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# “WE NEED TO TALK”<sup>1</sup>

Talking Therapies<sup>2</sup> – a snapshot of issues and activities  
across mental health and addiction services in New Zealand

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1 This is the title of a UK report *We Need To Talk: The Case for Psychological Therapy on the NHS*. 2006. London: Mental Health Foundation, Mind, Rethink, The Sainsbury Centre and Young Minds. Permission to use the title for this discussion document was sought and obtained on 14 December 2006 from Moira Fraser, Mental Health Foundation, UK.

2 Talking therapies in this document refers to evidence-based psychological therapies.

# CONTENTS

	Page
Executive summary	1
1. Purpose of this document	3
2. Acknowledgements	3
3. Policy context	4
4. Process to date	5
5. Language used in this report	5
6. Who do mental health and addiction services serve?	5
7. Why talking therapies?	6
8. What are the most commonly used talking therapies in New Zealand?	8
9. What therapies have the strongest evidence base?	11
10. Who undertakes talking therapies?	13
11. Where are talking therapies undertaken?	15
12. Much is being done already	16
13. Before talking we need to successfully engage with people	20
14. Existing strengths in services related to talking therapies	21
15. Challenges	22
16. How are we going to walk the talk – where to from here?	25
References	27
Appendix 1 People contacted	29
Appendix 2 Relevant national workforce documents/projects	31
Appendix 3 National workforce centres	33
Appendix 4 Funding for psychology training	35
Appendix 5 Specific work relevant to talking therapies currently being undertaken in New Zealand	37

## EXECUTIVE SUMMARY

This discussion document was undertaken for Te Pou (New Zealand's National Centre of Mental Health Research and Workforce Development, which is funded by the Ministry of Health). Its aim is to strengthen the recovery approach for people who experience mental health or addiction problems by enhancing their access to talking therapies. This document will inform workforce activities and planning processes.

This document includes an outline of calls for better access, a description of therapies used in New Zealand, some initial feedback on general issues around talking therapies canvassed from 46 people, and a brief look at who is doing what, where and with whom.

This project found the following.

- Service users, family members and clinicians agreed that better access to evidence-based therapies is needed, with some people being unclear as to where talking therapies fit into service requirements.
- There is a range of talking therapies used in mental health and addiction services, with people agreeing that the well-researched approaches with the widest applicability are cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), and motivational interviewing. Other therapies also have a solid research base.
- Increasing access to, and availability of, talking therapies is not a quick fix strategy – it requires a long-term approach (as recent efforts in other countries such as Australia, Scotland and England have shown).
- Several themes emerged from stakeholders around providing therapy.
  - Strengths were:
    - staff across services are increasingly upskilling and acquiring certificates, degrees and other training in talking therapies
    - there are pockets of expertise in specific therapies – some staff are very skilled and there are excellent trainers across both mental health and addiction services and in training agencies
    - some services operate in such a way as to enhance therapy provision (e.g. clinical leadership supports the approach, staff are able to practise therapeutic skills appropriate to the service user, and there is ongoing training and clinical supervision in place).
  - Challenges were:
    - it was reported that some staff do not see the need for training in therapy skills
    - there is a shortage of specialised staff (especially psychologists) and little attention has been given to addressing this
    - some services operate in such a way that learning or practising therapy skills is not seen as important or even possible (e.g. under a case management (generic) system where different disciplines are not supported to practise their speciality and their therapeutic skills)
    - we have little research on how Maori, Pacific, Asian (and other cultures) principles and processes might work alongside CBT and motivational interviewing to enhance the therapeutic process.

There appears to be a general consensus that access to talking therapies across mental health and addiction services would be improved by the following five recommendations.

1. The updated National Service Framework should include talking therapies in its approach to service delivery.
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 Real Skills work, which is then linked to the National Training Plan being developed by Te Pou).
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).
4. Research into making talking therapies culturally responsive should be prioritised, including:
  - 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)
  - the application of CBT and motivational interviewing by mainstream practitioners for service users of other cultures.
5. A talking therapies summit should be held in late-2007 to showcase best practice in this area.

## **Limitations**

There are two main limitations to this report.

1. Firstly, the wide scope and general nature of this project means that justice may not have been done for specific populations and specialist services. However, it is hoped that enough of the points made are relevant to many people and services.
2. Secondly, this work is largely anecdotal and should be viewed as such.

## 1. PURPOSE OF THIS DOCUMENT

This document aims to provide a brief summary of:

- the call for greater access to quality talking therapies in mental health and addiction services in New Zealand (talking therapies in this document are evidence-based psychological therapies)
- descriptions of therapies commonly used in the mental health and addiction fields
- views and emerging issues from the mental health and addiction sector locally and internationally
- recommendations for implementing core talking therapies that might be most effectively enhanced to improve mental health outcomes for people who use mental health and addiction services.

Although many documents from this sector are either mental health focused or addiction focused, this document attempts to cover both areas. This has been done deliberately as people that use either type of service who have only a mental health problem, or only an addiction problem, may be the exception rather than the rule (Ball et al: 2006). The focus in this report is on secondary services in mental health and addiction, while acknowledging that NGOs have an increasingly important role both in mental health and addiction.

This discussion document should be viewed as merely a start to a national process of enhancing core therapies across mental health and addiction services. It does not make recommendations about more advanced therapy skills for specific populations.

## 2. ACKNOWLEDGEMENTS

The author appreciates the 46 people who gave their time, expertise and ideas to this document (see Appendix 1 for names). Conversations and contact with individuals working in mental health and addiction services once again demonstrated that we have compassionate, thoughtful and skilled people who are working to better the lives of people who use services.

I am grateful for the guidance of Robyn Shearer from the Ministry of Health and Karl Metzler from Te Pou who gave advice during the development of this work. I am also appreciative of the valuable feedback given to me by Andrea Rowe (from addiction services) and John Thorburn (from mental health services) who peer reviewed this document, and to Carolyn Swanson and Anna Schofield from Te Pou who also gave very helpful feedback on the report.

### 3. POLICY CONTEXT

#### Ministry of Health

Several Ministry of Health publications have mentioned the need for better access to talking therapies and several workforce initiatives are ongoing in this area (see Appendix 2 for policy documents). It is important to note that the current mental health and addiction workforce infrastructure enables the ministry's mental health directorate to implement goals and objectives from *Te Kokiri* (Ministry of Health: 2006a), which is the action plan for *Te Tahuhu* (Ministry of Health: 2005a), and from *Tauawhitia te Wero* (Ministry of Health: 2005b); and also ensures a link between national, regional and local workforce development.

The directorate has supported the establishment and operations of four national workforce centres (Appendix 3 gives more information about each centre):

- Te Pou: New Zealand's National Centre of Mental Health Research and Workforce Development
- Te Rau Matatini (a national Maori health workforce development organisation)
- Matua Raki (National Addiction Treatment Workforce Development Programme)
- The Werry Centre for Child and Adolescent Mental Health Workforce Development.

Three of the four centres have a service or population focus, while Te Pou has an overarching focus on research and workforce development. The four centres are responsible for progressing the ministry's five strategic workforce development imperatives:

- research and evaluation
- training and development
- organisational development
- recruitment and retention
- infrastructure for workforce development.

In addition, regional workforce development services have been established to facilitate uptake of workforce opportunities within their regions and nationally.

#### Service contracts

The National Service Framework (upon which service contracts are based) does not currently include talking therapies. However, this framework is under review and it is expected that talking therapies will become a core component of service delivery.

In some ways, NGOs may be seen as the growth area of the future. Much addiction treatment work is currently undertaken by NGOs and they are increasing in size and number in the mental health sector. Currently NGOs are not funded to deliver talking therapies (although some of the larger NGOs choose to). It was noted that in a 2005 survey of 232 NGOs, 57 said that they undertake some form of counselling.<sup>3</sup>

Similarly, it is likely that recent activities in primary mental health care that enable people to have better access to therapy for depression and anxiety problems will continue to grow.

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<sup>3</sup> NgOIT 2005 Landscape Survey. 2006. Auckland: Te Pou.

## 4. PROCESS TO DATE

Similar work looking at talking therapies in other countries has been briefly reviewed. Key stakeholders have been contacted and asked their views – all of the people contacted were keen to be involved. A message was put on Platform’s website asking for feedback from NGOs.

It was originally envisaged that a small group of key stakeholders would be called together to discuss the report’s recommendations and implementation plan. However, the small group grew large as many people were interested in the topic.

As a consequence the Ministry of Health and Te Pou have decided that a more appropriate way forward is to use this discussion document as a way of influencing thinking in the sector. Thus it is suggested that the process should now be to:

- notify all those people involved to date about this report
- post the draft report on the Te Pou website and give people the opportunity for comment (within a timeframe).

The report would then be available to feed into other mental health and addiction workforce projects (e.g. those currently being planned or in action by Matua Raki, The Werry Centre, Te Rau Matatini and Te Pou); and would also be able to inform DHB and NGO funding and planning processes, and the National Training Plan.

## 5. LANGUAGE USED IN THIS REPORT

Mental health services generally use the term “service user/tangata whaiora”. Addiction services usually use the term “tangata whaiora/client”. Service user will be used in this report.

Addiction services call people who provide services “practitioners”, while mental health services usually use the term “staff”. In this report, people will be called staff, practitioners or by their discipline title, as appropriate.

