

**Comments on *Towards optimal primary mental health care in the new primary care environment: A draft guidance paper.***

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The New Zealand College of Clinical Psychologists (NZCCP) welcomes the circulation of the Ministry of Health (MoH) document, *Towards optimal primary mental health care in the new primary care environment: A draft guidance paper*, because it continues to address the significant problem of untreated mental health problems in New Zealand. The document aims to offer guidance in the already established process of introducing stepped care for mental health problems throughout the primary care system.

*Who we are*

The NZCCP represents 505 clinical psychologists and 178 postgraduate students enrolled in New Zealand clinical psychology programmes. 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. All have done research at the masters 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. As you can tell, we take being clinical psychologists very seriously. But we have to. We work with the minds of very vulnerable people and are aware of what

damage can be done to someone whose mind is messed with.

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 to these other health professionals. In the UK, where the Improved Access to Psychological Therapies (IAPT) programme is being piloted and gradually rolled out, clinical psychologists have been consultants in the development and implementation of a huge project involving assessment diagnosis, treatment planning, treatment, and monitoring of outcomes using psychometrics.

Despite having this expertise, the NZCCP only received this MoH document because another professional association sent it to us, and it does not contain the term “clinical psychologist” at all. Has the Ministry had any input from clinical psychologists on this plan up until now? And would the Ministry like some more?

Here are some of the areas we would like to see addressed more clearly in the next draft of the document:

*This plan will cost money, and could the money be better spent?*

The UK experience has been that enormous amounts of money have gone into training and hiring mental health workers to provide stepped care. There is still significant expense associated with the delivery of short interventions, or overseeing guided self-help. What is the estimated cost of this in New Zealand, and have the costs and benefits of the proposed system been compared with the costs and benefits of providing free or subsidised psychological therapies through private mental health practitioners (in the same way some physical health services are provided through GPs)?

*What is the evidence that brief interventions (4-6 sessions) are effective?*

The document includes a summary of the outcomes from PMHIs implemented in a number of PHOs throughout New Zealand. These results are encouraging (although a bit hard to interpret without documentation of interventions used, a control group, or clinical measures), but the authors of the document admit that not much research has been done in the area of brief interventions for mild to moderate mental health problems. A quick tour of the literature confirms this. Should we be in such a big hurry to effectively replace the current best practice with something so untested? Certainly progress is never made unless someone does something new, but what is described is a BIG and probably EXPENSIVE something new.

On page 29 it is suggested that best practice for adult patients with moderate depression is 6 to 8 sessions over 10-12 weeks, citing NICE guidelines from 2004. Those guidelines were updated in October 2009, and psychological therapies of such very short duration were not the best practice recommendation in the new guideline. Even in 2004, it appears (from what is still available on the NICE website) that this was only recommended as one of several possible low intensity interventions that were being explored at that time. In the current guidelines, brief individual interventions do not appear in the list of low intensity interventions for people with persistent subthreshold depressive symptoms or mild to moderate depression. The list is: individual guided self-help based on the principles of cognitive behavioural therapy (CBT), computerised CBT, and a structured group physical activity programmes. The 2009 guidelines suggest that “people with persistent subthreshold depressive symptoms or mild to moderate depressions who have not benefited from a low-intensity psychosocial intervention” (p. 250), offer either an antidepressant or a high-intensity intervention, which could be CBT, interpersonal therapy (IPT), behavioural activation (BA; there is less evidence for this), or behavioural couples therapy. The recommendations indicate that for all people with depression having individual CBT, IPT, or BA, the “duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months” (p. 252), with three to four follow-up sessions for CBT and BA; couples therapy should take 15 to 20 sessions over 5 to 6 months. If all these therapies are refused, one is guided to offer people with subthreshold, mild, or moderate depression counseling (6 to 10 sessions) or psychodynamic psychotherapy (16 to 20 sessions) but to discuss with the person the “uncertainty of effectiveness” of these two therapies (p. 251).

It may well be that clinicians in NZ and overseas have devised excellent short interventions that could be shown to be effective in controlled studies. If so, could the Ministry find out about these and include only interventions with some sort of evidence base in what is offered at the expense of the taxpayer?

*Are brief interventions acceptable to those with mental health problems?*

People like to know why they have the disorders they have, and could be disappointed when the sole focus of an intervention is symptom alleviation. Has this aspect of treatment with brief interventions been assessed?

