TALKING THERAPIES: WHERE TO NEXT?
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Executive summary

Talking therapies have a strong international evidence base for improving mental health and addiction outcomes (NZGG, 2008; NICE, 2009; Scottish Government, 2011). While New Zealand primary and secondary health care services offer this form of treatment, access to talking therapies varies greatly. This paper argues for a national approach to improving access across both primary care and specialist mental health and addiction services.

Te Kōkiri: The Mental Health and Addiction Plan 2006-2013 identifies that psychological therapies services need to be expanded. The Ministry of Health’s primary mental health programme has enabled some expansion over the last few years. During 2010/11, $23.765 million was provided to fund packages of care (commonly a series of brief talking therapies) in primary care settings. Significant increases in demand for primary based packages of care are predicted over the coming period (HWNZ, 2011). Similar messages have emerged through recent work undertaken to address two priority areas for young people with mental health and addiction problems, depression and suicide. The 2011 report Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence by Sir Peter Gluckman and others, identifies psychological therapies, particularly Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT), as core evidence-based treatments that too few practitioners are trained in.

Te Pou has been working to increase the quality and availability of talking therapies since 2007. Sector consultation summarised in We Need to Act (Te Pou, 2009), resulted in the Talking Therapies Action Plan 2008 to 2011. This work included the development of a stepped care framework spanning primary and secondary mental health and addiction services. This framework drew from similar international models and the stepped care approach recommended in the New Zealand guidelines for depression in primary care (NZGG, 2008). The stepped care framework aligns with the Government’s Better, Sooner, More Convenient policy objectives that focus on providing people with better access to primary care, and improving primary/secondary care service integration.

This discussion paper is the last activity within the Te Pou Talking Therapies Action Plan 2008 to 2011. It has been written for leaders, clinicians and managers in primary and secondary mental health and addiction services, policy makers, planners and funders and training providers.

The paper presents evidence from both NZ talking therapy initiatives and international research. It has two main objectives:

- to inform planning for the development of a national strategy for talking therapies
- to identify potential implementation activities and useful tools for services with an interest in developing workforce capability and capacity to improve availability of talking therapies for service users.

Available talking therapies and profiles of New Zealand-based pioneering practice are outlined. Primary mental health funding has enabled more access to talking therapies for the treatment of mild to moderate mental health problems. Innovative approaches such as e-therapy (eg Beating the Blues) and the National Depression Initiative provide a range of lower-intensity self-management and guided self-help options. More intensive talking therapies are available within secondary care. However, delivery models and availability tend to be inconsistent between services in both primary and secondary care.

Programmes to increase access to talking therapies in England, Scotland and Australia are reviewed to identify options for further development in New Zealand. In particular, the UK’s Increasing Access to Psychological Therapies (IAPT) programme has demonstrated that when
implemented with a focus on adherence to the therapeutic model and outcome measurement, talking therapies were able to deliver recovery rates\(^1\) of about 50 per cent, and improved employment status. The UK outcomes indicate a return on investment for services through savings in sickness pay and benefits, increased tax revenue, less absenteeism and increased employment (UK Department of Health, 2011, p. 5).

Australia’s Better Access programme demonstrated that alongside delivering good service user outcomes, increasing access to talking therapy can also reduce the large proportion of unmet need for mental health and addiction services. Of course New Zealand has a unique health system and population base, and careful consideration needs to be given to implementation in the local context. Key issues to consider, such as responsiveness to Māori and Pacific people, are noted.

The New Zealand policy context provides for action at both local and national levels to develop workforce capability and capacity. The final section draws from local and international work to identify potential implementation activities and useful tools for services with an interest in further developing talking therapies. It is argued that a nationally-driven strategy would provide direction and promote consistency in both standards and equity of access, and the paper summarises options to consider when developing such a strategy. These include identifying workforce capacity trends at a local and regional level, adopting a stepped care model that fits the New Zealand context, development of national competency sets for talking therapies, and identifying training needs and priorities. Trailblazer talking therapy initiatives and primary/secondary integration initiatives occurring in DHBs and PHOs provide opportunities for testing the provision of an integrated stepped care model that spans both primary and secondary care services.

International efforts to increase access to talking therapies have demonstrated improved service user outcomes and changes in employment status. Overseas experience suggests that increasing the availability of evidence-based talking therapies would assist in achieving health and disability sector national outcomes for New Zealanders: living longer, more independent lives and supporting the economic growth of New Zealand (Ministry of Health, 2011c).

\(^1\) ‘Recovery rate’ is used by IAPT to mean where a service user is assessed to no longer meet the criteria for the mental or substance use disorder after treatment.
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1. Talking therapies: the national landscape

Talking therapies (also commonly known as psychological therapies) delivered in both primary and secondary care settings have a strong international evidence base for improving mental health and addiction outcomes (NZGG, 2008; NICE, 2009; Scottish Government, 2011). While New Zealand health services currently offer talking therapies, their availability varies greatly. Quality and access could be improved by applying a more consistent approach across primary care and specialist mental health and addiction services.

The New Zealand policy context

Action point 2.5 of Te Kokiri: The Mental Health and Addiction Plan 2006-2015 identifies that the use of effective psychological therapies ought to be expanded (Ministry of Health, 2006, p. 20).

The recent Workforce Service Review Phase One report, Towards the Next Wave of Mental Health & Addiction Services and Capability also includes talking therapies in its vision for New Zealand’s mental health and addiction services by 2020 (Health Workforce New Zealand, 2011). The report highlights the need for radical service productivity lifts to meet growing needs with limited resources. It cites utilisation of low-intensity treatments such as e-therapies and brief talking therapies in primary care as examples of new models of care that can assist in meeting this challenge.

The HWNZ report’s service modelling indicates that a significant increase in primary care-based mental health and addiction packages of care (often brief talking therapies) will be required to respond to need by 2020. Better use and integration of existing community and NGO mental health and addiction services to support primary care-based treatments is recommended, as is training and credentialing of psychologists, mental health nurses and other health professionals to provide packages of care. The report also recommends exploring the value of developing a low-intensity psychotherapy workforce in primary care, similar to that introduced in the UK (see page 23 for further discussion), to lift capacity and lower costs.

This UK work is also referred to in the recent New Zealand report by the Prime Minister’s Chief Science Advisor, Sir Peter Gluckman, Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence (2011). Addressing depression and suicide rates have been identified as the top New Zealand mental health priority areas for adolescents. The specific strategies for young people presented in this report are to increase recognition of depression and provide greater access to evidence-based treatments. Psychological therapies, especially cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT), were identified as some of these effective core treatments for depression.
The Gluckman report highlighted a general shortage of child and adolescent mental health practitioners, with few trained in CBT or IPT. Similar to the HWNZ review, this report recommended increasing access to effective talking therapies through primary care by providing more access in youth-friendly community settings, and training more therapists. The cost-benefit analysis developed to support investment in the UK talking therapies programme (see page 18 for further discussion) was cited as a compelling economic case for investment in New Zealand. E-therapy was also identified as a useful complementary self-help treatment for depression that provided self-paced, less costly and easily accessible options for young people.

The Ministry of Health has funded talking therapies within primary care since 2005, as part of the primary mental health programme. In 2011/12, $23.765 million of funding was provided for primary mental health services for people with mild to moderate mental health and/or substance abuse problems. Because of the limited funding available, these services are targeted to groups that experience high needs for services but often access services less frequently such as Māori, Pacific and people living in high deprivation areas in NZ. This funding has meant that people can obtain access to talking therapies through their GPs; however sector feedback indicates that waiting lists for these services can be long. Anticipated increases in demand, as forecasted in the HWNZ service review, suggest increased funding of packages of care (which include talking therapies) will be required.

The Better, Sooner, More Convenient policy creates an environment where health professionals in the community are actively encouraged to work with one another and with hospital-based clinicians to deliver health care in a co-ordinated and co-operative manner (Ministry of Health, 2011, p. 3). A number of demonstration sites have been established for primary and secondary mental health service integration, and these provide opportunities for demonstrating how stepped care can be utilised across primary and secondary mental health services. Talking therapies fit well within a stepped care model, where ‘lower intensity’ treatments (e-therapy, guided self-help or brief talking therapy) are provided in primary care settings and ‘higher intensity’ treatments (talking therapies of a longer duration) are delivered in secondary services. This stepped care model has been used successfully in England and Scotland and will be discussed in the next section of this paper.

Te Pou has been working to increase the quality and availability of talking therapies for people using mental health and addiction services in New Zealand since 2007. Between 2007 and 2009 Te Pou engaged in sector consultation to identify New Zealand’s national priorities for talking therapies. The first report, We Need to Talk (Te Pou, 2007), identified key issues and related activities for the sector following brief consultation. We Now Need to Listen (Te Pou, 2007) provided a framework for wider and more formal consultation. We Need to Act (Te Pou, 2009) outlined the results of that consultation process. It described a stepped care framework for increasing access to talking therapies and identified a set of activities to progress talking therapies in New Zealand.
We Need to Act (Te Pou, 2009, p. 36) noted the following recurring themes from this sector feedback:

1. Inequalities of access, particularly for Māori and Pacific people and in rural areas
2. That demand often outstripped supply leading to unacceptably long waiting times
3. Lack of strategic planning for talking therapies in services was resulting in:
   - ad hoc training initiatives being undertaken that were motivated by personal interest rather than as part of a coherent service plan
   - trained staff being unable to use their new skills appropriately because of lack of support within the service
   - lack of defined career pathways for therapists
   - scarcity of qualified supervisors, limiting both training and opportunity to practice new skills, and little protected time for supervision (Te Pou, 2009, p. 36).

Recent sector feedback collected by Te Pou during national meetings with general managers and professional leaders and through conversations with clinicians, service managers, service users and planners and funders continues to reflect the feedback in We Need to Act. There is a need for a more co-ordinated approach to enhancing access to quality evidence-based talking therapies in New Zealand.

The Talking Therapies Action Plan 2008 to 2011 was developed in response to the recommended actions from We Need to Act. Key activities from this plan have supported training in Dialectical Behavioural Therapy (DBT) and CBT. Te Pou also developed a suite of talking therapy resources to raise awareness and understanding of talking therapies amongst service users and staff and fill key knowledge gaps when working with different population groups. These talking therapies guides have been well received with high sector uptake and positive impacts on therapeutic practice reported in a recent review conducted by Te Pou.

Objectives and audience for this paper

This discussion paper is the last activity within the Talking Therapies Action Plan. It has been developed for leaders, clinicians, and managers in primary and secondary mental health and addiction services, policy makers, funders and planners and training providers. It provides information for those who are in a position to influence planning at national, regional and local levels, and have an interest in further developing access to evidence-based talking therapies and improving outcomes for service users.

The paper does not attempt to address the use of pharmaceuticals in association with talking therapies, which is covered in detail in New Zealand and international evidence-based guidelines.

