SUBMISSION TO

Mental Health Commission Blueprint II consultation

Prepared by the New Zealand College of Clinical Psychologists

March 2012

Organisation: **NZ College of Clinical Psychologists**

Contactaddress/email: **PO Box 24088, Wellington/office@nzccp.co.nz**

Please tick which best represents your interest in the MH&A Sector:

Other (please specify):

The NZCCP is a specialist professional association representing 575 clinical psychologists and 179 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 members of NZCCP 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.

In what region do you live?

The NZCCP represents clinical psychologists nationally.

Consultation Questions

An outcomes oriented, whole-of-population life course

1. Do you agree with the five outcomes that are proposed to shape how things need to be?

a. Systems have been developed to respond earlier in the trajectory of development of mental health and addiction (MH&A) issues to reduce lifetime impact. ***YES***

b. Resilience, recovery and independence have been increased to minimise usage of high risk pathways through mental health, addiction, care and protection, and justice services. ***YES***

c. Resiliency of those with high prevalence MH&A conditions has been developed to reduce the impact on loss of health, functioning and independence. ***YES***

d. Recovery for those most severely affected by MH&A conditions has been strengthened. ***YES***

e. The effectiveness and productivity of the health system as a whole has increased. ***YES***

2. If you disagree, please tell us why.

N/A

3. Are there any other objectives we need to shape how things need to be?

The NZCCP recommends that mental health consumers are able to choose from a range of evidence based treatments for their presenting concerns, and options available to them include interventions with a established relapse prevention benefits. It is important that priority is given to the development of mental health promotion programmes and primary prevention for mental illness initiatives.

A system of care that is people centred, responsive, timely and integrated, builds resiliency and is recovery focused

4. Do you agree with the six areas of change required in system response?

a. Self care and resiliency support. Increase support for consumers and family-centred services to respond most appropriately, to build capacity for self care and promote resiliency and wellbeing. ***YES***

b. Develop a responsive "no wait" system to ensure prompt access to services, reduce escalation and loss of resiliency. ***YES***

c. Closer to home responses in less intensive settings, to shorten the response pathway and reduce pressure on limited specialised resources. ***YES***

d. Integrated responses across addiction, mental health and behavioural disorders, to provide a more effective balance of response. Where longer duration of support is needed, our systems of care must retain the focus on pathways to recovery. ***YES***

e. Strengthened focus on the flows along pathways to resilience and recovery; reduce coercion, reduce duration in services and frequency of relapse. ***YES***

f. Join up services across general health and the social sector to gain greater impact and synergy from combined capability and resources. ***YES***

5. If you disagree, please tell us why.

N/A

6. Are there any other areas required in system response?

It is important to plan for widespread training that teaches staff practical and effective strategies that provide them with the skills to appropriately practice consistently with the recovery approach.

Explanation: The Recovery Approach provides a strong philosophical position for guiding thinking in mental health services. However, to date the operationalisation of this philosophical position by development and teaching of practical and effective strategies has been limited and this has lead to a situation where many staff who understand what recovery is are not able to implement many aspects of it in their practice due to either 1) lack of skills to operationalise it, or 2) because they believe they are practicing consistence when their practice could be more closely characterized as "good-hearted business as usual".

Creating a step change in performance that maximises results we achieve from our limited resources of energy, time, capability and money

7. Do you agree with the ideas proposed to create a change in performance?

YES

8. If you agree with any of the ideas proposed to create a change in performance, please rank them in the order of priority for you.

YES

Ideas proposed to create change in performance

PLEASE INDICATE READINESS RANKING FOR EACH: 1=NOT READY; 3= SOMEWHAT READY; 5= COMPLETELY READY

a. **One system multi-funded** – aligning resources and integrating responses across health and social sectors. ***4***

b. A fast access **'no wait' system** that meets needs earlier, less intensively and can restore people back to their own support structures faster. ***4***

c. **Reducing variation** in clinical practice, safety and quality. ***2***

d. Increasing **clinical time to care** through reducing waste. ***4***

e. Organising roles and teams so that everyone is operating at the **top of their scope**. ***4***

f. Response pathways provide fast assessment & direct access to the **least intensive, most effective,** closest to home response possible. ***4***

g. Organising care into integrated **stepped or stratified layers of care**. ***4***

9. If you disagree, please tell us why, and tell us of any other ideas that you may have on how to create a change in performance.

The NZCCP feels that while we all wish to reduce variability in safety and quality, clinical variability often reflects variability in client and situational characteristics that are important for a successful outcome, therefore we need to avoid a too simplistic approach to clinical variability. This is very important professionally as the value Clinical Psychologists often add is through tailoring therapy (i.e. building in variability) to the needs of the client through a theoretically and evidence-based approach.

10. What do you think is needed for the MH&A sector to make these changes?

1) Clinical Psychologists working at top of their scope, adding to their specialist assessment and treatment roles a consulting/supervising/training role to assist the dissemination of evidence based psychological practice among other mental health disciplines. 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.

2) Adequate and consistent funding in DHBS for the training of clinical psychologists and other allied mental health professions, including psychotherapists, counselors and mental health nurses.

3) Creating more roles for clinical psychologists in primary care settings to help provide effective treatments to consumers who without these may experience deterioration and become more chronic users of secondary and tertiary services.

