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Mental Health and Addiction Inquiry

Feedback to the Ministry of Health from a small town GP (Fellow) with 37 years rural General Practice experience and to the **RNZCGP and NZMA** to assist in their submissions.

Introduction

Over the years there have been multiple reports and countless articles on mental health, drug addiction and suicide in New Zealand, none of which seem to have made the slightest difference to reducing our world leading position as achieving the worst outcomes as measured by youth suicide, domestic violence etc. There are other health areas we are performing poorly in, such as dental health and obesity. The difference between these poorly performing areas and those we excel in would appear to be strongly related to the fact that there is a lack of Evidence Based Science applied to these three poorly performing areas with decisions made by politicians (central and local), DHBs and managers without adequate scientific advice and individuals believing anti-science messages, usually obtained from the Internet. Politicians and the media seem to pay more attention to Comedians, ex-All Blacks, Accountants and Internet Bloggers when it comes to Mental Health than Psychiatrists, Psychologists, Epidemiologists and most importantly, front-line specialist General Practitioners.

Section 1

There are, I believe, five principles which should be applied to answering each question posed (see Section 2):

[1] The **Promotion of the Application of Science, particularly Evidence Based research findings** on establishing both the modifiable determinants of poor mental health and the best management, particularly as it relates to the New Zealand situation, so that any new programs and funding are directed to where they can achieve the most. Continuing with programs designed without evidence of effectiveness is just wasting scarce resources (and frustrates both GPs and patients).

- There is good evidence for appropriate medical (pharmacological and lifestyle) therapy, Cognitive Behaviour Therapy and combinations of these two in Depression[1] and many other mental health conditions.

[1] Prukkanone B, Vos T, Bertram M, Lim S. 2012. "Cost-Effectiveness Analysis for Antidepressants and Cognitive Behavioral Therapy for Major Depression in Thailand." Value Health 15 (Suppl. 1): S3–8 https://www.ncbi.nlm.nih.gov/pubmed/22265064

- Cochrane reviews of Psychoanalysis, Psychotherapy and Psychodynamic therapy reveal they "lack a robust evidence base" and are not helpful in schizophrenia[2] and there is no evidence for their use for children and adolescents following sexual abuse[3].

- The much promoted "Brief Intervention" is not effective for heavy alcohol use or dependence[4] and there is "insufficient evidence" to support its use by lay community health workers (LHWs) in the prevention of mental, and substance abuse disorders[5].

- There is poor evidence for "counselling for mental health problems in primary care" and a 2011 Cochrane review revealed only short term improved mental health outcomes, but no long-term benefit[6].

- "Mindfulness" is the latest mental health therapy demanding a share in the limited Mental Health budget of DHBs. Initial studies including Meta-analyses indicated some benefit in the treatment of depression and anxiety but the study designs were of poor quality with poor definitions and lacked controls to determine a placebo effect. Meta-analyses with more stringent inclusion criteria now report only very small to modest improvement[7] even after eight weeks of mindfulness training, and even less benefit after 3-6 months. Recent literature reviews show no benefit for mindfulness meditation to enhancing attention, curtailing substance abuse, aiding sleep or controlling weight[8]. There are now warnings being published to minimize harm, curb poor research practices and stop the flow of misinformation about the benefits, costs and future prospects of "mindfulness", particularly for health policy decisions. [9] [10]

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[2] Malmberg L, Fenton M, Rathbone J. Individual psychodynamic psychotherapy and psychoanalysis for schizophrenia and severe mental illness. Cochrane Database of Systematic Reviews 2001, Issue 3. Art. No.: CD001360. http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD001360/full

[3] Parker B, Turner W. Psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused. Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD008162. http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD008162.pub2/full

[4] Saitz R. Alcohol screening and brief intervention in primary care: absence of evidence for efficacy in people with dependence or very heavy drinking. Drug Alcohol Rev 2010;29:631–40. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2966031/

[5] Mutamba, Byamah Brian et al. "Roles and Effectiveness of Lay Community Health Workers in the Prevention of Mental, Neurological and Substance Use Disorders in Low and Middle Income Countries: A Systematic Review." *BMC Health Services Research* 13 (2013): 412. *PMC*. Web. 9 May 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852794/

[6] Bower P, Knowles S, Coventry PA, Rowland N. Counselling for mental health and psychosocial problems in primary care. Cochrane Database of Systematic Reviews 2011, Issue 9. Art. No.: CD001025. https://www.ncbi.nlm.nih.gov/pubmed/21901675

[7] Edo Shonin, E; Van Gordon, W; and Griffiths, Mark D "Editorial: Does mindfulness work?" BMJ 2015; 351 https://doi.org/10.1136/bmj.h6919