## 6. WHO DO MENTAL HEALTH AND ADDICTION SERVICES SERVE?

Mental health and addiction services exist to serve people and their families and whanau who may be of any age (e.g. children, adolescents, adults and older people) or culture (e.g. Maori, Pacific, pakeha and Asian people, refugees and new immigrants), and who experience moderate to severe mental illness, substance use or gambling issues. People may also have physical health problems or disability issues.

In addition, other specialist services may serve specific populations (e.g. forensic services, eating disorder services, Maori, Pacific or Asian populations, and gay, lesbian or transgender groups). Working with families is also seen as increasingly important.

As noted on the Matua Raki website the main addiction-related problems encountered by the addiction workforce are nicotine, alcohol, cannabis, methamphetamine and opioid dependence, and problem gambling. The most common coexisting mental health problems are major depression, social phobia, post-traumatic stress disorder and antisocial personality disorder (www.matuaraki.org.nz, accessed June 2007).

In addition to any or all of the above, some people may also be hampered by poverty, poor housing, educational difficulties, social isolation and employment issues – all of which contribute to poor health status.

## 7. WHY TALKING THERAPIES?

There are several reasons why it is timely to look at ways we can enhance access to talking therapies across mental health and addiction services in New Zealand.

Firstly, we have better information on the prevalence and incidence of mental health problems in New Zealand. The authors of *Te Rau Hinengaro* (Oakley Browne et al: 2006) state that around 20 per cent of New Zealanders are currently experiencing, or have experienced, a mental health, alcohol-related or drug-related problem. A smaller percentage of this group will access secondary services. We also know that people's mental health status affects their physical health (and vice versa). Thus we know that there is a need for therapies that are effective in mental health, addiction and primary care services. We also know that both Maori and Pacific people have lower rates of access to mental health and addiction services (Oakley Browne et al: 2006), present to mental health services late and are more unwell when they present, and that Maori are over-represented in addiction statistics compared with other ethnic groups. Census data also forecasts an aging population and that pakeha, Maori, Asian and Pacific people will continue to be the four largest ethnic groups (Oakley Browne et al: 2006).

Secondly, talking therapies are known to be effective for treating a range of mental health problems including depression and anxiety. The recent Mental Health Commission report *Te Haererenga mo te Whakaoranga* (2007) notes that cognitive behaviour therapies (CBT) have been found to be effective for the treatment of anxiety and depression and some form of CBT can be delivered by a range of health practitioners (similar findings have been reported in the UK in *We Need to Talk* (Mental Health Foundation: 2006). Given that depression and anxiety commonly present with addiction issues, this is relevant for addiction services. CBT is also seen as being effective for people who experience post-traumatic stress disorder, obsessive compulsive disorder, eating disorders and psychotic disorders (National Institute for Health and Clinical Excellence: 2007a). There is also growing recognition of the impact of trauma on mental health and the importance of talking therapies in treating trauma. This is reflected in the saying: "You can't give a pill for trauma". Dialectical behaviour therapies (DBT) have been shown to be useful for people with personality disorders and severe and complex psychological difficulties – in the past, these people were not able to access effective services, as early thinking was that they were untreatable. A range of other therapies are also gathering an evidence base (as outlined in sections 8 and 9).

Thirdly, people who use services, and their families, are now more aware of what “works” and the effectiveness of therapies. Information about therapies is readily available on websites and in brochures (e.g. from the Mental Health Foundation), and is given to service user and family agencies and GPs; therapies are taught in universities and training agencies; and people get together and talk about their experiences. As a result there have been calls by service users and families (and by clinicians) for greater access to evidence-based talking therapies. The call is for therapies that are high-quality and accessible in a more consistent way, and that are practised in a way that is consistent with a recovery approach. Such therapies are now seen as being a core part of service delivery for both mental health and addiction. A challenge however is to ensure that therapies are relevant and appropriate to New Zealand’s increasingly multicultural society.

Fourthly, feedback received as part of this project suggests that service users currently have variable access to therapies across mental health services in New Zealand. It appears that access depends upon many factors, for example, the location of the service (we know that rural areas may not be as well staffed), the ability of management to support training, individual clinician’s enthusiasm for a specific therapy model (or conversely a clinical leader’s disagreement with a particular model), access to trainers, cost, availability of back-filling for rostered staff, and access to supervision. In some cases, inclusion and exclusion criteria developed by services mean that staff may not see the need for training in some areas (e.g. if a services refers all sexual abuse issues to ACC, then staff do not see the need for even a basic understanding of this area). Thus some people (depending on where they live and what services are available) may have limited access to treatment.

Fifthly, staff are our biggest resource, making it particularly important that their knowledge and skills are continually updated. In an ideal world, staff should also be valued for the skills they bring. However, mental health and addiction services can be difficult places to work and staff “burnout” is not uncommon. Some service users do not want to be served, and the stigma and shame surrounding mental illness (although lessening through the efforts of the Like Minds Like Mine public health campaign) is still a strong deterrent for many in seeking treatment.

Sixthly, lack of treatment leads to unnecessarily prolonged ill-health and suffering, plus the cost of not treating people is immense (e.g. days of work lost or cost of antidepressants). The 2006 UK report *We Need to Talk* (Mental Health Foundation: 2006) states that offering timely access to evidence-based psychological therapies could help to reduce such costs. It could also help people to stay in, or rejoin, the workforce or to stay in work, rather than perhaps having to go on a benefit; to achieve chosen educational outcomes; and could prevent people suffering unnecessarily. The report notes that access to talking therapies: “is not an optional extra to existing health provision – it is as necessary as any proven technology for any illness in any part of the NHS” (page 2).

Seventhly, current international trends suggest that increasing access to talking therapies in both mental health and primary care is either underway or being planned in other countries. For example, a brief review of activities in Australia, England and Scotland indicates that all three countries are currently planning to increase access to talking therapies in both mental health and primary care. Internationally, a focus on the physical health of people with mental illness (e.g. the report for the National Association of State Mental Health Program Directors (Parks J et al: 2006)) and the role of depression in people with long-term health conditions is also growing (e.g. WHO, [www.who.int](http://www.who.int), accessed 2007).

Eighthly, the mental health and addiction sector now has multiple national workforce planning processes and it is timely to feed information into these processes. Better access to psychological therapies requires planning and investment – in mental health workers; in training and education about evidence-based therapies; and in systems that ensure high-quality standards, training and examination of outcomes.

## 8. WHAT ARE THE MOST COMMONLY USED TALKING THERAPIES IN NEW ZEALAND?

Talking therapies is a broad term covering a range of therapeutic approaches, all of which involve talking, questioning and listening in order to understand, educate and assist with people's problems. In an ideal world, any interaction by a staff member with a service user or family member should be therapeutic.

In its simplest form, talking therapies may be seen as a person with a mental health or addiction problem talking to a trained practitioner, with a view to working together so the person may learn how to resolve (or better manage) his or her difficulties over time. A key ingredient is the staff member's ability to successfully engage with the service user in a way that is supportive, empathetic and respectful.

Widening the above definition out further, such talking therapies might then range from a 10 minute phone call to a crisis mental health clinician, through counselling by an addiction worker, to a set number of sessions of CBT delivered by a clinician in a child and adolescent mental health services setting. The similarity is that all are using therapeutic techniques, with the CBT being a very structured process.

However, this can be a confusing area. Different people use varying names for therapies and practitioners of therapies, both in New Zealand and overseas. For example, the term "psychotherapy" is often used as a catch-all term to describe all talking therapies. For the purposes of this document, psychotherapy is not used, as it is seen more as a process, usually longer term and more unstructured.

The table below describes the names and evidence base of the therapies most commonly used in New Zealand, together with the therapy process and conditions best treated. This list is not exhaustive – only the more commonly used therapies are listed. Some of the information in the table is taken from the UK document *We Need to Talk* (Mental Health Foundation: 2006), but I have adapted the language and content to better fit the New Zealand context.

Therapy	How it works	Conditions and NICE evidence <sup>4</sup>
<b>Cognitive behaviour therapy (CBT)</b>	<p>The person works with a therapist to identify negative emotions, beliefs and thoughts to:</p> <ul style="list-style-type: none"> <li>• understand why and when they might be harmful</li> <li>• understand how they relate to the symptoms of their mental health problems</li> <li>• develop skills to get rid of them or learn strategies to manage them.</li> </ul> <p>Sessions are time-limited and focused on specific issues.</p>	<p>Evidence suggests that CBT is effective for people who experience:</p> <ul style="list-style-type: none"> <li>• depression</li> <li>• anxiety disorders</li> <li>• post-traumatic stress disorder</li> <li>• obsessive compulsive disorder</li> <li>• eating disorders</li> <li>• long-term mental illness (e.g. schizophrenia and bipolar disorders).</li> </ul>
<b>Computerised CBT</b>	<p>As with CBT above, but the therapy is provided via computer rather than in sessions with a therapist.</p>	<p>Evidence suggests that computerised CBT is useful for managing:</p> <ul style="list-style-type: none"> <li>• depression</li> <li>• anxiety disorders.</li> </ul>
<b>Bibliotherapy</b>	<p>As for CBT above, but delivered through a book-based system, rather than through face-to-face sessions with a therapist.</p>	<p>Evidence suggests that this may be useful for:</p> <ul style="list-style-type: none"> <li>• people with anxiety disorders.</li> </ul>
<b>Dialectical behaviour therapy (DBT)</b>	<p>A form of behaviour therapy designed to assist people with borderline personality disorder.</p> <p>The person is encouraged to adapt their reactions to emotional triggers. Therapy is given individually or in groups and may specifically aim to reduce self-harming behaviour.</p>	<p>Evidence suggests that DBT is effective for people who experience:</p> <ul style="list-style-type: none"> <li>• personality disorder resulting in self-harming behaviour</li> <li>• persistent binge eating disorder.</li> </ul>
<b>Psychotherapy</b>	<p>When the term is used to describe a model of therapy, it usually means that the therapist uses psychodynamic principles to provide a structure to understand and resolve emotional disturbance.</p> <p>Face-to-face therapy may be short-term, focusing on identified problems, or longer term if more pervasive personality issues are present.</p>	<p>Evidence suggests that focused psychotherapy is useful for treating:</p> <ul style="list-style-type: none"> <li>• anorexia nervosa</li> <li>• depression accompanied by other complex mental illnesses.</li> </ul>

<sup>4</sup> Evidence is from the National Institute for Health and Clinical Excellence (also known as NICE) in the UK. This agency publishes a range of clinical guidelines.

