much earlier on the care pathway would (a) reduce the demands on already over-worked General Practitioners, (b) avoid the need for Psychiatrists to act as secondary-care gatekeepers in all cases, and (c) provide an opportunity for earlier psychological intervention – whether this is by a qualified psychologist, or a psychologically trained practitioner under the supervision of a psychologist.

It is understood that psychological interventions do not always result in the anticipated outcome for the service user. However, effective evidence-based processes exist to monitor and evaluate this, and provide guidance about when and how interventions may be amended to increase the likelihood of a positive result. Process tracking and evaluation tools such as the Outcome Questionnaire (https://www.oqmeasures.com/)[15] or the Outcome Rating Scale (https://www.myoutcomes.com/fit-elearning-dashboard/)[16,17] should be adequately resourced as a standard component of psychological services.

Providing better access to psychological services will require a significant increase in resourcing to train/retain psychologists in the mental health workforce, and ensure non-psychologist practitioners are adequately trained and supervised.

Resource allocation

The current model within mental health favours traditional (deficit-focused) formulations of problem definition and intervention. Because of this limited resources are allocated to prevention and early intervention. As a result, those with mental health difficulties are often

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[11] Meadows, G. N., Enticott, J. C., Inder, B., Russell, G. M., & Gurr, R. (2015). Better access to mental health care and the failure of the Medicare principle of universality. *The Medical Journal of Australia, 202*(4), 190-194.

[12] Lockett, H., Lai, J., Tuason, C., Jury, A., & Fergusson, D. (2018). Primary healthcare utilisation among adults with mood and anxiety disorders: an analysis of the New Zealand Health Survey. *Journal of Primary Health Care, 10*(1), 68-75.

[13] Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R. M., Jones, P. B., & Lennox, B. R. (2014). Young people's views of UK mental health services. *Early Intervention in Psychiatry, 8*(1), 12-23.

[14] Woodward, L., & Shaw, I. (2017). The Medicalisation of Unhappiness? The Management of Mental Distress in Primary Care. In I. Shaw & K.Kauppinen, *Constructions of Health and Illness: European Perspectives* (pp. 134-146). London: Routledge.

[15] Lambert, M. J. (2017). Maximizing psychotherapy outcome beyond evidence-based medicine. *Psychotherapy and Psychosomatics, 86*(2), 80-89.

[16] Miller, S. D., Bargmann, S., Chow, D., Seidel, J., & Maeschalck, C. (2016). Feedback-informed treatment (FIT): Improving the outcome of psychotherapy one person at a time. In W.O'Donohue & A. Maragakis, *Quality Improvement in Behavioral Health* (pp. 247-262). Cham, Switzerland: Springer.

[17] Duncan, B. L., Sparks, J. A., & Timimi, S. (2018). Beyond Critique: The Partners for Change Outcome Management System as an Alternative Paradigm to Psychiatric Diagnosis. *Journal of Humanistic Psychology, 58*(1), 7-29.

required to wait until their problems are acute and/or chronic before they access assistance, by which time the intervention they require also needs to be acute and/or chronic, often making it complex and expensive. A more proactive approach to community mental health, building resilience, and allowing earlier access to support services is required to support those with mental health difficulties within their family/whānau and community, supporting service users to deal with difficulties while they still have the personal psychological resources to do this, and to take pressure off the overworked secondary mental health services.

There is understandable concern about the idea of transferring resources from secondary to primary mental health service provision, particularly because there is currently very limited capacity within the primary mental health system. Transferring resources has been likened to 'robbing Peter to pay Paul'; however, in the interim it may be necessary to pay both Peter and Paul.

Psychology workforce development

Improving access to psychological services within the mental health and addictions sector will require:

a. Greater appreciation of the relative benefits of such services among those who are not involved in the provision of psychological services. This would benefit service users by facilitating quicker referral to psychological services when appropriate.
    i. The apparent lack of general understanding about psychological interventions may be due, in part, to their lack of ready availability and hence not being 'at the table'. This lack of understanding can undermine the beneficial effect of bringing a psychological perspective to any mental health service environment.
    ii. This goal could be achieved by greater involvement of psychologists within multi-disciplinary teams, and within management, supervision, and training teams, even if they are not able to deliver direct psychological services.

