NZCCP Comments on *Mental Health and Addiction Service Development Plan (MHASDP): Draft Paper for stakeholder engagement*

The New Zealand College of Clinical Psychologists (NZCCP) welcomes the circulation of the Ministry of Health (MoH) document, *Mental Health and Addiction Service Development Plan (MHASDP): Draft Paper for stakeholder engagement*.

Our feedback focuses primarily on the delivery of evidence based psychological therapies and interventions, as this is an area where the College believes that clinical psychology can make a significant contribution to consumers and our colleagues from other mental health disciplines within the sector.

Who we are

The NZCCP represents 579 clinical psychologists and 165 postgraduate students enrolled in New Zealand clinical psychology programs. Clinical psychologists are trained in assessment and diagnosis, formulation (that is, generating a working theory about what has caused and maintains a person's mental health problems using established psychological knowledge), measurement (using psychometric instruments) and treatment of mental health disorders, and in the assessment of research into the efficacy and effectiveness of psychological therapies and interventions. All have done research at the masters or doctoral level. Clinical psychologists are registered under the clinical psychology scope defined by the New Zealand Psychologists Board; the Health Practitioners Competence Assurance (HPCA) Act 2003 requires clearly specified competences are met and maintained by all registered clinical psychologists; the title "clinical psychologist" is protected by this law. We are also bound by a comprehensive code of ethics.

At the moment, clinical psychologists employed by District Health Boards (DHBs) typically work in specialist mental health services, but also in some health services, usually as part of multi-disciplinary teams, and they take primary responsibility for providing psychological therapies to those with severe and/or complex mental disorders both individually and in groups, to both inpatients and outpatients. While mental health workers from other specialties do also provide psychological therapies, and some are very well-trained and experienced in these, there is a general acceptance that clinical psychologists are the experts in this area, and clinical psychologists often provide clinical supervision and training to these other health professionals. In the UK, where the Improved Access to Psychological Therapies (IAPT) program is being piloted and gradually rolled out, clinical psychologists are have been consultants in the development and implementation of a huge project involving assessment diagnosis, treatment planning, treatment, and monitoring of outcomes using psychometrics.

The value of psychologist to the health service has been recognized by a fast growth in the DHB and PHO psychologist workforce in times of somewhat limited

workforce growth. Stewart (2008) found that over a five-year period the psychological workforce in DHBs had grown by 26% in mental health services and a full 82% in physical health services. Particularly within physical health services, this growth is driven by perceived need, not historical precedent, as many of these services had not previously budgeted for psychologists.

The Ministry of Health has clearly indicated in the Te Tahuhu and Te Kokiri documents that expanding the availability of psychological assessments and treatments, including "talking therapies" must be a core part of the delivery of mental health services. The viability of these programmes is often reliant on psychologists, who are the health professionals with the most comprehensive and advanced training in this area, to support other staff to utilise these techniques in safe and effective ways, as well as undertaking advanced-level therapies with more complex clients.

Feedback and Comments

Support for the stated directions and priorities

The NZCCP supports the "draft goals for future mental health and addiction services" and the associated directions and priorities set out in the discussion paper. The College supports the emphasis on prevention, collaboration, self-care and e-therapies, peer support, early intervention, and effective value for money services. The College also commends the Ministry on promoting flexible, integrated, responsive services, which include the provision of access to primary and community care, and specialist secondary and tertiary services.

The references to better inpatient care, alternatives to inpatient care, and addressing co-existing mental health and addiction problems are important. In this context the College would like to see specific reference to genuine rehabilitation approaches and the significance of providing multi-disciplinary care and assertive outreach approaches for consumers who have persisting and complex needs. The emphasis on social objectives such as whanau ora, and related responsiveness to the needs of Maori are welcomed. So too are the references to additional populations with specific needs such as Pacific and Asian peoples, mentally disordered offenders, those in rural and remote settings, infants, children and youth, and older adults. These are all areas in which psychologists can have a strong role in promoting patient health, wellbeing, and function, and in contributing to more efficient and effective services. The College also backs the promotion of positive mental health, and a focus on recovery, wellbeing, and resilience within services as providing a healthy focus.

