

Psychologists Working in District Health Boards in New Zealand: A Survey

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A survey exploring the psychology workforce within District Health Boards (DHBs) in New Zealand was carried out in 2006 on behalf of the National DHB Leaders Forum. The leaders were used as key informants where possible. The survey assessed a range of indicators of service capacity including numbers of staff, Full-Time Equivalent (FTE) qualified staff and interns, vacancies, recruitment, growth, roles and leadership. There was 100% response rate to the items that quantified the workforce. The survey found a total of 541 psychologists (489FTEs) working within the 21 DHBs representing 29% of those registered in 2006. However, psychologist per population statistics indicated varied access across DHBs. Data on individual services across DHBs indicated where psychologists were located within DHBs. A lack of a critical mass across the country appeared to be an issue for some services. The implications include recruitment difficulties, and lack of collegial support, and supervision. Overall the profile was of an experienced workforce with 49% having experience of eight years or more. Particular attention is paid to the issues of leadership in psychology and the implications for strategic development.

DHB psychologist workforce at a glance:

- 541 Psychologists (489 FTE) in 21 DHBs, 29% registered psychs (2006)
- 49% have eight or more years experience
- 1.5% Maori
- 18.9% overseas trained
- 87% mental health and addictions services;
- 40.4% in adult services; 37.7% child/adolescent services; 6% older persons services
- 12.8% physical health services
- 48% of interns
- Wide variation in population ratio (1 FTE per 6k pop to 1 FTE per 39k)
- Avg. 14.9% vacancies with higher rates in specialty services

Introduction

The present survey provides the most comprehensive and contemporary description of the psychology workforce in New Zealand's 21 DHBs. The New Zealand Health Information Service (NZHIS, 2006) provides a good annual overview but is limited in detail. Other surveys have been useful in specific areas notably Lambie and Stewart (2003) in child and adolescent mental health services, and Stewart (2007) in physical health. The present survey seeks to create a more general baseline for psychological services (clinical) in DHBs.

The New Zealand Psychologists Board (personal communication, 11 June 2007) had 1,732 registered practicing psychologists as of 31st March 2007 (935 Clinical, 145 Educational, 652 General Scopes of Practice). There were 104 interns and 18 trainees with Interim Practising Certificates resulting in a total register of 1,854 psychologists in New Zealand in 2006. District Health Boards (DHBs) are the largest employers (29.5%) of psychologists in New Zealand (NZHIS, 2006).

Stewart (2007) reported that there were between 1 FTE psychologist per 6,000 of the population and 1 FTE per 35,000 (response rate 76%) with a staff numbers ranging from 2-90. Seventeen percent of these were working within a physical health service (PHS) setting. Twenty-six percent of this group were employed by mental health and addictions services to work in physical health settings. He noted

a growth rate three times that in mental health and addictions services (MHASs) with an 86% increase in the number of psychologists employed in physical health services in the last five years.

Lambie and Stewart (2003) found 36% of the DHB workforce worked in child and adolescent mental health services (CAMHS). There had been an increase in staff numbers of between 31-67% over the previous five years. They noted the importance of internships in CAMHS in facilitating good recruitment and retention.

Psychologists are traditionally associated with MHASs. However, with the exception of the studies mentioned it is not known how the workforce is distributed nor is there any data on the breadth of roles psychologists fulfil in MHASs in New Zealand. Some of these roles may be strategically important for the development of the profession within MHASs. For example it is not known how many are involved in service leadership or how many are fulfilling the role of Responsible Clinician required for the implementation of the Mental Health Act (1992).

In Britain, the Layard report (2006) led to the Labour Party Manifesto to expand psychological therapy within the National Health Service (NHS). Layard argued that evidence-based psychological therapies needed to be deployed "on a large scale" to treat mental health problems, according to National Institute of Clinical Excellence Guidelines (NICE, 2005). He indicated that to implement the Guidelines required 10,000 more therapists (5,000 of whom should be psychologists), working in 250 "Psychological Treatment Centres" to be set up over 7 years. His argument extended to the cost effectiveness of these treatments. The specifications for delivering on these objectives have already been put in place (Mental Health Choice, 2007).

In New Zealand *Te Kokiri*, the *Mental Health and Addiction Action Plan* for 2006-2015 (Ministry of Health, 2006) includes expanding the accessibility of psychological therapies. However, this places the responsibility for action at the DHB level, and does not identify any additional resources to support developments. Other government initiatives have the scope to develop psychological services imbedded within larger strategic frameworks e.g. Primary Health Care Strategy.