b. Development (via training and supervision) of a non-psychology workforce who are able to implement manualised psychological interventions under the supervision of a skilled and qualified psychological practitioner, in a similar way that some practitioners are able to prescribe medications in consultation with senior doctors. The IAPT programme has invested substantial funding into the development of Psychological Wellbeing Practitioners (PWPs), who are generally individuals who have undergraduate degrees in psychology. The PWPs deliver a majority of the low-intensity manualised psychological interventions which form the backbone of IAPT services. The rationale for training psychology graduates was the increased likelihood that high programme fidelity would be maintained in the event of a challenge to the treatment protocol because the practitioners had a sound foundation in psychological theory. If the practitioners had a foundation within another practice area, or even outside of mental health, then such programme fidelity would be less assured. To support such practitioners it is critical that supervision and leadership is provided by experienced psychologists.

c. Increasing the psychology workforce through training of new psychologists.
    i. There are currently many high quality applicants to clinical psychology training programmes who are not offered training places because universities are unable to support increased numbers of students. While additional funding is available to universities offering a doctoral level qualification (Massey and Auckland), most programmes in New Zealand do not offer a DClinPsych or equivalent qualification for a multitude of reasons.
    ii. The shortage of internship placements, and the lack of predictability in when these are available, means that all universities run their own training clinics to ensure placements and internships are available. This is an additional expense which is usually carried by academic psychology departments. Current legislation concerning the availability of student allowances for postgraduate study makes it necessary for internships to be funded, which is an impediment to many primary care providers being able to offer an internship placement.
    iii. Internship placements in primary care settings (both General Practice and NGO providers) are rare. It is unfortunate that this is the principal area in which developments in psychological service provision are required. A serious review of psychology training is required, possibly within the wider Allied Health context. Part of this review should include a careful consideration of the ethnic and gender diversity of the psychology workforce.

d. An associated area of psychology workforce planning is the retention of qualified and experienced practitioners. Recent data collected for the Psychology Workforce Task Group shows that 50% of psychologists working in the health sector rated the likelihood of them leaving their current role within the next five years as ‘quite likely’ (26%) or ‘very likely’ (24%)[18]. The reasons for leaving would be, to get better pay, improve work-life balance, and not feeling valued. It is also noteworthy that ‘lack of enjoyment’ was the least endorsed reason for potentially leaving. If the psychology workforce is to be expanded it is the senior and experienced practitioners who will be required to provide leadership, training, and supervision, so it is imperative that they are retained within the mental health and addictions service.

e. Psychological service providers, tertiary institutions and regulatory authorities have come under scrutiny for the lack of representation of Māori and Pacific peoples in the workforce, tertiary training, and in the delivery of psychological services. While Māori and Pacific peoples have the highest rates of incarceration (2nd in the world), rates of suicide, and mental health distress, services have yet to recognise the epistemologies relevant to Māori and Pacific peoples, and to recognise the impact of historical trauma, racism and the culture of colonisation that insidiously impact on their lives. A meaningful inquiry will

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[18] Stewart, M. (2017). Retaining the psychology workforce: Reasons for leaving and strategies for retention. Unpublished report: Psychology Workforce Task Group.

include these highly significant determinants of wellbeing across the life span and address the multiple intersections that influence and maintain mental health and wellbeing.

i. That Kaupapa Māori informed tertiary training for psychologists is supported and developed.

ii. That Kaupapa Māori informed models of care in mental health (for example, Whānau ora, and Te Kuwatawata in the Tairawhiti District Health Board) are appropriately evaluated, resourced and promoted.

iii. That the spectrum of psychological practice, clinical, community, health, etc., are considered as encompassing the relational and dynamic life experience of Māori and Pacific people, therefore, one mode of psychology is not privileged over another – that is, (Western) clinical psychology is almost exclusively used in DHBs, ACC, and Justice. We welcome opportunities to incorporate other psychologies.

Best practice

There exist a number of best-practice guidelines to support the application of psychological interventions with a range of presentations, either in combination with pharmacological interventions or in preference to them. Despite this it is biomedical interventions which are generally preferred because (a) they are cheaper in the short-term, and (b) the infrastructure is already established for their implementation. It is, therefore, often cost and convenience which drive service provision rather than evidence. This bias should not be tolerated.

