Date 20/08/2013

To the Health Select Committee
On the Petition for Better Mental-Healthcare Choices in NZ
Petition Number 2011/66

Introduction

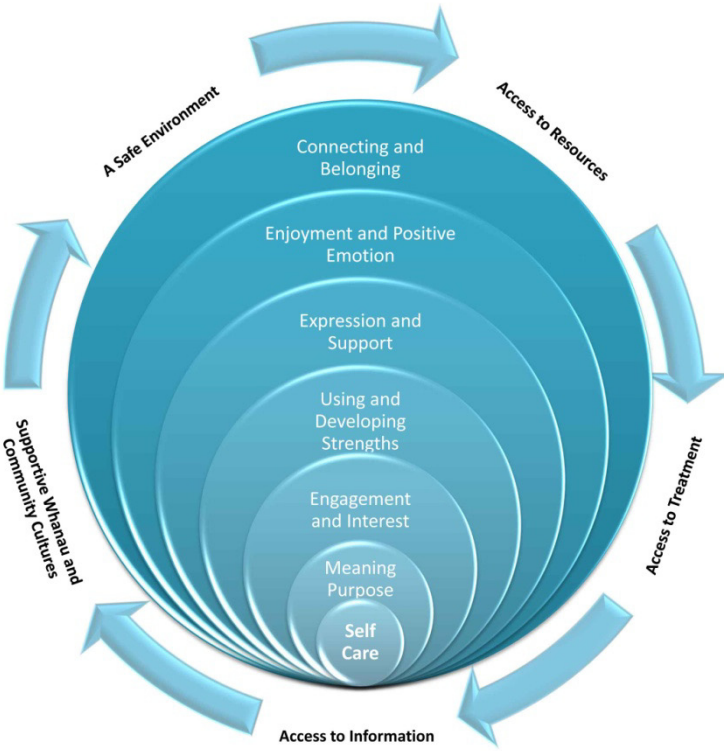
1. This submission is made on behalf of Engage Aotearoa and Community Mental-Health Resources Trust from Miriam Larsen-Barr, (MA; 1st Class Hons. Psychology), Service Director, Engage Aotearoa; Chair Person, Community Mental-Health Resources Trust.

2. I am available to answer any questions the Health Select Committee might have regarding how to best respond to the Petition for Better Mental-Healthcare Choices. References for all research cited is available upon request. I can be contacted at: 027 429 2102 or admin@engagenz.co.nz

3. (If an organisation, give the brief details of your organisation's aims, membership and structure and the people consulted in the preparation of your submission.)

Engage Aotearoa is a recovery promotion initiative governed by Community Mental-Health Resources Trust (CMHRT) using resources created by Engage Aotearoa Ltd. Improving treatment options is one of CMHRT's core concerns. With Engage Aotearoa, CMHRT aims to make it easier for New Zealanders to find the hopeful understandings, practical strategies, treatments and community connections they need to recover from mental-health problems or support someone they care about. Engage Aotearoa shares information and strategies online in the virtual world at www.engagenz.co.nz, works to get hard-copy information packs and recovery stories into the real-world and supports community events that bring the ideas and strategies alive, such as Mike King's Community Korero events. Engage Aotearoa is guided by the Engage Model of Mental-Health Promotion, which provides a strategy for promoting recovery that brings the research together with lived-experience perspectives.

The Engage Model of Mental-Health Promotion



The Engage Model of Mental-Health Promotion shows how individual practices associated with mental health fit inside a wider social environment. To promote mental health, both the individual and the social levels must be addressed. The Engage Model of Mental-Health Promotion is based on transdiagnostic research showing common vulnerabilities that are shared across different diagnostic categories, cognitive-behavioural understandings of mental-health problems and research from the field of positive psychology about what makes mental health.

This submission is based on the research evidence that gave rise to the Engage Model, the academic, personal and professional experiences of the CMHRT Board of Trustees and anonymous service feedback shared with Engage Aotearoa via the Voice Box function on the Engage Aotearoa website. This submission has been endorsed by CMHRT's Board of Trustees: Miriam Larsen-Barr (MA), Emma Edwards (MA), Kenneth Larsen (PhD), Taimi Allan, Daniel Larsen-Barr (BA), Sheree Veysey (MA), Dean Manly (PhD) and Diane Hewitt (MA).

