the future of
MENTAL HEALTH
in Aotearoa | New Zealand

APEX

The Future of Mental Health Care

APEX

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INTRODUCTION

At the beginning of 2018, the new Labour-led government announced an Inquiry into Mental Health and Addiction. Of the inquiry, Prime Minister Jacinda Adern said:

"We want to hear from service users, the wider community and the mental health sector about their experience and expectations."

APEX is the specialist union for allied scientific and technical professionals in New Zealand. We represent psychologists throughout the country, working both in DHBs and the Ministry of Education. *The future of Mental Health in Aotearoa|New Zealand* was produced by APEX in consultation with the members of our Psychologist Division, and is hereby submitted to the Inquiry on their behalf.

The bulk of this submission comprises comments from New Zealand Psychologists – this is their voice, and their document. We surveyed our members, asking for their input on a series of open-ended questions regarding the current status and, importantly, the future direction of mental health care in New Zealand. The fullness of the comments may be hard reading, but the emotion and concern it expresses is undeniably genuine.

In creating this document we had a choice. We could summarise the comments or we could provide all comments. We opted for the latter option, allowing the voice of psychologists, including repetition, to speak for and represent the importance of the issues raised. Therefore, this is a comprehensive report. The text provided in each section is a faithful, unedited recording of feedback.*

The APEX team organised the responses into themes:

- **CURRENT STRENGTHS of the system**
- **UNMET NEEDS in mental health**
- **SYSTEMIC ISSUES in mental health**
- **WHAT WE SHOULD DO to fix problems**

We then built a series of conclusions from the

views of our members. Finally, we provide a set of recommendations – action points – for the Inquiry to consider.

The voices contributing to this report are those from the 'coal face', from the professionals interacting with people with mental health and addiction issues in the community. They have direct, relevant, and valid experience to contribute to this Inquiry, and we encourage the Inquiry to carefully consider our recommendations.

We thank the Inquiry for the opportunity to contribute to this critical initative. We are keen to discuss any issues in greater depth, at your convenience. Our contact details are provided below.

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*The only changes made to the comments are for clarity, categorisation, and spelling.

RECOMMENDATIONS

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1. Increase funding, staffing and services in DHBs, primary care services and schools

2. Focus on families and early intervention

3. Address social and systemic issues

4. Facilitate closer collaborations between services

5. Build an integrated system that works from primary to specialist services

6. Ensure the working environment has a positive influence on the work of psychologists and their colleagues

7. Integrate the model of care

8. Develop the workforce

9. Improve managerial systems

10. Educate the public

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EXECUTIVE SUMMARY

What's Working Well

Good relationships exist across services and with families.

Mental health services are being held together by the compassion and hard work of clinical staff.

The multi-disciplinary team allows utilisation of the full array of clinical skills in a collegial setting.

Some services are high performing, and specialist, group and early interventions are highly regarded.

There is flexibility and freedom to work in the most beneficial way for clients.

Unmet Needs

Mild-to-moderate mental health issues are not being dealt with by primary mental health services.

GPs, NGOs and schools are not sufficiently resourced to deal with mild to moderate mental health issues.

There is a lack of service capacity for parents, infant and children experiencing mental health issues. We are not currently addressing all the need for family therapy, trauma counselling for children and interventions focused on attachment issues.

We do not have sufficiently robust and well-funded child development services.

Resourcing for older people's mental health services has not kept up with growing need. With an ageing population we need to ensure mental health services for the elderly are properly planned and funded.

There are insufficient options for care in supportive institutional settings. There are a lack of beds in inpatient and residential facilities for those with severe mental health and addiction.

Patients are medicalised and medicated instead of being understood in terms of their entire biopsychosocial wellbeing. The system needs to see pharmaceutical interventions as part of rather than the dominant mode of intervention.

Many mental health staff, including nurses, occupational therapists and social workers are not given adequate training in how to properly assess and treat mental health issues.

Patients with predominantly physical health issues such as cancer and chronic conditions are not getting adequate psycho-social support.

Mental health services are wasting scare psychology resource by having us case manage clients.

It is critically important that we support good parenting, and in particular we ensure foster options for our most vulnerable.

There are not enough psychologists working in the system to meet current needs. Growing population and demand for services has not been met by a matched increase in staffing of mental health services.

Social and Systemic Issues

Poverty, child abuse, domestic violence, and substance abuse are serious systemic causes of mental ill-health.

We need to address society-wide issues like bullying, digital disruption, and unaddressed trauma that impact on peoples' wellbeing.

A comprehensive plan to uplift the social, cultural and economic factors of health is as important as improving the quality and quantity of clinical services.

What Should We Do?

Ensure Oranga Tamariki is providing the best possible care and protection of children and young people. Provide early intervention with children, parents and families to address attachment, trauma and drug and alcohol issues.

Educate children about mental health and emotional wellbeing as part of the school curriculum. Ensure adequately trained and supervised counsellors are available in schools.

Provide better funding, staffing and services in primary care. Facilitate better provision of primary mental health services through General Practice, NGO and community services.

Redesign the mental health system to acknoweldge that the best possible system is one which is well resourced and integrated from primary to specialist services.

De-stigmatising mental health.

Invest significantly in the specialist mental health services of District Health Boards.

Set minimum staffing levels in secondary mental health services linked to population and need.

Ensure clinicians working in mental health are getting comprehensive and robust training both during their formal study and throughout their career.

Create stability of workforce supply for psychologists through investment in internships and support for new clinicians.

Address issues burn-out, poor moral, uncompetitive salaries, unsafe working conditions, poor therapeutic environments, and unmanageable workloads.

Put evidence-based psychological therapies at the centre of our model of care.

Prioritise, at a government level, well-resourced core services, but also invest in service development and innovation.

Facilitate the best care by allowing all agencies to work together and share information.

Ensure that services contracted out to NGOs come with robust reporting and accountability requirements.

Strengthen ethical leadership within mental health services and provide opportunities for psychologists to be involved in clinical governance and at service leadership levels.

WHAT'S WORKING WELL?

What currently works well within your service to address mental health and addiction issues? And why does it work well?

GOOD RELATIONSHIPS ACROSS SERVICES & WITH FAMILIES

Good care comes from strong relationships between services and with families.

We have an excellent working relationship with our NGO providers and we work closely with them providing education and assertive in-reach.

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Good relationships with schools and whānau

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Working with whanau as a whole. MOE and DHBs working closely together and sharing resources and hours for children.

Having the partnerships with other organisations to address the underlying issues.

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Generally good relationships with specialist alcohol and drug services

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More conversation around working well along with other agencies to offer a collaborative care is being discussed now which could improve the

We have invested in and built strong relationships / interface with school counsellors and NGO's; and better relationships with Oranga Tamariki.

....

It works well if there are sufficient resources to build relationships and have interagency collaboration between MoE, OT and Child and Family Specialty Services.

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My own service works alongside a local PHO, with some success, as an inter-service child and adolescent cluster. My own view is that the contracts here do need regular review to ensure that funded positions do meet expectations in terms of clinical skills employed, but that done well it is a good model.

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We are making some progress towards primary care interface.

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care of those who struggle with mental health and addiction issues in the community.

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Having a Professional Leader that is in touch with those of us at the coal face and who is able to make connections with relevant people in positions of power and advocate on our behalf so psychology can be the best that it can be for whanau who come through our services.

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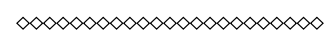
DEDICATED, COMMITTED AND CARING STAFF

Mental health services are being held together by the compassion and hard work of clinical staff.

Individual practitioners who have a commitment to their work - to do it to the best of their ability, to provide evidence-based best practice by keeping up to date with the research and their professional development, who have the interpersonal skills to connect to the clients that come through their door regardless of ethnicity, age, gender etc, and who feel valued by their team and management.

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There are a great many dedicated professionals striving in very difficult circumstances to deliver mental health care.

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Clinician who truly care about the wellbeing about their clients.

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Caring staff. staff staff staff staff staff.

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Existing secondary services in mental health work amazingly well; if you work inside the system, you see that. The staff are of a high calibre and are highly dedicated. The problem is there are simply not enough of them - not enough Psychologists, not enough psychiatric nurses.

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Good will of staff, who bend over backwards for client safety and service provision. This is probably making some things appear functional that would otherwise not be the case, because of the severe lack of staffing e.g. staff working unpaid overtime and through breaks. Some of us do this because we want to sleep at night and others because we are just caring professions who want to do the best we can. There are also a lot of skilled clinicians who do good work, and get good treatment outcomes despite the pressure we are under.

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Caring and dedicated work force (despite being worn out and over worked).

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Dedicated staff provide services above and beyond what is expected.

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Good will and dedication of staff.

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Great staff who are committed to helping people.

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There is a hard working dedicated workforce who is stretching to their limits to maintain services and doing the very best they can and they need ++ acknowledgement.

We have clinicians across the professions who are willing to go the extra mile to provide the best quality care they possibly can in the current environment. Clinicians generally have a good attitude towards service users on the unit.

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We have fantastic staff who spread themselves in every which direction to be all things to all people. **Our staff is our main asset.**

………………………………

The people that work in our DHBs are amazing with a wealth of experience who do great work. We support one another, share knowledge, and work in our clients' best interests.

………………………………

We have qualified and effective clinicians working at top capacity, but we wonder how long this effort can be sustained given the current need.

………………………………

Staff are passionate and committed.

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Every staff member works incredibly hard to do their best for people.

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High competency of staff.

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The staff. Amazing. Keeping going. Going beyond what they are resourced to do.

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One thing working well, is that the service hire consultants who offer their expertise and training to assist staff.

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Mental health staff work hard and are committed to put in their best effort to help clients.

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It is clear that in some sense the system is 'broken' at a macro level. What works well is largely a function of a group of dedicated mental health clinicians who strive to provide compassionate holistic services to the clients that they see and work with on a daily basis. These clinicians tend to hold wider understandings of the individual before them within a true integrated model of care that addresses needs across domains of physical wellbeing, mental health, social connectedness, work and spiritual support. Sadly these individuals over time find that they are unable to continue to do what they are and are either lost to other services such as private work or lose something more precious, their hope and belief that the work they do can effect change against the odds they face. It is this workforce that is perhaps most impacted by systemic failures and the narrow vision of previous governments that did not address service development needs to match a burgeoning mental health crisis affecting New Zealanders.

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I work in a multidisciplinary service with very experienced staff. What has worked has been their passion for the job and their consideration for each other. Management has also been somewhat understanding and supportive of staff workloads. However our service has not seen as much increase in demand for our service as in recent years and I have seen many very experienced staff leave the workforce in recent years because of burnout within the changing work environment.

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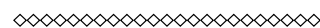
MULTIDISCIPLINARY TEAMS

Multidisciplinary teams that function well by each clinician using their specific skills and collaborating with others that do the same. Giving people choices, e.g., where they are seen, what interventions they would like to participate in. Having multiple psychologists in teams to ensure good support for each other, the team, and the people who use the service. Psychologists supervising other clinicians.

....

The multi-disciplinary team allows utilisation of the full array of clinical skills in a collegial setting.

Good IDT environment with most staff showing lots of care, compassion, and understanding. Lots of senior nurses with extensive experience in mental health. Biopsychosocial approach evident in the way we work with clients, family, and in rehabilitation planning.

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We have a very good MDT of nurses, psychologists, psychiatrists, OT's and social workers who, even given the tragic resourcing, are dedicated to help those who have mental health difficulties.

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Multidisciplinary teams provide holistic care and refer appropriately (medical consultant, nurses, physios, psychologist)

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All families with health conditions are screened by a psychologist when they are in to meet other professionals (i.e., Physio, Nurse, Doctor) to ensure any mental health needs are identified early and intervention is offered before mild problems escalate into moderate or severe issues. Strong communication with the multidisciplinary team regarding any concerns other professionals have for an individual in addition to appropriate referral systems in place to ensure such individuals are at the very least screened.

....

It's great that my service even has a psychologist. It works well that the psychologist is embedded within the multi-disciplinary team of cardiologists, surgeons, nurses and registrars. What works well is having regular meetings where we are able to discuss patients and to consider their psychosocial wellbeing. It's good for the patient as they feel cared for and supported as a whole person and not just for their physical illness.

....

Having a paediatrician and dietician involved at our service allows for better integration of services to address mental health and physical health needs.

....

Working across child mental health and paediatric physical health to provide coordinated care.

....

The MDT work well together to improve patient wellbeing.

....

The team driving changes within the service, focus on well-being of team. However this is all driven by a small number of individuals and this would not work if they were to leave.

....

Intensive Wraparound Service. This model increases the likelihood of a collaborative approach from all professionals involved.

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We work well within an interdisciplinary team. Each disciplines clinical background is respected and we work on shared goals.

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Work well as a team.

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Interdisciplinary team communicates well and is quick to respond to clients' needs as well as changes in presentation.

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Multi-disciplinary team based approach.

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Team work to wrap around a person all of the different ways of managing a problem.
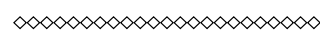
....

I think the Children's Team approach works well when services understand collaboration. This enables availability of resources and management of resources efficiently and allows therapeutic intervention to be what it needs to be. For effective therapeutic intervention to occur effective therapeutic boundaries need attention and care, this can occur in a collaborative Children's Team approach.

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Working embedded in the medical MDT

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Communication within the team via one daily (30 minute) MDT meeting.

....

In general a multidisciplinary approach is useful. Having more services in house or integrated with the mental health team means better communication and collaboration to the benefit of the service user. This includes e.g. work consultants, community support workers and other NGO supports. These are more or less well integrated with different teams (this varies as there are e.g. a range of NGOs involved).

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Integration of employment consultants in the team.

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SERVICES & PROGRAMMES
WORKING REALLY WELL

Particular services in mental health care are performing at a high level.

As a psychologist assessing service users to provide more clarification around the service user's diagnosis and broader psychological strengths and deficits has been very useful to the treating teams. **Designing and helping clinicians implement behavioural plans for complex service users has worked well.** Providing education

well resourced

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The service has endeavoured to recruit and retain experienced clinical staff across the MDT, and we have excellent managerial support at this time of high demand. There are a number of outreach clinics across the district, which enables

sessions and debriefing and supporting clinicians who are very overwhelmed by the pressure at times has also been welcomed.

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Inpatient services with structured environment and professional treatment and nursing

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I work in a service that recognises need & that most of the children, adolescents, parents we see definitely need experienced mental health clinicians' services & yet would not meet criteria for CAMHS or CMHC services. Consult Liaison Team at Starship. Physical health and mental health are related.

……………………………….

We have a really good team of psychologists. Inpatient units are

clients to be seen with less travel for them. Fleet vehicles are almost always available for staff to travel to these clinics, and to do home visits where needed. Some additional services are sometimes contracted out under packages of care. This seems to work well, although clearly there is a cost to this, and more in-house provision would probably reduce costs overall.

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We have made psychological therapies almost directly available in our locality and that works well. Our psychologists run groups and public wellbeing seminars.

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Some clients get good comprehensive interventions. The therapy they get is good but there can be await of many months.

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Brief psychological interventions work very well to help patients with health-related anxiety and procedural anxiety. Longer term psychological support works well to prevent and address psychological issues such as depression associated with the person's health issues.

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Group work where meet others with similar problems- helps them normalise, helps them acknowledge their strengths, reduces us vs them mentality (as if clinicians are trying to obstruct them!!), learn skills, time- limited.

……………………………

Evidence-based group treatment programmes.

……………………………

We have rolling mutidiagnostic CBT groups open to all clients. We have some excellent home based treatment, but not enough people to do it. We regularly review as a team treatment plans and progress of all our clients. We have enough staff currently. We were so stretched for a while when we had many staff resign or go sick
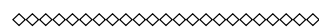
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We have practical approach with Choice appointment as a start. Groups are developing and there is a strong interface with primary care. Social aspects are taken seriously, social services, support systems, mental health, "outside mental health" (schools, social services) to lower the threshold.

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Evidence-based psychological intervention in collaboration with psychiatric services has proven to work well.

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Early intervention in psychosis services and child and adolescent services make positive enduring change.

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Some clients when able to access, get excellent care and treatment through our services.

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SPECIALIST SERVICES

Specialist, group and early intervention services are highly regarded.

Psychological intervention is available to everyone. Patients have a long stay and access to inpatient rehabilitation, assertive community case management and caseloads are kept to a minimum. Patients also have access to social workers and OTs, who do not have to case manage.

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We have more room to provide assertive outreach treatment as we provide in-reach mental health services to secure youth justice and care and protection residences. We always aim to deliver culturally responsive services and give our clients and whanau a voice and choices in the care that they receive.

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Within our service from WellStop we are able to comprehensively address the harmful sexual behaviours and help prevent further sexual harm. This could be extended more with education and prevention if funds would be available. Within Manuka services children have the opportunity to process their traumatic experiences and to support their parents/caregivers but the package of care is limited in the amount of sessions and it is only available for children going through the Gateway process. Many more children could profit from this kind of service.

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Having a dedicated psychologist in a specific physical health service

and training/upskilling in communation, self-care, treatment adherence, screening for psychosocial issues and other psychosocial skills

…………………………….

I work in a specialist service. We are adequately staffed (currently) to cope with the caseload, and it makes a huge difference to our experience of our jobs.

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Strong established specialist treatment programmes

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The specialist programme to treat Borderline Personality Disorder (DBT) is very effective, but there is currently a long waiting list - over two years.

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Eating disorder treatment using maudsly based family therapy is intense but very effective for teens with eating disorders. It is evidence based

Basing mental health clinicians within an older people's health service works well - there just needs to be more than 1FTE (which results in carrying 7 waiting lists, one of which is as long as 18 months!).

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(e.g. Congenital Cardiology) allows the psychologist to gain experience with identifying and treating specific psychological issues prevelant in that specific patient population. It also benefits the team having access to a psychologist for support, consultation

and is shown to have good results when done by qualified staff for 80% of eating disorders, and strengthens parent-child relationships. MST is fantastic when available for behavioural problems due to 24 hour support and has a good evidence base.

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Some more specialized sub-speciality services such as family therapy and DBT groups have developed over the past year.

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Our family therapy clinic is able to look beyond diagnostic labels and individuals to their wider family context and the wellbeing of everyone present. Unfortunately few people get this opportunity and we are only allowed to provide this one day a week. Most people who get access to service will receive some therapy to get them started on their journey to recovery.

....

Certain pathways, for example, eating disorder pathway, DBT - due to collaboration with relevant teams (eg. medical), clear pathways, expectations around training, regular supervision. A sense of working with systems as opposed to against them.

....

Where possible we provide evidence based treatments and we have for example a Dialectical Behaviour Therapy programme across the service which treats a range of people with complex presentations. The psychology team where I work are trialling and evaluation

group interventions to attempt to reduce the waitlist and provide a service for more people. I believe the specialist teams provide an effective service, which is partly due to the fact they have limits to their caseloads.

....

Specialised teams given time and space to deliver the therapy as indicated. This only is extended for a small proportion of clients with severe risk. This should be given to all clients as it

does work well.

....

When you get a patient who qualifies (!), mobile monitoring of suicidal patients at their own home over the weekend, respite care as an option, specialised services for treatment resistant/severe cases (e.g. anxiety disorders service, eating disorders service), AOD.

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Access to 24/7 crisis worker for urgent support.

....

The provision of group programmes in primary and secondary mental health (e.g. mindfulness-based stress reductions, distress tolerance groups etc). When clinicians have the time to liaise with family, schools, other providers/ agencies. Family-based interventions for children and adolescents.

....

I think the CAPA model works well in terms of responding to the first contact/referral in terms of having the expectation that they should be seen within two weeks of referral. There is also some matching in terms of clinician's experience and background with the client's needs or requests e.g. the service tries to be as client-centred as possible.

....

Intake/triage team - frees up more clinician time.

....

Greater focus on treatment programmes (i.e., group intervention) works well due to inability to provide individual therapy to the large case load. Specialist group interventions for psychosis, violence, relationships, substance abuse are effective, however, while some psychologists are very experienced, often staff delivering or supporting groups have limited training and are limited in the number of people that can attend specialised treatment groups.

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CLINICAL AUTONOMY

The flexibility and freedom to work in the most beneficial way for clients is valued highly by professionals in the field.

I am fortunate to work for a service with capped caseloads which significant increases the ability of staff to provide more intensive and longer terms support for clients. We have a focus on integrating families into our treatment. We have a

Not being limited to the amount of sessions that clients have access to. This is essential when working with families who suffer from multiple issues or trauma. Freedom to use different therapeutic models.

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CMDHB).

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The ability to work in a culturally responsive way. I have a manager that recognises that and respects the need for time/whanaungatanga to support any intervention

....

Flexibility/innovation in face of much increased referral numbers

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Being given the autonomy to manage my time without too much

dedicated psychologist who can home visit which allows our clients to more easily access the support they need. We are flexible and respond to clients' needs rather than making clients fit into our treatment models.

....

Clinicians having realistic caseloads that enable them to approach a situation in a holistic way. **There are many amazing individuals within many organisations, they just need to be listened to and be able to work in ways that support excellence.**

....

Having psychologists protected from having to take a keyworker role as it frees up time for high level clinical work.

....

Flexibility and autonomy allowed to take the time to understand and formulate a person's issues and give treatment not just repeatedly assess.

....

In my own team within the Waikato DHB, clinical psychologists are able to manage their own caseloads, and can decline to take on more work than they can safely handle (not my experience at

interference from management works really well for me.

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Access to regular therapy appointments the duration of which can be tailored to need I.e. not six sessions only.

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Flexibility

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UNMET NEEDS

What issues of unmet need for mental health and addiction services currently exist where you work? In your view, what is the impact on the person and the community of those unmet needs?

LACK OF PRIMARY MENTAL HEALTH CARE

Mild-to-moderate mental health issues should be being dealt with by primary mental health services. GPs, NGOs and schools are not sufficiently resourced to deal with these.

There are simply insufficient clinicians available to provide best-evidence treatment for anxiety and depression. These clinicians need to be available in both primary, secondary and tertiary healthcare. By the time people are severe enough to meet criteria for access to tertiary mental health, they are distressed, very unwell and not functioning. For many of these people, there needs could've been met much earlier in the community, if clinical psychologists were available and accessible for these people. There is a huge impact to the community in regards to costs of then treating a huge number of very severely unwell people, which takes longer and more intensive resources. In addition, costs to the community include lost work and contribution and negative impacts on families caring for unwell individuals.

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I am concerned about the lack of quality, evidence-based psychotherapy at the primary care level. There is a significant impact on people's mental but also physical health.

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I work in a child and adolescent team. Lack of capacity for local NGOs to be able to provide services at a sub-crisis level means we see an increased level of crisis referrals. As a consequence individuals often struggle to cope in the absence of services, but are then referred to us once their lives have started to completely unravel. This places a huge burden on their families, schools, peers, and the young person themselves.

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Having a lack of primary mental health services or NGO's to refer back to. Families are left with no support once discharged. Other organisations have no psychological input. They rely heavily on us to provide this support when the families don't necessarily have secondary-level mental health concerns.

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Too few quality primary care resources mean our service picks up more than it ideally should.

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Criteria for being accepted for secondary mental health are too high & **there are so few, if any, free options available for earlier intervention. We know that earlier interventions are more effective if they are accessible and provided by skilled staff.** At present, services are so stretched that one common way of coping with the increase in referrals is to make criteria for acceptance by the service even more strict. So many mental health services have all their staff taken up with suicidal behaviour & complex mental health issues that there are few other services for clients with other needs.

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Those people who do not meet criteria for more severe mental health problems are overlooked and not provided for, encouraging the development of greater chronicity and suffering in the individual and the wider community

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Gap between primary care and secondary mental health – those of moderate severity and/or middle class socioeconomic status. There are little/no resources for those who are not experiencing severe mental health difficulties (i.e. cannot work/study) and do not qualify for primary care resources / cannot afford them.

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Secondary mental health care is not resourced to provide primary intervention. However, due to the lack of sufficient primary care provision whaiora often deteriorate and then need secondary care. More robust training and supervision of school guidance counsellors would be a useful start. Counselling options within primary healthcare services also needs clear clinical governance and sufficient funding to meet demand. Greater prevention efforts would have a positive flow-on across mental health services. This may also address those who currently commit suicide and have never been known to mental health services. Schools and community agencies would be well-placed to offer basic courses on promoting wellbeing.

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There is a culture of "how do we get clients out of our service". Therefore, many clients are not accepted into or discharged from our service. Being discharged is not necessarily a reflection of these young people having received the care they require; they are sometimes discharged due to the young person not meeting criteria for a mental health service (but still requiring some service due to concerns), slight disengagement from therapy etc. The issue with not accepting or discharging clients from our service, particularly if they do not meet our service criteria, is that there are very limited, low-cost, and adequate services to discharge these young people to in the community. Therefore, they are pushed out of our service, with limited other resources to go to. Their difficulties then become more significant over time, and are then re-referred back to our service. It is my understanding that ADHB have a contract for under 18 year olds to receive step-down services, such as ProCare. Shouldn't arguably the most at-need catchment area in the country also be entitled to this level of step-down/community-based service?

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There is an unmet need for more evidence based talking therapies at every level. There are no comprehensive assessments done at the GP level to identify people early enough, there is not enough resource for psychologists to do brief interventions (evidence shows that 2-3 sessions is not enough). At the moderate level, there is not enough resource at the basic level of care i.e. case manager care that is geared to talking therapy and group work as the first line treatment. There is not enough resource for good supervision and mentoring for group facilitation at the more complex level and because we do not have enough well trained clinicians - psychologists to deal with the most complex of service users. The impact is that people do not get seen and assessed early enough, as each part of the patient journey is separate. For example at the moderate level where people do not get care until they are very unwell and meet criteria for secondary services, then their problems are entrenched and take longer to work on by which time people have less motivation and their lives are more affected. They do not experience well trained senior talking therapists at the front door so we socialise people to expect a psychiatric medical service involving taking psychiatric medications as the norm and that therapists including psychologists are an add on and a frill . We do not have psychologists at the front door in adult services, we do not have a joined up system and we therefore do not give best evidence based care which means that the person does not receive the help they need and this impacts on families and the community who need to care for very unwell people who need to be suffering majorly before they are seen.

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Lack of availability of comprehensive assessment at a primary healthcare & school level for complex cases or children with significant learning delays. We often see children and teenagers who have significant mental health difficulties along with significant learning delays, who, on assessment, are found to qualify for diagnosis of intellectual disability but have received minimal or no learning support since the intellectual disability had never been diagnosed. By the time this is clarified in a secondary mental health setting, major damage has been done to levels of confidence and the client has missed out on the majority of learning opportunities they have been exposed to.

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Criteria around entering service is not matching meeting needs clients- and services optimally: People enter the service triggered by risk e.g. suicidal or self- harming which is often triggered by social- economic factors and not necessarily MH. Or people enter the service because or moderate to severe mental health issues that regularly are not identified and treated at an earlier stage ("building up' until meeting criteria). "Mild to moderate" is a diffuse group with different services (GP, NGO') There are different services for trauma: DHB's and ACC, CDS that often have on overlap (e.g. trauma and attachment or personality problems). Clients express it's hard they have to "prove it's hard

enough" to meet criteria, to be eligible for (ACC or other) service, this can make threshold to take action to seek help higher Working evidence based: research confirms that difficult life events / trauma often play a role in existing MH issues where-as most funding/ specialist knowledge is now centered at ACC.

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Primary mental health care is underfunded and the type/quality of primary mental care offered varies between providers.

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No subsidies for private counselling and no expertise or time for this with GPs. Primary care is limited: could focus on training all nursing staff in CBT for anxiety and depression (with psychology supervising).

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Big gap in services for people with moderate mental health problems - too complex for primary services and not severe enough for secondary services. Impact is that problems increase and eventually they might meet criteria for secondary services but problems are much harder and more costly to treat.

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Simply no service available in public mental health if you are not extremely unwell, which is narrow visioned as by that stage many will not be able to turn themselves around and the burden the falls on family.

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There is a significant lack of services in the community where children and adolescents can access free psychological therapy for mild to moderate mental health issues, particularly for children aged 11 years and younger. CAMHS are only able to work with moderate to severe mental health issues.

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Anyone with moderate to mild issues are not accepted. There are no services for people with FASD, ASD. These young people fall through the cracks and their families are left unsupported. There are no funded cognitive testing services and again a group of young people who miss out. Our team is currently under so much pressure we have had to cut all our groups to free up staff to see more people. This means our clients miss out on opportunities for positive social contact and support from peers who go through the same things, a huge loss.

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Access to appropriate services due to high thresholds and long wait lists. The impact is that moderate to severe mental health issues are not addressed and the individual and their family (if there are family/support persons around the family) are left to their own devices.

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lack of funding has meant that only acute clients have been seen by child and adolescent mental health services

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There is an abhorrent lack of psychological services for service users in primary care. Existing service providers have very limited thresholds for services (mainly depression, PTSD under certain circumstances), leading to secondary care being swamped by service users in need of psychological therapies, leading to long waitlists, leading to poorer outcomes due to longer times to start intervention. More services at primary care will lead to earlier/shorter intervention, better outcomes and less pressure on the secondary and tertiary psychological services.

