



Lakes District Health Board - Mental Health and Addiction Services

# **Review of Psychologists and Psychological Therapies at Lakes DHB.**

**August 2017**

# Table of Contents

Introduction	3
<b>Purpose and Scope of Review</b>	3
<b>Review Methodology</b>	4
Reviewer	4
Terms of Reference	4
Document Review	4
Data Gathering	4
Participants	5
Analysis and Results Presentation	5
<b>Description of Service</b>	6
<b>Psychologists</b>	6
Psychologists within Lakes DHB	7
Clients of Psychologists	7
<b>Psychological Therapies at Lakes DHB</b>	10
Stepped Care	11
<b>The Context Lakes DHB</b>	13
Population	13
<b>Discussion of Emergent Issues Regarding the Service</b>	14
<b>Resources</b>	14
Staffing Levels	14
Physical Resources	17
<b>Clinical Care</b>	17
Model of Care	17
Length of Care	21
Assessment	25
Interventions	26
Outcomes-Led Approach	27
Supporting Psychological Therapy Delivered by Non-Psychologists	28
Cultural Factors	29
Psychologists in Physical Health Services	30
<b>Organisational Function</b>	31
Role of Psychologists within the MDT and Clinical Decision Making	31
Waiting List Management	32
Time and Workload Management	33
Simplified and Efficient Organisational Processes	34
Keyworking	35
Career Pathway for Psychologists	36
<b>External Psychologists</b>	37
<b>Psychology Advisor Position</b>	39
Time Allocation	39
Ability to Influence the Organisation	40
Ability to Influence Psychologist's Practice	40
<b>Future Directions for the Service</b>	41
<b>Summary of Recommendations</b>	44
<b>References</b>	49

# **Review of Psychologists and Psychological Therapies at Lakes DHB.**

**August 2017**

## **Introduction**

This document describes a review of psychologists and the provision psychological therapies (sometimes called talking therapies) at the Lakes District Health Board, and particularly, although not exclusively, its Mental Health and Addictions Services.

## **Purpose and Scope of Review**

This review was commissioned by the Mental Health and Addictions Services of the Lakes District Health Board to consider ways of improving the organisation, effectiveness, and cost-effectiveness of the delivery of psychological services by psychologists and other staff members at Lakes DHB. The overall purpose of the review was described as:

- 1) To review and describe the current utilisation of psychologists within the Lakes DHB.
- 2) To review and describe the current status of psychological service provision within Lakes DHB.
- 3) To determine a sustainable and cost-effective model for the delivery of psychological services within Lakes DHB.

More specific objectives were defined as:

- 1) Review of all psychological services provided by Lakes District Health Board provider arm services.
- 2) To evaluate and describe the current need for psychological services across the wider Mental Health Sector.
- 3) To develop and evaluate various options/models for psychological service delivery funded by Lakes DHB.
- 4) To prioritize these options as to its ability to most efficiently support the sector in meeting the current and future needs of this community with regard to specialist psychology service provision. Recognising or contributing to local, regional or national strategy.
- 5) Examine and critique the role of the Professional Advisor and make recommendations on the future duties and expectations within this role

## Review Methodology

### Reviewer

This review was undertaken by Malcolm Stewart PhD PGDipClinPsych DipMgt who is a clinical psychologist in private practice based in Auckland. His current practice involves assessment and therapy services for adult clients with mental and physical health difficulties; supervision of other health professionals including, but not limited to, psychologists; and consultancy to a range of DHBs, PHOs, NGOs, and government organisations, particularly regarding innovation in services and methods for evaluating the outcome of innovation. He was from 2003-2013 the Professional Leader – Psychology for Counties Manukau DHB and had previously been the Professional Leader – Psychology at Waikato DHB. He is also a former Senior Lecturer with the Department of Psychiatry and Behavioural Sciences at the University of Auckland.

### Terms of Reference

The Terms of Reference for the study were discussed between Michael Bland, General Manager Mental Health Services at Lakes DHB, George Furstenburg (now former) Psychology Advisor for Lakes DHB, and the reviewer, and a draft document was prepared. The document was circulated to the psychologist, the union that represents the psychologist (APEX) and some other stakeholders. Subsequent to this a final Terms of Reference Document for the study was prepared.

### Document Review

A large number of documents were supplied by Lakes DHB Mental Health or sourced from the Lakes DHB website and used to provide context and information for this review. Other national and international literature was accessed to provide context and to inform the analysis and conclusions of the review.

### Data Gathering

Interviews with stakeholders were held over three days and some subsequent interviews were undertaken by telephone. A semi-structured interview format was developed and utilised for most interviews, with a particular focus for each interview on those parts of the format that were of most relevance to the particular stakeholder. The semi-structured interview had the following major sections:

- Strengths and limitations of psychology services at Lakes DHB at present (including the service delivery model)
- Strengths and limitation of health and mental health service provision at Lakes DHB at present
- Perspectives on contracting in external psychologists to provide services for the DHB (Strengths and limitations)
- Perspectives on the Psychology Advisor Role (Strengths and limitations)

In addition to recording the perspectives of the participants, any suggestions made about future changes they would recommend were recorded as a separate section on the summary notes

- Suggestions for change
  - Provision of psychological services

- Provision of mental health services
- Psychology Advisor role
- Human resources issues

Detailed notes were taken during the interview and summarised into a written document that was then circulated back to the interview participants with the request that they correct and errors or omissions, and feel free to add any additional thoughts they had subsequent to the interview or on reading the notes.

## Participants

Approximately 45 people participated in interviews and discussions for this review. To protect confidentiality, most are not named specifically below. The range of participants is characterised below:

### Role/Position of Participants in the Lakes DHB Psychology Review

Role / position	Approx. number	Comment
Psychologists	12	Met jointly, individually, or with other members of their team Includes psychologists external to the DHB.
Service or team managers	9	From a variety of mental health and physical health services
Nurses	8	From mental health, primary MH, and physical health services
Psychiatrists	6	Met jointly or with other members of their team
Allied Health	2	OT and social worker
Team admin staff member	2	
Tangata whenua representative	2	
Service user representative	1	
NGO representative	1	
Planner and funder	1	
General Manager– MH&A		
Clinical Director – MH&A		
Clinical Nurse Director – MH&A		
Psychology Advisor (former)		
Psychology Advisor (current)		

## Analysis and Results Presentation

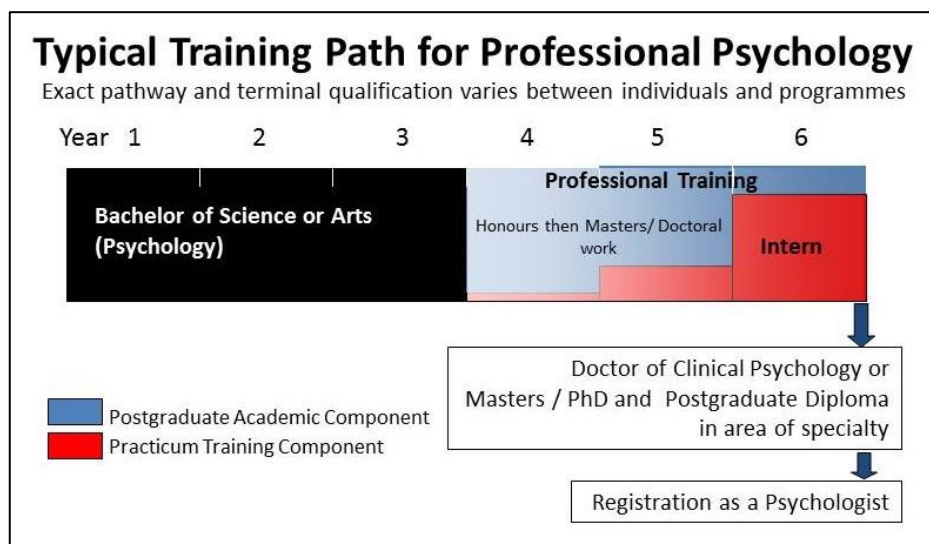
The notes were consolidated into a single thematically organised document. This highlighted the consistency or divergence of opinions expressed by different participants and groups. The results of the interviews regarding key issues relevant to this review are summarised in this document and considered in the context of the national and international literature and experience. Recommendations are primarily based on:

- Where there is a convergence of views from the various stakeholders, presenting this view and suggesting ways which change could be implemented.
- Where there is a divergence of views, attempting to understand what might underlie the tension and suggest approaches that may assist to resolve the situation causing tension

## Description of Service

### Psychologists

**Psychologists** are people who are registered as psychologists and hold an Annual Practicing Certificate with the New Zealand Psychologists Board. Most psychologists in Lakes DHB are registered in the Clinical Vocational Scope of Practice with the NZ Psychologists Board, and therefore practice as clinical psychologists. The typical training for a psychologist in New Zealand is to hold a Masters or PhD degree with the Postgraduate Diploma of Clinical Psychology, or a Doctor of Clinical Psychology Degree, or overseas equivalent. This involves 6-9 years of university study, the latter years of which involve 1500 hours of practicum experience in clinical settings alongside an integrated programme of coursework and research. The following graphic shows the typical training pathway for psychologists.



**Intern Psychologists** are in their last year of training and are employed four days per week in a clinical setting such as Lakes DHB to undertake psychological assessment and intervention under close supervision. At the time of writing, two interns psychologists were employed by Lakes DHB.

Some psychological work within Lakes DHB is undertaken by psychologists who work externally (e.g., in private practice) and are contracted by the DHB to undertake specific work. Unless explicitly mentioned, these psychologists will not be included in statistics or discussions in this report.

## Psychologists within Lakes DHB

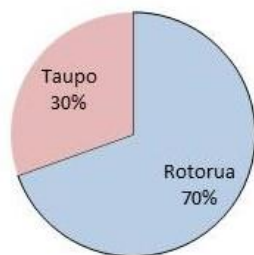
Data provided at the beginning of this review indicated that there were a total of 18 psychologists (13.6 FTE) employed at Lakes DHB, and there were two vacancies (1.5 FTE). Two of these were intern psychologists who were employed for a total of 1 FTE. One psychologist was on maternity leave.

	Number	FTE
<b>Lakes DHB - Employed Psychologists</b>		
Permanently Employed	16	12.6
Vacant positions	2	1.5
Interns	2	1.0
<b>Total</b>	<b>18</b>	<b>15.1</b>
<b>Private Practice Psychologist</b>		
Contracted – Set amount of work per week	2	0.4
<b>Vocational Scope of Practice – All psychologists</b>		
Clinical	14	
Psychologist (General)	3	
Educational	1	
Intern	2	
<b>Primary location of Work</b>		
Rotorua	12	10.5
Southern Lakes	5	4.6
<b>Service or Area of Work: Mental Health</b>		
Child and Adolescent Mental Health	6	5.4
Adult Mental Health	4	4
Primary Mental Health Services	3	1
Perinatal Mental Health Services	2	1
Mental Health Services for Older People	2	0.4
Leadership	1	0.3
<b>Service or Area of Work: Physical Health</b>		
Cancer Service	1	0.8
Paediatric Services	1	0.5
Child Development Services	1	0.5

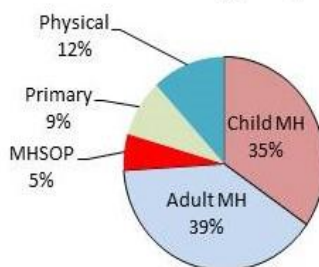
The following graphs describe the Full-Time Equivalent (FTE) percentage for these psychologists in terms of location, service type, and type of employment at the time of completion of this review<sup>1</sup>. The vacant positions described above remained unfilled or were filled by contracted psychologists, and were reported as often hard to fill.

<sup>1</sup> The data used for these graphs was from a later time than the tabular data, and with staff movements may not exactly correspond to the tabular data.

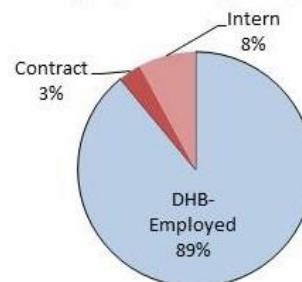
**Lakes DHB Psychologists:  
Location Type by FTE**



**Lakes DHB Psychologists:  
Service Type by FTE**



**Lakes DHB Psychologists:  
Employment Type by FTE**



Source: Lakes DHB. Mental Health Services

The population of the Taupo (Southern Lakes) area is approximately 30,000 (30%) of the whole area. The psychologist FTEs appear to reasonably accurately reflect this population distribution, although with a (Taupo-based) psychologist on maternity leave there is a substantial reduction in capacity in such a small team.

People under the age of 20 make up approximately 29% of the total population and people over the age of 65 make up approximately 14% of the population. The psychologist FTEs in mental health slightly over-represents child and adolescent services and under-represents adult and older adult services. This may reflect recognition of potential impact of preventing lifelong suffering, dysfunction, or disability if problems are addressed early in the life course, and the important role that psychologists and psychological assessment and therapy can play in the preventative work.

