Stewart,M.W., Bushnell,J., Hauraki,J., & Roberts,M. (2014). Evidence and wisdom: The role and value of psychologists in healthcare. *Journal of the New Zealand College of Clinical Psychologists, 24(1),* 3-14

Evidence and Wisdom: The Role and Value of Psychologists in Healthcare

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Abstract

Developments in society and the health system necessitate significant changes in the organisation and delivery of health services by provider organisations and practitioners, and important questions continue to be asked about the relevance and value of the existing health professions. This article addresses these issues in relation to psychological practice in clinical settings in the health sector. It discusses distinctive features of the role that psychologists currently play in the health sector, and considers some potential roles that may enhance the contribution of psychologists to health service users and to health providers in the future. This article draws primarily on the literature from clinical psychology, but much of it may apply to other psychological disciplines that utilise a comprehensive and integrated training programme of specialty knowledge and practicum experience to train practitioners to provide healthcare and related services. Many of the aspects discussed in this article may, to a greater or lesser degree, relate to psychologists practicing in areas other than the health sector.

The Current and Future Health Environment

In common with other countries, the Aotearoa/New Zealand health system faces considerable challenges in coming decades. The population continues to grow and age, increasing the demand for healthcare. The range and cost of health interventions continues to increase, as do public expectations for delivery of healthcare. For example, from 2008 to 2010, healthcare expenditure increased from 9.3% to 10.1% of Gross Domestic Product. Another consequence of the aging population is that in coming decades a progressively smaller proportion of the population will be of working age and contributing taxes to support a growing proportion in old age dependency (National Health Board, 2010). If the health needs of New Zealanders are to be met appropriately and sustainably in the future, it is important that healthcare providers perform efficiently and cost-effectively (Mental Health Commission, 2012; National Health Board, 2010).

In response to these challenges, there has been significant and ongoing change in the Aotearoa/New Zealand healthcare system, with substantial impacts on mental and physical health care delivery. This creates impetus for exploring different models of care. For example, the government's *Better Sooner More Convenient* (BSMC) healthcare initiative aims to improve the patient journey by providing the right care in the right amount at the right time and by the right carer. Similarly, the Whānau Ora initiative identifies the importance of family/whānau, community, and multi-sectoral involvement, and encourages integration and collaboration to achieve the best outcomes for Māori (Te Puni Kokiri, 2012). This environment has engendered ongoing questioning about the structure and function of professions within the health sector and exploration of new workforce roles and organisation (Health Workforce New Zealand, 2011).

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Particularly within mental health, there have been changes in the scope of health professional roles, leading to provision of psychotherapeutic interventions by some practitioners from a range of professions (e.g., psychologists, nurses, occupational therapists, social workers, and therapists trained in particular therapies without other health professional training). This increases access to psychotherapy, but also leads to variations in clients' experience of receiving therapy due to the differing emphasis and level of psychotherapy training for different disciplines (Earl, 2010; Peachey, Hicks, & Adams, 2012). It also raises the question "What is the unique value that psychology adds?" and begs consideration of the implications arising from that question. This article considers these issues.

Psychologists' Role and Value

A useful articulation of the unique value that clinical psychology adds was presented following a review of clinical psychology services undertaken for the British National Health Service (NHS) Workforce Planning Advisory Group by Management Advisory Services (MAS) in 1989. The aim of the study (often referred to as the MAS report) was generally understood to be to validate replacement of psychologists with "cheaper" alternatives. However, the review found that clinical psychologists in the NHS made a unique, valuable, and cost-effective contribution. The report identified that meeting the psychological needs of healthcare users is not solely the role of psychologists—it is in fact, the responsibility of all staff in health and social services. However, different professions have different contributions to make to this. The MAS report identified three levels of expertise in psychological input by health sector staff. These levels are shown in Table 1.