[8] Goyal M., Singh S., Sibinga E. M., Gould N. F., Rowland-Seymour A., Sharma R., , . . . Shihab H. M. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. JAMA Internal Medicine, 174, 357–368. https://www.ncbi.nlm.nih.gov/pubmed/24395196

[9] Van Dam, Nicholas T et al "Mind the Hype: A Critical Evaluation and Prescriptive Agenda for Research on Mindfulness and Meditation" Perspectives on Psychological Science Vol 13, Issue 1, pg 36-61, 2018 http://journals.sagepub.com/doi/pdf/10.1177/1745691617709589

- There is a divide in the mental health field between those promoting scientific therapies (evidence or outcome based, most often cognitive-behavioural) and those promoting the art of therapy (often therapist based), despite a general failure of the latter approach[11] [12].

[2] **Policies and funding must be better targeted so that evidenced based cost-effective prevention and management can be achieved**.

Setting vague "Goals" for some undefined person or group such as "Promote mental health and wellbeing, and prevent mental health problems" [the first Goal in the failed New Zealand Suicide Prevention Strategy 2006 – 2016[13]] cannot be expected to achieve anything, nor can specific goals such as defining the expected reduction in, say suicides, when the determinants are largely unknown and those best able to address the problem (GPs, Psychologists, Psychiatrists etc.) are not only not supported but not even mentioned in reviews.

- In depression, generic antidepressants and CBT have been shown to be cost-effective interventions in the acute, continuation, and maintenance treatment phases while maintenance treatment using CBT was the single-most cost-effective strategy, but this finding has to be balanced against the shortage of trained mental health personnel available to deliver psychotherapy services.[14] [see Principle 5]

- Youth suicide prevention cannot be changed by focusing on crisis management. Better adolescent mental health services are important, but not sufficient. Sir Peter Gluckman concludes that "the high-priority need is to introduce and reinforce programs focused on primary prevention starting early in life and developing secondary prevention strategies involving well-trained and engaged mentors including peer mentors."[15] A NZ Coroner reports that Suicide Notes have one thing in common, almost all have very poor spelling and bad grammar[16]. It could be that the Coroner is not familiar with youth "txting" but it is

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[10] Stetka, Bret "MENTAL HEALTH: Where's the Proof That Mindfulness Meditation Works? The ubiquitous technique for relieving stress and pain has remarkably little scientific evidence backing it" Scientific American October 11, 2017 https://www.scientificamerican.com/article/wheres-the-proof-that-mindfulness-meditation-works1/

[11] Nathan, Peter E "The Evidence Base for Evidence-Based Mental Health Treatments: Four Continuing Controversies" Brief Treat Crisis Interven 4 (3): 243, 2004. http://btci.stanford.clockss.org/cgi/reprint/4/3/243.pdf

[12] Lusk, Barbara "Boundary Work In Psychology: The Uneasy Relationship Between Scientific and 'Pop' Psychology" Department of Psychology
http://studylib.net/doc/6676109/the-uneasy-relationship-between-scientific-and-%22pop%22-psychology.pdf

[13] New Zealand Suicide Prevention Strategy 2006 – 2016
https://www.health.govt.nz/system/files/documents/publications/suicide-prevention-strategy-2006-2016.pdf

[14] Prukkanone B, Vos T, Bertram M, Lim S. 2012. "Cost-Effectiveness Analysis for Antidepressants and Cognitive Behavioral Therapy for Major Depression in Thailand." Value Health 15 (Suppl. 1): S3–8
https://www.ncbi.nlm.nih.gov/pubmed/22265064

[15] Youth Suicide in New Zealand: a Discussion Paper* 26 July 2017. OFFICE OF THE PRIME MINISTER'S CHIEF SCIENCE ADVISOR Professor Sir Peter Gluckman, ONZ KNZM FRSNZ FMedSci FRS Chief Science Advisor
http://www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf

[16] Factors Causing Suicide in NZ: A Coroner Speaks
http://www.life.org.nz/suicide/suicidekeyissues/suicidekeyissues3/

more likely that what he is observing is a reflection of low self-esteem secondary to poor education which is a major reversable factor in mental health. I would certainly want the spelling and grammar perfect if I ever wrote a suicide note!