Building evidence informed system change capability

11. Do you agree with the move to a more evidence informed approach to system level change?

a. Identify the small number of innovative system-of-care developments that can initiate the step change in performance needed. ***YES***

b. Using these as our focus, work with the sector to apply the evidence base for effective change to identify the system antecedents, system readiness and adoption/assimilation capabilities needed. ***YES***

c. Again drawing on the evidence base, make recommendations to Government and central agencies on change support infrastructure required that will align the formal policy, monitoring and resourcing frameworks with sector led change networks and the change intelligence support needed. ***YES***

12. If you disagree, please tell us why.

N/A

13. Are there any other approaches to system level change you would recommend?

Use of a standard client-completed measure of Quality of Life as a consistent measure of outcome in all appropriate mental health services would assist in helping services to focus on goals that go beyond symptom reduction and building truly recovery-focused services. Collecting such a measure would not only provide outcome data, it would also provide valuable data about the areas of strength and concern for service users, and assist staff to orientate towards a broader recovery-oriented conception of their client's view. The WHOQOL-BREF (World Health Organisation Quality of Life – Brief) would be an excellent tool to consider for this.

Developing effective sector leadership

14. Do you agree with the five proposed areas to develop sector leadership?

a. **Stronger national and regional mental health and addiction networks,** strengthened with a stronger role in shared governance and accountability for achieving agreed local outcomes and performance goals. ***YES***

b. **Ministerial targets for MH&A.** These targets should be seen as an opportunity to enhance the profile of MH&A as an important contributor to the wider system of government in areas such as employment, transition to adulthood and at-risk youth. ***YES/NO***

c. **Continued advocacy and championship**. The Office of the Health and Disability Commissioner (which will include a Mental Health Commissioner from 1 July 2012) should have the role of championing the new Blueprint and monitoring its implementation***.*** ***YES***

d. **Aligned accountability processes**. The National Health Board and Ministry of Health should support the development and implementation of new national KPIs and accountabilities for District Health Boards that step beyond the current Blueprint access targets***.*** ***YES***

e. **Aligned central agency support**. All central health agencies should work with their housing, education, justice and welfare partners to achieve a more supportive environment for recovery and resiliency. ***YES***

15. If you disagree, please tell us why.

N/A

16. Are there any other areas you would propose to develop sector leadership?

Clinical leadership structures at all levels that are more fully inclusive of allied health leadership voices including psychology. Allied health disciplines have traditionally not been a strong voice in many health sector leadership and planning forums, but there is an increasing recognition that, for many of our major health issues (particularly relatively chronic conditions and conditions with a substantial lifestyle component), allied health disciplines and psychology provide a potentially powerful and as yet under-utilised perspective and potential that may be critical for meeting the health challenges of the future.

Guiding outcomes oriented development and resourcing decisions

17. Do you agree with the approach to supporting sector led performance improvement?

a. **An evolution of existing KPIs.** Using the base of the existing national KPI programme, develop an agreed set of nationally consistent KPIs with a stronger output and outcome focus using the Triple Aim / Results Based Accountability approach that is aligned with broader sector based direction. ***YES***

b. **Providing an integrated, benchmarked, outcomes oriented approach to performance.** Develop the emerging benchmarking capability in the KPI programme into sector supported approach to whole-of-system development that supports change development and resourcing and contracting mechanisms***.*** ***YES***

c. **Introduce nationally consistent resource allocation guidelines.** Develop a MH&A resource allocation decision support tool. This tool would provide a consistent systematic process for analysing need, performance and resourcing, to inform DHB MH&A resource allocation decisions (described in next section). ***YES***

d. **Annual process of review**. DHBs would be required to apply the decision support tool on at least an annual basis. The data from this process would inform a national database that would enable improved benchmarking, cross system learning and a national view of required forward investment levels in MH&A outcomes***.*** ***YES***

18. If you disagree, please tell us why.

N/A

19. Are there any other requirements for supporting sector led performance improvement?

The college feels that this approach depends on whether the measurements are meaningful and the purposes to which they are put. We support promoting the use of reliable outcome measures, and possibly doing away with less helpful requirements such as HONOS.

Evolving how we organise funding

20. Do you agree we need to review how MH&A funding frameworks operate?

a. A modified ring-fence (i.e. over time, ring-fenced funding could be better aligned with population mental health and addiction needs and population-based health funding). ***YES/NO***

b. Increase the accuracy and reliability of future PBFF funding ***YES/NO***

c. Improve the balance between inputs, outputs and outcomes in monitoring. ***YES/NO***

21. If you disagree, please tell us why.

While not necessarily disagreeing with the concepts in b & c, the current data collection is inadequate to be able to provide a reliable basis for basing PBFF funding arrangements on. There will need to be considerable improvement in the type of data collected and the reliability and validity of collection or PBFF funding is likely to be entirely spurious and lead to little real gain. Outcome measures might be useful here too.

22. Do you have any other suggestions for evolving MH&A funding frameworks?

A major issue restricting the development of the psychological workforce in New Zealand is a relatively low rate of training psychologists with the advanced qualifications and skills required for working effectively in different parts of 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.

Where do we start?

23. What are the top three issues the MHC needs to take into account to support sector led implementation of any changes?

1. Further development of the collection of consistent, valid, and meaningful data on mental health services.

2. Assisting services to operationalise the Recovery Approach so that clinicians are able to "walk the talk".

3. Increase the focus on mental health promotion and primary and secondary prevention of mental health difficulties.

24. What are the top three issues the MHC needs to take into account to ensure better outcomes for vulnerable groups including Māori, Pacific peoples, refugees and people living under economic deprivation?

1 Working to enhance the ability of all people, including those with mental health conditions, of being able to have access to the necessaries of life including adequate resources, meaningful relationships, and meaningful activities such as work.

2. . Development of more culturally responsive services – either as specialist services or responsive generalist services.

3. Including mental health promotion as part of healthy lifestyle education from a young age – via schools, community based resources and support agencies – including a focus on refugee and other marginalized populations with a view to preventing their needing MHS – perhaps through the children.