Table 1
Levels of Psychological Input, Adapted from the MAS Report

Level 1:	Establishing, maintaining, and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as basic counselling and stress management. These should be within the skill set of, and undertaken by, all health staff.
Level 2:	Undertaking circumscribed psychological activities. These activities may be protocol-driven (e.g., manualised) therapy approaches with patients with mild-moderate difficulties and are undertaken by a variety of health staff (e.g., medical practitioners, nurses, occupational therapists, and social workers) with suitable aptitude and training. Therapies such as straightforward CBT for clients with relatively uncomplicated presentations may fit at this level.
Level 3:	Activities requiring specialist psychological intervention in circumstances where complexity or underlying influences require the capacity to devise an advanced and individually tailored therapeutic strategy. Flexibility to robustly adapt and combine approaches is a key competency at this level. This comes from a broad, thorough and sophisticated understanding of various psychological theories and approaches. While not exclusively the case, this level is primarily undertaken by psychologists.

The first level requires basic interpersonal and interactional abilities, and the counselling skills needed to assist people who are confronting health issues or other life challenges. These skills are necessary for anyone working with clients in the health sector. The second level involves the application of well-defined, often manualised, psychological interventions that involve application of specific techniques and are often directly derived from a single theoretical model. A variety of disciplines can engage safely and effectively in these activities after undertaking specific training

in delivering psychotherapeutic interventions.

The third level constitutes interventions founded on a more sophisticated understanding of the psychological theory and therapy that allows, through the psychological assessment (including the use of psychometric tests) and formulation process, the resultant therapeutic approach to be accurately tailored to the client's needs, situation, and personal attributes (e.g., learning style) to a greater extent than therapy at other levels. The importance of offering a range of therapies to meet the diverse needs and characteristics of people with mental health difficulties is widely recognised (Centre for Social Justice, 2012), and the ability to tailor the approach to the needs of the individual is also paramount in many situations (Bobart, 2005). Therapies utilised in level 2 may be used, but the therapeutic process is informed by a broad and in-depth understanding of psychological theory and literature leading to a sophisticated and individualised psychological formulation that guides the use of evidence informed therapies (British Psychological Society, 2010). The majority of, though not all, practitioners working at this third level are psychologists.

Much has changed in the health sector since the MAS report was published, but the MAS articulation of the value of psychologists remains highly relevant. More professions providing therapy increases access to psychological therapies, and technological changes have led to the increasing availability of comprehensive web-based self-help resources based on psychotherapeutic principles and techniques, but complex cases still require the level 3 skills. Some recent trends and developments in Aotearoa/New Zealand health care delivery, discussed below, increase the relevance of psychologists and the provision of level 3 care.

Stepped Care

Stepped care approaches are increasingly influential in mental health services in Aotearoa/New Zealand (Mental Health Commission, 2012). Stepped care aims to optimize the effectiveness and cost-effectiveness of therapy through a systematic approach to matching the right type and intensity of therapy to the specific needs of the client (Haga, 2000). Stepped care involves: 1) providing different types of intervention (steps) to meet different levels of complexity and severity of need; 2) having processes to systematically allocate clients to the step that will optimally (least intrusively, most effectively, and most cost effectively) meet their needs; and, 3) having systematic approaches to identifying when a client's needs change or are not being met at their current step, and changing step accordingly. The levels articulated in the MAS report are consistent with a three-level stepped care approach currently used in Aotearoa/New Zealand (Earl, 2010). Psychologists are often the staff who provide therapeutic services at the level 3 step and are often integral to decision-making about which step is likely to best meet the client's needs.

The stepped care/MAS conceptual model for the delivery of psychotherapies has ramifications for understanding evidence-based practice in psychotherapy. Whilst there is much to gain from collecting and using outcomes evidence, simplistic approaches to evidence-based practice have significant limitations in psychotherapy (Western & Bradley, 2005). The strengths and weaknesses of a narrowly defined evidence-based approach have been debated widely (e.g., Chambliss & Hollon, 1998; Bobart, 2005). However, common factors research (e.g., Duncan, Miller, Wampold, & Hubble, 2010) shows psychotherapy has substantial benefit for clients and, while specific therapies provide a useful scaffold for framing and undertaking therapy, slavish adherence to the particulars of a specific therapeutic protocol is less important than a robust and considered use of level 3

flexibility to optimize "fit" and credibility of the therapy for clients with complex difficulties. Use of terms such as "evidence-informed practice" rather than "evidence-based practice" has been advocated in part to signify the balance between the use of evidence and client-specific factors (Bobart, 2005).

