Continue to lead within the mental health sector and influence the ongoing development of policy, practice and standards.
About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care.

The RANZCP has more than 7400 members, including around 4900 fully qualified psychiatrists and over 1500 doctors training in the field of psychiatry. Of those, there are over 900 New Zealand members, including 240 doctors training in the field of psychiatry.

Background

In Aotearoa New Zealand, the National Committee, Tu Te Akaaka Roa, represents the RANZCP by advocating and working to improve the mental health of our community, and collaborating with stakeholders – government agencies, NGOs, tāngata whai ora, and other health organisations – to support the delivery of high-quality psychiatric care in New Zealand. The RANZCP values tāngata whai ora perspectives when developing relevant policies and position statements, and ensures the lived experience is incorporated in our documents. We view our role as a partnership with tāngata whai ora, guiding them through their journey to recovery. Psychiatry is a diverse discipline addressing the needs of people and their whānau/families from childhood and adolescence into adulthood and old age.

Contributions to this submission were received from RANZCP Committees including Tu Te Akaaka Roa, Te Kaunihera – the Māori Mental Health Committee, and the New Zealand Faculty of Consultation-Liaison Psychiatry Committee. RANZCP committees include psychiatrists and other people with lived experience of acute/chronic mental health conditions. The four Tu Te Akaaka Roa policy platforms were used to guide this submission. The following RANZCP position statements also provide additional information: Partnering with people with a lived experience, Partnering with carers in mental healthcare, Whānau Ora and a guideline for involving families and whānau.

The RANZCP’s main comment regarding the System and Services Framework (SSF) is that in theory it provides a good framework to guide continued work to transform Mental Health and Addictions services in Aotearoa. However, while the draft document provides high-level direction for system transformation, which is admirable, it lacks specificity or accountability and has no implementation plan. We suggest that some of the critical shifts are realistically long-term objectives that are unlikely to be achieved in the 10-year timeframe covered by the SSF. We also note that the SSF has little reference to clinicians and appears to have been drafted without consultation with mental health and addictions specialists. We are concerned that the document is bereft of reference to the specialist hospital-based services for people with acute/long term mental health and addictions needs. Our major concern is that people with serious mental illness are not receiving sufficient support, and this is contributing to significant inequities.

Early intervention services are given considerable emphasis in the SSF. The RANZCP view is that this service line will not affect the trajectory of the ongoing mental health support that 5% of the population afflicted with serious mental illness require over a lifetime. There are few offerings in the framework that suggest a commitment to service delivery for this 5%.

We believe that consultation through the SSF responses will help the Ministry of Health define the implementation infrastructure. Through that development the Ministry can then advise Health NZ and the Māori Health Authority on ways to coordinate and integrate the collective effort to drive concepts into action. The RANZCP expresses an interest in staying connected to the development of a detailed implementation plan.
The policy platforms
Tu Te Akaaka Roa have developed four key policy platforms that place people and whānau at the centre of mental health and addiction services in Aotearoa. To actualise this aspiration, people, whānau and community need be involved in planning services and policy. We believe partnering with tāngata whai ora is a key tenet to realising the vision of health equity for New Zealanders.

1. Don’t Forget the Five Percent
People living with serious mental illness are a priority and need to receive integrated, wrap-around care. The Mental Health and Addiction Inquiry report, He Ara Oranga, focused on funding and expanding mental health support to the 20% of the population with mild to moderate illness. The five percent with serious mental illness should not be left behind and must receive the expert care they need.

2. Let’s Work Together
Our focus is on connecting care and expertise across the sector by facilitating co-design, working with primary care, strengthening the NGO sector, maintaining and improving secondary care, and developing national strategies and services. Alliances forged across the social services sector, primary care, specialist services and national services will help people living with mental illness to access care when they need it and support their journey to wellness.

3. Look at the Evidence
We advocate for the greater sharing of evidence and knowledge regarding translation of evidence into practice, across the sector to reduce the likelihood of “reinventing the wheel”. Evidence is derived from both the scientific method, and established bodies of cultural wisdom.