The vast majority of psychologists working in Lakes DHB are regular employees of the DHB, either as qualified psychologists or as interns. The contracted work included above represents psychologists who have regular contracted FTE engagements with DHB services. There is a small amount of additional contracted work that is not reflected in these figures, in which external psychologists are contracted by the DHB to undertake specific therapy or assessment work. This work occurs across both mental health and physical health services. Figures for the total cost of this are not available.

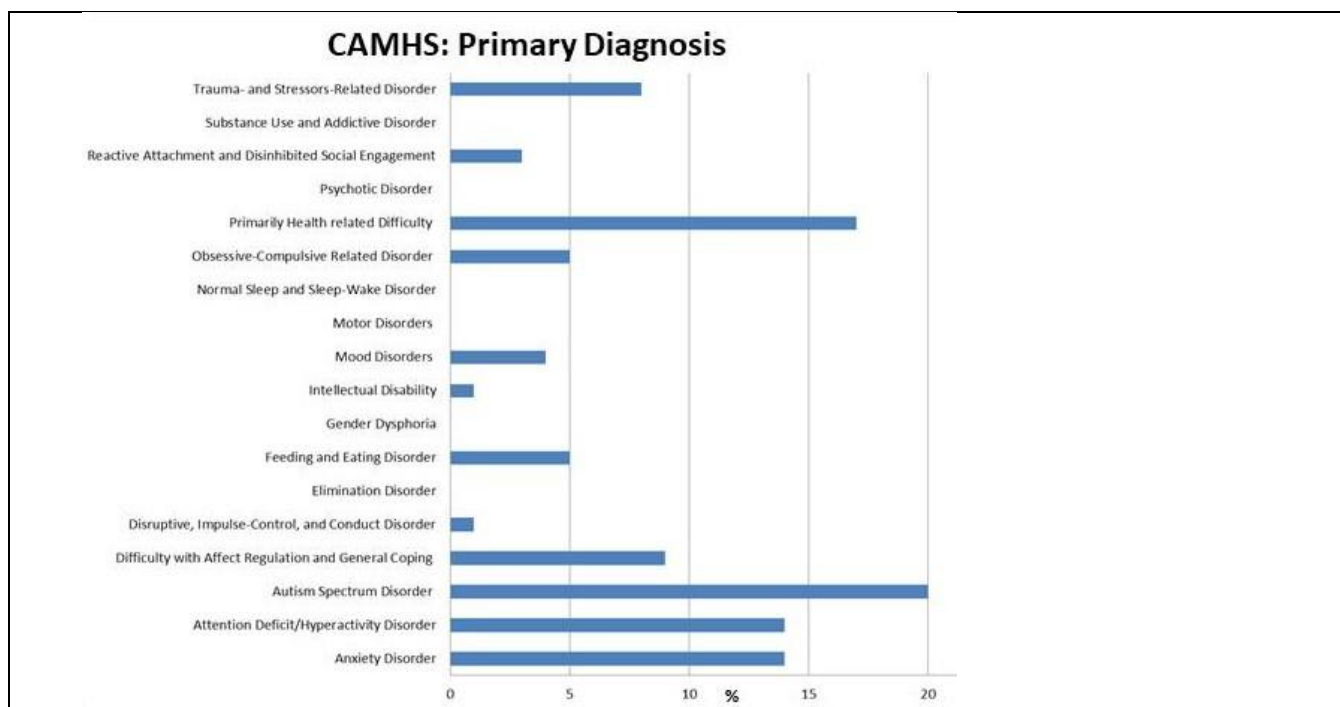
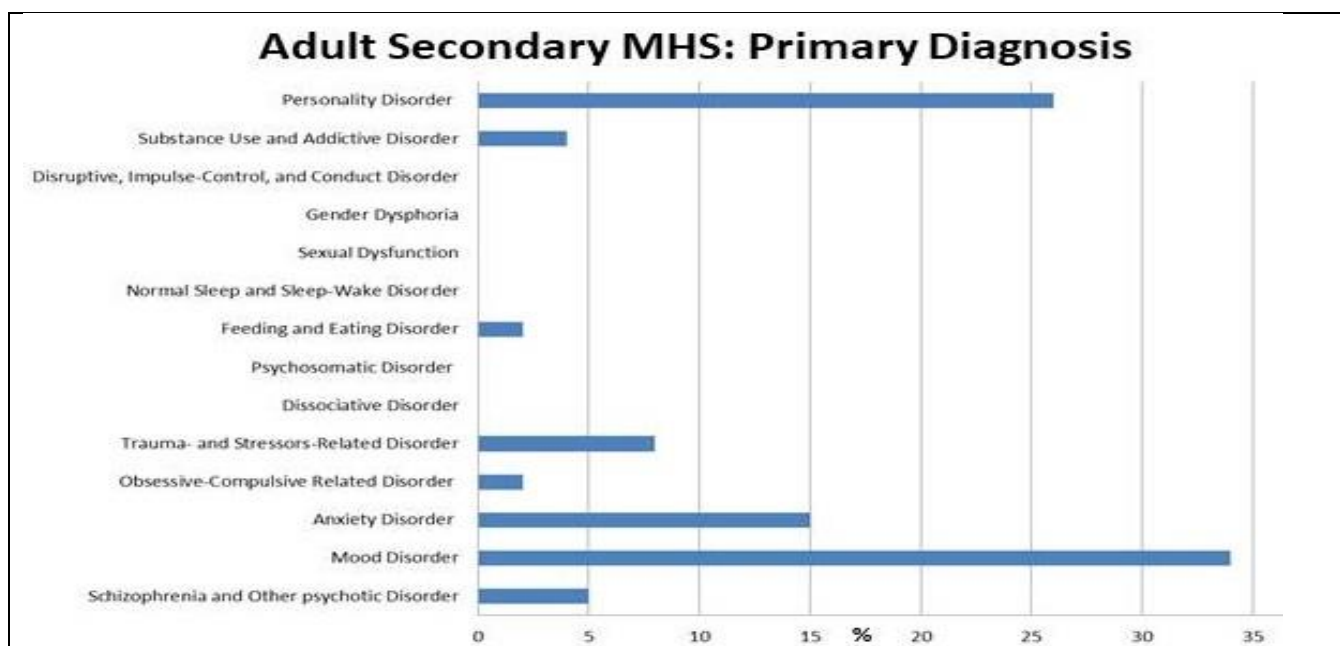
Whilst detailed comparison with other DHBs has not been undertaken, the distribution of psychologists between different types of mental health services appears quite typical of the distribution in many DHBs. The range of physical health services that have access to psychological inputs is more restricted than is typical amongst the DHBs, although the range of physical health services with consistent access to psychology is typically more limited in smaller DHBs.



## Clients of Psychologists

Data from 9 November 2016, showed that 275 clients of Lakes DHB Mental Health Services (225 in secondary MHS and 50 in primary MHS) were receiving care from a psychologist. This equated to an average caseload of 24 clients per FTE (21 per FTE in secondary MHS and 45 per FTE in primary MHS)

The following graphs show the primary diagnoses/reason for referral for clients seen by the psychologists in Lakes DHB on 9 November 2016



It is notable that people with a primary diagnosis of personality disorders, who tend to be relatively slow to treat, constitute 26% of the Adult Secondary MHS clients. Mood, anxiety, and trauma-related disorder which (depending on other complexities) might be expected to be quicker to treat, constitute the primary diagnosis for about 47% of Adult Secondary MHS clients.

It is also notable that Autistic Spectrum Disorders is the largest single primary diagnostic group within the CAMHS services. It is not clear from this data what proportion of these clients were primarily being seen for assessment and what proportion for therapy. Therapeutic input with this groups can be short or long depending on the goals and style of intervention utilised.

## Psychological Therapies at Lakes DHB

**Psychological Therapies** are defined in this review as any formal psychological techniques delivered by a person with extensive training in the use of such techniques. These services are not necessarily delivered by a psychologist, but the person delivering them needs to have an advanced level of expertise in utilising the techniques and to deliver them as an explicit psychological intervention (e.g., Cognitive Behaviour Therapy; Dialectical Behaviour Therapy).

A useful way of understanding the distinction between these psychological services and other good quality care was provided for the British National Health Service Workforce Planning Advisory Group (MAS report: Mobray, 1988; Stewart, Bushnell, Hauraki, & Roberts, 2014). The report identified that meeting the psychological needs of healthcare users is not solely the role of psychologists - it is in fact the responsibility of all staff in health and social services. However, different professions have different contributions to make. The MAS report identified three levels of expertise in psychological input by health sector staff. These levels are shown in Table 1.

**Table 1. Levels of Psychological Input, Adapted from the MAS Report**

Level 1:	Establishing and sustaining constructive relationships with clients and relatives, and using straightforward techniques such as effective questioning, basic counselling, collaborative problem solving, psychoeducation, and stress management. These should be within the skill set of, and undertaken by, all health staff.
Level 2:	Undertaking circumscribed psychological activities. These activities may be protocol-driven (e.g., manualised) therapy approaches with clients and are undertaken by a variety of health staff (e.g., medical practitioners, nurses, occupational therapists, and social workers) with suitable aptitude and training. Therapies such as CBT for clients with relatively uncomplicated presentations and some group interventions may fit at this level.
Level 3:	Activities requiring specialist psychological intervention in circumstances where complexity or underlying influences require development of an advanced and individually tailored therapeutic strategy. Flexibility to robustly adapt and combine approaches is a key competency at this level. This comes from a broad, thorough and sophisticated understanding of various psychological theories and approaches. While not exclusively the case, this level is primarily undertaken by psychologists.

Level 2 activities, when undertaken by a health professional with substantial training and expertise, and Level 3 activities constitute psychological services as defined in this review.

Within Lakes DHB a number of nurses have been trained in the use of psychological techniques such as cognitive behaviour therapy and motivational interviewing. Michael O’Connell, Clinical Nurse Director, indicated that approximately ten nursing staff had taken additional training in the use of psychological therapies, a small number to Postgraduate Certificate level. He also noted that most of the nursing staff had elected not to advance their skills beyond the Level 1 level above. Another participant, a nurse who has organised an interest group for people practicing therapies reported that typically only around two nurses attend, and most attendees are psychologists. Other nurses who participated reported that they were concerned that if they learned these skills it would take time away from their being able to function in their nursing role.

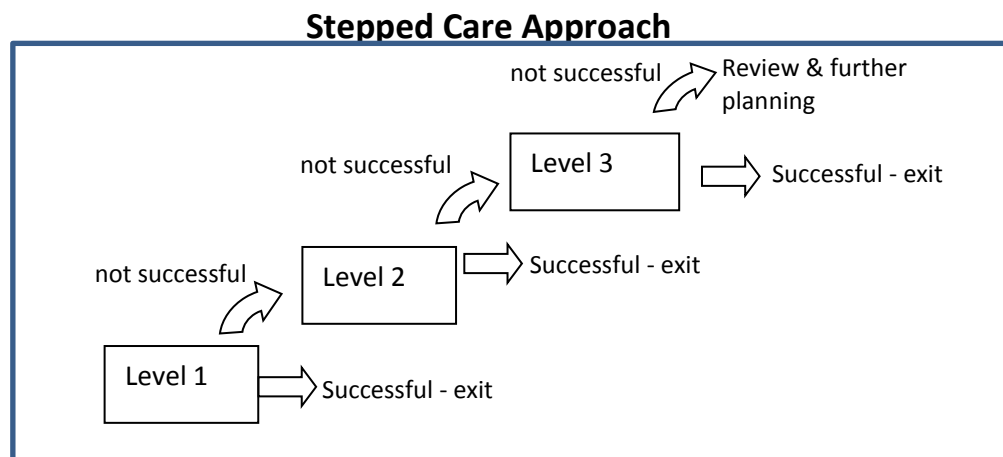
Nurses who provide therapy reported that psychologists are important in supporting their provision of therapy, though providing formal and informal training and supervision and advice, and through providing a potential referral pathway if the client’s difficulties prove to be beyond their skill level.