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General integration between providers of psychological services at a primary care level and at a secondary care level is lacking.

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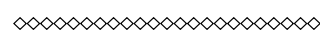
LACK OF SERVICES FOR INFANTS, CHILDREN AND FAMILIES

There is a lack of service capacity for parents, infants and children experiencing mental health issues. We are not currently addressing all the need for family therapy, trauma counselling for children and interventions focused on attachment issues.

There needs to be greater emphasis on interventions and support for families with children and adolescents with neurodevelopmental issues and behavioural issues. Need clear pathways from primary care and greatly reduced waiting times for services like Explore behaviour support services. Ministry of Education needs to be more responsive and carry out more assessments for those children in need at school. Learning issues are not adequately being picked up and families need to pay privately for cognitive assessments which is a significant barrier. Learning issues can lead to failing at school, lack of engagement, poor peer relationships and an increase in mental health issues.

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Paucity of service for zero to three year olds that focus on family and infant mental health = later life issues for children and families that could have benefited from early intervention.

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In mental health community teams we need more resource to do family and couples work. Clients with mental health problems do not live in a vacuum.

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No support for mothers with Post-Natal Depression.

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When children are living in homes with adults who have unmet mental health and addiction needs there is a massive impact. This includes possible trauma and neglect issues. The impact of homelife impacts education and social interactions as well.

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There is a desperate need for services that provide both children and their families with intensive, side by side support such as multisystemic therapy, functional family therapy, or attachment therapy in order to help whanau and children to heal. This kind of service seems to be non-existent for children under 10. **Early intervention is key.**

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There are a few barriers e.g. the courage needed to admit you need help and access services, at other times there is the threshold of costs if somebody wants to access counselling. The biggest need in my opinion is the lack of sufficient services for children and young people e.g great difficulty to meet criteria for service from ICAMHAS and not many alternatives to treating trauma, anxiety and other challenges.

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Services tailored to the needs of youth. Current system determines transition from youth to adulthood occurs at 18 years old, whereas the modern conceptualisation of youth throughout the psychological and sociological literature supports an age bracket up to 25 years old at least. **Youth have specific needs, and these are not currently being acknowledged or addressed within NZ society or the mental health system, hence the consistently high youth suicide rates.**

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Access for clients to specialized services - long waiting lists with DHB rejecting clearly mental health issues with the response 'behaviour needs to be addressed first before we'll look at them' - does not allow for positive effects medical intervention may contribute to changing negative behaviours. Consequences - families and schools continue to suffer unnecessarily due to limited resources that inhibit access.

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Failure of management structures in our organisation to even acknowledge the current climate group and complexity of children for e.g do not understand our clients have complex developmental trauma, attachment difficulties, and

exposure to intergenerational issues. Our organisation therefore does not offer appropriate service delivery such as therapeutic services across settings.

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Family support including family therapy is missing from most (if not all adult services) yet most service users family have a significant role in their

care and ongoing wellbeing. The lack of support offered to families has a direct impact on the clients' outcomes and has wider impacts on family health and the wider community.

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More funding needed for infant and perinatal mental health - particularly around birth trauma, PTSD, perinatal OCD, perinatal anxiety, as well as grief counselling for miscarriage and stillbirth and early infant loss. There is also a huge unmet need in Tauranga and in fact in all major cities for a short stay unit such as Mothercraft in Hamilton, and a drop in service day service such as the Family Centre in Hamilton to assist with feeding and sleeping issues with infants, as these can be big contributors to mothers developing PND and PNA.

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More access to programs such as in-home triple -p, or MST currently only accessible to families under oranga tamriki, but many families (eg with parentalMH issues) still need this program but aren't under MC- OT.

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Break down in family systems, maternal drug and alcohol use during pregnancy, disrupted early attachment, and insufficient support for families. An education system sufficiently resourced to be able to identify emerging mental health needs in children.

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Limited availability of parenting and behavioural support for families

where attachment difficulties are primary.

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Good, free primary mental health services for under 12s. This means issues that could be treated earlier wait end up waiting until moderate to severe - more issues with teenagers. A lack of free or cheap relationship counselling for parents and families - no replacement for Relationship Aotearoa. Often parental issues can go on to impact or maintain children's mental health. Services to support families where there are parental mental health issues if parents aren't under tertiary service. This can increase likelihood of children developing mental health or addiction issues.

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Poor link up between care and protection issues and mental health, means that children and adolescents needs are not being met. Care and protection issues seem to go unattended, even in urgent situations, where Report of concerns are made.

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We also find that there are underskilled school guidance counsellors serving hundreds of children and adolescents; they often express that they cannot manage the volume and magnitude of mental health needs in schools.

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Gaming addiction services.

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Lack of family therapy services, lack of therapy for parents with mental health problems, lack of therapists at community teams to do therapy (especially trauma work), lack of support by Oranga Tamariki for clients 16 years and older.

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In my area of work the waiting time for children to be seen by Child and Family Specialty Services is too long.

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Individual trauma counselling and/or play therapy with children especially around ages 12 yrs and under (play therapy can benefit children as young as 3yrs old).

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Inadequate resource to provide the lengthy, comprehensive neuropsychology assessments required for FASD diagnoses. Possibly 5% of the population are effected by FASD and within Northland we have 4-5 psychologists currently available to do these assessments. This is not their sole work requirement but an additional demand on already stretched resources. This means multiple children with likely neuro-developmental issues, possibly FASD are not being identified early enough, if at all in their life and experience increased risk of secondary problems i.e., learning difficulties, mental health problems, criminal justice involvement, and substance abuse.

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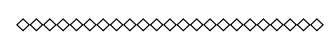
CHILD DEVELOPMENT SERVICES

We do not have sufficiently robust and well-funded child development services.

No specialist service for neuro-developmental disorders, which means conditions such as ADHD and Autistic Spectrum Disorders are treated for a service that should be focussed on mental illness not life-long conditions. Best practice guidelines state that these should involve specialist and multidisciplinary teams. The expertise and human resource is not there.

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Gap in assessments for people who have a possible intellectual disability or neurodevelopmental disorders (e.g., FASD). **These people are not properly supported which greatly increases their likelihood of mental ilnness and addiction problems (impact on person and society).**

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There are no clear intervention programs for some neurodevelopmental issues, like FASD, severe speech disorders (can be as disabling as ASD but no funding) –

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Child Development services and Mental Health: most of my ASD cases I have been seeing so far, are at CAFS BECAUSE there is no support for

(and even assessment before they see me) yet in place for their PRIMARILY developmental issues (ASD). When we do a functional analysis of the behaviour, the person is not self-harming and having difficulty with eating and sleeping because he's having mental health issues but because his ASD is not well managed. It can also happen with ID, I have a 6 year old girl, most likely having an intellectual disability (or other serious developmental issue), her teacher for the second year estimates her functioning on the level of a child that just has turned 3. She's on the waitlist for DAP > 15 months and will be seen most likely in the 3th term 2018. Again, this little girl is NOT self-harming (scratching to bleeding and running with her head in the wall) because she's having mental health issues but because developmental issues are not managed properly (at school they are, which gives a completely different picture). To assist this mother, it's crucial to understand ID and go from there but again, most experience, knowledge etc. on this is at EXPLORE. That's where the funding for those case is going to...It's very unreasonably this child would not have access to explore, being at CAFS for "mental health issues", as this is

behaviour which is the outcome of not well managed developmental issues.

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Students with ASD who are turned down from mental health services. This causes a large amount of stress on families.

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Children who have anxiety issues have difficulty accessing support. Without the support these children are often disengaged from school and miss opportunities to grow in social and communication skills with peers, leading to feelings of isolation and 'falling behind'.

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Lack of resources for neuropsychological testing and learning disorders, lack of therapeutic help for autism spectrum disorders, lack of facilities for clients with Intellectual disability.

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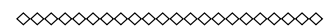
SPECIALIST SERVICES FOR OLDER ADULTS

Resourcing for older people's mental health services has not kept up with growing need and an aging population.

Older adults within MH system. Adult services are increasingly supporting adults past the age of 65 years old due to extremely narrow criteria for MHSOA, yet working with this age group is a specialty just like working with children or youth.

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Poor resourcing of services for older people. They often present with different problems from

children and adults in that there is a crossover with medical services. The result is that their mental health needs often go unrecognized as they are being dealt with from a medical point-of-view. They also lack opportunity to receive intervention which would be appropriate. Treatments revolve around medications: there is increased risk of side effects and drug interactions (eg increased risk of falls and injury,

premature residential care placement, and carer stress).

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Lack of specialised addiction program for older adults. - Older adults of mood disorders being turned away due to waitlist of severe condition such as dementia with BPSD - No older adult inpatient unit at Waitakere hospital, this impacts on the client and family hugely as there is often insufficient beds and long travelling to North shore hospital. West Auckland population has expanded hugely in the past 5 years but not on the mental health service team. - Increased ageing population but there has been no major expanding on the specialised mental health services for older adults.

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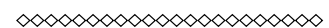
INPATIENT, RESIDENTIAL AND RESPITE SERVICES

There are insufficient options for care in supportive institutional settings, and a lack of beds in inpatient and residential facilities for those with severe mental health and addiction issues.

Too long for beds to become available for adolescents who need addiction services.

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Northland DHB do not have respite and inpatient options for children and adolescents who are experiencing an acute mental health episode, increased risk. Instead, IF a bed available whanau have to transport their child to Auckland hospital.

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Lack of respite and supported accommodation. Some service users are unable to function in the community and require a level of support, but unfortunately there is a severe lack of transitional and supportive accommodation.

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Too many clients admitted under MHA due to bed crises. Too little resource allocated to home based intensive care.

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Also very inadequate placement options for adolescents (often coming from inpatient admissions) whose families can't support them.

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Residential care for youth & children with complex presentations: safe, appropriate residential care for youth with complex mental health needs. This is especially problematic when mental health issues exist in combination with developmental disorders and/or intellectual disability. The most high-functioning families and parents are occasionally able to manage the care of youth with complex needs at

home (with adequate support/resources), but as soon as parenting capacity is compromised in any way (such as own mental health difficulties or substance use problems) it becomes impossible for families to provide adequate care at

home. These clients often do not meet criteria for admission to residential care units, psychiatric hospitals or respite services.

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Lack of respite beds. Lack of rehab beds and access to rehab facilities.

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No supported accommodation for people under 18.

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There is a need for some of the chronic clients to have supported living (we have gone too far away from institutionalisation- prisons are proxy MH & SU institutions now! Maintain or enhance residential SU treatment services like Napier's Springhill addiction - they have a place in treatment continuum that is sorely missing in MH. Would love to see a MH equivalent! 6-8 weeks. Follow-up care is important but more likely to see clients improve when an intensive is available

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Lack of supported accommodation facilities and the accommodation options in the communities leads to much longer admissions in the MH acute inpatient facilities than is necessary which is not conducive to their recovery back into their communities and causes a blockage in the flow of service users

in and out of the inpatient service, increasing the bed pressure and causing burnout of staff when the unit is consistently oversubscribed.

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Teens from age 16 onwards who had suffered trauma and whose families

Lack of adequate respite care services, lack of options for mental health clients who can't live with family, lack of inpatient facilities to treat drug addiction

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Women do not receive the same opportunities for care, their

community for those individuals with intellectual disability AND mental health problems (including Autism Spectrum Disorder). There are a sub-set of these individuals who are unable to recover from permanent disadvantages, and are criminalised and pathologised. They are unable to leave inpatient / locked environments due to lack of community options with trained staff, and inability to acquire funding for those who do not fit neatly in the intellectual disability or mental health category.

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There is almost no access to funded inpatient programs for service users needing short stay structured intervention, especially when intervention in the community will have very little benefit until the service user is stabilised. The current health care system is reactive, rather than proactive.

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Limited program based intervention at respite

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When service users are respited in secondary care, there is a significant lack of professional input at these respite providers. This means that a service user is afforded a 'time-out', but no active work is done to address their presenting problem. This leads to less effective intervention and re-presentation

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abandon them have an uphill battle to find suitable accommodation, resolve their mental health problems, finish their academic training, and move towards independence without robust support systems. These young people repeatedly present to acute mental health services with suicidal behaviour, and closing down all the services in the community that used to support them does not equate in the end to "saving on costs". One night in an acute inpatient ward costs about $1000.00, and is not always beneficial to the client. The money could have been spent much better to provide e.g. suitable supported accommodation in the community and adequate therapeutic resources. Sometimes, something as simple as a lack of transport prevents clients from obtaining the help they need and using taxis is exorbitantly expensive.

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In my area there are no local inpatient beds for young people. This means families have to travel, and young people can end up in adult inpatient units. There are no local inpatient services for eating disorders.

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Difficulties accessing respite care due to limited providers.

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needs often go unmet in the inpatient setting due to their relatively small number (Forensic inpatient setting). Furthermore, there is not enough support for those who are requiring detox in the community. We do not have the facilities for care for people in that state and it is highly distressing and at time unsafe for staff and patients. our facilities are lacking to provide adequate care.

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Another important unmet need is the provision for care in the
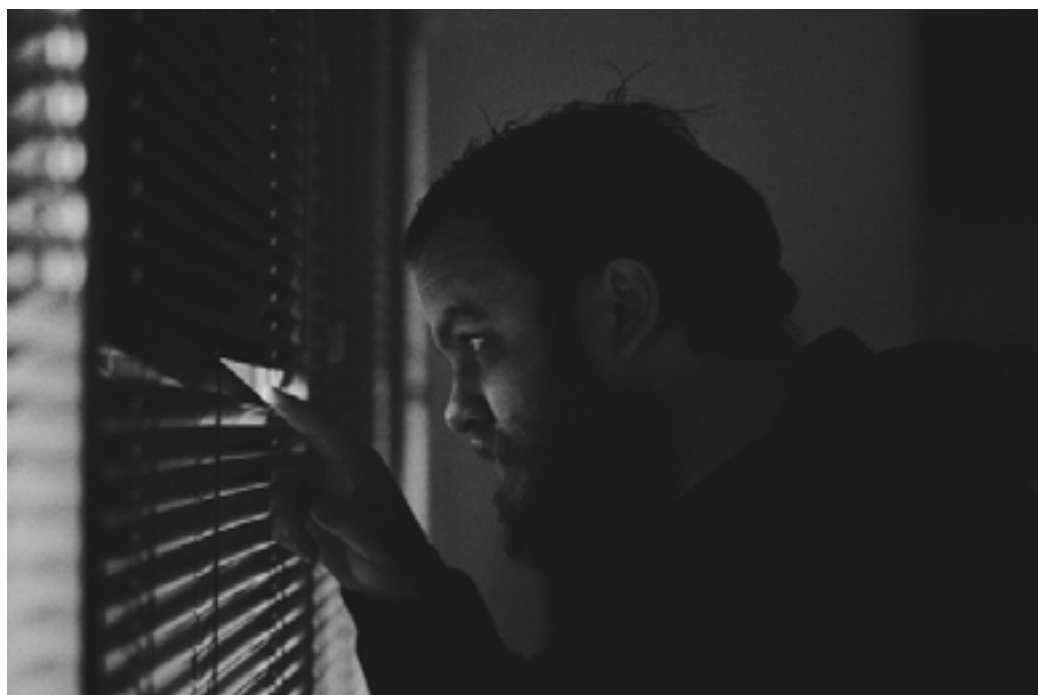
OVERRELIANCE ON MEDICATION

Patients are medicalised and medicated instead of being understood for their entire biopsychosocial wellbeing. The system needs to see pharmaceutical interventions as part of rather than the dominant mode of intervention.

The dominance of the medical model means psychological problems are seen as a disease and treated as such.

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Given the lack of psychological resources in the team, psychological formulations do not inform treatment (unless they are working with a

extent. This is significant given many of our clients present with difficulties that are understandable responses to adverse and challenging life events and circumstances. And can have adverse effects on the way in which clients' view themselves and their difficulties.

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through GP's and also in secondary care services medication is the most easily accessible intervention. This goes against all the scientific evidence. Psychological therapy interventions are in general more effective than psychofarmaca. These drugs too often become part of the problem as a result of their unintended side-effects. A shortage of psychological therapies leads to people getting the help they need too late and they get the help while their brains often have already been 'changed' by psychiatric medication.

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The reliance on medication, often prescribed in the first instance by GPs before offering evidence-based talk therapy that might resolve the difficulties for a fraction of the cost of medical is a gap in our health care system. As it stand, wealthy individuals can access specialised treatment for anxiety, depression, psychosis, on an outpatient basis, however, those who are unable to fund therapy themselves are likely to be passed from one service to another, potential assessing 6 therapy sessions to address a life-time of disadvantage. The government needs to review the availability and accessibility of evidence-based psychosocial therapy (i.e., registered psychotherapists, psychologists, counsellors) for mental health and addiction problems, including complex presentations (e.g., dual diagnosis, low IQ, Autism Spectrum, etc).

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The dominance of the medical model

psychologist) and clients' difficulties are continuously pathologised and medicalised, use of medications which we know to have dangerous side effects, and to be addictive, are relied on to a large

The emphasis is currently too much on problems of emotional and behaviour as health problems and hence demanding a medical (=psychiatric drugs) intervention. These are easy to access

within MH&A services means the main treatment is medication only, and most service users are unable to access non-

pharmacological interventions. If people want non-pharmacological treatment of their mental health difficulties, they are labelled as not having "insight into their illness" and they are discharged from MH services or placed under MH Act, which creates iatrogenic harm.

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One example is I had a client with severe anxiety, depression and violent suicidal ideation. I referred her to the intake and assessment mental health team as my client's risk was too high for me hold as a sole clinician in my part time role. My client was contacted by the intake and assessment mental health team and was told she needed to trial 3 different antidepressants through her GP first, before they accepted her for an assessment in mental health services. This was devastating for my client as she did not want anti-depressants, rather she wanted psychological therapy and support. The fact that this client as well as other clients of mine are unable to access the mental health support they need means a negative impact to their wellbeing, a lack of trust with reaching out to support services, and pressure on me as a physical health psychologist which has lead to symptoms of burn out for me.

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Psychosis: clients with psychotic symptoms (of varying diagnoses) are not treated with enough respect nor are any non-medical approaches - which I find can be life changing - put forward. I specialise CBT for psychosis but it is hard to even get a referral to Psychology here.

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I work in a forensic and mental health setting. We aren't part of corrections and are separated from mainstream mental health in many ways. There is a focus on the medical model and chemical interventions while there is a glaring gap in the ability to deliver evidence-

based psychological / social / family based interventions. There are too few psychologists to meet the demand to cover individual and group treatments targeting forensic needs / offending (including specialist interventions such as sexual offending), addictions, and mental

health (e.g., specialist interventions such as Cognitive Behaviour Therapy for psychosis).

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The design of mental health services in New Zealand still fall in the out-dated medical model. This approach is notable in the overreliance on pharmacological treatment. As the Inquiry will no doubt be aware there is growing concern about the efficacy of psychotropic medication, the long term effects with regard to psychiatric symptoms, and concern about the well-documented physical health side-effects. My observation of mental health services, across both child and adult settings, is that medication is often

relied on as there is little opportunity to access appropriate alternate treatment. In adult services there are insufficient clinicians confident in talking therapies for psychosis. Given the growth in studies showing positive outcomes, including amongst individuals who chose not to

take medication, it is short-sighted that there has not yet been commensurate increase in the offering of training for clinicians in CBT for Psychosis, ACT with emphasis on increasing quality of life, Behavioural Family Therapy, or exploration of the Open Dialogue model. New Zealand could take its lead from the UK in wide provision of training in NICE-endorsed therapies. Similarly, despite the research supporting meaningful occupation on quality of life and subsequent reduction in psychotic symptoms and risk of hospitalisation, there is lack of recognition of the important role of Occupational Therapy. In a CAMHS setting it is commonly noted that children presenting with behavioural issues where there is a history of trauma and current socio-economic disadvantage, are frequently inappropriately diagnosed with Attention-Deficit-Hyperactivity Disorder. It appears this is because we have medication readily available for ADHD. We do not have sufficient competent clinicians readily available to provide the evidence-based treatment for behavioural difficulties within complex systems or trauma.

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Far too much emphasis on medication as first line and often only treatment. Clients stay on high doses too long without attempts to reduce especially with history of psychosis.

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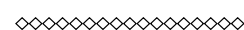
STAFF TRAINING

Many mental health staff, including nurses, occupational therapists and social workers, are not given adequate training to assess and treat mental health issues.

The NZ mental health system expects nurses, social workers and occupational therapists to do the work of clinicians with advanced psychological / therapeutic knowledge and skills which these professionals do not have. We need more clinical psychologists to lead these clinicians and provide for a meaningful stepped care approach.

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where this is their first job in mental health. While I acknowledge that we must continue to upskill clinicians, the outcome of this is that there are not enough experienced clinicians to support the upskilling of newer clinicians resulting in evidence based practice not being upheld. Again, clients will not receive best care.

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Not enough people trained in child and adolescent specific assessments and therapies. This impacts on the quality of treatment our young people get. Important connections between symptoms and behaviours get missed as staff aren't trained to do a good formulation. This means a higher risk of misdiagnosing people and offering wrong treatment.

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Other mental health workers in the team, not psychologically trained, are expected to work with these clients in the meantime, when there is often a very clearly indicated need for psychological input. This input can sometimes be detrimental to clients' progress and recovery, and trying to hold clients who

Social workers, nurses, occupational therapists expected to be jack of all trades, master of none despite not having the training. There is a case for them not knowing what they do not know leading them to think they are doing CBT, DBT, FBT, etc., without having done the training for it. Consequently, clinicians are not providing evidence based practice resulting in clients either becoming more unwell unnecessarily, or remaining in service longer than necessary. The DHB have employed a number of clinicians

Not enough staff qualified in evidence-based therapies. Staff from professions like social work and nursing are expected to do psychotherapy which they aren't trained to do. There isn't enough funding for resources needed for good psychological intervention. No funding for training in evidence-based therapies. A general mentality of "staff can just do whatever and it'll work out" instead of focusing on evidence-based therapies. Case-managing is not enough for a good long-term outcome.

need psychological input without the necessary skill set is stressful and can lead to burnout.

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We have insufficient staff to see everyone who meets service criteria, our staff are forced to cut corners and professionals who lack therapeutic training and adequate mental health knowledge are being tasked with specialised assessments and therapy work that exceeds their competency. This means service received is of variable

quality. Developmental histories are not being gathered, formulations are often missing or are not recorded and held only in the therapists mind. Therapy is being turned into skills training without the elements of alliance and rapport that are crucial to effectiveness.

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Lack of quality assessments for people with mental health and addiction issues - which means they can be in the system with inadequate treatment approaches for longer than would otherwise be necessary. Impact is lack of recovery for person and greater cost to system.

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Lack of properly trained staff- staff are poorly trained, rely on 'good old common sense' to do their jobs and also show little compassion towards clients. Clients, as a result receive poor care and emotional abuse, at times, from staff - especially in long term inpatient units. ACC and DHBs really struggle to work appropriately with clients with complex trauma issues and these clients often fall through the cracks and receive a very poor service. It is often left up to individual, private therapists to try and provide a better service but is a struggle without good support from ACC and specialist services. ACC wants to oversee sexual abuse claims but the way they operate shows little evidence of trauma informed care and they can sometimes treat clients in quite abusive ways.

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DHBs need to be more honest about how actually they are part of the problem because staff are so poorly trained and outdated ways of working with clients are often taking place. DHBs often hide a lot of bad treatment from the public eye. **Staff need better training in the latest evidence based treatments, such as positive behaviour support, good formulation skills, compassion focused therapy** not just for clients but for staff as well, so that they learn to interact with clients in a more compassionate and humane way and also don't burn out. **Nurses and support workers need consistent and regular psychological supervision to better work with complex clients.**

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I currently work in the Child and Adolescent Mental Health Service in South Auckland. The biggest issues facing our service at this time include understaffing, lack of skilled and experienced staff working in the service, limited step-down services in our very high-need catchment area, and no performance management or monitoring of unsafe practice; of which contribute to high staff burnout and low staff retention rates, as well as impact on the quality of

care provided to young people and their whanau. We have approximately 550++ clients under our team, which services the South side of the Counties Manukau catchment area (there are approximately 5 other teams operating under our service – including two cultural teams, early psychosis intervention, youth forensics, and the team servicing the North side of the Counties catchment area). The 550++ clients mentioned excludes the multiple urgent cases that are received to our team every day, which require urgent assessment and management. We have approximately 10 full-time staff that are employed to manage these clients under our service. Many of these staff are new graduate occupational therapists, social workers, nurses, who have no to limited mental health experience or training, and no to limited child and adolescent experience or training. The limited mental health experience or training of these staff, I believe, is largely due to the inadequate training programmes from which they graduate – where there is limited/inadequate focus on mental health, particularly in childhood and adolescence. There are limited trainings available and offered to staff in our service in order to upskill them, and when they are offered – people are too busy or being pulled into doing urgent assessment/intervention work to attend

and upskill themselves. While families experience such poor practice and subsequently disengage, they do not exert their health rights or make complaints/ request a new case manager etc. These issues have detrimental impacts on the young people we work with, their whanau, and communities. They are often receiving very little to no care while under our service. Clients are notoriously sitting on people's case loads for up to 3-4 months with no contact being made; this is in part due to the high case loads/ being over-worked, staff burn out, and underskilled staff. There have been multiple times where families/whanau have thanked me profusely for my work with them due to the "horror" stories they have heard from other families/whanau who have entered our service. These horror stories include underskilled staff being allocated to the young person and their whanau's care; poor coordination of care; poor quality of care received (e.g., therapeutic input); limited ability to be able to contact the case manager; not feeling listened to and "pushed out" of the service. In summary, the unmet mental health needs in our service are huge. In addition to the socio-economic, child abuse, and other social factors that significantly affect the catchment area within which we work.

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HEALTH PSYCHOLOGY

Patients with predominantly physical health issues such as cancer and chronic conditions are not getting adequate psycho-social support.

There is a huge need for mental health services in my sector. I work in physical health in the general hospital. Many people with chronic health conditions that affect any region of the body struggle psychologically to cope and adapt to an illness. In addition, there are mental health disorders which affect the body (functional neurological disorders for example), where psychological and psychiatric input is essential. I work through inpatient and outpatient clinics. I think there needs to be at least 4-5 times the amount of clinical psychology input

available in my area in my hospital.
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Health Psychologists are severely underfunded. There are so many more patients we could be helping but cannot due to lack of resource. Starting on dialysis is incredibly stressful and demanding and everybody deserves to be well supported, but aren't due to lack of funding. Prognosis is worse for those on dialysis than it is with cancer, yet they have only a fraction of the psychological support, and their treatment is life long! Similarly we can make a major difference in the lives of people with many different chronic illnesses, improving adherence, reducing morbidity and mortality, and

reducing the impact of illness on the person and whanau (depression, anxiety, stress, anger, adherence, adjustment to illness eg diabetes, cardiac, pain, respiratory, renal). The direct MOH funding for psychological support for cancer services was a big step in the right direction but we desperately need it for other health conditions eg diabetes and renal. Most of our patients are in hospital due to non adherence (eg not taken insulin, end up with cellulitis...) and health Psychologists are the only profession trained as adherence experts - extra funding would cut costs!!
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Lack of psychosocial care in physical health services resulting in prolonged suffering, increased health burden, poor use of health services due to shame/ avoidance
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I work in a pain service where we are overwhelmed by the number of referrals. Due to mental health understaffing we are having to manage a large number of mental health related problems what are not considered severe enough (or will need to wait for significant amounts of time) to be seen in a mental health setting. It has become the norm for mental health services to see that an individual in being seen at a pain service and decide that this means the individual does not need psychological therapy in mental health. Thus, we are treating people well beyond the scope of what our service probably should. Therefore, those with pain who don't also have at least moderate mental health difficulties are receiving less support.
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More funding to allow for positions in a range of areas - eg in the

public hospital I believe there should be a psychologist sitting in renal, one in neurology, one in repiratory, one in cardiac etc. There is a huge need in each of these areas. More positions are required for secondary mental health services too - the wait lists for psychology are long, and the clients are very complex, requiring long-term intervention.
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Please incorporate the work of psychologists working in physical health settings into this inquiry. We are often not recognised as 'mental health' because of the departments which we work in. Yet we contribute significantly to this area.
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Health Psychologists also help prevent severe mental health as catch it earlier and treat effectively
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Direct funding for chronic health conditions for health psychologist FTE. Health Psychologist representation at all levels of service.
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Fund psychosocial care in physical health hospitals nationally to ensure consistency of sevice across the population, not just in main centres
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Increased provision of consultation-liaison services and mental health clinicians based within medical services rather than artificially separating physical and mental health.
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Increase psychosocial care models in physical health settings
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More FTE and roles for psychologists working in physical health (e.g diabetes, Cardiology, woman's health, etc)
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There is no provision for young people needing mental health input for health conditions. There is no funded pathway to support gender dysphoria. The community are left with no support if they are unable to self-fund in these areas.
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Limited psychological care for youth with significant physical health needs. These youth often end up with significant mental health disorders

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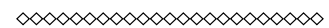
CASE WORKING

Mental health services are wasting scare psychology resource by having us case manage clients.