<b>Family therapy</b>	The therapist encourages dialogue among members of a family to resolve differences, and provides counselling to improve communication between them. Family therapy assists people to understand each person's difficulties within the context of the family as a group.	Evidence suggests that this is useful for: <ul style="list-style-type: none"> <li>• anorexia nervosa</li> <li>• moderate to severe and persistent depression in children and young people</li> <li>• families and carers of people who experience schizophrenia.</li> </ul>
<b>Multi-systemic therapy</b>	Multi-systemic therapy is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behaviour in young offenders using an ecological approach.	Evidence suggests that this is useful for youth with antisocial behaviour or diagnosed conduct disorder, or who are currently offending.
<b>Counselling</b>	The most basic form of psychological intervention. The person talks about their difficulties with a counsellor who plays a supportive role and may provide practical advice on problem-solving.	Evidence suggests that this is useful for: <ul style="list-style-type: none"> <li>• mild depression in children and young people</li> <li>• where CBT and family therapies are not available for people who experience schizophrenia.</li> </ul>
<b>Interpersonal therapy</b>	This therapy helps people to learn to link their mood with their relationships with people close to them, and to recognise that interacting differently with people may improve both their relationships and depressive state. Feedback suggests that there are few people trained in interpersonal therapy in New Zealand.	Evidence suggests that interpersonal therapy is useful for: <ul style="list-style-type: none"> <li>• people with eating disorders</li> <li>• moderate to severe depression in children and young people</li> <li>• depression in adults when the person expresses a preference for this therapy (or the clinician feels it may be beneficial).</li> </ul>
<b>Problem-solving therapy</b>	This is a brief, focused psychological intervention that aims to teach people how to identify and solve problems.	“Evidence suggests that problem-solving therapy is as effective as antidepressants in primary care and may be a useful part of chronic disease management programmes” (Dr Simon Hatcher, personal communication, 14 May 2007). A study is underway looking at this therapy for people who self-harm and present to emergency departments.
<b>Motivational counselling and motivational interviewing</b>	In this model the therapist focuses on issues that the person may be sensitive about in a way that avoids confrontation. Together they examine hopes and aspirations for life, relationships and work, with a view to identifying barriers and achieving goals.	Evidence suggests that this may be useful for: <ul style="list-style-type: none"> <li>• people with alcohol and substance misuse problems</li> <li>• people with the above problems, plus a mental health issue.</li> </ul>

## **Training**

Feedback suggests that there is variation in the delivery of training for talking therapies across DHBs and NGOs, particularly when the training gets specialised and expensive.

In general, staff in mental health and addiction services receive a lot of training in a variety of skills and processes, most of which are law-based or compliance related.

There is legislation-driven education and training (e.g. on the various acts: Mental Health (Compulsory Assessment and Treatment) Act 1992, Alcoholism and Drug Addiction Act 1966, Misuse of Drugs Act 1975, Children, Young Persons and their Families Act 1989, Privacy Act 1993, New Zealand Public Health and Disability Act 2000, and the Health Practitioners Competence Assurance Act 2003). In addition, other training ensures compliance with various processes (e.g. recovery training, Treaty of Waitangi training, working with families, orientation programmes, duly authorised officers training, and first aid). Furthermore, there are regional and local requirements for other training (e.g. MH-SMART, incident reporting), and training for clinical competencies (e.g. mental state examination, alcohol and other drug assessments, clinical risk assessment and supervision training).

Training fatigue has been reported by some staff.

## **9. WHAT THERAPIES HAVE THE STRONGEST EVIDENCE BASE?**

People generally want to know what interventions are effective. To understand the effectiveness of a treatment requires using evidence. One definition of evidence is: “The integration of best research evidence with clinical practice and client values” (US Department of Health and Human Services: Substance Abuse and Mental Health Services Administration: 2006, page 5).

With the emphasis of this project being on talking therapies that may have the widest application, the following assessments of effectiveness and potential usefulness are suggested.

### **For mental health**

Evidence suggests that the therapy most widely researched is CBT (Mental Health Foundation: 2006). CBT could therefore be seen as a core therapy skill useful for all mental health and addiction staff, and without exception, the people contacted for this project agreed with this view. Computerised CBT also has a growing evidence base ([www.nice.org.uk](http://www.nice.org.uk), accessed 2007) and the Ministry of Health in New Zealand is looking at the possibility of expanding this approach in primary care.

Other therapies also have a strong evidence base, for example DBT, which is largely based on CBT principles. However, these can be seen as more specialist therapy areas.

What is not so clear is how existing talking therapies might be effectively applied with other cultures (e.g. using CBT for Maori or Pacific people). One senior Maori psychologist uses CBT frequently for her clients, but has over time incorporated Maori principles and approaches so that both she and her clients are comfortable with the process and outcome. She also said that the name “cognitive behaviour therapy” is often off-putting for Maori. However, once it is explained, people see the thinking and commonsense behind the CBT approach and are comfortable with the process. Another person said: “I am sure that many would argue that Maori and Pacific as orally based cultures have a much longer history of talking therapies than mainstream disciplines”.

## **For addiction**

In alcohol and drug services the most well-researched and commonly used approach is behavioural or motivational interviewing. Feedback from addiction staff suggests that this approach is seen by service users of all cultures to be acceptable. Mental health staff also suggested that this approach is useful, particularly in supporting people to clarify and achieve goals.

Also important (particularly in addiction services) are approaches such as relapse prevention and guided self-change.

In addition to therapy skills, both mental health and addiction staff need basic education in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association: 2000) and alcohol and drug facts and effects (e.g. overdose risks, safe withdrawal management, drug interactions, neuro-pharmacology of drugs).

## **For working with families**

Across all services, working collaboratively with families, whanau and significant others (such as friends, colleagues etc) was seen as an important part of the recovery process. This may be particularly important for Maori, Pacific and Asian people. In addition, working collaboratively, where appropriate, with community support agencies was seen by one person as “a skill in itself”. Family therapy, however, should be seen as a distinct therapy process with specialist training required.

## **For stigma**

In the public domain, the Like Minds Like Mine public health campaign is making inroads into the problem of stigma surrounding mental illness. For secondary services, it is still an issue particularly for Maori and Pacific people (Oakley Browne et al: 2006).

For Asian cultures, a reticence to seek help (due to feelings of shame and stigma) may be the biggest impediment to recovery (Ho et al: 2002). Maori and Pacific people also report this reticence (Oakley Browne et al: 2006). In addition for Asian service users, finding appropriate ways of engaging with people, promoting adherence to western styles of therapy (e.g. homework), assessing health beliefs, values and religious beliefs (formal, spiritual or folk practices), and discrimination among health professionals have all been identified as issues affecting therapy.

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<sup>5</sup> Some service users feel that a strong emphasis on the *Diagnostic and Statistical Manual of Mental Disorders* is not helpful as this system: “is only an indication that medication might work given a certain set of symptoms and thus does not allow for the myriad of other factors and strengths that make up the person”.

The multiple layers, variations and sub-groups within the Asian population, plus age, gender, education, urban versus rural, and levels of westernisation factors, all have a part to play.

Within addiction, there is also a stigma attached to people who are on methadone programmes.

By enhancing communication and engagement skills, and introducing talking therapy skills, staff should be better able to address these concerns with these groups as they arise.

## 10. WHO UNDERTAKES TALKING THERAPIES?

Staff undertaking talking therapies may include registered health professionals (e.g. nurses, psychiatrists, counsellors, psychotherapists, occupational therapists, clinical and registered psychologists and social workers, among others). They may also include non-registered practitioners who have been trained in a specific model (e.g. CBT, motivational interviewing or addiction treatment) or may be people with personal experience of mental illness or addiction.

Staff may also have specific cultural expertise (e.g. with Maori, Pacific or Asian populations), expertise related to specific mental health or addiction conditions or diagnoses, or age-related expertise.

Common themes voiced about different professional groups include the following.

### **Nursing**

- As nurses are the largest clinical group in the mental health and addiction workforce, they are an important group.
- There is a growing trend for senior nurses to undertake postgraduate training, leading to an increasingly skilled workforce.
- Many nurses are keen to up-skill in therapy. However, a key issue is cost, and managing to back-fill positions when nurses are training can be very difficult.

