The New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

Submission to the Ministry of Health

On Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012-2017

Prepared by the

New Zealand Psychological Society
Te Rōpū Mātai Hinengaro o Aotearoa

November 7, 2012

Thank you for the opportunity to comment on this important paper.

The New Zealand Psychological Society, (NZPsS) is the premier association for professional psychologists in New Zealand. The Society is the largest professional association for psychologists in Aotearoa/New Zealand with over 1000 practitioner, academic and student members. Our vision is

> "To improve individual and community wellbeing by representing, promoting, and advancing psychology and psychological practice."

Our members are guided by four core principles in our Code of Ethics:

- Respect for the dignity of persons and peoples
- Responsible caring
- Integrity of relationships
- Social justice and responsibility to society

Contact: Dr Pamela Hyde
Executive Director
New Zealand Psychological Society
Ph: 04 473 4883
Email: executivedirector@psychology.org.nz

Responses from the NZPsS based on the feedback form-

1. **The "ABCD" overarching goals and desired results**

   The Society is supportive of the overarching goals and desired results noted in the plan. We are pleased to see that the needs of Māori and Pacific people and other groups are identified. We believe however that it is important that mental health and addiction issues are included in the Government health priorities. This would send a strong signal that mental health issues are given the same priority as other health issues such as for example, cardiac disease and cancer.

   We would like to see an **"E"** added to the goals – i.e. **E**ffective workforce development strategies are in place to ensure that the mental health and addiction workforce has sufficient capacity, training, supervision and support to deliver the planned outcomes noted in the document. Our psychologist members, many of whom work in DHBs are concerned about staff shortages, long client waiting lists, lack of follow-up of clients because of insufficient staff and burdensome administration workloads.

   We would also like to see an overarching goal which acknowledges the need for mental health services to be joined up with other services e.g. services related to welfare, justice and education to avoid a disconnected approach to mental health policy and service delivery.

   We also note the huge impact that poverty has on mental health and would like to see the service delivery plans acknowledge this broader context and identify ways in which the plans will link with other Government initiatives/plans to alleviate this very serious problem.

2. **Building infrastructure for integration between primary and specialist services**

   The NZPsS is supportive of greater integration between primary and specialist services and as noted above greater integration with other sectors where there are mental health needs which may not be addressed. An example of this is the significant mental health needs of the prison population.

   To work effectively integration needs to fully utilise the skills of all involved in the delivery of mental health and addiction services. We have concerns about primary mental health being effectively channelled through GPs. Research recognises that GPs are not especially good at identifying common mental health problems (Mitchell et al., 2009). GPs also tend to rely on medication as a standard intervention and there is little evidence for the effectiveness of this approach for the mild to moderate conditions that present at primary care level (Kirsch et al., 2008). Providing funding to allow clients direct access to psychologists for example would be one effective away of enhancing access to primary care and mental health interventions other than medication.

3. Resilience and recovery for the most vulnerable people with low- prevalence conditions and/or high need conditions

We are pleased to see this approach to the most vulnerable clients with some excellent initiatives identified. We would like however to see a greater emphasis on early identification of these high need people who are likely to present with mental health and behavioural issues as children and adolescents. Early identification and treatment is the best possible approach to these issues. Psychologists are well placed to assist. Educational psychologists for example have the skills for a broader role than they are currently engaged in as employees of the Ministry of Education and could play an important part in identifying and assisting at risk children and adolescents. If there is to be improved access to mental health services this will rely on working with the Ministry of Education. Schools are the most effective, direct way to reach youth and child populations.

We are particularly supportive of a greater emphasis on evidence-based prescribing. There is evidence that anti-depressants for example are being prescribed without sufficient attention to the lack of evidence for their efficacy in some clients. Side-effects of these and other psychiatric medications also need greater attention. More attention needs to be paid to the application of non-pharmaceutical therapies where there is evidence that these will be appropriate to the client's needs.

Whilst we recognise the importance of empowering clients to engage in 'self-care' and 'self-management', this cannot be a substitute for good quality professional care. We would not like to see the appropriate responsibilities of the Government being displaced onto those in need of mental health support. It is important that there are realistic expectations in relation to mental health problems which may require more than whanau support or a quick intervention.

We consider that priority should be given to children and youth mental health needs and as noted above that these priorities need to be addressed within the context of addressing of poverty in New Zealand.

4. Resilience and recovery for other vulnerable population groups –Māori, Pacific peoples, refugees and asylum seekers, people with disabilities and those living under economic deprivation.

We applaud the attention that this paper gives to vulnerable populations and would also include incarcerated populations and unemployed youth who are particularly vulnerable groups.

The NZPsS is of the view however, that actions suggested in the paper in relation to these vulnerable groups are far too limited. The issue of deprivation and poor outcomes will certainly be assisted by some of the measures noted. It is excellent to see suggested linking with Whānau Ora initiatives, building capacity to address the needs of asylum seekers and refugees and involving groups with poorer outcomes in service planning etc. However we believe that a bolder approach is required where all social policy development is viewed through a mental health and wellbeing lens prior to implementation. The Ministry of Health is well placed to ensure that this occurs. Punitive social policy related to beneficiaries for example is likely to impact on the mental health and wellbeing of this population. See

http://www.psychology.org.nz/cms_show_download.php?id=1744 for the NZPsS submission on this issue.

