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

Submission to the Health Select Committee

Petition of Amy Skipper: Increase funding for public and private mental health care services & Petition of Rylee Hays: Invest more resources into mental health and support

Amy Skipper's petition requests: "*That the House of Representatives increase funding for public mental health services and offer increased subsidies for private mental health care options, overall increasing the resources available for people who are struggling with their mental health*" and 1,358 people have signed in support.

Similarly, Rylee Hays' petition requests: *"That the House of Representatives urge the Government to allocate more funding towards all hospitals, mental health facilities, and counselling services for people in New Zealand"* and 665 people have signed in support.

1 Introduction

Thank you for the opportunity to address the issues raised in the above petitions. As requested, we have combined our responses the points raised by both Amy and Rylee in their submissions, which we found well considered and thought-provoking. We also thank Amy and Rylee for their oral submissions, where they shared their own experiences of accessing mental health services. Sadly, Amy and Rylee's submissions detail themes that our members frequently note in the mental health system: highly limited access to specialist services (particularly for those unable to pay), a perceived lack of 'care' and respect from mental health professionals and ineffectual (or even harmful) treatments approaches. These themes were prevalent throughout the He Ara Oranga Mental Health Inquiry report (2018).

The NZ College of Clinical Psychologists ('the College') is a membership-based professional association, representing one of the largest and most specialised mental health workforces. Clinical Psychologists are registered practitioners under the Health Professions Competency Assurance Act 2003, and there are currently approximately 1850 clinical psychologists registered with the New Zealand Psychologists Board. As Manatū Hauora, the Ministry of Health ('the Ministry') notes in its response to the petitions, there are many different types of psychologists (see Figure 1). *Clinical* psychologists' training is extensive and focusses specifically on mental health care.

As clinical psychologists are most commonly employed within the mental health system (including Te Whatu Ora, ACC services and privately funded clinics) **the College is fully supportive of the principle of both Amy's and Rylee's petitions, which is clearly to improve access and quality of mental health services**. While we are not in a position to appraise the proportion of funding allocated by the government to mental health (although we note that the Mental Health & Wellbeing Commission has also concluded that further funding is required), we have chosen to focus our submission on some of the key issues facing mental health services, as well as the current challenges facing the clinical psychology workforce.

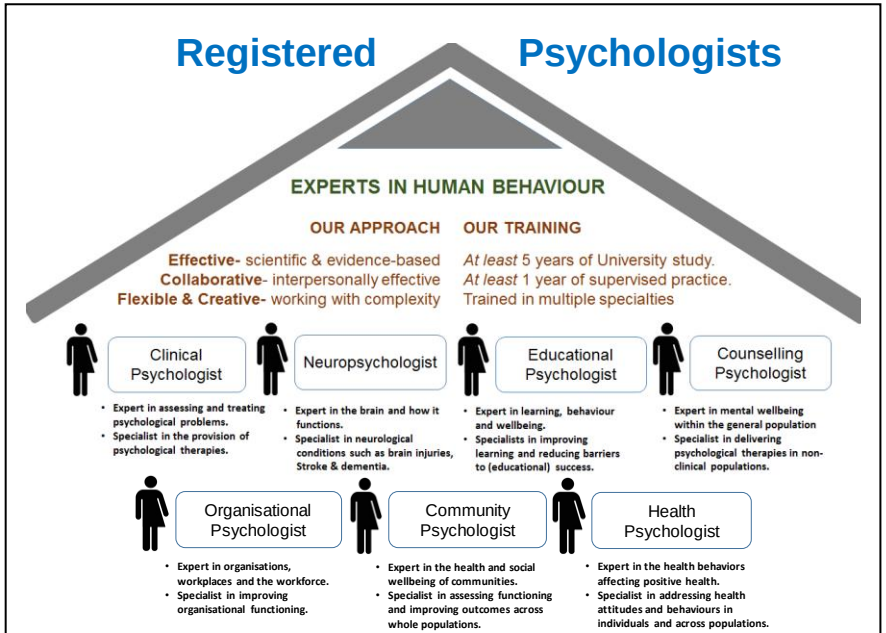

Figure 1: Scope of Practice for Registered Psychologists (Source: Psychology Workforce Task Force, 2018)

2 Background Context

2.1 Rising Demand for Mental Health Services

As we have detailed in a previous submission, it is generally accepted that there has been an exponential rise in demand for mental health services, both in New Zealand and internationally, over the last 10 years (see Box 1). The reasons for this rise are poorly understood, however rising levels of inequality, societal changes and an increased awareness of the importance of positive mental health have all been implicated in this trend. Within the last two years, the COVID-19 pandemic has also been shown to have further increased demand for mental health services- not only overseas, but also, within New Zealand. Prior to the COVID-19 pandemic, He Ara Oranga Mental Health Inquiry report suggested that approximately 1 in 3 New Zealanders are currently experiencing mental distress, with 1 in 5 meeting criteria for a diagnosable mental health condition at any one time.