4. Get the right people in the right places
Developing a strong workforce is paramount to achieving equity of health outcomes for tāngata whai ora. Building workforce capacity across the entire sector (both mental health and the health sector) is a priority. Within the mental health and addiction sector we need more psychiatrists, clinical psychologists, Alcohol and Drug clinicians, peer workers, mental health nurses and people versed in kaupapa Māori services. Given the key role of primary care in supporting people with mild to moderately severe need, a thriving capable primary care workforce is also critical.

General comments
Promoting holistic wellbeing
The RANZCP notes mental health cannot be easily separated from overall health and wellbeing (if at all). Many tāngata whai ora experience comorbidities and inequities in physical and other areas of health. For example, people with serious mental health and addiction issues are estimated to have a life expectancy up to 25 years shorter than those without such issues.¹

We understand that Equally Well is advocating for a range of changes to the SSF to help to acknowledge the scope of factors that impact on wellbeing. We strongly support an expansive view of factors that intersect with mental health and wellbeing which are influential determinants of health outcomes.
Development of the SSF

The RANZCP acknowledge the Ministry of Health’s assertion that this initial SSF consultation is its first step to guide the arrangements of Health New Zealand and the Māori Health Authority to implement transformational change to the health sector. We have noted the explanatory text guiding our response which describes the SSF as high-level and aspirational. We suggest the absence of detail ought not be an impediment to providing a coherent plan which is distinctly transformational.

Improving the health outcomes for Māori is a paramount objective

Previous reviews of the health system and mental health and addiction system have provided a series of recommendations from which such a plan could be presented. The current document by contrast can be viewed as a piecemeal approach to an opportunity to propose cohesive change that targets the health inequalities evident amongst New Zealand populations, notably Māori. We believe that first and foremost the mission of the SSF is to enable a collaborative cross-sector, cross-speciality arrangement to improve the health outcomes for Māori. The journey towards that mission has the potential to reform clinical practice and knowledge in the care of tāngata whai ora. The availability of Kaupapa Māori health services is a critical first step to building and strengthening the delivery of clinical, evidence based culturally safe care. Māori knowledge is the basis by which Māori health outcomes will improve. A future state of embedding Māori knowledge into the approach toward health care has the potential to change the way all health-related services are delivered to all populations.

At present it is paramount that the SSF prioritise Māori rangatahi to address the current inequality of outcomes for this young population. They are over-represented in CAMHS services, which are significantly under-funded; closing the equity gap will thus require investing in CAMHS services in general and Kaupapa Māori CAMHS services in particular.

Building services from scratch

Highlighting first and foremost the need to resource Kaupapa Māori services in the paragraphs above, the SSF also includes critical infrastructure yet to be built. For example, that required for peer support transformation. There are but a few examples of peer support services in Aotearoa New Zealand. Where available, they have operated at a local community level with limited, intermittent funding. Whilst it is admirable to support a rapid acceleration of peer support resources, it must start from scratch. We argue that the objective to build peer support infrastructure is largely dependent on the integration of social and health policy to achieve a successful outcome. Opportunities for employment and education support will be required to build peer support services. Employment and education support are also core components of a contemporary mental health and addiction system that meets the needs of tangata whenua, tāngata whai ora, whānau and carers.

The fiscal resource necessary to build sector wide peer support infrastructure requires substantial investment of new money. Recent governments and most likely those in the future have taken a fiscally conservative approach to health investment. At best it can be said that investment has attempted to keep pace with population growth. We believe that a 10-year timeframe with which to achieve some of the aspirations in the SSF has not factored in this pattern of government spending. The risk of subsequent governments not providing sufficient funding to operationalise peer support infrastructure is a real risk to this arm of development. That risk also extends to other arms of development in the SSF that propose services and approaches which, for the most part, don’t currently exist.
Attempts to directly link health outcomes to a combination of social policy initiatives and health care have not been mainstream approaches in public policy. Whānau Ora is perhaps the best example of where the link has been amplified. Whānau Ora outcomes are dependent on intergenerational population changes expected over two decades. We believe the SSF ought to provide the architecture by which aspirational, paramount, viable and realistic goals can be achieved across the health sector in the next decade. We suggest that the timeframe of 10 years is too ambitious to achieve the range of goals in the current SSF.