Evidence is presented from both New Zealand-based talking therapy initiatives and international research to help inform planning for talking therapies. This information is presented to meet two objectives:

1. to inform planning for the development of a national strategy for talking therapies.
2. to identify potential implementation activities and useful tools for services with an interest in developing workforce capability and capacity to improve availability of talking therapies for service users.
What are talking therapies?

The term talking therapies, often called psychological therapies, refers to a range of approaches based on psychological concepts and theories delivered through different mediums. The term may refer to, for example, face-to-face sessions with a trained therapist, therapy delivered via phone, computer-based therapy (‘e-therapy’), and guided self-help based on a psychological therapy construct. These approaches are designed to help people understand and make changes to their thinking, behaviour and relationships, in order to relieve distress and improve functioning (Scottish Government, 2011). The skills and competencies required to deliver these approaches effectively are acquired through training, and maintained through clinical supervision and practice.

A commonly-used example of an evidence-based talking therapy is cognitive behavioural therapy (CBT). While no psychological therapy has been proven universally superior to another (NZGG, 2008), CBT has a strong evidence base and is the main psychological therapy recommended for treatment of common mental health and addiction problems in Scottish and English clinical guidelines (NICE, 2009; Scottish Government, 2011). Mindfulness-based cognitive therapy has also been found to be very effective, particularly in the prevention of relapse of depression (NICE 2009).

The New Zealand guidelines for identification of common mental disorders and management of depression in primary care (NZGG, 2008) recommend that brief evidence-based psychological approaches are used to treat adults with moderate depression (six to eight sessions across 10 - 12 weeks). Structured psychological approaches of a longer duration (16 - 20 sessions) should be offered to adults with severe depression. These guidelines do not specifically recommend certain therapies, but do provide CBT, structured problem-solving therapy and interpersonal psychotherapy as examples of the types of therapies that could be used.

A wide range of evidence-based talking therapies are available in New Zealand including CBT, interpersonal psychotherapy, problem-solving therapy, psychodynamic psychotherapy, dialectical behavioural therapy, family therapy and multi-systemic therapy. Motivational interviewing is used quite widely within addiction services to generate behaviour change and reduce substance use. These therapies are briefly described in the Guide to Talking Therapies in New Zealand (Te Pou, 2009), which provide services users and their families/whānau with more information about what therapies are available in NZ.

Stepped care: a model for talking therapies

The stepped care model is considered an efficient way to make use of limited resources when providing treatment for a service user population spanning a spectrum of severity. The recent HWNZ service review recommends “integration across primary/secondary mental health and addiction services using stepped care approaches to improve access and recovery in the community” (HWNZ, 2011, p. 7). This integrated approach is central to initiatives undertaken as part of Better, Sooner, More Convenient (Ministry of Health, 2011 a).

As a result of the sector consultation that informed We Need to Act (2009) a stepped care framework for talking therapies in the mental health and addiction sector was developed by Te Pou and published in the Talking Therapies Action Plan 2008-2011. Recently this framework has been updated to integrate the types of talking therapies that can be made available in primary care settings to treat mild to moderate common mental health problems (see Figure 1). It provides a model for what an integrated talking therapies framework for New Zealand’s primary and secondary care services could look like.
A similar stepped care model to that shown in Figure 1 has been adopted by England and Scotland as the framework through which to provide better access to psychological therapies (see page 12-14 for further discussion). It involves the introduction of a tiered approach to service provision where low-intensity approaches are provided to a larger number of people with less severe mental health and addiction problems. Subsequent steps are defined by increasing levels of case complexity and intensifying forms of treatment (Scottish Government, 2011).

It should be noted that stepped care approaches generally accommodate the use of drug therapies which may be used alongside talking therapies. This model does not attempt to do so, and evidence-based clinical guidelines are recommended to address the use of pharmaceuticals in association with, or alternative to talking therapies.

This model presents five tiers of service. Preliminary assessment determines which tier of therapy will match the service user’s need. This model does not assume that all people receive the tier one first. Some service users may also need different tiers of therapy at the same time, if these are addressing different mental health and addiction problems.

**FIGURE 1: A STEPPED CARE MODEL FOR TALKING THERAPIES IN NEW ZEALAND**

It is also important to note that this framework relies on utilisation of a multidisciplinary health workforce. It recognises the leadership of certain professions such as psychologists and psychotherapists who receive dedicated postgraduate training in talking therapies as part of their qualification process. However health practitioners from any profession can be trained to deliver different types of talking therapies. As part of the Let’s get real Real Skill Working with Service Users, all practitioners are required to understand a “range of evidence-informed therapies and interventions available” (Ministry of Health, 2008, p. 9).

**New Zealand talking therapy initiatives through the lens of stepped care**

A number of mental health initiatives delivered to different population groups fit within the tiers of the proposed stepped care model. The following section identifies these related New Zealand programmes. It does not provide a critical review of their effectiveness or appropriateness to be included in a future national framework for talking therapies.
Tier one: mental health promotion and preventative work

The National Depression Initiative (NDI): aims to strengthen individual, family and social factors against depression using a variety of services: television campaign fronted by John Kirwan, a free 0800 helpline, interactive mainstream (www.depression.org.nz) and youth websites (www.lowdown.co.nz) backed up by personalised support services, and health education materials.

Like Minds, Like Mine: is a public education programme aimed at reducing the stigma and discrimination faced by people with experience of mental illness/distress. www.likeminds.org.nz

Suicide Prevention Information New Zealand (SPINZ): provides high-quality information to promote safe and effective suicide prevention activities. www.spinz.org.nz

MH101: is a national learning programme to raise mental health literacy. www.mh101.co.nz

Tier two: mild to moderate disorders in primary care

New Zealand's primary care guidelines for the management of common mental health issues (NZGG, 2008) suggest active management by the general practice team. This includes first-line treatment such as active support, advice on exercise and self-management, encouraging activation of social support networks (family/whānau) and referral to psychosocial helping agencies as required (e.g. relationship counselling). Access to e-therapy such as Beating the Blues can also be arranged. If substantial improvement is not reported at four to six weeks then it is treated as moderate depression.

The New Zealand guidelines recommend that initial management of moderate depression in adults in primary care should involve approaches including an anti-depressant medication and/or a psychological therapy (e.g. six to eight sessions of problem-solving therapy or CBT over 10 to 12 weeks). Packages of care, funded by the Ministry of Health as part of the primary mental health programme, assist people with mild to moderate mental health needs (Ministry of Health, 2010). These can be configured to include a variety of approaches. Most commonly, however, they consist of a brief course of some form of talking therapy such as CBT or problem-solving therapy. It is important to note that while the New Zealand guidelines recommend six to eight sessions of talking therapies, in practice the packages of care funded through the Ministry of Health's primary mental health programme tend to cover brief talking therapies comprising four to six sessions. This appears to be meeting the needs of people with mild to moderate mental health problems.

A primary care example: ProCARE Psychological Services

The programme: Auckland based ProCARE has established a team of mental health professionals (the ProCARE Psychological Service or PPS) who provide access to brief, effective psychological treatments for people who attend the 177 practices in the greater Auckland area encompassed by ProCARE’s three Primary Health Organisations (PHOs).

Its inspiration: Since the 1990s ProCARE has recognised that unmet mental health needs is a key issue amongst its population. In 2003/2004 ProCARE received Ministry of Health funding to run primary mental health pilots in each PHO. In 2007/2008 positive evaluations of the pilots meant that this programme received ongoing funding through the Ministry of Health’s primary mental health investment.
How it works: The PPS is one of three core strands in an overarching primary mental health programme designed to support and enable ProCARE’s general practitioners and practice nurses to work more effectively with people who have mental health needs. GPs assess the person and refer them to the team to receive a brief psychological intervention. The PPS team is made up of clinical psychologists, health psychologists and psychotherapists, supported by two part-time psychiatrists.

I guess we are a bit of a pioneering force as well, in that we have this whole philosophy of brief interaction and rather than curing the person, working with what they present with here and now, recognising that change occurs in people’s lives, not in therapy.

Pam Low, health psychologist, centre clinical leader.

When the programme was first established, an average of six talking therapy sessions were delivered to people with mild to moderate mental health problems. However more recently this has been reduced to an average of four sessions to meet increasing demand with limited funding. CBT-based e-therapy and the Stanford structured self-management programme have been shown to increase treatment outcomes when combined with therapy. As additional ways to reduce waiting times for the service, ProCare is now testing whether these less therapist-intensive treatments are effective as stand-alone approaches. Mental health nurses have been employed to assist with triage and providing support to people who are on waiting lists for therapy.

Therapists are finding four sessions adequate to meet the needs of people with mild to moderate difficulties, but insufficient to meet the more complex needs of people with more severe mental health problems but who do not meet the ‘3%’ criteria for specialist services. PPS also offers up to 12 sessions for population groups that experience inequitable access to health services: Māori, Pacific peoples and people living in high deprivation areas. These therapy packages are proving effective to address the spectrum of need that service users can present within primary care settings.

Outcomes to date: The following methods are used to routinely monitor outcomes: Kessler 10 scores (a measure of depression and anxiety), ‘no show’ rates, the average number of sessions attended, and person satisfaction. More recently the ORS and SRS (service user-led outcome and therapeutic alliance measures) have been introduced, providing session-by-session measures of outcome and the therapeutic alliance, completed by the service user. These results are then compared with an international database to help identify the effectiveness of the therapy. On average, after four sessions of talking therapy through the PPS programme, people’s scores on the Kessler reduce by 10 points. GP uptake of the PPS service has risen from 10-15 per cent at start-up to over 90 per cent currently. Each year a 20-25 per cent increase in referrals to the service is noted.

E-therapy

Evidence-based computerised therapy is recommended as a low-intensity treatment for mild to moderate depression and anxiety problems (NICE, 2009). New Zealand has a number of innovative e-therapy programmes available:

The Journal: launched in June 2010, this online self-management programme is available via the main National Depression Initiative website. The Journal is based on a combination of behavioural activation, structured problem solving and positive psychology, which is freely accessed online. A recent evaluation reported that over 11,000 people had registered for The Journal in its first seven months, 24 per cent of this group had completed at least three
of the six sessions, and 84 per cent of this group’s PHQ9 scores (an indicator of level of depression) had improved (Wyllie, 2011). www.depression.org.nz.

**Beating the Blues**: the computerised cognitive behavioural therapy (cCBT) programme used by the NHS in the UK to treat mild to moderate depression was trialled by PHOs in Northland. Funded by the Ministry of Health, it has now been rolled out in New Zealand by the Northern District Health Board Support Agency. It can be accessed free to the user via GP referral. More information on the **Beating the Blues** programme can be found at www.beatingtheblues.co.nz.