Allow psychologists to work in their strengths and do psychology not be generalist practitioners.
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Multiple silos currently for child and adolescent mean clinical staff cover duty, emergency services, and initial assessments. Leaving little FTE for intervention.
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Use the specific skills of mental health staff, instead of expecting them to fill "generic roles", e.g. expecting a clinical psychologist to do therapy, do case work, organise accommodation, liaise with the school, etc. keeps them so busy that there is no time to do therapy. This is not a cost-effective way of using their skills.
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Ability for all users of the mental health system to be able to access psychological therapy due to a lack of therapists. [...] There needs to be a system that helps people access therapy with sufficient sessions to address the issues they face.
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Lack of psychology input- psychologists used as generic case managers and have no time to perform psychology specific roles or end up doing this IN ADDITION to case management role too.
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In many services psychologists are required to case manage which limits access to therapy.
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With the under resourcing, there is also increased pressure on psychologists to be case managing which leaves less time for psychology specific work, and in particular, a lack of capacity for specialised trauma work despite the fact that a significant portion of children presenting to specialist mental health services have a history of developmental trauma which is a known risk factor for various pathological issues/diagnoses.
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Psychologists doing keyworking role, this takes away their time in doing psychotherapy and neuropsychological assessment
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Prioritising the importance of psychology - using psychologists to provide assessment and treatment for complex clients, and leaving case management to other professions.
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No case management by psychologists - focus on providing assessments, therapy, consultation, service development etc.

Psychology specifc roles-focus on assessment and therapy not case management or social work or occupational therapy
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Expanding staff at mental health services to cover the keyworking role so the psychologists could focus on delivering interventions
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Allow psychologist to do psychological work around assessment, formulation and intervention and consultation and leave the case managment to professinals who are skilled at using this model as their intervention (social workers, nursing staff).
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More psychology-specific work: in my view the CAPA model limits the role psychologists can play within DHBs. The expectation that psychologists do key working / case management alongside therapy and assessment work, means that the psychology-specific services are limited. In my experience teams at the DHB do not function as multidisciplinary teams. we have psychologists, nurses occupational therapists and social workers mostly performing the same generalist duties. This means that psychologists have limited time for psychology-specific work and also that we are continuously having to learn new information that really falls outside of our scope. As an example, we do not have social workers co-working with us on any cases which means we have limited input on the legislation around care and protection issues, but are expected to play a significant role (representing our service) in legal procedings such as family group conferences. apparently within the CAPA model social workers are not appointed in a social work role, but rather in a mental health practitioner role. I think this is a gap within our service.
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Ensure psychologists deliver psychological services, we are trained to do so, and ensure time available for adequate supervision of non-psychologists who are performing these roles. Wider criteria for service entry
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Making sure staff are recognised for their skills and not assigned to roles where their skills are not useds e.g., psychologists working as case managers.
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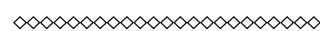
PARENTING AND FOSTER SUPPORT

It is critically important that we support good parenting, and in particular we ensure foster options for our most vulnerable.

I work in the area of child and adolescent mental health. I believe there is often a lack of awareness of the environmental underpinnings of mental health difficulties in children, i.e. poor parental attachment relationships, neglectful or abusive parenting or undiagnosed learning difficulties that result in a child feeling inadequate in the school environment. Even if there are more services offered, which would also help, I feel strongly there need to be more services put toward both Oranga Tamariki and the Ministry of Education to address the fundamental problems children and adolescents face in their everyday lives. The pure mental health issues that arise within the context of a loving supportive environment are relatively easier to address with psychological intervention. If there were more supports and ability for Ministry for Children to address inadequate and abusive parenting, including using out of home placements when necessary, many children would not have to suffer and would perhaps be saved from livelong mental health difficulties.

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Under-resourcing of Oranga Tamariki affects us - gaps in how to support kids when there are care and protection (and closely related poverty) issues.

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A lack of good foster placements/homes is another area of significant concern. This means that children & young people are being kept in unsuitable living environments or moved from one placement to another. The message this gives to the child or young person is highly damaging & further jeopardises a stable placement.

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Addiction treatment programs for parents of youth and for youth. The impact falls heavily on children of parents who have substance addiction challenges as parenting is often not a priority.

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The threshold for when Oranga Tamariki intervene in our community is very high. When children are in their care, there is a significant shortage of caregivers, especially caregivers with specialized training in order to support children with significant mental health needs.

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The lack of paid trained foster parents to support whanau where everyone is struggling and children are past around. Parents who are unable to provide the basics of a safe secure enivornment being monitored by Oranga Tamariki with no observable change. Mental health problems are what draws attention but the underlying unmet systemic needs of young people are not being addressed sufficiently: a safe supportive place to live with someone with the capacity to be there for them emotionally and a supportive school environment.

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Lack of funding to support parenting programmes to support/access children/whanau.

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Even though not a mental health need as such, there are not enough specialised foster placements for children with severe (attachment)trauma, limiting their opportunity to engage in trauma focused therapy. This then gets in the way of their further development, perpetuating the cycle of trauma.

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NOT ENOUGH PSYCHOLOGISTS

There are not enough psychologists working in the system to meet current needs. As a result, patients are waiting for unacceptable periods of time before they get access to psychological therapies. Growing population and demand for services has not been matched by increases in mental health service staffing.

Shortage of talking therapy for clients with high and complex needs e.g. Psychosis.

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Urgent need for more Psychology FTE.

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Lack of resourcing / funding for psychologists in order to provide interventions required. Number of FTE for psychology should be linked to population needs, rather than an arbitrary (low) number that does not take into account the community need, therefore underserves the community.

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Lack of access to psychological therapies for which there is a lot of evidence for efficacy and reduced likelihood of relapse. There is a lack of psychologists and other adequately trained clinicians to provide these services. **Impact - people don't get the best care which costs them personally and is more expensive for services in the long run.**

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Services are significantly understaffed and under resourced to be able to provide sufficient psychological interventions.

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Lack of access to psychological therapies. People are denied evidenced based treatment for their mental health and addiction difficulties that could improve their quality of life and support their recovery.

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Just not enough of it; far too few clinicians to meet the need, so a) people are eligible for services only when they are acutely &/or severely distressed/ unwell which makes them more difficult to treat b) the resulting pressures on clinicians is making it difficult to recruit to services; many professionals are avoiding or leaving public services for the comparative ease and better working conditions of private practice. Clients are more unwell, for longer, with concomitant effects on their families and communities.

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Access to psychological therapy. The worst possible outcome is suicide while on a waitlist, which has occurred several times.

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Not enough clinical psychologists (CP) s, clients in need just aren't seen by a CP, if they are there is a pressure to discharge them before work is finished. They need CPs in the crisis teams, people and staff would benefit hugely from this, preventing the "revolving door" phenomena.

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Unmet needs include lack of timely access to treatment with children waiting up to seven months between their initial triage appointments and treatment due to significant under resourcing (not enough staff capacity). This is extremely stressful for both families who really need the help and are trying to cope with distressed children, AND mental health staff who want to be able to meet these children's needs but are simply unable to due to the under resourcing. The pressure is also causing increased case load numbers and significant rates of staff turnover and burn out (which further impacts on the capacity available). For example in a period of 5-6 weeks last year I witnessed 7 resignations leaving 7 caseloads to be absorbed into service and effectively grinding routine pick ups to a halt. The repercussions of this also include stress on schools/teachers who are trying to manage very challenging behaviours with no active clinical guidance during the time these children are waiting (who also have very limited Ministry of Education support); as well as other community agencies who try their best to assist where possible but do not always have the resources to cope with the complexities. Then there is the fact that whilst waiting for treatment

a number of the children's mental health and parent-child attachment relationships deteriorate such that by the time they receive treatment the clinical picture is more complex and requires more resources than it would have if the treatment had been earlier.

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There is a severe shortage of psychologists to provide meaningful rehabilitation for clients. The bulk of clients receive medication support and a keyworker who, unfortunately, often have very limited skills in helping a client significantly improve their mental health problems. For example, clients with psychosis or BPAD are generally 'maintained' on meds and keyworker support, but do not receive psychological

input. Waiting lists for therapy are 6-8 months long and most clients do not get referred for therapy as keyworkers are aware how under resourced the psychologists are.

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Not enough staff for the need. Wait lists for people and therefore delays to be seen and treated.

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There is a significant shortage of staff. It is absolutely unacceptable. The impact is that suicidal teens are waiting 6 months to be seen.

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Oh God, where to begin? I am in a good position to view the problems with mental health system as I work in private and public sector. How many cases and stories would you like me to share that makes me embarrassed and cringe about our appalling mental health system? It's hard for people to imagine the impact on a patient if you are not a mental health professional working in the field. For example, a community mental health team such as cottage (CMDHB) has only 3 psychologists. Their team handles roughly the population of 1000. What would you say? How can you justify having only 3 people for the population that this team caters to? We just don't have enough psychologists within all the

teams in Counties Manukau DHB. I can write an essay here but I will limit with one example.

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Shortage of psychologists.

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Generally a lack of funding and resource - not enough psychologists and other therapists to provide care for all clients referred. Long waiting lists and many people slipping through the cracks because of this, not getting the support they need. An "ambulance at the bottom of the cliff" approach where people only get support in the worst of crises, rather than psychological interventions early on where they would make the most difference.

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A lack of psychologists' hours for psychological, cognitive, and neuropsychological assessment and psychological interventions or therapy.

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Probably, the ratio of the referrals received for psychological input / talking therapies and the ratio of Psychologists FTE probably not matching. Maybe increasing the number of trained psychologists could meet the need of offering services without much delay or waiting period.

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I work in secondary mental health services. We have not had an increase in FTE in many years despite considerable increase in population (South Auckland). Presentations have also increased in severity and complexity. Waiting lists for psychological therapy are often 6 months or more which is unacceptable. We are trying to both deal with mental health issues but also huge

social issues as no one else is dealing with these. Our staff are running around being crisis workers due to the high unmet need and there is little time to do actual recovery/treatment work for those not in active crisis.

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The demand for services greatly exceeds capacity leading to over focus on assessment at the expense of provision of intervention.

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There is a massive shortage of psychology time to provide effective evidence based treatments for high risk disorders like Borderline Personality Disorder. The risk of completed suicide in this group is as high as any other psychiatric group but the waiting list in my service is currently approximately two years. This means two years where people live with very high risk and distress and it greatly limits their ability to participate effectively in the wider community.

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The wait list to see a psychologist is long.

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Too few Clinical Psychologists for the workload.

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Inability to fill vacant psychologist positions leads to unsatisfactory levels of care provided to those in need of services delivered by psychologists. In particular, long wait times for assessments and therapy, as well as therapies not being conducted with the necessary intensity (especially in the early stages of treatment), therefore resulting in reduced effectiveness for the whaiora.

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Lack of staff, especially psychology time, leading to significant delay in treatment and potentially increased risk, insufficient/ineffective treatment, staff burnout.

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Ongoing staff shortages in psychology are a major issue for this service (inpatient adult mental health) and others across the mental health sector. This leads to increased workload, stress, and pressure for existing staff. For an inpatient unit of this size, the FTE allocation for psychology is below expectation compared to overseas guidelines. Current working environment (e.g., staff shortages, focus on biological factors in recovery) is not conducive to therapeutic work/interventions. Many clients remain vulnerable to relapses following discharge as they usually return to same environment and triggers, with poor coping strategies and no insight/

awareness around existing issues.

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Limited FTE for psychology time means long wait times for whanau, pressure on existing psychologists to reduce wait times, get creative with how we meet the needs, whilst working with the most complex cases. CAMHS services in other regions have more psychology FTE due to the increased focus on therapy as opposed to medication. Just not enough when we factor in the health challenges of our whanau and tamariki. Adult MHS psychology services are significantly stretched as well. We constantly struggle with the challenge of recruiting so in the meantime existing staff feel under constant pressure to meet the demands that are impossible to meet and basically either operate in a burnt out state or leave to do private practice or other.

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CAMHS Services need to be adequately funded by DHBs to cater for increased referrals over the past five years. This is due to population growth, greater awareness about mental health issues in the community and greater complexity/acuity of presenting concerns being seen in teams. This is at a stage that it is significantly impacting staff recruitment and retention - senior staff are leaving to go to private practice, majority of new staff are junior and leave the service due to burnout. Staff are being expected to manage significant risk and high volumes of clients, which can lead to compromises in safety and inability to provide evidence based therapy as services are overloaded. This impacts on both staff and clients.

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Only having four psychologists on the team in the whole region. Only two work full time. Providing support for the children and adolescents in the population of approximately a population of 100,000. Not providing an adequate service to the rural areas. Not having services that provide evidence based interventions. Having unskilled staff on our team. High caseloads of very complex clients for psychologists. Few qualified psychologists to conduct cognitive assessments or neuropsychological assessments.

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Access to service when the person is ready to enter treatment and lack of follow up and support increased the chances of continued addiction and return to use.

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Understaffed services. This leads to service users missing out on treatment in some cases, or waiting until they are in crisis. Also means that some people do not receive the type of therapy that would be most beneficial for them as there is not a clinician available at the service who is trained in that area.

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At my workplace the numbers of clients and the increasing complexity and acuity of their needs is not matched with the number of clinicians, and psychologists are especially under represented. Clients have to wait for significant periods of time for psychological input. Long wait times can also negatively impact on clients' motivation and readiness to change, impacting on recovery

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Waitlists have blown out to around 8 months for a full assessment and subsequent treatment. This means that families are sometimes reaching crisis point while waiting to be seen, which means we see them urgently, but this then means others on the waitlist get pushed back. Schools in particular are struggling to support young people on the waitlist, and this impacts on the young person in question as well as teachers and other young people in the school environment. Waiting for assessment can also be detrimental to the family system as well as the child's self-esteem, as they wait for answers and appropriate intervention.

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I started working on the Acute Adult Inpatient MH Unit in November 2017. There has not been a psychologist on this unit for around 15 years. Whilst I am very appreciated by colleagues on the unit I am the only psychologist providing psychological services to a 53 bed unit, which is consistently oversubscribed due to increased demand. The unit consists of 4 wards, each with their own Drs, OTs, SWs and nurses and one psychologist to share between the 4 wards. The impact of this is that the resource is too limited to provide group interventions and individual psychotherapies to service users as needed. This impacts on both community and community MH Teams as important work can at least be started with the service user during their inpatient stay.

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More psychologists need to be appointed. Currently, the approach of not addressing the core of mental health problems, waiting for mental health problems to develop and then attempting to put out raging fires (with medication), is not helping anyone. Talking therapies (different approaches thereof) has been proven to make a difference over time in a "prevent the fire before it starts" approach. This is what psychologists do. We need more money to be spent on appointing psychologists, less money to be going to "fighting fires" with medication and psychiatrists.

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I work in a CAMHS service. Unmet needs include not being able to work
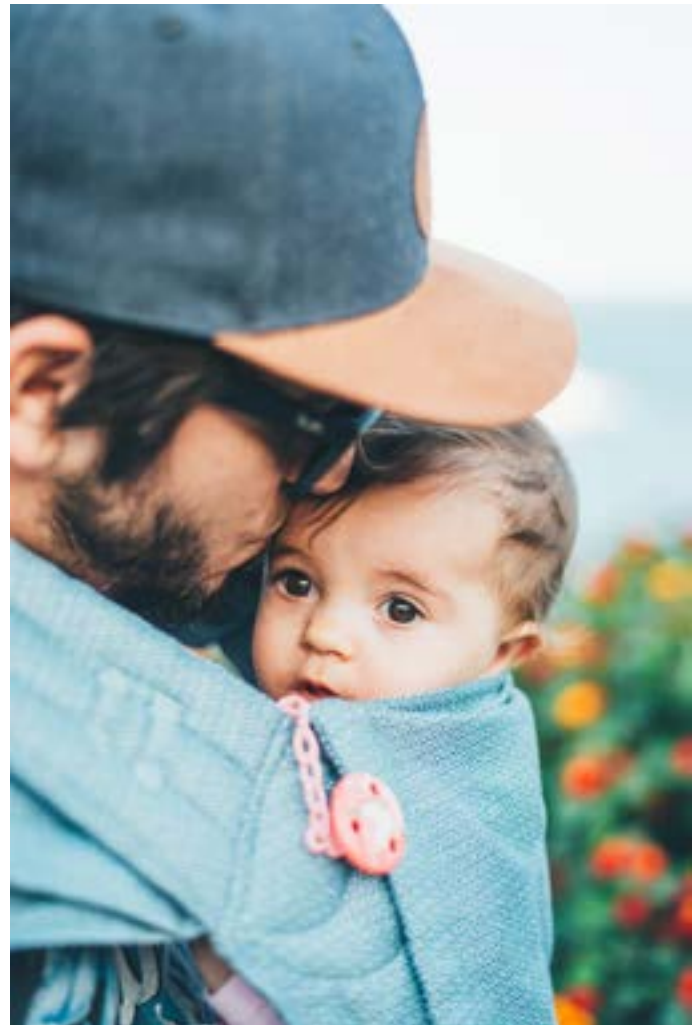
with clients as long as needed because of new clients coming through doors. Not being able to offer as much (especially conjoint youth and family) work as we have in past when we routinely had two staff involved with each family - now only have one.

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We are forced to see people only briefly and often discharge before change is solidified and people relapse and return. I believe this prolongs their recovery. Many people miss out on even a triage appointment to properly assess need for service.

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Huge wait list for child and adolescent services (approx. 200) after initial choice appointment. Risk increases and problems become more ingrained as clients wait up to a year between initial assessment and following appointment. Pressure on schools and community services to manage these young people who should have access to specialist services while they wait

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The rate of referrals to primary and secondary mental health services has been steadily increasing over the years. However, staffing levels are not being increased at a rate that can meet this demand. As a result, clinicians are working with a higher number of clients with higher acuity presentations, people are waiting longer to receive treatment, and staff turnover is increasing as burnout follows. People's mental health is deteriorating as they wait for treatment, experienced clinicians leave the service, and the treatment on offer can also

become compromised (speed of delivery/ early intervention, length and breadth of treatment). Finally, NGO and alternative community resources are being defunded meaning there is no place to discharge clients therefore secondary mental health becomes a bottle neck.

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There are very limited addiction services available, and none of the programmes involve therapy by a

psychologist (as per best practice and evidence-based treatment). Intakes are limited, and outcomes variable. This limits what can be done for the large number of clients we see that have co-morbid alcohol or substance issues that require input before other rehabilitation is possible. As a rehabilitation service we routinely see patients with mental health diagnoses, some of which are severe. Due to the waitlists and limitations of community mental health services it can be difficult/impossible to refer these individuals in to specialist services for the help that they need.

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We do not have the time or resources to provide evidence based treatment for our clients, but have to do a more rough, short version, which feels wrong given this means we are not providing what we know works. This results in discharging people who are only partially treated, and result in repeat presentation, or no further help seeking due to the perception that MH treatment is not helpful because it didn't work the first time. There is also heaps of pressure to reach government targets that are often unrealistic, which takes time away from face to face work.

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I work in a small town (population 25,000). There are not enough Psychologists available. I work with ISSC clients (ACC) who are amongst the most complex with a life history of trauma, and many of them have been seeing non-Psychologist counsellors who have been effective in making their symptoms worse and this sometimes results in the client seeking comfort in substance abuse.

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One of the primary unmet needs where I work currently is in accessing evidence-based approaches to problems. For example, we have 600 clients and 1.6 psychologists offering evidence-based therapy. We also have three other staff (two nurses and one social worker) trained in evidence-based therapy, but they are trained in a single modality and are not as able to meet the needs of a complex client group, nor do they have the time to offer therapy to many

clients. This means that the only other approach available is medication, which is not appropriate for many clients, and not effective for many others. Keep in mind that this is in a specialist mental health service where only 10% of staff have training in evidence-based therapy. The impact of this to clients is that they their problems 'managed' and 'maintained', but that real resolution of these issues is rare. This leads to clients staying in services for too long, which leads to unhelpful changes in identity and increasingly hopelessness and reliance on services. These individual clients then become dis-empowered and non-functional, which means that there is one less engaged member of the community.

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There is always a greater need for psychological therapies and non-medical interventions. These are poorly resourced. As a result, patients often have few choices for treatment or management and biased towards accepting medication (sometimes alone) in lieu of other interventions which are more palatable to them and can effect longer term gains.

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More psychology positions - the majority of clients entering our service would benefit from psychological input. Psychologists have specialist skills in assessing, formulating and treating complex psychological difficulties. Waitlists in our service can be up to a year and this means people are not getting the treatments they need. More staff in general, increasing demand has not been met with increased staffing over the years, this leads to burnout, very few clinicians can sustain full-time employment in DHB services. Mental health services need to be improved as mental health issues continue to increase and to become more visible. The societal impacts of not improving our services is significant in terms of reducing capacity to work/ go to school, be an effective parent or family member etc.

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The increase in referrals to secondary mental health services has not been met with an increase staffing and this is putting excessive demands of people working in the services (e.g. excessive caseloads) and it means that clients aren't being seen in a timely manner. Maori and Pasifika populations are not getting equitable access to mental healthcare services.

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Not enough staff to meet demand.
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Referrals continue to increase in numbers and complexity, and there has not been an increase in funding and staffing to match this change. Consequently staff are loaded with higher and more complex caseloads. This affects

the quality of care provided as well as the staff mental health and burnout.

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The main one is long waiting times for therapy or formal psychometric assessments by clinical psychologists. There is also a shortage of mental health nurses to 'keywork' clients, i.e. assist them with general difficulties in living that are not targets for therapy , e.g. housing, income and socialisation and medication issues. The impacts include these: social workers and occupational therapists are drawn away

from their specialist work and enlisted as generic 'keyworkers' . This makes them unavailable for much of their own discipline specific work. Long therapy waiting times mean people suffer their mental health problems for longer.

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I do not believe there are enough skilled clinicians employed by DHBs in mental health to deliver adequate services to those who need mental health treatment. The volume of work being greater than the capacity of the service (capacity being not just staff numbers, but staff with the necessary skills) means that the community are often receiving inadequate care.

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Limited Psychologist FTEs within the community mental health service team lead to long waiting lists and pressure to see complex clients for short periods of treatment.

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Not enough money being put into mental health to keep up with population increase; at same time, existing jobs being eroded in hours with staff leaving not replaced. Short term cost-saving by middle management who do not see the value of Psychological therapy and who think it can all be done by psychiatric nurses untrained in therapy, especially complex therapy with moderate-severe mental illness. The impact is the waiting lists at secondary services grow longer and longer and consumers suffer and become more severe in presentation because not getting

appropriate, targeted timely input. The work becomes more unsatisfying for the Psychologists (being asked to do more, with less resource and more stress), and turnover rates increase - Psychologists move into private practice, which further depletes the public sector.

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Capacity - increases in volume of referrals has led to an increase in the cut-off for those seen. More and more severe and complicated cases are dealt with, often showing less change. Leads to burn out of staff, and fewer resources going to those who are of moderate or mild severity, where real change could be made before deterioration.

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Shortage of clinical staff to provide intervention. Long waitlists. Disrupted patient journey with multiple assessments prior to intervention.

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Service provision is targeted / restricted to the top 2% of the population in theory. In practice this is further limited by pressures on services, limited beds/community places, staff shortages, resulting in long waiting lists especially for talking therapies which while in high demand are difficult to access on a timely basis. Curiously we see the reverse of the psychology:psychiatry ratio than what is common in other developed countries as the UK where a typical ratio is 2 psychology positions for 1 psychiatry position. This results in a largely uneven service delivery which inadvertently privileges a medical model approach which is outdated in terms of what is the critical need/demand from service users, i.e. empathic long term relationships that allow for change at ones own pace and based in holistic models of mental wellness.

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The psychology team where I work have a long waitlist for people referred to therapy. I am aware the other three adult mental health services also have waitlists. At our service it can take up to six months and sometimes even longer for people to access therapy. These are often people who have made suicide attempts and are struggling significantly. The population in South Auckland where I work has grown in recent years and the socioeconomic problems have increased as well. The mental health resource has not increased. Hence waitlists are getting longer and the threshold for accessing specialised therapy in secondary mental health services has increased. Very few

people can access this form of help and in essence it means that people may be forced to escalate and e.g. attempt suicide before the relevant help might be available, and even then it is a long wait. Due to the level of complexity of problems we see it also means that therapy takes longer and turnover is slow. Therapy is not the only resource that is too scarce to meet the existing need. Other mental health clinicians in the community teams now function more as a crisis service than a general treatment team due to the same pressures on resource. There is also a shortage of residential support options

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In order to bring some relief to the lack of resources it is timeous (as is the case in some other countries) for clinical psychologists, who choose to, and work for DHBs to be given limited prescription rights. This will obviously be subject to further training and should not be obligatory but available for those clinical psychologists who choose to.

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Many DHB mental health patients / clients experience enduring emotional distress due to pathological marital / partner relationships which are supposed to be remedied by poorly qualified staff employed by NGOs / Agencies. The quality of service and expertise level of these is such that it is a waste of money. Ideally DHBs should as part of a patient's treatment / recovery plan also be funded for these services to be provided by clinicians who have at least an appropriate masters degree.

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It is very difficult to get patients into mental health care. The required severity level to get care, goes up and up. Recently I was told by Crisis resolution staff, that they had been told that in order for them to take on treating a patient they needed to have a suicide plan. This is a very high threshold for getting treatment. The mental health services are increasingly providing assessment (sometimes excessive) but not TREATMENT. All of this means that patients miss out, and that clinicians in other areas end up having to mop up the care that should be provided by mental health services. This often cannot be safely done. For example, other lower lever services are not able to offer the level of minoring that high risk patients need. This leads to clinicians outside the mental health service feeling highly stressed and unsupported as they are aware they do not have the resources to appropriately manage these risky patients. This has an adverse impact on staff retention.

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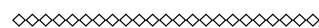
SYSTEMIC & SOCIAL ISSUES

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What are the social and systemic causes of mental health & addiction issues that need to be addressed?

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POVERTY, CHILD ABUSE, DOMESTIC VIOLENCE, and SUBSTANCE ABUSE are serious systemic causes of mental ill-health. We need to address society-wide issues like bullying, digital disruption, and unaddressed trauma that impact on wellbeing. A comprehensive plan to uplift the social, cultural and economic factors of health is as important as improving the quality and quantity of clinical services.

Poverty, substance abuse, family violence, educational support for children.
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Reduce poverty.
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Poverty, family violence, drug and alcohol use.
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Poverty, parental mental health, lack of education, social isolation, intergenerational trauma, transient families, poor housing.
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Poverty, inter-generational trauma, discrimination, family violence, care and protection issues not addressed and leads to mental health and substance abuse issues.
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Poverty, lack of education, lack of employment, alcohol and drug issues.
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Poverty is definitely outstanding as well as the fragmentation and isolation in society - not having the 'village' around to raise the children. There are still barriers in underlying values and beliefs, e.g, like the outcome of the survey in gender roles showing that men should be 'tough' and not show any emotions.
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Poverty, stigma, alcohol availability.
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Poverty, inequality, domestic violence.
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Poverty, hopelessness, drugs, alcohol addiction. Poor options for children &

young people who cannot be adequately cared for in their biological family/whanau. The ever increasing gap between the haves and have nots is impacting on the mental health of New Zealanders. I think we need to look internationally to countries where the gap is less and how they do this. I think countries like Sweden and Japan are doing much better than us in minimising the gap and as a consequence their population rates more healthy in all statistics.
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Poverty. Lack of education about mental health/addiction. Unaddressed trauma in large proportions of the population.
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Poverty, drugs and alcohol, domestic violence and intergenerational trauma.
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Poverty.
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Poverty, domestic violence, missing out on education.
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Poverty, intergenerational cycles, social isolation.
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Poverty is the root cause of many other social issues (family violence, homelessness, criminality) which has a knock on effect for mental health and addictions. Poverty in New Zealand is the primary issue which needs to be addressed. Family friendly work policies, increasing minimum wage.
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Poverty. Inequality.
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Poverty, discrimination, racism, housing.
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Poverty and inequality, social isolation and punitive treatment of addiction problems.
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Poverty, gap between richest few and poorest many. Systemic intergenerational abuse and neglect in specific family groups.
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Poverty, lack of education, family violence and abuse. Isolation/loneliness. Cultural values around mental health - enduring stigma, perceptions that mental health is less important/ not as valid as physical health. Particular issues especially evident within male subcultures (but not limited to this) where it is not seen as okay to ask for help, to speak about difficulties and

emotions.

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Poverty - high housing and rental costs. Adult mental health not adequately addressed impacting on child and adolescent mental health. Access to tertiary education.

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Poverty.

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Poverty, barriers in accessing support such as 'does not meet the criteria', waiting lists, 'not quite suicidal enough'.

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Reducing poverty. Increasing parenting support.

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Childhood abuse and neglect, trauma, financial strain, dismissive cultural norms, parent-child attachment disruption.

Poverty, education, housing, child abuse and family violence.

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Poverty and economic issues are the key factors. Cheap and readily available methamphetamine may also be a factor.

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More parental leave and flexibility in combining work with families would help in establishing a solid and secure attachment between the child and parents which is the foundation of a healthy social-emotional development. In many professions it is still difficult to work part time as a parent or carer for an elderly parent for example.

