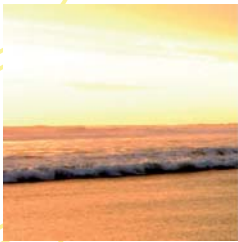


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# WE NOW NEED TO LISTEN

A summary of key issues from feedback on  
*We Need To Talk*

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## 1. BACKGROUND

*We Need to Talk* arose as a continuation of previous work that had called for better access to talking therapies for service users. Documents from both the Ministry of Health (e.g. *Te Kokiri*) and Mental Health Commission (e.g. *Framework for Recovery based Services in 2020; Report on Progress*) mention the need for exploration and progression of this area.

## 2. TALKING THERAPIES

Exploration of the provision of therapy in mental health services might be complex for many reasons:

- Internationally: as yet no country has applied a consistent approach or strategy to talking therapies. The only countries that have done some significant work nationally are England and Scotland, with Australia funding work at the primary care level and, more recently, transferring responsibility for provision of therapy from statutory mental health services to private psychologists and other therapists.
- In New Zealand this area has not been addressed at the national level. Whilst several groups have a particular interest in furthering talking therapies, to date there has been a lack of a coordinated and informed framework to guide planning in this area.
- In general it appears that there is a lack of a “whole of system” approach to talking therapies. Service users and their families seek wellness, and clinicians quite naturally are focused on the service user and family rather than taking into account the system within which they work.
- Several professional groups see therapy as their core expertise (e.g. psychologists, psychotherapists and some psychiatrists). More recently other disciplines have increasingly trained in specific therapies (e.g. DBT, MST, CBT and psychotherapy, among others). There are also groups of very skilled and well-trained staff whose work settings target the high-end complex-need service users and hence have developed high level skills and experience with a range of talking therapies.
- Currently most models of therapy are Western-centric in their conceptualisation, research and theories. Some work on the applicability of therapy approaches to other cultures has been undertaken by individual clinicians. For example, individual clinicians report work has been done on the appropriateness of CBT for Maori and Pacific nations’ peoples, but it appears that such issues have not been explored nationally and in depth. With an increasingly diverse mix of cultures this area needs examination.
- Finally, as the earlier report noted, there are still people working today in mental health services who believe that some clients are “too unwell for talking therapy”.

### 3. APPROACH

As a starting point to the discussion document was the question: “*What might lead to the most positive change for the most people?*”

The initial thinking was to hold a small meeting of interested people (e.g. a ‘Talking Therapies Summit’) to then take this work forward. However it became clear that this is not an area in which consensus might occur early or easily. The sector was informed that such a meeting would not occur but, rather, a draft of the report would be placed on the website for comment.

Then a process would be determined as to how to progress this work.

### 4. PROCESS OF WRITING THE REPORT

This report was written over several months and completed in August by Janet Peters with the oversight of Karl Metzler (National Workforce Manager, Te Pou) and Robyn Shearer (acting Group Manager, Mental Health Group, Population Health Directorate, Ministry of Health). The report was then peer-reviewed by:

- John Thorburn, Professional Leader Psychology, Auckland DHB
- Andrea Rowe, AoD Consultant
- Anna Schofield, Nursing Leadership Manager, Te Pou
- Carolyn Swanson, Service User Workforce Development Manager, Te Pou

### 5. FEEDBACK PROCESS

The *We need to Talk* report was placed on the Te Pou website in the last week of August 2007 with a comment that people were welcome to give feedback using Te Pou’s standard online feedback form. The deadline for feedback was 1 October 2007. It was also stated that a summary of this feedback would be undertaken and posted on the website by 1 November, 2007. This was then changed to 8 November. This current document fulfills that requirement.

## 6. FEEDBACK RECEIVED

We are very grateful for the feedback received. It is heartening that people took the time to respond to this report.

There was a total of 27 responses: some people sent very brief feedback (e.g. three lines), others several pages. Most feedback was sent by email, predominantly from mental health service clinicians but also from some service users and academic staff. Feedback ranged from very supportive of the report, to very critical.

To give a flavour of the wide range of feedback:

<i>“It is excellent I thought. How refreshing to read a well balanced report that highlights therapy (talking that is).”</i>	<i>“In summary this document does not signal to the MHS/Addictions sector any confidence in the author’s process or conclusions.”</i>
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The table below summarises the *main* issues arising from feedback and notes Te Pou’s response. It is divided into content issues and process issues. It does not cover all points made but the most commonly made ones.

## 7. SUMMARY OF ISSUES

No	Process issue	Te Pou Response
1	Some people were critical of the process suggesting that wider consultation, a more transparent process and more clearly defined scope and purpose were needed.	The document was seen as a start of a process; however, this is useful feedback and this suggestion will be taken into account in the next phase of the project.  We will aim to ensure clarity of scope, purpose and process.

No	Content issues	Te Pou Response
1	The document should not have put “Recommendations” as it was merely exploratory and a document aimed at starting discussion in the sector.	Agreed - an alternative could have instead said “Possible ideas for discussion” or “Issues for future exploration” etc.  In hindsight, the exploratory nature of the report could also have been reflected in the title.