Commitment to Te Tiriti o Waitangi

As the RANZCP outlines in the position statement Recognising the significance of Te Tiriti o Waitangi, Te Tiriti o Waitangi is a founding document and fundamental to health policy in Aotearoa. We acknowledge the commitments outlined in the SSF. These could be further strengthened through the changes such as the following:

- ‘The SSF aspires to progress beyond obligations to proactively give effect to the text and principles of Te Tiriti in all elements of commissioning and service provision.’

We note the importance of “direct[ing] Treaty principles towards achieving the aspirations of te Tiriti, rather than the principles becoming the aspirations themselves”.

- Equity – ‘The SSF affirms the mental wellbeing rights of Māori and provides guidance to planners, commissioners and providers to ensure that structural arrangements do not prevent Māori from attaining mental wellbeing in taha hinengaro, taha tinana, taha whānau and taha wairua, and to ensure all Māori and non-Māori have equitable rights and privileges.’

We note that Māori and non-Māori are afforded equity under Te Tiriti o Waitangi, and it is important that inequities experienced by non-Māori and intersecting groups are also addressed – for example, Pacific peoples, disabled people and LGBTIQ+ people.

Principles

An additional principle could be considered to recognise the value of evidence, monitoring and evaluation in informing the system and practices that effectively support wellbeing. For example, comprehensive information on mental health needs across the country could help to identify gaps in service provision, stimulate modelling of data to project demand and help to plan services into the future. Kaupapa Māori research and qualitative data will also be key to understanding people’s experiences of the mental health and addiction system and services and how they can be improved.

Related to this, we highlight the view shared by medical colleges of Aotearoa New Zealand that interoperability of health data is imperative to an integrated system of care. The RANZCP emphasised this critical success factor in a written submission to the Pae Ora Select Committee. For psychiatrists delivering care to people who are acutely unwell, timely and accurate transfer of information to clinicians, GPs, allied health workers and whānau is needed to support an integrated response. There are few examples in the contemporary documents shaping the health sector of an absolute commitment to the interoperability of health sector data.

At a future stage when the SSF is aligned to workstream funding for research, we emphasise the need to repeat the epidemiological survey of mental health in Aotearoa New Zealand, Te Rau Hinengaro. Much of our current knowledge is based on data collected almost 20 years ago. We urgently need new
information that reflects contemporary changes in population, the prevalence of mental health conditions and access to mental health services.

**Human rights**

Reference could be made under this principle to Indigenous rights, as guaranteed under the United Nations Declaration on the Rights of Indigenous Peoples.

**Anti-discriminatory**

We recommend the aspiration be to ‘eliminate’ rather than ‘reduce’ discrimination.

**Strengths-based**

We recommend this principle is expanded, for example to acknowledge the skills, knowledge and relationships within whānau and communities.

**Critical shifts**

**Critical shifts 1-2: Actively deliver on Te Tiriti, Design out inequities**

We recommend that racism and cultural safety are explicitly called out under Critical shift 1: Actively deliver on Te Tiriti and/or Critical shift 2: Design out inequities. Having services designed and led by Māori and grounded in te ao Māori is of key importance, but a significant proportion of the health workforce is non-Māori. It is important the non-Māori workforce and services led by non-Māori are culturally safe and work to address systemic racism. Key documents that can inform this work include:

- Tuku Iho, Tuku Iho, Culture in Māori Health Service Provision – Te Rau Matatini
- Cultural safety within vocational medical training – Council of Medical Colleges (CMC) and Te Ohu Rata o Aotearoa (Te ORA)
- Statement of cultural safety – Medical Council of New Zealand (MCNZ)
- Cultural safety position statement – RANZCP.

We suggest acknowledging ethnicities beyond Māori, Pasifika and Asian. Middle Eastern, African and Latin American peoples are not necessarily refugees, and they also experience health inequities. Cultural safety is key for these groups, particularly as the mental health workforce within their communities may be limited.