## Stepped Care

A developing approach for increasing the responsiveness of health services to the psychological needs of their population is to institute a formal stepped care approach ([www.tepou.co.nz/resources/lets-get-talking-introduction/646](http://www.tepou.co.nz/resources/lets-get-talking-introduction/646)). Stepped care involves a planful approach for tailoring the therapeutic response to the needs of the service user in terms of type and intensity of service delivered as well as the approach. Stepped care involves:

- defining two or more levels of care of different intensity of input (and different presumed effectiveness for people with different intensity of need) and
- utilizing assessment processes to guide the allocation of clients to the different levels of care, and determining if they should move from one level to another (up or down)

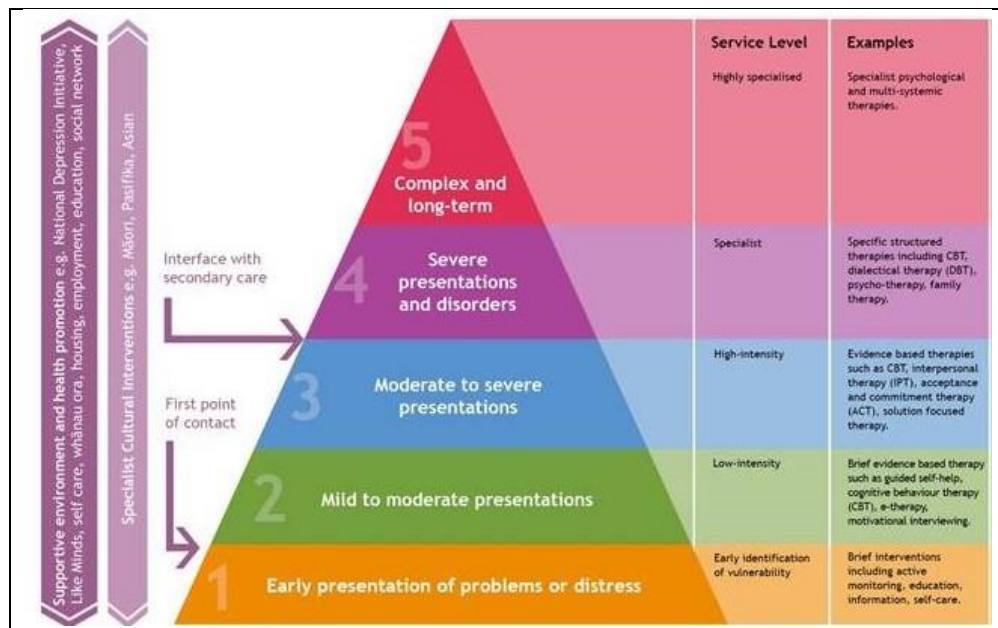
This process can be presented graphically as below.



A stepped care approach is a structured way of involving staff with a variety of different skill sets in provision of talking therapy skills appropriate to their level of skill.

Stepped care differs from much of standard care because it involves a formal and well-developed system of criteria for determining whether a client should move from one step to the next. In much of standard care the processes by which clients may move to different types or levels of care is more haphazard.

The following graphic describes a stepped care system spanning primary and secondary mental health.



Source: [www.tepou.co.nz](http://www.tepou.co.nz)

Stepped care make it possible for a wide variety of psychological assistance to be provided to people by a wide variety of staff, and by other resources (e.g., internet based self-help). However, to ensure that a stepped care system operates safely and effectively it is important to have good processes for allocating clients to the appropriate level and to ensure that staff are well trained and supported in providing interventions appropriate to their skill level. Psychologists are frequently recognized as having a significant role in providing this support.

## The Context: Lakes DHB

A detailed description of Lakes DHB, its population and services is beyond the brief of this review. However, the following thumbnail sketch is presented.

### Population

The Lakes DHB has a population of approximately 105,000 people, It has approximately one fifth of the population of the largest DHB and has approximately three times the population of the smallest DHB.

The Lakes DHB population can be characterised as<sup>2</sup>:

- Age Distribution:
  - Approximately 29% of the Lakes DHB population are under the age of 20 (slightly higher than the national pattern).
  - Approximately 14% are over the age of 65 (slightly lower than the national pattern).
- Ethnicity
  - Approximately 35 % of the Lakes DHB population are Māori (well above the national pattern)
  - Approximately 2% of the Lakes DHB population are Pacifica (Well below the national pattern)
- Deprivation
  - 35% of the Lakes DHB population are in Quintile 5 (the most deprived) for deprivation, and 56 % are in either Quintile 4 or 5 (the two most deprived categories). Nationally, only 40% of people would be expected to be in these two categories, so this indicates more than average deprivation in Lakes DHB.

---

<sup>2</sup> Data from Ministry of Health website.

## Discussion of Emergent Issues Regarding the Service

This section outlines the results of the review, summarising and integrating information from review participants with information gained from other sources such as the national and international literature and the reviewer's previous experience. Recommendations arising from the review findings are shown in text boxes. In many cases comments regarding the implications of the findings to the broader health sector is presented at the end of the section.

## Resources

### Staffing Levels

The most common limitation of psychological service provision described by participants was the difficulty to gain access to psychological input for many clients. Many services, even the most psychologically well-resourced, reported that access to psychologists could not quickly be gained, and that some contributions that psychologists could very usefully make were not made as other activities had to be prioritised. Three approaches to improve this limitation are:

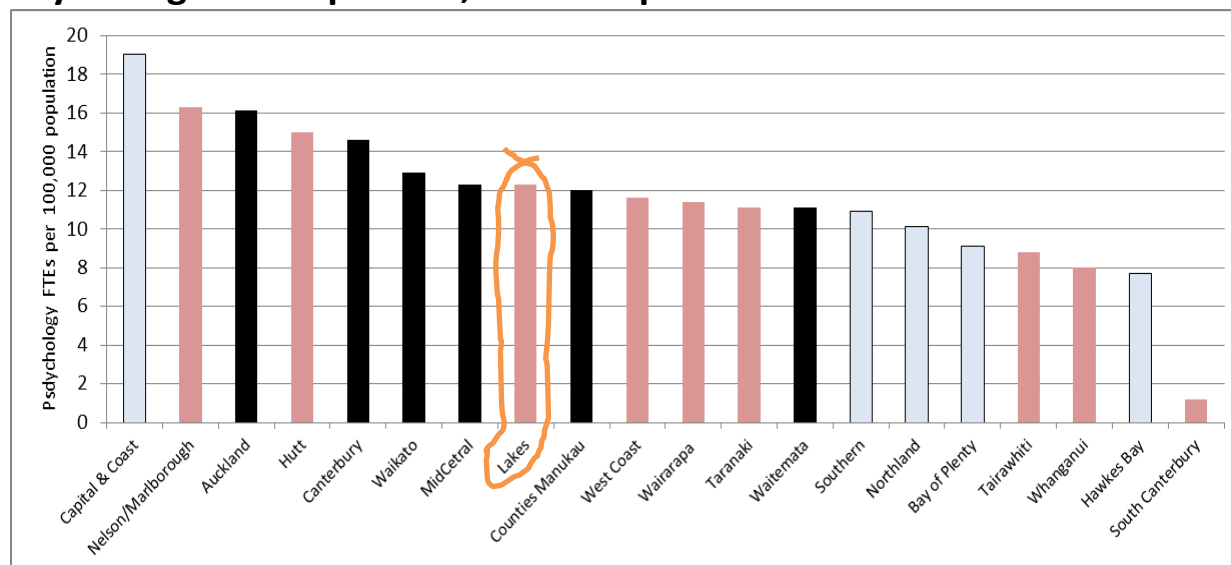
1. Increase the number of psychologists and potentially the range of services that have access to psychologists.
2. Improve the efficiency of psychologists' delivery of assessment and therapy.
3. Increase the amount of psychological therapies delivered by staff other than psychologists.

Each of these approaches will be explored in subsequent sections of this document. Whether there is a case of increasing the number of psychologists is explored in this section.

To improve the responsiveness of health and social services to psychosocial problems that limit quality of life and create expensive strain on services, the future need for psychologists both as providers of high-level psychological assessment and intervention services and to support the provision of psychosocial services by other providers is apparent. There is a paucity of good data from which to estimate the optimal number of psychologists for a service like Lakes DHB. One approach to assess Lakes current staffing levels is to compare it to other DHBs.

Data regarding the relative psychologist FTE per capita in different DHBs has been collected by the Psychology Advisors and Professional Leaders – Psychology for the different DHBs. This data is presented on the graph below. The DHBs with different population levels (smaller – < 150,000; mid-sized – 150,000-300,000; and larger -> 300,000) are shown as bars of different colours.

## Psychologist FTEs per 100,000 of Population for Different DHBs



■ Smaller DHBs (up to 150,000)    ■ Mid-sized DHBs (150,000-300,000)    ■ Large DHBs (>300,000)

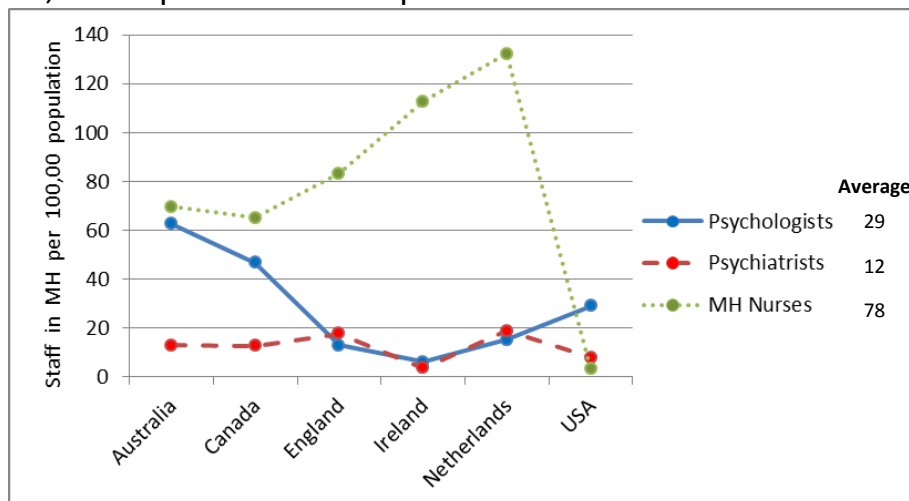
Source: Psychology Professional Leaders Group. Also reported in the APEX Psychologists Newsletter, Sept 2016

This data indicates that Lakes DHB is sitting in the middle for psychologist FTEs per capita, and is also mid-range for DHBs of comparable size. However, this normative data does not necessarily reflect optimal situation. Research is currently underway through the Ministry of Health / Health Workforce New Zealand to determine what level of FTE per 100,000 population is likely to be necessary to minimise the waiting lists that occur in many DHBs, but it is likely that positioning towards the higher levels of FTE per 100,000 population rather than the middle will be necessary to reduce waiting lists, even in efficiently operating services. Increasing the provision of psychological therapies by non-psychologists is also likely to be important to as much as possible meet the demand for psychological therapies.

## International Comparisons of Psychologists Working in Mental Health

Another approach to considering this data is to compare the number of health professionals working in the mental health sector in different countries. The following graph shows the number of psychologists employed in the mental health sector across countries that have mental health systems most comparable to New Zealand (full data for Scotland was not available).

### Psychologists, Psychiatrists, and Mental Health Nurses per 100,000 Population in Comparable Countries



Source: W.H.O. Mental Health Atlas 2011

This data shows that there are wide variations across comparable countries in the rate of involvement of psychologists and other professions in the mental health sector. The average number of psychologists across these countries is 29 per 100,000, which is approximately twice the current rate for Lakes DHB.

#### Recommendations:

- Consideration could be given to increasing the number of psychologists in existing services and providing psychologist input into a broader range of services. Areas which are seen as priorities for future input from psychologists are discussed later in this report.
- Establishing intern positions is often a valuable recruitment strategy as they are generally significantly productive from early in the internship, add to the total available workforce, and frequently choose to stay in the organisation and area in which they train.<sup>3</sup>
- Ensure that vacant positions are advertised and filled as quickly as possible.

<sup>3</sup> A study by one DHB showed that, over an nine year period, 79% of interns who were considered for employment were employed by the DHB for part or all of the following five years. In several of the remaining cases, a position in their area of specialty was not available.



## Physical Resources

Few psychologists commented about lack of physical resources except to do with working space. Several noted that limited number of interview rooms in some settings interfered with their ability to schedule clients, and small shared office spaces sometimes made work requiring intense concentration (e.g., analysing neuropsychological data, writing reports) or quiet and privacy (e.g., sensitive or confidential phone calls with clients or other clinicians) difficult. This may slow the completion of particular tasks such as report writing.

Psychologists appeared satisfied with their access to professional resources needed for their work, such as psychometric and neuropsychological resources. Effective systems for ensuring that such resources were obtainable were described.

Some non-psychologist staff described difficulties that are caused by a lack of cars and in some instances limited access to computers.

### **Recommendations:**

- Psychologists are able to work better if they have offices and a stable situation in which to see clients. For some complex clients “keeping the frame of therapy stable” (ie always meeting in the same room) is important.
- Psychologists benefit from quiet spaces to do complex thinking and tasks in. Relatively private office space is preferred, but in the absence of this “quiet room@ space is important.

## Clinical Care

### Model of Care

Model of Care broadly defines the way health services are delivered. It outlines how care and services will be delivered for a person, population group, or client cohort while they are in contact with the service. For the purposes of this review, two aspects of model of care are important:

- The Model of Care of psychologists working within Lakes DHB.
- The Model of Care of the Mental Health Service as a whole, and the role of psychological services within this.

In considering the model of care, two different aspects are of key importance:

- The treatment approaches that are used.
- The way services are organised to deliver treatment.

### **Psychologists Clinical Model of Care**

It has been said of mental health that the type of care you receive is often as much determined by the professional you meet with as it is by the condition you have.