Recent events in Christchurch have prompted a huge amount of work from College members at a local and national level around ways to maximize support and wellbeing for those affected by the earthquakes. The discussion paper's timely reference to improving services' reactions and responses at times of disasters is therefore also applauded by the NZCCP.

The emphasis on improving the range and capability of services, including the provision of psychological therapies, is something that the NZCCP views as particularly important given clinical psychologists' potential to contribute significantly in these areas. Given the need for these inputs to be effective, the

College strongly recommends that they be evidence based. Finally, and also of particular and related relevance to the NZCCP, we strongly endorse the goal of supporting and equipping the mental health and addiction workforce to function efficiently and strategically, and see an evidence based approach as being essential to this. In the context of psychological therapies, we see the delivery of the more substantial cognitive behavior therapy and dialectical behavior therapy training programs in New Zealand in recent years as positive examples of this.

Barriers and Solutions

The College views the quality of the mental health workforce as being a central factor in the delivery of effective services. It further sees the development of the clinical psychology workforce as having the potential to enhance and extend the delivery of effective evidence-based psychological interventions through other mental health disciplines, and through this to a wider pool of consumers.

Of relevance to this is a submission made in 2010 by the New Zealand Psychologists Board, in conjunction with the NZCCP, New Zealand Psychological Society, the University Professional Psychology Programmes, and the DHB Psychology Professional Leaders, to Health Workforce New Zealand regarding supporting improved provision of Psychology Interns (final year trainees – typically in their sixth or seventh year of University study) in the health sector Psychologists Board, 2010). The following is taken directly from that paper:

> *"Meeting the psychological needs of healthcare users is not the sole province of psychologists - it is in fact the responsibility of all who work in health and social services. However, different professions have a different contribution to make in meeting this need. Mowbray (1989), an independent management consultant, in evaluating the role of psychologists for the British National Health service defined three levels of psychological input that is provided by health staff. These (somewhat abridged) were:*
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> *Level 1: Activities such as establishing maintaining and supporting relationships with patients and relatives and using some simple, often intuitive techniques, such as 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 described by protocol (such as standard and manualised therapy approaches with patients with mild-moderate difficulties). These activities can be undertaken by a variety of health staff (for example, medical practitioners, nurses, occupational therapists, social workers) with suitable aptitude and training. At this level there should be awareness of criteria for referral to a psychologist.*
> *Level 3: Activities requiring specialist psychological intervention in circumstances where there are deep-rooted underlying influences or which call for the capacity to draw on multiple theoretical bases, to devise an individually tailored strategy for complicated presenting problems. Flexibility to adapt and combine approaches based on a coherent and robust formulation of the presenting problems is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories and approaches. This level is primarily undertaken by psychologists.*

This analysis of levels of psychological input remains valid today (Stewart, submitted). In the time since the publication of the MAS report, there has been considerable growth in training for, and the practice of, psychological and associated therapies by non-psychologist health professionals (Kennedy-Merrick, Haarhoff, Stenhouse, Merrick, & Kazantzis, 2008). There is more than enough work for everyone, and, when done competently, this work enhances considerably the effectiveness and efficiency of the health service and can reduce the disappointment and waste associated with the inappropriate application of other, often far more costly, health resources. Psychologists maintain a strong role in providing and supporting work at all three of the levels defined above:

1. The Level 3 work remains - and is probably increased due to better detection and on-referral by having more clinicians working at Level 2.
2. There is an increasing awareness of the need to address the psychological issues both to improve overall wellbeing and to reduce inappropriate and ineffective use of other health services. This is reflected in substantial growth in the number of psychologists employed in DHB mental health and physical health services (Stewart, 2008).
3. Psychologists often have a role in teaching, supervising, mentoring, and otherwise supporting non-psychologists colleagues who are working at Level 2. This role is likely to expand further if programmes such as the Real Skills (Ministry of Health, 2008) programme for up-skilling mental health staff in a range of basic-intermediate psychosocial skills proceeds.