**Critical shift 3: Build peer-led transformation**

We welcome the aspirational shift to building peer led transformation. We acknowledge the important contributions that a peer-support workforce would make to improve the mental health of tangata whai ora. For the peer support and lived experience leadership to expanded, it will be important that this workforce is adequately resourced. As discussed above, there is a significant distance to go to achieve a critical mass of peer support services. Growth and sustainability are key elements to achieving the critical shift.

This critical shift should also acknowledge:

- Whānau as important leaders and partners in transformation
- People with very serious mental health and addiction issues and/or dual disabilities may not have the capacity to provide leadership and peer support. It is important that hard to reach groups are allocated a voice in the consideration of consumer advice regarding system and service design.
**Critical shift 4: Get in early to support whānau wellbeing**

We strongly support a focus on early intervention and support and recognise this can take many forms.

While telehealth and digital services are a valuable tool to supplement or enhance existing services and support, in many cases they are not sufficient on their own. For example, mother and baby services and support rely on observational analysis of behaviour theories such as attachment, which are not readily assessed via digital engagement. Telehealth and digital services may also be inaccessible for some populations, including older people and those without digital hardware or connectivity.

We note that early support and prevention of mental health issues, distress, and substance abuse issues cannot be achieved by the mental health system alone. Early support for these issues may also involve connecting people to income, housing, education, employment and cultural supports.

The inclusion of distress as a category in the list of conditions that will benefit from early support and prevention is inappropriate. Distress is a human experience. We are sending the wrong message regarding a fit for purpose system if distress is identified as a criteria for early mental health intervention services.

**Critical shift 5: Create connected, locally driven networks**

It is not clear if ‘cross-sector’ refers to connections within or beyond the health sector. We believe the critical shift to create connected networks needs to articulate that this encompasses general health, hospital and mental health and addictions services, and services and support in other sectors.

As noted in the comments regarding critical shift 4, support, prevention and recovery for those with acute/long term serious mental health and addiction issues requires the integration of social and health policy agendas. We suggest the SSF acknowledge the important role other sectors play in addressing social determinants of health. Local driven networks that interface with tāngata whai ora and the intersects of the justice system, for example, are an important support for people with mental health and addiction issues who must face such interactions. System and service design must depict the connections to external sectors to directed operations so people with mental health and addiction issues are supported across all areas of their life. In so doing, actions would mitigate further marginalisation and disadvantage to tāngata whai ora through the delivery of services outside the scope of what is currently a health service. We support the aspirational goal of a healthy future made up with ‘cross sector’ building blocks. Whānau Ora approaches provide good examples of weaving connections between policy sectors and could help to inform integrated and holistic services for the SSF – see the RANZCP Whānau Ora position statement for more information.

**Critical shift 6: Do whatever it takes: Choice and control**

We suggest this critical shift explicitly references self-determination for tāngata whai ora and whānau. We support this goal but we consider the replacement of the short supply of inpatient beds with bespoke community services is a short-sighted objective and is not in the best interest of people with acute and long-term mental health conditions. Aotearoa New Zealand currently has a low number of inpatient beds per capita by OECD standards. Bespoke community services should certainly be created and enhanced, to exist alongside improved inpatient facilities. Many tāngata whai ora cycle through secondary services to receive intensive treatment for short periods of acute mental illness. It is not necessarily the case that community services residential or otherwise will be best placed to deliver the specialist care that is required to stabilise and support people who are very unwell.
We note the goal of providing community support options for people with addictions. A holistic view of that support would include the provision of safe and appropriate accommodation. Currently there are few options to house people with addictions in community supported settings and to do so requires significant, well planned, long-term investment.

**Service structure and landscape**

The SSF service landscape diagram is helpful for picturing the system that the Ministry of Health has proposed. We make the following comments:

- It would be good to understand the rationale for the differences in services available for 0–4-year-olds, 4–14-year-olds, and 12–24-year-olds. For example, it would be beneficial for whānau with 4–14-year-old children to be able to access parenting support, as well as whānau with 0–4-year-old children. School-based wellbeing services may benefit rangatahi aged 14+, as well as 4–14-year-olds.