Psychological therapy is perhaps more varied than many other areas of health care in that there are a wide variety of different therapeutic approaches, often based on very different theoretical models. This diversity has a number of significant implications for the model of care:

1. Interpreting what is best practice in psychological therapy is complex: Perhaps more than in some areas of healthcare, it is difficult to define a “best practice” approach to psychological therapy. While documents such as the NICE guidelines from the UK ([www.nice.org.uk](http://www.nice.org.uk)) indicate particular therapies for particular conditions, they perhaps conceal more than they reveal. There is strong evidence that psychotherapy works for many conditions, but the evidence is much less clear about the relationship between outcomes for particular forms of therapy and particular conditions (Duncan, Miller, Wampold, & Hubble, 2010).

This may be in part because different therapeutic approaches may be differentially effective for different clients depending the interaction of a range of factors such as:

- Personal factors (e.g., cognitive style, intelligence, personality characteristics, etc.)
- Contextual factors (e.g., family/whanau situation, finances, other social determinants)
- The Condition (e.g., diagnosis; their experience of the condition, etc.)

These and other factors may impact on how well a therapy works for an individual.

2. Psychologists are often adept at using several forms of psychological therapy. The core training and philosophy of different psychologists at Lakes DHB is reflective of a wide range of these approaches. As described previously, a core skill that psychologists often bring to teams is the ability to tailor therapy to the needs of the individual based on a sophisticated understanding of psychological theory and therapy.
3. Different models of psychotherapy often have different assumptions about aspects of therapy such as the typical time course for therapy and the role of the psychologist/therapist in actively assisting skills development. Some therapies tend to assume a longer engagement. At the risk of over-simplifying, shorter term therapies often take more of an active strategy-based approach whereas longer term are often more insight-driven. Some forms of therapy (e.g., Interpersonal Psychotherapy, Stuart & Robertson, 2003)) often specify a particular number of sessions, with the rationale that this will focus both therapist and client on engendering therapeutic change. It is notable that brief forms of psychodynamic psychotherapy have been developed and have a reasonable evidence base in conditions such as depression (Leichsenring, Rabung, & Leibing, 2004).

The psychologists working in Lakes DHB come from a wide variety of countries and have widely varying models of psychological therapeutic approach, ranging from the Cognitive Behaviour Therapy approaches that underpin training in almost all New Zealand psychology training programmes to psychodynamic psychotherapeutic approaches. This variation in model of clinical practice was noted by several participants. The variation of model was not reported as a difficulty except that it was seen as sometimes hard to know what clients would get if they were referred for psychological assistance. It was mostly only seen as a problem if the clinical model of practice unusually often seemed to lead to long interventions. This will be discussed more below.

In a public healthcare context, irrespective of the therapeutic approach to care, engendering meaningful change in the person's wellbeing and function is the key objective<sup>4</sup>.

Many participants described psychologists clarity about the approaches they use as being a strength, and appreciated psychologists sharing their approach to support others. Several participants, including psychologists, reported believing that some psychologists were relatively unclear about their model of practice, leading to interventions that often lacked momentum to change. This was seen as under-utilising the psychological resource and was stated by one participant as "Psychologists just doing supportive counselling is not enough". The overall impression that was gained across the participants and services was that psychologists practicing in many different models of clinical care were appreciated and respected for their skills, the most satisfaction appeared to relate to teams in which psychologists were practicing relatively brief, change-oriented therapeutic approaches, often with a quite active strategy-enhancing focus.

### **Psychologists Organisational Model of Care**

Model of care also involves how service provision is organised within a service. Three common organisational models of care are found for psychological services:

1. **Embedded model:** Where psychologists are resident with other team members and form an integrated part of the multidisciplinary team.
2. **Departmental model:** Where psychologists form a separate service within the organisation and provide psychological services to other teams.
3. **External model:** Where psychologists are not employed by the organisation and instead are contracted in to provide services to teams within the organisation on an as-needs basis.

The primary model within Lakes DHB and most if not all other DHBs is an **embedded model**, in which psychologists are employed as a part of a particular team or teams and provide services for those teams. This approach allows the psychologist to develop specialist expertise in the relevant area of practice and tends to maximise the opportunity for the psychologist to contribute formally and informally to other team activities and processes. It tends to foster a sense of "ownership" by the team that can encourage engagement with and appropriate use of the psychologists. The downside can be that, particularly in smaller organisations and teams it can leave the psychologists feeling professionally isolated and unsupported. It also means that if a psychologist leaves or is absent, or if no-one can be recruited to a position, then no psychological service provision is available.

The **departmental model** was common in New Zealand until the late 1980s. It provided a strong professional base for psychologists and maximised the ability to share resources. Typically, psychologists within the department had particular areas of expertise and services that they worked with more. It did allow for some cover of services during the absence of a psychologist, although this tended to be limited by existing commitments. It often limited the quality of the relationships between psychologists and other team members, frequently leading to a degree of antipathy and dismissiveness towards psychologists and their contribution.

---

<sup>4</sup> Accepting that in some situations "meaningful change" may include slowing or stopping a trajectory of deterioration rather than achieving actual improvement.

The **external model** has been present as a small component of DHB psychological service provision over time, primarily to allow provision of specialist skills or to cover particular service needs that the in-house psychologists were not able to cover. A typical example has been the provision of a neuropsychological assessment for a service where the psychologists' skills in this area were not current or where their other workload did not allow time to complete the assessment. Use of external psychologists within Lakes DHB, and the advantages and disadvantages of doing this, will be discussed in more detail later in this document.

The vast majority of participants in this review indicated that having the psychologists embedded within teams was important and the preferred model. Many described the access to the psychologist that this provides, and their ability to contribute to team function and processes other than through direct therapy provision, as being an important benefit. Teams in which psychologists had only a small time allocation frequently described the difficulties that occurred as a result of relatively infrequent contact.

There was also reasonably wide support for the use of external psychologists for specific tasks such as some assessments, some brief therapy interventions, and to provide some input if a psychologist position could not be recruited to. Many participants noted the loss of access for teams to the other contributions that psychologists can make if a preponderance of external psychologists were used, and this was not favoured. This will be discussed in more detail later in the document.

The idea of a Psychology Department was raised at a meeting of psychologists. Little support for this was received from other participants, including psychologists interviewed individually. The objective of this seemed to be to increase the level of collegial support and integration. Other participants suggested there may be other ways of doing this, including reviewing the regular psychologists meeting to improve its ability to meet the needs of the psychologist.

Overall, a broad range of the participants supported an organisational model of care in which psychologists are embedded as part of the multidisciplinary team, with some judicious use of external psychologists to assist with specialist tasks and cover some service gaps. The economics of the embedded and external models are discussed later in this document and indicates that with reasonable levels of efficiency and productivity the embedded model is perhaps the most economically viable as well as the model that can readily provide the broadest range of assistance to the DHB.

**Recommendation: Model of Care**

- That all psychologists develop amongst their skill sets, and become comfortable in using, forms of therapy that are brief, change-oriented, and which include components of strategy development.
  - These may not at all be the only skill sets they use, but are within their range of skills.
  - Psychologists whose foundational practice models tend to be longer-term therapies may wish to explore the use of brief approaches closely related to their foundational model.
- An organisational model of care involving primarily psychologists embedded within teams and with some judicious use of external psychologists, be maintained. This is broadly in line with current operation. It is expected that the difficulties that proposed changes in this model were intended to address will be addressed by other recommendations made in this document.

## Implications for the Mental Health Service

Some participants described the belief that many of the Lakes DHB mental health services did not have a very clear model of care. This created some of the tensions that were identified with other services in the sector such as NGOs. They believed this often led to difficulties of role definition, who the clients are, what their needs are, and what services should be offered by the mental health service. A number of participants mentioned that there seems to often be “a tussle” between the biological and psychological perspectives within the services rather than an integration of these perspectives and that this was not productive.

One participant in a senior leadership position saw the potential for development of a different kind of model of care for the whole mental health service. This model would include:

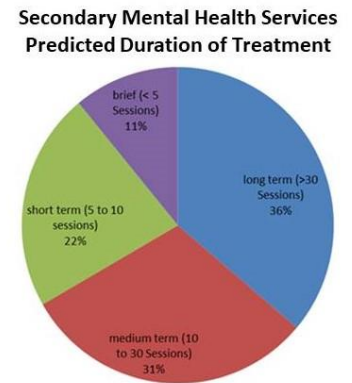
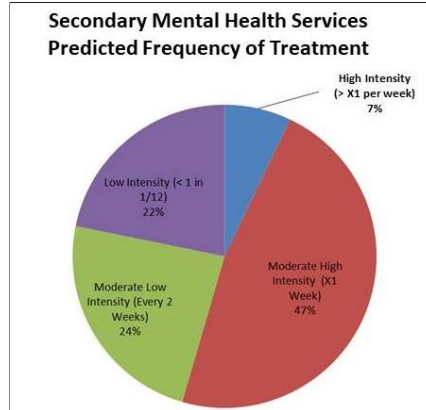
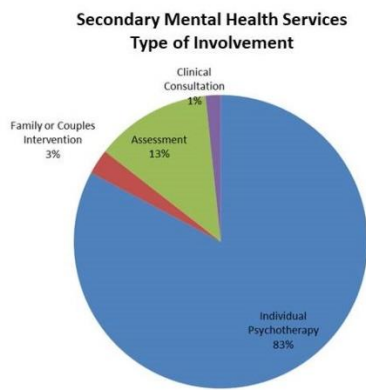
- A different discourse about where MH care is delivered and how.
- A different relationship between primary care, secondary care, and NGOs.
- Co-location of primary and secondary care staff/resources to improve joined-up working. Possibly 67% of MH staff could be collocated with primary care services while Te Ngako staying as the hub
- NGO staff possibly becoming the principal care coordinators. This would require a route for rapid re-entry to secondary service if needed. It would also require upskilling of NGO staff regarding crisis recognition and response.

This model of care was seen as leading to being able to better meet the mental health and addictions needs in primary care and better meeting co-morbid physical health needs of mental health clients.

## Length of Care

As stated previously, the most common limitation of psychological service provision described by participants was the difficulty to gain access to psychological input for many clients. The first strategy for addressing this difficulty is to increase the number of psychologists. A second and compatible strategy is to improve the efficiency of psychologists’ delivery of assessment and therapy. Many mental health staff, including psychologists, are not immediately comfortable with considering this approach as they already experience their work as stressful and “overloading”. However, improving efficiency can often lead to reduced work stress and increased satisfaction.

A common cause of concern that was expressed by many participants in this review was that many of the clients are seen for long periods of time, often with little apparent benefit resulting from the input. This concern was expressed by a wide range of participants, including some psychologists. One of the concerns resulting from this was the impact on access and equity of access which occurs when lengthy episodes of care are maintained for clients. The graphs below shows the primary type of interventions, the estimated frequency of contact, and the estimated length of engagement (in terms of number of sessions) for all secondary mental health clients seen by psychologists.



Source: Psychology Advisor

This data shows that 36% of intervention clients are predicted by psychologists to take longer than 30 sessions in treatment. This percentage for very long treatments does seem to be surprisingly high.

### What is an optimal length of care?

The complexity of secondary mental health clients means that it may take longer for change to occur than is the case in many other settings. For example, a study by Harnett, O'Donovan and Lambert (2010) showed that reliable improvement for clients with significant psychiatric difficulties was achieved by 50% of clients after 8 sessions and by 85% after 21 sessions. More substantial recovery (moving from a score on the relevant measure in the dysfunctional range to a score in the functional range) was achieved by 50% of clients after 14 sessions and by 70% after 23 sessions.

However, Duncan, Miller, Wampold, & Hubble (2010) showed that in general much of the change bought about by therapy starts very early in the therapy process, with the greatest gains typically being made in early sessions and a slowing rate of change (although frequently consolidation) happening with later sessions. That is, there is frequently a **“diminishing return”** in that the incremental benefit achieved by each additional session decreases. Beyond a particular point the potential risks of additional sessions (e.g., increased dependency, reduced self-agency, and or loss of belief that change can occur) can outweigh potential gains.

Taken together, these results indicate that substantial change from psychotherapy for clients in secondary mental health services will often take longer than the “eight sessions of CBT” that people often envisage, but change should be evident from early in the therapy process if it is likely to happen.

When one client is seen for an extended period, this creates an **opportunity cost**. Opportunity cost is a term indicating that when one choice is made (e.g., when one client is seen for thirty sessions) there is a cost associated with that choice (e.g., two other clients who could also have been seen if clients were seen for ten sessions each will receive no input).

As discussed earlier this document, a value that psychologists particularly add to a service is not only the ability to practice standard psychological therapy, but also to be able to tailor the therapeutic

approach to the needs of the individual, based on a thorough knowledge of psychological theory and therapy.

The dilemma these complexities create for Lakes DHB is to balance the delivery of effective psychological therapy to clients in ways that maximise the benefit (therapy that brings about real improvements in wellbeing for clients and their family/whanau) whilst achieving as much equity of access to psychological services as possible.

Some people with some conditions will require extended therapy to make substantial gains. For example, Dialectic Behaviour Therapy, which is utilised primarily for treatment with people diagnosed as having borderline personality disorder, is typically regarded as taking about two years to complete. However, a wide variety of stakeholders including managers, other clinicians, external stakeholders and some psychologists, expressed concern about the opportunity cost, and other potential risks associated with a preponderance of extended interventions. An overall trend that was evident was that services in which the psychologists utilised briefer, and more strategic/change-oriented approach generally had shorter waiting lists and higher levels of satisfaction tended to be expressed by others.