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Greater acknowledgement of social determinents of mental health and projects to address these.

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Most mental health and addiction problems, like most health problems, have socio-economic roots. Poverty, unemployment, poor housing, limited access to basic health, violence, etc. are all contributory factors to the above. We can't address the one without the other. We can't pour water into a bucket with holes in the bottom. There is no amount of 'treatment' that the non-provision of basic needs will 'cure'.

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Address t he social inequalities that lead to mental health.

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Addiction, digital devices, poor parenting capacity, poverty, intergenerational transmission of trauma, lack of assertive outreach options for mental health in CAMHS teams.

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Take a holistic perspective to mental health. This might include addressing poverty issues by increasing income equality (eg through reforming the tax system). Resisting the temptation to listen to industry body lobbyists. Developing policy aimed at reduction of intake of harmful substances (including fatty foods, sugary food, and alcohol) throughout the life course. Addressing mental health needs for those in the justice system.

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Too high incarceration rates for minor crimes & drug crimes. Poverty. Poor education. Lack of early years resources. Stigmatisation around substance abuse and mental health. More support for families with family violence and systemic family concerns.

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Needs to actually rediscover the disciplined and decent society and not over indulge children.

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Intergenerational poverty, family stress, social and cultural disenfranchisement, poor engagement in education.

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Youth employment, addiction. CYF's practice of keeping whanau/family together is questionably effective for child outcomes. Maternal mental health. Addiction. Long term physical conditions and management of these.

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Lack of parenting education and support, for parents of infants and young children e.g. about fostering secure attachment, different developmental needs, and how to promote emotion regulation. Poverty causing parents to

have to work and stress so much that they aren't being as emotionally available to their children, who are then less able to regulate themselves, with increased risk of developing self-harming and suicidal behaviours.

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Unemployment and housing. Poverty, cost of living and income inequality. Child abuse, family violence, sexual assault rates. Bullying. Stigma and discrimination about mental health problems. Racism.

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Increase understanding of cultural factors in the aetiology of mental health and addiction. Support interventions that are informed by and based on that understanding.

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Domestic violence. Untreated trauma and mental health symptoms in parents who then struggle with parenting. Unchecked use of technology (exposure to bullying via social media & extensive amounts of daily screen time impacting negatively on development of self-regulation skills & social skills).

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Poor quality rental housing with insecure leases, lack of employment security in low paid work, parents who have intellectual disabilities and severe mental health and addiction issues being solo parents with no overseeing welfare guardian.

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Domestic violence, financial stability and healthy homes.

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Domestic violence, trauma, poverty, intergenerational violence.

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Substance use - health based access not legal framework. Poverty. Bullying. Sexual abuse. Parenting skills.

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The damaging cycle created by physical and sexual abuse which typically results in adult mental health and addiction issues that impact generation after generation. Community impact is seen in poor educational outcomes as well as crime rates against other vulnerable populations.

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Ill health, poverty, relationships - familial discord and stress which can contribute to disrupted attachment relationships and trauma.

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Sociocultural breakdown in the community.

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Child poverty. Drug policy - too many people in prison for drug offences, stripped from their whanau and costing a huge amount of money with very poor

evidence that it is effective in changing behaviour. Use that money save to invest in communities and more psychologists.

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Poverty, racism, poor housing, bullying (for both children and adults), unhealthy diets, unhealthy sedentary and stressful lifestyles, ease of access to alcohol and drugs, boredom - our young people lack access to stimulating fun healthy social activities and turn to drugs, negative social media, a capitalistic materialistic society, lack of connection with nature, polluting our environment, chronic illness, lack of knowledge and research on effective treatments for mental illness, lack of access to

psychosocial care, lack of education about emotional wellbeing, advertisements about junk food, social stigma of mental illness and help seeking

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Poverty, crime, inter-generational trauma, unemployment, inequity in access to education.

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Maybe less attractive advertisement boards on the roads and on magazines for alcohol. The film industry probably not conveying to drink is the way to deal with problems? Creating health parks & swimming pools in every area possible with a subsidised or small fee so that everyone can have access.

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Significant social issues - low incomes for many, high levels of drug and alcohol abuse, ongoing mistreatment of children (sexual abuse, physical abuse, mental abuse, neglect) Raising a generation without resilience, who can't tolerate normal negative emotions, who want perfect 'social media' lives. Families being so busy with both parents working and often struggling and little connection within families and within communities.

Internet overuse and misuse. Children not getting adequate non-technology play and exercise. Internet bullying. Some Maori being dis-empowered and disconnected from their culture. If combined with social deprivation then mental health issues are frequent.

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I see many young people disaffected by not seeing that they have any kind of sustainable or hopeful future, or in some cases, see no chance of breaking out of a family cycle of joblessness and poverty. Addictions seem to become the default coping mechanism, which both suppresses the sense of despair and perversely ensures that motivation to change is thoroughly destroyed. Addressing families living in poverty with targeted mentoring for those young people may help to break this cycle. Police often appear to lack the will and possibly the resources to tackle the production and distribution of drugs in our communities. I believe this is a systemic issue for the police force to address.

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Cultural attitudes in NZ to "harden up" etc that negates the emotional and psychological impacts of the multitude of stressors in contemporary society. Children and youth in NZ are not taught how to respond to their emotions. Instead they are taught to suppress any emotional experiences via self-harm, suicide, substance use, etc.

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Many clients in distress are dismissed from the psychiatric system because they don't have a diagnosis. Work stress, bullying, sexual abuse, interpersonal conflict are all issues that could be effectively addressed with very little cost to the system.

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Job creation. Education. Curb gangs. In poor areas the only ones flourishing are gangsters. Kids want to emulate them. Job creation and a re-focus on secondary school education could help.

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I am fully in agreement with the latest Gluckman report that we lock up far too many people for far too long periods in our prisons. Crimes such as sexual offending against children appear to be primarily health issues and are treated like that in Scandinavian countries. The extreme punitive approach does not work, as we have seen in the US – but we do not seem to learn from it. It remains a matter of political popularity. The mental health impact of imprisonment is horrendous and effectively set people up to fail for the rest of their lives. The attention should be on preventive work rather than on punishment.

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The amount of pressure on kids, especially through education and NCEA. 10 year olds are routinely coming in with fears about failure at school that will ruin their lives. A highly risk averse society is leaving us with anxious kids and parents who lack resilience. The focus on obesity has come with more eating disorders - the focus should be health for all, not constant hammering of the idea that people need to lose weight to be healthy.

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There is lifelong intergenerational abuse happening within families which is not acknowledged. The whangai system allows it to perpetuate because the mother retains legal rights to the child and foster parents can't prevent the child from returning to the home of the abuser. Addiction and substance abuse, in my experience, results from early exposure to trauma and the substance abuse works to relieve the pain associated with the trauma experiences. The families and communities need to step up and teach each other to value children as gifts and as beings to be nurtured rather than representing pay packets. We need to do more (prioritise) to protect the rights of unborn children, rather than the rights of people to have children, which is currently prioritised. The public need to understand that children learn from their environments - if they grow up with violence and punishment, then that's what they may learn to be. Children need to be nurtured, not just fed and clothed.

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The loss of the idea of community and increases in poverty and use of substances to cope with feelings of isolation and loneliness. Loss of jobs and status which will continue and that we need to develop a new way of looking at with increases in technology.

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Stop treating NZ like a limited company that needs to make a profit and invest deeply in infrastructure: health, education, employment, public transport...

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A disproportionate number of those in prison have mental health and literacy issues. Increased adult literacy teaching availability, increased mental health support for offenders with early (pre-hearing) triage, and increased use of specialist courts for those with addictions who actually are prepared to try and make changes. Prison service in particular needs to make much more effort in separating gang members from those on remand, who routinely are threatened and sometimes join gangs in order to try and survive in prison. Thereafter these typically young offenders have a much increased likelihood of further and more serious offending, are often traumatised by their prison experiences and can become highly alienated from society.

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Address the social justice issues that impinge upon people's mental health such as income inequality, housing, discrimination, cost of living, unemployment.

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Preventing easy accessibility of drugs and alcohol. Providing free/rewarding workshops for people to understand the harmful effects and reduce young age addiction

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Provide funding for all staff to engage in further training as part of their professional development the way psychologist and psychiatrists do.

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Have funding for low income families to get kids to appointments, including being able to get paid time off work to join their child, money for the basics of living that they are missing that is impacting their mental health, and some self care and enjoyment for the child and family.

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Given that mental health and addiction problems have biological, psychological, social, cultural, and environmental determinants this is a big ask. Certainly what the government can do is make sure that people have access to the opportunity for well-being, such as natural spaces, free/cheap exercise and sports, social interaction, community involvement, healthy diets, care for physical health problems, and information. Having such opportunities accessible and encouraged will go a long way to preventing mental distress.

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Housing: Lack of social housing causes increased stress on families which leads to increased depression, anxiety and substance use and increased need for MH services. Use of illicit drugs: An increase in the use of Methamphetamine

particularly has increased the demand for acute inpatient services. When intoxicated with Methamphetamine service users can often be extremely difficult to manage increasing the need for restraint and increasing the risk of harm to staff. Prolonged use of illicit drugs increases the risk of service users developing psychotic disorders which impacts significantly on MH services; police; and family/ whanau and communities. Unemployment and poverty: Unemployment leads to financial stress on individuals and their families increasing their risk of developing a range of mental health issues. Family system issues: A lack of a sense of belonging for various reasons increases the risk of individuals developing mental health problems (depression, anxiety, social isolation etc); finding meaning and a sense of belonging by joining gangs. Individuals participating in gang related crimes causes many trauma related problems not only for the individual but for their families / whanau and communities.

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Please stop privatising services and public assets. They belong to the people of the country. The secondary health service may be 'public' but the primary health space works like a business in many respects. The cost to see the G.P. is exorbitant; the cost to see the practice nurse equally so. The cost for procedures is ridiculous! No matter how much money the government pours into those private businesses, it will never be enough because they are profit driven. There would be similar parallels in just about every sphere of society. There are roles and responsibilities for government that the private sector cannot and does not deliver better. Stop pouring public money into private hands!

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Studies such as the ACE significantly implicates family wellbeing, health and finance as predictors of trauma, mental health, illness, and death in the future. Supporting people to live meaningful, healthy and productive lives means supporting families into housing, supporting their health and education, and providing individuals with skills to manage their distress, relationships, and wellbeing. This is a systemic issue that requires a community wide response

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Poverty... education - the cultural dissonance of Western institutions continues to impact negatively on non-western cultures in NZ. Institutional racism still exists and compounds inter-generational trauma experienced by many Māori in NZ. Underage drinking/ access to drugs.

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Inequality is strongly linked to adverse mental health outcomes. Likewise a sense of hopelessness and worthlessness. These are seen more frequently across particular groups, and in lower socioeconomic populations. Opportunity and equality do not remove mental health issues, but they reduce them. A holistic approach needs to be taken rather than thinking that it is mental health services alone that can make any changes on a societal level.

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All mental health and addiction issues predominantly result as a response to complex trauma/poor attachment/ family violence and parental addiction/poverty. Very, very few presentations in specialist services are as a result of only organic issues such as ASD/ADHD.

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Increase support and opportunities for low income families, improve housing, focus on better education support and transport in socially deprived areas.

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Poverty, domestic violence, parental mental health. Physical access to mental health services.

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sector.

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Address the social determinants of health and wellbeing in earnest and you'll save yourself a lot of money in the long run. Anything else is throwing good money after bad - a waste! Addressing unemployment, poor housing, etc., etc. will stem the tide of people coming into mental health services in the first place and lessen the burden of those already in the system. It will also save the system having to keep people in hospital at +$1000.00 per day because there's no available and affordable housing in the community. Talk about a criminal waste of money and resources!

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Addressing poverty & hopelessness are essential. This will take a while to address & current services need to be expanded to manage until such changes can have an impact at a societal level. Easier access to relevant (including culturally appropriate) services sooner.

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Recognise parenting as an important role and make sure low income families have the living wage.

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To begin with, early prevention strategies should be identified. Research on identifying at-risk individuals for mental health issues is important in terms of targeting resources. There is a lot of "patient blaming" across society and the mental health sector for poor mental health and outcomes long-term. Mental health is a challenging social issue as it is still poorly understood with a lot of assumptions and a "sense of unknown". Focusing on things that work, using success stories, good mentoring, etc. can provide hope to both general population and staff working in the

Extend paid parental leave as more support for new mothers means babies the best start in life in terms of attachment relationships Increase benefits to address poverty and deprivation as there is a strong connection with mental health difficulties and too many children are growing up in poverty

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Child abuse rates, including an underfunded and understaffed child protection system. Systemic racism. Ongoing impacts of colonization. Significant disparity in wealth. Unhealthy

culture and understanding of mental health and help-seeking behaviours.

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There is a very male dominated and rather aggressive culture that permeates through all aspects of NZ society - it is valued by many but this needs to change if we want to reduce mental health issues. The amount of violence and abuse of all types is a huge problem in NZ and a major contributor to mental health issues.

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Poverty, institutional racism + effects of colonisation + intergenerational trauma. P addiction. Family relationship difficulties, housing situation in Auckland.

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New Zealand will fall down hard in suicide and trauma rates if it doesn't quickly accept the psycho-socio-economic factors heaving impacting on mental health rather than keep going down biological routes as a mainstay. With the second highest levels of bullying in schools and in workplaces in the developed world, this is a breeding ground for mental illness and is not down to individual pathology in many of the cases we are seeing.

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Work on the incredibly harmful "macho"'culture that really is not seen anywhere like this outside of NZ. This will explain: high rates of domestic violence; high rates of incest/sexual abuse - thus many traumatised women

they can't even afford to live. Address workplace harassment (including sexual) and bullying that is running rife in DHBs. If the staff who are trained and trying to help are broken down then they become part of the statistics! Teach people about

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human rights and how to treat people kindly right from school and model it: the majority of my patients have been traumatised by (sexual) violence and others are clinically depressed. That is the mainstay of the work. Don't allow the label "borderline personality disorder" (80 percent of the time given to female survivors of sexual abuse) mask that this is a trauma response. Provide counselling

in prison but because it is trauma it isn't always seen. Statistically analyse at risk populations e.g. children of suicide victims are far more likely to commit suicide themselves. As a Psychologist - listen to Psychologists? We are the poor

relation, both in management structures and respect. That's a culture shock as a pill or a chat does not "fix" depression, trauma or psychotic symptoms.

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Generational impacts. I.e. generation experiencing the same abuse. Generations of poorly modelled emotional regulation etc.

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This is already known by successive governments - poverty - housing - sparse community supports e.g. respite services for young people, parenting support/courses. Bring back apprenticeship funding.

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Inequity.

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There needs to be a redistribution of wealth in order to decrease poverty and inequality.

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Social dynamics (poverty, abusive relationships, parental discord, neglect, parental AOD use etc.) have played a significant role in most of the youth suicides I have become aware of in my work.

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The lack of affordable housing and the way that the rental system is set up that does not offer stability or security for families is a major source of stress for a lot of families.

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(and men) later coming to services; "boys don't cry" attitude while being bullied - hence depression and suicide rates. This is really, really shocking for outsiders from New Zealand and truly isn't seen in most developed countries. If the government do not start focussing on this then the suicide rates and rates of trauma will not change and I think will go up. People can't be mentally healthy when

in prison - not just for the offending but for their mental health. I worked with so many prisoners (especially Maori) with so much potential who suffered multiple traumas in childhood. They weren't addressed and gangs provided some pseudo family plus protection in prison that needed "repaying" once out: then reduced employment choices. So many people with mental health issues

Addressing wider social stressors to improve family/community well being.

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Poverty, obviously. But also growing inequality - which also causes stress for middle and upper SES groups. Lack of community and systemic supports for young people - too easy for them to get lost.

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The cost of housing means people cannot afford suitable housing and are sometimes forced to live in boarding houses where addictions may be perpetuated or with families who are abusive. Domestic abuse, child abuse and violence are also significant parts of the presentations we see, trauma is prevalent. Addictions are very much part of the community and local cultures.

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Mental health and addiction issues are invariably associated with lack of opportunity and modelling of poor social behaviour by whanau and peers. The cycle perpetuates due to a lack of genuine options to break the cycle even at the point of identifying a need. For

instance, an unskilled man with facial tattoos and a criminal record might have a period of two years free of offending in a secure environment. He might develop the motivation to work. He may have some options through the prison system, but if placed within inpatient mental health his options are diminished even further. His ability to work will be restricted due to legalities (and in some cases social and media pressure) beyond the time when he is ready and able to be integrated into some employment. Once legally able to work he will have 2-3 work rehab options being paid a few dollars an hour as a rehab rate due to being a patient in care with oversight from Occupational Therapists, etc. While these services are excellent as a first step, he will be restricted to one or two suburbs, likely away from his family or supports in a geographical sense, he will be restricted to work in an area which may be entirely disconnected from his interests or

areas of prior skill. Work as a protective factor against violence, addiction and mental health problems is emergent in research but not well-addressed in NZ for a minority of individuals. We need to actively take lessons from countries who are considering addiction as a heath issue, not a reflection of a 'bad' or criminal individual.

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I think they already are addressing some of them, e.g. child poverty and homelessness.

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Invalidating home environments have a significant impact on subsequent mental health difficulties for children and adolescents. Education about the emotional needs of children is likely to have an impact on reducing problematic 'core beliefs', which significantly influence mental wellbeing. Bullying is another significant area of concern

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Pressured family environments.

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Developing a proper set of social services so that social factors don't

become so disturbing that children aren't standing a chance, nor vulnerable adults. Socio-economic deprivation needs tackling (as does sexism and racism which is shockingly prevalent - even within mental health employment). Where there is poverty there are forced choices and poverty and depression are strongly linked.

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Macho, bullying culture which NZ has so many statistics on - school, work, medical professions, legal professions, even HRC - nobody's mental health can thrive with this underlying, unaddressed issue. People are frankly not encouraged to be kind to each other and bullies are enabled across the board. 2. Socio-economic deprivation. Poverty is a major issue here, more so for certain sectors of the community (single parents, Maori, pacific islanders, people with health and disability issues). Basic welfare needs to be improved and the standards and

costs of housing is frankly shocking. It is constant stress for certain groups of people. NZ makes it easier if one is injured than ill. 3. Family violence and sexual abuse is rife. Do you know why mainly men in NZ think that is ok?

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The breakdown of marital relationships, blended families where children feel unloved and unwanted, the lack of family values to provide a moral compass for youth, uninvolved parents and the reliance on electronic media to keep them busy, childhood abuse in the home, bullying at school, the social acceptance of alcohol and drug use, the use of "synthetic cannabis" and other drugs by youth, dropping out of school and having no future prospects.

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There is a plethora of research showing social and economic disadvantage, adverse childhood experiences, and trauma are the strongest predictors of mental distress. These factors have been shown to predict the severity of distress as measured by impact on functioning, chronicity, rates of dual diagnosis, and economic burden (with respect to the individual's employment, need for support from others who may otherwise be in paid employment, and cost of treatment to the health system). These factors have been found to be stronger predictors than the long-touted 'genetic predisposition'. However, mental health services are still designed within that out-dated biological disease model. During discussion of whaiora, when it comes to considering diagnosis a frequent comment is "shit life syndrome". That is, their mental distress is due to their life circumstances. Similarly, when seeking to ascertain why whaiora have deteriorated in their mental health a ubiquitous observation is that their circumstances have worsened. Their distress is a response to the circumstances. Currently socio-economic disadvantage, exposure to adverse childhood experiences, and support following trauma are managed across various government agencies (WINZ, Housing NZ, MVCOT, ACC) and NGOs. This silo approach misses the interrelatedness of such difficulties, with mental health and addictions services sitting as further separate agencies. The challenge of the interrelationship of such difficulties also identifies a possible way forward. Thus, as part of the Mental Health Inquiry, I believe it is important to highlight the importance of efforts to address poverty, racism, inadequate housing, domestic and child abuse, over-reliance on incarceration without effective rehabilitation, and basic physical health needs.

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WHAT SHOULD WE DO?

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In your view, what more could we be doing to prevent, and respond to, mental health and addiction problems?

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SUPPORT FOR FAMILIES & EARLY INTERVENTION

We need to ensure Oranga Tamariki is providing the best possible care and protection of children and young people. Early intervention with children, parents and families to address attachment, trauma and drug and alcohol issues.

Please, please, please focus on early intervention! If at-risk families are identified and supported early on (at a more intense level than services like Early Start etc. can provide), we would be

seeing fewer children and adolescents in the mental health service presenting with developmental trauma and attachment difficulties. Also, if child and adolescent mental health services are seen as an important early intervention service, and resourced as such, we may see

fewer adults in the mental health and corrections pathways. There continues to be more of a focus on adolescent mental health than on children, both within DHBs and in the availability of community services (this is often due to acuity and risk). It would be great if more child and family specific community initiatives could be funded, and if children and families could be prioritised in DHB services.
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More free community services for children (under 12 years) in the mild to moderate category of mental illness so they don't have to sit and get worse before they get help. Free educational assessments for kids struggling at school - a SPELD assessment is upwards of $300 and has to be done privately unless a child meets criteria for the child development team. Most families cannot afford this, yet having one may highlight learning difficulties that are causing anxiety/ low mood that can be resolved without specialist mental health services.
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We need to accept clients into services and offer support with lower end issues eg: to catch people early before they deteriorate into crisis. We need more holistic services which

incorporate family support and better communication with families, so that they can better support the individual with mental illness.
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Greater emphasis on early intervention and prevention programmes such as the Incredible Years, Triple P and Circle of Security parenting programmes. Also Oranga Tamariki needs to have more support, training and funding to provide in-house mental health support and assessments. Caregivers need adequate support and training to care for children with significant trauma, attachment and behavioural issues so placements do not break down.
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Intervene earlier - we know who the at-risk groups are, we know what kinds of conditions infants and young children need to flourish. Better coordination between agencies and service MOE, MCOT and DHBs.
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Preventing mental illness working with families and their children who are struggling financially; experiencing domestic violence; have drug and alcohol related problems; are unemployed etc needs to be prioritised.
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Early intervention is crucial. Almost all clients in adult mental health have difficulties that could and should have been addressed in childhood. We know early intervention works and we also know that health, education, and SES are significant predictors of well-being in childhood. Fund sectors that provide wellness maintenance, assessment and education to families and children e g Plunket, schools/teachers, police etc. refer to psychologists to guide policy, early intervention, and psycho-education for primary service providers. Get more feet on the ground, get more eyes in homes, get more early awareness, education, and prevention out there. Don't just focus on psychology as a fix for mental health difficulties arising from stress, mood, anxiety, and trauma. Use psychology as a tool to guide policy, funding, and education. Children should be learning emotion regulation strategies in school, parents should have access to parenting resources during pregnancy and early childhood.
....

Early intervention for the child and their family, in order to strengthen family systems and provide whanau with the skills to foster their own supports once the services are withdrawn. Oranga Tamariki needs more specialized staff in order to support this, and more therapists need to be available in the regions. At

the very least, their needs to be one psychologist per office to work alongside social workers, families, and caregivers in order to facilitate this support.

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Early intervention that wraps around at risk infants and families to improve attachment, reduce adverse events and improve outcome.

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More assertive outreach needs to happen in 'at risk' communities, so that families who do not have the means to travel to centralized clinics can access care close to home.

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Early intervention for treatment as early trauma underlies a huge percentage of the psychopathology we see at secondary services in adolescents and adults.

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Children and family systems are becomingly increasingly complex and we need to address the underlying issues with considered assessment and interventions. Failure to do this will not only lead to significant social issues going forward but an increase in psychologists leaving the profession due to the inability to create change and impact in their clients lives.

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In Ministry of Education, having more psychologist to assess and provide treatment rather than fly by visit to only children who are at the verge of

being expelled or already expelled. Early intervention is the key. With DHBs, again, early intervention is the key. By the time a person is referred and accepted by DHB mental health systems, the issue has taken root and behaviours are more set and difficult to shift as well as the long lasting effect on self-esteem and

psychological/social/financial impact on the child and families.

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Infant mental health (0-3 years) has been introduced to DHB services and need to be integrated with perinatal services and need to be a ring-fenced division within mental health if effective change is to occur, given the strong correlation between disorganised caregiver-infant attachment styles and later mental health illness. Training for assessment and management of children with foetal alcohol syndrome disorder a neglected area within mental health services.

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Oranga Tamariki children. They're often not getting any mental health treatment, or only crisis treatment. Understand that it is hard to put a monetary value on psychological treatment that is given to a four year old on an antisocial developmental trajectory which changes the trajectory and keeps them out of youth justice and justice. Early intervention saves money in ways that are difficult to quantify.

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Please invest in our children to prevent more complications, crime and addictions later on in life.

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Fund the ambulance further up the cliff. A Stitch in Time Saves Nine!

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We need more on prevention and early intervention as our "ambulance at the cliff" approach is not working and those services are extremely stretched for resources

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More funding on early intervention services such as proving access to psychosocial care in primary settings (GP clinics).

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Reduce the limited resources for young children to obtain therapeutic support when they have been negatively impacted by physical or sexual abuse and/or parental addiction challenges.

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Investing in early intervention is paramount.

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Attachment disorders/poor attachment to caregivers (which can be the result of a number of reasons), lack of support around parenting or access to parenting support and guidance, financial pressures on families.

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Parenting support - there is a huge need for parenting skills to teach/ socialise children in social/emotional regulation etc.

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Many of our clients need help and support from people who can demonstrate successful parenting skills.

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MoE needs to come to party and support vulnerable children with their learning, this is not happening. ORS funding is there, but I have not seen any support other than a teacher's aid shared by many students to support the vulnerable child. Lack of service and reach out in our school system adds leads to ongoing issues later, whether drug addiction, criminal behaviour, etc. In my opinion, mental health services need to be accessible to children in school and at university level, free of charge.

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Treat Trauma! Both in the parent and child. Allow this services to not be siloed but delivered together in one combined approach. More specialist service for under 5s – i.e. intervene much earlier!

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Allow people to get help early not late. Aim to treat people more in their communities - other than rehab.

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Adequate support services for families impacted by conduct whether antisocial type behaviours or in relation to developmental delay. Again here assessment is covered but not

comprehensive intervention.

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Resourcing of good foster placements- well supported. Early intervention that is free & accessible.

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Assure that parents of small children are able to access effective addiction treatment programs and support those parents to find appropriate and safe care givers for the young children who are negatively impacted.

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Parenting programs offered to both parents along with midwife visits that could be done as a package in groups of ten couples who are expecting to deliver at the same time.

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It's a wider issue of social disadvantage and inter-generational trauma and abuse. Supports for parents and families, encouraging positive attachments.

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Provide a better wrap around for kids under MCOT care. Increase funding for staff in child development teams so they can see kids sooner and less kids fall through the cracks of fitting no one's criteria. Put lots of money in to intensive childhood treatments to prevent future problems.

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More educational, clinical and counselling psychologists could be employed in the Ministry of Education at schools and in NGOs to identify and provide treatment to children with behavioural and MH problems to prevent or slow down MH problems during adulthood.

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Early intervention for all families. Upskill Plunket and midwives. Focus on relationships and attachment of parent-child relationships not just behaviour Management programmes.

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Innovative services with more flexibility for helping iwi/hapu/whanau not just individuals.

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Earlier intervention & prevention.

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Early intervention in schools. Greater focus on prevention-maternal mental health, supporting the development of secure attachments in children

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Access to/establishment of therapeutic services, mental health support in primary schools, mental health specialists working in each Oranga Tamariki office. With this said, it would be great to see a stronger focus on prevention and early intervention from both DHBs and MoE.

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Many mental health problems relate to disadvantage, abuse or neglect in early family relationships or communities that if addressed appropriately could perhaps reduce the prevalence of problems later in life. Resources aimed at addressing this at a community level - this is everyone's responsibility is vital to success.

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I believe that Oranga Tamariki is failing. There is a need for mixed disciplinary teams within this service at ground level. I am shocked by their lack of understanding of basic psychological issues and best practice. In addition to this, I believe that this service needs to be given the ability to take on dual custody at an early stage so that they can fund support for caregivers - especially when children are relocated within the whanau. The government should have a review of this service in general and specifically on the number of children who are placed within the whanau and what supports are given to those whanau members. The number of times that I have heard "we cannot provide support as we do not have custody of that child" and then this is followed up by "we cannot take custody of the child as we are mandated to do whatever we can so that they stay in the whanau". Although we should support children staying in the whanau this funding structure and policy is meaning that kids are not getting the support they need. I feel that this is an area where a legislative change, alongside guidance from the government, could prevent a huge amount of damage to young children and provide support for them. Our ethos should always be empowering whanau to support children, rather than saying it is the whanau responsibility for that child.

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Early intervention and more staffing in those areas - anxiety levels are increasing in younger children and their families. Teaching and supporting parenting skills training, social/emotional regulation, and easier access to DHB/ specialist services.

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Align with international service delivery around complex trauma, attachment, and addiction issues. Need to be offering children and adolescents more access to therapeutic services alongside family systems interventions.

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At the top of the cliff there needs to be more parent education and support, to foster secure parent child relationships, as this would be extremely protective for a lot of mental health difficulties we are seeing at the bottom of the cliff.