There is potential for psychologists to have a greater role in physical health. The importance of psychological and behavioural factors in health status and outcomes are well recognized (Stewart, 2007). Research supports the application of psychological interventions to improve medical treatment outcomes, enhance adherence to treatment, decrease long term complications of disease and decrease medical over utilization (Gatchel & Orardt, 2003). Government health objectives include reducing the impact of chronic disease, an area where psychologists could make a significant contribution.

This potential contribution needs to be targeted for Maori. A primary government objective is to reduce the inequalities in health, particularly for Maori. *He Korowai Oranga*, the Maori health strategy (Ministry of Health, 2002) targets health inequalities for Maori across both mental health and physical health, but targeting Maori is a theme throughout government health policy.

Levy (2005), in a report commissioned by the New Zealand Psychologists Board, outlined a strategic framework to support psychologists in making a contribution to government health objectives. She suggested that as a precursor to this there was a need to address the "limited perception" of the profession and to establish psychology as an effective contributor to health objectives. She outlined three goals; (a) a robust information base from which to inform key stakeholders, (b) the development of strategic relationships across the profession and with key stakeholders, and (c) the building of strategic capacity to explore and realise the contribution of psychology to health objectives.

The present survey was undertaken on behalf of the National DHB Psychology Leaders Forum. The objective was to obtain a more detailed and complete description of the DHB psychology workforce, that is, those employed in the provider arms of DHBs and who undertake clinical work (Clinical Psychologists, Educational Psychologists, Health Psychologists, and Neuropsychologists). It does not include contractors. It was intended that the data would provide a good description of the psychology workforce, provide a baseline against which to measure growth, and inform discussion of issues such as recruitment, workforce planning and strategic direction.

Method

Questionnaires were completed between April and July 2006. Sixteen of the questionnaires were completed by the DHB's representative at the Psychology Leaders Forum. In one of the larger DHBs there were two informants. Where there was no representative at the Forum (five DHBs) data was gathered by the writer via telephone from DHB Human Resources and Payroll Departments, or managers. The latter DHBs had a combined workforce of 18 FTE, including Interns representing 4% of the total workforce FTE. These DHBs were not asked the more detailed questions about the workforce. This resulted in 100% response rate for some of the items in the questionnaire (i.e., all of the questions related to current FTEs and vacancies were answered by all DHBs). There were fewer

responses to questions requiring more detailed descriptions of the workforce or workforce issues (e.g., qualifications and growth).

The survey was constructed, and then trialled by three advisors. Review of questions was carried out by another member of the Leaders Forum. Amendments were made before sending it out to members of the Forum. Amendments included the range of service areas common to DHBs. Once data was collected and entered it was checked for errors by members of the Leaders Forum.

Results

In this section a description of the workforce will be followed by an overview of the results followed by a breakdown into service areas. Subsequent sections address vacancies, recruitment, internships, growth, leadership, and role diversity. In each section the number of responding DHBs is noted.

Overview

The NZHIS (2006) survey provided a profile of the psychology workforce as mainly female and New Zealand European/Pakeha. Questions related to ethnicity and gender were not repeated in the present survey except for Maori and Pacific Island psychologists. NZHIS (2006) identified 34 (2.9%) Maori and five Pacific Island psychologists. There was a 66% response rate for this question in the present survey finding eight Maori (1.5%) and five Pacific Island Psychologists (1%). The present survey's reliance on data collected from key informants rather than self report requires caution as data validity depends on how well informed the respondents were on a wide range of issues, and with a range of quite specific data sets.

The present survey found 102 (18.9%) of the psychologists employed in these DHBs were trained overseas. However, there was substantial variation across DHBs. One reported an entire compliment of four were from overseas, in another, overseas trained psychologists were 70% and another 48% of their more substantial workforce. These DHBs served a predominantly rural population.

The data on professional experience indicated a highly experienced workforce, 49% of which were identified as having eight or more years experience, 20% with 4-7 years and 21% with 1- 3 years experience. Ten percent were interns.

Informants reported 90% of the workforce registered under the Clinical Scope of Practice, 8% under the General Scope and 2% the Educational Scope. Qualifications included PhDs or Clinical Doctorate (19.3%), Masters and Post-graduate Diplomas or their equivalents. Sixty-six percent of those with doctoral qualifications (PhD or professional doctorate) obtained their qualification overseas.