### **Psychiatry**

- Psychiatrists suggest that they need to be involved with taking talking therapies forward, as they are a powerful lobby group and often wear the risk for treatment<sup>6</sup>.
- It was reported that “some psychiatry training schemes are squeezing psychotherapy out of psychiatrists’ training” and that some services do not want psychiatrists to undertake one-to-one therapy, as managers see that the expense (in terms of time) does not justify their involvement. This was seen as a retrograde step by members of the profession who maintain that the service user loses out.
- Psychiatrists have continuing medical education to draw on if they want to further their professional development.

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<sup>6</sup> Some service users disagree with this statement saying that it is: “always the service user who wears the most risk – staff can leave and work in other fields, we don’t get that choice”.

## **Psychology**

- Psychologists are important for supervising and training in talking therapies (particularly for CBT and DBT, where there are few other disciplines accredited with supervisor status).
- People acknowledge the high level of skill of psychologists. However, the greatest problem is that they are difficult to recruit and retain. Levy, in her seminal document on the psychology workforce (2005), noted there is a shortage of clinical psychologists in New Zealand owing to the lack of numbers being trained and the opportunities for them in areas other than health. It is surprising that no national agency to date has tackled this long-standing problem. (See Appendix 4 for more information about the reasons for this shortage.)
- It was suggested by other disciplines that some psychologists see themselves as having “ownership” of certain therapies, which is not helpful.
- On the other hand, psychologists argue that some non-psychologists appear to be unaware of the breadth of training behind CBT (e.g. animal research and cognitive research), which all goes towards having a broader base for the practice of the therapy. As one person said: “It would be like me learning to do intramuscular injections without learning anatomy”.

## **Social work**

- Many child and adolescent mental health services expect staff to have therapy skills, and all staff (including social workers) are supported to learn appropriate therapies.
- It appears that in other services that support social workers to develop and practise specific therapy skills, some social workers have been trained in CBT and DBT, multi-systemic therapy, motivational interviewing, educational group work and family therapy, as a result of such support.
- However, in services that operate in a generic way, the ability to learn and practise therapy skills is very limited.

## **Occupational therapy**

- An occupational therapists’ role is also often prescribed by the way a service operates. Thus an occupational therapist may or may not be able to practise his or her skills, depending on whether the service enables this to occur.
- Basic counselling skills, group facilitation and brief focused interventions have always been part of occupational therapy training and the recovery approach has been widely adopted by occupational therapists in their daily work.
- The psychiatric rehabilitation course run through Boston University is seen as an excellent course for upskilling staff in tools and techniques.

## **Addiction services**

The Matua Raki strategic plan notes practitioners in addiction services may include all of the above disciplines, as well as those listed as “other staff” below. A large component of the addiction workforce is made up of people who have experienced addiction.

## **Other staff**

Other staff important to service delivery across mental health and addiction services are service user advisers, cultural advisers (e.g. Maori, Pacific or Asian), peer support workers, community support workers, medical officers and family advisers. They can all play a key role in supporting clinicians in therapy goals, as well as providing support in their own roles. Maori elders (i.e. kaumatua and kuia), elders of other groups (e.g. matai) and traditional healers are also valued staff in some services.

## **NGO staff**

Feedback suggests that, in general, NGO staff focus on life skills and relationship skills – both are important for service users. In realising the importance of communication and relationship skills, some NGOs have contacted Relationship Services (a not-for-profit NGO providing counselling and education services) to deliver basic training for staff.

## **11. WHERE ARE TALKING THERAPIES UNDERTAKEN?**

It appears that most talking therapies in the mental health sector are undertaken in community settings (e.g. community mental health services or specialist mental health services).

Most addiction treatment is undertaken by NGOs (i.e. residential addiction treatment), with DHBs undertaking outpatient and opiate substitution services. Some alcohol and drug work is undertaken in therapeutic communities (e.g. communities have been established within prisons by Care (NZ)). Such communities offer an intense therapeutic environment in which a range of approaches (e.g. 12-step, spiritual methods for Maori) and skills (e.g. communications skills, assertiveness, dealing with emotions, relationship skills) are used. Mental health services also offer assessments in the courts and clinical input into prison medical units.

Talking therapies are one part of an overall package. We need staff who can effectively engage with service users and their families, who can assess people well, plan and carry out appropriate interventions, manage risk well, refer appropriately and effectively plan for discharge.

In the future the growth areas in mental health and addiction services are likely to be NGOs and primary care, which means these areas are likely to increase their delivery of talking therapies (and will need trained staff to take part in them).

## 12. MUCH IS BEING DONE ALREADY

### New Zealand

It is acknowledged that much work is already being done in talking therapies in New Zealand, particularly in the mental health and addiction sector.

The list below is not exhaustive, but gives an indication of some general activities that are occurring.

- Universities and other training agencies offer many courses relating to talking therapies (e.g. CBT is taught as a multidisciplinary course by Massey University, the Eastern Institute of Technology and University of Otago in Wellington; and the National Addiction Centre offers postgraduate addiction courses).
- Some DHBs have developed their own innovative local training initiatives (e.g. Bay of Plenty DHB is establishing a training programme for staff for treating personality disorders, which aims to include DBT, mentalisation-based treatment, schema focused therapy and cognitive analytic therapy).
- Several DHBs (e.g. Southland) have documented comprehensive frameworks for educating and training staff. The frameworks outline legislative and compliance requirements, service priorities, Clinical Training Agency funded post-graduate education for 2007, some profession-specific post-graduate education and conferences.
- Each professional group undertakes training that is usually able to be accessed by other disciplines (e.g. a cognitive analytic therapy course was run by the New Zealand College of Clinical Psychologists and the New Zealand Psychological Society).
- Training is also undertaken for mental health and addiction staff by people working in the private sector (e.g. Dr Joel Porter, an expert in motivational interviewing, offers training, and the Centre for Cognitive Behaviour Therapy is running a series of CBT-based courses in several New Zealand cities).
- Training has been offered to help staff become more culturally aware when working with Asian service users (Tse et al: 2006). A two-day programme was developed and evaluations showed that attendees felt better able to understand how Asian cultures and traditional health practices can improve (or impede) mental health outcomes for Asian service users. Staff also felt better skilled to provide individual services for Asian people, and had more knowledge about community support available for them.
- Activity has increased recently in the primary care sector, with the advent of primary health organisations and their ability to develop innovative ways to reach service users who may be in need of talking therapies. An evaluation of a range of primary health organisation demonstration projects is underway funded by the Ministry of Health, and an interim report *Primary Mental Health Initiatives* completed in December 2006 by Dr Tony Dowell and colleagues is available.
- Talking therapies are used in the physical health arena (e.g. for heart transplants, pain management and psychological input into long-term conditions such as diabetes). This area is not the focus of this discussion document.
- It is also important to state that there is a large and growing group of people in private practice (primarily psychiatrists, psychologists, cognitive behaviour therapists, counsellors and psychotherapists) who undertake work on a fee-for-service basis. Again, this private sector group is beyond the scope of this discussion document.

More specific descriptions of talking therapies work that is occurring and the agencies leading it are in Appendix 5.

## **Internationally**

A quick look at countries doing relevant work shows that Australia, Scotland and England are all active in this area.

### *Australia*

Two key areas of recent policy in Australia that focused on improving access to talking therapies are relevant to this project.

In mental health, the most recent initiative heralds a shift of statutory mental health services on to the private sector, and is being funded to the tune of A\$538 million. The Better Access to Psychiatrists, Psychologists and General Practitioners initiative provides people with better access to mental health care through general practitioners, psychiatrists, clinical psychologists and other appropriately trained allied mental health professionals. Funding comes from the Medical Benefits Schedule. The initiative will encourage team-based mental health care in the community, with psychologists working alongside general practitioners, psychiatrists, mental health nurses and other allied mental health professionals. Training will be available for practitioners to improve the detection of mental illness and the quality of services offered. This initiative aims to:

- encourage more general practitioners to participate in early intervention, assessment and management of people with mental health conditions, and to streamline access to appropriate psychological interventions in primary care
- encourage private psychiatrists to see more new service users
- provide referral pathways for treating people with mental disorders, including by psychiatrists, general practitioners, clinical psychologists and other allied mental health professionals
- support general practitioners and primary care service providers, through education and training, to better diagnose and treat mental illness.

The Australian government website notes: “It is expected that by 2010–11, an additional 35,000 patients [sic] with severe mental illness will be able to have access to psychiatric care as a result of this initiative. Over the first five years of the initiative almost 960,000 clinical psychology services are expected to be provided.” (www.health.gov.au, accessed July 2007).

Commentators have suggested that the initiative is effectively pushing services over to the private sector, with the fear being that statutory services will not continue to be developed and that staff (psychologists in particular) will leave statutory services for the more lucrative private sector.

In primary care, the Australian Better Outcomes in Mental Health Care programme improves community access to quality primary mental health care. The programme was introduced in 2001, with funding of A\$120.4 million over four years. It is improving community access to quality primary mental health services by providing better education and training for general practitioners and more support for them from allied health professionals and psychiatrists. Further funding of A\$142.7 million over four years has been provided to continue and expand the programme to 2008-2009. Of note is that an evaluation of 108 projects has shown a marked positive impact for service users in terms of level of functioning, severity of symptoms and quality of life (www.health.gov.au, accessed March 2007). The programme has five integrated components, which are described on the website.

Increasingly, therapies are being delivered online, particularly for the treatment of anxiety and depression. E-therapy examples are MoodGym ([www.moodgym.anu.edu.au](http://www.moodgym.anu.edu.au)) and ClimateTV ([www.climate.tv](http://www.climate.tv)), which are aimed at both doctors (as a training process) and service users.