The cost of the mental health crisis is not just a human one. The He Ara Oranga Mental Health Inquiry report also speaks to the substantial economic costs of poor mental health: "*The economic costs of mental illness are substantial. Recent estimates for OECD countries are that mental illness reduces gross domestic product (GDP) by approximately 5%, through disability leading to unemployment, work absenteeism and reduced productivity, and the additional costs of physical health care among people with mental health problems.*" 5% of New Zealand GDP would equate to approximately $17 billion per year. The Word Bank has previously estimated that, for every dollar invested in treating mental

conditions, there is a return of between 3.3. and 5.7 dollars in economic and social benefits. From both a human and economic perspective, we believe that strong, sustained investment in mental health is likely to lead to significant returns for New Zealand society.

2.2 Strong Demand for Psychological Therapies

While Amy and Rylee's petitions do not specifically focus on the types of mental health treatments available, both spoke of their wish for greater availability of psychological therapies. Traditionally, there has been a strong focus upon the 'medical model' of mental health- considering it as an 'illness' to be predominantly treated using medication. The He Ara Oranga report, for example speaks to a significant "over-reliance" on medication as a treatment for mental distress (p.56). In contrast, the review speaks to the strong preference of consumers to have access to effective psychological therapies, making over 130 references to the need to increase access in the (219 page) report. While there is good evidence that medication can certainly be helpful, the general public is increasingly calling for a wider range of approaches to mental health to be available to them.

Box 1: Rising Demand for Mental Health Services 2010-2020

- The number of unique MHA service users, or "clients seen" in DHB and contracted (nongovernment organisations) NGO services grew by approximately 40% in the years 2010/11 to 2019/20
- New self or family/whānau referrals to MHA triage teams increased by 128% from 2010/11 to 2017/18. Referrals from GPs have increased by 92%.
- Māori comprise 34% of the number of clients seen (Māori comprise roughly 16% of the total population)
- More than a third of MHA clients are in the poorest 20% of the population.
- The estimated number of adults with anxiety disorder more than doubled between 2011 and 2019. The estimated number of adults with depression grew by 32% over the same period.
- The estimated number of children with anxiety disorder doubled between 2011 and 2019. In 2019, the estimated number of children with depression was 75% higher than in 2011

Source- Association of Salaried Medical Specialists: What Price Mental Health? ASMS, 2021

2.3 Providing Treatment Approaches that Work

As we have detailed in a previous submission, there is strong research evidence that psychological therapies are more effective than medication in treating a range of mental health conditions, have wider application (e.g. can be applied to relationship difficulties, grief, work-related stress and burnout, etc.), have fewer (if any) side effects and generally cost the same to deliver over the lifetime of treatment (with psychological treatment generally being shorter but more intense). The UK ('improving access to psychological therapies'), Australia ('Better Outcomes in Mental Health Care') and parts of Canada have invested heavily in recent years in the mass delivery of evidence-based psychological therapies, with a corresponding investment in the clinical psychology workforces.

3 Some Key Challenges for Mental Health Services

As we have noted above, many of our clients describe particular difficulties in accessing mental health services in New Zealand: namely, (1) a lack of available services/clinicians, (2) unhelpful models of care/attitudes of healthcare workers and (3) ineffective (or even harmful) treatment approaches.

3.1 Improving availability of Mental Health support

Unlike the use of medications, many of which are prescribed by General Practitioners, access to psychological/psychosocial interventions cannot be achieved without a significant investment in the mental health workforce. The Ministry, in its submission, has detailed the government's recent investment in both the mental health workforce and into specific schemes, such as the Integrated Primary Mental Health & Addiction Services (IPMHA), to meet some of the current demand for services.

The Te Hiranga Mahara Mental Health and Wellbeing Commission's ('the Commission') review of the Primary Mental Health & Addiction Service concluded that a large number of people had accessed the service in its first three years of operation (more than 95, 000 individuals between July 2021 and June 2022), however this figure was lower than initially projected by the Ministry. The Commission also noted their concerns that this scheme required registered clinicians to be 'borrowed' from other areas of the mental health service and may not represent 'additional' contacts with services (p28).

The lack of specific barriers to referral (the scheme claims to be accessible to anyone) is seen as a particular advantage to people accessing help at an early stage. These services are designed to offer 'low intensity' interventions for people experiencing 'mild' levels of mental distress. Sessions are designed to be 30 minutes long, compared to 60-minute sessions employed in most evidence-based psychological interventions.