The recent policy to remove student allowances for postgraduate students which is likely to reduce the number of students training as psychologists is an example of a policy that should have been picked up by the Ministry of Health/HWNZ as adversely impacting on the mental health workforce. The lack of this social policy "lens" is currently leading to unfortunate policy paradoxes which result in adverse consequences for vulnerable people.

We are of the view that addressing economic disparities is of the highest priority. This needs to be done in collaboration with the communities most affected. The provision of mental health services by a culturally competent and skilled workforce is also of the highest priority and this needs to be supported by appropriate workforce development planning.

5. Increasing access for infants, children and youth

We are supportive of all the initiatives identified and reiterate the comment made previously regarding the need to address social issues impacting on these age groups. Addressing poverty and youth unemployment in a culturally competent and effective way in combination with providing accessible mental health care are key issues. Providing "well-being hubs" in conjunction with schools and other educational institutions would also greatly assist access.

6. Increased access for adults

The NZPsS is of the view that there a number of major barriers to people accessing effective mental health services. These include,

- a lack of sufficient, trained mental health practitioners (e.g. psychologists)- leading to waiting lists and insufficient follow-up
- equipping the mental health workforce with the skills to provide psychological interventions as opposed to just medication and monitoring.
- the concentration of mental health primary care funding on PHOs and general practice making it difficult for those with mental health needs to directly access affordable mental health care other than through their general practitioner ,
- a lack of training of general practitioners in mental health diagnosis and care and workloads in general practice which prohibit sufficient time being given to mental health issues
- a lack of awareness regarding the range of psychological therapies that can be utilised for some mental health conditions

We would recommend that any mental health and addiction plan explicitly outlines:

- how the workforce will be developed to ensure effective services at both primary and tertiary level

- how training will ensure that those on the front-line of primary health care are able to deliver this effectively and make appropriate referrals where necessary

- how those with existing skills in psychological therapies (psychologists, psychotherapists and counsellors) can be utilised effectively in the proposed system.

- how the skills of allied health professionals such as psychologists can be better used. Private practitioner psychologists are an untapped workforce and their skills in providing psychological therapies, training and supervision could be utilised

- how a joint approach to mental health care with interagency collaboration and cooperation can be facilitated. It is important to consider the expertise that is required for different 'levels' of therapy. ".

- ways to ensure better GP and nursing training on the screening and treatment of common mental health and addiction problems including strategies to improve access to psychological therapies (across the primary/secondary sectors, and NGOs).

In the primary care sector, GPs need to look beyond the medical model and pharmacotherapy to address mental health issues. They need to recognize the skills of allied health professionals to provide "better, sooner, more convenient" primary mental health care and refer appropriately.

There needs to better integration between primary and secondary services. For example, psychologists in specialised mental health and addiction triage services that work across primary and secondary services

- This would consist of appropriately knowledgeable and qualified clinicians (preferably from multiple disciplines, from primary and secondary services) who could classify referrals based on level of symptoms/functioning/risk (mild to severe).

- A range of 'eligible interventions' would be available at each level. These would include psychological therapies, ranging from self-help/computer-based approaches through to group, family and individual work.

- If triage services like this were set up, they could also play a support role through consultation, education and supervision across the sectors.

- Areas in which psychologists could usefully have a role include

    - Development of criteria for classifying referrals
    - Deciding appropriate psychological interventions at each level
    - Delivering psychological interventions

- Providing education, consultation and supervision to therapists from other disciplines (working at levels appropriate to their qualifications and level of expertise)

Whilst the suggestions above require increased resources in the short-term, they would be expected to significantly reduce longer-term costs. They fit well with the "better, sooner, more convenient philosophy".

7. Increased access for our growing older population

We are supportive of the actions and priorities noted and also draw attention to the mental health needs of carers so that these can be addressed also. We also note that some older people are experiencing cuts to the support services they require to remain in their own homes and note once again that social policy impacting on this age group also needs to be viewed through a mental health and wellbeing lens.

8. Supporting and strengthening our workforce

We support the priorities identified in the plan and note the importance of recognising and using the full extent of skills of allied health mental health workers. An approach to mental health which is skewed towards a medical model is currently impeding the access of some clients to non-pharmaceutical approaches which would better address their mental health needs.

We have already noted a number of workforce issues which require attention- these include

- The cuts to postgraduate student allowances and their impact on the mental health workforce
- Better use being made of the existing workforce e.g. educational psychologists and private practitioner psychologists
- The need for cultural competence (it is excellent to see this included in the plan)

Other important issues include

- Providing incentives for Māori and Pacific students to train as psychologists
- Expanding the hard to staff bonding scheme to include psychologists
- Ensuring that there are sufficient intern placements for psychologists. Internships which are guaranteed and targeted e.g. towards particular mental health priority areas such as youth or the elderly will allow trainees to develop skills in these areas. Currently trainees go to where ad hoc vacancies exist

- Ensuring that patient safety is protected by regulation of counsellors and others under the HPCA Act

- Ensuring that skills aren't diluted by shorter training periods e.g. CBT being seen as a technical skill which can be quickly learned. Our members tell us of situations where they need to spend time assisting clients who have not been adequately treated by non-psychologist staff who have been inadequately trained for example, in CBT.

Conclusion

We appreciate having the opportunity to comment on this paper and look forward to seeing progress being made on these important issues.

Yes – we would like to receive a copy of the summary of feedback- thank you.