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In terms of prevention, funding long term early intervention services for families of children who are at risk of trauma and attachment difficulties, as it is the impact of these that we see much of in our service.

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To provide support from an early stage e.g. from the start of pregnancy and intense support straight after birth.

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I think we should focus on early intervention and promoting wellbeing in our families. Early intervention should begin with improved ante-natal and post-natal care. Our midwifery and family doctor services are disjointed from one-another and opportunities are lost for supporting maternal mental health and promoting strong attachment which is the basis of good many good outcomes in an individual's life.

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Support earlier intervention and education of mental health, teach parenting skills

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Mental health cannot be addressed without due attention to concomitant social issues including care and protection. Some children need residential options as they will not get well while they are still exposed to daily trauma

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We need more money and a plan starting from child services and infant, maternal mental health to older person's health and seamless ways in which people can get help when they need it rather than when they are suicidal.

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More funding towards mental health services including services for people with mild to moderate problems and early intervention - not just focusing on severe end of mental health issues.

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Target early intervention areas.

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More funding to infant, child and adolescent - get things right early on with prevention and early intervention. Fund more evidence based parenting programmes such as Incredible Years. Fund more FTE within MICAMHS services so that psychologists aren't overwhelmed with huge caseloads.

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More resources for early intervention, e.g. child abuse, trauma, autism spectrum disorders, learning problems, bullying in schools, instead of waiting

until clients have developed a psychiatric disorder. Provide funding for individual and family therapy instead of relying on medication to treat psychological problems.

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More opportunities to include families in care. Better conversations, better services and services working together rather than being so stretched they pass the hard clients between each other….

typically Oranga Tamariki clientele…. attachment and trauma issues along with unstable and perpetuating living environments.

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Make stop violence sessions free (versus $50 per session). I have had patients who aren't harming their family, but they are worried they are going to do so, so they want help. $50 per session gets in their way of trying to stop violence.

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Support families early on to help prevent mental health issues developing.

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More resources in children and families.

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The MOE got rid of most of their educational psychologists years ago, and those who are still there don't do cognitive testing. Instead, clients with intellectual problems or learning disorders struggle on for years, fall behind their peers, are bullied, etc. and nothing is done until they come to the attention of mental health services when they present with acute anxiety,

depression and suicidality. This is the ambulance at the bottom of the cliff, and it is not fair to expect clinical psychologists to do all the assessments that should have been done years ago by the education system.

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Substantially more initiatives and funding into early intervention research and programmes.

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Increase resourcing for CAMHS, but also for early intervention services I.e, parents and infants, young children.

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Care and protection issues with Oranga Tamariki need to be sorted out. I see this has the biggest effect on the mental health of vulnerable young people. Too often I make a report of concern, which is then inadequately followed up.

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Greater focus on parenting support and recognising attachment difficulties and emotional neglect in infancy and early childhood. Greater support for parents of foster children in particular.

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Increased resourcing of primary mental health services for children, relationship counselling, and support for parents with mental health issues. In tertiary mental health services have Supporting Parents Healthy Children guidelines, but no increase in resources to put into practice.

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Early intervention is key!

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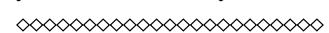
ACT IN SCHOOLS

Educate children about mental health and emotional wellbeing as part of the curriculum. Ensure adequately trained and supervised counsellors are available in schools. We need better and more psychological services by the Ministry of Education in schools.

I would like to see a counsellor, social worker, or psychologist based in primary schools (or small clusters of schools).

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Ministry of Education could complete specific learning assessments as a regular part of their function - children and adolescents with undiagnosed SLD often present to mental health and require cognitive assessments to assist with differential diagnosis. If these were done by Ministry of Education this would improve efficiencies across the service and improve outcomes for young people.

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Fund specialist service within schools that actually provide brief intervention.

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Explore preventative/educational interventions regarding safe and appropriate use of technology/screen time, especially for children, based on available research.

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Hire educational psychologists and clinical psychologists within schools (or within Kahui Ako or patches of schools) to provide ongoing service (and build good relationships) with schools and the children who attend them. They are currently very far removed from the community in which the problems occur.

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There is a huge need and the current services only touch the surface of people needing it. There is not enough service to support young people with suicidal ideation and risks. More emphasis needs to come on prevention; teaching emotional intelligence and self-regulation from an early age with people based in the schools to provide this training alongside the teachers.

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Implement school-based interventions from childhood through adolescence - for students and parents to increase coping skills.

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It is increasingly evident that many people presenting to secondary mental health services have not had the opportunity to learn that the experience of difficult and challenging emotions are a normal part of life, and have not had the opportunities to learn effective and non-harmful ways of regulating, tolerating and managing stress and painful emotions. Many of my clients' difficulties result from the non-effective and harmful coping strategies they have developed to manage difficult emotions (often based on avoidance of these emotions altogether). I believe the government should put money into prevention through developing a skills based curriculum to be taught in schools around managing distress and regulating emotions.

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School guidance counsellors are insufficiently trained and exposed to mental health problems. Qualified mental health professionals who have therapy training (and in youth alcohol and drug issues) e.g. psychologists should be in schools and supporting/ supervising them to truly make a difference in managing the needs of youth mental health. A parent of a young person with severe mental health problems should be resourced to full time support their young person until they reach recovery.

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Early intervention, not just identification. Rather than putting a nurse in every school (which will be useful for identification of problems rather than intervention), have a multidisciplinary team (e.g., nurse, psychologist, social worker) available for clusters of schools. This team can help identify and refer on, but also provide brief interventions that reduce the load on already stretched services.

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Could organize "values" based education from primary / high school levels. A trained Psychologist could be appointed in every school for this purpose. Impact of alcohol & drugs on mind and body to be included as part of curriculum / syllabus in the schools (11/12years of age).

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Make mental health part of the curriculum, with a focus on wellness and resilience.

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Provide more educational psychologists in the Ministry of Education and NGOs to reduce the extreme caseloads they currently have and pay these psychologists what other psychologists in government services are being paid.

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Resilience skills need to be taught in every school.

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Introduce 'life skills' in schools.

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Education about emotional wellbeing, mindfulness and self-compassion at schools.

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Ministry of Education has a need for more educational psychologists in

my area, and I believe should be more prepared to complete psychometric testing where educational deficits are identified, which may relate to cognitive issues.

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The education system needs integration of psychosocial care and education on emotional wellbeing at schools.

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More resourcing for the schools to provide the support needed for their high percentage of challenging children e.g. having all services in one hub with the public health nurse, social worker and ideally psychologist/counsellor as well as professionals from the Ministry of Education, Learning Support to provide psycho-education and support. To link this with the communities of learning to make it well co-ordinated and accessible. The children's teams are a good start but sometimes slow in their process to encourage strong collaboration between services.

....

Preventative education to commence at a young age and be part of the education system. This should cover the dangers of alcohol and drugs, learning to understand emotional distress, learning how to deal effectively with emotional distress and accepting the concept of asking for help when one cannot cope instead of reverting to unhelpful escape mechanisms.

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Teaching emotional skills to kids at school would be really useful.

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Coping skills. Teaching children how to cope with change and general ways of caring for self.

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Well-being programs funded by the Ministry of Education for all schools with professional development for all teachers. Counsellors in all primary/intermediate schools (or at least shared by a cluster of schools).

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Teach emotion regulation skills in school.

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Lack of coping skills for emotional and behavioural challenges. Simple skills could be taught from a young age in schools.

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Put MDTs in schools not just nurses as you need to be able to deliver brief interventions there and then.

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When part of MoE work requires input from DHB mental health services, the hold-up/expectations in order to access MICAMHS services is disruptive to the child/whanau/kura/caseload and those waiting to access our service. The waiting list is too long. The need is too great. Utilise systems such as schools to support psychoeducation. Schools having their own school psychologists could be helpful both systemically and individually.

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Easier access to service with more investment in resourcing (staffing) and psychological services to be delivered by trained professionals (rather than nurses or OTs or other). We have a tradition of using the cheapest resources to deliver services to the most complex people rather than the best trained people. We are under-resourced. Within MoE, psychologists need to be allowed to do more one on one work with children concentrating on building resilience.

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Psychologists in school could be part of the solution - part of holistic approach/point of contact for the child/whanau.

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School counsellors in primary schools.

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Add emotion / mental health education to the school curriculum. Include a mental health nurse in schools who is able to offer brief intervention and refer students on to appropriate support systems in the community

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There should be more mental health promotion and early treatment of mental health issues i.e early detection and treatment in schools.

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Funding specialty positions in schools to support students and teachers in managing behaviour and mental health concerns. More funding in education and research about alternative education options for young people who school does not fit.

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Develop clear training and supervision requirements for school guidance counsellors. Ensure additional resourcing is available to meet such requirements.

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Employ more educational psychologists for schools to target early intervention of school engagement. Only the most serious cases are targeted in current funding with lots that fall through the gaps that end up in the justice and welfare system. Teachers are already overloaded with being everything for students and SGC are not qualified enough, schools need specialist access to psychological work and advice so students and families are supported to make the most of school.

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Develop global prevention programmes to be delivered in schools and community settings. Such courses should be designed in accord with evidence-based best practice and delivery should be informed by local need and preference. It will be particularly important to incorporate kaupapa Maori delivery approaches. The work of Diana Rangihuna, Mark Kopua, and Lisa Cherington may be useful to consult for this.

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Ministry of Education needs to complete cognitive assessments and address learning issues not just behaviour difficulties.

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Increase funding for pastoral care in schools. Include resiliency building skills in early primary education.

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Improve access to specialist service, increase support for children and families in the community, and greater staffing to services to provide prompt and competent intervention.

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Approving funding support to schools/families so can access specialist services, even with in the professional opinion of a psychologist that a child's application (to ORS for example) has mental health challenges or meets criteria for intellectual disability with concerns of functioning in their environment, these children are still declined and are needing to wait another 2-3 years for the 'gap' to increase before another application for ongoing support can occur.

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Educate schools or equip schools with resources to access specialist services to support students at high risk.

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Providing mental health education and early intervention in schools e.g., mindfulness based programmes; more sophisticated knowledge shared to young people in intermediate and high schools. More psychologists in schools, aimed at preventing those from accessing specialist mental health services.

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The approach needs to be bottom up with significantly more mental health promotion and prevention (i.e in schools).

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Invest in mental health interventions at schools e.g. mental health nurses, psychologists, OTs

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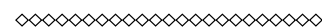
BETTER FUNDING, STAFFING AND SERVICES IN PRIMARY CARE

Better provision of primary mental health services through General Practice, NGO and community services will reduce pressure on secondary services and allow for earlier and more effective intervention.

Adult services - starting from GP practices, **recognise that GPs will not case manage mental health service users in 15 mins according to their business model so put MDTs in GP practices** - including psychologists. Triage people there and integrate triage for PHOs and DHB secondary services based on need so that it is seamless.

Prioritise this and fund services appropriately for both primary and secondary care. Focus on prevention. Acknowledge the key role trauma and adverse events in childhood have on the development of mental health difficulties. Target services and prevention strategies to this.

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Government needs to place more emphasis on child and adolescent mental health services in the community. Services like Youthline need to be adequately funded, and other therapy services for adolescents available at a primary level. There is a particular gap for therapy for children aged 11 and under with very few options for families. We need more free, accessible therapy services!

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Greater provision of primary mental health care.

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Increased funding to NGOs specifically tied to the provision of mentoring, coaching and counselling support by qualified staff, for children and adolescents. Auditing subsequently to ensure that the funding is in fact being appropriately applied, with contracts reviewable.

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More supported NGOs/community services to relieve pressure on secondary mental health services.

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Fund family and couples therapy once again.

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We definitely need to train more psychologists and to offer access to psychosocial care in primary care settings.

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Have more free community services for children under 12 years who are in the mild to moderate range. Reinstate the family court counselling sessions.

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More primary health services including access to psychologists being available in doctors' surgeries. Health centres could be one-stop shops with all specialists covered.

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Mental and physical health are also heavily interlinked so we need more psychologists and psychosocial care staff at GP clinics and hospitals.

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Hold primary mental health service providers to account. Secondary services are predicated on a working primary sector. In the Eastern BOP this is not the case. Mental health is not the focus for primary care.

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The option for longer term support (e.g. more than 4-6 sessions) to be provided in primary settings

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More funding for psychological approaches to be used earlier with people struggling.

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Put more psychologists into primary health organisations to develop therapy interventions including group and media based interventions.

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Lack of capacity for NGOs to provide crisis respite to a service users in need, leading to increased demand on acute child/adolescent and adult inpatient services.

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Support primary health care to access psychologists.

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Funded sessions run by psychologists in primary care.

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Initiatives aimed at reduced cost for accessing therapeutic services – e.g., such as that in Australia.

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More free primary mental health services.

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MAJOR increase in the number of Brief Intervention Counsellors (up to 6 free sessions with an approved counselling, referred by a GP, no silly exclusion criteria). I gather need currently far outstrips demand and the counsellors are getting burnt out. Without exaggeration, Christchurch could easily absorb 10 times as many counsellors.

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Increase funding to primary mental health services and have more oversight of them so that there is more consistency. Clients in primary mental health services should be offered a minimum of six individual therapy sessions in addition to access to groups.

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Currently the primary health system is the 'gateway' for secondary and tertiary mental health services but a lot of adults and families do not go to their GPs to discuss their concerns given the cost/user pay system. Often they do not receive the appropriate help they need at the early stage because they can't access primary health service to begin with.

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Better provision of primary mental health.

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Allow earlier access to care, rather than waiting until issues reach the moderate to severe cut off for access currently in place.

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We are being hamstrung by the lack of sufficient services in the community and often have to deliver the disappointing news to clients who then feel that "nobody cares" about them.

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More step-down services, NGOs etc. who hire quality staff – providing very low cost (if not free) support services. This would allow for people to receive necessary supports before difficulties become worse, entrenched and require specialist mental health support. Again, this needs to be well-funded in order to attract quality staff to be employed there.

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Enable GP practices to administer anti-psychotic injections/medications.

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More funding for mental health services in primary care and for NGO to reduce pressure on the secondary and tertiary mental health services.

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Ensure primary care counselling services have appropriate clinical governance. Increase resourcing to enhance capacity to provide mental health care while it as at primary-care level.

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Improve access to PHO provider psychological therapies, including increasing the number of low cost/session available for adults over 65.

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Continue with funding of Primary Mental Health sessions: issue national guidelines to DHBs on number of sessions that should be minimum. In our region, PHO management randomly decide to offer a standard 3 sessions to everyone, which is contraindicated in research i.e.it is okay for mild problems, but it is not possible to treat moderate problems with 3 sessions. Yet, that is what clinicians are expected to do

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Offer free time limited (eg 10-12 sessions) group treatment in the community targeting low mood and anxiety symptoms using a CBT approach. Referral needs to be by GP and the GP retains clinical responsibility (otherwise the whole thing will get bogged down by assessment, as happens in the mental health services).

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More provision for services at mild to moderate level within the DHB service - not just outsourcing to NGOs who despite their best efforts are not staffed with those who can deliver quality interventions e.g. clinical psychologists.

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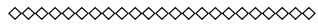
AN INTEGRATED SYSTEM FROM PRIMARY TO SPECIALIST

The best possible system is one which is well resourced and integrated from primary to specialist services.

While I totally agree that more preventative work needs to happen in schools and primary care, we need to also increase the resources in specialist secondary mental health services so that they can adequately respond to those prescribing and monitoring whereas the psychological approaches are often the first line treatment recommended in the literature e.g. Cochrane reviews, NICE guidelines. We should be implementing care based on best practice so that it is physical symptoms will also resolve. It needs to be easy for people to go to the doctor and have access to MH services, just like they were going to the doctor. If someone has a mental health issue, it's too hard and too expensive to get the help they need, but if they break a leg, it's taken care of. Much of substance abuse starts when people struggle to cope with mental health issues. Much of the time, people who have experienced trauma may resort to substances in efforts to relieve the mental pain from the trauma. If we start working with trauma and mental health sooner, then the substance abuse may not even happen. We need to acknowledge more the effects of trauma - and we have a lot of it happening in New Zealand from childhood - e.g., witnessing domestic violence, victims of childhood sexual abuse, experiencing abusive parenting, experiencing abusive relationships, and sexual abuse in adulthood.

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Resource psychological services to be more available in MH&AOD services. To invest in more GP liaison teams at all levels. To provide more community activity services designed to suit non-school aged Asperger clients. To invest in more effective and responsive ID services.

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who are actively unwell. **We need a national intervention plan (such as exists in Scotland - the Matrix) to deliver psychological therapies at all levels of severity.** At the moment it seems different and ad hoc services are developing around the country without a coordinated and research-driven plan. This plan would then ensure that the people delivering the therapy were adequately training and supervised for the level of intervention that they are offering. At the moment secondary services (because they are stretched) are highly focused on medication defensible and quality driven. We can then evaluate what we are doing and make evidence-based changes as needed. We can also adapt known best practice to the cultural setting of Aotearoa and evaluate whether these changes are effective and add value.

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Mental health needs to be viewed and funded the same as any other health problem. There needs to be recognition that many of the physical health symptoms may have resulted from mental health issues with wellbeing. Clear up the MH issues and many of the

Better funding of psychological services, especially in the public sector (DHBs, Education) to provide scope for more psychologists working with clients in order to respond adequately to their needs (currently there is a lot of prioritising which means many clients miss out early on which can lead to their problems being maintained and worsened in the future).

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Greater resourcing all round. Particular attention to primary care. Greater resourcing to addiction services, social services, youth employment. There is a gap between primary care (sparse) and secondary care (too high a threshold) and this needs to be better integrated.

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Increase funding and employ more psychologists across the sector.

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Psychologists in primary care and secondary care with sufficient sessions to do the work.

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Adequate staffing to meet demand,
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Huge gap between primary and secondary services / sectors. Many require more intervention than 4 sessions provided in primary care but do not fall in the top 3% of severity to require secondary MHS.
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Rural services need a boost as travel in to urban areas is often long and tedious. Strengthen primary care collaborations and assist in removing blocks to flexible working patterns to accommodate mums with babies to attend treatment sessions, to assist workers to access treatment and protect jobs while they attend. Resource services for Asperger/ID clients to achieve appropriate/ Responsive services to achieve social contact and meaningful activity.

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Crisis services integrated with secondary teams so that there is a seamless service for clients becoming more acute. Isolated crisis teams lead to reduced relationships with other parts of the secondary mental health services and a less co-ordinated provision of service.

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Fund the services to hire the actual number of staff needed to run a good service, in which staff are not holding massive complex caseloads.

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Both primary and tertiary healthcare need to be well supported in the short term, to treat the people who need tertiary care effectively and also to then prevent more people from becoming unwell. Simply supporting primary care to treat anxiety and depression will not help treat the huge number of people that continue to require tertiary, specialist interventions.

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There is recognition of severe and mild mental health problems. Those who fall anywhere between are falling through the gaps. The system is working as silos. Overall there just needs to be more services made available or existing ones need to be expanded.

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There needs to be additional funding for new psychological positions to be developed across the sector. Acute mental health needs more funding, as does the milder-moderate end (the people that may consider accessing psychology privately.) I used to work in Australia, and the private system there is partially funded by the government, making it easier for everybody to access psychological intervention, not just the people 'at the edge of the cliff'.
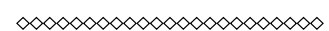
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More psychologists at primary care level offering structured therapies that prevent mild and moderate MH issues becoming severe. Absolute need for better access to AOD rehab. Greater resource going into ICAMHS and high risk families.

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I also believe that more resources are needed both within primary and secondary care, as if more resources are poured into primary care, although necessary, this will undoubtedly increase demand on secondary services.

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More funding is needed across the mental health and addiction sector. Increase access to psychological therapies through increasing the numbers of psychologists trained and introducing a strategy that includes a greater focus on this aspect of care. **Reduce gaps between services by creating a system that is person-centred and integrated from mild through to severe (e.g., a single point of entry with a skilled assessment up front to identify needs and level of service required).**

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Generally there needs to be a massive increase in the provision of evidence based intensive psychological treatments. Please do not waste the money by funding short term treatments for complex and serious psychiatric problems.

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More mental health clinicians working at the primary and secondary health level.

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Invest in evidence-based group programmes in the community e.g. anxiety group for children/young people and their parents that they don't have to access through secondary mental health services

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More adequate triaging and screening of referrals to differentiate which ones need to go to community counsellors and which need the specific skills of Clinical Psychologists in community (eg. Anxiety disorders, moderate Depression, OCD).

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We need to prioritise mental health, it is as or even more important than physical health.

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PUBLIC EDUCATION

Keep up the work that has been done in public education de-stigmatising mental health, and step-up efforts to improve awareness of the impacts of alcohol, smoking and drug use during pregnancy.

To give explicit messages about the damage done in drinking and smoking during pregnancy e.g. showing the impact on the brain, using a wide variety of media. To explicitly promote contraception, especially in high risk families where there are already children uplifted from their home. I know this is a huge ethical dilemma and complex issue but it is so extremely sad to see children put in the world without any thought or responsibility who need to be taken away into care as the parents have no idea how to provide appropriate care.

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Encourage more people to go for therapy from an early stage in their mental health problem or even before they have been diagnosed. Educate people about the value of self-reflection, acknowledging and dealing with emotional trauma.

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Social campaign to reduce stigma and discrimination towards mental health.

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One thing clients ask for is a reduction in stigma - particularly re impact on employment & childcare.

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We also need the government to raise awareness and education on mental wellbeing through the media. Our education systems need to teach young children and people how to adaptively deal with their emotions. We need to reduce self-harm and suicides. Teaching mindfulness and self-compassion in all schools would be a good start.

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Education that mental health should be treated the same as physical health - perhaps don't even separate it, it's all health and we need to remove the stigma associated with getting help.

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Some of the clients I work with are addicts and they feel judged and ostracised by the clinicians who work with them. The police are also judgemental and have low expectations for their recovery. My particular work addresses the 'why' of the addiction and helps clients find meaning in recovery.

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Continue the program of public education around mental health.

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People need to be taught that they should acknowledge what they are feeling, deal with emotional losses, deal with emotional trauma, and become empowered to live meaningful lives. People use substances to numb their uncomfortable emotions because they are not equipped to deal with their emotions. They need to be taught to do this. Psychologists are ideal to do this. Attempting to teach people to "think positive" is not effective. People need to be taught to face their hardships AND how to conquer them. This is what happens in psychotherapy. The new government needs to hear this message and make funds available to appoint more psychologists to make this service available to more people.

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Education, education, education. Also recognition of effect FASD and impact of other drugs on fetus. Hence education of the effects of smoking, alcohol and drug usage on the fetus and its long term life long effects so we have a more educated conscious group of socially and morally responsible adults.

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Increase the awareness of the importance of self-reflection and effective psycho-therapy - to the public but also to all team members working within the mental health services - nurses, social workers, doctors etc.

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Education (Kirwin type ads/ other means than TV) of public about what to expect in services/ how people get better - Nigel Latta perhaps could do a series on moving recovery forward. DN longitudinal study was helpful on TV to explain why problems develop. Also make these continuously available after screening on appropriate websites.

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Education and raising awareness of the negative impact of substance use on

mental wellbeing.

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Teach people skills for coping with stress as night classes.

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Public health campaigns.

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Media campaigns aimed at mental health – embedding different ideas regarding mental health, that it's okay to reach out for help, reduce stigma associated with help-seeking behaviours and therapy.

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BETTER FUNDING, STAFFING AND SERVICES IN DHBS

Significant investment in the specialist mental health services of District Health Boards is urgently required. We need to set minimum staffing levels in secondary mental health services linked to population and need.

Increase funding to match population growth and the rise in mental health problems. E.g. research shows that in the past 20 years the rate of anxiety in youth has doubled. Better Funding, Staffing and Services in DHBs.

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Proper population based funding to meet recognised needs with treatment that is effective and desired by the community.

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Better funding and better staffing in community mental health providers, especially for children and adolescents so that intervention can occur earlier.

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Invest in rehabilitation services like those available in forensic services to stop the revolving door that defines adult inpatient areas. Put psychologists, social workers and OTs back in these wards full time so that intervention for those admitted goes beyond pills and ECT.

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Adequate staffing and funding so that biopsychological model can be practised as intended.

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There are many things I can write but believe me, it's very simple. You may write fancy reports, make wonderful flow charts etc but the answer is very simple - You need to recruit more psychologists! Why? - It is straightforward. Which mental health professional can cater to vast amount of mental health issues?

What do patients demand? More and more counselling and psychotherapies rather than just drugs. It can lead to long term solutions rather than dependence on drugs.

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More staff in specialist mental health services. I've seen increased staffing in community agency settings, and moves to outsource work from our specialist services, but no talk of extra staff at the specialist end that I have heard and we are drowning in the work at the specialist end.

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More paediatricians and child psychiatrists need to be employed so that they can intervene earlier and waiting lists can come down.

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Recommend specialist trauma services where services can actually be based on research and best practice – i.e. trauma informed services. Trauma informed services do not fit with medical model and Mental Health Act focus within mental health services so perhaps would be more realistic to have separate services that can be easily accessed by those needing it.

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Adequately staff our services to meet demand without causing burnout and contributing to high turnover and loss of expertise. Widen service criteria to allow mixed severity caseloads and improve accessibility. This will require even more staff. Ensure specialised services are established for ASD and FASD. Ensure services include psychological therapies alongside social and physical health initiatives so they are truly holistic.

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Provide much, much more psychological support for clients so that they can receive appropriate assessment, formulation, validation, insight and skills to move forward and through their problems. This will also enable them to become independent on their journey of mental health, rather than dependent on a system that continuously seeks to provide minimal support and creates 'revolving door' clientele.

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Explore ways of providing specialised residential care to young clients with complex presentations whose parents are unable to care for them and who do not meet criteria for existing residential & respite care facilities.

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Open up ACC sensitive claims funding to include physical trauma and neglect. This would make a huge change, yes it would cost a lot but it would save a huge amount in the future. I have lost count of the number of children from low socio-economic families who have been exposed to trauma but there is no clear account of sexual abuse, but clear developmental trauma or PTSD and there is no support available to the children. I have seen these children re-enter the service at a later time and I have assessed adults within mental health and forensic settings who had early life trauma and no support. This is a huge problem in a country with our rates of abuse of children and child poverty. Alongside this is the lack of psychologists, and therapists in general, working for the DHB so that they do not have the capacity to provide trauma support for anywhere near the number of children that require it. This is a stark failing of this country.

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Adequate staffing to meet demand and safety, less pressure on staff as huge caseloads leading to burnout and poor staff retention, high staff turnover putting pressure on remaining staff.

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DHBs to look at balance of disciplines in community and hospital teams e.g. most adult teams are nurse heavy compromising their ability to provide diagnosis therapeutic work. Consider funding specialist teams in areas of high demand eg ADHD ASD DBT -re suicidal youth.

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Please don't use an Inquiry as an excuse to deflect blame away from lack of resourcing, onto the staff in mental health or even management, in mental health.

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Mental health services in South Auckland are in a dire state. There appear to be significantly more psychologists working in ADHB compared to Counties; the needs of the different catchment areas are substantially different and yet we don't have this acknowledged in the expertise and quality of staff working accordingly. Further review of how different DHBs are operating and providing services to their people is needed.

Improved alcohol and drug detox availability. Cannot stress enough that we need more staff in specialist mental health services to cope with the unprecedented demand we are seeing, particularly in CAF services in Canterbury.

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Our drug treatment services are inadequate compared to the demand. We need more services and more help for families who struggle with the problem. Consider better early identification systems, perhaps at schools and through primary care services.

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More staff in specialist mental health services.

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Appoint more psychologists. Psychotherapy addresses the core of where mental health problems come from.

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Fund community mental health and ICAFS/CAMHS services much better, and make sure professionals employed there are looked after so they don't burn out (which leads to high staff turnover, which interrupts service delivery and breaks relationships).

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In Canterbury, improving access to Brief Intervention Counselling and perhaps developing other, subsidised access to clinical psychologists for the treatment of mental health would be a great start. Increasing staff and funding for psychologists working in tertiary services would also assist in treating a number of people who need our service.

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Resource many more staff so clients are seen earlier, and so staff have the time to actually plan treatments and manage cases, rather than just rushing from appointment to appointment.

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Easier access to therapy. Not just seen for an assessment and then put on a list for ages.

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Significant increases need to occur in staffing of secondary mental health services particularly in South Auckland where there is significantly social deprivation and disparity in health outcomes for Maori.

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Fund the DHB mental health services appropriately.

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Provide additional funding and address the serious deficit in salaries for qualified clinicians.