A randomised controlled trial of an interactive computer-based CBT programme for young people with symptoms of depression, **SPARX**. was completed in April 2011 by the University of Auckland www.frozenflameweb.com/sparx, with very encouraging results.

The University of Otago is conducting a randomised controlled trial to test the efficacy of an Australian CBT programme, **MoodGym**, for treating mild to moderate depression within a New Zealand population. www.otago.ac.nz/rid/

Currently sector discussion is occurring about the need for national guidelines to identify when and how e-therapies should be used. Rather than occurring in isolation, it would be important to include this work in a broader strategy for the further development and uptake of talking therapies in New Zealand.

**Tier three: moderate to severe disorders treated in primary care**

For treatment of severe depression in adults in primary care the New Zealand guidelines suggest consulting with a psychiatrist and offering a combination therapy: anti-depressant medication plus a structured psychological approach (e.g. CBT or IPT for 16-20 sessions) supported by clinical review at one to two weeks and close monitoring. If this is ineffective then the person is referred to secondary care.

While packages of care funded through the Ministry of Health’s primary mental health initiative have enabled more access to brief talking therapies to assist with mild to moderate disorders, there is less availability of higher intensity therapy in primary care to treat more severe mental health and addiction problems. This observation is supported by HWNZ’s service review recommendation to “build on primary mental health initiatives to scale up primary/community based responses to mental health and addiction issues which fall outside the ‘3%’ eligible for specialist services but are severe in their impact on people’s overall health and ability to function at work” (HWNZ, 2011, p. 24). Up to six talking therapy sessions available through current packages of care are often not able to adequately address the more complex needs of this group. Some district health boards offer an entry pathway service that provides limited specialist support to this population group as part of primary/secondary integration initiatives. Lower level entry criteria enable people who would previously have been unable to access community mental health services to receive assessment and brief intervention to assist their recovery. In addition, the initiative provides an avenue for GPs to seek a specialist assessment or opinion so they can determine whether they are on the right track to meet the person’s needs.
Primary/secondary mental health integration projects

These initiatives stem from the Government’s Better, Sooner, More Convenient policy, which aims to “facilitate service development by showcasing successful implementation of mental health and addiction initiatives delivered in primary care settings that improve people’s access to services, improve continuity of care and reduce duplication of effort” (Ministry of Health, 2011b, p. 1). The approaches being demonstrated are electronic note sharing, specialist mental health telephone advice to general practitioners and integration of primary/secondary mental health services. Some key learnings from the demonstration sites that will be applicable to an integrated stepped care model are:

- Clinical input and buy-in at primary and secondary levels should not be underestimated; views and expectations of all participants need to be carefully understood and needs met.
- GPs need to be reminded of the availability of services; this can be particularly challenging where there is a high proportion and turnover of locums.
- Time required to promote the concept to GPs and build relationships between primary and secondary providers is a necessary precondition for any integration efforts to succeed. GPs can be reluctant to free the time to attend presentations to discuss new projects. New initiatives may need to be taken directly to GPs by secondary care.
- Include practice nurses in any engagement strategies for introducing new services.
- There is a financial cost for people with mental health problems in accessing primary care services with back-up secondary service support. Some service users may not be able to meet the payment required to attend a GP appointment.
- NGOs are critical community-based service providers that need to be active partners in planning and implementing integration of primary and secondary services.
- While some GPs are comfortable to discuss, and confident to manage, mental health and AOD issues with their patients, many are not. Thought must be given to how GPs and others in general practice are equipped with the knowledge and skills they need.

(Ministry of Health, 2011b, p. 6.)

Tier four and five: specialist therapies delivered in secondary mental health and addiction services

Te Pou has engaged in work to support talking therapies within New Zealand, particularly for secondary mental health and addiction services, since 2007. Sector consultation to identify national priorities for talking therapies resulted in Te Pou’s Action Plan for Talking Therapies: 2008-2011. Table 1 provides an update on this activity.
### TABLE 1: An update on the Te Pou talking therapies action plan 2008-2011

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>OUTCOMES</th>
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<tr>
<td>Revision of the National Service Framework is informed by the outcome of the talking therapies consultation</td>
<td>Talking therapies has been included in the National Service Framework as a purchasable item.</td>
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<td>A draft talking therapies framework is developed to underpin the growth of talking therapies</td>
<td>Framework developed that incorporates Te Pou’s national consultation with international best practice (see Figure One).</td>
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<td>Service users, families and staff are informed about levels of therapy and who provides them</td>
<td>The Guide to Talking Therapies in New Zealand booklet was developed for service users and family/whānau.</td>
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<td>Staff have access to engagement skills training</td>
<td>Two sets of two-day workshops for enhancing the therapeutic relationship, delivered by Dr Scott Miller (US), were funded by Te Pou.</td>
</tr>
<tr>
<td>Service users benefit from staff implementing best (and promising) practice with regard to assessment and treatment of talking therapies with different population groups.</td>
<td>Development of a suite of resources when using talking therapies with different population groups (Māori, Pacific, Asian, refugee, asylum seekers and new migrants, older adults and people with problematic substance use).</td>
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<tr>
<td>Service users who would benefit from Cognitive Behavioural Therapy (CBT) have access to it and New Zealand can grow and sustain its own quality CBT workforce.</td>
<td>Funding for postgraduate training in CBT provided through Skills Matter.</td>
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<tr>
<td>Service users access staff who have a basic level of essential skills (i.e. engagement and counselling skills) identified in Let’s get real. <a href="http://www.tepou.co.nz/letsgetreal">www.tepou.co.nz/letsgetreal</a></td>
<td>The Principles for Engagement paper is produced that supports development of engagement skills for people entering the mental health and addiction workforce, complements undergraduate curriculum.</td>
</tr>
<tr>
<td>Identify a plan to achieve a sustainable DBT training programme in New Zealand</td>
<td>Report commissioned that recommended establishment of DBT NZ as an independent company to co-ordinate and deliver Dialectical Behaviour Therapy (DBT) training in New Zealand. Te Pou worked with DBT NZ to establish this company, affiliated with Behavioural Tech.</td>
</tr>
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</table>

At a national level these activities have contributed to developing psychological therapies through training (CBT, DBT, Scott Miller workshops), as well as producing resources to assist clinicians to develop their practice.

Service delivery models and availability of talking therapies in specialist services tend to be inconsistent between services. However, a number of services are engaging in innovative work to further develop talking therapies in both community and in-patient settings. Waitemata DHB provides an inspiring example of what can be achieved to increase access in a community mental health setting.
A secondary care example: Waitemata District Health Board’s psychological therapies project

Waitemata DHB is piloting a stepped care model to increase access to a range of evidence-based psychological therapies matched to need. Prior to the programme a variety of therapeutic models were being utilised without a strategy or co-ordination. Many clinicians had trained in certain therapeutic models but their application was not systematic. A stocktake of WDHBs use of psychological therapies was undertaken in 2008 and the resulting report recommended the implementation of a stepped care model, increased access to lower-intensity therapies and greater choice for therapy to support training and provision of talking therapies. A suite of outcome measures were established to measure the effectiveness of the stepped care model, which follows.

Step 3: High intensity therapies to treat severe and complex conditions. Therapy Type: CBT, IPT, DBT, family therapy, trauma therapy and other specific indicated therapies, delivered by psychologists, psychotherapists and other trained specialist clinicians.

Step 2: Lower intensity therapies to treat moderate to severe disorders. Therapy Type: ‘Strategic and core interventions’ - basic CBT and DBT therapy, guided self-help, psychoeducation groups, skills groups, PST, solution-focused therapy, behavioural activation, motivational interviewing, e-therapy, delivered by trained clinicians.

Step 1: Recognition, assessment and support provided to all service users. All staff provided with training where necessary, to create a culture of ‘psychological mindedness’, where everyone is able to engage with the person and establish a therapeutic alliance that supports people in their recovery.

Implementation of this model has been trialled by the Rodney Adult MH team (RAMHS) and evaluated by WDHB and AUT across a one-year period. A review of therapy competence level of clinicians was also completed. Processes including referral, allocation, treatment review and discharge were adapted to fit with the stepped care model. Seventeen clinicians (nurses, social workers, OTs) were trained in solution-focused therapy (Step 2 of the model).

Clinicians refer people to talking therapies after first intake interview. A case discussion then occurs with the multi-disciplinary team, where a senior psychologist/therapist is present. Level and type of therapy is recommended. Further assessment is conducted by a psychologist, if needed, to confirm needs. The person receives treatment at the appropriate level (low- or high-intensity), and type of therapy, for the recommended number of sessions where the Session Rating Scale and Outcome Rating Scale are used during every session to measure outcomes and the therapeutic alliance. Progress is reviewed at eight weeks; therapy is then either continued or stepped up or down. A change of therapy or therapist may also be indicated.

Early results showed positive outcomes through employing the stepped care model. Analysis of therapy contacts indicated that there was increased access to therapy (both face-to-face and group contacts) when compared to another community mental health team which was not using this stepped care model. Further results looking at the effectiveness of the treatment are expected for release early in 2012.
2. An overview of international talking therapy activity

Systematic reviews of the literature have resulted in the development of UK and New Zealand guidelines recommending that evidence-based talking therapies are used to treat common mental health problems such as depression and anxiety (NZGG, 2008; NICE, 2009; Scottish Government, 2011). Many international programmes have been initiated to improve the availability of talking therapies for service users. This section provides an overview of programmes in England, Scotland and Australia.

England: improving access to psychological therapies (IAPT)

Lord Layard, founder of the Centre for Economic Performance in the London School of Economics and Political Science (Centre for Economic Performance; 2006) developed an economic analysis based on the National Institute of Clinical Excellence (NICE) guidelines for treatment of depression and anxiety. It proved to be a major driver in initiating the extensive NHS Increasing Access to Psychological Therapies (IAPT) programme.

The evidence that proved CBT is as effective as medication in helping people with depression and anxiety disorders - and better at preventing relapse - led to the economic case that secured annual funding to begin the national roll out in the three years to March 2011. Key to the economic case was an argument that effective therapeutic interventions combined with employment support could reduce the numbers of people on sick pay and benefits.

Department of Health, 2011, p 6

This economic case argued that half of those with anxiety disorders or depression can recover with CBT, and that currently no more than 10 per cent of people in the United Kingdom with these mental health disorders received psychological treatment for their problem. Layard et al. (2006) estimated that when comparing employment rates and considering absenteeism the total loss of output due to depression and chronic anxiety (including benefit costs and lost tax) was £12 billion GBP a year.