The Commission's recent review of more specialist services, for individuals with more 'moderate to severe' need, noted that access has not significantly improved- with wait times remaining the same over the last 5 years and, in some instances, increasing. A psychology workforce survey in 2017 indicated that wait times to see a clinical psychologist through a DHB were, on average, 15 weeks in adults' services and 11 weeks in children's services and we understand that services are now facing an even greater demand. A recent survey of Te Whatu Ora (formerly DHB) services showed that some regions had more than a 30% vacancy rate for psychology and a number of recent press reports have also indicated significant shortages of psychologists in ACC services.

Clients who are unable to access Health-funded mental health treatments have been characterised by the Royal Australia & New Zealand College of Psychiatrists (RANZCP) as "the missing middle"- requiring a higher intensity of care than is available from 'primary' care services but not being considered 'severe enough' to be able to access to specialist, 'secondary' care services. Where they are able to do so, many consumers and families will seek to pay for private sessions from a clinical psychologist, which is likely to involve a significant cost for long-term treatment. Even then, this does not guarantee access to a psychologist- a survey of our members in 2021 suggested that many clinical psychologists in the private sector are currently 'overwhelmed' with referrals and may not be able to offer timely support.

Amy's submission includes the suggestion that a greater number of private therapy sessions should be subsidised. This is a model that has been strongly embraced in Australia where the public have been able to access up to 10 Medicare-funded psychological therapy sessions per year since 2011, which was then increased, in response to the COVID-19 pandemic, to 20 per year. This approach has also been advocated in New Zealand, where schemes like Gumboot Friday have subsidised free psychological sessions for young people.

There are clearly some significant advantages to subsidised therapy schemes, which Australian research suggests have led to significant improvements in mental health outcomes, however it is important to note that such schemes also have some significant limitations. Firstly, such a scheme would not directly address the current lack of clinicians available. With private practitioners already fully booked and Te Whatu Ora services experiencing high vacancy and turnover rates, one of the key issues appears to be a lack of workforce. Secondly, Australian data suggests that these schemes tend to better serve families in affluent, urban areas over rural or economically disadvantaged regions and so significant thought would need to be given to maintain equity within the system.

It has been the view of the College for many years that the mental health service delivery will not be possible without significant and ongoing investment in the training, recruitment and retention of clinicians qualified in the delivery of specialist, high-intensity psychological therapies. While there is good evidence from overseas that non-psychologists can be trained to deliver high-intensity therapies under supervision, we believe that clinical psychologists remain central to the training, development and oversight of this workforce (see our joint report with the Psychology Workforce Task Force, 2018).

The He Ara Oranga Inquiry report highlighted that the psychology workforce should be a priority for investment in 2018 (p128) and we are pleased, as the Ministry has noted, that there have now been some initial investments made into training more clinical psychologists in New Zealand. We believe that this work must remain a key priority for Te Whatu Ora, as it takes over workforce planning and funding from the Ministry. We believe there is still significant work still to be done to improve training, recruitment, retention and development of psychologists

in New Zealand. Indeed, the Commission has noted that "*it will be a significant stretch*" for services to recruit sufficient workers over the next two years.

3.2 Delivering effective therapies

Clinical psychology is a primarily scientific profession, relying heavily on scientific method and evidence-based practice, as well as receiving a high level of training in the delivery of psychological therapies. In our view, investment in mental health should have a clear focus on the quality and effectiveness of the interventions being offered, alongside the overall dollar value. The importance of 'effectiveness' has been highlighted as part of the Commission's He Ara Āwhina delivery framework and we would strongly emphasise the importance of commissioning evidence-based therapies, that have been proven to be effective.

Many different approaches to psychological therapy are currently available. As we have detailed in previous submissions, there is currently no clear commissioning framework or body for psychological treatments in New Zealand, with practitioners frequently looking to overseas bodies such as the UK's National Institute for Clinical Excellence (NICE) or NHS Scotland's 'Matrix' evidence-based guidelines. Nor, to our knowledge, are there clear arrangements or plans for governance of psychological therapies in Te Whatu Ora.

While we acknowledge that the IPMHA services are intended to provide 'low-intensity' therapies for clients with 'mild' levels of mental distress, data as to which psychological therapies are being offered and/or whether the service is delivering effective interventions, have been slow to emerge. According to Te Pou training guidance, Health Improvement Practitioners (HIPs) receive 4 days of training in "fast Acceptance and Commitment Therapy" (fACT), which is not currently recommended by NICE or Matrix guidelines, for any diagnosable condition.

