NZCCP Comments on *HWNZ's Health Workforce Strategy Concept Note.*

The New Zealand College of Clinical Psychologists (NZCCP) welcomes the circulation of the Health Workforce New Zealand concept note *Draft New Zealand Health Workforce Strategy*. The College is particularly pleased to see that this document confirms mental health and rehabilitation as priority health areas for New Zealand, given how central these fields are to the practice of clinical psychology.

Our feedback is relatively brief and reiterates views articulated in previous submissions within the sector pertaining to workforce development and service delivery. This is due to the short feedback period and timing of this over the Christmas New Year break when our office has been closed and many of our executive office holders and members on annual leave. Consequently, we would welcome the opportunity to provide more extensive feedback around the Strategy Concept Note in the future.

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 bound by a comprehensive code of ethics.

Currently, 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 psychologists 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

Context

What environmental issues or trends have you identified that will need to be considered in forming this strategy?

We are fortunate in New Zealand to have been included in the World Mental Health (WMH) Survey Initiative run by the World Health Organisation (WHO). The New Zealand component of this project "Te Rau Hinengaro" (TRH, Oakley-Brown, Wells, & Scott, 2006) provides recent and robust estimates of the prevalence of mental disorder, physical conditions, and associated disability. Wells (2006) reported findings for the prevalence and severity of aggregated mental disorders. Just under 40 percent of respondents met criteria for one or more mental disorders at some stage during their lifetimes (this figure predicts a lifetime prevalence of 46.6%). Of these individuals, 20.7 percent had experienced a mental disorder within the previous year. An important finding in TRH was that there was a high rate of co-occurring mental disorders in New Zealanders (Scott, 2006). That is, 37% of people who had a mental disorder over the 12-month period surveyed actually had at least two mental disorder diagnoses. Two additional findings reported by Scott (2006) pertain to the issue of comorbity across mental and physical disorders. Firstly, that those who met criteria for mental illness diagnoses had higher levels of many long-term physical conditions (including chronic pain, cardiovascular disease, high blood pressure, and respiratory conditions) than people who did not have mental disorders. Consistent with these findings, those with mental disorders had higher levels of risk factors for chronic physical illness (i.e. being a smoker, being overweight, having high blood pressure, and misusing alcohol). Secondly it was noted that those survey participants who had long-term physical disorders had elevated rates of mental disorder (25 - 29%, depending on the particular physical condition) when compared with those without and chronic physical illness (15.1%). Scott (2006) has pointed out that these comorbidity findings "underscore the challenge of providing for the concurrent mental and physical health needs of service users within the context of a health system where specialist medical and mental health services function largely independently of each other" (p. 86).

The epidemiological research from TRH and the wider WMH Survey Initiative provide clear evidence that mental disorders are common, frequently present together in individuals, and are just as disabling as physical conditions. Moreover,

mental disorders often present concurrently with chronic physical conditions, and where these mental-physical comorbidities occur their associated disabilities may have a synergistic effect. Implications arising from these findings are clear. As Prince and colleagues note “Mental health awareness needs to be integrated into all aspects of health and social policy, health-system planning, and the delivery of primary and secondary general health care” (2008, p. 859).

The Workforce

What workforce specific trends or issues does this strategy need to address?

The College views the quality of the mental health workforce as being a central factor in the delivery of effective mental health and rehabilitation services. There may well never be enough clinical psychologists trained to adequately meet the need for evidence based psychological treatments identified within the New Zealand community as identified in Te Rau Hinengaro. The College 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:

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)

In addition to assisting other disciplines to undertake psychological treatments usually carried out by clinical psychologists, there may also be a role for clinical psychologists undertaking roles typically undertaken by other disciplines. A relatively recent successful example of this is found in the Criminal Procedure (Mentally Impaired Persons) Act (2003), which has provided clinical psychologists with the ability to undertake roles within forensic mental health that had traditionally been carried out only by psychiatrists. Exploring the potential for clinical psychologists to take up the role of prescribing some psychotropic medications may provide another example of where clinical psychologists could reduce the heavy demands on our

colleagues in psychiatry (American Psychologist, Practice Guidelines Regarding Psychologists'
Involvement in Pharmacological Issues).

Processes and Infrastructure

This section of the concept note discusses HWNZ's role in supporting DHBs to "standardize education and training, co-ordinate career planning and administer initiatives such as workforce innovations and bonding schemes".