- Long-term strategies are also needed to address the known predictors of poor mental health, well documented in NZ's world leading large prospective Dunedin Multidisciplinary Health and Development study[17] which often shows we are not addressing the appropriate problems. For instance, "*Self-control in childhood is more important than socioeconomic status (SES)*" is a huge concept not yet taken up by Education, Social Welfare and even sporting Policies. However, addressing child poverty as early in life as possible is still important with the finding "*Growing out of childhood socioeconomic disadvantage by adulthood did not undo or mitigate the damage caused by early adversity*", with the implication that "adversity" was not just an economic problem but could include violence, drug misuse and addiction, bullying etc. The challenge here is to not lose sight of the importance of imparting self-control, resilience, confidence etc. to children and not just addressing economics. A third finding was "*The very high cumulative prevalence of psychiatric conditions over the life course*" with the prevalence of anxiety, depression, and substance dependence being about twice as high as the mental health community has been led to believe.

[3] **Wasting resources on unproven or disproven approaches has to be discouraged**. We know that approximately 70% of suicides and suicide attempts have a psychiatric basis (eg depression, psychosis etc.) Beautrais[18] and there are good pharmacological and Evidence Based psychological therapies for these disorders yet there is poor access to these while resources are wasted on unproven generic counselling or media advertising about "talking to the neighbour". Doctors assume that once novel clinical techniques have been refuted by research, they will be promptly abandoned but this often fails to occur in psychotherapy and yet still attracts public funding. It may be time to have country wide **evidence-based** recommendations and funding instead of each DHB or worse still each District Council promoting services, similar to removing the Fluoridation debate from local councils so that Evidence Based decisions can be made nationally. More examples include:

- Therapies that have been shown to be harmful or ineffective continue to be promoted by the media or used by counsellors and mental health workers[19] and therefore DHBs, Police, Schools etc. continue to waste money on Debriefing Counselling to prevent PTSD or other

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[17] Poulton R, Moffitt TE, Silva PA. The Dunedin Multidisciplinary Health and Development Study: overview of the first 40 years, with an eye to the future. Social Psychiatry and Psychiatric Epidemiology. 2015;50(5):679-693. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4412685/pdf/127_2015_Article_1048.pdf

[18] Beautrais AL, Collings SCD, Ehrhardt P, et al. 2005. Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention. Wellington: Ministry of Health https://www.health.govt.nz/system/files/documents/publications/suicideprevention-areviewoftheevidence.pdf

[19] Scott O. Lilienfeld, Julia Marshall, James T. Todd & Howard C. Shane (2015) The persistence of fad interventions in the face of negative scientific evidence: Facilitated communication for autism as a case example, Evidence-Based Communication Assessment and Intervention, 8:2, 62-101 https://www.tandfonline.com/doi/abs/10.1080/17489539.2014.976332?src=recsys&journalCode=tebc20

psychological distress if someone happens to see a dead body (other than on TV or while gaming) or experiences something frightening, despite strong advice to cease this practice because it doubles the risk of PTSD [NICE, Cochrane][20]. The same applies to counselling after a traumatic birth [21]. It would also appear that the NZ media want GPs to screen veterans for PTSD despite the fact that most have successfully separated their war experience from their current lives[22] and counselling could undo this protection.

- Current Media reports frequently criticize the often appropriate use of modern antidepressants, promoting undefined "talking therapy" as a better alternative when there is little funding and even less availability of qualified Psychologists and CBT Therapists.

- Brief counselling sessions through limited DHB funded schemes are available in many parts of New Zealand but there appears to be no definition of or required qualification for the "Mental Health Worker" or "Counsellor" and no expectation of sessions being "Outcome based".

- There is an increasing amount of resources being diverted into "Brief Intervention", "counselling for mental health problems in primary care" and "Mindfulness meditation" not supported by evidence (as outlined in Principle 1), so any public resources for these interventions should be limited to well designed trials or pilots where there is some reason to expect a different and better outcome from the reviews showing no significant benefit.

- Attempts to predict completed suicide have been shown to be a mathematical impossibility[23] but sometimes preventable[24], yet resources continue to be wasted in looking for "warning signs" [25] and placing people on "suicide watch". Suicide may not always be avoidable, but this does not mean that every effort should not be made to prevent it or vigorously treat illnesses that are often contributory[26]. High quality programs for people with mental health problems are more appropriate ways to prevent suicide[27].

