NZ College of Clinical Psychologists
Te Whare Wānanga o te Mātauranga Hinengaro

Submission to the Petitions Committee

Petition of Marion Maw: Ensure access to ERP therapy for people living with OCD.

1 Introduction

Thank you for the opportunity to address the issues raised in the above petition. We note that the petition requests: *"That the House of Representatives ensure that people living with Obsessive Compulsive Disorder have timely and equitable access to effective therapy by expanding the workforce trained in Exposure Response Prevention therapy (ERP) in primary and secondary health services; and note that 1,290 people have signed a petition in support."* We also note that a further 25 individuals have added their names to this petition, since it was submitted.

The College of Clinical Psychologists is very much in support of the principle of Marion Maw's petition- to increase the access of people with significant mental health issues to evidence-based treatments- Exposure Response Prevention Therapy for OCD, in this case. We also note that several of our members are signatories to the petition. At the same time, we acknowledge that people with OCD are not alone in their struggle to access evidence-based psychological therapies and it is part of a wider context of recent mental health reform.

As well as the broad request to increase access to ERP therapy for people with OCD, we noted that the submission by Marion Maw and Fixate makes a number of specific requests (p5), which include:

- A request for acknowledgement that the current provision of primary and secondary services is not meeting the needs of people with OCD.
- A 'stocktake' of services and an evaluation of the workforce 'pipeline' to develop professionals who are able to meet the needs of people with OCD.

For this reason, we have chosen to focus our submission upon current access to ERP (and other evidence-based psychological therapies) in New Zealand, and the current training pathways available.

2 Provision of Evidence-based Psychological Therapies in New Zealand

2.1 There is increased demand for psychological therapies

As we have previously reported to the Petitions Committee, there has been an exponential demand for mental health services in New Zealand (and internationally) over the past 10 years, which appears to have been accelerated by the COVID-19 pandemic. As the He Ara Oranga Mental Health Inquiry report noted, approximately 1 in 3 New Zealanders were experiencing mental distress at that time, with 1 in 5 likely to meet criteria for a diagnosable mental health condition. In that context, the He Ara Oranga report spoke to a significant "over-reliance" on medication as a treatment for mental distress (p.56). In contrast, the review spoke to the strong preference of consumers to have access to effective psychological therapies, making over 130 references to the need to increase access in the (219 page) report.

Indeed, research suggests that psychological therapies are generally more effective than (or, at least, equally effective as) medication in treating a range of mental health conditions, they have wider application (e.g. can be applied to relationship difficulties, grief, work-related stress and burnout, etc.), they have fewer (if any) side effects and generally cost the same to deliver over the lifetime of treatment (with psychological treatment generally being shorter but more intense). On this basis, the UK ('improving access to psychological therapies'), Australia ('Better Outcomes in Mental Health Care') and parts of Canada have invested heavily in recent years in the mass delivery of evidence-based psychological therapies, with a corresponding investment in the clinical psychology workforce.

2.2 There is currently no clear commissioning body or framework for psychological treatments in New Zealand

Whilst PHARMAC is responsible for commissioning pharmacological treatments for mental health conditions in New Zealand, there is currently no agency with similar responsibility for evaluating and commissioning up-to-date psychological treatments, with the most recent guidance on OCD issued by the Ministry of Health in 1998. For this reason, New Zealander clinicians typically look to overseas institutions such as the National Institute for Clinical Excellence (NICE) who have extensively reviewed the international evidence for treatments of mental health (and other) conditions, although they have no official standing in New Zealand.

2.3 Internationally, CBT with ERP is the recommended 'first line' treatment for OCD.

Current NICE guidelines recommend Cognitive Behavioural Therapy (CBT) with ERP as a 'first line' treatment for OCD- stating that it should be offered to everyone experiencing distress from OCD. The intensity (the number of individual hours with a therapist) recommended depends on

the current impact OCD is having upon the person's everyday functioning, the length of time the person has been experiencing distress, and whether they have other, associated physical and psychological difficulties.

Medication (in the form of Selective Serotonin Reuptake Inhibitors, or SSRIs) are only recommended where the person has 'moderate' to 'severe' difficulties in daily functioning and *only in combination with CBT and ERP*.

NICE guidelines are diagnosis-specific, therefore their recommendations do not cover instances where the person may have other, co-existing mental health difficulties, suicidal thoughts and behaviour, neurodiversity or other challenges in their lives. Such co-existing conditions are common and likely to require a more individualised and specialist approach.

2.4 Access to evidence-based therapies is 'patchy' and inequitable across the country.

As Marion Maw's submission highlights (p10), Te Pou have previously advocated for a 'stepped care' approach to the delivery of psychological therapies in New Zealand, with care split between primary (formerly PHOs) and secondary care (formerly DHBs).