A major barrier to clinical psychologists being able to contribute to mental health and addiction services in the supervisory/consulting/training role noted above is the low rate of training within the clinical psychology profession itself. 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:

"Barriers and Proposed Strategies for Addressing the Barriers

- *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.*

Proposal
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)

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.

Capacity

Is the concept of a national/regional careers service one we should develop? What would its merit and priorities be? How would we go about establishing and funding it?

What can be done to enhance the interface between education and health employers to promote careers in health to young people and to promote wider awareness of the health sector 'brand'?

DHBs often contribute to careers days for school leavers, and the inclusion of clinical psychology in these opportunities is key to promoting this as a career choice.

However the competition for a limited number of places in the clinical training programmes likely means that many students who would have the potential to become excellent practitioners, are deterred into other career choices.

What new actions/interventions to increase the number of Maori and Pacific people in the workforce are required? What will success look like by 2020?

How can we incentivise retention of older workers? Is there good practice that can be shared?

Many experienced Clinical Psychology practitioners move away from employers such as DHBs into private practice, which is a loss to the health service in terms of expertise and experience, particularly related to complex cases, but also the supervision of newer graduates to support them to continue to practise in the health service. The national MECA salary scales have improved renumeration to some degree, although access to the Merit steps remains an issue and there continues to be inconsistency about this across the DHBs. For senior practitioners, the availability of a consistent Continuing Education process has been an issue that has not yet been resolved. Recognition and respect for the role and contribution of senior practitioners will be enhanced by the broader focus of the health system on the allied health workforce.

What efforts to reduce reliance on locums and agency staff should be developed and shared?

What targeted initiatives are happening already at a local level to recruit from overseas or to repatriate New Zealand health professionals? What are the opportunities to have a more strategic approach?

How can we better manage the inflow and outflow of health staff, acknowledging the benefits of international exchanges and the shifting dynamic in workforce mobility as a result of the global economic environment?

How can the carer be supported by the employed workforce to best effect? What are the potential opportunities for volunteering?

How can workforce development support WhanauOra?

Capability

How can DHB and education institutions ensure an effective transition from education to clinical practice?

As discussed above, the joint proposal from the Psychologists Board on behalf of the Board, professional bodies and clinical training institutions has made recommendations which would improve capability and transition from the training programmes into the health sector. The shortage of intern placements in the DHBs has meant that Interns have had to find alternative placements, often in primary and community agencies. This does not provide the Intern with experience of more severe and complex clients, and likely has an effect on their choice of future employment. Pressure on the health service can affect a preference for employing clinicians with experience in areas such as mental health, so that they do not require extra support / supervision before being able to take on a case load.

What is the role of regional training hubs in increasing workforce capacity?

The development of regional training hubs in specialist areas such as treatment of eating disorders has been beneficial in the provision of training from a national perspective, and for smaller DHBs to access this more easily. Clinical psychologists have played a key role in identifying the needs and best practice treatment so that appropriate training opportunities have been available, e.g. Maudsley Family Based Therapy.

What strategies will ensure transferability and improved opportunities for continued career development for those who choose it? Is there merit in development of a national careers framework?

What more can be done to support local innovation and to encourage the spread of learning on workforce innovation across the sector?

How can we best empower and support patients and the public as consumers of health care and informal carers? What good practice examples can be shared? What opportunities are there to create new partnerships with local government, NGOs and others?

Culture

How can we better use the standardised staff survey to improve staff satisfaction and organisational culture?

How can staff surveys be better aligned with patient surveys?

Is there an opportunity for benchmarking/metrics?

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 psychometric measures.

Do you have examples good practice on staff engagement that could be shared nationally?

Is there value in developing staff recognition processes?

Change Leadership

How can more cross-organisational working be facilitated?

Do you have examples of clinical networks best practice?
Clinical Psychologists have developed clinical networks to support clinical practice, provide supervision, information and education, for example website forums for private practitioner, neuropsychologists, This is particularly valuable for practitioners in specialist areas without easy access to the opportunities for ingoing education available in larger cities.

What incentives or levers can be used to encourage development of clinical networks?

What should the priorities be for leadership training and funding over the next 5-10 years?

Which areas of change to funding/remuneration systems could be explored?
A more equitable model of funding continuing education for all health professionals.

What would be the impact of training funds being allocated on a regional basis?

What should our priorities be for enabling workforce development through IT?

Social Responsibility Issues
What opportunities should be explored for staff development and sector learning eg through humanitarian placements/sabbaticals? – particularly supporting Pacific nations.

Summary for Action

How can we measure the impact of workforce initiatives?

What are reasonable targets and performance measures at local regional and national level?

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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