It is acknowledged that our understanding of mental health and its attainment, maintenance, and enhancement is multifaceted and evolving. It is vital that those developing and managing services are open to new discoveries and evidence that existing approaches have become outdated, or even dangerous. To achieve this we need robust systems for generating new understanding of the expression and experience of mental health in Aotearoa New Zealand, and for evaluating interventions across the whole community. This is not just the measurement of outcomes which are primarily for service planning, but also process monitoring to ensure service users are getting what they need from the service. [19,20] We must also be open to the reality of diversity and inequities in our communities.

Conclusion

It makes sense to apply public resources to encourage and develop the capacity of communities to provide support for their people through existing (and new) social networks, alongside programmes to promote wellbeing. An example of this type of intervention at the community level is the Northern Ireland project behind the Community Development and Health Network, which aims “to empower communities and tackle health inequalities using

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[19] Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiology and Psychiatric Sciences, 14*(1), 1-3.

[20] Millar, S. L., Chambers, M., & Giles, M. (2016). Service user involvement in mental health care: An evolutionary concept analysis. *Health Expectations, 19*(2), 209-221.

community development", some of the outcomes of which are described in the impact report.[21]

However, responsibility for positive community development should not fall on the health sector alone; rather, it requires collective effort and investment from health, welfare, education and other areas - or the whole of government. The potential benefits from higher levels of wellbeing in our communities will not only be evident in improved health and mental health outcomes but can also be expected to appear in economic indices (such as productivity, employment and reduced reliance on welfare), higher education engagement and success, and fewer social problems such as violence, crime and antisocial behaviour as our communities grow stronger and more resilient. The implementation of the IAPT model in the UK gained political support on the basis of the economic returns from having more effective services, estimated to not only recover the costs of the programmes but shown as likely to produce equivalent return of that much again. [9] It should be noted that there are models of support agencies within Aotearoa, such as the Kaupapa Māori programme at Moana House in Dunedin, which has received funding from Corrections, Health and MSD for its services for Māori, Pakeha and Pasifika clients of those sectors.

Cross-sector collaboration in community-based services will become increasingly important (and essential) as climate change impacts on the wellbeing of our people become a reality. The Royal Society of New Zealand has acknowledged the anticipated effects on communities from severe climate events. Altered resource availability and rising sea levels will have significant effects on mental health and wellbeing. [22] Displacement of people from the Pacific to Aotearoa and from coastal, flood prone and drought affected areas in New Zealand will put major pressure on systems and services, not least of which will be our mental health services. Being prepared for that increase in demand will require expert planning and resource allocation that needs to begin immediately and must focus on how affected communities can best be assisted with efforts to mitigate effects and adjust to the changing conditions.

It is important to recognise that the way we conceptualise mental health in Aotearoa New Zealand could/should be about so much more than a narrow focus on alleviating symptoms with medically-based interventions. We need to consider what good mental health means and work towards the adequate provision of resources that ensure people can lead rich and rewarding lives, but also receive the right treatment if they do have times when they struggle with their mental health. Psychologists come with psychological formulations and therapies that have a great deal to offer in both reconceptualising mental health and providing evidenced clinical interventions that have a far broader focus on the wide range of factors likely to be impacting on any individual's mental health. However, for New Zealanders to be able to benefit from these approaches there will need to be significant changes in the way that psychologists are utilised within services and the overall number of psychologists

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[21] https://www.cdhn.org/sites/default/files/downloads/Impact%20Report%20ONLINE%20VERSION%202017.pdf

[22] https://www.royalsociety.org.nz/assets/documents/Report-Human-Health-Impacts-of-Climate-Change-for-New-Zealand-Oct-2017.pdf

working in mental health. The recommendations made in this submission provide comment on how to achieve this goal, which would allow many more New Zealanders to have access topsychological interventions and a consequent improvement in their mental health.

It is against this background that we reiterate our call for:

- broader psychological understandings of health, mental health, addictions anddisability within service provision (and the community);
- improved and earlier access to psychological informed assessment and interventionoptions for those who are psychologically distressed;
- a quick, but considered and purposeful, expansion of the psychological workforce. This will include both qualified registered psychologists and psychologically informedpractitioners who are able to skilfully implement psychological interventions, and more dedicated senior and clinical leadership positions in psychology supporting anddirecting the provision of psychological therapies;
- greater recognition and adherence to best-practice models of care, with resourcing priority given to services that are evidence-based, responsive to community needs, and accountable;
- resource allocation that is consistent with a more ecological model of care, rather than following traditional lines of resourcing. That is, fund what we want to have, not just what we have had.