Some psychologists talked about the “trap” which they can find themselves in of being asked by the team to keep seeing a client (in part to help the team feel safe that “something is being done”) even though the psychologist doesn’t think they are being particularly helpful.

The following recommendations are to achieve a balance between facilitating psychologists to use their expertise to develop an optimal therapeutic pathway with their clients, while at the same time achieving as efficient use of psychology time and as much equity of access as possible for all clients. These recommendations came from many participants in the review, including the psychologists, with additional contributions from the international literature and the reviewer’s experience.

**Recommendations: Addressing Length of Care Issues**

- All psychologists (and other staff) utilise a regular outcomes measurement tool to evaluate progress in therapy. This may be session-by session measurement or less frequent, but should be at least every 5 sessions.
- At regular intervals (e.g., every 10 sessions) these outcomes are considered with a small group of relevant MDT colleagues. If the client is not showing appreciable change, alternatives are considered, such as:
  - A further block of therapy sessions may be instituted.
  - Assistance of a different kind (e.g., social work assistance with some social determinants of ill-health) that may be more beneficial at this stage may be initiated.
  - Less intensive supportive assistance, possibly involving consolidation of some aspects of therapy may be implemented by another staff member as part of an ongoing relationship. The psychologist would ideally be available to support the keyworker or other therapist to maintain this.

Routine (particularly session-by-session) outcome measurement has been shown to have a larger positive impact on outcomes than the type of therapeutic approach used (Duncan, Miller, Wampold, & Hubble, 2010). Several psychologists and other staff in Lakes DHB are already using the

MyOutcomes system ([www.myoutcomes.com](http://www.myoutcomes.com)) which provides session-by-session feedback on outcomes. The applicability of this system across the mental health services may need to be explored.

The practice of regular reviews after a certain number of sessions is common in services such as Corrections and with ACC clients. Psychologists who had worked in these systems reported that they had found such systems sustainable and ultimately useful for the client and the clinician. While it may take some time, it often has benefits for ensuring that the client is able to get the help they most need, the therapist is not left trying to struggle for change with the client alone, and both the psychologist and the service has a mechanism to help ensure that psychologists' time is effectively used.

### **Whole of Mental Health Implications**

The outcomes-led approach that is described above would be useful across all disciplines and services. Although some progress is being made, mental health services remain remarkably unsophisticated about using their own data to inform their practice ("practice based evidence").

An example of this kind of review being used in mental health services is the Early Psychosis Prevention and Intervention Programme (EPPIC) in Melbourne, Australia, which assesses outcomes 12 weeks after service entry and at 12 weekly interval by various means including standard measures (EPPIC, 2001). If at this review the patient is on the expected trajectory of improvement, current treatment continues. If the client is not on the expected trajectory a special formal review is held that reviews medication management and psychosocial factors such as alliance with staff, comorbid conditions (e.g., substance abuse), peer and family factors, impact of social determinants, etc., and makes recommendations regarding treatment.

Although not sensitive enough for assessing changes from psychotherapy, the HoNOS family of measures can be used as a tool for the evaluation of whole-of-service outcomes for clients. Utilising this, including as part of the MDT process, can be a low-cost way of implementing outcomes-led team function that utilises data that is already collected. Techniques for doing this are discussed on the Te Pou website ([www.tepou.co.nz/resources/using-honosca-in-multi-disciplinary-teams/246](http://www.tepou.co.nz/resources/using-honosca-in-multi-disciplinary-teams/246)).

There is advantage in also having self-report measures as part of this mix. If a more detailed and client completed measure that was broadly applicable across the services was desired, The CORE Outcomes Measures ([www.coreims.co.uk](http://www.coreims.co.uk)), which are available in a variety of forms from 5-34 items (a 10 item form could work well for many services) could work well as an overall measure for many people in mental health services from 11 years of age to old age.

In some instances the goals may be maintenance of current status rather than positive change, although even in these situations aspects such as functional gain, improved wellbeing, or improved life circumstances may be viable recovery-focused goals.



## Assessment

Undertaking formal diagnostic and similar assessments for various functions including diagnosis and characterisation of Autistic Spectrum Disorder (ASD), neuropsychological assessments, and cognitive assessments related to Intellectual Disability was noted as a unique and valuable role for psychologists by several services and participants in this review. It was also noted that demand for this type of services was tending to increase, due in part to various other agencies (e.g., the Department of Education Special Education Services) reducing their provision of such services, leaving DHB psychologists to pick up the function as best they are able with their available time. Undertaking such assessments was also a role for which external psychologists were often contracted by various DHB services.

It was noted by several participants, and confirmatory evidence was seen by the reviewer, that processes used by different psychologists to undertake such assessments varied widely in terms of the kind of assessment offered, and the number of sessions required to undertake the assessment. While there may be some variation due to the time needed to establish rapport and similar factors, the variation, and the length of time reported by some participants, seemed surprisingly long for some assessments. Some participants also described reporting requirements from other organisations for reports that were over-inclusive to the extent of being time-consuming without adding value. One participant said

“At one stage we [simplified the reporting] and it allowed us to really reduce the waiting list, but then [an agency] invented a new form that added a lot of extra information we had to provide [and which did not seem particularly relevant] and now the waiting list is long again”

There is a risk that longer processes may add little additional value while taking up more time, creating a poorer cost-benefit ratio. Striking a balance of reports that are sufficiently detailed to be useful for current and future needs, ethically robust, and yet brief and efficient enough to facilitate timely completion and quicker throughput is feasible. Developing consistent assessment processes to be used as far as possible by all psychologists doing such assessments (including those who may be contracted into the DHB for this kind of work) would make provision of this kind of service as feasible and sustainable as possible. Working with agencies who use these reports to establish clearly the information that is necessary and most useful for them would be highly advantageous as part of this process.

### **Recommendation: Assessments**

- For formal assessments undertaken regarding specific conditions (e.g., Autistic Spectrum Disorder, Intellectual Disability) particularly if to facilitate or support access to other services, an agreed efficient and consistent approach to undertaking these assessments will as far as possible be used by all Lakes DHB psychologists. The process for establishing this approach would likely involve
  - If the assessment is for use by other agencies, discussion and agreement with the agency to define the minimum reporting requirement that is fit for purpose to meet their needs.
  - Development and agreement between psychologists of a consistent and efficient approach to achieving these assessments.

This approach would include (as far as possible) use of consistent measures and, if appropriate, a templated report structure.

## Interventions

The role of psychologists in providing specialist psychology interventions was widely acknowledged. Their role in supporting others to deliver psychology interventions was also widely recognised.

### Treatment of Personality Disorders

Several participants indicated that there was considerable confusion within the service regarding the treatment of personality disorders. Several participants said there had been mixed messages about whether the service would and should be treating people with personality disorders. Some medical participants reported that polypharmacy seemed to be surprisingly and inappropriately common in treating these clients.

Darren Malone (Clinical Director for Mental Health Services) indicated that he believes that people with personality disorders should be treated within the Lakes DHB mental health services. He was keen for psychologists to take a large role in offering evidence-informed psychological therapies for these clients and through this activity to help reduce inappropriate use of medications. He and others indicated a desire to see more access to DBT for people with personality disorders.

The perception gained by the reviewer was that there is no real disagreement that people with personality disorders should be treated by the mental health services. The point of anxiety that led to disagreement was concern that the service can be overwhelmed by these clients, particularly if intervention for them is not effective and/or expeditiously organised. This would seem to be borne out by their high prevalence within the service (26% of adult MHS clients) relative to their prevalence compared with other mental health conditions. There was anxiety that treatment approaches may not always be as efficient or effective as possible at returning the person to a level of independent function where they do not require active ongoing management by the MHS. There was an additional concern that some work may actually encourage dependency on the services or therapists.

While it is hard to make generalisations about the treatment needs of a diverse and complex group of clients, one approach which may assist in addressing some of these concerns is to ensure that staff (including psychologists) who are working with people with personality disorders have in-depth and up-to-date training and knowledge in the use of clinically proven techniques for intervention with personality disorders. Approaches such as Dialectic Behaviour Therapy (DBT) and Schema Therapy have demonstrated efficacy for treatment of personality disorders and training is frequently available in New Zealand. Ensuring that psychologists (and, as appropriate, other staff) working with people with personality disorders have these skill-sets in addition to their other skill sets may assist with ensuring interventions offered are as effective and cost-effective as possible.

#### **Recommendation: Psychological Interventions for Axis II Disorders:**

- Ensure as far as possible that all relevant services have psychologists and/or other clinicians who are trained in the assessment and use of evidence-informed therapies for Axis II disorders.
  - This would include the delivery of DBT in both individual and group formats.
- These psychologists should be encouraged as appropriate to assist with upskilling other staff in the management and treatment of people with personality disorders.

## Supporting use of self-help resources

There is a proliferation of self-help resources in paper form and in the electronic media such as on the internet. Participants recognised the potential value of these, but also noted that the quality of the resources was highly variable, and some could be unhelpful or even harmful. It was suggested that psychologists have the skills to be able to identify safe and useful self-help resources and share these with other staff. These resources might be used to assist another staff member to undertake appropriate self-help or therapeutic work with the client and, if they are to be referred to a psychologist, to start work and support the client while they are on the waiting list.

Te Pou o te Whakaaro Nui ([www.tepou.co.nz](http://www.tepou.co.nz)) has recently been involved in a project to identify some on-line resources that can be used as a starting point for people with mild to moderate mental health difficulties and which may also be of considerable benefit to people who enter secondary services.

## Outcomes-Led Approach

An outcome led approach involves routine collection of outcomes data for clients and utilisation of this data to guide care and improve outcomes. The data should be used both to guide the care for the individual and to improve the operation and development of the service.

The importance of outcomes both the psychology services and the broader mental health services was discussed earlier in this document. Using this data is arguably one of the changes that could most significantly positively impact on the outcomes for clients.

### **Recommendation: Outcomes-Led Approaches**

- All psychologists utilise an outcomes-led approach to gather information about their clients' therapeutic progress and utilise this information to guide therapeutic decision making.
- The rest of the MHS consider and explore using appropriate outcomes information to guide clinical care.

## Supporting Psychological Therapy Delivered<sup>44</sup> by Non-Psychologists

A wide range of participants identified psychologists as important in supporting the delivery of psychological and talk therapies by non-psychologists working in the DHB. The role of psychologists in training up other staff in psychological concepts and techniques was discussed by participants from mental and physical health services. Representatives of the NGO sector reported that the involvement of psychologists in upskilling their staff would likely improve the quality of the services they offer and also be useful for improving the linkages between DHB and NGO mental health services. A similar role was noted in relation to primary care.

The kinds of roles that were proposed for psychologists to support this activity included:

- Training other staff in psychological approaches to assist them to undertake safe and effective therapy.
  - This could sometimes usefully be done by engaging other staff as co-therapists
  - This could also involve engaging other staff in co-leading groups.
- Supporting other staff to deliver psychological and talking therapies.
  - This might include formal or informal assistance
  -

It was suggested that to make this feasible and sustainable, it would be helpful to make it a specified component (with allocated time) of some psychologists' job role.

### **Recommendation: Supporting Psychological Therapy Delivery by Other Staff**

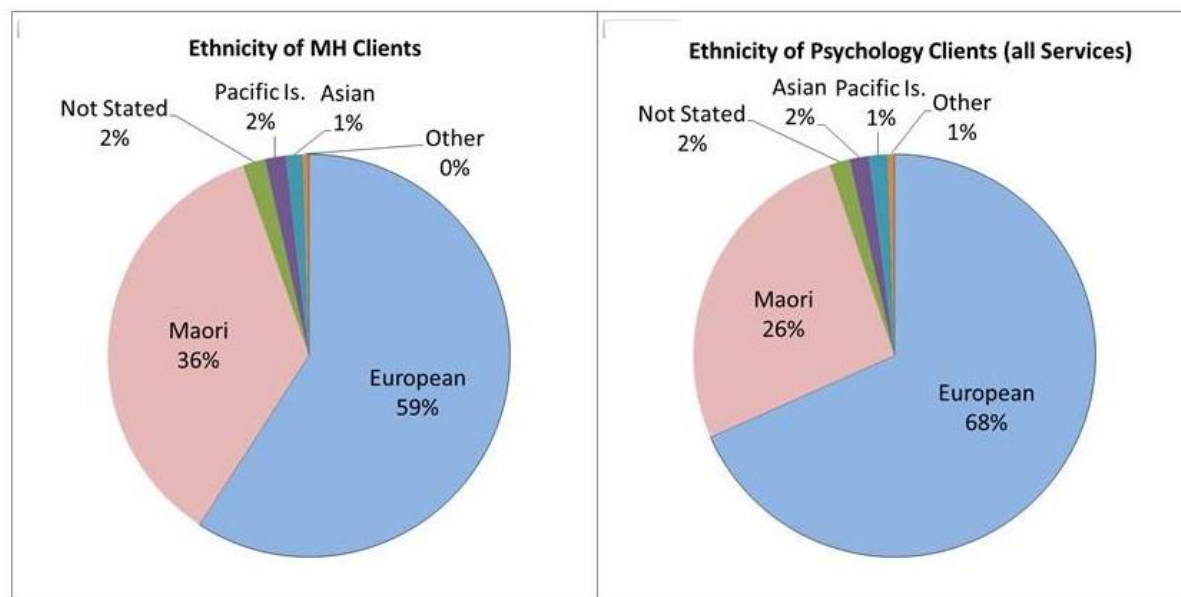
- Make supporting psychological therapy delivery by other staff a formal part of the role of all psychologists.
  - This may become a significant job component for some psychologists – may need to be recognised in the time allocation and job description.