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[20] Rose SC, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews 2002, Issue 2. Art. No.: CD000560. http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD000560/pdf/abstract

[21] Bastos M, Furuta M, Small R, McKenzie-McHarg K, Bick D. Debriefing interventions for the prevention of psychological trauma in women following childbirth. Cochrane Database of Systematic Reviews 2015, Issue 4. Art. No.: CD007194. http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD007194.pub2/pdf/abstract

[22] Kurt Bayer "NZ veterans 'suffering in silence'" NZ Herald 23 May, 2012
https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10807871

[23] Alan Eppel MB, FRCPC "SUICIDE IS NOT PREDICTABLE" Editorial Journal of Psychiatry Reform 16 Oct 2016
http://journalofpsychiatryreform.com/2016/10/16/suicide-is-not-predictable/

[24] Large, Matthew & Nielssen, Olav. (2012). Suicide is preventable but not predictable. Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists. 20. 532-3.
https://www.researchgate.net/publication/233881204_Suicide_is_preventable_but_not_predictable

[25] Rajeev Ramchand, Enchanté Franklin, Elizabeth Thornton, Sarah Deland & Jeffrey Rouse (2017) Opportunities to intervene? "Warning signs" for suicide in the days before dying, Death Studies, 41:6, 368-375
https://www.rand.org/pubs/external_publications/EP67027.html

[26] Walter G1, Pridmore S. "Suicide is preventable, sometimes." Australas Psychiatry. 2012 Aug;20(4):271-3
http://journals.sagepub.com/doi/pdf/10.1177/1039856212449880

- There appears to be no restriction on who can offer mental health services in New Zealand, or the type of therapy, be it exorcism or astrology-based psychotherapy and little or no responsibility for poor outcomes. Public resources should be limited to qualified and registered therapists providing evidence-based therapy.

[4] **Promoting improved Access to Evidence Based Therapy** and support. Mental health gurus and even the media constantly tell people to "talk to someone" and "get help". All previous reports are deficient primarily because they fail to involve outcome-based professionals, be they Psychiatrists, Clinical Psychologists or General Practitioners (and there is not one mention of GPs in the New Zealand Suicide Prevention Strategy 2006 – 2016).
Access to GP assessment by patients with mental health problems is an issue that needs attention. Most new mental health presentations will take far longer than a 10-15 minute consultation and many GPs, particularly in rural areas, have excessive patient loads due to GP shortages. Having a 30-60 minute GP consultation, even in a Very Low Cost Access (VLCA) clinic is unaffordable for many patients with mental health issues and so they may avoid or delay seeking help and many GPs end up providing the service "pro bono" or at minimal cost, despite borderline practice viability. GPs then find access to publicly funded specialist Psychiatric and Psychology services very limited and have virtually no access to publicly funded CBT services. Therefore, unless the patient is extremely unwell, or a crisis exists, the General Practice is left to manage alone and possibly get a few funded generic counselling sessions or access some on-line services.
Other issues include:

- Pregnant women who develop mental health problems do not have any funded access to their GP and Midwives have very little education on mental health assessment and admit they lack confidence and feel unsafe when providing care for women with mental illness[28] [29]. Mental Health Screening tools and guidelines for midwives seem to jump from using a screening tool (eg the Edinburgh Postnatal Depression Scale) to invoking compulsory assessment, while referral pathways assume both a level of competence of the Midwife above her training and an availability of funded services beyond reality.

- Maori mental health needs have been highlighted for this review and the statistics reveal a higher proportion of Maori are affected, particularly in areas such as youth suicide. Maori youth suicide was a topic on the TV1 Marae program of 6 May 2018[30], highlighting the small North Island town of Murupara, with a population of 1,656 and falling, partly

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[27] Rajeev Ramchand (senior behavioral scientist at RAND studying suicide) A Novel Approach: Psychological Autopsies reported in Doug Irving Is Suicide Preventable? Insights from Research May 8, 2017
https://www.rand.org/blog/rand-review/2017/05/is-suicide-preventable-insights-from-research.html

[28] MCCAULEY, K. , ELSOM, S. , MUIR-COCHRANE, E. and LYNEHAM, J. (2011), Midwives and assessment of perinatal mental health. Journal of Psychiatric and Mental Health Nursing, 18: 786-795. https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2850.2011.01727.x

[29] Bayrampour, Hamideh et al. "**Barriers to addressing perinatal mental health issues in midwifery settings**" Midwifery , Volume 59 , 47 – 58
https://www.midwiferyjournal.com/article/S0266-6138(17)30526-0/abstract

[30] Marae Episodes, Season 2018, Episode 7, Sunday 6 May
https://www.tvnz.co.nz/shows/marae/episodes/s2018-e7

because there has been one suicide a month for the last four months. The most significant comment on this Marae program was from Michael Naera, Maori Suicide Prevention Officer for Te Rūnanga o Ngāti Pikiao who states "Our whanau can't cope with dealing with someone who is psychotic and when they reach out for help, the help doesn't come."