Expansion of Talking Therapies

The publication of *We Need to Talk* (Peters, 2007) signalled growing policy interest in increasing access to talking therapies for people with mental health difficulties. Cost benefit analysis[1] has shown very positive results for talking therapies. An economic analysis of the value of talking therapies in Aotearoa/New Zealand (Te Pou, 2012) calculated benefit-cost ratios of 15:1 when provided in primary care and 5:1 when provided in secondary care, with the cost per Quality Adjusted Life Year (QALY)[2] being just under $8,000 per QALY, which is approximately a third of the average cost per QALY for comparable medication treatment. Responses to this focus on talking therapies have included development of many training programmes in talking therapies of different levels of complexity for workers from different professional backgrounds. However, safe and effective translation of training into practice requires supervision and support in implementing the new skills. Psychologists are frequently requested to offer this assistance. The MAS report emphasises the contribution and value of all three levels in supporting psychologically healthy clients and societies. Level 1 and 2 activities give access to psychological care for a wider range of people than could ever be served by level 3 practitioners alone. Therefore, there is considerable societal benefit when level 3 practitioners, such as psychologists, support the efforts of people working at levels 1 and 2 through activities such as training, supervision, mentoring, and role-modelling. Undertaking these activities expands the positive impact of the level 3 practitioner as they benefit the clients of practitioners they train, supervise, and lead as well as the clients they work with directly.

There have been several ambitious international initiatives to improve public access to brief, publicly-funded psychological therapy for people with mild to moderate mental health difficulties. The British *Improving Access to Psychological Therapies (IAPT)* initiative began in 2006, with the goal of increasing access to brief, future-oriented psychological therapies. Consistent with a stepped care approach, clients with lower intensity needs undertake intervention with therapists who receive specific training in low-intensity therapeutic techniques, while people with higher intensity needs access more intensive therapeutic approaches delivered by clinical psychologists, psychotherapists, and some other health professionals with advanced therapy training (Department of Health, 2008). IAPT teams consist of staff that deliver low-intensity psychotherapeutic services and those delivering high-intensity

[1] The benefit-cost ratio is an indicator used in cost-benefit analysis to summarise the overall value for money of a proposed or actual activity. It is calculated by dividing the benefits of the activity (expressed in present-day dollars) by the costs of the activity (also expressed in present day dollars). A benefit-cost ratio of greater than one indicates that the benefit derived from the activity is greater than its cost. Generally, a larger benefit-cost ratio is considered better.

[2] The quality-adjusted life year (QALY) is the number of additional years of life lived as a result of a health intervention, adjusted to take account of the quality of life during those years. Each additional year of life is given a value between 1 (perfect health/high quality of life) and 0 (death) with scores closer to 1 indicating better health/quality of life. The values for each additional year are summed. For example, a person who lived five additional years as a result of an intervention (5 non-adjusted life years) with one of those years in perfect health (QALY value = 1) but the remaining four years with very poor health/quality of life (QALY value = 0.2 for each year) would have a total QALY of 1.8. The QALY is used to calculate the value for money of an intervention by dividing the cost of the intervention by the total QALY. The lower the cost per QALY, the better the value for money.

services, and are frequently led by psychologists who provide team leadership, supervision, and training as well as providing high-intensity therapy. A recent evaluation of the IAPT initiative (Department of Health, 2012) found: More than one million people have received service from IAPT; two thirds of those completing treatment showed clinically meaningful improvements and 41% attained complete recovery; more than 45,000 of the participants had moved off sick pay or benefits; and 4,000 new therapists had been trained as part of the programme. The programme has been expanded to include older adults and an IAPT programme for child and youth is planned.

In 2006, Australia took a different approach to increasing public access to psychotherapy through its *Better Access to Psychiatrists, Psychologists, and General Practitioners through the Medicare Benefits Schedule Initiative* (Better Access Initiative). This programme funds members of the public with mild to moderate mental health problems to receive up to six (and sometimes an additional four) psychotherapy sessions from private practitioners of a variety of professional backgrounds, on referral from a psychiatrist, GP, or paediatrician. Also using a stepped care approach, two levels of care were defined: *Psychological Interventions* (typically delivered by a clinical psychologist) and *Focused Psychological Strategies* that are typically delivered by other health workers. Evaluation of this programme (Purkis, Harris, Hall, & Ftanou, 2011) has shown substantial uptake, including by disadvantaged population groups. Ninety percent of users reported significant or very significant improvements, and substantial improvements were also shown on standardised outcome measures. The average number of sessions per client is 5.2 per annum. The proportion of eligible Australians using the service increased from 3.4% to 5.3% between 2007 and 2009, and has levelled off since then (Purkis, et al., 2011).