One course of CBT (10 sessions) costs £750 GBP and is likely to produce 12 extra months free of depression (NICE, 2009; Centre for Economic Performance; 2006). Layard’s team calculated that this amount of depression-free time was likely to equate to nearly two months more of work, and nearly two months less on benefits. The cost of one month’s benefit is £750 GBP, so it was argued that the treatment pays for itself.
This argument prompted the British government to fund two demonstration sites to test whether these cost benefits could be realised in practice. Evaluation of IAPT’s two demonstration sites reported clinical outcomes broadly in line with the benefits forecasted by Layard’s team (Centre for Economic Performance; 2006). Fifty-five per cent of people who had attended at least two sessions (including the assessment interview) were classified as having returned to a well state when they left the services and five per cent had improved their employment status (Clark et al., 2009). Further analysis of the IAPT programme’s results to date report similar, though more conservative, positive outcomes. Forty per cent of the people who attended IAPT sessions experienced significant improvements for depression or anxiety (Richards and Borglin, 2011).

This most recent evaluation of the IAPT programme is summarised as follows:

*Once people engage in and receive treatment, we could expect between 40–45 per cent of people treated in such a system to be below the criteria for having a diagnosis on all measures after a short period (six sessions of low-intensity CBT delivered predominantly using the telephone). When people are stepped up to high-intensity treatment, similar proportions of people might recover where low-intensity treatment has failed.*

Richards and Borglin, 2011

Through the IAPT’s stepped care model high-intensity, fully qualified therapists provide supervision to both low- and high-intensity therapists. Low-intensity therapists use guided self-help interventions based on CBT principles to assist people with mild to moderate depression and anxiety. High-intensity therapists provide a set of psychological therapy sessions to people with moderate to severe disorders in primary care settings. The predominant therapy used within the IAPT programme is CBT. Appendix B provides a diagram of the IAPT’s stepped care model. A national curricula (including competency sets) and qualifications have been developed for both the low- and high-intensity therapy training courses. This was a large-scale programme where 3,600 new therapists were trained by 2010 to implement the first phase of IAPT national roll-out.

Use of session-by-session monitoring has meant that systematic data is available for more than 90 per cent of people receiving treatment. This data indicated that by September 2010 the programme had helped more than 72,000 people to recover from depression and anxiety disorders in the previous two years. Also, almost 14,000 people had moved from sick pay and benefits and started or returned to work following their treatment (Department of Health, 2011). The British Government has now committed a further investment of around £400 million over four years to 2014/15 to complete the national roll-out of the IAPT programme.

Between 2009 and 2011, the Department for Work and Pensions funded a £4m demonstration project to place Employment Advisers within psychological therapy services. These advisers focused on people receiving therapy services for depression and/or anxiety who were still in work—supporting them to stay at work, return to work from sick leave, or find new jobs without falling out of work. The external evaluation of this work was due for release in late 2011; however previous empirical and anecdotal evidence has meant that for the 2011/12 IAPT roll-out, employment support and advice is now seen to be crucial to successful service delivery. This evidence has found that people who received a combination of CBT and employment support were more likely to return to work earlier than those who received CBT alone (Blink, Brenninmeijer, Lagerveld & Houtman, 2006).

See www.iapt.nhs.uk
Scotland: psychological therapies HEAT access target

The Scottish Government has been working with National Health Service Boards to develop a HEAT (Health, Efficiency, Access and Treatment) access target for psychological therapies for 2011/12. To assist NHS boards to meet these targets, the recently updated Matrix - A Guide to Delivering Evidence-Based Psychological Therapies in Scotland (Scottish Government, 2011):

• summarises the most up-to-date advice on evidence-based treatments
• provides information on strategic planning issues for delivery of effective psychological therapy services
• explains the levels of training and supervision required to deliver psychological therapies safely and effectively.

The Matrix recommends multi-disciplinary delivery of psychological therapies, with training and accreditation in therapies that is competence-based. A clearly articulated and well-governed matched/stepped care system is recommended as the framework for implementing this psychological therapies service.

Support to implement this change employs a three-pronged approach by focusing on 1) careful measurement of outcomes, 2) workforce development, and 3) service redesign to optimise access to quality psychological therapies. To support service redesign the Scottish team has developed a suite of tools and resources focused on measuring demand and capacity, identifying ways to create more clinical time for therapy through good system management, reducing DNA rates and enabling effective matching of therapy to clients.

To support workforce development, a range of nationally accessible workshops to develop expertise at low-intensity, high-intensity, and highly specialist levels are being offered. All workshops are based on formal qualification and certain courses will require that people have appropriate pre-requisite knowledge.


Australia: the Better Access initiative

Similar to the NHS system, Australia has recently invested in a programme to increase access to talking therapies in primary care settings. The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative began in 2006 with the aim of increasing treatment rates for common mental disorders. $753.8AUD million was committed to funding access to psychological therapies within primary health care. In late 2011, the Australian Government moved to cap access to individual allied mental health services (Department of Health and Ageing, 2011).

A recent evaluation of this programme reports that uptake has been high, with over one million people receiving at least one Better Access service in 2010 (one in every 19 Australians). During the time that Better Access has been operating, the overall treatment rate for mental health increased from 35 per cent to 46 per cent. Although it is difficult to know how much of the increase can be attributed to this new programme, evidence from a range of sources does indicate that Better Access is reaching new people. Between 50 and 70 per cent had not used mental health services or received psychological therapy before (Pirkis, Harris, Hall & Ftanou, 2011). Service users were reporting positive outcomes, assessed by reductions on standardised measures of psychological distress, depression, anxiety and stress (Pirkis, Harris, Hall & Ftanou, 2011).
A summary of international evidence

- The UK’s IAPT programme has demonstrated that when implemented with a focus on adherence to the therapeutic model and outcome measurement, CBT can deliver significant improvements in depression and anxiety for between 40 and 55 per cent of people treated and improved employment status (Richards and Borglin, 2011).
- These realised benefits mean the therapy can potentially pay for itself, through savings in benefits, increased tax, less absenteeism and increased employment.
- Further cost savings can be achieved through the use of stepped care including: preventing a proportion of cases from escalating to costly high-intensity treatments, reducing cost of care for people with co-existing physical and mental health problems, and reducing likelihood of relapse (Department of Health, 2011).
- The Australian Better Access programme has demonstrated that alongside delivering good service user outcomes, increasing access to talking therapy can also reduce the large proportion of unmet need for mental health and addiction services (Pirkis, Harris, Hall & Ftanou, 2011). Other findings from the Australian programme are:
  1. The availability of talking therapies can improve access to mental health treatment for people with common mental health problems.
  2. Symptom reduction was reported for people with moderate through to severe mental health problems, indicating that primary care providers are able to assist people with the full spectrum of mental health problems.

Considering this international work in the New Zealand context

While outcomes emerging from this international work to increase access provide a compelling case for the further development of talking therapies in New Zealand, it should not be assumed that international programmes such as IAPT offer the best solution for the New Zealand context. The NHS health system is very different with, for example, a free at point of delivery funding model. However, both the HWNZ service review (2011) and the Gluckman report (Gluckman, 2011) recommend exploration into whether some of the UK activities such as increased training in CBT, Interpersonal Psychotherapy (IPT) and development of a ‘low-intensity’ workforce, could be applied in New Zealand. The following factors need to be carefully considered.

Responsiveness to Māori and Pacific peoples

New Zealand possesses a unique cultural mix that talking therapists need to be responsive to. Māori and Pacific people experience higher rates of mental health and addiction problems when compared with other ethnic groups. During any 12-month period 29.5 per cent of Māori, 24.2 per cent of Pacific peoples and 19.3 per cent of the Other composite ethnic group experience a mental health or substance use disorder. Anxiety disorders are most common across all ethnicities, mood disorders and substance use disorders are the next most prevalent disorders (Oakley Browne, Wells & Scott, 2006). Despite these higher rates, Māori and Pacific people access health services to address these mental health problems
less frequently. Te Rau Hinengaro: The New Zealand Mental Health Survey (2006) revealed that 25.4 per cent of Pacific people made a mental health visit compared with 32 per cent of Māori and 41.1 per cent of the other composite ethnic groups.

Further analysis of Te Rau Hinengaro findings in the Māori mental health needs profile reveal that less than one in three Māori with a mental health need had any contact with services, highlighting a significant unmet need (Baxter, 2008). GPs were the group Māori were most likely to make contact with to address their mental health problems, reinforcing the importance of ensuring that primary care is responsive to the needs of Māori.

As Baxter (2008) reiterated:

*These findings support the need to ensure that services to address Māori needs are adequately and appropriately supported across a range of interventions and services. Within a Whānau Ora context, poverty, physical health, socioeconomic disadvantage, and health service access and effectiveness all need to be addressed.*


If New Zealand were to embark on work to further develop talking therapies at a local and national level, careful consideration would need to be applied to identify therapeutic models that are responsive to Māori and Pacific peoples’ needs. Work to identify and address barriers to access to enable more Māori and Pacific people to engage with talking therapy services is also required. One major barrier to access reported in the Māori mental health needs profile is the costs of health visits (Baxter, 2008). Kaupapa Māori primary mental health initiatives established through the Ministry of Health’s primary mental health funding provide important demonstration sites for this work. The talking therapies guides for Māori and Pacific peoples developed by Te Pou provide useful information about how therapy can be tailored to be more responsive to the specific needs of these population groups.

**The different health systems**

Much of the leading international work to increase access to talking therapies is emerging from the UK’s IAPT programme. However it is important to recognise that the NHS has some key differences to New Zealand’s health system which could impact on the success of rolling out a similar programme here.

The NHS provide health services that are free to service users, while New Zealand has a fee-for-service funding structure in primary care, with lower costs for identified populations (government subsidised). A large-scale programme to increase access to talking therapies across primary and secondary care may be hampered by the need for people to pay for a GP appointment before being able to access talking therapies, even if this cost is subsidized through various mechanisms.

Community mental health teams have been in place for longer in the UK through Primary Care Trusts and the rural/urban split is less apparent. In New Zealand, providing access to mental health and addiction services in rural areas can be difficult and careful attention would need to be paid to identify ways that a talking therapies programme could be accessed by people in more remote locations. Some of the Better, Sooner, More Convenient case studies are focused on strategies to address this issue (Ministry of Health, 2011).
The IAPT programme design

The IAPT programme has been running since 2008 and has provided opportunities for review and identification of areas for development when implementing talking therapy programmes. CBT was adopted as its core therapy; however recent evaluation of the programme indicates that people want more choice to be able to opt for a therapy that fits their requirements and preferences. Additional evidence-based therapies are likely to be introduced in the second phase of IAPT roll-out (Department of Health, 2011a). Currently there are a variety of evidence-based talking therapies capable of treating the spectrum of mental health and addiction problems present in New Zealand. It would be important to maintain this choice of therapy in initiatives focused on developing talking therapies in New Zealand. (See page 22 for further discussion.)