- DHBs have made access to **Psychiatrists** very difficult except in crisis situations and public access to clinical **Psychologists** and/or **Cognitive Behaviour Therapists** is almost unheard of because generic counsellors are cheaper to employ or contract with. In Taranaki access to funded counselling and Psychology even by GP referral to "Primary Connections" has become "extremely limited" and ONLY available to Maori, Pacific, Youth and Low Income (CSC holders)[31]. It is frustrating for General Practice to be criticized for an apparent over use of medication instead of "talking therapies" when public evidence-based psychotherapy is unavailable and even non-evidenced based counselling is severely restricted.

[5] **Access to mental health services has to be for ALL NEW ZEALANDERS**, as this Government continues to claim. However, the reality is that access is often dependent on factors such as DHB, PHO membership, income, race, General Practice type and who is referring.

- The largest disparity is the most disadvantaged people in New Zealand, those **not enrolled in a PHO**. National figures show an average of 93% of the population are enrolled, leaving 7% outside any programs and funding run exclusively through PHOs. 7% of the NZ population of 4,880,228 [32] is over **340,000 people** (almost the size of Christchurch) who for whatever reason have not joined a PHO in 16 years (so are unlikely to now). These include the homeless, the transient and disaffected, in other words those at highest risk of having mental health problems. In South Taranaki where 24% of the population are not registered with a PHO, half of these identify as Maori. The primary care for this 340,000 plus can be non-existent, episodic through Emergency Departments and A&M clinics and some attend Independent Practices such as mine where we try to obtain alternative funding for them (eg the WINZ Disability Benefit). Any proposed mental health changes have to make provision for this high risk non-PHO population.

- **Maori** have been identified as a group where mental health disparity exists as demonstrated by the fact that 130 of the 606 suicides in the 2016-17 year were Maori. I believe we need to move from just describing bad Maori health statistics to looking at **modifiable causes and better management.** The 130 of 606 figure (21% compared to Maori being only 15% of the population) raises two issues:
    1. Are the determinants for suicide different for Maori or are more Maori in high risk situations (such as the high unemployment rate in Murupara)?
    2. If we focus only on causes of Maori suicide alone, do we risk not helping the 476 (78%) who are non-Maori?

  The answer to these issues is likely to be that we should not only look at what the evidence tells us on causes and successful managements for all, but also recognize that there are

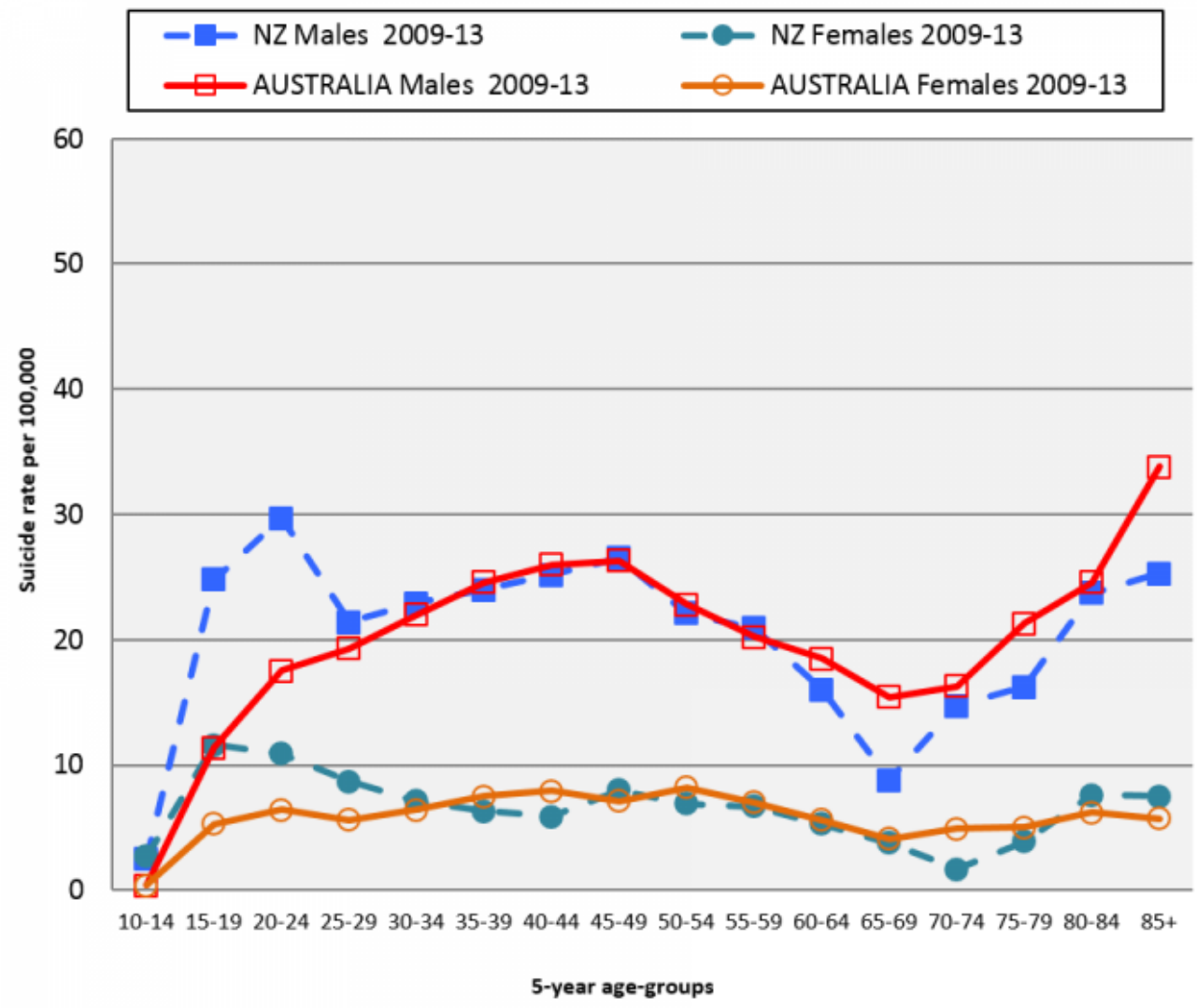
[31] "Counselling and psychology referrals Taranaki update" Email correspondence from Mentally well programme lead, Pinnacle Midlands Health Network 3 May 2018

