NZCCP submission to *the Mental Health and Addiction Workforce Action Plan 2016-2020*

The New Zealand College of Clinical Psychologists (NZCCP) welcomes the circulation of the Ministry of Health (MoH) document, the Mental Health and Addiction Workforce Action Plan 2016-2020.

Who we are

The NZCCP represents over 700 clinical psychologists, and 200 postgraduate students enrolled in New Zealand clinical psychology programs. Clinical psychologists are trained in assessment and diagnosis, formulation (that is, generating a working theory about what has caused and maintains a person's mental health problems using established psychological knowledge), measurement (using psychometric instruments) and treatment of mental health disorders, and in the assessment of research into the efficacy and effectiveness of psychological therapies and interventions. All have done research at the Masters or doctoral level. Clinical psychologists are registered under the clinical psychology scope defined by the New Zealand Psychologists Board; the Health Practitioners Competence Assurance (HPCA) Act 2003 requires clearly specified competences are met and maintained by all registered clinical psychologists; the title "clinical psychologist" is protected by this law. We are also bound by a comprehensive code of ethics.

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 some 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 are relied on to provide clinical supervision and training to these other health professionals.

The value of psychologists to the health service has been confirmed by a rapid growth in the DHB and PHO psychologist workforce in times of somewhat limited workforce growth overall. 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 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 mostly 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

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

The NZCCP supports the overall directions and priorities set out in the document. The College supports the emphasis on better integration between primary and specialist services, and the focus on training pathways for both sspecialist workforce capacity and addiction treatment and recovery.

The NZCCP also agrees with the feedback summary from the regional meetings held in December 2015, particularly around 'how' the actions will be implemented, and 'who' is responsible for implementing the actions and strengthening the concepts in the Action Plan of the social determinants of health, self-management, particularly of long term conditions, and co-existing problems. We also agree that the language is medically oriented, and that it should be broadened to capture a wider range of professions, roles and interventions.

The following is feedback to specific sections of the action plan:

Priority one *– workforce development in primary health and community care*
We endorse the emphasis on prevention, early intervention and stepped care approach and would like to point out that Te Pou have already developed resources to support this, http://www.tepou.co.nz/initiatives/lets-get-talking-toolkit/146

Action 2(c) 'Increase training provision in' should include the following:

- "training in the **application of the stepped care approach**." It cannot be assumed that clinicians know or practise this, and this will significantly enhance efficiency and efficacy of therapy interventions, along with supporting **Priority two.**
- training in **Brief Interventions.** This is important in primary care especially the goal stated in action 2(a) *to increase training in screening.* If practitioners are to deliver screening then they must also be able to follow this up with brief interventions, especially at the first point of contact (para 2 pg 15).
- training in **Emotion regulation and distress tolerence skills** with special reference to provision of these skills in a **group therapy setting**. This is a particularly useful & efficient approach for addressing a broad range of presenting problems and disorders, especially in primary care.
- training in **Outcome Measurement** to ensure and demonstrate effectiveness of therapy practice. If practice is to be outcome-based, then it is important to ensure that a client receives an effective intervention and that progress can be shown to occur.

Action 4 (c) Ensure the primary health and community care workforce promotes of self management information and tools…. should include **"including information on the social determinants of mental health and addiction,**

such as social, financial, housing, education and employment." This broader area of self management also needs to be supported.

Priority two – *developing the workforce to improve integration between primary and secondary care.*
Action 5 (a) Expand and implement successful integrated ….workforce models , and (f) embed the national principles for models of care….
These actions are supported by **education and training in the application of the stepped care approach** – see suggestion for action 2(c). This underpins implementation of a successful integrated model. It provides a consisent pathway across primary and secondary care and ensures consistent application of the model, leading to effective practice across integrated care.

Action 6 (a) Facilitate training and development to develop staff understanding of roles and responsibilities of different services and groups across the sector.
As above this is also supported by **education and training in the application of the stepped care approach**

Action 7 a) Increase support for new and existing roles, that can work across primary and secondary mental health and addiction services
This list should also specifically include Clinical Psychologists as this is really 'bread and butter' work for a clinical psychologist.

Priority three *– specialist workforce capacity and training pathways*
Action 8(a) Implement targeted recruitment, retention, learning and development strategies for specialist workforce groups
Again this list should specifically include clinical psychologists, as there is a skills shortage, and this is also an issue which is a priority area for HWNZ.

Action 8 (c) Develop demand roles for clinical psychologists …
This is highly necessary for

- training in stepped care;
- for provision of specialist levels of clinical intervention under the stepped care model;
- for training other workforce professions in therapies;
- and for supervision of other workforce professions providing therapies.

Feedback from a recent review of IAPT (Increasing access to Psychological Therapies) programme in UK found that (from a review by Psychological Therapies, NHS Education for Scotland, Sept 2015)

- Recovery is higher where there are more highly trained and experienced therapists (A4C band 8 specifically clinical psychologists)
- It is higher where patients receive the appropriate number of sessions to treat the problem. Arbitrarily capping numbers of sessions below those specified as effective in the research trials reduces recovery rates.
- Recovery rates are higher where there is a high rate of step-up to High Intensity treatment where Low Intensity Treatment has failed
- Recovery rates are higher where people are treated in line with NICE guidelines.

Action 9c) Enhance specialist workforce capability and competencies
This list should also specifically include both CBT and Motivational interviewing as these are the two interventions with the strongest research evidence for their effectiveness in both addictions and mental health.

Summary
The emphasis on improving the range and capability of services, including the provision of evidence-informed psychological therapies, is something that the NZCCP views as particularly important, given clinical psychologists' potential to contribute significantly in these areas. We strongly endorse the goal of supporting and equipping the Mental Health and Addiction workforce to function efficiently and strategically, and see an evidence-based approach as being essential to this. In the context of psychological therapies, we see the delivery of the more substantial cognitive behavior therapy and dialectical behavior therapy training programs in New Zealand in recent years as positive examples of this.

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

It is important to note that a major barrier to the potential impact that clinical psychologists could contribute to Mental Health and Addiction services in this manner is the low rate of training within the profession. While there has been a rapid growth over recent years in the number of 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. This also affects the number of students that the clinical training programmes can train. It is important to promote the 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.

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.

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.

References
Ministry of Health. (2009). *Let' s get real: Real Skills for people working in mental health and addiction.* Wellington: Ministry of Health.
Mental Health Commission. 2012b. *Blueprint II: Improving mental health and wellbeing for all New Zealanders: Making change happen.* Wellington: Mental Health Commission.
Stewart, M.W. (2008). Psychologists in physical health services in New Zealand. *New Zealand Journal of Psychology, 37*, 50-54.