Cognitive behavioural therapy is a key treatment within the IAPT programme. A recent review of CBT-based guided self-help approaches suggests that this can be effective for people who have proactively engaged with the service through media campaigns; however it is less effective within routine clinical practice (Coull and Morris, 2011). These results are contrary to previous research in this area (Driessen et. al, 2010; NICE 2009). Evidence for the effectiveness of CBT-based guided self-help is still inconclusive and therefore caution should be applied about how this approach is used.

The IAPT programme’s roll-out has relied on the development of a new workforce to deliver low-intensity talking therapy treatments. This is a large-scale endeavour and may not be feasible given New Zealand’s fiscal restraints. One option could be to upskill the current multidisciplinary health workforce to deliver different types of talking therapies depending on the level of support required. This is likely to require significant developments in training for talking therapy in New Zealand. The UK is currently experiencing difficulty monitoring the quality of training programmes established to meet the demand for a new therapy workforce. Careful consideration would need to be given to New Zealand’s training requirements and how this training could be standardised to ensure the quality levels required to deliver effective evidence-based talking therapy.

The IAPT programme found that it was not enough to offer the low-intensity high volume service. An active advertising and promotion campaign was required to elevate the profile of the guided self-help service to the degree required to be utilised as a high volume service. This learning highlights the important fact that it may not be enough to make more talking therapies available through primary care, active communication and outreach services may be required to engage people with these services.

The Journal provides a good example of a guided self-help programme promoted through a very successful New Zealand advertising campaign. Well-designed research on the effectiveness of this approach compared with guided self-help options offered within primary care would be extremely helpful in designing future access for New Zealanders.

Only half of all people who were referred to IAPT went on to receive treatment. Therefore while the programme did increase access to services, further work is needed to improve routine engagement of service users with anxiety and depression (Richards and Borglin, 2011). Te Pou’s talking therapies guides emphasise the important role that engagement plays in successful therapy. Let’s get real is another valuable framework to support people’s development of the skills, knowledge and attitudes required to form effective therapeutic relationships with service users, family and whānau. These could be useful references when identifying methods to keep people engaged with therapy after their first session.
3. Where to next for talking therapies in NZ?

New Zealand has engaged in many innovative talking therapy initiatives which have evolved within a relatively supportive policy and funding context. For example, over the last few years primary mental health funding provided by the Ministry of Health has enabled more access to brief talking therapies for the treatment of mild to moderate mental health problems. In addition, innovative programmes such as e-therapy and the National Depression Initiative provide a number of lower-intensity self-help options. However, delivery of talking therapies in New Zealand remains ad hoc, with pockets of best practice apparent. Recent national documents (Gluckman, 2011; HWNZ, 2011) and sector feedback indicates a need for a more co-ordinated approach to enable better availability of talking therapies across primary and secondary services. International examples demonstrate how this has been achieved within other health systems.

Action needs to happen at both a local and national level to develop workforce capability and capacity to improve availability of talking therapies for service users. The first part of this section draws from local and international work to identify potential implementation activities and useful tools for services. Actions that could occur at a national level are then discussed.

Analysing population needs and supply

Therapist workforce stocktake

The Waitemata DHB Psychological Therapies project offers a great example of how a New Zealand service has taken a strategic approach to implementing talking therapies, using a stepped care model. The first step taken by the project team in 2008 was to conduct a service-wide stocktake of psychological therapies. Information about population needs was collected from service users and information from clinicians was collected to identify capacity and any barriers to delivery.

This stocktake revealed a range of service activities that could be improved to enhance access to talking therapies. These formed the basis for Waitemata DHB’s pilot project to increase access to talking therapies using a stepped care model. This successful pilot was completed in late 2011; plans are now being made to implement the stepped care approach across more Waitemata DHB community mental health services. Waitemata DHB has made their stocktake template available for other services to use; it can be accessed through Te Pou.

Workforce capacity tools

While a stocktake will highlight current capacity and the type of talking therapies available in a service, work will also need to be undertaken to identify the demand for therapy. The mental health team at the Scottish Government’s Quality and Efficiency Support Team
(QuEST) produced a Data Summary for Demand and Capacity work for Psychological Therapy Services to measure demand and supply (personal communication, Ruth Glassborow, National Programme Manager, Mental Health, QuEST, July 2011. See Resources section for more information).

IAPT have also developed a sophisticated workforce capability tool that considers the population needs for therapy that a Primary Care Trust can expect (national prevalence and service access rates applied to the local service) and identifies the workforce capacity required to meet this need (administration and clinical time). While these NHS tools would require modification they provide services with examples of the type of modelling templates that could be developed to establish workforce capability requirements for talking therapy.

System change to optimise efficiency, performance and accountability

Identifying a framework

If a service has identified that further capacity is needed to meet peoples’ need for talking therapies, it is important to adopt a framework to provide direction for these activities. Stepped care provides a useful model for delivering talking therapies at the level of support required. Services may wish to take the stepped care framework developed by Te Pou (see Figure 1 on page 11) and tailor this to their local context. Some of the factors to be carefully considered by key stakeholders include:

- How can the stepped care model be optimised to ensure it is recovery oriented and focused on returning people to a state of wellness?
- What components might enable better access for underserved population groups?
- How can specialist cultural approaches (e.g. Māori, Pacific, Asian) be incorporated into the stepped care model?
- Which tier/s of the model will our service deliver?
- What types of evidence-based therapies will services commit to using?
- Who will deliver them?
- Who will supervise their use?
- What outcomes measures will be used and how will progress be routinely monitored?
- Do existing systems need to be reviewed to support a stepped care model?
- How will integration with other services occur (in particular, across primary and secondary sectors) to step people ‘up’ or ‘down’ tiers within the stepped care model? What entry and referral criteria will be established for the tiers?
- How will services (particularly lower-intensity services delivered to more people) be promoted to support increased access?
- How will the approach be linked with community initiatives, employment support and other psycho-social agencies to support participation in the wider community?

At Waitemata DHB, this stakeholder consultation was managed by establishing a project team of stakeholder representatives, including service users. They developed a tailored stepped care model that was then signed off by the district governance and senior management team before the pilot was initiated.
Service integration and identifying the care pathways

A key aspect of designing a stepped care model is to establish a clear pathway and protocol for an individual’s progression within the model. The IAPT programme provides a good example of this where referral pathways, assessment processes, thresholds for accessing different tiers of treatment and processes to monitor stepping up, discharge or referral on are all clearly defined. Appendix B provides a visual map of the IAPT care pathways that may be useful for New Zealand services who would like to create a stepped care pathway for talking therapies.

It is important to note that the IAPT programme was developed for primary care, and is now working on expanding into secondary care, whereas this paper recommends a stepped care approach that spans both primary and secondary services. Services may also wish to refer to Scotland’s matched/stepped care model which integrates primary and secondary talking therapy services (Scottish Government, 2011). Primary/secondary service integration can be particularly difficult and therefore needs to be carefully managed. The findings of the Ministry of Health’s Primary/Secondary Mental Health Integration projects will be helpful in identifying ways to manage this interface as smoothly as possible. Also as discussed earlier in this paper, care needs to be taken to ensure that people with moderate to severe mental health and addiction problems, who do not meet the criteria for access to specialist services, receive the right type of treatment.

Tools to enhance system efficiency

The Scottish NHS has taken an active approach to reviewing how system efficiencies can be achieved to create more talking therapy capacity (i.e. clinical contact time is optimised). They have developed a number of resources and tools to enable services to critically review their systems.

- The mental health improvement game, delivered via one-day training, simulates a poorly performing community mental health service. The team’s goal is to make improvements to the system, where the impact of their changes is modelled in the simulation. After the game, teams spend time considering how they can apply these changes to their own service.
- The capacity calculator is a simple tool used to highlight how much time activities such as travel and meetings can take up, that can build a good case for change.
- The activity tracker tool enables staff to audit how they spend their time (direct clinical / indirect clinical / non-clinical time) and look for opportunities to release time for direct client work.

In Scotland, teams are in the early stages of engaging with this work and are starting to collate evidence for the potential efficiency gains. One team which completed an activity audit found out it was spending 25 per cent of its time on clinical administration and for years had been frustrated about how much time they spent sitting at the computer. The activity tracker tool highlighted this in a way that got management’s attention. Key for them now is to look at ways of reducing this and releasing time back to clinical work. Another team managed to release 312 hours a year of clinical time just by removing their allocation meeting
and allocating directly to caseloads (personal communication, Ruth Glassborow, National Programme Manager, QuESt, June 2011.) Another focus of the Scottish service redesign work is reducing the average number of sessions each individual has where appropriate.

Results that demonstrate value for money

It is vital that services are able to clearly demonstrate their effectiveness and value for money, especially in the current economic climate. Evidence-based talking therapies are well positioned to provide a clear link between treatment and outcomes because they enable session-by-session monitoring of progress. As highlighted previously, despite budget cuts to the English health sector the IAPT programme still secured generous funding to complete its roll-out. This is because it has been outstanding in collecting the sessional outcome data (92 per cent data collection rate) which demonstrated that talking therapies can result in significant improvements for about half of people who receive therapy, and movements from sick pay and benefits to paid work. IAPT have produced a very popular Data Handbook that provides guidance on recording and monitoring local outcomes to support evidence-based practice. This can be downloaded from www.iapt.co.uk.

Session-by-session outcome monitoring is an essential aspect of efforts to increase access to talking therapies. Not only does it provide the case for service sustainability, but it also provides the necessary data to monitor people’s progress within the stepped care service model and step people up to a higher intensity therapy if required. In the IAPT programme, people complete the PHQ-9 (measure of depression) and GAD-7 (measure of anxiety) every week. In New Zealand, options could include regular completion of New Zealand’s mandated outcome measure for mental health services, Health of the Nation Scale (HoNOS), the Patient Health Questionnaire - PHQ-9, the Kessler-10 scale, and session-by-session use of the Session Rating Scale (SRS) and Outcomes Rating Scale (ORS). To achieve this ongoing measurement and analysis of outcomes it is essential to have a sophisticated IT system that is easy for therapists to interface with (personal communication, Geraldine Bienkowski, Lead for Psychological Therapies, NHS Education for Scotland, June 2011).

The SRS and ORS are brief measures completed by the service user that provide outcome and alliance feedback which is valid, reliable and with a short administration time (Duncan, 2011). They can be downloaded free for individual use at http://heartandsoulofchange.com/measures/. Clinicians can use this feedback to adapt their approach to better fit people’s needs, session-by-session, as well as measure the overall improvement rate achieved by the talking therapy approach. Using outcome measures that capture both the service user’s and clinician’s perspective is important. Arguably, systematically measuring the service user’s perception of their improvement and relief from distress is the more direct and accurate measure of success. Waitemata DHB is using these measures in their pilot, alongside standard clinical measures currently in use. Additional measures such as return to work rates, changes in benefit use, engagement in meaningful activity, and involvement with family/whānau, friends and the wider community are other important outcome data to systematically gather.