[32] "Population Clock, as at Thursday, 10 May 2018 at 10:18:01 p.m." Stats NZ - Tastauranga Aotearoa http://archive.stats.govt.nz/tools_and_services/population_clock.aspx?url=/tools_and_services/population_clock.aspx

cultural and biological factors that may need to be part of the equation for Maori, Pacifica and other groups which cannot be ignored. I would love to see research in New Zealand change from describing the existence of a disparity to controlled trials comparing interventions (designed with Maori participation), to "usual care". Interventions could include addressing social determinants such as employment in Murupara (although randomization and controlling for other factors could be difficult).

- Youth suicide has also been highlighted and as one can see in the graph below, there is a peak in male adolescents, but there are more non-youth in total who commit suicide, so programs aimed just at youth will miss the majority. I'm sure programs won't exclude female youth, despite their much lower suicide rate so we can't ignore non-youth, particularly mid-life and very old males.

New Zealand and Australian suicide rates per 100,000 in 2009–13.[33]



[33] Snowdon, John "Changes in the age pattern of New Zealand suicide rates" NZMJ 13 January 2017, Vol 130 No 1448
https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1448-13-january-2017/7121

- The last few points highlight the dangers of profiling, particularly using only some data to focus on one group at the expense of another. Just like high-lighting young Maori men to ensure their needs are being addressed should not exclude the greater numbers of older and non-Maori, putting more resources into Very Low Cost Access (VLCA) practices misses both the greater numbers (already getting lower or no subsidies) in non-VLCA practices and the greater need in the 340,000 outside the PHO system without capitation subsidy.

- However, as pointed out by Snowdon the NZ suicide 2017 NZMJ article, suicide rates for Maori and Aboriginal Australians were similar. This should make us look at issues facing indigenous peoples that need to be identified and addressed eg restoring self-control, resilience, and confidence in ways relevant to a person's culture.

- Funding of mental health services through DHBs and PHOs has not been very successful, not just because it misses large sections of the community but because economic and management philosophies control the type, quality and extent of the services, unlike nationally based programs like Immunization which are evidence based and universal. I would suggest that the ideal "Gatekeeper" for appropriate access to public mental health services should be the GP, not some faceless DHB or PHO bureaucrat with no clinical knowledge of the patient and usually no understanding of psychiatry or psychology. Nor, I suggest should it be the therapist as they have a vested interest in approving the service they provide and in recommending their own philosophy or model of therapy, irrespective of the evidence. Access should not be determined by the type of General Practice but the appropriateness of the referral and if funding is limited (if the nation can't afford it to be universal), instead of funding cheaper non-evidence-based therapy, targeting should be on inability to pay, such as holding a Community Services Card (CSC) and NOT area code, race, religion, PHO membership, type of General Practice etc.

- Similarly, funding for GP assessment has to either be universal (i.e. ALL NEW ZEALANDERs), independent of practice organization, or restricted to CSC holders and perhaps "Working For Families" recipients, unless a better way to define lack of ability to pay is devised. That funding should also be realistic to cover a 30-60 min. first consultation and 20-30 min. follow-ups and claimed directly like Maternity, ACC or Immunization claims. This could save considerably on DHB spending on E.D.s and Psychiatric Outpatient costs and free up psychiatrists to see those patients for whom the GPs felt needed specialist input. It would also prevent DHB and PHO "top slicing" funding. Most importantly, the patient would be seen by a generalist with the best skills to identify and manage contributing medical and social co-morbidities and make the most appropriate referrals if needed (and if available).