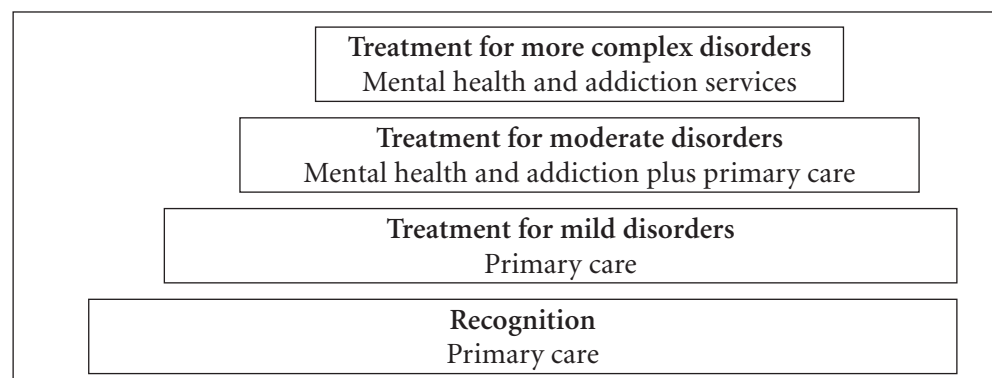
## *England*

The National Institute for Health and Clinical Excellence (also known as NICE) recommended in 2004 that the UK's National Health Service should provide a range of psychological therapies. The institute argued that there is persuasive evidence of such therapies' effectiveness and cost-effectiveness in improving outcomes for people experiencing a range of common and severe mental health problems. In April 2007, the institute published amended versions of its clinical guidelines for managing anxiety and depression. As part of a range of options, CBT is recommended to be: "delivered only by suitably trained and supervised people who can demonstrate that they adhere closely to empirically grounded treatment protocols" (National Institute for Health and Clinical Excellence: 2007a: page 24). The guidelines give recommended length and duration for CBT and computerised versions of it.

The *We Need to Talk* (Mental Health Foundation: 2006) report was commissioned by five leading UK NGOs and is supported by 11 others. It promotes the recommendations of the National Institute for Health and Clinical Excellence guidelines and makes the following recommendations on page 2:

- "That the National Health Service should implement the NICE guidance as a matter of urgency
- The Government's 2007 Comprehensive Spending Review should provide for improved access to talking therapies
- The NHS should introduce waiting time measures for access to mental health treatments
- The Department of Health should make a realistic assessment of the workforce and training implications of delivering psychological therapies
- The Department of Health and regulatory bodies should ensure substantive measures for public protection from malpractice
- The Department of Health should investigate the current bias in research priorities and address it by supporting more research into psychological therapies."

The National Health Service, in *Commissioning a Brighter Future* (2007), states that a stepped care model is desirable: "The idea is simple: to provide patients [sic] with the most cost effective and appropriate treatment, in the least invasive manner, as close to home as possible" (page 11). A diagram demonstrates this approach where the higher the step illustrates the greater the interventions.



Practice-based commissioning is heralded in the UK as one way to enhance the public's access to psychological therapies in primary and secondary services. Services included in this approach are:

- bibliotherapy
- psychological therapies (e.g. counselling, CBT, interpersonal therapy and psychodynamic therapy)
- guided self-help (psycho-education)
- information and support
- telephone support (for CBT)
- prescribed activity (e.g. exercise, social activities, participation in education or the arts).

The UK government is also looking at how psychologists can work differently in the future to increase access to talking therapies. Reviews of undergraduate and masters degree curricula are underway, with the notion of psychology assistants or associates being mooted.

As noted in a recent presentation:

**“Why the focus on psychological therapies:**

- People want it
- Unmet need
- Evidence base in place (e.g. CBT)
- Improves health & well-being (happiness)
- Benefits society (& the Treasury)
- Supports mental health reform
- Important component of the Government's manifesto
- Improved choice of pathways.” (www.bps.org.uk, accessed 12 July 2007)

Several national groups have been established to assess various aspects of this review of psychologists' work (e.g. reviewing undergraduate curricula, examining current career pathways and the role of psychologists in multidisciplinary teams, plus reviewing the role of psychiatrists in reformed services) (www.bps.org.uk, accessed 12 July 2007).

The UK is also promoting the use of two computerised CBT programmes: Beating the Blues for the management of mild and moderate depression; and FearFighter for the management of panic and phobia (National Institute for Health and Clinical Excellence technology appraisal 1997, www.nice.org.uk, accessed February 2007).

## Scotland

In *Delivering for Mental Health* (National Health Service Scotland: 2006) the Scottish government stated: “Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers” (page 4).

In Scotland, it is noted: “the term Psychological Therapies is wide-ranging and covers:

- all evidence-based therapies
- for all conditions
- across the range of presentations – from mild to severe and enduring
- in a range of settings – from primary care to forensic
- across the age range
- in physical and mental health.” (Geraldine Bienkowski, personal communication, May 2007.)

The first phase of this endeavor is underway, with a high-level training plan being undertaken focused initially on primary care (Geraldine Bienkowski, personal communication, May 2007). Information is being gathered from national health service boards about what they currently fund and deliver by way of psychological interventions and therapies, and what their future commitments are.

Scotland is similar to New Zealand in that few psychologists are trained each year. There are 450 clinical psychologists in Scotland for a population of five million. Scotland is revisiting the role of clinical psychologists and it is envisaged that in the future they will spend more time teaching, training and supervising other staff. In addition, given that few graduates are able to access clinical training, Scotland has developed a masters-degree-level qualification to enable psychology graduates to work with mild and moderate mental health problems. Such clinicians will be able to work in primary care, in general health settings (such as chronic disease management), and with children, young people and families (National Health Service Scotland: 2006).

## 13. BEFORE TALKING WE NEED TO SUCCESSFULLY ENGAGE WITH PEOPLE

Feedback suggests that staff need to have excellent engagement skills, in order that they may be able to quickly establish rapport with service users, establish good relationships, and work with respect, empathy and skill. Service users want staff to work in a way that is collaborative and empowering, and that enables the service user to be an active participant in the process. This finding reflects that found in the recent Real Skills consultation process<sup>7</sup>. Clinicians suggested that (particularly in the mental health sector) the art of rapport building and successfully engaging with service users and their families appears to have been undervalued in the past few years. Perhaps there is an assumption that people who work in the mental health and addiction sector are either “natural people people” or well-trained in communication skills. It is acknowledged that ways of engaging with different cultures and ages may require different communication skills and approaches.

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<sup>7</sup> *Let's Get Real: Real Skills for People Working in Mental Health and Addictions: Analysis of Workshops and Feedback.* Unpublished report.

Other comments that were made were:

- excellent communication skills were needed to undertake an effective assessment process (as well as therapy)
- new graduates of all disciplines are not as well-trained as they might be in communication skills
- staff who had been in services for many years may not see the need to regularly up-skill in this area
- people who are not clinicians (e.g. service user workers, support workers, Maori, Pacific and Asian workers) are often very effective at getting alongside people who use services and thus can play a key role in assisting the therapy process
- engagement skills (and the time to develop them and practise them) need to be better valued by service leaders and by funders and planners.

Several people suggested that services may need to review what training staff have had recently, and plan for up-skilling as appropriate.

## 14. EXISTING STRENGTHS IN SERVICES RELATED TO TALKING THERAPIES

- Some DHBs have recently put effort into training staff in engagement skills. One example is Auckland DHB, which has a training programme that focuses on a recovery approach and includes communication and listening skills.
- There are pockets of excellence in specific therapies (e.g. motivational interviewing, CBT, DBT, multi-systemic therapy and others), but also in age appropriate, culturally appropriate, gender appropriate and other specialist services (e.g. refugee services, forensic services). These appear to be primarily driven by clinical leaders with a passion for a particular therapy (or for getting the best for a particular service user group). As a consequence there are also some very knowledgeable staff and some very skilled trainers across mental health and addiction services in New Zealand. Historically, the addiction area has valued those who are in recovery from addiction and it is estimated that between 25 and 30 per cent of the addiction workforce are in recovery (Adamson: 2005, reported in [www.matuaraki.org.nz](http://www.matuaraki.org.nz), accessed January 2007).
- It is commonly thought that excellent training (and supervision) can assist with shifting the values base of a service and support the recovery culture, and that with careful thought and planning, systems can be put in place to support training being turned into practice, and to ensure it is continually reviewed and embedded into services.
- It is also acknowledged that adherence or fidelity to specific therapy models is seen as critical for successful outcomes. Such adherence needs quality training, good staffing levels and consistent systems of supervision. Some services appear to be good models for such approaches (e.g. some child and adolescent services and some that are set up to use DBT).
- The existing national workforce centres are seen as welcome additions to the mental health and addiction arena. Although some people have made calls for a national centre of excellence for psychotherapies, most thought that if the existing workforce centres (i.e. Matua Raki, Werry Centre, Te Rau Matatini and Te Pou) worked in a strongly collaborative way, gains could be maximised, for example in training and supervision.