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Improve staffing levels in MH services. We are at a point now where staff can no longer "work smarter not harder" to accommodate the rapid increase in
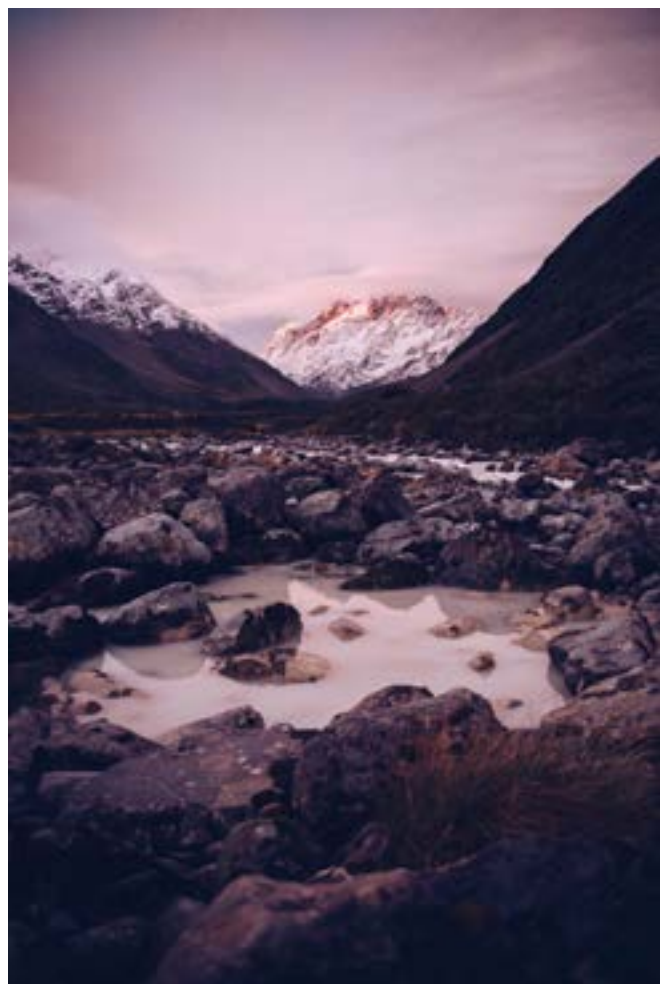
demand for mental health services.
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More funding, employ more psychologists, offer more individual therapy (rather than only groups), enable people to access services earlier on e.g. not when they become the most unwell.
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Overall we need significantly more funding and support for clinicians to better support our clients - and significantly more psychologists employed in the sector. Our clients are suffering because dedicated staff are suffering under untenable working conditions.
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Fund more positions in mental health, especially psychologists, where this specialist role is under represented in public mental health, and does not match evidence based practice.
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Increase funding to the mental health sector to ensure more psychologists

and other suitably qualified staff are employed so services can meet demands with reduced waitlists and to ensure that individuals with moderate mental health issues are still seen with intervention options.
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Provide funding, and ensure it is funnelled into the right services so we

have the resources we need to do the job of treating and caring for our patients.
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Providing more funded treatment for addictions and developing a capable workforce of competently trained mental health professionals, including psychologists, social workers, occupational therapists and educational specialists to address the range of needs.
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There are no shortcuts. We need more funding and FTEs, in order to provide a, safe, ethical and effective service to our community.
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More funding for services.
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Funding. Most DHBs are actually run adequately, if they had enough funding to do so.
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More clinicians are needed
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Smaller caseloads (more staff).
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We need more qualified staff.
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More psychologists! Psychologist led psychotherapy (not half trained other professionals with variable supervision).
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Increased psychology FTE in all areas.
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More staff and more provision of psychology specific FTE within mental health services, to be doing specific psychology work. Psychologists in CAF services are case managing where they do not in adult services, resulting in a lower net provision for psychology in CAF services. There also needs to be a service for providing publicly funded learning assessments. At this time in Canterbury, neither the MofEd or CAF are doing this, so children are missing out whose parents cannot afford to pay for this testing, and this is a likely factor contributing to many children's school related behavioural difficulties.
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Increase FTE.
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More psychologists.
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Employ more staff to help cope with the increasing numbers of referrals.
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We need more psychologists and other types of therapists to offer more individual therapy and consultation to teams.
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Look ahead to where the future needs lie. In my region, the 65+ population is projected by Stats NZ to increase by 12% between now and 2026. And it will continue to increase. We know that there will be more older adults - we need to prepare for this fact. Research indicates that psychological interventions work well with older adults so input into this area equals investment, especially considering that there might be fewer individuals of working age. It's hard working in an organisation where child and youth are provisioned with almost 14 times more psychologists than older adults. Taking it in context, older men are amongst the most at risk of suicide too.
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There has been a long history of service cuts and underfunding across mental health and addiction services. More funding is needed instead of trying to make existing allocations stretch across increasing demand. In particular there is limited availability of psychology in both areas, despite extensive research evidence into the necessity of psychological therapy for long-term improvement across mental health and addiction.
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Increase in staffing in mental health (currently 1-1 1/2yr waiting list for some diagnosis such as ADHD/FASD).
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Ensure DHBs are adequately funding mental health services to account for population growth. Staff are currently faced with greater complexity and acuity of cases and high caseloads and this is not sustainable in terms of staff burnout and providing interventions that are safe and effective - best practice evidence based therapies. Either services are funded adequately, or services are remodelled to only offer assessment or brief intervention for example, in order to cater for the demand. However this would not be effective, and only putting a 'band aid' on things.
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More staff, overhaul processes - go back to basics of providing quality care. Realistic expectations regarding waiting times. Protecting specialist services as such and supporting with

other services to meet the needs of those not meeting criteria.

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Increase number of mental health workers. All recent funding seems to have gone to primary health. This fails to acknowledge number of people who already have moderate to severe mental health problems. Need to significantly increase funding to secondary and tertiary services. Will take some time to address the issue of reputation of services - ours used to be seen as great place to work - now has reputation for high stress and burnout - many senior and mid-career staff have left, leaving very junior workforce.

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Make up for the neglect of health services by the Nats.

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Recommend more funding / focus on areas of specialty rather than requiring adult mental psychologists and other disciplines to be generalists, i.e. youth service (up to 25yrs) and older adult services.

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Increase staffing so evidence-based treatment can actually be done!

Increase staff working in front-line mental health initiatives. Ensure DHBs are looking after their staff so senior staff can be retained. Ensure DHBs are prioritising comprehensive assessment and evidence based treatment, rather than initiatives that are unlikely to work for moderate to severe mental health problems, such as brief assessment and intervention.

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Employ play therapist and specialist child trauma therapists.

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Increase access to evidence based psychological therapies (e.g. reverse the trend that medication is tried before therapy).

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Making wait list shorter (particularly for drug and alcohol rehab).

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More psychologist roles - able to see more people.

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More clinical psychologists.

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Ensure that there is an increase in psychology FTE.

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Increasing staffing for psychologists in all DHB services.

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Have greater staffing numbers in mental health services to meet the need and provide evidence based treatment in a timely manner.

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Significantly more staff, especially specialists like psychologists, who have generally studied mental health for longer than any other profession. A social worker or nurse cannot do the same job as a psychologist, only ever a close approximation.

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Increase the availability of psychotherapy. Starting off with more psychologists, group therapy, and easier availability to individual therapy.

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If a service has waitlists of six months or more, it is probably not staffed enough to meet demand - maybe look at more funding instead of trying to strictly enforce targets that clearly aren't working.

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Youth specific services, which would also address specific needs of LGBT youth community. Trauma informed services that recognise and address the central role trauma plays in mental health difficulties. ACC would cover

psychological therapy for all types of trauma not just sexual abuse (i.e. physical and emotional neglect and abuse). Secondary MHS that are adequately funded, rather than consistently under resourced and understaffed to meet the needs of the growing population

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Our CMDHB is in a complex mess. The changes that the management has made have led to enormous issues, hence the complaints in media and HDC. Can you imagine one psychiatrist on duty over the night and has 120 patients on crisis board? What do you think can happen?

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Funding that takes account of population growth and changes.

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Employ more psychologist to address need for especially child trauma counselling and play therapy and decrease unqualified staff from carrying out professional services

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Need vs staffing levels vs population estimates need to be looked at.

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Increase accessibility of funded psychological services for older adults, Asian and other cultural group.

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Help us do our job by providing the resources to help improve the lives of our patients. Right now it seems like mental health in the DHB is being ignored and devalued.

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Psychology hours. There are services that are best performed by psychologists that are currently not occurring because of the lack of psychologists in services. It is scary that MOE in Northland are not doing cognitive assessments and DHB have a two year weight list to do them. This is unacceptable and would be preventable if there were more psychologists hours available for both services.

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Provide more psychology FTE for acute inpatient units so that psychological interventions can be started to help service users in their recovery from an acute episode, for example, how to self-regulate and better manage suicidality and drug related problems. This work can also help relieve the pressure on psychological services in the community.

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Expanding on mental health services for older adults to match the needs in the growing ageing population.

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Provide more psychology FTE for community mental health services so that meaningful psychological work can be accessed by the majority (rather than

the minority) of services users. This will reduce waiting time for service users who are often waiting for six months to see a psychologist.

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Resources (number of employees) need to be increased substantially, supply is outweighing the demand. We need more doctors, nurses, OTs, social workers and psychologists.

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Mental health services are chronically underfunded and staff are under-valued for the work they do.

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In our area, South Auckland, the significant population growth has not been met with any increase in funding, which is the primary problem in delivering the necessary service.

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There also needs to be more funding put into mental health services where staff are currently pushed beyond their capacities and are steadily burning out and leaving the workforce.

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Provide greater access to physical health professionals across all DHBs (i.e., on site access); Physical health / exercise is associated with improved mental health outcomes and is largely incompatible with using illicit substances and has a strong research base.

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Dramatically increase the budget (and staffing) for the mental health service.

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Depending on the area where clients live, they may or may not be able to access mental health service even if they are under the same DHB. For example, a client may meet criteria for service or psychological therapy if they live in the North Shore but if they move to Henderson (still under the same DHB) they may not meet criteria for service given the lack of resources, lack of staff members, higher criteria given the acuity/severity of mental health presentation. These clients may also have to be assessed again to see if they can access talk therapy which is very frustrating, and affects the continuity of care for them.

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Resource for provision of more highly skilled clinicians particularly in tertiary mental health services.

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Develop secure (tiered hospitals): low, medium, high rather than sending everyone to prison, which also captures those at risk who can be stopped from, say, violence by treating underlying conditions. 2. A major overhaul of women's services: there is a phenomenal amount of sexual abuse and violence in society and many women are not safe at home even, and this can start in childhood. It is not good to avoid facing this blatant fact head on (I am aware men are affected to but with sexual abuse I would say it's still disproportionately women: so PTSD/BPD is common). 3. Young Maori/Pacific island men: research the reasons and put safeguards in place. I hardly have any referred to Psychology. Am aware many will go to designated services but there are not often psychologists involved. 4. A huge change in the risky and negative culture of many DHBs re. mental health is required. People who love working in the mental health field are leaving in droves and that, and lack of structures leading to chaos, is why.

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Greater access to therapists / psychologists / programme facilitators / on-site researchers or research assistants through increased FTEs. Comparability of resources available across DHB hospital sites (e.g., gyms / rehab equipment, onsite café, therapy rooms with audio-visual capability / fit for purpose). Community-based residential facilities allowing supervision from nurses / psychologists with a secure funding stream able to be accessed by forensic psychiatric services. Development of employment options for forensic mental health service users in different locations and fields of work

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Increase staffing across the board of specialist mental health service. In Christchurch there has been additional intervention into every school at an NGO level. This will continue to put pressure on an already pressured specialist service.

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The previous government has not kept up resourcing in the DHBs to match the increase in a) population and b) public education and expectation around getting help with mental health. I have worked in a DHB for 20 years, and I have seen various governments come and go, and have seen the increase in resourcing under the Helen Clark government, and then then seen the decrease in resourcing under the John Key government. The same excellent staff have worked in the system, but now they are expected to do twice as much with twice as many clients coming through. Staff burnout is high and morale is at an all-time low. There is nothing wrong with the existing staff or how they do things (they know exactly how to make unwell people better) - they simply need more staff hired to do the work. And to get those, one needs to train a) more psychiatric nurses and b) more clinical psychologists. This takes funding and commitment from the government. Don't fix something that isn't broken!

Just do the maintenance work (correct funding) to make sure it doesn't continually get run down until it finally does break.

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In DHB systems referrals are rapidly increasing in numbers and complexity and the workforce has not changed to accommodate this change. There needs to be more funding and staffing as well as consideration of staff mental health which is impacted by the work.

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Fund community mental health teams to ensure they are resourced with adequate FTEs.

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There needs to be more funding and support in secondary mental health services such as DHB community services who seem to be flooding currently.

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Fund more FTE for psychologists.

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Increase FTEs for psychologists.

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Increase funding for Psychology positions in secondary services; insist on ringfencing around existing funding, so middle management do not use process of attrition to deplete the services even further.

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Look at better funding and resourcing for psych geriatrics to future proof increasing numbers of elderly.

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The government could provide funding for supervised (24/7 in required for safety) community placements for those individuals with intellectual disabilities (including those in the 'grey area' that do not strictly fall under the IQ = 70 cut-off) and co-occurring mental health difficulties. A working group set up through forensic psychiatric services might provide a basis of what would best support these individuals who may not be appropriately placed long-term in forensic mental health services, but for quality of life and to ensure human rights are upheld are overseen with support, boundaries and compassion in a community residential placement.

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We get a lot of people who are unable to manage their mental health recovery due to poor follow up by services and having the social supports such as adequate housing, and access to work (or volunteer and recreational opportunities). More funding and resourcing.

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WORKFORCE DEVELOPMENT

Ensure clinicians working in mental health receive comprehensive and robust training both during their formal study and throughout their career. Create stability of workforce supply for psychologists through investment in internships and support for new clinicians.

Upskilling of mental health staff who do not have a required level of knowledge/experience in delivering low level psychological therapies.

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With more training we need an increase in paid internships for clinical, health, and counselling psychologists.

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Western-models and schools do not counter racism. Earlier intervention through teaching at tertiary levels for future teachers to understand the basic psychological needs of their students from a cultural perspective. This quote from Tariana Turia says a lot "As psychologists you frequently have as your clients, Māori people. The challenge I put to you is: Do you seriously believe that you with the training you get, are able to nurture the Māori psyche?" Current training programmes in tertiary institutions that provide mental health/psychological training do not meet the need.

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More training and support for new clinicians.

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Front line staff are not adequately equipped to identify and respond to mental health and drug related behaviour. Police, social workers and teachers (and even parents) should know much more about these issues and how to respond to them

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More focus on workforce development.

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More learning and practical opportunities for the individuals without too much worrying about what if "it was failed", whose taking the responsibility?

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Look at training institutions and develop better more fit for purpose education for nurses, Social workers and OTs but also allow them to use their discipline specific skills.

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Increase funding and training of all disciplines.

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More funding for ongoing training for all disciplines (not just for doctors).

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Give more power and funding to services such as the Werry Centre to ensure evidenced based practices are consistently and effectively provided in CAMHS across the country. In addition, providing resourcing for evidenced based training for staff employed in MHAS that is adequately supervised following completion of the training. Look at what works with services such as the Children's Teams, HCN and IWS and take the learning and apply it more widely to whanau and tamariki.

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We need more funding for training and more qualified staff! And by qualified I don't mean just any qualification in the health sector but mental health specific qualifications.

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Provide funding that ensures qualified staff have the skills listed in the Real Skills guidelines listed in the Werry Centre guidelines. These skills should be compulsory and training automatic for staff before working with clients in an infant, child and adolescent mental health service.

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The government needs to invest in education for nurses, social workers and occupational therapists to have training so that they come to the DHBs with skills fit for purpose.

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Develop psychological therapy career paths for nurses, social workers and

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occupational therapists.

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Create scholarships to stimulate interest in the profession and reduce barriers to specialised training.

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Greater use of professionals like clinical psychologists in consultation and supervisory capacities.

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Upskilling of staff and making sure they have training and appropriate qualifications before starting the job.

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We need more funding for training and resources.

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The vast majority of people working in this area are very motivated and invested in their jobs, and they do this work in order to help people. These clinicians need to be trained and resourced in order to do this effectively.

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through collaboration on Children's Teams with allied services nurses, social workers, occupational and educational services. The children's team approach is an excellent approach which is also under-utilised and underpins a community approach. Effective implementation in mental health services is compromised by diluting skills (using spin rationalisation) to reduce costs. The service will be as good as the resources. Theatres and surgeons needs would never be compromised the way mental health is compromised - because you can't visibly see or measure emotional pain. On discharge from surgery the amount of medication available to manage pain is incontestable, not so with the treatment and resource consequences for emotional pain which apart from medication is better mended through relationship therapies.

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More funding for training and resources.

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Good training opportunities.

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The Ministry of Education have over the past ten years increased the number of psychologists as opposed to special education advisors and expect this has improved services in education intervention for children with special needs. The reason is (if you remove cost from the equation) psychologists are trained specifically for this purpose, as are psychotherapists who have excellent training.

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Psychologists within MoE also need better access to Professional Development, particularly with a focus on trauma.

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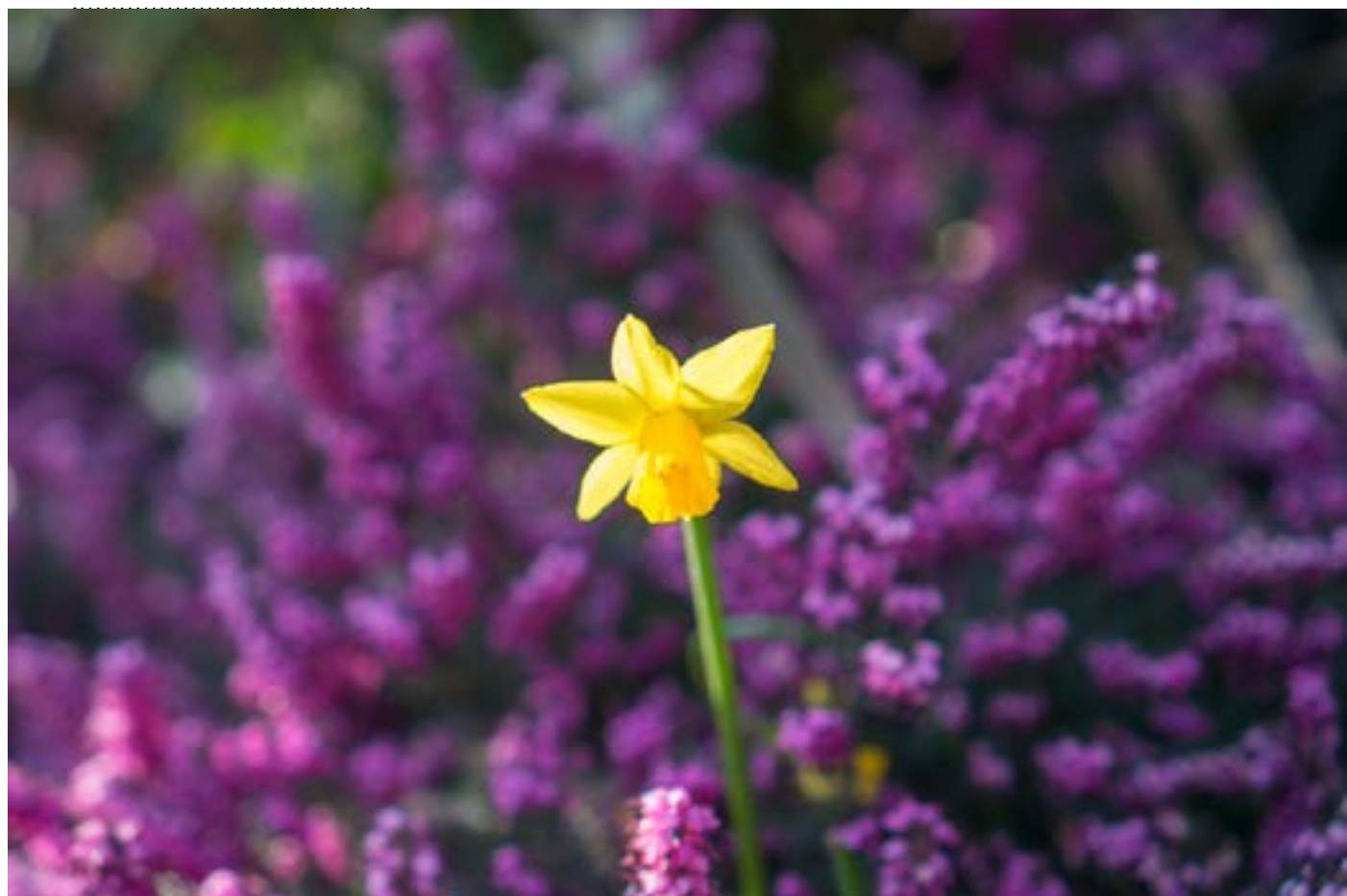
Mental health is psychological health at a secondary and tertiary level and requires a specialist service and mandatory range of skills among the staff.

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Skill level of staff. Child and adolescent mental health services should be staffed with registered clinical psychologists, registered child & adolescent psychotherapists (an under-utilised profession) and psychiatrists. Collaborative practice can be effected

External PD for whole teams to be up skilled.

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Sharing of skills/knowledge within different professions on a more regular basis.

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Increase number of skilled therapists and utilise disciplines as such, rather than working towards generic roles.

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All staff working in government services, like WINZ, justice, housing etc should be properly trained in the basics of mental health issues and compassion in order to deal with clients in a humane way. This also includes ACC staff. In addition ACC needs to operate from a trauma informed care model and have a senior psychologist well versed in this model overseeing the process - at the moment it is a neuropsychologist who knows little about trauma.

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Psychologists of all grades are doing the same work: seeing 1:1 clients. Doesn't work for obvious reasons. **We should be supervising less "expensive" staff in transferable skills and training more.** Or the government should make access and scholarships to study rather that recruiting overseas psychologists (who find it a shock to the system due to being so disrespected/haphazard). I spoke to Maori students who said they could not afford to continue after year 1 in their studies! I'm sure this happens with other students too but clearly you have high rates of suicide in young Maori and Pacific Islander males but hardly any trained psychologists from these backgrounds because statistically you are more likely to be from less wealthy families if you are in these groups (legacy of colonialism).

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Paid internships for psychologists ring-fenced at each DHB site.

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Invest in better training for staff, including in things like proper formulation, compassion focused training for organisations and positive behaviour support for inpatient units to prevent abuse of clients.

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Encouraging on going advancement and specialization for all health clinicians. So they can legitimately call themselves specialist mental health.

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The government could provide ring-fenced funding for paid internships for trainee psychologists in the DHBs. They could provide a competitive salary to ensure money spent on training early career psychologists is not wasted when the move to an area which is willing to provide a higher salary.

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Change needs to occur at the training level of professionals (social workers, occupational therapists, nurses etc.) working in mental health – more emphasis and quality training in mental health. There is very limited training for allied health professionals in relation to mental health. I work with allied health professionals who often have limited skills and knowledge in working in mental health. If we wish to model services overseas, this also needs to be reflected in the training programmes – we cannot sustain nor replicate services overseas if we don't have the same level and rigor of training.

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More funding for training mental health professionals including clinical psychologists and psychologists. For example, currently clinical psychologists in last year of training may not receive paid internship which means that students who do not have the financial or family support are disadvantaged from entering the training programme. Review the student allowance criteria - currently postgraduate students above the honours level are not eligible for student allowance - again this affects who and the number of people who can specialise in mental health e.g. psychologists/clinical psychologists.

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More funding and resources to prevent staff burnout. Increased financial support for staff in Auckland to combat higher cost of living. Services have junior staff and senior staff, but not many middle level clinicians. In the past month 3 clinicians have resigned from my service to move out of Auckland because it's cheaper. Hard to recruit any experienced clinicians. DHBs to advertise on Seek and Trade Me jobs not just Kiwi Health jobs that no-one out of NZ would know about.

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Invest in training psychiatric nurses to do basic skills work with clients e.g. DBT training for emotional regulation; behaviour scheduling for mood management; anxiety management skills. Referrals to Psychology can then be for when this is not working, and there is a level of complexity that needs the more indepth training that Clinical Psychologists have.

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The lack of trained clinicians competent in cognitive, behavioural, family, and occupational therapies appears to be exacerbated by a 'case management' model of care. With reliance on medication, the nursing or allied health clinicians allocated as case managers appear to hold the expectation that they provide 'management' and support rather than intervention. There appears to be support for clinicians accessing short training courses in specific interventions, however, these are typically insufficient for competence and are not followed through with appropriate supervision. I believe multi-disciplinary team approaches are useful when they support the provision of specialist intervention by multiple disciplines. This is not currently the case. Rather, the current design is for clinicians to work generically providing case management without specialist intervention. Greater emphasis needs to be given in recruitment to employing clinicians competent in providing appropriate assessment and intervention.

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Stop investing in the medical model and psychiatry as the primary group who have all the control and power. Allow other professions to train as responsible clinicians. Increase the number of psychology FTE in mental health with pay parity and a system that ensures psychologists have the skills and expertise equivalent to psychiatrists.

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Stop having para-professionals such as nurses and social workers providing psychological services such as assessment of psychological needs of children in child and adolescent services.

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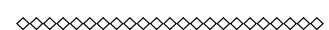
BETTER WORKING CONDITIONS FOR PSYCHOLOGISTS AND OUR COLLEAGUES

Our psychology workforce feels burnt out and demoralised. Uncompetitive salaries, unsafe working conditions and unmanageable workloads are causing attrition of long-serving and experienced staff.

I recommend that both DHB and MoE seriously look at how they can improve working conditions for their existing staff, so that they can increase staff retention, and decrease staff turnover and burnout. The essence of any intervention is the relationship, and people get into these roles because they are passionate about helping. The big government organisations need to focus on looking after them so that they can look after their clients, and delivery quality over quantity in their work.

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In health we have had very small wage increases over a lengthy period of time. This is making our professions less attractive to the next generation and the workload and burnout is known and also contributing to our professions being less attractive. There are some very good people doing amazing work and this needs highlighting and valuing (both through pay and through other methods).

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If the psychology workforce for the future is to be developed/expanded these clinicians need to feel valued by the system in which they work not just their clients and families (which they often do). This not only includes a recognition of what they actually do - many managers remain unaware of or don't care enough to find out, pay discrepancies between DHB's and Department of Corrections for example and ongoing acceptance of this by DHB's, when experienced clinicians leave the mental health services this often relates to dissatisfaction with systems and feeling undervalued but no one ever asks these questions or tries to address this issue.

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Better pay for mental health practitioners to attract and retain the best.

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After years of neglect and underfunding services are stretched to the absolute limit. Staff burn out and fatigue are a real issue. Ensuring and allowing for appropriate support for staff too is essential.

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My current work environment is toxic as I am being told that the pressure and stress is a product of my own working practices. Management refuses to verbally acknowledge the growing caseloads/acuity, I cannot prioritise my clients care the way I'd like and I believe clinician turnover is a major issue. We are losing a number of experienced clinicians to private or overseas work.

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Attract and retain well trained psychologists, OTs, psychotherapists and other professions committed to understanding and addressing mental health (i.e. psychologically minded). Similar pay scale for DHB psychologists as Corrections and ACC in order to attract and retain psychologists.

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In DHBs, psychologists often burn out due to excessive caseloads, and leave for much more lucrative and less stressful private practice. We are left with dedicated older clinicians, but fewer all the time as they are expensive to employ, and are often 'encouraged' to depart; and younger less experienced psychologists, who often do a couple of years then leave.

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In my DHB (and presumably in others) we have struggled to recruit nurses to work in community mental health teams as they can be paid significantly more working in inpatient units with shift work and overtime. This is despite significantly more responsibility and management of risk in the community. This needs to be looked at urgently.

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The government could look into increasing the pay at all levels. This could be one of the reasons private practice is preferred over working in government agencies.

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These jobs are challenging and difficult and remuneration for allied health staff and nurses, especially those living in Auckland is significantly low, this should also be reviewed. The impact of this is evident in number of senior employees, especially psychologists who remain in DHB roles - this has a significant impact on level of care people receive as well as

training and development needs of newer psychologists.

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There continue to be serious deficits in pay rates for qualified staff which does little to encourage new people to join the profession.

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Psychologists get fed up with the system and hence they leave to work outside and overseas. You just have to see the demand for psychologists and the positions available. It's so simple. Our patients just respect, admire and appreciate our sessions so much which keeps us going. Simple recommendation - just evaluate how many positions are needed per head. Calculate the ratio and see how under resourced we are. Secondly, compare the psychologists pay with any other developed nation. For e.g. Australia pays 30% more than NZ.

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Flexible working conditions (part time, job share, better support when returning from maternity leave).

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Psychologists mostly working for part times due to dissatisfying salary.

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Good working conditions and lower caseloads for staff so they can respond to need remain compassionate and not be burnt out by the sea of need and being able to do a thorough job not once over lightly.

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Pay psychologists and other staff more.

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Most psychologists working in the public sector "burn out" due to workload, stress, and expectations to fix something (that one person cannot do) and other issues, which leads to short career life in this sector where unfortunately our most vulnerable people are and their needs are highest. Better pay and recognition of psychologists is also a factor in terms of work satisfaction and longevity. The hierarchy of different professions within services is evident which can lead to feeling lack of respect and being valued as a profession despite considerable expertise and training.

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Two of our best staff resigned in the last fortnight. The latest said she wishes she could keep doing this work, but she "can't take it anymore" with the unrealistic workload, high acuity, and administrative systems that discourage us from following our best practice guidelines. There is a staffing crisis and it is getting worse.

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It's a bit broken. So many staff so few with excellent skills and passion, such

poor morale. So sad for clients.