*Who should receive mental health input?*

The document's section on prioritizing delivery is entitled “Clarity regarding inclusion/exclusion criteria”, and this section reflects how difficult it is to make the trade off between providing services to those who need it most (that is, who have the most severe disorders) and providing help to as many people as possible as early as possible with a limited budget. The idea presented is that the criteria of greatest need and greatest potential to benefit should be applied sequentially, but that is not what this section describes.

The section on “greatest need” starts by defining those with the greatest need, quite sensibly, as those with the most serious problems, but then admits that primary care (as already laid out in the particular kind of stepped care system described in the rest of the document) is going to be “better positioned to meet the needs of people with mild to moderate mental health and/or substance use disorders”. Greatest need is redefined as referring to “patients, within the target group of people with mild to moderate mental health and/or substance abuse problems, whose symptoms or functioning make them more impaired than others” (p. 37), that is, not the people with the greatest need, but those with the greatest need in the groups with lesser need.

The section that follows describes what is meant by the criterion “potential to benefit”, but what follows fails to meet the stated goal of being client-centred – the “benefit” referred to appears to be benefit to society, largely. There is an element of considering whether the patient might improve with treatment (which always brings up that worrying question about which disorders we can treat and which people we consider hard to help), but the first part of the discussion refers to whether treatment will get the person back to work and/or caring for his or her dependants. Although this does not have the direct logical implication that priority will be given to those who have children, or a job, there is a vague sense of this, and that even those people might miss out on an intervention if it does not appear that it will not actually get that person working again, either with pay or without.

*What will happen to people with moderate to severe mental health problems who cannot access specialist mental health services?*

Everyone knows that there are pretty seriously impaired people in our communities who do not get psychological intervention services from the District Health Boards (DHBs). The discussion in the previous section makes it clear that the stepped care system is not designed to cater for people with moderate to severe group. Who will look after these people? It appears they will filter through the stepped care system (hopefully no worse off if they have proceeded unsuccessfully through a lower-level intervention) and be referred to specialist mental health services, which are already struggling to provide sufficient psychological input.

*Who will provide supervision of practitioners, and what form will it take?*

The document rightly records the need for clinical supervision for all practitioners involved in the stepped care system; who will do this, and how? A talk given in Christchurch late last year by a clinical psychologist involved in one of the IAPT pilots in the UK revealed that supervision is delivered to the mental health care workers who are triaging people who present with mental health problems at the alarming rate of about two minutes per person on the worker’s caseload. In the model of supervision used by clinical psychologists in New Zealand, that would not be considered long enough. The seriousness of this situation is enhanced by the fact that these practitioners will be required to diagnose, a skill we acquire

over at least three years of clinical training. In particular, the prioritization of treatment of co-morbid disorders would be difficult without the ability to generate an individual formulation.

*Will screening tools become defacto diagnostic tools?*

Some questionnaires developed to provide auditing information for managers do not have basis in any established theory of psychopathology, and are not that clinically useful. All psychometric scores should be interpreted by those with appropriate training. Do all the tools chosen for the stepped care system have adequate validity and reliability? Is there a danger that they become used for diagnosis, despite the fact that it is a very rare tool that is designed for this?

*Will practitioners have adequate training?*

The document good emphasis on the need to provide adequate training for all practitioners, as required by the HPCA Act. What is the plan for providing this training?

*What role might clinical psychologists play in the development of mental health services in primary care?*

As a group, clinical psychologists have not yet had a chance to discuss what role they might play in a stepped care mental health service, however here are some preliminary ideas. Clinical psychologists in private practice already provide assessment and treatment services, and some of these have delivered very brief therapies as publicly funded packages of care during the piloting of the Primary Mental Health Initiatives (PMHIs) run through the some Primary Health Organisations (PHOs). However, as the packages tended to provide fixed amounts of money rather than a fixed number of sessions, these packages sometimes only paid for a very small number of sessions, not really enough in which to assess and provide intervention. In general, it could be that clinical psychologists could fill roles as high-intensity therapists, supervisors, trainers, consultants, and advisors to PHOs and the Ministry.

*Summary*

Overall, the plan represents a great step forward in providing mental health care to New Zealanders. It appears that there has not been consultation with clinical psychologists up to this point, but it is not too late! The significant issues of best practice, training of therapists, supervision, use of psychometrics, and prioritizing who receives services could still receive some attention.