Another example of initiatives to improve access to publicly-funded psychological therapy is the "Primary Care Psychologist Programme" that has operated in the Netherlands since 1978. Under this programme, the whole of the population is eligible for up to eight sessions per year for treatment of mild-moderate mental health difficulties. Approximately 5% of the population utilise this service each year, with 75% of these using less than eight sessions (Derksen, 2009).

These programmes are likely to reduce later demands on the health sector caused by conditions becoming more severe prior to effective treatment. The cost-effectiveness of early intervention has been clearly demonstrated, with often substantial positive benefit-cost ratios for common mental disorders and associated difficulties (Knapp, McDaid, & Parsonage, 2011). The role of psychologists, either as providers of high intensity therapeutic services or as team leader, supervisor, mentor, and trainer is central to all the initiatives described above. Psychologists can also take considerable leadership in the decision making process that allocates clients to the appropriate initial level of care (step) and ensures that the level of care is changed (up or down) as needed. Similar leadership and mentorship can be taken by psychologists in enabling non-professionals to undertake health interventions based on psychological principles (e.g., Cox, Treacy, & Taylor, 2011).

In Aotearoa/New Zealand, Blueprint II (Mental Health Commission, 2012) emphasises the need to improve access for consumers to mental health and addiction services, recommends the use of a stepped care approach, and recommends increased provision of "services that are known to add value (for example, talking therapies)" (p.20). This emphasis, and the development of some primary care-based psychological services (Dath, Yang Dong, Stewart, & Sables, 2014; Lyons & Low, 2009), supports increased access to talking therapies and

could foreshadow an initiative similar to those described above.

Tailoring Therapy to be Culturally Appropriate

Psychotherapy outcome evidence is rarely derived from minority populations such as Māori or Pacific Island people. Tailoring the evidence-informed psychotherapies to be appropriate for the ethnically diverse clients of the health sector is a level 3 activity in MAS terms, requiring a sophisticated understanding of psychological theory and therapy and a strong understanding of the cultural context in which it is to be introduced. Psychologists, armed with a respectful approach and learning from, or in collaboration with cultural experts, frequently act as a bridge by using Western talking therapies in a way that is appropriate to the diverse ethnic populations in Aotearoa/New Zealand (Glover & Hirini, 2005). Non-Caucasian psychologists often feel the tension of being caught between Western talking therapies and their own cultural background (Banks et al., 2008), but in holding this tension they can act as translators who adapt the therapy to the values, beliefs and norms of their culture, and through this and other activities, can improve access to psychological therapies for people from diverse ethnic communities.

Psychologists' Involvement in Service Evaluation and Improvement Activities

The scientist-practitioner model and extensive involvement in research is an integral component of psychologists' core training (British Psychological Society, 2010). This leaves psychologists able to lead evaluation activities such as analysis of service functioning and developing, refining and/or evaluating service innovations (e.g., Feather & Ronan, 2009; Stewart, Wilson, Bergquist, & Thorburn, 2012). One of the challenges for psychologists in undertaking these activities is often to scale down from the rigour of masters- or doctoral-level research to develop evaluations that retain sufficient validity to be useful but which are feasible and sustainable within the resource limitations of busy services. However, psychologists who use their research and evaluation skills to support the development and effective function of services are generally highly valued.

