NZ College of Clinical Psychologists
Te Whare Wānanga o te Mātauranga Hinengaro

The Mental Health and Addiction System and Service Framework

Response to 'Core Concepts' Consultation Document, June 2022

Background

We are pleased to be asked to give feedback on the proposed Mental Health and Addiction System and Service Framework. Current mental health services require significant modernisation and redesign, and we feel that clinical psychologists are central to successfully delivering the recommendations of He Ara Oranga mental health inquiry.

The NZ College of Clinical Psychologists (referred to as 'the College' in our submission) is a professional association, that represents the interests of more than 1800 Clinical Psychologists registered in New Zealand. Clinical Psychologists are experts in mental wellbeing and disability, working across a large range of specialties and employers- including District Health Boards, ACC, Oranga Tamariki, Corrections, NGOs, PHOs and as private practitioners.

This submission was prepared by members of the College's Executive Committee and is based on the feedback submitted by our members. The College also engages with external agencies, particularly those representing service user groups, some of whom will be referenced in our response to this consultation.

NZCCP Members Feedback on the 'Core Concepts' Document

1. Are there any system or practice principles missing or that you disagree with (please explain)?

The College would like to offer congratulations to the Ministry of Health's team on developing some excellent, comprehensive service-user focussed principles for delivery of its vision. In addition to the principles of Te Tiriti o Waitangi, the Ministry listed these aspirational principles in its approach:

System-wide principles

- Person- and whānau-centred
- Human rights
- Holistic
- Equity-driven
- Accessible
- Community-focussed
- Anti-discriminatory
- Collaboration and innovation

Practice principles for all services

- Recovery-oriented
- Harm reduction
- Suicide prevention

- Trauma-informed
- Strengths-based

Our members felt that these principles were both positive and comprehensive. We applaud the Ministry for its focus on Human Rights, ease and equity of access, and freedom from discrimination (which we suggest might better be termed 'inclusive'). Our members did note, however, that these four principles are very closely related (for example, freedom from discrimination is a Human Right enshrined in both NZBORA and the UN Convention of the Rights of Persons with Disabilities) and perhaps could be synthesised into fewer concepts. Similarly, 'strengths-based' approaches are generally considered to be part of a 'recovery-oriented approach' or 'the recovery model'.

There was some significant concern amongst our members that the proposal appears to contain no principle associated with the delivery of *quality, evidence-based* or *feedback informed* services. Ease and equity of access are not, *in themselves,* sufficient if the services delivered are ineffective, of a poor quality, or not evaluated to assess whether they have achieved their aims. We do not feel that services can be person-centred if they do not deliver positive outcomes, as this is the primary consumers seek help.

2. The initial critical shifts aim to prioritise the most pressing changes required over the coming years and will be refreshed over time. Is there any critical shift missing that you would include (and why), and if so, which lower priority critical shift would you drop?

Once again, the College would wish to congratulate the Ministry on its focus on Te Tiriti, the delivery of equity, ease of access and consumer-led change. The priorities listed by the Ministry were:

1. Actively deliver on Te Tiriti
2. Design out inequities
3. Build peer-led transformation
4. Get in early to support whānau wellbeing
5. Create connected, locally driven networks
6. Do whatever it takes: Choice and control

While our members were broadly supportive of these transformational ideals, there was some concern that these are not, actually 'objectives' that can be 'delivered' *per se*.

Most significantly however, our members feel that **the 'critical shift' needed is in the model of care of mental health services- towards a more evidence-based, recovery-focussed approach.** Simply put, the evidence suggests that psychological therapies are the most evidence-based, recovery-focussed treatments available in mental health services and are consistently favoured by service users over medication and hospitalisation.

We note that other professional associations- including the Royal Australia and New Zealand College of Psychiatrists (RANZCP)- have also consistently argued for this shift in the model of care. Indeed, in its 219 pages, the He Ara Oranga mental health inquiry report mentions the need for 'therapy', 'therapies', 'counselling' or 'psychotherapy' 132 times, and always in a positive context (in comparison medication is mentioned 28 times, in phrases such as "*an over-reliance on medication",* p.56). The College would argue that, since it is not only clear from the He Ara Oranga report, the voices of consumers and the research evidence that there must be a 'critical shift' towards greater access to psychological therapies, this should undoubtedly be considered to be a high priority for change.

3. The framework lists the key types of service that need to be available locally, regionally and nationally. Are there any key types of service missing, any included but should not be, or any that you believe are in the wrong category (and if so, what is your reasoning)?