## Cultural Factors

### Ethnicity of Clients

Concern was expressed by three participants / groups that access to psychologists may be inequitable for different ethnic groups. The following data was obtained regarding the ethnic breakdown of psychologists clients compared to all mental health clients 2012-2017.

#### Ethnicity of Lakes DHB Mental Health Clients and Psychology Clients, 2012-2017



These results show that, compared to all mental health clients, psychologists see fewer Māori clients and more European clients, with other ethnicities being approximately comparable. This may in part reflect the kinds of needs that are identified for Māori clients when they attend the service. Perhaps Māori are more often recognised as having needs related to the social determinants of health (e.g., poverty, housing, employment, etc.) which take priority over addressing psychological issues. However, it may also reflect under-referral or under-engagement with psychologists for Māori clients.

Members of the Taupo Mental Health team talked about a Marae-based psychology initiative that helped to increase the acceptance of psychology by the Māori community. This kind of approach could be extended.

Several psychologists mentioned that lack of cultural training and supervision as a constraint on successful work with Māori.

#### Recommendations: Cultural Factors

Ensure equity of access to psychological services for Māori clients of Lakes DHB mental health services. Strategies suggested by participants in this review to achieve this include:

- Update and extend cultural training regarding Māori and other cultural groups for psychologists and other staff
- Seek out opportunities for more Marae-based and similar initiatives that take psychological

services “out of the clinic” and to Māori

- Consider cultural assessment practices within the DHB services and how psychological assessment and intervention can dovetail with these to ensure psychological input is optimally contextualised regarding cultural factors.

## Psychologists in Physical Health Services

Amongst physical health services, psychologists are currently employed in paediatrics and in cancer services. A small amount of contracted time is bought in at time for some other services. As described previously, this is towards the lower end of psychological coverage for physical health services within DHBs nationally. The types of physical health services that are most frequently served by some dedicated psychology input (0.1 FTE or more) nationally are shown below, in decreasing frequency of the number of DHBs reporting involvement of psychologists in the services.

### All DHBs: Physical health services that employ psychologists - decreasing order of frequency of involvement

Area of Activity
<b>Adult Physical Health</b> Pain, Diabetes, Physical/Neuro Rehab, Respiratory, Cardiology, Consult Liaison, Renal, Oncology, Neurology, Spinal Unit, Bariatric Surgery, Breast Services, Burns, Oncology, Eating Disorders, General Surgery, Gynaecology, Haematology, Intensive Care Unit, Older Adult Services, Memory Clinic, Otolaryngology, Smoking cessation
<b>Child Physical Health</b> General Paediatrics, Consult Liaison, Child Development, Oncology Endocrinology, Obesity,

**Source:** Stewart, Fontanilla, Morunga, & McGuigan (2016)

The pattern varies widely nationally as to what services are covered by psychologists, and have typically mostly been driven by the interest of local clinical leaders, although service guidelines increasingly specify the presence of a psychologist within physical health teams, such as is the case with for cardiology and cancer services (New Zealand Guidelines Group, 2002; Ministry of Health, 2014). Large DHBs tend to have psychological coverage of more physical health services than do small DHBs, but the establishment of positions where an experienced psychologist serves the needs of a several physical health services, similar to a psychiatric liaison model, can provide effective coverage for a range of services.

### **Recommendation: Physical Health Services**

An experienced psychologist could be engaged to provide part-time support for several physical health services that do not have an embedded psychologist, similar to the liaison psychiatry model. This can be a good way of establishing the value and utilisation of psychology in physical health.

## Organisational Function

### Role of Psychologists within the MDT and Clinical Decision Making

Psychologists were identified as valued and respected members of the multidisciplinary team. A comment from one participant was:

“We have a fantastic group of psychologists – variations in background, modalities.. a passionate committed group of people.. lots of experience and seniority... generally well-accepted and well-regarded... get good outcomes and have a good reputation in the community”

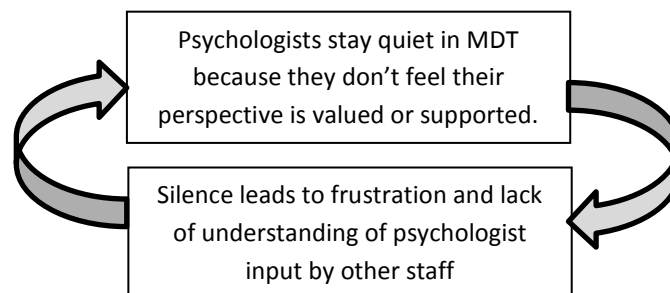
### Participation in MDT Discussions

However, several services and individual participants indicated that there were some difficulties that emerged with some psychologists that it would be helpful to address. Amongst these were ensuring that the psychologists role within the MDT is functional and effective.

One difficulty participants described was that in some services the psychologists seemed to be often absent or non-contributory in MDT discussions and clinical decision making processes. In response Psychologists similarly described feeling that many MDT meetings had a strong biomedical/crisis focus and that their input was not particularly welcome. However, another psychologist said

“If not much is said by psychologists the attribution is often that they do not do much. It would be hoped/expected that a psychologist (as any with any other staff member) should be able to give a brief concise account of what they are doing with a person if they are working with them in a planful manner.”

This pattern suggests a “vicious cycle” as pictured below.



### Recommendation: Psychologist Participation in MDT Discussions

- If an MDT discussion is being held about a client that a psychologist is working with, it become a standard and expected component of that discussion that the psychologist will briefly describe their perspective on the person’s difficulties (formulation), a brief description of the therapy process they are involved in, and any recommendations for action by other staff.

Implementing this recommendation should have the effect of providing an entry into the MDT conversation and ensure that the psychologists’ voice is heard. The same kind of process could be applied to other staff whom also work intensively with the client. The psychologist’s summary need be a minute or two long, so does not need to greatly extend the presentation of the client, and may provide considerable benefits outweighing the cost of time.

## **Treatment Goals Not Clear or at Odds with Other MDT Members**

Several participants described situations in which the treatment goals established by a psychologist working with a client seemed unclear or were different from the goals that the MDT had requested assistance with. Some psychiatrists expressed frustration that psychologists feel the need to “do another assessment” when they start working with a client, as the psychiatrists felt that the assessment already done should be sufficient.

The psychological assessment is substantially different from the psychiatric assessment and is necessary for a psychologist to deliver effective therapy, particularly “Level 3” therapy as described previously. For example, for a psychologist working from a cognitive behavioural perspective, the psychiatric assessment will not provide sufficient detail about the cognitions involved. The psychiatric assessment will also not necessarily provide the depth of contextual information which is necessary to guide successful therapy.

As a result of their assessment, the psychologist may see the client’s needs as being different from how it has appeared to others. Having the potential for change or refinement of therapeutic goals is an important part of the reason for having psychologists, with their different perspective and skill set, involved. It would seem that the key issue here is less about assessment than about communication and negotiation between the psychologist and the team. It is hoped and expected that, if the psychologist is routinely discussing their formulation and activity when the client is presented in meetings, this should allow opportunities for ensuring that the goals of the psychologist and the team are sufficiently aligned and in the client’s best interest,

## **Waiting List Management**

### **Psychology Waiting List Management**

Managers, other clinical staff, and some psychologists expressed that the current arrangements for Psychology Waitlist management create difficulties in some services, due to the Waitlist not being visible by others, a lack of transparency with the process, and the lack of input of other staff into prioritisation and movement of people through the waitlist. This was typically expressed as it being difficult to know if or where a client was on the waiting list and when they might be likely to be seen. It also created potential risks of people who were believed by staff to be on the list not actually being so.

The suggestion was made from several quarters that having the Psychologist’s Waitlist visible to (though not changeable by) other staff members would assist other staff and their clients to know more accurately their situation regarding psychological input. While other priorities may emerge, some degree of visibility would be valuable.

The suggestion was also made from several quarters that it would be useful to have at least one senior non-psychologist team member involved in the discussions about the waitlist, to be able to provide the broader MDT’s perspective on the cases.

It is the reviewer’s opinion that these suggestions have considerable merit and no significant downside. They are unlikely to substantially decrease the length of the Psychologists Waitlist but may help



with providing surety to staff and clients and provide an opportunity for ensuring optimal alignment between the psychologists efforts and the MDT's goals and needs for the client.

**Recommendation: Changes to the Psychology Waitlist Processes:**

- Routine involvement of a non-psychologist representative of the MDT in discussions of the Psychologists' waitlist (e.g., discussions about who is on the waiting list, prioritisation, allocation, goals, etc. ) to assist with ensuring that the goals align with the MDT goals.
- The Psychology Waitlist be stored in a form that is visible for staff of the relevant team (e.g., on a shared drive) so staff are able to check who is and is not on the list. Consideration be given to setting up a system to indicate the approximate time until when a client is likely to be seen.

## Time and Workload Management

### Expectations Regarding Amount of Client Attributable Work Undertaken

Several participants in the review including managers, other clinical staff, NGO staff, and some psychologists expressed the belief that some psychologists tend to see relatively few clients per day, and that this, along with long treatment durations, led to low access rates. The former Professional Advisor for Psychology said that he did not believe that psychologists on average spent less time in contact with clients than other staff, believing that their contact time was probably higher than most staff. Contact data that was seen indicated highly variable contact rates between different psychologists.

Psychological sessions are typically around an hour long (with the exception of first assessments and formal assessment sessions such as ASD assessments, which are usually longer). The DHB Psychology Leadership Group has for many years wrestled with the issue of how to define reasonable contact rates, and the point of agreement has tended to be that around 50% face to face contact time is sustainable for a psychologist whose roles is primarily therapy. In some PHO settings, and expectation of 5 contact hours per day has been set. This has been sustainable in that setting but the DHB setting is likely to involve more liaison and similar activities (with the MDT and external agencies in relation to clients) which makes an average of 5 contact hours probably unrealistic.

The psychologists group talked about the importance of factoring in other patient-attributable time if setting expectations. This becomes more difficult to quantify but may be of particular importance for positions which involve a particularly large amount of non-contact but directly patient-attributable time, such as when writing up formal assessment reports (such as cognitive assessments or ASD assessments) is a large part of the job role. In situations where this applies an agreed way of factoring this in to contact hours may be necessary. For example, if a formal ASD assessment was completed 4 hours of patient attributable time may be added to the contact hour total in addition to the actual contact hours.

General patient-attributable time such as writing of clinical notes can best be regarded as part of what happens in the 50% of non-contact time.

One psychologist reported that they keep their contact numbers low for fear of being swamped and risking burn-out as a result. Tools to assist with caseload management can be helpful with balancing

caseload to manage this difficulty. A caseload tool was developed by the former Psychology Advisor. This tool classified cases into 16 classes on the basis of two dimensions as below:

		Projected duration of treatment/assessment			
		>30 sessions	30-10 sessions	5-10 sessions	<5 sessions
Projected frequency of contact	Twice weekly				
	Weekly				
	Fortnightly				
	Monthly				

Each case was assigned to one class on the basis of this tool. If this tool is kept current, the total projected weekly caseload can be calculated and the distribution of shorter vs longer term cases can be observed.

#### **Recommendation: Time and Workload Management**

- All psychologists should aim to achieve an objective of 50% face-face contact time.
  - For most this may translate to achieving an average of four face-face contacts a day.
  - For psychologists with a large component of non-therapy oriented work (e.g., those frequently undertaking cognitive or ASD assessments), non-face-to-face but directly client-attributable time may be added as contact time at an agreed-on rate.
- To make the above feasible, consideration should be given to making other MDT and service processes as time-efficient as possible.
- Psychologists, particularly any who are concerned about their caseload becoming overwhelming, may wish to use the caseload tool developed by the former Psychology Advisor to assist them to evaluate and manage their caseload.