The psychologist's training model and practice is well-suited to operationalising and advancing the development of the strengths-focused and recovery-oriented mental health system envisaged by the New Zealand Mental Health Commission (1998, 2001). While many psychologists work extensively cross-culturally, psychologists of non-Caucasian origins, including Maori and Pacific Island psychologists remain under-represented in the psychologist workforce. Addressing this issue also remains a challenge for psychological workforce development."
(pp. 4-5)

A major barrier to clinical psychologists being able to contribute to mental health and addiction services in this manner is the low rate of training within the profession. While there has been a rapid growth over recent years in positions available for clinical psychologists within the sector (from primary to tertiary services), the lack of availability of funded intern placements is limiting the potential for these roles to be filled. The report from the Psychologists Board has elaborated on these barriers and proposed solutions as follows:

"<u>Barriers and Proposed Strategies for Addressing the Barriers</u>

- *The health sector is one of several government and private employers of psychologists. The health sector is somewhat disadvantaged in pay and conditions. Internships are seen as a valuable recruitment strategy as well as a strategy for ensuring that psychologists are trained with the specific skill sets needed for working in the health sector.*
- *In contrast with most other health disciplines, funding for psychology internships within the health sector has been on an ad hoc basis, and is*

neither mandated nor supported by any agency external to the employing organisation (e.g., a DHB). In general, funding has been derived from under-spend and has been dependent on the goodwill and support of DHB managers. The number of positions has been variable from year to year and often uncertain to within months or even weeks of the start of the new internship cycle. These factors put health at a disadvantage in recruiting interns.

- *With the difficult economic times in the general economy and the health sector in the last year there has been a 24% decrease in the number of internship FTEs available in DHBs, who are a predominant provider of internships in the health sector. Other providers within health are likely to experience similar pressures to divert funding for other purposes.*
- *This indicates that significant improvements in the organisation and funding of psychology internships is needed if we wish to achieve the contribution that psychologists can make to the health of the nation in the future.*
- *The highest priorities for improving support and training of psychology interns in the health sector are:*
    - *Increase the consistency, predictability, and sustainability of the number of internships.*
    - *Develop a more consistent approach to remuneration of psychology interns across the nation and between different programmes and services.*

<u>Proposal</u>
In order to improve the development of the psychological workforce for the New Zealand health sector through enhancing the training of new graduates, the following is proposed:

- *That psychology interns working in eligible health services receive a salary for the 12 months period of their internship, based on the present employment awards for Intern Psychologists (approx. $48000), adjusted pro rata to 4 days per week in recognition that one day per week will be allocated to University study.*
- *That a minimum of 75 psychology intern places be funded, increasing in number in subsequent years as determined by workforce development modelling and projection. This initial starting point of 75 is based on the numbers of internships (paid and unpaid) identified in health services over the last five years across several psychological sub-disciplines.*
- *That the funding for these positions be held centrally, and allocated through an agreement between the funder, training programmes, and internship providers. This agreement should be renewed on a three-yearly cycle to provide certainty to all parties regarding the availability of training positions over a reasonable time period."*

(pp.2-3)

Conclusion

This 2011 report from the Psychologists Board could serve as a useful basis for considering funding strategies in relation to Psychology Interns (and may have some relevance to the training of other allied health disciplines). It would promote enhanced training of clinical psychologists with a view to meeting broader needs in the mental health and addiction sector, including the provision of support and training for other mental health disciplines to provide effective

interventions for consumers. The University of Otago Wellington's successful Te Pou funded postgraduate courses in CBT provide a helpful example of this model in action.

An additional recommendation to enhance the mental health workforce would be to extend the Ministry of Health Voluntary Bonding Scheme for medical, nursing, and midwifery graduates to allied mental health professionals including clinical psychologists.

Measuring whether goals have been achieved

Clinical psychologists training in research makes them well placed to undertake outcome measures pertaining to the effectiveness of their participation in projects where their role involves the teaching, supervision, or mentoring of other staff. As noted above in the UK, clinical psychologists' roles in the Improved Access to Psychological Therapies (IAPT) have included monitoring of outcomes using psychometrics.

Thank you again for the opportunity to comment on this document. We trust you will find these comments of value. Please do not hesitate to contact the College if we can be of any further assistance.

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