General Summary

4. We support this petition because:

4.1. The research literature from the field of psychology combined with our personal experiences of accessing mental-health services and our professional experiences of working with people who experience mental-health problems, leads us to wholeheartedly believe that New Zealand's mental-health services are not currently functioning in the best interests of those who need them. Medication is not the most empirically supported form of treatment for mental-health problems.

4.2. The availability of alternative treatment options, an adequate standard of care and the ability to give informed consent are three of ten inalienable rights that people with mental-health problems are afforded in the Health and Disability Commissioners Code of Consumer Rights. Ensuring adequate access to treatment options is a crucial part of ensuring people who experience mental-health problems are able to truly give their informed consent or assent for the treatments they use. Choice is considered a fundamental part of consent and choice requires being provided with more than one option. In the recent Partnership Report from Changing Minds, service-users specifically call for a greater range of choice when it comes to their recovery.

5. SUBMISSION

5.1. We submit that everyone with any mental-health problem, regardless of its severity be provided with prompt access to a minimum of 10 sessions of the talking therapy of their choice, whenever they are ready to engage with it.

5.1.1. **Everyone:** Research shows that people experiencing mental-health problems share many psycho-social factors that are open to change via the same or similar methods, regardless of their diagnostic category.

5.1.2. **Promptly:** Research shows that early access to talking therapies is associated with improved long-term outcomes including lower rates of hospitalisation, medication dependence, relapse rates and improved quality of life and symptom severity. This is true for people who have schizophrenia, first-episode psychosis, bipolar disorder, depression and anxiety. Talking therapies need to be freely available to everyone admitted to an acute unit, as research shows this is a crucial time for anyone who is able to engage.

5.1.3. **Whenever they are ready:** Research shows even people with longstanding chronic experiences of mental-health problems can recover when provided with talking therapy.

5.1.4. **A Minimum of Ten Sessions:** Meta-analyses have clearly demonstrated that randomised controlled trials of CBT for depression and anxiety do not generalise to real-world, community settings with real-world people who experience multiple complicating factors. In community settings, a greater number of sessions are generally required.

5.1.5. **Talking Therapy of their Choice:** Research shows the most reliable predictor of treatment outcome is the quality of the relationship between therapist and client, not just the type of therapy that is offered. People need the freedom to choose the therapist that suits them, including therapists that suit their culture and world-view.

5.2. We submit that funded talking therapies should be available upon direct request from the person who needs it.

5.2.1. Getting a GP referral is often financially prohibitive and adds another layer of disclosure that is not necessary. If someone thinks they need talking therapy, they likely do; most people are able to judge their need for help better than anyone else.

5.2.2. Talking therapists always conduct a first-session assessment and are the best people to judge whether their modality is suited to the individual's needs.

5.2.3. Talking therapists are not easily available (see submission 5.3) and GPs tend to prescribe to more people than they refer for psychological services (73% vs 29%).

5.3. We submit that New Zealand requires more NZ-trained clinicians, particularly clinical psychologists and particularly in rural areas.

5.3.1. **More NZ-Trained Clinicians:** NZ has a unique cultural heritage that requires a sound knowledge of and appreciation for the Treaty of Waitangi and the bicultural relationship

between Maori and Pakeha. NZ-based training holds cultural considerations and the needs of Maori and Pacifica people at its centre.

5.3.2. **More clinical psychologists;** Recent analysis published in the Journal of the New Zealand College of Clinical Psychologists shows there is only one clinical psychologist for every 3421 members of the national population. Over Christmas 2012, there was an 8-month waiting list to see the psychologist at a Central Auckland Community Mental-Health Service. Currently, anecdotal reports suggest waiting lists are 4 months long. For someone in crisis, this wait may be a matter of life and death. There are particular gaps in the number of psychologists from Asian, Maori and Pacifica cultures. This need for additional clinicians is likely true for counsellors and psychotherapists too.

5.3.3. **In Rural Areas:** While there are 171 clinical psychologists in Auckland, 192 in Wellington and 143 in Christchurch, there are only 73 in Dunedin and less than 5 in large rural areas like the Far North and Southland.

5.4. We submit that talking therapies must be offered before people receiving Supported Living Benefits for mental-health problems are channelled into employment.

5.4.1. Engage Aotearoa has received feedback from members of the community who have recently lost loved ones to suicide after being assertively managed into employment they were not ready for. When people have not been equipped with the skills they need to overcome their difficulties, employment can often add stress rather than alleviate it.