- To achieve a change to better access to Evidence Based therapies there needs to be a change in Education Policy to train more Psychiatrists, Psychologists and CB Therapists and to recognize and value them when trained. There is also a need to better identify those practising evidence and/or outcome-based therapy, their registration qualifications and their college membership so that referrals and funding can be directed appropriately and reduce the cost and harm of the current failing system using generic, alternative and even "over the fence" counselling.

Section 2

Answers to Specific Questions

In the context of mental health and addictions services in New Zealand, what do you think is currently working well?

Once accepted into specialist (psychiatric) care, patients with acute and serious psychiatric issues are managed well. Private Psychology services when referred by a GP.

Why do you think it is working well?

Because patients are seen by trained specialist (or trainee) psychiatrists to diagnose and to plan management - medical, pharmacological, psychological and social, not just by a counsellor with limited understanding of the complexity. Private registered psychiatrists and psychologists are generally ethical and outcome based so they want to see their clients regain control of their lives.

Who is it working well for?

Patients with severe psychosis, Bipolar disorders and Major Depression including attempted suicide. Drug Addicts lucky enough to be accepted onto A&D programs in Taranaki (but not Auckland). Patients who can afford private psychiatrists and psychologists.

What mental health and addiction needs are not currently being met?

All other mental health problems expecting care in the public system.

Who isn't receiving the support they need and why?

Those unable to afford private psychiatric, psychological or Cognitive Behaviour Therapy services. Those who do not meet criteria (often illogical) for access to Mental Health services or offered only non-evidenced based care. Those patients outside the PHO system, particularly those without access to a GP. The reasons are varied but most importantly is the lack of publicly funded Evidence Based services for less acute patients and the distribution of mental health funding to PHOs (often excludes non-PHO patients) and NGOs (with inappropriate targeting) for access to cheaper generic non-registered and/or non-evidenced based therapists. A lack of community projects (see below).

What is not being done now that should be?

DHBs are not providing appropriate access (at least from GP referral) for patients needing psychiatrists and/or psychologists and Evidence Based Cognitive Behaviour Therapists. There could be more Community projects (with perhaps joint financial support from DHB, Social Welfare, Justice, Local Bodies) to help mental health patients, the disadvantaged and disabled members of society to find work.

What are your ideas about what could be done better or differently to improve mental health and wellbeing in New Zealand?

The first thing I would do is to remove management control, at all levels, from clinical pathways and processes for all New Zealanders. Drug and Alcohol addiction services would have the resources to not just "reduce harm" (=supply methadone) but to put in place a program of rehabilitation, work (even if supported work) and gradual weaning off the methadone.

What could be done better or differently to prevent addiction from occurring?

The best long-term fix has to be to do what the Dunedin Study suggests, namely ensuring pre-school and school policies are to educate kids to have self-confidence, **self-control and develop resilience** etc., teach them how to manage different and difficult life situations and of course know the dangers of drugs and smoking. They are already addressing intolerance and bullying so this shouldn't be too hard a change to implement. There is a current move to change drug addiction from a legal to a health problem but evidence would suggest this isn't just GPs or Addiction practitioners dishing out methadone or sending someone somewhere to detox. We still need programs that restore self-esteem and provide education and employment to help patients get on with their life without the drug.

What could be done better or differently to prevent people taking their own lives and support those affected by suicide?

Again, we should be following our own research (Dunedin Study) to develop **self-confidence, self-control and resilience** in young children. I have described above how we should stop doing things that are not helpful on one hand and look at what is appropriate to ensure people feel valued, be it middle-aged men going through a marriage break-up or loss of job or an unemployed Maori lad in Murupara, while not forgetting the lonely elderly gentleman [NZ studies show it is male youth, midlife and very old who make up the vast majority of completed suicide]. The evidence points more to social causes and answers than to the current belief in "talking therapy" but where real chemical based psychiatric illness is involved, as it is in at least 70% of suicides, the GP and Psychiatrist offer the best hope with their access to appropriate modern pharmaceutical treatments. Patients should not be constantly told they shouldn't be on anti-depressants by the public or media who do not understand that their "talking therapy" is either not generally available nor particularly effective.

How could support be better provided to those who need it be?