Behavioural Healthcare

In developed countries, much of the burden of physical disease, disability, and premature mortality may be preventable or reduced by modification of behaviour and lifestyle factors such as smoking and other substance use, obesity, lack of physical activity, and unsafe sexual practices. For example, the World Health Organisation (WHO) estimates that 40% of global premature mortality can be attributed to high blood pressure, tobacco use, high blood glucose, physical inactivity, and obesity (WHO, 2009). People with mental health difficulties are at higher risk of potentially preventable mortality or morbidity than the general population (Prince et al., 2007). Lifestyles associated with, and some treatments for, mental health issues may exacerbate these risk factors. The WHO has therefore defined as one of its key priorities promoting health and development and preventing or reducing risk factors for health conditions associated with lifestyle/behavioural factors. Psychology has a long history of developing interventions to positively modify health behaviours and to reduce other factors that may impede healthy lifestyles (Stewart & Young, 2007). During the past thirty years, clinical psychology in Aotearoa/New Zealand has broadened from its origins in mental health and now many physical health services focused on conditions such as heart disease, diabetes, and renal disease have psychologists working directly with patients, and helping to guide, train, and support other members of the team. Given the increasing importance of these interventions in the future, psychology is well poised to expand this impact in both physical and mental health (Johnson & Radcliffe, 2008) through contributing expertise in evidence-based treatment design and evaluation, supervision and training as well as working with complex clients.

Another of the WHO strategic priorities is to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and reflect pro-poor, gender-responsive, and human rights-based approaches. The importance of the social determinants for both mental and physical health is substantial (Marmot, Friel, Bell, Houweling & Taylor, 2008), and for psychologists to maximally contribute to improving health, it is important they remain mindful of the systemic dimension of psychology and remain active in attempting to improve the social determinants of health both at client level and at broader societal levels.

Neuropsychological and Cognitive Assessment

Neuropsychological assessment involves evaluation of brain structure and function by analysis of patterns of performance on standardised tests of different behaviours and aptitudes (Levin, 1994). The tests are interpreted by comparison with data from relevant populations integrated with other information such as behavioural observation and client and family report. Amongst other uses, neuropsychological assessment is used for diagnostic clarification, client and family education, determining the appropriate type and intensity of treatment, identifying cognitive strengths and weaknesses, and using this information to guide rehabilitation and compensatory strategy development to optimise day-to-day function. Clinical neuropsychological assessment is an important resource for clients in health services who have cognitive deficits due to intellectual disability, neuro-developmental disorders, age-related disorders such as dementias, or acquired disorders such as traumatic brain injury or substance abuse (Levin, 1994). Cognitive deficits may trigger, exacerbate, or mimic mental health difficulties. Mental health difficulties may also impact adversely on cognitive function. The potential recovery of physical and mental health clients can be impeded by cognitive deficits that exacerbate their health problems, interfere with social and occupational function, or interfere with their ability to utilise other treatment effectively (Levin, 1994). For example, in child and adolescent mental health, a plethora of issues may contribute to the presenting difficulties, and the identification of cognitive deficits and strengths may be essential for differential diagnoses and developing a clear formulation and treatment plan.

Advanced neuropsychological assessment is primarily undertaken by specialist neuropsychologists or clinical psychologists with specialist interest and training in this area. Some New Zealand organisations, such as the Accident Compensation Corporation (ACC), only utilise experienced psychologists for these assessments. Many (if not most) other clinical psychologists have been trained to undertake more limited cognitive assessments that can also benefit clients. These cognitive assessments use a more limited range of standardised tests to produce briefer assessments that fulfil tasks such as assessment of eligibility for intellectual disability support, identifying the role of cognitive deficits in impeding mental health treatment, and identification of cognitive strengths and weaknesses to help guide rehabilitation and compensatory strategy development to maximise function and wellbeing. In many settings the ability to undertake neuropsychological or cognitive assessments is unique to psychologists.

Meeting the Needs of Special Populations

While the complexity of assessment and intervention in any population with mental or physical health difficulties varies, some populations are particularly complex so that the skills and aptitudes of a trained psychologist may be of particular value. Some such groups are people with intellectual disabilities, older adults, and the forensic population.

People with intellectual disabilities often present with many psychosocial and behavioural difficulties, often in the context of sub-optimal care environments, and often

with coexisting physical problems. This makes management of their difficulties particularly challenging (Webb, Verhoeven, & Eggleston, 2007). Psychologists are often uniquely skilled at providing the cognitive and other assessments required for development of effective individualised care plans, and to provide the behavioural, systemic, and skills-focused interventions that fully take into account the social, cultural, and care context in which the person with an intellectual disability lives. Most specialist assessors under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 are psychologists (Webb, et al., 2007).