The survey found that within clinical areas there was a total psychology workforce of 541 people working in the 21 DHBs. Of these 489 were qualified and filled 391.9 FTEs. The figures included a total of 424 qualified staff in Mental Health and Addictions Services (MHASs) and 65 in Physical Health Services (PHSs). It also included 52 Interns, 43 in mental health and 9 in physical health services. There were part-time and full-time staff. As FTEs represents actual positions or parts thereof it was considered to have more utility in the present survey. Therefore FTEs are used to quantify psychological services in DHBs in Table 1, and the remainder of the paper. Interns were present in significant numbers, but are not included in the following analyses unless specifically stated as there was some variation in the employment of interns across DHBs.

Table 1: Total Psychologist FTEs across 21 DHB's

	<u>Qualified</u>	<u>Interns</u>	<u>Vacancies</u>	<u>Total</u>
MHS	344.2	41	54.9	440.1
PHS	47.7	8.6	3.4	59.7
Total	391.9	49.6	58.3	499.8

Distribution across DHBs

DHBs range in population coverage from 39,200 to 501,500. The number of qualified Psychologists employed across DHBs ranged from 0-102 (0-71 FTE). The survey found variable service provision across the country, ranging from a ratio of 1 (qualified psychologists) per 5,938 population to 1 per 39,200 ($M= 13,259$, $SD=9,738$). These figure were derived from current qualified FTE positions plus vacancies. One DHB, with a population of over 50,000 was not included as it had no psychologists, but contracted in cover from a neighbouring DHB. Table 2 shows population per psychologist across 20 DHBs. Four DHBs with a population of fewer than 100,000 had the highest population per psychologist. With the exception of one, the remaining DHBs served a population of over 100,000. The larger and medium sized DHBs (i.e. population of over 100,000) and one small DHB (under

100,000) fell into two groups which varied substantially according to population per psychologist (see Table 2). However, there was no discernable relationship based upon size between these DHBs with the largest and medium sized DHBs ranging from 1 per 5,937 and 1 per 16,439. This mix of access was evident whether the DHBs served a predominantly rural or urban population. The six DHBs who ranked last did not have any FTE allotted to clinical leadership for psychology.

Table 2: Access to Psychological Services in DHB Populations

<u>Population per FTE</u>	<u>Number of DHB's in range</u>
5,900 – 10,000	12
10,500 – 16,500	5
30,500 – 39,500	4

Distribution across services

Mental health and addictions services

Of the total psychology workforce (qualified staff and Interns) employed 385.2FTEs (87%) were employed in MHASs. Of these 155.5 FTEs (40.4%) were employed in adult services and 145.1 FTEs (37.7%) in child and adolescent services. Six percent (23.6 FTEs) of the workforce were found in older peoples services. A combined workforce of 37.5 FTEs (9.7%) was employed in forensics, consult-liaison, drug and alcohol, and maternal mental health services. There were under 18 qualified FTEs employed in each of these services across the county. There was a further 23.5 FTEs (6%) who were not categorized and were included under “other.” Figure 1 shows the distribution of qualified FTEs and vacancies across MHASs.

Figure 1. FTE and vacancies in mental health and addictions services.

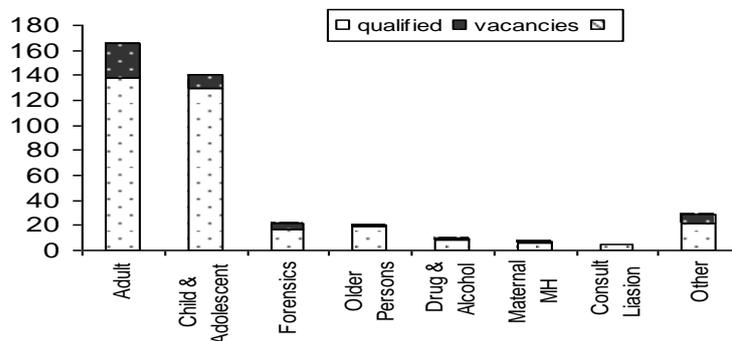


Table 3 provides the national ratio of psychologists per capita based upon the 2006 census statistics (Statistics NZ, 2007). These figures should be treated with caution as there are overlaps between services, particularly between child and adolescent and adult, and adult and older person’s services. That is, while the census figures show children and youth up to the age of 19 years, 18 - 20 year olds will be seen in adult services. In addition, clients who are over 65 years may be seen in adult services, and some in adult services will also be seen in older person’s services. Because of this the most likely scenario is that the adult figures will slightly underestimate the population per psychologist.