It is vital that any outcome data collected provides meaningful information that is useful for the service user to support their recovery, and demonstrates return on investment for services.
Maintaining therapy quality standards

*If we say we are delivering therapy in line with the evidence base then we have to be able to demonstrate that our therapists are as well trained as the ones in the research trials.*

Geraldine Bienkowski, Lead for Psychological Therapies, NHS Education for Scotland, June 2011

To deliver the outcomes indicated by research in routine practice, a strong focus on quality and adherence to the evidence-based model is required. Competency sets are key to ensuring the consistent quality of therapy. To avoid duplication and ensure consistency, development of national competency standards linked with *Let's get real* is recommended. Recently Scotland and England combined efforts to develop a suite of psychological therapy competencies, viewed at [www.ucl.ac.uk](http://www.ucl.ac.uk), which could be used as a foundation document to develop competencies for the New Zealand context. In addition to this competency development, clear qualification and training requirements and standards need to be established, and good supervision must be available.

What therapies to commit to

Based on the NICE guidelines for treating depression and anxiety, IAPT have adopted CBT as their core therapy (NICE, 2009). However this position is receiving criticism from some UK groups who say that this approach is leading to serious reductions in patient choice within the NHS. The UK Council for Psychotherapy recently released a paper ‘NICE under scrutiny’ which argues that by “treating issues of mental health for research purposes as if they are the same as those of physical health [where random controlled trials are considered the best form of evidence], NICE is effectively excluding the majority of existing psychological therapies from being seriously considered in its recommendations.” (Guy, Thomas, Stephenson & Loewenthal, 2011, p. 4). Their paper argues that a more pluralistic approach to what constitutes evidence should be employed. An approach that recognises practice-based evidence, alternative quantitative methods and qualitative research is essential. It may be best to adopt a model for evidence similar to how the American Psychological Association (APA) assesses evidence-based practice in the United States. Evidence-based practice for psychology is defined by the APA as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences. More information on this approach can be accessed through their website: [www.apa.org](http://www.apa.org).

While the New Zealand clinical guidelines also recommend using psychological therapies to treat common mental health disorders such as depression, no single therapy type is recommended above others (NZGG, 2008). In New Zealand, CBT has been adopted by many services as a preferred therapy because of its strong evidence base. *We Need to Act* (Te Pou, 2009) and its related Action Plan for Talking therapies 2008-2011 emphasise strengthening access to CBT. Training in CBT and other therapies is available through a number of educational providers, and it has also been supported by the provision of limited places for postgraduate training in CBT through Skills Matter. However, it is important to highlight that there is a variety of evidence-based treatments capable of treating the spectrum of mental health and addiction problems present in New Zealand as outlined in the *Guide to Talking Therapies in New Zealand*. One type of therapy is unlikely to suit the needs of all people; a more flexible approach is advisable.

When considering which therapies to invest in, a service should consider (1) the need to provide a choice of therapies for people and recognise that one size does not fit all, (2) what therapies (or ways to deliver the therapy) are more likely to be responsive to Maori and Pacific...
people, (3) what types of therapy are currently being offered by the service and how they could fit within a stepped care framework (4) what the evidence base is for these therapies and (5) what talking therapy training is available, accessible and affordable.

**Workforce development**

**Who delivers the therapy and what are the training needs**

Stepped care requires different levels of workforce capability at each tier within the model.

**All tiers:** Everyone working in mental health and addiction services in primary and secondary care should have the basic engagement skills to form a therapeutic relationship with service users and their family/whānau. Responsibility for development of basic engagement skills needs to sit with undergraduate and postgraduate training providers to ensure people enter the workforce with this skill set. However, services could run short training courses to supplement these skills. Training support material is available through the Te Pou Let’s get real web page. This material includes a summary resource on Principles for Engagement when working with service users and family/whānau.

**Tier Two: Low-intensity therapy.** Examples of these therapies include a brief series of talking therapy such as CBT, solution-based therapy or problem-solving therapy, guided self-help, e-therapy, phone counselling, and behavioural activation. Training varies depending on the type of approach employed by the service. Mental health nurses are an important workforce to involve in the provision of talking therapies. The mental health nurses’ practice standard three requires a mental health nurse to provide nursing care that reflects contemporary health care and nursing standards. This includes a range of psychological, behavioural, social, biological and complementary treatments and interventions utilised in mental health care (Te Ao Maramatanga, 2011).

Training in talking therapy, particularly motivational interviewing and guided self-help approaches, can add a great deal of value to the essential assistance provided by peer support workers.

Talking therapies can be delivered by health professionals such as practice nurses in primary care, primary mental health co-ordinators, peer support workers and community support workers. Personalised support from trained telephone counsellors is funded for low-intensity NDI interventions The Journal and the Lowdown via text, phone and email.

IAPT focused on building a new workforce of low-intensity therapists who are recruited from a variety of backgrounds and complete a 45-day training course. Scotland has been up-skilling their workforce through the provision of a national workshop programme to build on current qualifications. Information about both training models can be accessed from Te Pou.

**Tiers Three to Five: High-intensity and Specialist therapies.** Examples of these therapies include CBT, IPT, and Dialectical Behaviour Therapy. To deliver these therapies practitioners need a qualification recognised under the Health Practitioners Competence Act 2003 and demonstrated specialist training in an evidence-based talking therapy. These include a Masters or Doctorate in Clinical Psychology, a Masters in Psychotherapy, or Postgraduate Diploma in CBT. While any allied health professional can specialise in therapy, the disciplines that currently incorporate specialist training in their professional qualifications include psychology, psychiatry, psychotherapy and counselling. Therefore these professions are likely to be the most common providers of specialist therapeutic approaches.
While training in various talking therapies is currently available in New Zealand, it is necessary to identify what is available including the gaps that need to be filled to upskill health professionals at each level of the stepped care model.

This stepped care model takes a multi-disciplinary approach to delivering therapy, where trained therapists are drawn from a range of allied health professions. It is important to recognise the integral role that highly specialised professionals such as psychologists, psychotherapists and psychiatrists will have in the development of a quality framework and provision of supervision and specialised therapy. There is a shortage of registered psychologists in NZ. In particular, there is a national shortage of intern training places, which is limiting the number of psychologists being trained – particularly clinical psychologists. This issue will need to be addressed if work to increase access to high-intensity talking therapies is undertaken.

The importance of engagement skills when working with service users and their family/whānau

Engagement, also referred to as the therapeutic relationship (or alliance), is the connection assisting therapeutic work between the service user and the worker (Todd, 2010). Engagement is a critical factor in supporting recovery across different cultural and demographic groups, with service users, family/whānau and workers consistently emphasising its importance. Practitioners interviewed for the talking therapy guides collectively highlighted that therapy will not be successful unless time is taken to establish the therapeutic relationship. This feedback is also supported by research that has identified engagement as one of the most important factors contributing to therapeutic effectiveness (Warwar & Greenberg, 2000; Vasquez, 2007). Indeed some researchers argue that having the skill set to engage with people and their family/whānau to form an effective therapeutic alliance has more impact on outcomes than the type of therapy delivered (Duncan, Miller & Sparks, 2004). Ensuring that practitioners delivering any type of talking therapy possess good engagement skills is a critical foundation for workforce development activity.

Responsiveness to Māori and Pacific peoples

The Te Pou talking therapies guides for Māori and Pacific peoples highlighted that for talking therapies to be effective, the type of therapy used was less important than being able to first engage and form the relationship with the person and their family/whānau. Seeking cultural guidance when working with a person from another culture is a critical element to ensuring that therapy is responsive to Māori and Pacific peoples’ needs. At ProCARE Psychology Services (a primary care provider of brief talking therapies) a Māori psychologist provides monthly group supervision to therapists. Therapists have found this to be an excellent way to bridge the cultural and clinical gap. While cultural competence training is important, being able to have real case discussions has proven particularly effective in enhancing culturally responsive therapeutic practice. It is vital that the practitioner providing this clinical supervision has strong cultural expertise, alongside an understanding of clinical practice. Therapeutic models that have been designed specifically to address Māori and Pacific culture and tikanga should also be considered.

What are the supervision requirements

Access to good quality supervision is critical to the delivery of quality talking therapies in routine practice. For IAPT (2010) low-intensity therapists receive one hour per week of ‘clinical case management supervision’ and all therapists (low- or high-intensity) receive one hour
per fortnight of ‘clinical skills’ supervision. To establish the supervision capacity required both the Scottish and English programmes developed supervision training. Extensive information about the IAPT’s course can be viewed on their website: www.iapt.nhs.uk. Te Pou has developed professional supervision guidelines and resources for mental health nurses that may be useful when developing supervision models for talking therapy.

**A national strategy for developing talking therapies**

While local services can take the initiative to develop talking therapies for their population groups, a nationally-driven strategy is needed to provide direction, consistency in standards and equity of access. In addition, a national strategy will bring the various components and sectors into alignment, for example through the inclusion of both talking therapies and e-therapies, and an integrated primary and secondary model. Internationally, it has been action at a national level that has created the momentum to achieve significant increases in access to talking therapies, resulting in greatly improved outcomes for service users. As the IAPT programme highlighted, talking therapies can deliver significant improvements in both health outcomes and employment status (Richard and Borglin, 2011). They can also equip people with tools for life to manage their wellbeing.

New Zealand has already made advances for provision of talking therapies with the introduction of the primary mental health strategy, enabling more people to access brief talking therapies in primary care settings through packages of care. This strategy is complemented by options provided by New Zealand’s e-therapy programmes and the National Depression Initiative. More intensive talking therapies to address moderate to severe mental health and addiction problems are available, mainly through secondary care or private practice, however access varies throughout New Zealand. In addition, the recent HWNZ report (2011) anticipates that a significant increase in access to packages of care in primary care will be needed to meet demand by 2020.

New Zealand can build on progress by developing a national framework and strategy for talking therapies that connects the initiatives currently offered and develops areas where there is unmet need. The Better, Sooner, More Convenient policy supports a stepped care approach to health service delivery, where evidence-based talking therapies can be delivered at different levels of intensity to address different levels of need.

As highlighted earlier in this paper, New Zealand’s health system is very different from the UK’s health system therefore careful thought is needed to identify a national strategy likely to be most effective for delivering talking therapies in New Zealand. This work would need to involve key stakeholders including service user leaders, representatives of professional bodies such as the New Zealand Psychologists Board, New Zealand Association of Counsellors, New Zealand Association of Psychotherapists, Te Ao Maramatanga (New Zealand College of Mental Health Nurses), The Royal New Zealand College of General Practitioners and other groups. Following are key areas to consider for a national strategy.