## Simplified and Efficient Organisational Processes

As described earlier, one important strategy for optimising access to psychologists is to ensure that organisational processes are as efficient as possible and require the minimum amount of time to undertake as possible. Making organisational and clinical processes as simple, brief, and time-efficient frees up time that could then be used for more client contact and client-attributable work. Several participants and groups commented that many processes are not efficient and make it difficult for staff to work effectively. Some examples of this that were given included:

- Lengthy MDT processes that have minimal effectiveness in changing client management
- Documentation that is longer than is useful for it to be. The comprehensive assessment form and risk assessment tools were cited as examples of this.
- Some people also described the systems for keeping contact statistics as time-consuming.
- Lack of text reminders for clients meaning DNA rates are higher than need to be
- Limited availability / Unavailability of resources such as therapy rooms, cars, computers, which at times decrease ability to meet with clients or complete other tasks efficiently

Many teams report that their MDT processes are time-consuming and make limited contribution to client care and wellbeing. Many clinicians report that large MDTs mean that there is little scope for most people to contribute as they don't know the client and so often are more spectators than active participants. Rearrangement of the large MDTs into smaller (still multidisciplinary) groups who

discuss the clients with whom they have in common may offer a more time-efficient and effective way of organising MDTs.

For psychologists specifically, more efficient documentation processes might include using structured clinical notes formats<sup>5</sup> and, as discussed under formatting, negotiated briefer and standardised report formats<sup>6</sup>

For the whole of the service, more efficient documentation processes might include reducing the size and complexity of the comprehensive assessment form for mental health.

An electronic clinical notes system is shortly to be introduced to Lakes DHB. Although some of the forms are being rolled out for the Midland region. This change may provide an excellent opportunity for simplifying forms and increasing the efficiency of processes. For instance, if contact data can be extracted from the clinical notes there is no need for clinicians to complete a separate record of it.

## Keyworking

### Keyworking by Psychologists

Some manager participants regarded psychologists' reluctance to keyworker a significant limitation. Other managers and most other participants expressed the opinion that, as a rule, psychologists performing keyworker roles was not an effective use of psychologists' time. Undertaking general keyworking was seen as having a high opportunity cost in that time spent undertaking these functions was not then available for psychology-specific tasks. Another difficulty that was identified was that some keyworker functions such as managing crisis situations was incompatible with maintaining a schedule of pre-arranged appointments.

The possible exception to this general rule noted by some participants was that if the psychologist is the only clinician who is regularly involved with the client, then they will know the client best and will be able to carry out some keyworker functions (for example, completion of the HoNOS measures). In these situations it may make sense to them to effectively function as keyworker. To address this situation, some other DHBs have adopted the following three criteria regarding psychologist keyworking:

1. There is a compelling clinical reason for them to be working with the client (not just "the next cab off the rank").
2. The psychologist is the only or main person working with the client at the time,
3. If a situation that requires urgent attention but the psychologist is engaged in other activities (e.g., seeing scheduled clients) that precludes them from attending to the person's needs, other staff will be prepared to address the issue.

---

<sup>5</sup> E.g., The SPIAP (Situation, Presentation, Information, Activity, and Plan) note format for ongoing clinical notes provides a straightforward structure for notes that many people find reduces the time taken to write up notes substantially.

<sup>6</sup> E.g., In many cases a much shorter format report will provide all of the necessary information without requiring anything like the same investment in time.

The issue of metabolic monitoring (of clients taking medication that may have the side-effect of causing liver damage or similar) was raised by psychologist and other participants, with several psychologists being reluctant to undertake it due to seeing it as outside their scope.

**Recommendation: Keyworking**

- Psychologists should not in general be involved as keyworkers for clients. The exception may be if they are effectively the only/main staff member working with the client, and the conditions that are discussed above apply.

## Career Pathway for Psychologists

Psychologists noted that there is a very flat career pathway with the only career progression step for advancement at present being the Psychology Advisor position. At the moment within Lakes DHB there is no official recognition of seniority. The APEX MECA under which psychologists are employed has provision for people to be designated as Senior Psychologists and Consultant Psychologists, and contains descriptions of the competencies associated with these levels. Some other DHBs have well-developed mechanisms assessing for these titles.

These titles are currently honorific and not linked to salary advancement, although some DHBs have marked obtaining them with progression of a step (or in a few cases two steps) on the MECA scale. Despite not necessarily having a monetary reward associated with the title, the experience of other DHBs is that they do have meaning to the psychologists and provide a mechanism for signalling career advancement and contribution in well-functioning employees. They are also organisationally useful in terms of helping to identify people who have shown advanced skills and often leadership potential.

It was also noted that psychologists often have a range of skills related to research, service development and evaluation, and leadership that are rarely formally engaged and utilised to the benefit of the organisation. Use of these skills an opportunity to improve services and also increase job satisfaction, and potentially retention, of psychologists. Significantly engaging psychologists in these roles without compromising psychological service delivery may require some back-filling of positions, but is highly likely to be worthwhile.

**Recommendation: Career Pathway**

- Establish the use of the Senior and Consultant Psychologist terms as defined in the APEX MECA. Mechanisms for evaluating suitability for these scales are well-developed in several DHBs and could be obtained and utilised by Lakes DHB.
- Utilise the non-clinical skills that many psychologists bring, related to research, training, service design and evaluation, and leadership and consider creating opportunities for them to formally contribute these skills to the benefit of the organisation and its clients.

## External Psychologists

Some psychological work within Lakes DHB is done by private psychologists who are contracted in to provide additional services. These psychologists are often used to undertake specific assessments ( e.g., cognitive assessments, ASD assessments ) or for particular discrete pieces of intervention work (e.g., a specified number of sessions). In a few situations where a suitably trained psychologist has not been able to be recruited to a service, an external psychologist has been contracted for a specific FTE to fill the place.

There are a variety of advantages of having external psychologists, including:

- It is a way of bringing in particular specialised skills and can fill gaps which cannot be recruited to.
- As they are not involved in a lot of the extraneous activities that employees are required to be involved in, they can focus on assessment and therapy work more, This has in some instances been helpful at times for reducing waiting lists and therefore can relieve strain on other psychologists and improve equity of access.
- Encourages a targeted assessment and therapy approach involving limited number of sessions –
  - This works particularly well for cognitive and neuropsychological assessments and ASD (ADOS) assessments. Undertaking such assessment as an internal psychologist can be difficult due to competing demands for time, and can be a lengthy process.

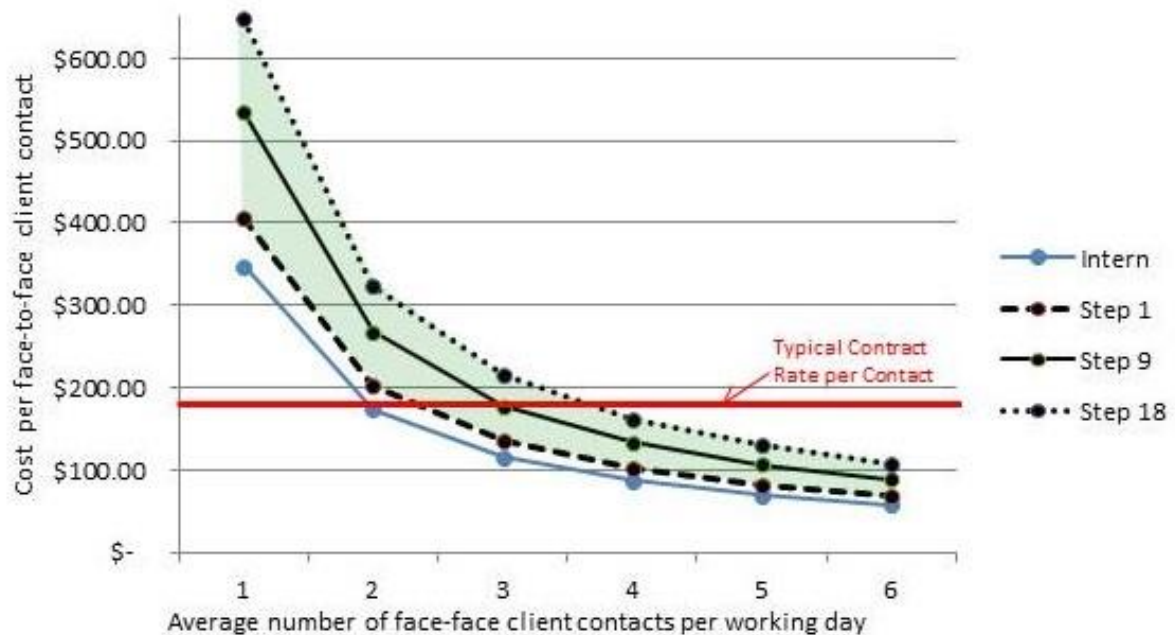
Some disadvantages were also noted by participants:

- Short packages of care can lead to inadequate or incomplete assessments or poor therapeutic outcomes.
- Work outside of the therapeutic session greater for secondary care clients – difficult to undertake this / pay for this on contract basis – likely to drop off
- Them not being “part of the team” and are not available most of the time may prevent other contributions that psychologists usefully make.
  - Prevents opportunity for psychologists to train interns or other staff – may have negative impact on longer term recruitment, responsiveness of whole team to psychological needs of clients.
  - Decreases opportunity for psychologists to offer formal or informal support of the activities of other staff (e.g., consulting on talking therapies)
  - Service misses out on ready availability of the other skills that psychologists bring – paid for particular tasks so not able to give time to additional assistance
  - Decreases sense of integration of psychology into the team
  - Decreases “ownership” of psychologists and psychology by other team members
- Can push the service towards medical model – driven by what is requested rather than what psychological assessment indicates as what is needed.
- May give some insecurity of continuity of position for the service – a contracted position may more easily disappear at the end of the contract than a permanent position.

Almost all participants were supportive of psychologists primarily being employed by the organisation, but utilising external skills when there was a particular reason to do so. Several participants expressed the belief that the major driver of discussion about having external psychology input has been to try and improve access to psychological services and to improve the effectiveness with which psychology skills are provided in the DHB

There has been discussion about the cost of providing psychological services by contracting in psychologists compared with the cost of these services being provided by DHB employees. To explore the relative cost of these two approaches a cost model was developed that compared cost per client contact provided by DHB employees with the per-session cost for contracted external psychologists.<sup>7</sup> The results of this modelling are shown below.

## Average Cost Per Face-to-Face Client Contact for DHB Employed Psychologists Compared with a Contracted Psychologist Rate



This modelling shows that a psychologist employee who has face-to-face contact with 3-4 or more clients a day has a lower cost per session than a contracted psychologist, irrespective of their position on the APEX scale. However, if the psychologist is seeing less than 3 clients per day, the cost per contact rises sharply.

This modelling does not factor in the other benefits that accrue from having psychologists employed in the service and able to participate in other clinical and service enhancement activities as discussed elsewhere. It also does not factor in the benefits that may accrue from being able to “buy in” specialist skills sets not possessed by DHB staff or other advantageous factors that may relate to external psychologists. However, this approach nevertheless does provide a useful way of considering different models of service delivery.

<sup>7</sup> Further detail on the cost model is available on request. In brief, the model works out a cost per contact per working day using the true cost of employment calculated (using MBIE processes) from the APEX MECA salary scales, and calculating the number of working days per year excluding annual leave, sick leave, statutory holidays, and training days. Contract rate data was provided by the GM Mental Health.

### **Recommendation: External Psychologists**

- There is a place for careful use of external (contracted) psychologists in the provision of psychological services within Lakes DHB, although the number of additional benefits that accrue from having internal psychologists who can support other staff and service functions in a way that external psychologists are unlikely to be able to do suggests that internal psychologists should remain the main approach.
- A hybrid model which allows for primarily internal psychologists and careful use of external psychological for undertaking specific tasks is recommended. The kinds of tasks the external psychologists may particularly (but not exclusively) focused on include.
  - Specialist Assessments (ID, ASD, Somatoform disorders) where there is not the internal resources of skill and time to do these resources
  - Brief therapeutic interventions (specialist areas and to reduce waiting lists e.g. panic disorder, adjustment disorders)

## **Psychology Advisor Position**

The Psychology Advisor position has been a 0.3FTE role that has been in existence for approximately 20 years. It was indicated that up until approximately 14 years ago it was a 0.5FTE position. It has been held by George Furstenburg for approximately the last 14 years . He has recently been replaced by Jacqui Gregory. The previous holder of this position, Steve Osborne, left to become the CEO and Registrar for the New Zealand Psychologist’s Board.

The majority of feedback from participants about the Psychology Advisor role was very positive. The role was seen as providing considerable value to the development of psychological services, the maintenance of standards of practice, and supporting the wellbeing of psychologists. It was also noted that the recent Psychology Advisor had taken a broad sectoral view and had worked closely with primary care, NGOs, and Planning and Funding to ensure a more cross-system perspective to the provision of psychological services.

Project work undertaken by the recent Psychology Advisor, such as his work on implementing the tools for outcomes-led service provision, and his establishment of a caseload tool was acknowledged by participants and is well-respected for its innovativeness nationally.

The breadth of the role was noted to sometimes lead to conflicts of interest, such as supporting an individual psychologist while attempting to improve psychological services. However, these can usually be managed as must many other dilemmas within healthcare and management.

Three particular areas of difficulty with the role were identified by participants. These are outlined below.

### **Time Allocation**

The 0.3FTE time allocation was seen by many participants, psychologists and non-psychologists, as insufficient to adequately address the wide scope of the job, with its strategic, professional standards, and “pastoral care” components. Additional time for the role would be valuable, perhaps

in particular to increase the ability to lead initiatives that encourage innovative and improved practice.