5.5. We submit that couples therapy and family therapy options receive adequate funding so that families can work together to stay together in healthy ways.

5.5.1. **Adequate funding:** Two funded sessions is currently available through the family courts. As per submission 5.1.4, talking therapies require adequate time and two sessions is insufficient time to undertake an assessment, set goals and even begin to achieve them.

5.5.2. The Open Dialogue approach implemented in Finland places family therapy at its core and demonstrates an 84% recovery rate for people with psychosis at two years follow-up, with only 33% of those people having used medication.

5.6. We submit that talking therapies need to be made available as a preventative measure to young people and people who experience any kind of trauma, crime victimisation or prolonged hardship (such as lengthy unemployment, disability or illness).

5.6.1. As a preventative measure: People tend to show early warning signs of the development of a mental-health problem. Making talking therapies available to people who show early warning signs can allow people to avoid experiencing a mental-health problem and incurring all of the personal and social costs involved.

5.6.2. To young people: 50% of all people who will develop a mental-health problem show onset before the age of 18. Addressing difficulties early can prevent the need for future and ongoing interventions and the need for medications.

5.6.3. To people who experience trauma and hardship: Trauma, inequality, disadvantage and prolonged stress are risk-factors for mental-health problems. Providing talking therapies to people who experience these things can prevent the development of mental-health problems and all of the associated costs, as well advance other public-policy goals such as reducing psychological barriers to re-employment.

5.7. We submit that improving access to mental-healthcare options requires improved centralised information sharing across the sector and with the general public.

5.7.1. Engage Aotearoa actively attempts to collect and share this information in a centralised way but as yet receives no funding and is limited to the labour-hours that can be provided by a small team of volunteers. Our regular rate of 2 500 – 6 000 individual monthly visitors (89% of whom make repeat visits) proves this form of information sharing is valuable to the community and requires greater support from the top down.

5.7.2. Mental-health services require promotional budgets so the public knows they exist before they actually need them. This is especially important now that antidepressant and antipsychotic medications are being advertised on television. People require information about both the risks and the benefits of different treatment options.

6. Conclusions

6.1. 40% of the NZ population had experienced a mental-health problem in 2005 and by the time they reach 75 estimates suggest 46.7% of the population will have been through a mental-health problem at some time in their lives. There are few other conditions that affect such a large proportion of our population, while at the same time being preventable and resolvable with the right kinds of support and treatment. Mental-health problems are serious conditions that affect the person's body, mind, emotions, behaviour and relationships. There are several empirically established talking therapies for mental-health problems available in New Zealand. But the people who need them are unable to access them due to insufficient numbers of clinicians and financial restrictions.

6.2. Adequately funding talking therapies from counsellors, clinical psychologists and psychotherapists will empower New Zealanders who experience mental-health problems to make the best recovery choices for them and freely give their informed consent – choice is considered a fundamental part of consent and choice requires an awareness of and access to multiple options. The Health and Disability Commissioner's Code of Consumer Rights sets these conditions out as core rights for all people using mental-health services. The Health and Disability Commissioner Act enshrines these rights in law. In the recent Partnership Report from Changing Minds, service-users specifically call for a greater range of choice when it comes to their recovery.

6.3. Adequately funding talking therapies will cost money but will translate into savings in the areas of reduced unemployment, absenteeism, hospitalisation, doctor visits, medication-related health problems and long-term prescription costs. Adequately funding talking therapies will also lead to higher quality of life and greater long-term recovery rates for people who experience mental-health problems. This will benefit the wellbeing of whanau and communities into the future.

6.4. Summary of Submission

I. Everyone with any mental-health problem, regardless of its severity should be provided with prompt access to a minimum of 10 sessions of the talking therapy of their choice, whenever they are ready to engage with it.

II. Funded talking therapies should be available upon direct request from the person who needs it.

III. New Zealand requires more NZ-trained clinicians, particularly clinical psychologists and particularly in rural areas.

IV. Talking therapies must be offered before people receiving Supported Living Benefits for mental-health problems are channelled into employment.

V. Couples therapy and family therapy options need adequate funding so families can work together to stay together in healthy ways.

VI. Talking therapies need to be made available as a preventative measure to young people and people who experience any kind of trauma, crime victimisation or prolonged hardship (such as lengthy unemployment, disability or illness).

VII. Improving access to mental-healthcare options requires improved centralised information sharing across the sector and with the general public.