- Clinical supervision is critical to some therapies (e.g. CBT and DBT). However, there is a dearth of senior experienced supervisors. This means that in some cases practitioners train and then either don't use their skills, as supervision is not available, or use their skills but are not supervised. Supervision of supervisors is also important. Some services have innovative ways of ensuring that strong clinical supervision is in place. Examples include:
  - hiring a very skilled person to act as clinical supervisor for a service that has enough staff to support this role
  - using the Climate model of e-based learning
  - effective use of videoconferencing.
- Some therapists are very good at using innovative ways to evaluate the therapy process and progress. These may range from (at the very least) asking "Are you doing any better?" through to using standardised instruments and protocols for assessing change over time. It was also suggested by several people that asking the service user to assess the therapist may be a useful part of the evaluation process (e.g. Scott Miller's work on therapy – [www.talkingcure.com](http://www.talkingcure.com)).
- Feedback suggested that issues important for staff to understand are:
  - awareness of personal boundaries for staff
  - awareness of the need for service user self-responsibility (e.g. doing therapy homework or trying tasks related to therapy), while being careful to encourage a non-blame culture
  - self-care skills for staff
  - the need for a greater understanding about trauma and sexual abuse issues.

## 15. CHALLENGES

The following challenges that emerged are primarily (but not exclusively) related to mental health services.

- Questions were raised about the inconsistency in approaches across New Zealand. One person asked: "Is what is called CBT the same in Kaitia as in Christchurch?" Lack of clarity on when therapy is appropriate, and the knowledge and skill required to deliver it, varies across services. Any national work to enhance consistency would be helpful (e.g. specifying accredited trainers or training courses for specific therapies). It appears that in addiction services, training is undertaken in a more consistent way, perhaps because there are key trainers who work nationally with agreed treatment approaches.
- Mental health service users believe that in some cases normal human emotion and behaviour may be given a pathological slant by staff. For example, while there are some clinicians who advocate strongly for service user access to trauma therapy, some service users suggest that acknowledging their past trauma may be enough and that in some cases trauma therapy is thrust upon captive service users who don't want it. In a similar vein, it has been suggested that one outburst of anger by a person in an inpatient unit can lead to an assessment of a need for anger management (when in fact the anger may have been justified). It was argued that a thorough assessment of each situation is warranted, rather than assuming symptom-driven behaviour or illness. (However, following the thorough assessment, staff then need to have the skills required to work effectively with the person).

- The way most mental health services are structured can be detrimental to the therapeutic process. For example, case management often means that clinicians are not able to practise their specialist therapy skills (e.g. in one service all staff are called health clinicians, irrespective of their discipline). One person noted that DHB mental health services generally see two types of people: those with psychotic illness who may have enduring needs, and those who experience severe depression, anxiety or Axis II problems. The latter group would benefit most from CBT, but what people get is a doctor and a case manager who is unlikely to be skilled in CBT. This person suggests that case management should be the role of the support worker, thereby enhancing access to clinical staff and therapy skills. In addition, ongoing supervision and skills training is required. There is no easy solution to this. However, anecdotal evidence suggests that some services do work effectively, allowing each staff member to develop, practise and maintain their skills – if some services operate this way, others can too. One DHB has a core set of competencies for all mental health practitioners and for each discipline. This makes it easier to identify training needs and for all to be aware of expectations.
- Service users made the point that it would be preferable for planning for therapy to occur at first contact with a service. For example, for people who have a mental health inpatient stay, therapy could start (or be planned to start) from the time they enter the unit: “People come into an inpatient unit with their ‘issues hanging out’ but are not able to start therapy in the unit and often are discharged and then have to wait too long before they can access therapy in the community”.
- People suggested that there are historical and current tensions between mental health and addiction services. The services have differences in therapeutic approaches and the language used in each area is often different. For example, in addiction services, motivational interviewing is the key approach used. Other similar approaches include motivational enhancement therapy, social behaviour network therapy, and community reinforcement. One addiction leader said that sometimes mental health clinicians appeared to treat addiction staff as either a “threat or a joke”. Another mental health clinician said that “addictions staff have a simplistic view of mental illness”. Importantly, as noted earlier there is recent New Zealand evidence to suggest that the dual diagnosis of mental illness and addiction is the rule rather than the exception (Ball et al: 2006). Thus, any way of bringing greater understanding of each other’s areas (e.g. in joint training) would be useful.
- Therapy is not seen as part of core business by some clinical staff. “People who use mental health services are too ‘unwell’ to benefit from therapy”: was a statement made by a clinical leader of a DHB (this person is not named in this document). Such attitudes will naturally hinder staff training and development in therapy areas. Doing something because “this is the way we have always done it” is no longer a viable argument. Clinical staff are in the business of supporting service users to change and yet sometimes may be unwilling to undertake change themselves.

- There appear to be varying views around the appropriateness of some therapies for some cultures. Some clinicians (Maori and non-Maori) noted that they use CBT with Maori service users with positive outcomes. A review commissioned by the Mental Health Commission found that there was little work examining this area for Maori. One study by Krawitz (1997) did tailor therapy to address the needs of Maori, but without a comparison group it is hard to determine the efficacy (reported in Ball et al: 2006). We need more information on what therapies work for various cultures and what culturally relevant processes support them working.
- With regard to Pacific people, one Pacific clinician noted: “Talking therapies are not a problem for Pacific clients (with regard to cultural issues) as they have been disenfranchised from therapies, so therapies are as relevant if not more so now”. An issue also important for Pacific service users is for staff to have excellent skills in coordinating and managing family meetings in order to assist the therapy process.
- Once a staff member has been supported to undertake further training (e.g. postgraduate training in CBT), they then become a marketable commodity and are likely to be head-hunted and leave for another agency (e.g. in prisons, private practice or to work in primary care).
- It has been suggested that one impact of the Health Practitioners Competence Assurance Act 2003 has been to reinforce the reliance on employing registered clinicians, thus disallowing a competency approach that could enhance and widen workforce opportunities in mental health and addiction (e.g. for counsellors and support workers).
- Feedback suggests that in mental health, community support workers are taught that clinicians equate to a medical model, which equates to “bad”. Thus the roles that clinicians play in the treatment process may be undervalued and (at times) undermined. Ideally, each person’s role should be working toward the same aim of supporting the recovery process for the service user. If (as was suggested elsewhere) support workers’ roles were widened to include a case management function, this would free up clinicians to undertake more therapies. Any change in roles needs to include all parties, so that people are clear about how they contribute to the recovery process.
- Service users have noted that for people who train overseas (particularly psychiatrists and psychologists), the country of origin may affect their approach to therapy. For example, often those trained in South Africa have a more psychodynamic approach, which in turn may lead to longer-term therapy for service users. If within one team, a person is seen for many sessions over months (or years) this is seen as more valuable by service users, compared to those who see another psychologist from the same team for six sessions of CBT (which may be seen as of lesser value).

## 16. HOW ARE WE GOING TO WALK THE TALK – WHERE TO FROM HERE?

This report may serve to raise more questions than it has answered, but it is hoped that it will stimulate discussion and debate on how services currently operate to best serve the people who use them.

As one senior clinician said: “If you’re going to do it, do it properly – clients come with complex issues and staff need to be skilled to work effectively”.

From the feedback gathered it appears that people agree that effective engagement skills, plus motivational interviewing and CBT, will establish a more consistent basic set of skills for staff, which will allow service users to have better access to talking therapies.

A key issue that emerged is the way some services operate, which disallows therapy to be undertaken. Enabling clinical staff to practise their discipline-specific or expertise-specific (e.g. cultural) skills and valuing them for those skills, would seem to be a sensible way forward. This needs to be done in parallel with valuing the roles of other cultural and support staff.

Based on the information obtained to date (and using the rationale that too many recommendations are not conducive to action) the following five recommendations are made.

### **Recommendation one**

The soon to be updated National Service Framework should include talking therapies in its approach to service delivery.

### **Recommendation two**

Priority should be given to training and development for CBT and motivational interviewing as core basic therapy skills. (In this way they will become core competencies linked to the Real Skills work, which then links to the National Training Plan being developed by Te Pou).

- It is assumed that very basic engagement skills (e.g. empathy, listening, and reflective mirroring) are included in any training that might occur.
- Good assessment skills are also a core part of a practitioner’s skill set. How might these be defined?
- Related processes to support such training need to be addressed (e.g. Deciding which particular approach or model of CBT and motivational interviewing should be offered? What resources are needed? How might such training take place? Which staff should receive such training first? Who should undertake it? How do the skills get embedded in services? What is the best care pathway process? How can regular supervision be assured?).
- Training could be included as part of the National Training Plan (a joint project between the Ministry of Health and Te Pou).
- Joint training, where agreed, could take place with NGO and primary care staff.

### **Recommendation three**

DHBs and NGOs should employ and recruit staff trained in both CBT and motivational interviewing. They should also work towards systems that provide staff with the processes and resources to support their CBT and motivational interviewing practice (e.g. ongoing training, supervision and educational resources).

- Information about such processes and resources could be communicated via the national workforce development centres' websites (i.e. Te Pou, Te Rau Matatini, The Werry Centre and Matua Raki), among other avenues.

### **Recommendation four**

Research should be prioritised into the culturally responsive application of talking therapies by Maori, Pacific and Asian practitioners, including those therapies based on cultural principles and processes, as well as mainstream talking therapies (such as CBT and motivational interviewing). Research is also a priority into the application of CBT and motivational interviewing by mainstream practitioners for service users of other cultures.

This work could be prioritised in Te Pou's Mental Health Research and Development Purchasing Plan.