No	Content issues	Te Pou Response
2	<p>Nearly all people agreed that this was an important area worth focusing on and that it should be progressed in some way.</p>	<p>This level of interest will be helpful in progressing this work.</p> <p>Given the level of interest it is perhaps surprising that no person/agency has tackled talking therapies before?</p>
3	<p>Nearly all agreed with the recommendation that talking therapies should be added to the National Service Framework.</p>	<p>This feedback needs to be noted by the Ministry of Health.</p>
4	<p>Psychotherapy was seen by some as not well described in the report. I have noted the quote below as it appears to summarise some of the concerns:</p> <p><i>“Our main concern was that psychotherapists as a skilled workforce were not represented well and that there was a lack of acknowledgment of the specific Talking Therapies that psychotherapists are trained in and how they may contribute to service delivery and better outcome.”</i></p> <p>Another person notes: <i>“We do not wish to take away the ability of other professional groups to do some psychotherapy as a scope of practice, but think that the public needs to know that there is a difference between psychotherapy as a tool and psychotherapy as a profession”</i>. And further: <i>“While Psychotherapy is a talking therapy, not all talking therapies are psychotherapy”</i>.</p> <p>The arguments for “practice-based evidence” as opposed to (or as well as) “evidence-based practice” were also made.</p> <p>In addition, several very helpful articles were forwarded by members of this profession.</p>	<p>Agreed - the document did not do this important group justice.</p> <p>We will ensure that psychotherapists are included in further progression of this work.</p> <p>The merits of both needs to be debated.</p>

No	Content issues	Te Pou Response
5	<p>Relationship building/engagement skills were seen as critical, with about a third of respondents mentioning the importance of this area.</p> <p>People were unsure whether basic training of all clinical professions was comprehensive enough. As one person noted:</p> <p><i>“I feel we need to look at ensuring that we actively promote and challenge our systems to ensure that we actually have contact and engagement prior to upskilling as there is no point in training staff when they are office bound (in an inpatient unit) for the majority of a shift”.</i></p> <p><i>“Perhaps we should be identifying that we need to engage before we need to talk.”</i></p> <p>On the other hand, some people thought that this should remain in the domain of clinical training agencies and should not be confused with this current work.</p>	<p>Examining what skills are taught in each clinical discipline may be useful? People may know of excellent training that is available?</p> <p>The area of relationship building links to the Let’s get real work, as engagement is seen as a core Real skill in this work.</p>

No	Content issues	Te Pou Response
6	<p>A key criticism was that some people saw that introducing a focus on CBT and MI was not useful. A variety of reasons were given:</p> <ul style="list-style-type: none"> <li>• Some suggested that this idea is not supported by the literature (e.g. that the CBT literature is mainly based on a non-mental health population)</li> <li>• It was noted that both are ethnocentric models thus applicability to other cultures is limited</li> <li>• Some thought that more training around engagement skills was more important than focusing on CBT and MI</li> <li>• The focus on CBT and MI could be <i>“interpreted in a narrow way and influence planners and funders to exclude other evidence based and effective therapies which skilled and advanced practitioners can deliver”</i></li> <li>• Some thought DBT should also be added to CBT and MI</li> <li>• Some cited workforce issues: <i>“Key workers already have very high caseloads and multiple expectations placed on them by services, clients and their families. If trained in CBT and MI it would add to the expectations on key workers for what they ‘should’ provide to clients. In a sense they would be expected to be therapists as well as key workers and yet it would seem unlikely they would be supported to reduce their caseloads accordingly. Consequences of this could be increased stress and distress for key workers”.</i></li> <li>• This person continues: <i>“Further, even if key workers were allowed to reduce their caseloads, if they are not fully trained in the empirically supported treatments for clients with complex issues, then their interventions are unlikely to be effective”.</i></li> <li>• The importance of trauma was discussed by some people: <i>“Evidence based research (and our experience) on trauma work indicates that treatment needs to be multi-modal and multi-phasal. A singular reliance on CBT will not provide the appropriate treatment to complex disorders. This also applies to the treatment of personality disorders”.</i></li> <li>• Several people supported a mix of workforce training initiatives structured over various levels (i.e. entry level NGO through to services that work with people with more complex problems – e.g. DBT and talking therapies for people who experience psychosis).</li> </ul>	<p>A comprehensive review of the literature in terms of the appropriateness of CBT and MI being used with people who use mental health services will be undertaken.</p> <p>Some people appeared to read into the report work that all other modes of therapy will be ignored or diminished in some way. This was not stated and is not the intent. A wide range of therapies is needed across the sector.</p> <p>A process in which people can discuss these issues will be put in place. The focus of such discussions would be on solutions.</p>

No	Content issues	Te Pou Response
7	The importance of considering work that has been done on “cross-cultural” perspectives was asserted. One service in Auckland, that works with people from migrant and refugee backgrounds, works in this area and the feedback from this service states: <i>“It is my experience that the quality of the relationship between therapist and service user that is more relevant than adhering to a particular Western therapeutic modality”</i> .	This information needs to go into any progression of this work.