- We note the term Consultation Liaison (CL) in the diagram and its community domain. Consultation Liaison is a sub-specialty of psychiatry, training, practice and knowledge. Hospital services are named CL Psychiatry Services with a team of doctors, consultant psychiatrists, registrars, mental health nurses and psychologists. Adopting the CL term into the community domain where the purpose is different to the interface between physical and mental health applied in the setting of a hospital is disconcerting. We believe CL as a health workforce reference is inextricably linked to the practice of psychiatry. It is our strong preference that the Ministry of Health adopt a different descriptor which is not disruptive to the traditional use and association people have to CL as a sub speciality of psychiatric practice and knowledge.

- We understand that CL Psychiatry is located within the hospital service domain of the diagram. More substantive information from the RANZCP Faculty of Consultation Liaison Psychiatry (FCLP) in Aotearoa New Zealand was provided in March 2022 to Health New Zealand regarding a future blueprint for this subspeciality of care. The report highlighted that CLP services are struggling to deliver benefit due to chronic under-investment and under-development. This has flow on effects for treatment and recovery where consultation liaison, outpatient work, teaching, supervision and research are all currently stretched beyond the rationale of a demand elasticity equation. Findings from countries where investment in CLP has been proactive show a clear cost benefit. The RANZCP report identifies 14 components which constitute the policy, service and workforce initiatives required to form the foundations of a blueprint. The blueprint provides information to guide the future direction and development of this psychiatric sub-specialty. It is available on request.

- Services for people with intellectual disabilities appear only under ‘Community’ within regional services. Some people with serious mental health issues and intellectual disability will need intensive specialist support. Expertise is required to guide care related decisions including assessing the capacity for tāngata whai ora to self-identify their choice of treatment. Appropriate services will include specialist treatment located in hospital and community services. The depiction of regional services for people with intellectual disabilities is more honestly represented as an intersect between hospital and community operations. An accurate representation would reinforce the intent to implement an integrated system of health care for people with serious mental health issues and intellectual disability.

- We note that there is no provision for behaviour addictions. This includes services and supports for gambling addiction and the issue of gaming. This stream of mental health and addiction care must be identified and factored into budgets for delivery of regional and local services. Interestingly the
Department of Internal Affairs are also linked to gambling addiction through a role to prevent harm from pokies machines. It is another example of a different government portfolio which contributes to the mental health and addictions outcomes of tāngata whai ora. Overall, the SSF could be improved to capture the inter relationships of health activities with allied government entities.

System enablers

We support the enabler domains listed in the SSF and agree they are the key to supporting a high quality, accessible and effective system of services to the improve mental wellbeing of the New Zealand population. We emphasise the imperative to have excellent data through interoperable digital systems connecting secondary services with primary and community care to support the wellbeing of tāngata whai ora.

Workforce

Shortages of critical mental health and addiction staff are an urgent and pressing concern for the RANZCP. Immediate investment in specialist clinicians and psychiatrists is needed as is an increase in the number of nurses, psychologists, doctors and allied health workers. For example, the current ratio of child psychiatrists to population is 1 to 100,000. The RANZCP advocate for an increase in the psychiatry workforce to the ratio of 2–4 per 100,000 for both child and adult psychiatry.

We note that the list of actions regarding workforce enablers does not explicitly identify an intent to advocate for an expansion of specialist secondary service roles or increase in numbers. It appears that psychiatry has been left out of the workforce equation.

Additional enablers

Relationships could be considered as an additional enabler. Relationships within communities and across sectors are key to ensuring an integrated system and services.

A necessary next step for the SSF is to define the implementation infrastructure that coordinates and integrates collective effort and drives ideas into action.

The implementation plan or roadmap needs to include clear actions, lines of responsibility and timeframes for achievement, supported by proof of underlying need and gaps, adequate investment of funds for services, transparent performance data and evidence of impact for the wellbeing of tāngata whai ora and all people in Aotearoa.

References

1 Te Pou. The physical health of people with a serious mental illness and/or addiction: An evidence review.
3 TO ADD
4 Te Rau Hinengaro: The New Zealand Mental Health Survey


6 Consultation-Liaison Psychiatry in Aotearoa New Zealand – past, present and a blueprint for the future, Occasional Paper, RANZCP, February 2022