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Value of current staff, many highly skilled and very knowledgeable, need to retain workforce to continue to develop an effective mental health services.

Maintain workforce with better pay for mental health workers, more annual leave, more positions.

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Show some form of appreciation for us who decide to stay in DHBs.

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Valuing clinicians particularly senior clinicians with salaries commensurate with their level of experience

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Pay mental health workers enough that it's a viable career.

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More funding - current caseloads for services do not meet the increasing demand. Pay parity between the two in itself does not draw the needed psychological staffing to MoE (little incentive to join OR stay for very long - undervalued/ overworked).

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I would like the needs of the clinicians taken into account as we strive to deliver a quality service under difficult circumstances. I would like more flexible work hours so I could juggle dependent family and partner- illness more effectively, as well as a decent salary increase.

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Endorse and value the work of Psychologists and make sure they have the tools to do their work

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More pay and respect for psychologists so we don't lose them to the private sector.

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Psychology workforce within many DHBs remains static whilst demand for high quality psychological therapy is increasing, combined with DHBs being less popular workplaces increasingly due to a lack of competitive pay is very concerning for the future of psychology in DHBS. Psychology interns are not supported anywhere near as well as medical and nursing students.

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Equal pay between education, DHB and Corrections. Better funding of training. Decrease in work load by increase in staffing.

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Overall staff need to be better supported with lower caseloads and more resource to support their clients to prevent staff burnout and loss of compassion.

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Better career prospects.

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Improving career development for psychologists.

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Many psychologists leave the DHBs due to burnout as the pressure and workload is unsustainable. This lack of retention of experienced psychologists results in even less psychological resources for services.

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More pay to stop people moving to private practice.

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Pay parity across government departments.

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More positions to reduce pressure of caseloads.

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There needs to be a focus on staff retention as change cannot happen without consistency of skilled and experienced staff in services

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Health is wealth - so within the services promoting wellness programs for the individual staff working could be a way to promote wellness among those who offer services. This is because every single human being is going through something in life. So de-stressing and relaxing in between is crucial to offer improved services to the community.

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Employ more psychologists and pay them more, so that they can use their specialist skills to provide evidence based treatment that is often not provided currently due to lack of psychologists and lack of recognition of their value.

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Lack of experienced psychologists as many leave the DHB due to poor pay and high burnout etc. Retention

of psychologists a significant issue across the country yet DHBs make no changes to address this. Psychologists have clearly indicated that they are undervalued, not appreciated, underpaid, not respected, and high levels of bullying. Other professions/disciplines have lack of awareness / understanding of the emotional investment required to deliver such intensive psychological interventions (i.e. complex trauma). Therefore not only are psychologists trying to cope with significant work demands that are often unsustainable, they are also unsupported by managers who do not understand their work.

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Ensure caps on caseloads so that staff wellbeing is maintained and burn out is reduced.

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In Auckland public mental health services are finding it increasing difficult to employ experienced clinicians, and many clinicians are moving to more affordable areas - have extra money for staff living in Auckland to combat increased cost of living.

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More work needs to be done improve the working conditions of those working in mental health, to increase staff retention and decrease burn out.

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Better pay and conditions for staff, more staff - leading to less burn out, less staff turnover and retention of experienced staff.

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It needs to be more appealing for Psychiatrists and Psychologists to remain employed at DHBs. As it stands much less stressful, more highly valued employment, with better remuneration is available elsewhere.
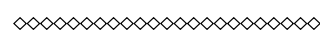
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Psychologists are treated badly. Do a survey to all Psychologists within DHBs. APEX surveys are quite damning already. It is not worth the personal cost although the patients are wonderful. There will be a crisis with regard to this but because specialist therapies are rated by patients but so underrated by

organisations/the government I think it will reach crisis point with mental health and an incident before change will occur.

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Capped caseloads (including number and complexity of cases) – to ensure that clinicians can maintain a quality of practice without burning out or reducing capacity to provide quality service. There needs to be incentives for good, quality, hard-working staff to be working in mental health. I don't believe that just more jobs would be sufficient in helping meet the unmet needs of the mental health/additions services alone – you need to incentivise clinicians to work in mental health. Such incentives could be reducing student loans of those working

in mental health, increased salaries (I can work in Sydney for $40,000 more per year), more paid leave.

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Endure clinicians are well paid and cared for… It's stressful work and there is too much. Care and appreciation go a long way to workforce wellbeing.

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Better pay and conditions and number of staff, increase retention. This leads to better provision of services. The service I work in literally is at crisis point.

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Make pay competitive with private practice / department of corrections psychologists - Consider pay adjustment for psychologists working in rural areas or areas where the cost of living is high - 'Ring fence' and provide paid psychology internships at all DHBs - Advertise for vacancies immediately following resignations and streamline the process to reduce common practice of vacancies being unfilled even 6 months after a new employee has accepted a position due to holds ups in the system 4. Consider options to develop the local psychology workforce from the point of training in Universities. Provide a specific focus on support for Maori, and also pacifica individuals to have the financial and cultural support required to train as a psychologist; This will fill a much needed gap with for example less than 5% Maori psychologists.

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An increase in funding for cultural workers and cultural supervision. Designated funding for interns within DHBs.

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Undertake an impartial comprehensive review of why so many nurses on acute wards in the mental health service are getting assaulted

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Consider issues around remuneration to retain skilled psychologists.

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Better provision and funding of staff training. Doctors are the only ones with guaranteed funding that they decide on how they spend it, computers, books, overseas conference and training while the rest of the staff have to fight for training and be out of pocket with hope of being refunded.

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While I understand there may be initiatives aimed at increasing the number of nurses working in mental health in schools, many nurses I know do not want to work in mental health due to the high emotional tax of the work, and less pay than shift work offered in other roles.

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We have high staff burn-out rate and low staff retention. High staff burn out inevitably affects good practice. Our Psychiatrist has resigned after 6-7 months of being in our service. I am personally leaving after one year, due to the impact that working in this service has had on my mental and physical health, as well as how difficult it is to work alongside unsafe and poor practice on a daily basis. Further, due to the underskilled staff in the service, new staff employed feel a lack of support and guidance in order to work effectively and safely in the service. Due to the high caseloads, high referral rates and other significant difficulties facing the service right now, performance management of poor and unsafe practice falls to the wayside.

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We are as a service unable to attract skilled (or even early career) psychologists / therapists due to our poor working conditions and facilities, lower pay relative to Dept. of Corrections or compared with private practice.

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If people were paid decently and felt supported/valued in their work, there wouldn't be such a high burn out rate and the most skilled clinicians would be attracted to this work, instead of going to work privately.

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BETTER WORKPLACE FACILITIES

The quality of therapeutic environments and facilities has a significant impact on patient and employee wellbeing.

We also need new purpose built facilities that are child and adolescent friendly, and in suitable locations. A child service right next door to a long term residential service for older adults with severe and long term mental health difficulties is not okay, and does not promote client safety or confidence.

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We need better buildings, with therapeutic environments, welcoming decor. We often run out of therapy rooms, three services are squashed into one office. We need updated computers, proper cell phones, computer programmes for scoring psychometrics efficiently, reliable clocks, the small things that make a difference.

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Better facilities for specialist services that are appropriate for client ages, needs and safety.

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Office space, clinic rooms which are not leaky and have sufficient heating to be first, rather than third world.

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Strengthen teams by resourcing them with the tools for the work - cars you don't have to beg for, computers etc, resourcing for groups and to see people in the community. Allow us to do our best work rather than battling the system.

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Work spaces need to be improved, to assist the mental health of psychologists in these services. Poor, substandard and temporary conditions have been endured post-earthquake with no future changes made clear.

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Showing value for mental health services in many ways including ensuring we have the resources and space to do our work - this also includes healthy and safety building and the means to do more assertive outreach work - ie cars to do home visits etc.

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Provide more clinic rooms so we can do our job.

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More facilities.

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There needs investment in infrastructure such as buildings in the community where clinicians can run groups for instance, DHB clinicians need to move out into the community - not just nurses but all clinicians to provide service near where people live.

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Adequate facilities.

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Designated therapy rooms. More appropriate space and not having to juggle and hunt for facilities.

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Although a relatively small issue in the big scheme of things, we are mindful that facilities for individual and group psychotherapy in the Waitemata DHB are inadequate and often not conducive to effective treatment.

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At WDHB mental health we have been having our resources taken away slowly but surely over the years. This includes a significant loss of office space (we are now in a leaky building) as well as rooms to conduct assessments and ongoing therapy. This is having a significant impact on patient care.

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Alongside this is a distinct lack of infrastructure, a lack of spaces to conduct assessments and perform therapy.

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Better designed facilities would be helpful with rooms specially set aside for therapy. Inpatient units often don't have any rooms set aside for this purpose. Stop the use of de-escalation facilities being used to punish clients.

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Old buildings not fit for purpose.

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Run down facilities and high caseloads disempower staff which affects team morale and burn out, and this has an indirect impact on our clients.

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Upkeep work environments/ facilities and reduce administrative pressure so that staff are effective and efficient with client contact.

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The government might review the facilities of forensic mental health services and adult inpatient services in comparison with general medical hospitals and reconcile the provision of quality treatment rooms, cafes, gyms on site (whether for patients or staff), etc., and provide an consistent service across DHB sites.

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Improve facilities across all DHB sites, particularly treatment rooms, resources for treatment programme delivery and training, living areas for inpatient units, etc; environments provide more effective rehabilitation when they are clean, fit for purpose, and can be utilised by trained staff with rehab goals at the forefront of their practice.

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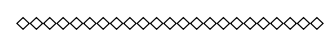
A NEW MODEL OF CARE

Put evidence-based psychological therapies at the centre of our model of care. We need to fully embrace the bio-psycho-social model and decrease the medicalisation of care. The Government should prioritise well-resourced core services but also invest in service development and innovation.

A philosophy of funding new projects rather than improving existing services. Sticking to the medical model of service delivery and staffing which is 30+ years out of date is not working. This includes the funding model where funding medications is outside the DHB service cost and therefore appears cheaper than talking therapies. It is easier to write a prescription for addictive anti-anxiety medications than to pay for clinical time to do therapy.

In responding to mental health and addiction problems the biggest difficulty is in not pathologising normal behaviour and experience. Mental distress is a normal part of life and humans must be willing to experience this if they want to engage in a meaningful life. To frame and discuss normal mental distress in terms of 'mental illness' or 'mental disorder' further damages a person's sense of identity and makes them less willing to experience distress in the future. Therefore, we have to be very certain about what we are speaking about when we say 'mental health and addiction' before we even begin to speak about how to respond to these things.

We need to strengthen MDT ways of working and have clinicians delivering what they are trained to do. The Government needs to be injecting funding into basic services rather than special projects and expect reasonable outcomes measurement not focus on KPIs that have no meaning. We need to develop a nimble system that is not built on tradition but is built on evidence and best practice. This will also need to involve integration with education and social welfare as these are social determinates of mental health and need far more integration.

More definitive evidence base e.g. NICE guidelines with expectation DHB and primary care providers follow these.

True multi-discipline approaches with wellbeing at the core rather than a medical model of illness.

MoH needs to have more input into how funding for mental health is rolled out. It seems clear that the current model of psychiatrists offering primary intervention (medication) is not leading to long-term improvements on an individual or population level.

Instead looking at what the treatment evidence says about improvements in mental health functioning, and funding in line with this, would seem the only way of seeing change. This needs to start in adequate resourcing of psychologists and social workers, as well as medical staff for child and family mental health, to stop individuals being involved in the system across their entire lifespan.

There isn't a model or treatment that is a panacea. Mental health services need to reflect this offer a wide range of evidence based treatments/ services. It needs to cater for a spectrum of distress from mild - severe with multiple comorbid problems. Stepped care models offer a solution to this.

The Child and Family Specialty Services need to use a collaborative and ecological framework rather than a medical model which can disenfranchise families.

Dominance of medical model means medication is primary (often the only) intervention offered to clients. Biopsychosocial model – bio element highly resourced, psycho not resourced enough to meet need, and social needs not resourced at all (would need to be addressed in society, i.e. MH anti-stigma campaigns, parenting and school prevention programmes).

Mental health services are often impeded in the doing of the work by demands regarding paperwork completion, risk assessments, getting stuck in a medical model and providing generic treatments rather than having the time to consider what may be causing/ contributing to this person's difficulties and how best as a community do we assist.

Utilising the biopsychosocial approach fully. The biological model works to an extent and social/psychological factors need to be addressed in prevention, early intervention, and follow-up care to maintain mental health well-being.

The current mental health system is based on an incredibly outdated, medicalised model where psychiatrists sit at the top, and medication is considered the primary (and cheapest option). Psychological therapy continues to be seen as a luxury, rather than an essential part of treatment or "best practice". Psychologists and therapy are considered expensive, however, costs of medications are hidden from running costs.

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There needs to be a shift away from the medical model. Pills do not teach skills. Seeing human distress and formulating it as a disease is out of step

with the literature on the problems associated with the DSM.

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More follow up, currently we do some intensive work with children and once showing signs of improvement are encouraged to 'close' the case.

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Shift the model of care away from the medical model.

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A shift from a medical psychiatric model to a therapeutic consumer focused model.

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Provide formal, comprehensive assessment options (such as IQ assessments) for clients with complex presentations to identify primary characteristics (such as intellectual disability and developmental disorders) that are likely to significantly impact the persons functioning for life and limit their ability to engage in mainstream education.

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Rebalance therapy to medication opportunities. Sick of hearing

psychologists cost too much therefore we won't hire so many. Case management is not what clients want - they ask to be listened to (often affected by caseload pressure; need for defensive practice as secondary services will scapegoat the clinician (change this to airlines approach). Clients also ask for skills – non-psychologists have few avenues to PD/learn skills to pass on to clients cf psychologists. Therefore system spends most of its time gatekeeping & monitoring MH for risk - not offering change treatment backed by evidence.

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The service is currently simply a crisis service which means risk-management by admission to a hospital ward for safety reasons, together with medication and discharge when settled with a management plan. These clients should be partnered with a professional following discharge assessed for appropriate therapy and provided with appropriate therapeutic service to enable fundamental shifts to enable healing and wellbeing.

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Pay more attention to psychological treatment. The mental health system is currently a "psychiatric system" that spends too much resource on assessment and diagnosis, without offering any effective interventions. Many clients with high distress (including those with self-harm) are dismissed from the mental health system. There are many experienced clinical psychologist that could provide brief and effective treatments for this group

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Trauma informed care. More consumer involvement. Community focus. The psychiatric model as an adjunct to a

consumer/community lead model.

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Group work & working with families more than individuals more efficacious.

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Ensure real evidence based interventions are used and not hobby horses (NZ is a country with a very high use of an intervention that has been deemed to be very damaging by all independent research: electroconvulsive therapy). We should demand that in the prescription of drugs and the application of psychological therapies the evidence is paramount.

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Currently the emphasis seems to be on medication

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We are too medically modeled. We have an AOD relapse prevention group but no treatment groups. We have diverse psychological therapies but scarce resource.

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Stop letting the drug companies dictate treatment of choice because it is cheaper, particularly in adult services, instead of working with evidenced based best practice

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I think NZ could benefit from implementing more online care. In the Netherlands much is invested in online programs and blended care (= you meet the therapist but a lot of the work is done online). There are safe online environments developed for that. It suits this time, it suits the younger generation. It suits people that don't like to go into the MH building. I work with children and adolescents and I am pretty sure a lot of them would be really happy with online possibility of care. And... if a lot of trouble is coming from the internet, why not approaching this group trough the same medium. This is where they are!

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We are not funded to see the whole population, so we need clear criteria and protocols to ensure we provide a service to the people who meet the criteria.

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Move away from the dominance of the medical model.

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Shift from medical model to psychological model where psychology lead the services - not automatic psychiatric lead.

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Quality psychological intervention programs/targets nation-wide. Best-practice evidence-led service development rather than ad hoc (and centred around the current managements

bias (e.g. if a nurse is manager of mental health there may be a bias toward nursing-led programs and so on). The Matrix in Scotland is an example of this.

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My primary recommendation would be to increase the access to evidence-based interventions (including medications and therapies) for the following reasons: limited resources should be used in the way most likely to be effective (in mental health and addictions our resources are clinicians, and so our clinicians should be used in the way most likely to be effective, which would entail them being trained in evidence-based therapies. Outside of psychologists other disciplines receive no structured training in therapy as a part of their standard training); evidence-based practice reduces the risk of harm to clients (this includes in medication where numerous clients are prescribed drugs that are unsuitable and have a high risk of harm through mechanisms such as addiction (e.g. opiates and benzodiazepines) and side-effects (e.g. weight gain)); evidence-based practice reduces staff turnover and improves communication between clinicians and clients; evidence-based practice is also a part of ethical practice and properly informed consent (e.g. people should know what is most likely to help them). The outcome of evidence-based practice for clients is that they get a structured plan for recovery, they are more likely to improve faster and to a greater extent, and they get to see progress faster.

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There is a growing expectation for us to see people with chronic and severe difficulties for a shorter period of time in order to see more people on the ever growing waiting list. The terms "work smarter not harder" and "do more with less" are used favourably, but there is a lack of understanding of the length of treatment for people with severe and complex presentations. It is an ethical issue to not provide the right dose of treatment for complex presentations and I believe we are doing harm to the community by being pressured to not provide people with optimal treatment. The ever growing population and referral rate does not seem to be taken into account by the funder.

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Follow up, currently we do some intensive work with children and once showing signs of improvement are encouraged to 'close' the case.

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No care pathways and exceptionally poor/ignored referral systems means a limited resource is not used wisely or with a clear rationale. CPN role undefined: central role is care coordination but a care programme

approach to facilitate this doesn't happen. I think the Psychiatry-nurse hierarchy in the medical model really ignores psychological therapy and also very important socio-economic factors that are prevelent in the community and pathologises mental illness. It can make patients feel 'defective' as a result rather that ''normal'' but struggling in a way that we can help them with. An unmet need is also forensic mental health (deflecting mentally ill people from the criminal justice system where possible but also recognising when capacity is there and criminal justice methods are needed and several other át risk" associated issues).

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Provide clear expectations to mental health services regarding provision of non-medication therapies. Expectations could be outlined following guidance similar to the UK model of commissioning of services. Under the UK system, funding comes with the requirement that certain standards of care are provided and services must

be able to provide evidence of this. A simple start to promote uptake of non-medication treatment could be to require documentation of adequate (evidence-based, provided by a competent clinician with suitable supervision) therapy offered whenever poly-pharmacy or off-label prescribing is undertaken. Support adequate training opportunities with requirement of ongoing supervision to ensure competent practice. The UK Early Intervention Service training initiative (for CBT-P and Family Therapy - NICE endorsed therapies) may provide a useful guide for this. Emphasise recruiting clinicians competent in providing appropriate assessment and treatment.

Roth and Pilling's work in outlining core competencies required for various disorders as they present at differing levels of severity may help inform recruitment considerations. Promote the use of specialist skills across disciplines to provide individualised care. Increase number of specialist clinicians training in talking therapies to, at a minimum,

match number of specialist clinicians in medication. Ie, number of Clinical Psychology Interns should match number of Psychiatric Registrars. Remunerate clinicians to reflect importance of bio-psycho-social-cultural model of care, rather than assigning higher dollar value on biological care. Funding for such changes could be managed through the reduction in use of medication. That is, instead of paying for the current high use of medication, adequately fund cognitive, behavioural, family, and occupational therapies.

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This is a once in a lifetime opportunity for the inquiry to seek full answers to the crisis that impacts the current MH and Addictions frameworks in New Zealand. It is nearly three decades since the Mason inquiry/report - which focused on issues of institutional care

There are a number of positives in the organisation of mental health systems being led by mental health clinicians. It promotes the use of systems that make sense from clinical experience, and a sense from staff that their management is 'in tune' with their needs. There are challenges within this however. Those systems that seem to make sense, often do so within the context of the out-dated medical model of mental health, rather than incorporating bio-psycho-social-cultural approaches. This is particularly problematic with who management positions tend to appeal to. The majority of services are managed by Registered Nurses and have a Psychiatrist as Clinical Lead. Thus both positions of leadership are professionals with training in the medical model. A challenge in increasing the interest of allied health professionals in taking management

Stop looking to use the medical model because this looks for the solutions in individuals rather than in society and communities.

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More focus on evidence based practice across the board would be good.

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Support prevention so make provisions that support thorough assessment and intervention for children and families…. if we create change there then generationally we will see a reduction in overall mental health consumers. Restriction on the length of intervention means DHB have capacity to just address core risk not the underlying issues which means problems stay unresolved and consumers come back again and again. We need time to intervene with underlying issues not just 'sticking plaster' the difficulties
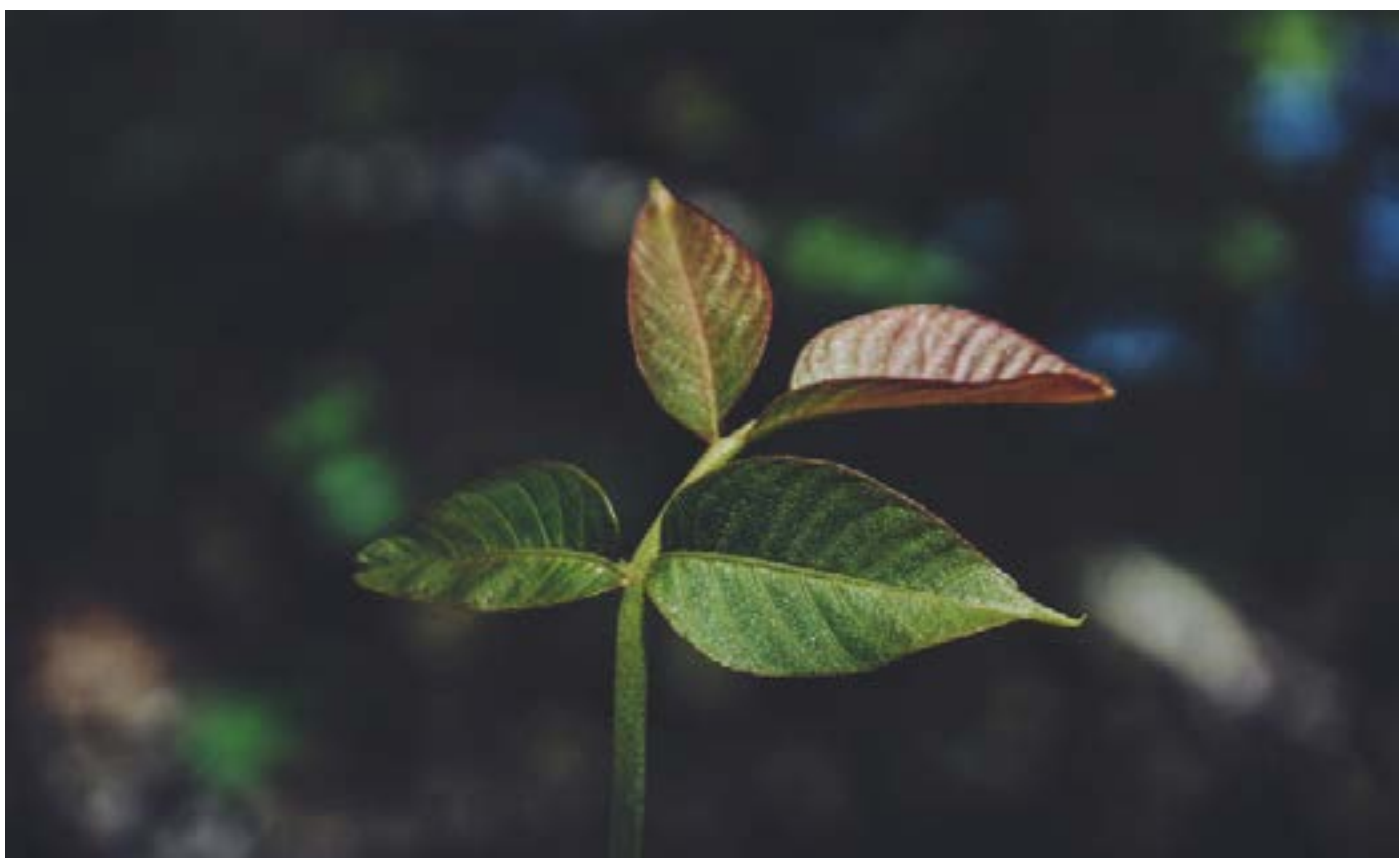
and community reintegration. The issues facing us now are deeper and wider, and the question is one of socially embedded systems of care. We need to revision our health, housing, work/educational and correctional systems as critical components of a core social justice paradigm - where every citizen has the ability to access social goods equally to ensure the best mental health outcomes for all of Aotearoa. A clear direction in terms of where/how will the other theoretical 98% of the population access mental health support is required with funding/resources to build a truly world-class integrated mental health-social care infrastructure over time.

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positions, is the effort required in making movement within the organisation to adopt meaningful bio-psycho-social-cultural approaches. At a recent clinical psychology conference I was surprised it appeared the majority of Consultant Clinical Psychologist attendees were working in private practice. When I commented on this to a group, the response was that they were "tired of pushing shit uphill" in the public system.

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Further empowerment of consumers to work on their problems not passive consume services. Try not to put people in categories. People's life stories are complex and require time and sensitivity.

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Using a more ecological and holistic lens and strengths based approach to problem solving.

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The government could review the way mental health is administered, e.g. the dominance of psychiatry and the medical model as applied to mental disorders. We would do better to approach mental health difficulties by examining people's personal and societal histories and formulating their problems primarily in these terms, with diagnosis as a secondary matter in those cases where medication can be useful. At present in community mental health systems everyone is given a psychiatric

diagnosis and medication as the first step.

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The medicalisation of mental health tends to place the fault with the individual rather than society so I do think that, as I said the government needs to break the stranglehold that psychiatry has on mental health. Using psychiatrists as consultants (in the true etymological sense of the word) rather than administrators, front line staff, and principal treatment providers would mean we need fewer of them and that there would be fewer medications prescribed and these would save money.

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It is difficult to do much without increased funding. But in addition to this I believe a stepped care model would assist in providing more therapeutic interventions to more of the population. This would make the most of the psychology workforce who would treat the complex presentation and support and train other staff to provide less intensive interventions. This should be implemented with a view to how it has worked or not elsewhere. In general more focus on evidence based interventions would be appropriate.

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Review all the models of mental health in each of the services and ensure consistency across mental health services and DHBs. Currently a lot of Child and Adolescent Mental Health Services are utilising the Choice and Partnership (CAPA) model but even within the same DHB, two CAMHS utilising the CAPA model have very different criteria for services, services that they offer and what it actually looks like on the ground etc. Again this reinforces that where you live and which service you can attend really matters to what you can get in terms of help for mental health and the quality of this. There is a lack of transparency as well for clients and families in terms of what they can receive given that often the service they get depends on staffing capacity e.g. whether there is a clinician trained in a particular treatment modality or for specific presentation (e.g. EMDR, Trauma focused CBT, PTSD etc) - and this constantly fluctuates. I think there should be more communication to clients and families from the DHB in terms of the services that will always be available, and should not change depending on staffing capacity.

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Working in a Kaupapa Māori service that is not resourced in line with cultural needs that are part of how the service adds value to the clients

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Provide clear guidance on expectations for bio-psycho-social-cultural approaches in mental health service organisation and design.

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Change measures used to view mental health. We do assessments to meet the 3 weeks criteria for child/adolescents. This means there is then a waitlist internally for children and adolescents. They then have ANOTHER assessment before intervention. Sometimes this is several assessments. The government needs to change this criteria for assessments within 3 weeks, or increase staffing to address this additional pressure.

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I think that formulating people's mental health issues in terms of their life courses and present circumstances, as psychologists do gives back to people the power to make changes, with help and support , rather than waiting for pills to make them feel better.

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Further adding to our workload in our service is that we currently don't have a triage team. The role of triage and intake and assessment was absorbed by each team in our service as of late 2017, adding immensely to the already large role we do. For instance, our clinical lead often spends nights (until midnight sometimes) triaging new referrals into our service.

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Review of the MHA 1992 which is now more than 25 years old, a need for the MOH to take active lead in setting an agenda of openness, communication and engagement with all stakeholders' especially frontline MH staff and consumers. Revise current practice in terms of almost automatic assignment of Responsible Clinician and DAMHS roles to medical staff - with view for each service to be required for these roles to be equally distributed across the spectrum of mental health clinicians. New models of care based on the person receiving services at the cornerstone of service delivery and planning, better integration of MH access and employment/housing opportunities, expanding specialist services targeting high and complex needs client population, a focus on group based programme interventions for multiple client groups, the creation of specialist therapeutic teams attached to secondary services that are designed to allow a broader workforce including trained therapists, counsellors, indigenous practitioners to work within DHB settings. Regular treatment integrity and adherence monitoring from outside the immediate DHB context, extension of KPIs to clinical metrics such as number of face to face clinical assessments, psychological sessions, therapy groups. Explicit disestablishment of a medical model which emphasizes mental unwellness as a disease.