**The cost benefits of talking therapy**

To better understand the cost benefits of talking therapies in the New Zealand context, Te Pou has commissioned the University of Auckland to undertake a New Zealand-based economic analysis, based on the method developed by Lord Layard (Centre for Economic Performance, 2006).
The report and model will assist the:

- utilisation and incorporation of New Zealand-based data to develop a cost-benefit analysis for talking therapies
- development of a robust, transparent and best practice method for economic modelling and cost-benefit analysis of talking therapies
- enhanced knowledge of, and reference to, the relevant international cost benefit literature.

The report will advise on ways to analyse potential cost effectiveness and economic impact of talking therapy programmes within the New Zealand context. In this way it will help inform future investment decisions and development of related policy.

**Applying the stepped care model**

- Consider the different type of stepped care frameworks used for delivering talking therapies and identify a model that could work for New Zealand that integrates the range of initiatives currently available. Care would need to be applied to ensure this model was responsive to the needs of New Zealand’s diverse population group, particularly Māori and Pacific peoples.
- To operationalise the stepped care model, care pathways would need to be developed to identify when service users are ‘stepped up’ or ‘stepped down’ the levels of care. The IAPT programme offers a clear example of this where referral pathways, assessment processes, thresholds for accessing different levels of treatment, and processes to monitor stepping up, discharge, or referral on are all clearly defined. The Primary/Secondary Mental Health Integration Projects will offer valuable learning about how to successfully integrate services across primary and secondary settings.

**System efficiency**

- Identify workforce capacity to deliver talking therapies and the extent of unmet need for talking therapies. Workforce stocktake templates and tools to analyse demand versus capacity for talking therapies could be designed and used to identify local and regional trends.
- Explore the Scottish work which has looked at how system efficiencies can be achieved to create more talking therapy capacity. This work has included production of a variety of guides on demand, capacity and administration of talking therapies; tools to track activity and capacity; and a service simulation to identify possible system improvements.
- Include talking therapies as a priority treatment for regular outcome measurement. Talking therapies enable session-by-session monitoring of progress. A large contributor to the ongoing success of the UK’s IAPT programme was their systematic collection of data (92 per cent collection rate). This does rely on being able to collate data nationally on services and outcomes in primary care. Systems are not currently in place within the New Zealand context for this to occur. This would require significant developmental work.
Workforce development

- Develop a national competency set, aligned with Let’s get real, to maintain the quality of talking therapies and support training standards. Therapy competency sets developed by the NHS could be useful references for this development work.
- It would be important to link this competency development work with provision of good quality clinical supervision that is vital to translate the application of these competencies in practice. The professional supervision guidelines and resources developed by Te Pou would be useful to inform this work.
- Provide further training in talking therapies and therapy supervision, which could be offered through regional training hubs. A careful training needs analysis would need to take place to identify what type of training is needed to support the identified national framework and strategy for talking therapies, to better meet the needs of people with mental health and addiction problems. In England this training programme involved the development of specific curricula to accredit people in low-intensity and high-intensity CBT-based interventions. A new 3,600 strong workforce was formed to deliver this stepped care approach. A smaller scale training programme was employed by Scotland who developed a series of nationally accessible workshops for health professionals to develop expertise at low-intensity, high-intensity and highly specialist levels.
- Consider the recent IAPT programme extension where talking therapy delivery is combined with evidence-based employment support to optimise likelihood of a quick return to work.

Suggested next steps

Policy makers

- Consider government initiatives occurring in Britain, Scotland and Australia and look at introducing a similar stepped care approach for delivering talking therapies in New Zealand, tailored for the local context.
- Provide guidance on the use of e-therapies available in New Zealand.
- Establish two or three DHB demonstration sites to build the workforce capability necessary to meet local demand for talking therapies, and evaluate outcomes.
- Develop an implementation strategy for the delivery of talking therapies within New Zealand, in consultation with key stakeholders, including addressing inequities in access.
- Work with the Ministry of Social Development on linking the strategy to employment-related social outcomes.
- Consider improving access to talking therapies for long-term beneficiaries, to assist them back into the paid workforce.

District health boards

- Support better secondary and primary care integration to ensure a smooth interface when stepping people up or down the tiers in the stepped care model.
- Identify whether there is an unmet need for talking therapies in mental health services, or a need to reduce waiting times.
- Review the cost-benefit data to identify whether further investment in psychological therapies is warranted.
- In consultation with senior management, clinical directors and general managers can consider whether the cost-benefit argument justifies establishment of a project to develop their talking therapy service.
• Establish a project to identify how talking therapies could be developed, whether the stepped care model could be applied, whether further training and supervision is required.

• Undertake a systems review to increase system efficiency and optimise the clinical time available for qualified talking therapists.

• Introduce session-by-session monitoring of outcomes to demonstrate the effectiveness of talking therapies.

Primary care teams

• Address inconsistency in access to talking therapies across the primary healthcare centres supported by the PHO.

• Ensure clinical staff are aware of the talking therapies currently available in New Zealand, for example, e-therapy programmes such as The Journal and Beating the Blues, and encourage their use.

• Identify and promote learning from services that have introduced psychological therapies as part of primary care or primary/secondary integration in this area. These will assist promoting how current talking therapy services could be more effectively developed.

• Provide training opportunities to GPs and practice nurses about identification and treatment of mental health problems, talking therapy options available and appropriate referral pathways.

• Work closely with secondary services to ensure a smooth interface between primary and secondary services when ‘stepping service users up’ to more intensive forms of treatment, or ‘stepping down’ to less intensive treatment in the community. This will include ensuring that clear access criteria, treatment pathways and referral processes are in place.

Education and training providers

• Monitor demand from health services to develop further talking therapy courses, including short courses or workshops to up-skill appropriately qualified clinicians.

• Continue to find ways to build the development of engagement skills and ‘psychological mindedness’ into the mental health and addiction undergraduate curricula.

Te Pou

• In conjunction with a national clinical steering group, Te Pou could develop a competency skill set that identifies the attitudes, knowledge and skills required to deliver therapeutic interventions at the different levels of the stepped care model (i.e., low-intensity versus high-intensity therapies).

• Align the competency set with Let’s get real and promote as part of the national talking therapy framework, along with professional supervision resources. Therapy competency sets developed by the NHS can be used as a reference for this work.

• Provide implementation advice to services, including supporting the establishment of DHB demonstration sites.

• Provide a suite of tools to assist services to analyse need and supply for talking therapies.
Conclusion

New Zealand has already made advances for provision of talking therapies with the introduction of the national primary mental health initiative, enabling more people to access brief talking therapies in primary care. However variability in access is still apparent across primary and secondary care. In addition, the recent HWNZ service review (2011) anticipates that a significant increase in access to packages of care in primary settings will be needed to meet demand by 2020.

The drive for more use of evidence-based treatments for people who experience mental health and addiction problems has seen the emergence of a number of overseas national approaches to increase the availability of talking therapies. Trail blazer projects have also been undertaken by New Zealand DHBs and PHOs. These programmes provide mental health and addiction services with a wide variety of systems, processes, resources and tools to draw upon when considering ways to improve the availability of quality therapy for service users.

Summarised within this report, these overseas programmes usually take a three-pronged approach to developing talking therapies. First, demand and supply for talking therapies is analysed using stocktakes and workforce capacity service modelling. Systems efficiency is considered to identify ways to optimise the time clinicians have available to deliver therapy. Workforce development is also a key feature of these programmes, where training and supervision is provided to upskill health professionals. While international work provides great examples of potential approaches, it is necessary to adapt them to fit the New Zealand context.

This report’s first objective was to inform the development of a national strategy for talking therapies. While local services can take the initiative to develop talking therapies, a nationally-driven strategy will provide direction, consistency in standards and improved equity of access. Internationally, it has been action at a national level that has created the momentum to achieve significant increases in access to talking therapies. An overarching national strategy and associated plan is necessary to support local and regional talking therapies developments.

Areas to address in support of a national strategy for talking therapies implementation include:

- adoption and testing of a stepped care framework that fits the New Zealand context, such as that presented in this report
- identification of talking therapy workforce capacity trends at the local and regional level
- development of national competency sets for talking therapies
- identification of training needs and priorities for talking therapies
- identification of tools and resources to assist implementation at regional and local levels.

This report’s second objective was to identify potential implementation activities and useful tools for services seeking to develop talking therapy workforce capability and capacity. Relevant tools and resources are listed in the following Resources section.
Areas to address at local levels to systematically implement and advance talking therapies include the provision of tools to support services to review current capacity and to identify opportunities to improve access. Useful tools include a talking therapies stocktake template that services can use to identify current workforce capability and gaps to implement the stepped care model, along with a talking therapies service modelling template to assist local services identify workforce requirements to meet local demand. Services can also engage in system efficiency work to optimise therapist time with clients, and workforce development activities. As the report has identified, there are many initiatives underway in New Zealand to inform the national strategy and local implementation initiatives. There are also many useful overseas-developed resources and tools that could be adapted to the New Zealand context.

Increasing the availability of evidence-based talking therapies at a local and regional level can enable services to maximise their performance towards achieving the health and disability sector national outcomes of New Zealanders: living longer, more independent lives and supporting the economic growth of New Zealand (Ministry of Health, 2011). Specifically, international programmes to develop talking therapies have demonstrated improved service user outcomes and changes in employment status (UK Department of Health, 2011). To achieve this will require a national strategy that promotes a stepped care model across the primary and secondary continuum of care, as well as aligning the range of different therapy approaches to the stepped care model.
Resources

Related policy documents

Action point 2.5 of this plan developed by the Ministry of Health lists psychological therapies as an effective and integrated service that needs expanding.
See [www.ministryofhealth.govt.nz](http://www.ministryofhealth.govt.nz)

**Better, Sooner, More Convenient Health Care in the Community**
This booklet describes a new policy direction for health, introduced two years ago, which creates an environment where health professionals in the community are actively encouraged to work with one another, and with hospital-based clinicians to deliver health care in a co-ordinated and co-operative manner so that more services are delivered in the community, people wait less for services and are kept healthier in the community.
See [www.nationalhealthboard.govt.nz](http://www.nationalhealthboard.govt.nz)

**Primary/Secondary Mental Health Integration Project. Review report on demonstration sites**
This Review Report provides a status update of the Primary/Secondary Mental Health Integration Project at 30 June 2011. Demonstration sites in New Zealand that volunteered to participate in this project were reviewed to assess status of progress and showcase their initiatives, identify what has worked well and has not worked as well, and what has been learned.
See [www.primarymentalhealth.org.nz](http://www.primarymentalhealth.org.nz)

**Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence**
This report by the Prime Minister’s Chief Science Advisor, Sir Peter Gluckman, highlights the need for greater access to evidence-based treatments such as Cognitive Behavioural Therapy and Interpersonal Psychotherapy to treat depression and reduce suicide amongst New Zealand’s adolescents.
See [www.pmcsa.org.nz](http://www.pmcsa.org.nz)

**Towards the Next Wave of Mental Health & Addiction Services and Capability. Workforce Service Review Report. Phase 1 Report.**
Mental health was one of the nine service reviews supported by HWNZ and led by small groups of clinicians who are developing a vision of the workforce for 2020. Talking therapies, particularly in primary care, are discussed as a key evidence-based treatment in this new vision.
See [www.healthworkforce.govt.nz](http://www.healthworkforce.govt.nz)

**New Zealand talking therapies work**

**We Need to Act**
This Te Pou report summarises the results of sector consultation to identify New Zealand’s national priorities for talking therapies. It also describes a stepped care framework for talking therapies and identifies a set of activities to progress talking therapies in New Zealand.
See [www.tepou.co.nz](http://www.tepou.co.nz)
Talking Therapies Action Plan 2008 to 2011
Identifies the high level actions to emerge from national consultation conducted by Te Pou to identify New Zealand’s priorities for talking therapy.
See www.tepou.co.nz

Series of talking therapy guides for working with different population groups
Te Pou has developed a series of guides for mental health and addiction staff to support the growing diversity of people they work with. These guides focus on how to engage with people to form the vital therapeutic relationship, and how therapy can be adapted to meet people’s specific needs.