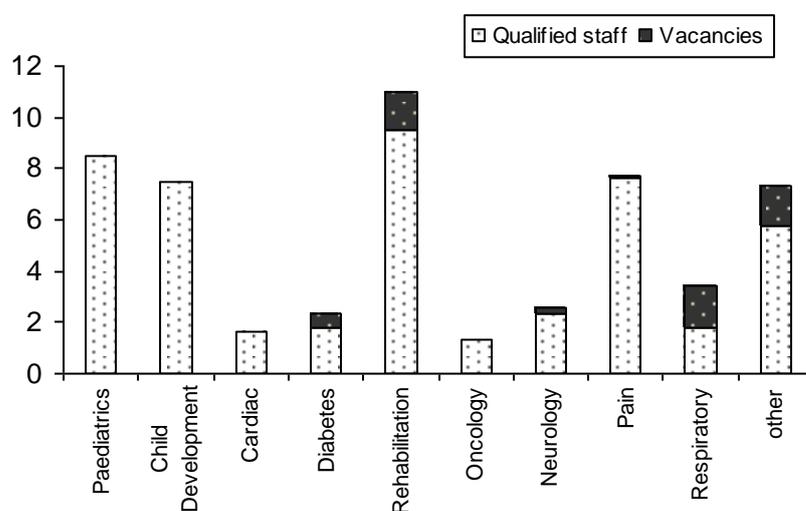
Table 3. Ratio of mental health Psychologists per capita within age ranges

	<u>Up to 19 years</u>	<u>Adults</u>	<u>Over 65 years</u>	<u>Total Population</u>
2006 census	1,211,909	2,421,747	509,623	4,143,279
Population per psychologist	7,794	16,690	21,594	10,382

Physical health services.

Of the total workforce (qualified and interns) employed 56.3 FTEs (12.8%) were employed in PHSs. This does not include positions in Consult-Liaison services employed by mental health of which there were 4.2 across the country. There was large variation across physical health services both between and within DHBs. Nine (43%) of the DHBs reported that they had no psychologists working within physical health. Eight of these DHBs have the smallest populations. One of the largest DHBs reported only one intern in PHS. There were four small (under 100,000 pop) to midsize DHBs (100,000 – 200,000) with 1 FTE in PHS. In the remaining eight DHBs there did not seem to be a pattern based upon size or geography. FTEs ranged from 1.4 to 15.8. The largest FTE allocations were 15.8 and 6.2. Eighty-two percent of positions were in six of the largest DHBs. Although one large DHB did not have any psychology positions within PHS. Figure 2 provides data across DHBs for particular PH services. The “other” category included psychologists in Gynaecology, Haematology, Renal, Child Obesity, Child Oncology and Rheumatology.

Figure 2. FTE and vacancies in physical health services



Recruitment and vacancies

DHBs reported a total of 58.3 vacancies for qualified staff representing 14.9% of established positions. There were 54.9 vacancies in MHSs and 3.9 in PHSs. There was a vacancy rate of nearly 20% in adult MHS and 11% in CAMHS. Figures 1 and 2 also present the data for actual vacancies in each service compared to FTEs in post. For the smaller services overall vacancies were low, but in forensic (5 FTE vacancies) and alcohol and drug services (2 vacancies) they represented 29% and 24% respectively of the established positions. There was a low overall establishment in these services across DHBs (22.2 forensic and 10.2 alcohol and drug). In PHSs the largest number of vacancies 1.5 FTE (16%) was in rehabilitation services.

Seventeen representatives at the Leadership Forum reported their top three “hard to recruit to” areas were adult MHS (12x), followed by CAMHS (9x), rehabilitation (3x), forensics and Alcohol and Drug services (2x each). This reflected the relative size of services with Adult and CAHMS services representing 75% of the total establishment.

Sixteen DHBs reported length of vacancies ranging from one week to five years. However, there was a large variation in the estimated length of time both within DHBs across positions (e.g. “1-15months”, “1-5 years”) and between DHBs (new positions vs. 1-5 years). Six DHBs reported vacancies of 1 year or more in duration, a further three had vacancies of six months, two reported new vacancies or new positions. Numbers were not reported against length of vacancies, that is, it is not clear whether vacancy data is related to single or multiple positions.