### **Recommendation five**

A talking therapies summit should be held in late-2007. This could be open to staff from NGOs and primary care and include:

- practical skills training in CBT and motivational interviewing
- stories of success (service user and family narratives)
- best practice options for training for staff (e.g. courses available in CBT and motivational interviewing and trainers available)
- processes for effective supervision (e.g. videoconferencing and e-supervision, among others).

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## APPENDIX 1 PEOPLE CONTACTED

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## APPENDIX 2 RELEVANT NATIONAL WORKFORCE DOCUMENTS/PROJECTS

### Ministry of Health

Directorate	Publication	Comment and relevant national ministry funded projects
Maori health	<i>Te Puawaitanga: Maori Mental Health National Strategic Framework</i>	Information from this framework should feed into all workforce activities.
Pacific health	<i>Te Orau Ora: Pacific Mental Health Profile</i>	Information from this framework should feed into all workforce activities.
Mental health	<i>Te Rau Hinengaro: The New Zealand Mental Health Survey</i>	Further projects are expected to progress aspects of this publication.
	<i>Te Tahuhu: Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan</i>	Calls for greater access to psychological therapies for people who experience mental illness, in both mental health and addiction, and in primary care.
	<i>Te Kokiri: The Mental Health and Addiction Action Plan 2006–2015</i>	Describes the specific actions, key stakeholders and milestones required to meet the expectations of <i>Te Tahuhu</i> (2005a). Notes that psychological therapies should be part of the range of effective and integrated services available.
	<i>Tauawhitia te Wero: Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006–2009</i>	Te Pou, Te Rau Matatini, The Werry Centre, Matua Raki. A National Training Plan outlining workforce training for the next two years is being documented by Te Pou.
Primary care	<i>The Primary Health Care Strategy</i>	Notes that primary health care includes health improvement and preventative services such as health education and counselling, disease prevention and screening.  Demonstration projects among 21 public health organisations – many public health organisations have developed innovative ways of ensuring better access to CBT for people with depression and anxiety problems. These look at innovative ways of providing therapies for people with mild to moderate depression, anxiety and addiction. The report is available ( <i>Primary Mental Health Initiatives</i> , 2006).

Public health	<i>New Zealand Suicide Prevention Strategy 2006–2016</i>	National Depression Initiative – a public health campaign aimed at greater understanding of depression and encouraging people to seek help early. Part of this campaign is access to telephone counselling via Lifeline.
	Like Minds Like Mine	This is a national public health campaign using mass media and grassroots community action to decrease stigma and discrimination associated with mental illness. A multi-agency plan has been developed to collaborate across several key national agencies.

## Mental Health Commission

Improving access to talking therapies has also been an area of interest for the Mental Health Commission, with several of its publications mentioning the need for better access.

<b>Publications/documents</b>	<b>Quotes/findings</b>
<i>Te Haererenga mo te Whakaoranga 1996–2006: The Journey of Recovery for the New Zealand Mental Health Sector</i>	Improvements have been found in psychological therapies available in New Zealand over the past decade.
<i>Framework for Recovery Based Services in 2020: Explanation and Summary</i>	“Talking therapies such as CBT, and other approaches that have gathered an evidence base, will be available to all service users.”
<i>Literature Review on the Effectiveness of Treatment/Service in Contributing to Recovery</i>	“The literature on talking therapies found good evidence for the effectiveness of these therapies for a range of mental health illnesses, with strong evidence for CBT. Talking therapies have been found to be highly acceptable to service users, particularly for the treatment of depression.”
<i>Journeys of Despair, Journeys of Hope: Young Adults Talk about Severe Mental Distress, Mental Health Services and Recovery</i>	There was little access to talking therapies for the young people interviewed in this research.
<i>Report on Progress 2004–2005</i>	Service users would like to see a wide range of effective treatments including counselling.

## APPENDIX 3 NATIONAL WORKFORCE CENTRES

Who	Current activities and training programmes relevant to talking therapies
Te Pou	<p>Te Pou (<a href="http://www.tepou.govt.nz">www.tepou.govt.nz</a>) has three main work areas: workforce development, research and information. There are over 20 projects currently underway all of which are related to workforce development. The Talking Therapies Project is funded by Te Pou.</p> <p>Projects related to Talking Therapies include:</p> <ul style="list-style-type: none"> <li>• training in DBT</li> <li>• drafting a National Training Plan, which will include a review of the content of undergraduate and postgraduate curricula to assess whether the content meets the needs of the mental health and addiction sector (or more accurately) the needs of people who use services</li> <li>• coordination of the implementation of the mental health nursing framework</li> <li>• developing an Asian mental health education programme for teachers in tertiary education institutions</li> <li>• Real Skills, which is a project in collaboration with the Ministry of Health, aimed at identifying and establishing core competencies for the workforce in mental health and addiction services. Seven draft Real Skills have been developed across six areas and the intent is to develop these further with input from the mental health and addiction sector. Knowledge, skills and attitudes are being established.</li> </ul>
The Werry Centre	<p>The Werry Centre for Child and Adolescent Mental Health Workforce Development (<a href="http://www.werrycentre.ac.nz">www.werrycentre.ac.nz</a>) is funded by the Ministry of Health. The website states that the centre’s vision is: “A workforce that is clinically and culturally able to meet the needs of children and young people with mental health concerns, and their family/whanau”. The website is structured under four topic areas: workforce development, teaching, research, and the child and adolescent mental health services (CAMHS) conference.</p> <p>Part of the Werry Centre’s contract is for training in evidence-based therapies. The centre provides training in:</p> <ul style="list-style-type: none"> <li>• CBT with a child and adolescent focus</li> <li>• Incredible Years – parent management programme, which currently has eight trainees</li> <li>• family therapy, which until approximately four years ago was undertaken by Sally Merry.</li> </ul> <p>Issues:</p> <ul style="list-style-type: none"> <li>• inconsistency around the country in staff skills and training in CBT, DBT, multi-systemic therapy, child psychotherapy and family therapy</li> <li>• good supervision is needed to ensure fidelity to the model – currently strong supervision processes are lacking in some areas as some managers won’t fund them (however, work is underway through Te Pou to address this)</li> <li>• staff need training at the undergraduate level (i.e. in basic CBT and family systems approach)</li> <li>• staff who do DBT training should have a good understanding of CBT first</li> <li>• there is a growing literature that DBT may be effective for adolescents.</li> </ul>

Matua Raki	<p>The National Addiction Treatment Workforce Development Programme (Matua Raki) (<a href="http://www.matuaraki.org.nz">www.matuaraki.org.nz</a>) was established by the National Addiction Centre and is funded by the Ministry of Health. The Matua Raki website notes: “High priority is given to developing sector infrastructure, recruitment, retention and training. This will allow for flexible career pathways that not only allow practitioners to develop necessary competencies, but also allow practitioners to move from entry level qualifications to graduate and postgraduate qualifications”.</p> <p>The programme’s aim is that: “In 10 year’s time one-third of the dedicated addiction treatment workforce will have addiction-related graduate qualifications. Another third will have addiction-related postgraduate qualifications with the remaining third having training related to their level of clinical responsibility”.</p> <p>Training is done through universities. Ian MacEwan from Matua Raki and Dr Joel Porter from Hamilton also run courses on an ad hoc basis when asked.</p> <p>On the Matua Raki website it is also stated that there is a move to establish (under the Health Practitioners Competence Assurance Act 2003) scopes of practice for:</p> <ul style="list-style-type: none"> <li>• registered alcohol and other drug practitioners</li> <li>• alcohol and other drug associate practitioners</li> <li>• alcohol and other drug support workers.</li> </ul> <p>A concern is that currently (where a person presents with a serious mental illness in coexistence with an addiction) any psychosocial intervention must have the approval of a Health Practitioners Competence Assurance Act registered worker.</p>
Te Rau Matatini	<p>Te Rau Matatini (<a href="http://www.matatini.co.nz">www.matatini.co.nz</a>) is a national Maori health workforce development organisation that aims to progress Maori workforce development to enhance whanau ora, mental health and well-being. The aims are progressed through a range of projects that contribute to Maori mental health, as well as to primary care and public health workforce policies at a national and regional level that expand the Maori workforce, increase responsiveness to Maori health needs, and promote rewarding career opportunities for Maori.</p> <p>Te Rau Matatini is important for communicating and networking, funding and scholarships, and for progressing its aims through its various projects.</p>

## APPENDIX 4 FUNDING FOR PSYCHOLOGY TRAINING

By Ron Chambers, Psychology Adviser, Mental Health Services, Canterbury DHB, and Dr Fred Seymour, Associate Professor and Head of Department, Department of Psychology, Faculty of Science, University of Auckland.

In New Zealand, psychologists (particularly clinical psychologists) are frequently employed in mental health services. However, driven by the empirical evidence and overall cost-savings, in recent years there has also been a move towards using psychological interventions both in specialist physical health areas (e.g. heart transplant services, burns centres, oncology and respiratory services) and by primary health care agencies. Increasingly also, psychologists are being employed by other government agencies such as the corrections, court and probation services, as well as in the Child, Youth and Family Service, Group Special Education Service, and in NGOs. Psychologists also now frequently work in private practice, rather than working for public sector organisations.

In New Zealand, and world-wide, there is a shortage of health professionals including psychologists. Current evidence is that in the health system and other government agencies such as the Corrections Department, vacancies are often unable to be filled either with locally trained psychologists or by recruitment overseas. It appears that the numbers of psychologists trained in New Zealand are unable to meet the needs of government and health agencies. It is likely that this unmet need will only increase in the future, unless strategies are put in place to increase the availability of training placements.