The talking therapies guides are for: older adults, Māori, Pasifika people, Asian people, refugees, asylum seekers and new migrants, and people who experience problematic substance use.
See www.tepou.co.nz or contact Te Pou to order hard copies.

Talking Therapies: A brief review of recent literature on the evidence of the use of cognitive behaviour therapy, dialectical behaviour therapy and motivational interviewing; on cultural issues in therapies and on the therapeutic alliance
A brief review of recent literature conducted by the New Zealand Guidelines Group on the evidence of the use of cognitive behaviour therapy, dialectical behaviour therapy and motivational interviewing; on cultural issues in therapies and on the therapeutic alliance.
See www.tepou.co.nz

Principles for Engagement
This resource draws from extensive consultation with New Zealand practitioners, interviewed for the suite of talking therapies guides for different population groups. Key principles for engagement to emerge from this consultation are summarised to assist people entering the mental health and/or addiction workforce to form the rapport and connection required to demonstrate the Let’s get real Real Skills at essential level. This will also be a useful support document for undergraduate curricula.
See www.tepou.co.nz

Talking Therapies Research Update - December 2011
Te Pou produces a regular talking therapies research update. This first edition presents mindfulness-based cognitive therapy (MCBT), a psychological therapy proving effective for preventing relapse of depression. The growing evidence base for shorter forms of psychodynamic psychotherapy is highlighted.
Evidence-based talking therapy for people who experience psychosis is presented. The update ends by featuring research reviewing the efficacy of new national programmes in England and the United States that aim to increase access to talking therapies.
See www.tepou.co.nz
New Zealand e-therapy initiatives

The Journal
Launched in June 2010 this freely accessed online self-management programme is available via the main National Depression Initiative website. The Journal is based on a combination of behavioural activation, structured problem-solving and positive psychology.
See www.myjournal.depression.org.nz

Beating the Blues
This computerised cognitive behavioural therapy (cCBT) programme used by the NHS in the UK to treat mild to moderate depression was trialled by PHOs in Northland. It is currently being rolled out in New Zealand through the Northern District Health Board Support Agency, accessed via GP referral.
See www.beatingtheblues.co.nz

SPARX
SPARX is a self-help computer programme for young people with symptoms of depression. The programme was developed by a team of specialists in treating adolescent depression from the University of Auckland. Funding was provided by the Ministry of Health.
See www.sparx.org.nz

Guidelines recommending talking therapies

Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline.
See www.nzgg.org.nz

Provides a comprehensive review of the psychological therapies literature to identify the most robust evidence-based talking therapies.
See www.nes.scot.nhs.uk

Depression: the treatment and management of depression in adults.
National Clinical Practice Guidelines for England developed by the National Institute for Clinical Excellence that recommend CBT for routine treatment of depression in adults.
See www.nice.org.uk/CG90

The economic case for talking therapies

The Depression Report. A New Deal for Depression and Anxiety Disorders.
Led by Lord Layard, founder of The Centre for Economic Performance in the London School of Economics and Political Science, this report builds the economic case for investment in talking therapies.
See www.cep.lse.ac.uk

This 2011 report evaluated both the health benefits and cost effectiveness of this programme to increase access to psychological therapies for Australians.
See www.health.gov.au
International talking therapy initiatives

England: Improving Access to Psychological Therapies
An NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. This national website includes a wealth of resources to support implementation of the Improving Access to Psychological Therapies programme. See www.iapt.nhs.uk

Scotland: Psychological Therapies Heat Access Target
This website links to a variety of initiatives the Scottish Government are undertaking to increase the availability of psychological therapies. See www.isdscotland.org

ATAPS enables GPs under the Better Outcomes in Mental Health Care (BOIMHC) programme to refer consumers to allied health professionals who deliver focused psychological strategies. This website summarises the programme, including an evaluation report. See www.health.gov.au

Analysing population needs and supply

Waitakura DHB Psychological Therapies stock take template
In 2008 WDHB conducted a service-wide stock take to inform planning for psychological therapies. They have made this template available for other services. Contact Te Pou to access this.

The IAPT Workforce Capacity tool
A tool that considers population needs for talking therapy and the workforce capacity required to meet this demand. The current tool is under development, but IAPT have made it available to NZ services as an example of the type of modelling templates used. Contact Te Pou to access this.

DCAQ Framework
This one-page framework designed by the Scottish NHS summarises a range of activities focused on designing systems to optimise access. www.qihub.scot.nhs.uk

System change to optimise efficiency

This comprehensive plan includes the stepped care model employed by England and the care pathways developed to deliver psychological therapies across mild to severe mental health problems. www.dh.gov.uk
Introductory guides to managing Demand, Capacity and Administration of psychological therapies
Developed by The Scottish NHS for services looking to optimise their use of psychological therapies
See www.scotland.gov.uk

Mental Health Improvement Game – Delegate hand out
Delivered via one-day training, this game simulates a poorly performing community mental health service. The goal is to make improvements to the system, where the impact of team changes is modelled in the simulation. After the game, teams spend time considering how they can apply these changes to their own service. The delegate hand-out for this Scottish game can be accessed by contacting Te Pou.

The Capacity Calculator
Also developed by the Scottish NHS this is a simple tool used to highlight how much time activities such as travel and meetings can take up, that can build a good case for change. Contact Te Pou to access this.

The Activity Tracker
Designed by the Scottish Mental Health Collaborative to enable Mental Health Teams to audit how they spend their time. It is developed for use at individual practitioner level and can be aggregated to provide service level data. It can be used to inform wider Demand, Capacity, Activity and Queue (DCAQ) work. Contact Te Pou to access this.

Measuring performance
The IAPT Data Handbook
Guidance on recording and monitoring outcomes to support local evidence-based practice. See www.iapt.nhs.uk

The SRS and ORS
Brief measures completed by the service user that provide valid, reliable and feasible outcome and alliance feedback during each therapy session. See http://heartandsoulofchange.com

Workforce development
Psychological therapy competence frameworks
Recently Scotland and England combined efforts to develop a suite of psychological therapy competencies. See www.ucl.ac.uk

The IAPT national training curriculum
A series of documents is available for download on the IAPT website, that provide an outline of the training curricula used for low- and high-intensity therapists, as well as supervisors. See www.iapt.nhs.uk

The Scottish Psychological Therapies Training programme 2011-12
The Psychological Interventions Team has commissioned and developed a training programme for 2011 - 2012 that includes training opportunities for each Scottish Government Health Department priority area (Alcohol, Forensic, Low Intensity Interventions, Older Adults and Trauma). www.nes.scot.nhs.uk
An evaluation report of the 2010/11 programme is available at www.nes.scot.nhs.uk
References


### Appendix A: NICE-indicated treatments for depression and anxiety disorders

#### Step 3: High-intensity interventions

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression: moderate to severe</td>
<td>Cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT), each with medication</td>
</tr>
<tr>
<td>Depression: mild to moderate for individuals with an inadequate response to initial interventions at step 2</td>
<td>CBT or IPT</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Behavioural activation (BA), a variant of CBT&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Couple therapy if the patient has a partner, the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy</td>
</tr>
<tr>
<td>Generalised anxiety disorder (GAD)</td>
<td>Counselling&lt;sup&gt;1&lt;/sup&gt; or brief dynamic interpersonal therapy&lt;sup&gt;2&lt;/sup&gt; (consider if patient has declined CBT, IPT, BA or couple therapy)</td>
</tr>
<tr>
<td>Obsessive compulsive disorder (OCD)</td>
<td>CBT</td>
</tr>
<tr>
<td>Social phobia&lt;sup&gt;1&lt;/sup&gt;</td>
<td>CBT or eye movement desensitisation and reprocessing (EMDR) therapy</td>
</tr>
</tbody>
</table>

#### Step 2: Low-intensity interventions

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Guided self-help based on CBT, computerised CBT, BA, structured physical activity</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Self-help based on CBT, computerised CBT</td>
</tr>
<tr>
<td>PTSD&lt;sup&gt;3&lt;/sup&gt;</td>
<td>None</td>
</tr>
<tr>
<td>GAD</td>
<td>Self-help based on CBT, psycho-educational groups, computerised CBT</td>
</tr>
<tr>
<td>OCD</td>
<td>Guided self-help based on CBT</td>
</tr>
<tr>
<td>Social phobia&lt;sup&gt;1&lt;/sup&gt;</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Step 1: Primary care/ IAPT service

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of problem</td>
<td>Assessment/referral/active monitoring include careful monitoring of symptoms, psychoeducation about the disorder and sleep hygiene advice</td>
</tr>
<tr>
<td>Moderate to severe depression with a chronic physical health problem</td>
<td>Collaborative care (consider in light of specialist assessment if depression has not responded to initial course of high-intensity intervention and/or medication)</td>
</tr>
</tbody>
</table>

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1. Although the recent update of the NICE guidance on depression recommends BA for the treatment of mild to moderate depression, it notes that the evidence base is not as strong as for CBT or IPT. See NICE (2009) Depression. CG90.

2. NICE (2009) Depression. CG90; NICE (2009) Depression in adults with a chronic physical health problem. CG91. The two guidelines are very similar; however, it should be noted that CG91 does not recommend IPT, BA, counselling or brief dynamic interpersonal therapy as high-intensity interventions.

3. NICE has not recommended low-intensity treatments.

4. NICE has not yet issued guidance on the treatment of social phobia. However, there is a substantial body of evidence that supports the effectiveness of high-intensity CBT. Low-intensity versions of CBT are being developed by several groups around the world and are likely to play a useful role in the future. At least one trial has also demonstrated that IPT is effective.
Appendix B: IAPT's care pathways