Internships

According to the Psychologists Board register for 2006 there were 108 Interim Practicing Certificates issued for interns. There were 52 (49.6 FTE) interns reported within the DHBs at the time of the survey indicating that 48% of New Zealand’s psychology interns were working in DHBs at the time of the survey. Employment practices for interns differ between DHBs (e.g. paid or unpaid). No data was

collected on the type of training programmes that the interns were enrolled in. The majority of internships were in Adult Mental Health (17.7 FTEs), followed by CAMHS (15.4 FTEs) and then a large gap to MHS for Older Persons (3.8 FTEs). This reflected the relative size of the services. Forensics had 0.8 and Alcohol & Drug services 1.0 FTEs. Intellectual Disability or dual diagnosis service (ID and mental health) had 1.5, and a further 0.8 unidentified. Across PHSs the spread was fairly even given the small number of FTEs involved with 2.6 in child development, 2 FTE in diabetes and one in each of Paediatrics, Rehabilitation, Oncology and Pain services. No other services had interns.

Growth

Only fourteen (67%) of the DHBs provided an estimate of growth in FTEs over the preceding five years. One indicated a loss of 1.3 FTE positions over this time. Growth ranged from 6.9% to 64%. Total growth across these DHBs was 94.9 FTE or 1.36 FTE per year per DHB. There was a mix of large and small DHBs who did not provide information on growth.

Leadership

All DHBs reported a *unit dispersement* model of service provision. That is, psychologists were employed as part of a multidisciplinary team or service and were managed within this model, typically by someone from another discipline. Fourteen DHBs employed Professional Advisors or their equivalents (Director, Professional Leader). These roles typically work in partnership with management, with no line management responsibilities. They provide leadership for the discipline and are involved in activities such as strategic development and planning, establishment and monitoring of clinical standards, policy and procedures, advice to management, and may be involved in performance review processes, professional development, credentialing, and recruitment.

Six advisors had a brief across the whole of their DHB provider arm. Two DHBs had separate advisor allocations for MH&AS and PHS. The total FTE in Professional Advisor or equivalent roles across all DHBs was 5.5. In one PHS the role of professional advisor was allocated but no FTE time was allotted to the role. The remainder ranged in FTE from 0.1 to 0.8 and was not associated with the size of the DHB.

With the exception of those in PHSs, and one Director who reported to a Director of Allied Health, all reported to the equivalent of a General Manager or Clinical Director of Mental Health.

In addition, three of the larger DHBs had another tier of clinical leadership in MHASs. The total FTEs in clinical leadership roles was 7.8, with 3.9 vacancies giving an establishment of 11.7 FTEs in clinical leadership across 21 DHBs. To find psychologists per leader figure the total establishment FTE (including interns) was compared to total leadership establishment. The range was one to 16.2 to one to 191 FTE. ($M=61.6$, $SD=50.6$). Two DHBs had senior members of the profession at the Leadership Forum, but they did not have specific leadership positions or time allocated to leadership within their respective DHBs. The remaining DHBs who employed psychologists (four DHBs) had no leadership (although one was reviewing the issue at the time). The combined total psychology workforce in these DHBs was 18 FTEs. The total workforce across all DHBs without allotted leadership FTEs was 27.9 FTE.

A total of 15.8 FTEs (17 people) reported by 19 DHBs were in leadership roles not specific to psychology. This included one Director of Area Mental Health Services (DAMHS), four in Clinical Director (CD) positions (four people inclusive of DAMHS), and 11.2 in senior and middle management. Based upon the present survey psychologists within any kind of leadership role totalled 27.5 FTEs.

Skills utilization and role diversity

Fifteen informants (71%) identified roles or skills other than direct assessment and intervention utilized within their DHB. These responses represented large and mid-sized DHBs. They were also asked to identify other professionally trained psychologists (e.g., organisational psychologists and community psychologists) as well as those who were trained to deliver direct clinical services (e.g. clinical and health).

They reported 1.8 shared appointments with universities (within one DHB) and 39 research projects involving psychologists which were underway at the time of the survey. However, whether this equated to actual FTE allotted to research was not reported.

In terms of particular clinical roles as reported earlier there 4.6 FTE CDs and one DAHMS.