Over the last few years, the government has invested heavily in Integrated Primary Mental Health and Addiction (IPMHA) services, primarily in the form of the Access & Choice programme. As part of this programme, Health Improvement Practitioners are trained in brief interventions (with sessions intended to be less than 30 minutes long, compared to usual 60-minute therapy sessions). According to Te Pou training guidance, Health Improvement Practitioners (HIPs) receive 4 days of training in "fast acceptance and commitment therapy" (fACT), which is not currently recommended by NICE guidelines for any diagnosable condition. fACT would not be indicated for use with people with OCD and, as Marion Maw's submission suggests, inadequate, delayed or incorrectly delivered therapy will typically lead to increased distress and disability. While HIPs may have previous experience or have undertaken further training on OCD, this is not currently a requirement of the role, and skill and knowledge is likely to be extremely variable.

Where people with OCD are unable to access suitable support through Primary services, Secondary services are typically commissioned to work with individuals with 'moderate to severe' mental health conditions. As Marion Maw's submission notes, our members currently report that clients face significant barriers to accessing secondary care services- where treatment is typically only available to people with significant risk of harming themselves or others.

Where people are able to access secondary care services, they may include a significant wait time to meet with a psychologist. A workforce survey in 2017 indicated that wait times to see a clinical psychologist through a DHB were, on average, 15 weeks in adults' services and 11 weeks in children's services and we understand that services are now facing an even greater demand.

Clients who are unable to access Health-funded mental health treatments have been characterised by the Royal Australia & New Zealand College of Psychiatrists (RANZCP) as "the missing middle"- being unable to access suitable services through either primary or secondary care. Where they are able to do so, many consumers and families will seek to pay for private sessions from a clinical psychologist, which is likely to involve a significant cost for long-term treatment. Furthermore, a survey of our members in 2021 suggested that many clinical psychologists in the private sector are currently 'overwhelmed' with referrals and may not be able to offer timely support.

2.5 CBT with ERP requires significant training to deliver and there is a shortage of skilled clinicians to deliver it.

As Marion Maw's petition suggests, the current main provider of psychological therapies to people with OCD in NZ are clinical psychologists. As we have previously outlined to the Petitions Committee, there is a significant shortage of clinical psychologists within New Zealand. A comprehensive analysis in 2017 from the Psychology Workforce Task Group (a cross-agency group convened by the Ministry of Health) suggested that 1000 more psychologists were required (at that time) to meet the increased demand within the (then) DHB and PHO sectors. In response to this, the Ministry of Health has recently announced some increases in the funding of training placements for clinical psychologists, which we hope will lead to modest increases in that part of the workforce in future years.

As we have previously detailed, clinical psychologists are not the only professional group who are capable of delivering psychological therapies, although non-psychologists typically require a significant level of extra training and supervision to be able to do so. In New Zealand, Te Pou currently fully-funds more than 70 postgraduate training places in CBT, which is available to registered mental health practitioners. The training is split into a 1-year postgraduate certificate, which is a prerequisite for a further year-long postgraduate diploma in CBT. In this context, ERP/CBT for OCD is considered an advanced skill, and the programme have informed us that it is typically only addressed as a small part of the diploma (after two years of study).

Even when a mental health professional has achieved the necessary foundational skills to deliver ERP, we would continue to recommend that they engage in further specialised trainings in OCD- to maximise and maintain competence in working with this group.

2.6 OCD is more prevalent than the submission suggests

The submission by Marion Maw suggests that the prevalence of OCD in the population is likely to be approximately 1% of the population (equating to 50,000 people in New Zealand), however data from the Dunedin longitudinal study suggests that the figure is likely to be closer to 2% of the population in New Zealand (or 100,000 people). According to data from the Dunedin study, more than 10% of the population will experience some of the symptoms of OCD, although not all will go on to meet full criteria for a formal diagnosis.

3 Summary and Conclusions

The College fully supports the key message of the petition submitted by Marion Maw and signed by more than 1300 people at the time of writing. People with symptoms of OCD currently face significant barriers to accessing evidence-based psychological therapies in general, and ERP in particular, due to a lack of specialist provision across both primary and secondary care.

Delivering specialist therapies such as ERP requires significant training and expertise and should typically provided by either a clinical psychologist, or clinicians specifically trained in this approach under supervision from a clinical psychologist. There has recently been a focus from the Ministry of Health on increasing the number of training places available for both clinical psychology and for postgraduate training in CBT. While we hope that these improvements in the training pathway will lead to corresponding increase in access to evidence-based psychological therapies, this is not specific to ERP/OCD and, at the current rate, is likely to take several years.

We note that, as part of the submission by Marion Maw and Fixate, they have called for a national multi-agency ‘working group’, including representation from professional bodies, to guide the development of service for people with OCD. The College would welcome the opportunity to collaborate on ways to improve current service provision for people with OCD.

Many thanks for the invitation to respond to this petition. We hope the above information is useful to members of the Committee in addressing the issues raised.

The New Zealand College of Clinical Psychologists, 3rd of October 2022