In New Zealand, training for clinical psychology has historically been via a three-year postgraduate programme completed in conjunction with a masters degree or a doctoral degree in psychology (e.g. PhD, D.Clin.Psy.). Supervised practical experience throughout the course is a requirement of the qualification. The completion of the New Zealand Psychologists Board requirement of 1500 hours supervised experience occurs in the third or internship year of the course. The internship is usually taken in the public sector organisations listed above, most frequently in DHBs. However, clinical training programmes have often struggled to find internship placements due to lack of direct funding for them. Although some DHBs recognise the value of having interns and provide funding for a limited number of placements, others provide no funding for them. The limited availability of funded placements in DHBs and other public sector organisations has imposed limits on the number of students training programmes can take and ultimately the numbers of psychologists entering the workforce. This has hampered the development of the profession at a time when there has been a growing call for psychologists who are equipped with the competencies to provide psychological assessments and interventions.

Historically, funding for clinical psychology training has been through Ministry of Education funding of university courses. Funding for internships has been provided by DHBs, albeit in an ad hoc way, and via annual negotiations between university clinical programmes and their local DHBs. The number of internships available in any year to any programme is subject to the vagaries of each DHB's budget planning processes. Thus the number that will be available to a particular programme is never assured beyond the short-term. This results in university training programmes adopting a cautious approach to the numbers of students admitted to programmes. There is no apparent commitment to providing psychologist internships from the Ministry of Health itself, either through direct contribution and clear direction to DHBs, or through the Clinical Training Agency. The Clinical Training Agency funds applied postgraduate medical and some other allied health professional training, (e.g. for pharmacists, sonographers, nurses and anaesthetic technicians).

This issue has been of concern to the profession (the New Zealand Psychologists Board, the New Zealand Psychological Society and the New Zealand College of Clinical Psychologists) for several years. As a result, a number of approaches have been made to both the Clinical Training Agency and the Ministry of Health about the exclusion of the psychology workforce from Clinical Training Agency funding and from alternative support. Historically, one of the reasons for this exclusion is that the training funded by the Clinical Training Agency has to occur after qualification and entry to a profession. In the past, clinical psychology students did not obtain registration until after the completion of their internship.

This situation changed with the introduction of the Health Practitioners Competence Assurance Act 2003 under which the New Zealand Psychologists Board now requires clinical psychology interns to be registered. It was hoped that this change might open a potential Clinical Training Agency funding stream for internship placements within the health sector, allowing programmes to expand student and intern numbers. The change in registration requirements for clinical psychology interns was raised by the psychologists' board with the Clinical Training Agency in 2005. Unfortunately, although the Clinical Training Agency accepted that clinical psychology internships now meet Clinical Training Agency post-entry clinical training criteria, it still declined to fund clinical psychology internships in their present form. A key reason for this was that the programmes were still seen to be funded by the Ministry of Education.

Psychologists look forward to progressing this area.

## APPENDIX 5 SPECIFIC WORK RELEVANT TO TALKING THERAPIES CURRENTLY BEING UNDERTAKEN IN NEW ZEALAND

This is not an exhaustive list but covers some key projects and agencies.

Who	What
Debra Lampshire	Working with distressing voices and beliefs.  Debra describes herself as an “experienced-based expert”. She has developed this training, which has been picked up by Auckland DHB and incorporated into service-wide nursing practice. This appears to be one of the few service-user developed training programmes available.
National Addiction Centre	This agency is based in the Department of Psychological Medicine at the Christchurch School of Medicine and Health Sciences, University of Otago. The centre was responsible for the establishment of Matua Raki and has a strong research and training focus. It provides addiction and coexisting disorders education at a postgraduate level. An important feature is that courses are offered on a national basis.
Clinical Training Agency	The Clinical Training Agency funds CBT and post-entry clinical training (although this contract is currently out for tender).
Department of Psychiatry Auckland University	Problem-solving therapy for self-harm.  This is a study led by Dr Simon Hatcher. It aims to determine the effectiveness of a brief psychological intervention for people who have presented to an emergency department following self-harm. It started in 2005 and people will be recruited through four DHBs until June 2007. Research therapists will deliver the intervention, all of whom will be members of a professional body and receive ongoing supervision.
Care (NZ)	This organisation operates units in several prisons with the aim of treating people with addiction problems using a therapeutic community approach.
New Zealand Guidelines Group	The New Zealand Guidelines Group is contracted to update the <i>Guidelines for the Treatment and Management of Depression by Primary Health Care Professionals</i> published by the National Health Committee in 1996. The aim is to finish the content of the guidelines by 30 November 2007, at which stage it will be sent out for consultation. Following the feedback from key stakeholders, the New Zealand Guidelines Group will sign off on the final version by 31 March 2008, and the print-ready version will be completed by 30 April 2008.

District health boards and Te Pou	<p>Auckland DHB leads the Balance Programme (<a href="http://www.adhb.govt.nz/balanceprogramme">www.adhb.govt.nz/balanceprogramme</a>), a DBT programme for the health board's service users who have a diagnosed personality disorder (otherwise known as people with "complex needs"). The programme has an ongoing link with the Marie Institute in the US (<a href="http://www.behaviouraltech.com">www.behaviouraltech.com</a>). The strength of the programme's approach is that there are clear treatment goals and measurable outcomes (e.g. keeping people in the community).</p> <p>In 2004 two clinical psychologists wrote a proposal and in 2005 DBT training was initiated in the central regions through Dialectical Behaviour Therapy New Zealand, an organisation formed by five people all of whom were US trained. The actual training has been organised through Te Pou, with the following undertaken to date:</p> <ul style="list-style-type: none"> <li>• a two-day orientation to DBT in Wellington on 5 and 6 December 2005</li> <li>• a one-day consultation meeting with a trainer from the US on 7 December 2005</li> <li>• a DBT intensive for 70 people (made up of two week-long training sessions in 2006, with a two-day follow-up in 2007).</li> </ul> <p>According to one expert in this area, the most established DBT programmes (in descending order) are at Auckland DHB and Waikato DHB, with some work being done in Manukau and Waitemata, and less in the central areas.</p> <p>For DBT to be effective, there needs to be fidelity to the model. However, staff leave and senior people get drawn into other service imperatives, which makes maintaining a critical mass of trained staff difficult.</p> <p>A thorough grounding in CBT is needed by people wanting to be trained in DBT. Some psychologists believe that clinical psychologists are best suited to being the trainers. In addition, ongoing management and senior clinical support is critical. Feedback suggests that the model needs to be supported at a broader systemic level within services overall, otherwise treatment can be easily undermined by other staff (e.g. a person may be admitted by a psychiatric registrar worried about risk, when in fact the admission reinforces a range of behaviours that are part of the person's ongoing problems).</p>
University of Auckland	<p>Brian McKenna at the University of Auckland is looking at the various models of supervision and at "what works?". The results of this research will be useful in the future.</p>
National Personality Disorder Advisory Group (NPDAG)	<p>The advisory group has suggested that Te Pou could host a national website, which would allow clinicians access to best practice information and resources related to the treatment of personality disorders.</p>
Centre for Cognitive Behaviour Therapy	<p>Based in Hastings, this agency undertakes fee-for-service courses on CBT and rational emotive behaviour therapy around New Zealand (see <a href="http://www.rational.org.nz">www.rational.org.nz</a>). The teachers also teach at the Eastern Institute of Technology. One of the teachers (Wayne Froggatt) has written several books aimed at the public (e.g. <i>Choose to be Happy: Your Step-by-Step Guide</i>. 2003. Auckland: HarperCollins).</p>
Accident Compensation Corporation (ACC)	<p>ACC may fund access to psychological interventions if the injury "is diagnosed as a direct consequence of physical injury". The most common example would be people who experience sexual abuse. Private psychiatrists and psychologists who have a clinical scope of practice are contracted to undertake this work. Other examples of areas where psychological therapies are contracted are for neuropsychological testing (e.g. for head injury) and pain management.</p>

<p>Work and Income New Zealand, Ministry of Social Development</p>	<p>Providing Access to Health Solutions (PATHS) is a Ministry of Social Development Project that aims to help people who receive the sickness or invalids benefit to return to the workforce. The service uses a case management model to coordinate and facilitate access to health services for people who want to work, but need additional health services to manage their condition in order to become ready for work.</p> <p>Typically people under the project have complex health and mental health needs. A coordinator identifies any barriers to the person receiving health care, and if care is not publicly available then the person may be referred to a private health care provider. Examples are a referral to a clinical psychologist for an assessment or to a surgical clinic for varicose vein treatment. Currently nine DHBs are involved in the PATHS Project. Counties Manukau is one DHB that is actively collaborating on the project and an evaluation of its involvement is planned (Hughes et al: 2006).</p> <p>A new programme being developed by the Ministry of Health, ACC and Work and Income New Zealand is called Working New Zealand. It targets people who:</p> <ul style="list-style-type: none"> <li>• have chronic pain</li> <li>• have addictions</li> <li>• have mental health problems</li> <li>• are awaiting a health service.</li> </ul> <p>Again the aim is to get people working.</p>
<p>Mental Health Foundation</p>	<p>The Mental Health Foundation produces a range of publications, both for clinicians and the public, that explain various mental health problems and their treatments (for example there is a 21-page document on personality disorders, which is very comprehensive and written by a range of clinicians, service users and family members).</p>



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