Responsible Clinicians (RCs) are required under the Mental Health Act but only two DHBs reported having RCs who were Psychologists. One was the same DHB where the DAMHS role was undertaken by a Psychologist.

They reported 13.5 FTE non-clinical roles (leadership not included) including organisational and community psychologists. Most were involved in project type roles. As these roles were not clinical they did not sit within the oversight of the advisor/leader. Therefore, there may be psychologists in roles that are unidentified by the informants.

Conclusions

The present survey was a comprehensive stocktake of psychology services within New Zealand's 21 DHBs. It provides a baseline for future evaluation and points to particular strategic issues facing the profession as part of the health workforce. The conclusions presented are not comprehensive as more discussion is warranted.

The overall workforce findings were fairly consistent with NZHIS (2006) and Stewart (2007). The present survey found 29% of psychologists registered in 2006 were employed in New Zealand's 21 DHBs. There was substantial variation in the provision of psychological services across the country, ranging from 1 FTE per 5,937 population to 1 to 39,200 population. Except for the smallest DHBs there was no pattern associated with geography or size of DHB. In addition, the present survey found a large variation in growth across the 14 DHBs who responded to the growth question.

Mental health and addictions services employed 87.2% of the DHB psychology workforce and 12.8% worked within PH services across all DHBs. This differed from Stewart's (2007) data of 17% in PHSs in the DHBs with clinical leadership in psychology. Additionally, Stewart's (2007) figures in PHS included psychologists employed in MHASs who were primarily providing services to PH. In the present survey these would have been included under consult-liaison services in MHASs.

The limited perception that psychologists are only in MHASs is being challenged by an increasing presence in physical health in some DHBs (57%). Although service configuration differs between DHBs the fact remains that there is still a large number of DHBs (43%) who do not have psychologists in PHSs or have only one FTE across their PHSs (19%). The present survey did not provide data on services outside the DHB provider arm and it was not known the extent to which contractors contribute or how many psychologists are now working for Primary Health Organisations (PHOs). However, even within DHBs who had psychologists access across PHSs was not equitable.

In mental health and addictions services it would appear that adult services were comparatively less resourced with psychologists than CAMHS services, even when accounting for the percentage of the general population served (5% of children and youth for CAMHS and 3% of adults for Adult services). In addition, adult services had nearly twice the number of vacancies compared to CAMHS. In CAMHS the Werry Centre survey (Lambie and Stewart, 2003) found 36% working in CAMHS compared to the 37.9% found in the present survey in 2006. With an increasing proportion of older adults reported in the most recent national census data it is likely the demand in older adult services area will increase over the coming few years.

Only two DHBs reported having psychologists in the RC role (three active RCs). One had a DAMHS and 4.8 FTE CD roles. The RC role is the person "in charge" of treatment for the particular "patient" who is under the Mental Health Act (2002) and is traditionally held by psychiatrists, of which there is a shortage. It could be argued that DAMHS, CDs and managers are in positions that have the best potential to influence mental health and addictions services and these roles are more traditionally held by psychiatrists and nurses (managers).

The irregular pattern of capacity and growth within and across DHBs suggests planning occurs at a service level rather than wider DHB level. Within a unit dispersment model the decision to employ psychologists has rested with the budget holder and is dictated by the constraints of their budget and whether they could access further funding. Increasingly, there appears to be restrictions on the flexibility of these budgets with growth only occurring in a few strategic areas. There is also a move to have more services delivered through primary health care.

One of the major impediments to increasing the workforce is the ability to recruit psychologists. Overall vacancy rates were at nearly 15% of positions for qualified staff. Although not unusual this is compounded in particular services where high vacancy rates were found and where the length of time reported for vacancies was over six months. The risk of having unfilled positions is that they will be lost and it is not known how many positions have been lost to psychology in this way.

In small services, recruitment could be further hampered for the lack of a 'critical mass'/presence working to attract new staff (e.g. Forensics, Older Persons, most PH services). The implications of this are more significant when DHBs nationally employ most of the psychologists that work in the area (e.g. Forensics). It could be argued that the total pool of psychologists in these services across all DHBs or the DHBs providing those services (e.g. Forensics is a regional service) is too small to facilitate recruitment within New Zealand. In PHSs this may be mitigated by the newly developed programmes such as Auckland University's Post-Graduate Diploma in Health Psychology

There was a significant reliance the ability to recruit from abroad with nearly 19% of all DHB employed psychologists being recruited from overseas, and an even higher rate in rural DHBs. There are implications for the orientation and training for this workforce both culturally and professionally, particularly in areas where recruitment is predominantly from abroad.