For older adults, there is an increasing range and severity of biopsychosocial needs with age (Peachey, et al., 2012). Difficulties of older age include, but are not limited to: older people with pre-existing mental health difficulties; late onset mental health difficulties; difficulties associated with physical health problems and disabilities; and difficulties associated with late-life transitions such as grief over the loss of loved ones or emotions associated with confronting one's own mortality. Many older people prefer to have psychological rather than pharmacological treatment, and polypharmacy associated with other conditions may militate against additional pharmacological mental health treatment (Peachey, et al., 2012). Psychologists are often a significant part of the multidisciplinary team to assist with management of the biological, psychological, and social complexity faced by older people, with the goals of overcoming as much as possible mental and physical health problems, enhancing their well-being, and achieving maximum wellbeing and potential during later life (Prasadarao, 2007).

A further example of a specialised and complex group for whom psychologists contribute significantly to the treatment and management is the forensic population. Forensic psychologists are frequently requested to undertake specialist assessments, evaluating matters such as fitness to plead, the appropriateness of a defence of insanity, suitability for treatment, risk of recidivism, and other issues specified in various laws. Psychologists integrate their knowledge of psychological theory and research to provide an individualised risk formulation for the offender which offers information on the probability and likely characteristics of future offending. Psychologists also make recommendations for treatment and rehabilitation activities to reduce recidivism (Wilson, Tamatea, & Riley, 2007).

Expanding and Future Roles for Psychology

All professions need to grow and change their roles over time. Assessment and therapy are likely to remain the core tasks for many psychologists working in the health sector. The other roles discussed above will remain important, but new roles are likely to emerge. With the previously discussed heath sector changes, there is impetus for professions to undertake the full range and complexity of healthcare tasks that they can competently and safely perform ("working to the top of their licence", Health Workforce New Zealand, 2012). In addition to the value added by psychologists, discussed above, potential new roles are being explored. Examples of these are described below.

Focus on Positive Psychology and Strengths-Based Approaches

The recovery approach is regarded as a philosophical cornerstone of the aspirations of the mental health system in Aotearoa/New Zealand (Mental Health Commission, 1998, 2012). One of the central values of recovery is an optimistic and strengths-based approach that aims to utilise the client's strengths and abilities to assist with bringing about positive change, rather than a more deficit-focused approach. A strengths-based approach has been evident to a greater or lesser degree within most psychological sub-disciplines but has

been brought more strongly into focus by the development of positive psychology (Seligman & Csikszentmihalyi, 2000). Positive psychology is influencing other branches of psychology and also developing a range of explicitly strengths- and wellbeing-focused interventions. One of the limitations of the recovery approach in mental health has been limited operationalisation of the philosophy into strategies that are understood and usable by a variety of mental health professionals. Positive psychology may assist with developing more strategies that can take the recovery philosophy and embed it more solidly and effectively in practice. Psychologists can have a central role in the development and dissemination of these strategies, both within psychological therapies and other health interventions based on psychological principles.

Responsible Clinician Status

A responsible clinician under the Aotearoa/New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992 is the clinician who is in charge of the clinical care and ensuring that the correct legal processes are undertaken to protect the rights of a person who is currently subject to the Act (Ministry of Health, 2001). Only a small proportion of mental health service users are under the Act at any time, but all these are required to be assigned a Responsible Clinician. Psychiatrists have traditionally undertaken this role, but the law allows other registered health professionals also to undertake this role, and there are instances of clinical psychologists fulfilling this role. There has been an increasing willingness in several parts of the country for psychologists to undertake this role with appropriate clients. "Appropriate" can be defined as the psychologist is currently working with the client and/or has good clinical reason to work with them. Being the Responsible Clinician potentially provides the opportunity more effectively to influence the total care provided to a client (Ministry of Health, 2001). Some psychologists have expressed concern that undertaking this role may adversely impact on the therapeutic relationship, which can be a concern, but is by no means always the case.