DHBs are not using resources in evidence and outcome-based ways and claim a lack of resources (money and staff). It is the job of this inquiry to change that. Instead of continuing the current failure to provide the needed support, there needs to be a change from DHB and management driven programs to national Evidence Based systems and an indication to students wanting to study psychology and/or counselling that there will be a real need for evidence-based therapists. Removing management control of mental health and psychiatric services will help reverse the loss of trained psychiatrists and encourage more medical students to enter the field, just as it would in General Practice if managers and politicians stopped trying to control GPs.

As there will always be a shortage of funding and appropriate therapists, free public access for "talking therapies" could be limited to Evidence Based psychologists and Cognitive Behaviour Therapists, and perhaps only publicly funded when a GP or Psychiatrist does the referral having given consideration to the medical and social background.

What would a refreshed system look like, how would it be different from what we have today, where would you start and where would you focus your effort?

Essentially, New Zealand's Mental Health Service has to face the fact that it is failing to meet current needs and despite Government promises, will always be short of resources (staff and money). Therefore, we need to get smarter, look at the evidence, invest in research that will provide local answers as well as take note of existing New Zealand and international research. In particular we need to move away from research that repeatedly shows what we already know (such as poorer Maori statistics) to research on modifiable determinants and effective interventions. Pilot studies need to be well designed and where possible be compared to "usual

therapy" so that the results are of sufficient quality to help determine social, therapy and medical prevention and intervention changes.

We need to have an Evidence Based system, not one based on "feel good" or "pop" psychology. This essentially means removing non-scientists, especially PHO and DHB managers from any decision making on mental health policies and have evidence based national policies, guidelines and programs (based where possible on well-designed national NZ trials) for ALL New Zealanders with exceptions only where there are particular different cultural or local determinants.

Social determinants based on good evidence need to be addressed to improve the resilience, self-esteem and confidence of children who become the youth and adults with less mental health issues. This is largely up to parents, educators, community organizations and national policies but there will continue to be youth and adults who need to gain these and other abilities with the help of appropriate evidence-based therapy. They may also need input from community and Government programs such as retraining, job and business creation, social support, housing etc. to help deal with adult life issues and determinants. Then there is the large number of mental health and psychiatric problems relating to genetic, biochemical and hormonal factors that no amount of "talking therapy" can help.

A refreshed system would see a nationally and universally appropriately funded access to GP assessments who would be able to refer to timely public social, psychiatric and psychological services, including Cognitive Behaviour Therapy (with appropriately qualified and registered Evidence Based therapists). Those who want non-evidence-based therapy should be free to access it but not with tax payer support. The funding for and access to GPs must not be regionally or PHO based, but universal like Immunizations. If this inquiry achieves nothing else other than better access for the 340,000 odd most at risk New Zealanders, namely those outside the PHO system, it will benefit the most deprived, those experiencing **child poverty**, the homeless, those living rough, the transient, the alcoholics and drug addicts, the disaffected and those who don't trust authority. In South Taranaki 24% are not in a PHO, 50% of which are Maori, many of whom feel alienated. There are also patients of the Independent GP who want continuity and "face to face" care from a NZ GP and value their health above highly subsidized VLCA clinics and are severely discriminated against by both Labour and National Governments, who seem to prefer control of General Practice over the health of New Zealanders.

Dealing with mental health issues in General Practice without funding and with poor access to psychiatrists, crisis teams, psychologists, CB Therapy (or any counselling) is soul destroying and one of the factors driving GPs overseas and discouraging students to train in General Practice. If vocationally qualified GPs were valued as the "specialist generalists" they are, paid for an assessment of the needs of a patient with mental health needs (like a first presentation for depression) with no restrictions on appropriate referral which was given priority over referrals from non-specialist Medical Officers, Community Nurses, Paramedics etc., not only would management of the 70% medically based causes of psychopathology become more efficient but GPs would feel better valued and more likely to recommend the career to students.

Is there anything else you want the Inquiry to know?

In an area where everyone is an "expert", reviews are usually conducted by politician selected members with little scientific input, and reports tend to have no evidenced based or even practical recommendations, or if they do they are ignored by DHBs, it is time to establish a single national **Mental Health Advisory Group** made up largely of practising clinicians (including at least one GP, one or two psychiatrists, at least one science based adult psychologist, one child psychologist and one Cultural Advisor but preferably no accountants, no PHO and DHB managers, in fact no-

one with an MBA) to review current literature, recommend and approve funding for areas of research needed (including pilot studies) and make recommendations on where resources and services are likely to make the most impact on improving mental health in New Zealand. The recommendations of this Advisory Group should have independence from political control and its recommendations to Government and the Ministry of Health would by law be the basis of all public decisions in this field and would over-ride any DHB or other regional policy.

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