## 8. SUMMARY OF FEEDBACK VERSUS RECOMMENDATIONS MADE IN THE FIRST REPORT

Recommendation	Comment
1. The updated National Service Framework should include talking therapies in its approach to service delivery.	All agreed with this recommendation.
2. Priority should be given to training and development for CBT and motivational interviewing as core therapy skills. (This would mean they become core competencies linked to the Let’s get real Real skills work, which is then linked to the National Training Plan being developed by Te Pou).	More discussion is needed.
3. District health boards (DHBs) and non-government organisations (NGOs) should employ and recruit staff trained in both CBT and motivational interviewing, and should work towards systems that provide staff with the processes and resources they need to support their CBT and motivational interviewing practice (e.g. ongoing training, supervision and educational resources).	More discussion is needed.
4. Research into making talking therapies culturally responsive should be prioritized, including: <ul style="list-style-type: none"> <li>• the therapies’ application by Maori, Pacific and Asian practitioners (including both therapies based on relevant cultural principles and processes, and mainstream talking therapies, such as CBT and motivational interviewing)</li> <li>• the application of CBT and motivational interviewing by mainstream practitioners for service users of other cultures.</li> </ul>	Some people agreed with this, but more discussion is needed.

Recommendation	Comment
5. A talking therapies summit should be held in late-2007 to showcase best practice in this area.	Given the disparity in feedback it is too early to hold such a forum at this time. It is hoped that this could occur in mid-2008.

## 9. NEXT STEPS

The summary above highlights some of the complexity of this topic. It is clear that this work needs to be progressed in a wider systems context.

Some people had very helpful suggestions and solutions about the need to look at the wider systems context. The following is a shortened version of one comment:

*“We suggest a ‘stepped care’ model as in the UK, right from the start as:*

- a It ensures that service users receive timely and appropriate treatment before their problems progress (i.e. clinical intervention early on is often preventative)*
- b. However it also ensures that people with complex problems who deserve treatment now receive it. We believe that all service users with moderate to severe conditions should be able to access appropriate psychological treatments.*
- c. Specialist services already exist and these could be built on to provide the supervision/consultation/training that is needed in the primary and secondary services to develop psychological therapies. The best way to ensure the rapid availability of basic psychological therapies is to simultaneously resource centres of excellence that can provide the necessary support via supervision and training.*
- d. It allows for a range of specialist services which in turn make it easier to develop the critical mass of psychotherapy practitioners (from any discipline) who can concentrate on their primary task of developing the expertise needed to treat people with complex problems”*

In the absence of an informed, coordinated approach/framework, service users will continue to be disadvantaged, service providers will lack clarity in training and education priorities, funders will be none the wiser on purchasing directions and clinical staff will continue to feel unsupported. Clearly, there is a need for a tiered approach to talking therapies training that supports new graduate clinical staff along a continuum towards highly qualified and experienced practitioners. This is a complex arena to negotiate a way forward through, and requires significant service development to occur in parallel if we are to be effective.

However, it would seem useful to first listen more to what people have to say.

## **Phase 1: In the short term (i.e. by 8 March, 2008)**

**First, a series of small meetings around New Zealand will be undertaken.**

The purpose would be to listen and gather solutions for a way to take this work forward. The agenda for each meeting would be:

- Issues for the group (other than what they have already submitted – if they have) (i.e. new feedback)
- Examples of “what works, for whom and why”
- Solutions
- Ideas for the future process of taking this work forward.

Given the current feedback, the following would seem a useful start. We will seek meetings by letter with representatives from:

DHB Family Advisers DHB Consumer Advisers Psychology College of Mental Health Nurses Social Work Occupational Therapy Psychotherapy Association representatives RANZCP Pacific Psychology Group	Maori Psychology Group Regional Personality Disorders Services Segar House - Rauaroha Asian mental health workers Transcultural mental health workers Family-oriented services Support workers NGOs Primary care organizations Alcohol and Drug services
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Some of these meetings may occur together.

**Second, summarise the information from this information gathering exercise in a report by 8th May 2008:**

- New issues
- Examples of “what works, for whom and why”
- Solutions
- Ideas for the future process of taking this work forward.

**Third, in parallel with the above, a literature review will be undertaken examining the use of CBT and MI in mental health and addictions populations.**

## **Phase 2: In the long term**

This will be determined based on the information received in the process to date, but it would be hoped that we, as a sector, can meet and agree possible ways forward in a Talking Therapies Summit by mid-2008.

## **10. IN CONCLUSION**

The sector requires clear direction and strong leadership in planning a way forward, in the absence of these, we will continue to “get more of the same” and the health dollar will be stretched to support a myriad of modalities and approaches, some of which are well supported by research and others by the loudest voices.

We have an excellent opportunity (if we are courageous) to make a genuine contribution to our sector. Te Pou hopes that in the months to come we will have the support of the sector as we embark on this process.