Psychologist Prescribing

A potential area for an expanded psychologist role is prescribing privileges for some mental health medications. At the suggestion of Health Workforce New Zealand, this is being explored by the New Zealand College of Clinical Psychologists (NZCCP), with input from the New Zealand Psychological Society, the Psychologists Board, and other professional groups, leading to a broad stakeholder consultation of professionals and the public. There is a wide divergence of opinion within psychology about prescribing rights. Fitzgerald and Galyer (2008) found a small majority of psychologists were in favour of prescribing privileges, and similar results in an earlier survey (NZCCP, 1995) indicated that this ambivalence was stable over time. Multiple reasons for and against psychologist prescribing have been advanced (Fitzgerald & Galyer, 2008). The nub of the debate could be seen as: On the one side, that prescribing psychologists would use less of their psychology skills if they had access to prescribing, and on the other, that psychologists' ability to both undertake talking therapy and prescribe medications would allow clients to access a more integrated and balanced use of both modalities than is currently readily available. The NZCCP has proposed that a pilot of psychologist prescribing could be undertaken by senior psychologists who undertake additional voluntary training (e.g., a masters-level qualification) in psychologist prescribing based on similar programmes in the United States (American Psychological Association, 2008). However, future developments in this area are uncertain.

Inter-professional Education

The WHO (2010) has identified that inter-professional education enables effective collaborative practice, which in turn strengthens health systems and improves

health outcomes. The Auckland University of Technology has committed to support inter-professional education between its various healthcare programmes and is undertaking projects to encourage inter-professional education in health provider organisations. The value of psychologists in the inter-professional model is evidenced by the strong presence of psychologists researching and teaching across a wide variety of health professional training programmes within the School of Healthcare Practice and in other institutions.

Conclusion

The trends discussed in this paper have significant implications for health services and for the discipline of psychology. From a health service perspective, an implication is that psychologists will be delivering therapy that is somewhat different to that delivered by most other members of the healthcare team, even if it is subsumed under the same general label. The tailoring of the therapy approach to the individual should be based on a formulation developed using a thorough understanding of evidence-based psychological theory and practice, and provides a form of flexibility that may be critical for assisting clients with more severe and complex difficulties to gain from therapy.

A multidisciplinary team, like a good sports team, is made stronger by having members who have a diversity of specialist skills as well as basic generic skills. This paper is not intended to detract from the contribution made by any other health profession to the care and wellbeing of clients. It does, however, argue that the best outcomes are likely to be achieved when all the disciplines "play to their strengths" (described by some as "working at the top of their license"). For psychologists, this is likely to be achieved when they deliver evidence-informed and theoretically nuanced therapy that takes into account both the relevant psychotherapy outcome literature and factors relevant to the personal and situational factors of the client, as identified in the formulation. In a society like Aotearoa/New Zealand, the need for psychological assistance to address health and other concerns and to enhance wellbeing is such that there is "more than enough work for everyone". Psychologists do have a unique role in contributing to meeting this need and also in supporting others to offer their contributions to meeting this need.

This paper also indicates the broader range of roles that psychologists can and do play in health services. Psychologists often don't put themselves forward for formal leadership roles, more frequently developing "informally mandated leadership" (leadership that is given by colleagues due to recognition of ability, rather than leadership recognised with a formal job title). However, the range of people-skills, systems-thinking skills, clinical skills, and situational analysis skills that is central to training and functioning as a psychologist often makes psychologists highly capable in formal leadership roles of many types, as evidenced by the range of roles described above.

This paper has particularly focused on psychologists working in the health sector. However, many of the issues discussed will be familiar to psychologists working in other social services and similar sectors. Similarly, with some variability (e.g., due to the differing roles and organisation of psychologists across sectors), the content of this article may, to a greater or lesser extent, have resonance with psychological practice in other sectors.

"Evidence and wisdom" in the title of this paper does not mean to claim that all psychologists, irrespective of their experience level, are extraordinarily wise people. Rather, it refers to psychologists' professional training and approach that: Actively seeks to utilise and create the evidential wisdom about the human condition and what works in therapy and in services; works with clients (individuals, families, groups, or organisations) to

optimise the clients' ability to contribute their own wisdom to the change process; and utilises a thoughtful, ethical, and practical approach that can and does support psychologists to offer wise and effective service to the clients and organisations they work with.

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