Our members expressed some disappointment at the diagram representing a proposed service structure for mental health services- particularly as they largely appear to replicate the current, existing model of service delivery, rather than proposing a new vision of care based on the principles and 'critical shifts' described above.

In particular, our members hold **significant concerns with regard to the lack of inclusion of people with disabilities in the model of delivery**. While the deaf community have been mentioned in the 'consultation liaison' services, and the existing 'Mental Health / Intellectual Disabilities' community teams are included, the **current model makes no mention of neurodiverse populations including people with Autism, Attention-Deficit Hyperactivity Disorder (ADHD), Foetal Alcohol Syndrome, Acquired Head Injury, dementia or other physical or sensory disabilities**. Nor does it adequately consider people with Intellectual Disabilities who do not meet criteria for the existing specialist mental health / Intellectual Disabilities Services. The mental health needs of people with disabilities are frequently complex, and people with disabilities report that generic, or primary-level services rarely meet their needs.

The He Ara Oranga Mental Health Inquiry report specifically includes a number of populations who are poorly served by the current model of mental health care, as well as being disproportionately affected by mental health issues. In particular, He Ara Oranga notes that people with disabilities represent ¼ of the NZ population, and as much as 59% in the over 65s. In making our submission, the College has engaged with external organisations representing service user groups- most notably Altogether Autism and ADHD NZ- who we understand have also expressed their concern in the lack of focus on neurodiverse populations in the current document.

The suggested principles of mental health care- including equity of care, freedom from discrimination and human rights-based care- are clearly ***not met*** for people with disabilities by this proposed service structure. As it stands, the proposed model clearly discriminates against people with additional disabilities and should be reconsidered, in light of New Zealand's commitments to the UN Convention on the Rights of Persons with Disabilities.

Similarly, our members have indicated their belief that the Ministry should give serious consideration to the provision of telehealth and digital tools that are *accessible* and *inclusive* of people with additional sensory and communication needs. At a minimum, we would argue that digital tools should be provided in 'easy read' format for people with cognitive disabilities, alongside provision for deaf and visually impaired people, to reduce discrimination and improve equity of outcomes.

4. Are there any enablers for implementing the framework that are missing or that you think should not be included?

Feedback from our members suggested that the listed enablers are broadly appropriate, however we would be keen to understand the specifics of how those enablers are to be achieved. Given the strong arguments from He Ara Oranga, from service user groups, professional associations and from the scientific consensus that a 'critical shift' in care must be away from "*an over-reliance on medication*" (He Ara Oranga, P.56), we would argue that the Service Framework **must** consider the delivery and ongoing governance of psychological therapies. In terms of delivery and governance of psychological therapies, we would argue strongly that there is a need to include:

- **Leadership** and governance by Clinical Psychologists
- A focus on the development of the Clinical Psychology **Workforce**
- **Information**-driven, feedback-informed delivery of psychological therapies.

Summary

- The New Zealand College of Clinical Psychologists applauds the Ministry's principle-based approach to reform of the mental health system.
- Our members would suggest that the Ministry reconsiders the principles described, given that there are many principles with significantly overlapping concepts (e.g. human rights, freedom from discrimination).
- The College strongly advocates that the Ministry considers including principles of *quality*, *evidence-based* and/or *feedback-informed* care.
- He Ara Oranga, as well as service user groups, professional associations and the scientific consensus, suggest that we must make a '*critical shift*' toward the delivery of evidence-based psychological therapies as the mainstay of our mental health (treatment) response, which is currently missing from the Service Framework.
- The SSF Service Landscape, as it is currently presented, would discriminate against New Zealanders with additional disabilities- including significant numbers of people with Autism, ADHD, dementia and other physical disabilities. The College suggests that significant consideration must be given to how this document will support the needs of those disadvantaged groups to deliver equity and meet commitments under the UN Convention on the Rights of Persons with Disabilities.
- As noted above, a 'critical shift' is required in the model of care and service delivery in mental health- away from the biomedical to psychological/recovery-focused approaches. As such, Clinical Psychology leadership, workforce development, service governance and evaluation are likely to be critical in delivering a high quality mental-health system.

The College is committed to supporting the delivery of high-quality, person-centred health services for all New Zealanders. We would welcome the opportunity to be involved in further consultation and discussion of better models of mental health care.

Acknowledgements

The College would like to acknowledge the additional contribution of representatives from associations representing neurodiverse New Zealanders- particularly Altogether Autism and ADHD NZ for their useful feedback at an early stage of this submission.

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For further information, contact office@nzccp.co.nz