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The model of care is changing to an integrated care model, which is based on holistic intervention and prevention strategies. The model is sound, but relies heavily on good strategic management of both medical and allied health services. Allied health (including psychology) has been largely ignored, and the change of model is still heavily medically driven and managed exclusively by medical staff, with no clear strategy or leadership being appointed for allied health. This leads to service users being further disadvantaged with access to psychological and behavioural interventions and represents a repeat of the previous model, where intervention in secondary services were based on intervention once the client is already in acute crisis (chasing the ambulance) – thus costing more and needing longer intervention times (reactive rather than proactive).

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The scope of practice for allied health staff is under significant pressure from management to 'broaden' and move away from specialised roles to generic mental health clinician roles (basically making each clinician a glorified case manager, rather than a specific clinician). This has led to almost non-existent access for service users to much needed occupational therapy individual interventions and groups, social work groups and nurse led groups in the community. Psychology has been fairly successful at protecting their scope in CMDHB, but this has also led to ruptures in the team, decreasing morale. Service users are also directly being impacted by this – as OT and social workers do not spend time delivering their more specialised, but less intensive behavioural interventions, thus leading to psychology having to focus on/deliver these interventions as well (e.g. behavioural activation) before being able to move onto more complex/specialised higher intensity psychological interventions).

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Clinical Psychologists have similar diagnostic expertise as psychiatrists (we study the same mental illness text books) yet the Act only mentions psychiatrists and as such disempowers clinical psychologists.

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Stick to core business of assessment, diagnosis and treatment of moderate to severe mental health issues. Stop resourcing multiple new initiatives that take staff away from this core business e.g. screening appointments and brief intervention for mild to moderate mental health.

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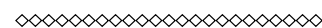
CLOSER COLLABORATION OF SERVICES

People receive the best care when all agencies work together and share information.

We need to be able to work in a more collaborative way with other areas of the government. We need to get away from 'budgets' and 'contracts' that set artificial parameters and limitations. There are serious problems that people and the community face and being passed from one department to the other is neither helpful nor effective. We need a stronger whole-community approach to wellbeing, not a narrowly defined focus on health vs illness and certainly not such an exclusive focus on the individual. If our whole community is struggling, it effects everyone.

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We need to integrate all services involved in health and look at our tamariki and whanau as a whole. This not only includes mental and physical health but also housing needs, education, care and protection etc etc. No need to reinvent the wheel, just take what is already working nationally and internationally and apply it here.

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Stop the fragmentation. In my region there are at least 10 different organisation, each with their small part of the pie. None of the service delivery is decently coordinated (having said that, this would take up a lot of time and resources). Why not organise for each region/locality a one stop mental well-being/mental health access point. Especially the artificial distinction between primary and secondary care is daft.

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The biggest change that needs to be made here is for the government (in the form of the Ministry of Health and DHB's) to stop funding so many businesses (somewhat disingenuously known as NGO's) in this area. I understand that about half of all the funding for mental health and addictions currently goes to NGO's. The result of this funding split is that there are now so many different NGO's offering such specific services to such specific clients that even accessing a basic service such as short-term housing requires negotiating a maze of over 12 NGO providers (in my region), all of whom have different but overlapping criteria and referral processes. This situation

makes navigating such services almost impossible for clients (who have mental health and addiction problems to contend with) and very difficult for clinicians, to the point where entire services have been set up just to help people navigate other services. Privatizing and splintering services in this manner does not seem to work and needs to be reversed. Doing so will result in services for clients being properly integrated, available, transparent, and accountable.

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All government organisations providing services to Mental Health could be working collaboratively using the same computer based system to improve communication between them. For example the DHB MH services, NGOs and PHO could all be working off the same assessments and recovery plans for service users to improve consistency in care across the services. Healthcare hubs could be set up in main towns and cities where Drs rooms, NGOs and MH Services all operate from the same building to improve integration, help remove the stigma of MH and provide better access to service users and their family/whanau.

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Need a viable stepped care model so people can move smoothly to and from primary and secondary. More resources to pho for psychological therapy. I'm not a huge fan of the multitude of standalone NGOs, not sure they deliver well on outcomes and all march to their own drum

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Ministries are working in silo's. More collaboration between Ministry of Health (even within this ministry - eg. CAMHS and Paeds), Ministry of Education, and Oranga Tamariki as currently it's a "pass it on" situations when, for most cases, issues cross many systems. Care and Protection continues to not be managed well for our rangatahi and, consequently, significant mental health issues result from this.

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Oranga Tamariki and other social services need to work in collaboration. This business of who will

support, who will fiancé MOE or MOH, ridiculous. At the end, we have one pot of money. Best to spend where we can shape and guide, on preventative rather than costly "fixing it".

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There needs to be a redesign of the pathways of help seeking so that there are psychologists and others trained in evidence based therapies at every level. Lines of management need to be joined up- we have too many smaller organisations delivering things independently with no overarching plan of treatment. We need NGOs and PHOs to be joined better to clinicians at a DHB so that there is a whole of system view and we don't keep reassessing people and doing disjointed pieces of work.

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There is a current lack of integration within services (DHB) and between services (primary care, ACC, Oranga Tamariki, disability, forensic). Consequently care is fragmented and difficult to coordinate. This then impacts on people's capacity to engage and likely creates a negative experience of the services. Technology IT solutions, co-location of services, taking a whole service / whole community approach. Develop a unified system.
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Greater partnership working between MSD, MoE and MoH so Oranga Tamariki, Health and Education work closer together. This means less siloed off working and more integrated/systemic formulations.
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MCOT, MoE and MHS should all be working together but instead we're busy defining our patch because we can't meet the demand so in the process Tamariki suffer.

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Combined mental health with community services, so that the person is treated holistically.

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Streamlining processes across services and improve consistency.

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An integrated mental health database nationally would be a start.

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Across DHB's there is far too much variance in service delivery, resources, and ability for clients to be seen and treatment they have access to.

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Develop an integrated client system so that relevant information can be shared between agencies and facilitate expediency

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Currently the funding structure is set up in a way that the government services are set up in a way to compete to not support whanau - i.e., we receive a referral at the DHB and say "that is not the right place it should be a Oranga Tamariki referral" then it bounces around different services. There should be more integration between the services, especially MOE, Oranga Tamariki and Health. If psychologists in the DHB had the capacity to work alongside Social Workers at OT. This can happen in High

and Complex Needs cases but that is such a time consuming and costly process that takes an age to come into effect - a case I am currently working has taken over six months to come into effect, which for a 10 year old is too long. Mixed disciplinary teams on the ground for Oranga Tamariki. A trauma focused ethos across sectors. More psychology hours for Ministry of Education, Oranga Tamariki and DHBs.

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Better coordination of services at different levels.

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There needs to be a more integrated process.

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Better collaboration of services.

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More collaboration.
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Better integration across sectors - PHO, DHB, NGO. Competition for funding the work is a barrier.

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More liaison between primary, secondary, and tertiary services

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There is great disparity of what is offered in different regions and aligning the basics of DHBs would go along way - being able to see mental health notes of different DHBS and support transient youth. More alignment between health and social services given the huge link between these.

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Widen single point of entry approach by ceasing differentiation between primary and secondary.

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One agency across education/welfare/ mental health so that we see a true collaboration across complex issues without barriers around policy/funding/ politics across casework.

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Appropriate communication and collaboration between services to provide consumers with the best care and rehabilitation input (i.e., less avoiding of taking responsibility for a consumer and

"allocation dread" – who can pick up and support?)

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If funding could be used where needed agencies may be less likely to be protective of what they can offer/

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Primary and Secondary services need to be providing a tiered service to better support the community instead of having gaps in services.

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As said above we need a co-ordinated national approach to psychological therapies across primary and secondary care to ensure availability of the appropriately skilled clinician for the right level of intervention. Psychologists should be at the table in the development of this.

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Often individuals with complex social situations who are under mental health services are disregarded by other services who put it all back on the mental health services. A specific community based case management system may be more beneficial than having the case management done by mental health.

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Confusing array of services which are inaccessible (e.g. multiple name changes of organisations, over-reliance on e-therapy).

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Agencies working together to ensure the health and wellbeing of every member of each family (such as sharing information, working collaboratively)

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The entire process of providing psychological treatments is poorly managed and uncoordinated. There is no measure of demand, wait listed managed on the back of an envelope and no resources allocated to meet the demand. Those patient who could respond to targeted evidence based psychological interventions do not receive effective intervention and spend time sitting in the system.

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More integrated approaches from the beginning, not just for the very complex cases that reach the HCN threshold.

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Increased collaboration between government agencies so that children do not fall between service gaps.

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Improve coordination of services to help clients navigate the systems to access relevant resources, but also to assist service providers in clarifying roles and performing complementary tasks.

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There is a considerable number of people with high and complex needs (e.g. Borderline Personality Disorder with suicidal tendencies and those with intellectual deficits but just not sever enough to be eligible for NASC services or with dual diagnosis, as well as those with ADHD and related symptoms) who often don't meet the criteria for services of any of the agencies. Those individuals appear to become "hot potatoes" who no agency really wants and so they fall through the cracks. They are a huge burden on their families and the available systems (e.g. GPs and EDs). We need "safe places"

where these people can be treated, even if for short periods while they experience acute symptoms). If not, they tend to take things in their own hands either by self-harm or through drugs.

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We all need to be working collaboratively for the wellbeing of the children we are working with. I work in the severe behaviour service, and many of the children I work with are involved with Oranga Tamariki. It is rare for Oranga Tamariki to work collaboratively without considerable effort on my behalf, and I rarely receive reassurance that the care and protection needs are adequately addressed, as I see them. It is also very hard to get the local child and family mental health service to accept children

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Improve access to technology and sharing of information so that primary care and physical and mental health services can work better together. - Relationships between teams/clinicians are vital for wrap around care. Consider strengthening partnerships with NGOs e.g. co-locating to facilitate this.

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Treatment, rehabilitation outcomes should be hand in hand with the availability of government financial support (WINS ACC).

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Same services and service structure across different regions. Clear service criteria.

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Secondary services depend on a fully functioning primary service. Therefore the planning of funding, coordination of the wrap around MH service should be planned from primary level up. Funding at the moment is piecemeal.

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Resourcing to enable services to work together. Documentation of children, families/whanau where there is a clear need but no services (either no services or people do not fit criteria for existing services) to ascertain need.

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Make NGOs more integrated, coordinated, and accountable, and develop clear pathways between primary and secondary services. They receive half of all mental health funding and what they actually do is very murky and unclear.

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It may be timely for the government to consider an integrated health care model which is seamless (as far as possible) in terms of mental health service delivery.

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Mental health service provision is somewhat split across DHBs, NGOs and ACC, who all work in quite different ways. This system can be difficult to navigate for service users and standards

There needs to be closer links and cooperation between the MoH and the MSD, e.g. so that it is easier for mental health clients to access housing and benefits. In my adult community mental health centre we used to have a WINZ staff member coming to us and providing a one-stop service for any benefit issues. This was stopped some time ago.

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placed to provide a service.

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I don't believe the census is an accurate measure of population in South Auckland. The area is home to many cultures, people living perhaps too many to a house, people who are physically or mentally unwell, and in general a lot of people for whom the census is either not a priority, not understood, something people feel paranoid about or don't even know is going on. Hence using the census as a basis for funding is fraught as it ends up missing out on the most vulnerable who are our service users.

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Providing services that focus on the overall care and needs of the client. Currently services have specific criteria and only meet specific needs of a particular age group. There is no integrated care plan and funding that is client-focused. Many clients don't "fit" the criteria of services and therefore fall through the cracks. It is sad that only when they start offending and become part of the forensic system, funding and services become available to them.

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are different for different services.

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Supporting more collaboration between services.
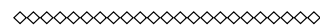
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A more collaborative approach between different organisations involved with the person.

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There is a lack of integration between government services e.g. Ministry of Education and Ministry of Health. Even within the DHB there is a lack of integration and cooperation/communication between services e.g. paediatrics and child, adolescent mental health service. I think the funding and organizational structure means that there is a real divide between mental health service and 'other services' - I'm not sure exactly what specific changes that need to be made to improve this.

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Government services need to share information and possibly some budget so that individuals are not passed between services but rather everybody teams together and takes responsibility for the good of the individual.

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Review the communication/IT system between DHBs, currently there is a lack of integration given the different record system between DHBs e.g. HCC in Auckland region vs. Concerto in other regions.

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Look at funding mechanisms to allow flexibility of service provision so that there is not such a big divide between health and education services which is based on funding rather than who is best

Plan changes to services. We have not been involved in changes at all in 16 years, and have been dictated to by Tauranga (urban) and we are a rural area. MH services need to be planned with coordination and cooperation between primary and secondary services. Piecemeal services do not help.

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ACCOUNTABILITY FOR FUNDING

Ensure that services which are contracted out to NGOs come with robust reporting and accountability requirements.

Revise the way MoH measure our performance. Whether or not we complete an awesome care plan is not going to make a huge difference to the child if we do not have the therapy skills necessary to treat their presenting problems. Maybe those in government making decisions should use the measure - would I want my child, whanau member to be treated by this service? MVCOT is a failure.

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Know where the money is going and what is happening with. More accountability from management. For example, there are a number of NGOs that may have the money but there are limited services.

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We need to have a hard look at where we are spending our money and whether the results justify such expenditure. For example it seems that in many organisations there is a great deal being spent on paying the salaries of managers rather than a focus on the health professionals providing the services and workforce development for these professionals. Clinicians also need to be accountable for the outcomes they provide.

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More efficient ways of measuring our data so the needs are actually seen. More efficient note systems. Upper management who make themselves visible and accountable.

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Accountability - I was told my DHB gave funding to PHOs for health psychologist fte but they used it for severe mental health issues - there was no accountability.

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It mostly boils down to two issues: 1. Funding 2. Management Lack of adequate funding and poor management are the main causes. A good question - who is running the mental health system here?

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Concerns regarding amount of funding invested in NGO's who do not have the specialist professionals required to provide adequate assessments and interventions.

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Changes to school governance structures under National, mean that Ministry of Education cannot require a school to work with their psychologists or child specialists, and some schools decline to implement recommendations from ministry or child mental health services, preferring to make a child's life miserable to encourage them to leave. Increased support funding for children with needs should be accountable (I have seen this money held back and then used to buy new sports gear or other equipment in some schools). A change in the rules for schools, providing ministry of education with a greater ability to intervene where a child's mental health is compromised by the actions of a school/teacher/principal is in my view an essential change.

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BETTER MANAGERIAL SYSTEMS

Strengthen ethical leadership within mental health services and provide opportunities for psychologists to be involved in clinical governance and at service leadership levels. Pressure on and through managers to cut costs has eroded the quality of staff and manager relationships.

Revise the way they measure "outputs" and allocate funding for MHS. Focus on outcomes and effectiveness of the services being provided rather than how many people are seen, how quickly they are seen, how quickly they are discharged etc. Revise the usefulness of outcome measures such as HONOSCA so that there is consistency in what is being measured regardless of who completes the measure.

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Less management, better managers. The financial model for service delivery is the single biggest factor in problematic service delivery. In poor areas this prevents access, causes secondary MH workers to perform primary services. Thus, fund and PLAN better

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Talking to those at the coal face. I believe there was recently a visit to the hospital I work at by MoH but they met with management. Management don't have a clue what's going on - when we tell them they brush us off (there's no money for funding...) or are bullying so no one wants to speak up.

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I think management positions of psychological services should be held by trained psychologists/ psychotherapists.

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Have leadership structures that promote professions who understand the causal psychological mechanisms and are able to design interventions that target those and not diseases. Ensure their management

structures focus on their staff and not KPIs. The latter do not provide any good data about the efficacy of intervention, and community wellbeing. Have strategies in place to keep the workforce at levels sufficient to deliver good care. Stop putting changes in place that have not had clinicians involved in the process.

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Reduce paperwork expectations. Ensure mental health services are focussed on their core business - assessment, diagnosis and treatment of those with moderate to severe mental health problems, not providing brief intervention for mild to moderate problems which could be done in the community.

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Reduce the number of DHBs and have leadership teams full of people who understand what leadership means.

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Improved understanding of the role of psychologists at a managerial level.

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Clinical oversight - management make decisions all the time without actually understanding how things work in reality

and what the decisions mean.

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Have more psychologists in leadership roles.

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The mental health services need maintain their professional human resource, providing financial,

environmental, professional, and emotional support

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There also needs to be more collaboration between clinicians and management. Under the National Government a culture developed within DHB's where managers saw their role to save money at any cost. A culture of meanness and blame developed where the needs and views of service users and clinicians were largely ignored. These relationships need to be repaired to enable services to be more responsive and effective.

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Management of mental health teams is usually by nurse managers. Their degree of skill varies, as does their level of understanding of psychology. Frequently there is pressure to do 'brief' therapies, which often fail to meet the needs of clients who are by the time they reach DHB services, often at high risk, and with long-standing untreated issues. These take time to address safely and effectively. Increasing the 'voice' of clinical psychology at governance level would be sensible. If nothing else, psychologists can bring considerable skill to the process of engagement with employees across disciplines, can offer consultation around ways to increase staff engagement around their work, as well as change processes, and may have good understandings of the ways in which organisational decisions may impact on workforce mental wellbeing. Poor representation of allied health disciplines at governance level has been a theme in some DHBs.

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Less punitive environment.
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If we want to change the services provided to clients, perhaps culture of how staff are treated needs to change, i.e. risk aversive practice (rather than best practice), environment of fear and bullying. High micromanaging, low autonomy, high pressure systems lead to high staff turnover due to burnout.

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Greater support for frontline workers from managers and directors. Staff are currently being asked to work with greater numbers and acuity with the same personal resources (energy, time, and training). The message is consistently "Work smarter" which is discouraging and leads to burnout/turnover. We need more funding for greater staff members, a review of the facilities and whether

they are "fit for purpose" we need to review the availability of culturally appropriate services. We need greater consistency of care across teams - we do not use the same computer systems across DHBs which means we cannot share information about clients. We do not run teams similarly which means we cannot be held to the same standards nationwide. The attitude to risk needs to change, and the response to serious adverse events/suicides needs to be reviewed. Too many clinicians are being asked to be held accountable for risk that is outside of their control.

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Streamline structures to ensure that frontline clinicians are resourced to do their job and that funding is not

lost on admin, and "would be nice" type initiatives

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Change system in where nurses or social workers are managers of clinical psychologists.

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Inadequate management burns me out not clients. Let psychologists be managed by people with equal or better qualifications

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Communication by managers with staff to support their goodwill, and enhance practice - all we ever seem to hear is staff vacancy info, budget cuts. Very demoralising. How do we carry the hope for clients when they can't do it themselves in this type of organisational culture?

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Address management issues- staff have lost faith that their very serious concerns are going nowhere, along with poor working environments and desire for safe practice, impacting of staff

retention.
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There has become a culture of blame in these services. As clinicians we are being told that we aren't productive enough and that we need to see more, fill quotas etc. There is no recognition of how hard we work in jobs which are very challenging. I think that this attitude needs to change and the work that we do needs to be acknowledged.

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Better management and clinical guidance of service and staff. Better service structures- nationwide approach. Same services in each region. Same service structure in each DHB. Services need to have clear criteria and referral criteria.

Bullying and power battles in management need to be addressed urgently.

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Invest in coordinating psychological treatments (or require the DHBs to do so), like we do for other essential treatments in the health sector. Measure the demand, ask the DHBs to report on the number of sessions provided, ask the DHBs to run a professional waitlist and treatment pathways system - and ensure the DHBs allocate resource where it is required. Our DHB asked patients what they needed and the overwhelming response was "more talking therapies". The DHB has ignored his survey.

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If mental health services were managed by psychologists, psychotherapists and psychiatrists (who actually have the appropriate training) the approach to treatment would be more holistic with a range of assessment and treatment skills rather than the current 'basic CBT' skills - the cheap option.

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Increase psychology FTE and promote clinical leadership for this group of clinicians. We are the only profession to spend our university careers studying human behaviour, engage in robust research, and learning effective therapy approaches. Our training means that we bring a range of skills to the DHBs but only a restricted range is utilised by management. Reduce the number of DHBs and have managers in place who have leadership skills and are held accountable. Ensure they have their clinicians drive change in response to need. Encourage and promote psychologists into clinical director roles- we have the requisite skills to manage people, lead, understand human behaviour and respond flexibly to changing environments.

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Maintain a biopsychosocial stepped care approach as only this will address the needs of NZ more effectively. Clinical psychologists should have the option of extending their scope of practice to feature more prominently in the Act, officiate as Responsible Clinicians and assess persons' mental state / diagnosis in terms of the ACT.

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We need strategic guidance at a national level in many areas, for instance in the provision of talking therapies akin to models such as the MATRIX within the Scotland NHS. It may be that creation/appointment of new positions at a national level/in the MOH need to focus on cross disciplinary input which extends to strong psychological therapy leadership positions with the ability to influence/shape our current metal health strategy.

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Disconnection between and within services, 'silo' mentalities with each service area trying to manage their own 'turf', entry and/or succession to leadership/ managerial roles within mental health largely unsystematic with limited training for current/future leaders and managers, limited mechanisms for engagement with consumers/service users and incorporate their feedback into future designs/service delivery. Outdated and archaic models of care in many services with an over reliance on hierarchical teams and decision making as opposed to consensus based empathic engagement and collaboration with service users and staff alike.

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If you really want to know what is going on, come and talk directly to the staff - not middle management. There is too much politics to get the straight information. It would provide a much better insight if those in charge came and spent some time on the shop floor. That would provide more insight than any survey (no offence!)

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I think probably there are some issues around different work groups cultures, so having managers who are structured but also honest and fair from each of the main disciplines, who could meet together to sort out basic structures regularly, would make life an awful lot easier for the rest of the staff. We could then get on with our jobs rather than constantly firefighting around the interferences.

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There is a disconnect between the clinicians and what they need to be effective and the resourcing for this. There are too many middle people who do not understand the requirements of our mental health service, and it's at this level where the funding appears to be decided upon. Each area within specialist mental health also has their specific needs, and they need to be treated separately for them to work as effectively as possible.

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Introduction of policies that require DHB leadership structures to monitor any systemic bullying within teams and privileged roles that prevent true inter-disciplinary functioning. A regular cycle of localized inquiry that is time-based with independent annual audits of DHBs by statutory Mental Health Commissioner's 'delegates' who are tasked to review not only fiscal/operational lines but performance against clinical/social outcomes - with these 'delegates' reporting directly to the MH Commissioner to limit any potential/real conflicts of interest. These delegates to be comprised of a range of health profession groups.

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Consult staff before making changes and respond to feedback. Put people in leadership roles who have good leadership skills and are able to make decisions for the betterment of the service not for their career development or in an attempt to create their own legacy.

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Innovation should be valued by management and they should lead it. KPIs should be more relevant.

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Resourcing/funding needs to be decided upon by those on the floor there is a great disconnect between where the money goes and the clinical need.

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Each profession needs to be recognised independently and treated as such, an MDT where the same thing is expected of everybody regardless of their

skill set does not work well. There is a need for more highly skilled clinicians who are specifically trained in mental health. There is a need for highly skilled managers who are innovative. There is a need to make systems more efficient and address the issue of excessive amounts of administrative work which takes time away from face to face contact with people.

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It helps where there is a manager who is psychologically minded - where managers are very medical model focused the service is usually not so good.

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When there is an innovative and highly skilled manager things work much better as there is opportunity to change broken systems. We have had an extremely high turnover of management due to burnout unfortunately. When staff are valued and their capacity is respected the service runs best.

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This inquiry is clearly a first step - it is important that the inquiry canvass more than just issues at the coal-face but also the systems that are currently in place in terms of public health service delivery. It is unfortunate that New Zealand while adopting a strong social democracy model struggles to implement this within the health sector with the DHBs increasingly been governed as fiscally driven corporations. It is incumbent on this government to ensure that the health sector is governed by a social care model with clear accountability structures that extend to checks and balances of salaries/allowances that are afforded to DHB chiefs. In essence we need a sea change in terms of the DHB leadership narrative - one that is based on promoting social good over protecting fiscal lines, whether corporate or of a specific health professional group.

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I also believe the mental health management at Counties Manukau are out of touch with the work required and the clinicians providing it. They operate with a secretive and very top down approach, implementing one reorganisation after another without properly evaluating or addressing the impact of the previous changes. They are further very medically oriented and tend not to include allied health and psychologists in planning. Hence scrutiny and evaluation of the effectiveness of this approach would be useful.

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Have Psychologist line management and structures. It is not working when we have nurse managers who do not have a clue what we do, how we do it and why; and then a Psychiatry Manager overarching. It becomes so deskilling and risky/unethical when we are asked to work with no structures, evidence based tools, care coordination that most people leave for private practice/ACC where you can focus on your client work. I would put working at a DHB hands down the worst working environment in my life and would not let a family member use the service in absolute honesty. It would cause more harm than good more often than not. Please give psychologists some autonomy and proper line management structures and a voice at government level. Poll patients to see what they think of their nurse/psychologist/psychiatrist/OT: it will give a better picture.

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There appears to be a lack of understanding (probably linked to the management structure) on what psychologists do and how to effectively


utilise the resource. This disadvantages service users and leads to significant work dissatisfaction among psychologists. As a result rapid staff turnover is common, thus leading to even poorer access and outcomes for service users. There is very little investment in retaining psychological staff and seniority (a very scarce resource). Psychologists have effectively been locked out of higher (strategic) management positions, and have not been allowed to actively participate in higher level clinical governance. Again this leads to poor strategic planning for access to psychological services, lack of a unified approach, decreased 'team' culture and decreased outcomes for our service users.

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There is a general lack of positive reinforcement and 'team-culture', largely attributable to higher

management. This leads to poor morale, associated higher staff turnover and less access to psychological therapies. Management's focus has become increasingly critical and unbending. They appear to be deaf to repeated feedback/suggestions from psychology on how to address poor morale and how to improve access to psychological services. They rely on direction from medical specialists to guide the profession, rather than input from the profession itself.

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Doctors receive significantly more financial and other initiatives (clinical time, training funding, privileges) that other clinical staff. This negatively affects morale.

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Appears that decisions on allocation of staff/specialities based on demographic data. There appears to be no consideration of epidemiological data for each region. This leads to psychological services not being allocated appropriately according to diagnosis/

level of complexity (different types of interventions/expertise are needed based on the complexity of the service user problem). The level of service user complexity and associated interventions are not understood at a management level, leading to pressure being put on psychologists to apply intervention types and treatment -lengths to service user presentations that are not supported by research/evidence. This can, in cases where it is not resisted, lead to poorer outcomes for service users.

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The workload is immense, there are simply not enough psychologists being employed/retained to provide the services needed at CMDHB. Psychology also has no influence on strategic direction taken, so very little input can be provided on how to do 'more with less'.

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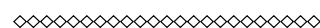
FINAL REMARKS

As President of the Psychologists' Division of APEX I find myself moved to highlight and synthesise the breadth of voices recorded in this submission.

It is clear we need more psychologists within public mental health systems, from primary to secondary to tertiary care. But we also need more leadership from psychologists to move beyond outdated medical models, models which see people with mental health issues as objects of care rather than unique individuals. Our clients are people – complete with flaws and strengths – who, like many of us, are in recovery. And to effect this change we need leaders with compassion, foresight and integrity, from those in the Ministry to those who lead and manage clinicians, to those designing truly multi-disciplinary teams.

Can psychologists be effective leaders in initiating and progressing change? Responsible leaders? I think so. Our discipline is founded on the principles of robust and critical self-reflective practice, and the values of equality and social justice. These attributes are important when working with some of the most vulnerable people in our population: the mentally unwell; the dangerous and criminalised; the young and the old; the alone and sometimes the homeless; the unwanted; the forgotten.

Can we make a difference, as psychologists? The voices in this submission say we can, we should, and that we are ready to make this difference. To do so, we may need a drastically reorganised system, one in which talking therapies are valued as highly as medication, and one in which we have incorporated into our roles space for clinical innovation and excellence. For this, we need cross-sector parity for employment conditions, salaries, and the valuing of psychologists. We need services – DHB, secondary and primary, education and child, youth and family services, prisons – to be obligated to create sufficient positions for psychologists so people can access help when they need it, and so people can live lives that are meaningful and lead to social good. We should ensure sufficient accountability – mechanisms that regulate services and report on what is and is not working.

All of this requires leadership from government. A world-class healthcare system cannot be achieved without the necessary funding, including that which allows infrastructure to grow. We need more beds, high complex needs services, intensive/assertive teams, specialist bespoke centres for state-of-the-art tertiary treatments, step-down housing for service users leaving hospitals, sheltered work . . . the list goes on. Can we do it? Yes, but without the tools, the resources, the safe spaces for therapy, we will keep seeing repetition of the cycles of need; we'll keep seeing limited provision and services stretched to breaking point; we'll keep seeing caseloads that prevent true empathic relating with the people in front of us, whose suffering compels and requires attention.

It has been almost three decades since the Mason Report was first released. That report led to a sea change in terms of how and what we do. Is it time for another change, a redefining of what is needed? It would seem so. We are at another watershed point in the history of mental health.

The voices in this submission can light the way. We don't have all the answers, but we have some, and together with other voices that are sure to emerge, especially those of tangata whenua, we must take responsibility and lead the country towards necessary change.

Ma tini, ma mano,
ka rapa te whai.

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