As mental health services continue to develop, specifically with a focus upon psychological care, we would strongly recommend that Te Whatu Ora seek to commission approaches with a strong evidence-base and involve clinical psychologists in the leadership of these processes, to ensure that we are able to offer services that are likely to be effective. We would advocate an approach, similar to that adopted by the UK's 'Improving Access to Psychological Therapies' (IAPT) scheme that:-

- Ensures that the correct psychological therapies are delivered at the appropriate 'dose' (number and intensity of sessions) based on international recommendations (e.g. NICE).

- Develops an appropriately trained and supervised workforce: where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver, and who receive supervision weekly by senior clinical practitioners.
- Routinely monitors outcome on a session-by-session basis, so that the individual and their therapist have data on whether therapy is working, as well as allowing for service improvement, transparency and accountability to government.

3.3 Delivering person- and whanau- centred services.

The He Ara Oranga inquiry report strongly emphasises the need for services to move towards *"He tangata, he tangata (the person first)- from service and provider priorities to the priorities of each person"* and this is strongly echoed in the Commission's He Ara Āwhina delivery framework. Both Amy and Rylee's submissions suggest that we still have a long way to go, to deliver on this vision. We have frequently heard from our members that mental health services are often providing what they experience as a 'one size fits all' approach- with Māori, Pacific people and those with additional disabilities frequently missing out on adequate care. For many clients, they experience 'not meeting criteria' as being considered 'not being worthy' of care, which we believe Amy's submission speaks to.

In our experience, mental health services (particularly those in adult, 'secondary' care) continue to be organised around a largely medicalised, 'illness' model, designed to manage 'symptoms' and 'clinical risk', with the most common treatment being medication or hospitalisation. Services are most commonly led by psychiatrists (a medical doctor) and staffed predominantly by nurses. Psychologists, social workers, peer-support workers and other 'allied health' staff represent a minority and are rarely appointed to clinical leadership positions. Indeed, previous workforce surveys have suggested that the most common reason for psychologists to leave the public sector relate to poor organisational leadership, ineffective models of care and feeling psychological approaches are undervalued. Reports of high levels of turnover, burnout and staff vacancies amongst psychologists and other mental health professionals are likely to be a significant challenge to delivering person- and whanau-centred care, and we believe this will need to be addressed within the Te Whatu Ora system.

4 Summary and Conclusions

- The NZ College of Clinical Psychologists is fully supportive of the underlying principle of both Amy's and Rylee's petitions, which is clearly to improve access and quality of mental health services.

- Amy and Rylee's submissions detail themes that our members frequently note in the mental health system: highly limited access to specialist services (particularly for those who cannot access private treatment), a perceived lack of 'care' and respect from mental health professionals and ineffectual (or even harmful) treatments approaches.
- Psychological therapies are some of the most effective, and flexible treatments available in mental health and are increasingly being sought out by the public.
- Many different approaches to psychological therapy are currently available. Clinical psychologists, the most highly trained providers of psychological therapies, typically advocate for an 'evidence-based' approach- to ensure that the person receives care treatments that are likely to be effective (and not likely to lead to harm).
- There is currently no clear commissioning framework or body for evidence-based psychological treatments in New Zealand. Nor, to our knowledge, are there current arrangements for governance of psychological therapies in Te Whatu Ora.
- Recent investment appears to have led to an improvement in access to 'low intensity' therapies, delivered in primary care services, but not to 'high intensity' therapies typically offered in secondary care to individuals with more complex needs.
- We welcome the Ministry's recent investment in clinical psychology training, which we believe must remain a key priority for Te Whatu Ora. We believe there is still significant work still to be done to improve training, recruitment, retention and development of psychologists in New Zealand.
- Despite significant policy changes in mental health, advocating for a move towards more psychological approaches, it is the perception of our members that the mental health system (particularly 'secondary' care, for adults) remains organised around a largely 'medicalised' model. This model of care is not well-placed to meet the needs of many New Zealanders- including Māori, Pacific people and those with additional disabilities.

We are grateful to Amy and Rylee for raising these issues, and for the opportunity to respond. We hope the above information is useful to members of the Committee in addressing the issues raised.

The New Zealand College of Clinical Psychologists, 3rd of February, 2023

The New Zealand College of Clinical Psychologists is a professional association that represents the interests of more than 1800 Clinical Psychologists registered in Aotearoa. Clinical Psychologists are experts in mental wellbeing, behaviour and neurodiversity, working across a large range of specialties and employers- including Te Whatu Ora, ACC, Oranga Tamariki, Ara Poutama, NGOs, PHOs and as private practitioners.

This submission was prepared by the College's Executive Committee,
with the direct support of our members and consultation with wider experts in the field.