The number of psychologists who are Maori (8) and Pacific Island (5) is low both within the profession and within DHBs. Particularly, the low percentage of psychologists who identify as Maori (1.5%) within DHBs when addressing health inequalities is a primary concern (Ministry of Health, 2006). However, reducing inequalities in health cannot be reliant on the recruitment of Maori as addressing cultural needs has to be more firmly imbedded in the way we deliver services within health. This is broader than individual cultural competences.

Lambie and Stewart (2003) noted a strong relationship between pre-qualification training and successful recruitment. This suggests internships are an important recruitment strategy. However, there were services where there were few or no internships and few qualified psychologists to support them.

Recruitment strategies may include targeting overseas recruitment for specialist areas, access to more specialised or advanced training within targeted areas and increasing the number of psychologists trained. The profession needs to address issues such as generalist versus specialist competencies. Currently the Code of Ethics and the New Zealand Psychologists Board's Core Competencies provide national guidelines to practice. What expectations do we have about people transitioning into specialist areas? How do we define these? How do we facilitate support and supervision for successful transitions? Do we make effective use of the experienced psychologists we do have, particularly in specialist areas?

Traditionally supervision is thought of as a face-to-face process. However, where geographically that is not possible alternatives are required. Providing the support and supervision people need may be facilitated by increasing email groups (which are happening in some areas), video links (nationally and internationally) and establishing links with other disciplines. There is also a role for the Psychologists Board, the Psychological Society, including the Institute of Clinical Psychology, the College of Clinical Psychologists, universities and DHB psychology leaders in seeking the higher level solutions and establishing guidelines for practitioners.

To effectively address the issues there needs to be an adequate level of leadership for psychology within DHBs. Within the unit dispersement model of service provision, leadership is provided through Psychology Advisors/Leaders or Directors and for most there will be a strategic element to their position descriptions. For three DHBs there was another tier of clinical leadership under the advisor. The range of psychologists per leadership FTE varied widely and clearly indicates deficits. Less development was apparent in DHBs where no leadership existed. Although there are obviously many factors involved leadership roles are important in advocating for psychology. At the time of the survey half of the leadership positions were vacant. It may be that there are less clear pathways for psychologists to take into leadership than for other professions (e.g. nursing, medical). Further work could compare leadership levels in psychology with other disciplines and consider how psychologists are best prepared for leadership positions.

As Levy (2005) has advocated, strategies need to be developed and implemented to challenge the limited perception of the profession and the profession needs to be strategic about positioning itself within the health system. Formulating an approach to health could unite views and skills from our professional associations, universities, the Board and the DHB Psychology Leaders Forum. The Professional Psychologists Advisory Forum (PPAF) is possibly the closest working group that would align these aims.

In such a small profession, especially in areas where there is not a critical mass in the workforce, each psychologist is the flag bearer for the discipline. Limited budgets require arguments to be politically persuasive and targeted. Promotion of the profession is an inherently political process. This coupled with small numbers and less in leadership suggests effort should be strategic rather than reactive, with a clear vision for the profession in health. Psychology could make a significant contribution to make to health objectives at a national level. Strategies could include lobbying for a clearer pathway nationally for psychological services such as that Layard (2006) inspired in Britain. More research could be supported locally to culturally align interventions for mental health problems where there is significant suffering (e.g. depression and anxiety disorders), but where presently most would only receive GP treatment (medication). In physical health it may be those that address the burden of the chronic disease that is increasingly an economic and social imperative.

Thinking outside the budget box is required, with DHBs and psychologists considering how psychological services are best configured and delivered. Consideration needs to be given to new technologies, the roles that psychologists fulfil (e.g. RC), joint initiatives outside DHBs particularly in

primary health care, and alternative avenues for funding. Psychologists will not be able to provide for all of the psychological needs within health services. This would necessitate a shift in the focus from a profession of face-to-face practitioner, to the development of expertise in sharing psychological knowledge with other health care providers to enhance health care in this country.

The present survey relied on the report of key informants. It was requested that they be accurate with the figures for the workforce questions. However, some questions only required estimates and therefore are likely to contain greater error. This report has indicated this fact where pertinent. Some caution needs to be exercised around interpreting overall deficits as the present survey did not tap those who contract to DHB services or PHOs.

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