One possibility is to increase the Psychology Advisor's time. Another possibility is to appoint one or two Associate Psychology Advisors who have a component of FTE also focused on leadership. One possible division of labour between these roles is that the Associate Psychology Advisors may particularly focus on the professional standards and pastoral care aspects of the role, freeing the Psychology Advisor to focus more on the strategic and systemic aspects of the role. However, all would be able to contribute to any parts of the roles as was appropriate and useful.

Ensuring that there is a service-type and geographical spread across the two-three roles would also assist to provide more accessibility of professional leadership for all psychologists, and facilitate a broader range of perspectives involved in leadership.

### Ability to Influence the Organisation

Several participants noted that the ability of the Psychology Advisor to influence decisions appeared to be limited. Until recently the Psychology Advisor was not part of the Senior Management Group and consequently was not present to be a voice when many decisions regarding psychology or psychological aspects of the broader service were discussed. This has changed in the last few months, with the Psychology Advisor now a member of the Senior Management Group for mental health.

The possibility of the Psychology Advisor role spanning the whole sector, including primary care and the NGO sector as well as the DHB was raised by some participants. This was seen to be useful to help develop "seamless" and integrated cross-sectoral function. Involving the Psychology Advisor at multiple levels of planning was also seen as valuable, due to the psychosocial focus they can bring.

It was also suggested that re-constituting a regular meeting that used to be held between the professional leaders of the different disciplines within mental health would be useful to help coordinate activity. It was thought this group could focus on defining strengths of each of the disciplines with a view to developing approaches and team function that allow "playing to the strengths" of all disciplines.

### Ability to Influence Psychologist's Practice

Several participants, including some psychologists indicated that it seemed the Psychology Advisor had relatively little ability to influence psychologists when difficulties with practice or similar issues arose. As one psychologist said, the Professional Advisor needs "More "teeth" to be able to influence services and to address situation if psychologists have performance issues." Several managers mentioned that it was often difficult for them to deal with issues related to psychologists, and they felt the help of a Psychology Advisor who was empowered to offer assistance would be helpful. The psychologists noted that they often heard about difficulties indirectly ("third hand" rather than having the difficulties addressed with them directly, and said they would prefer a more transparent and direct approach. The Psychology Advisor could be effective at assisting this.



The psychologists also thought it would be helpful to have a six-monthly meeting with the General Manager and Clinical Director at which any such issues that were occurring could be addressed.

**Recommendations: Psychology Advisor Role**

- Increase FTE associated with Psychology Leadership either by Increasing the FTE for the Psychology Advisor role or by establishing one or two Associate Psychology Advisor roles to assist with performing the various functions of this role.
- Maintain the Psychology Advisor as part of the Senior Management Group and ensure that they are involved in planning and service development in as many levels of the DHB and sector as is feasible.
- Review and perhaps strengthen the mandate by with the Psychology Advisor and other Professional Advisors can influence professional practice issues, either by facilitating changes in psychological systems and practice, or at the individual clinician level.
- Some of this work would be undertaken in collaboration with the service managers and the processes for how this is undertaken may need to be addressed. For example, in concert with managers, Psychology advisor has a role in ensuring that reasonable expectations for psychologists, such as those described above, are achieved.

## Future Directions for the Service

### Suggested Areas for Expansion of Service and Role

#### Areas in Which Service Expansion Was Most Requested

If the provision of psychological services within Lakes DHB could be expanded due to increased staff numbers or increased time availability (e.g., due to decreased time spent on non-specialist tasks), then the following were identified as areas which participants would particularly like to see more psychological input occurring.

Activity	Comments
<p><b>Assessment (Mental Health )</b>  <u>Specialist psychological assessments, e.g.,</u></p> <ul style="list-style-type: none"> <li>• Personality assessments,</li> <li>• IQ assessments,</li> <li>• Somatisation disorder</li> <li>• Autistic Spectrum Disorder</li> </ul>	<ul style="list-style-type: none"> <li>• These assessments are often critical for diagnostic purposes, to ensure that appropriate services are provided, or are necessary for clients to be admitted by other services (e.g., NGOs).</li> <li>• Some were formerly undertaken by other agencies (e.g., Education) but are no longer undertake, or they no longer have capacity. In some situations this has left mental health as the “provider of last resort” for services that may not be in-contract.</li> <li>• These activities currently occur but are time-consuming and it is frequently difficult for them to be fitted into busy workloads. This often leads to long delays in completion.</li> <li>• Ensuring that specified time for these assessments is allotted and recognised in statistics would be helpful.</li> </ul>
<p><b>Intervention (Mental Health)</b></p> <p>Specific brief individual therapies</p>	

<ul style="list-style-type: none"> <li>• CBT</li> <li>• Mindfulness-Based CBT</li> <li>• DBT</li> <li>• EMDR</li> <li>• Individual therapies for addictions</li> <li>• Psychological therapy (e.g., CBT) for people with psychosis/schizophrenia</li> <li>• Brief therapy as part of broader early intervention strategies for psychosis and other conditions</li> </ul> <p>Systemic/Family therapies</p> <ul style="list-style-type: none"> <li>• Systemic therapy approaches that address the broader system as well as the individual.</li> <li>• Family therapy approaches – working with whole family/whanau</li> </ul> <p>Group Therapy</p> <ul style="list-style-type: none"> <li>• Mindfulness groups</li> <li>• Anxiety management groups</li> <li>• Dealing with Distress / Emotional Regulation groups</li> <li>• DBT programme groups</li> <li>• Addictions Group</li> </ul>	<ul style="list-style-type: none"> <li>• Briefer interventions were seen by many participants as a strategy to improve service efficiency and access, a variety of brief individual therapy approaches were suggested.</li> <li>• Ensuring psychologists are universally able to utilise brief therapy approaches in addition to any other approaches they may be trained in was seen as an important training priority.</li> </ul> <p>• Systemic approaches to therapy were seen as particularly important given the elevated levels of deprivation and related difficulties for the Lakes DHB population.</p> <ul style="list-style-type: none"> <li>• Use of family therapy was seen as an important strategy for bringing sustainable change across child services and other services.</li> </ul> <p>• Greater use of group therapy to achieve better access and outcomes was seen as an important potential area for development of services.</p> <ul style="list-style-type: none"> <li>• Psychologists may have an important role in developing and leading groups but also supporting other staff to learn how to lead the groups and utilise the techniques.</li> <li>• Ensuring that time for developing and running groups is allotted and recognised in statistics would be helpful.</li> </ul>
<p><b>Psychology in Physical Health Services</b></p> <ul style="list-style-type: none"> <li>• Increase psychology input in physical health services. Psychologists attached to specific services: Top priorities mentioned: <ul style="list-style-type: none"> <li>○ Cardiology</li> <li>○ Diabetes</li> <li>○ Child oncology</li> <li>○ Palliative care</li> <li>○ Bariatric surgery</li> </ul> </li> <li>• Liaison psychology / Behavioural medicine service to cover areas without embedded psychological input.</li> <li>• Easier access to psychological assessments</li> <li>• Staff training</li> </ul>	<ul style="list-style-type: none"> <li>• Many physical health conditions have a significant psychological component which may: <ul style="list-style-type: none"> <li>○ Have a causal role in the occurrence of condition (e.g., smoking, suicidal behaviour)</li> <li>○ Adversely affect coping and functional recovery</li> <li>○ Adversely impact self-management or ability to undertake treatment effectively</li> <li>○ Cause psychological and emotional difficulties that adversely affect quality of life.</li> </ul> Addressing these issues can be important for improving physical health outcomes, mental health outcomes, and minimising unhelpful use of physical health resources </li> <li>• An experienced psychologist could be engaged to provide part-time support for several services that do not have an embedded psychologist, similar to the liaison psychiatry model. This can be a good way of establishing the value and utilisation of psychology in physical health.</li> <li>• It was reported by SMOs from services with psychologists in physical health that there is scope for much more input.</li> <li>• For some services, easier access to cognitive and neuropsychological assessment was seen as important to improve service outcomes.</li> <li>• Training staff in understanding and addressing the psychosocial aspects of patient's conditions etc was seen</li> </ul>

<p><b>Primary Mental Health Care</b></p> <ul style="list-style-type: none"> <li>• More psychology time in primary care settings.</li> <li>• More flexibility for somewhat extended interventions for primary mental health care clients.</li> <li>• Allow “booster sessions” some weeks/months after therapy completion.</li> <li>• Increase psychologist time in primary care but not at the expense of time available in secondary care.</li> </ul>	<p>as an important role for the psychologists.</p> <ul style="list-style-type: none"> <li>• Several participants described the value added by having psychologists undertaking brief interventions in primary care settings.</li> <li>• A gap between the threshold for entry to secondary service and what can be dealt with by existing “packages of care” was noted. Flexibility for a small extensions of session numbers may assist to reduce this gap and potentially prevent the client requiring secondary care later when less well.</li> <li>• The effect of therapy may be increased if a “booster session” is scheduled for some time after therapy completion. This can consolidate improvement and prevent relapse. This is particularly the case in primary care but is also useful for secondary care (even if the client has been formally discharged)</li> <li>• Psychologist time in primary care may prevent some people from needing secondary services but will not replace the need or potential of psychological services in secondary care.</li> </ul>
<p><b>Supporting the Development of Stepped Care and Other Staff Undertaking Therapy</b></p> <ul style="list-style-type: none"> <li>• Psychologists more involved in supporting stepped care therapy delivery by other staff.</li> <li>• Training staff to become competent with assessment and psychological interventions</li> <li>• Support and involve other staff in delivering/co-delivering therapy</li> <li>• Acting as a therapeutic consultant supporting other staff to undertake safe therapy</li> <li>• Involve and support other staff in learning to lead groups</li> </ul>	<ul style="list-style-type: none"> <li>• Some non-psychologists who were delivering therapy in Lakes DHB reported that they felt it would be unsafe from them to practice therapy without the support of a psychologist.</li> <li>• One non-psychologist participant said “Have supporting other staff to be able to offer safe and effective talking therapies a standard, valued, and recognised part of the psychologists’ job description”.</li> <li>• It was noted that this may include upskilling workers in NGOs, which could strengthen NGO operation and strengthen links between the NGO and secondary services.</li> </ul>
<p><b>Service Development and Leadership</b></p> <ul style="list-style-type: none"> <li>• Input into service planning and pathway development</li> <li>• More utilisation of psychologists’ research skills more involvement in this by psychologists and more support for it from the organisation</li> </ul>	<ul style="list-style-type: none"> <li>• Psychologists often have a useful perspective and skills to contribute to service development but several participants noted that these skills are rarely used.</li> <li>• Many psychologists have strong skills in research and service evaluation which are seldom currently used.</li> </ul>
<p><b>Triage Role</b></p> <ul style="list-style-type: none"> <li>• Assisting with assessment and determining the appropriate level of care for primary, secondary, or NGO services as part of a more integrated and seamless service.</li> </ul>	<ul style="list-style-type: none"> <li>• Psychologists were identified as having a potentially useful role in terms of assessing needs (triage) and directing to appropriate level of care.</li> </ul>

**Managing Staff Stress/Trauma**

- Helping with staff stress/trauma
  - Active involvement with “psychological first aid” processes after stressful events for staff

- Psychologists were seen as having a potential role to assist when traumatic events happened for staff in the course of their work. This would be

Thus, a range of areas have been suggested by participants for the potential expansion of psychological services if additional availability of psychologist input was achieved (either by increasing psychologist resource or enhancing the effectiveness of time utilisation).

**Recommendation: Future Directions for Psychological Services at Lakes DHB**

- Consideration be given to increasing the psychologist resource available in the Lakes DHB mental health and physical health services.
  - The areas for expansion could be prioritised, and business cases built for expansion in those areas adjudged as most likely to contribute substantial gains for the population and to overall service effectiveness and cost-effectiveness.

## Summary of Recommendations

### Resourcing

#### Psychologist Staff Numbers

1. Consideration could be given to increasing the number of psychologists in existing services and providing psychologist input into a broader range of services. Areas which are seen as priorities for future input from psychologists are discussed later in this report.
2. Establishing intern positions is often a valuable recruitment strategy as they are generally significantly productive from early in the internship, add to the total available workforce, and frequently choose to stay in the organisation and area in which they train.<sup>8</sup>
3. Ensure that vacant positions are advertised and filled as quickly as possible.

#### Physical Resources

4. Psychologists are able to work better if they have offices and a stable situation in which to see clients. For some complex clients “keeping the frame of therapy stable” (ie always meeting in the same room) is important.
5. Psychologists benefit from quiet spaces to do complex thinking and tasks in. Relatively private office space is preferred, but in the absence of this “quiet room@ space is important.

### Model of Care

#### Model of Care

6. That all psychologists develop amongst their skill sets, and become comfortable in using, forms of therapy that are brief, change-oriented, and which include components of strategy development.
  - These may not at all be the only skill sets they use, but are within their range of skills.
  - Psychologists whose foundational practice models tend to be longer-term therapies may wish to explore the use of brief approaches closely related to their foundational model.
7. An organisational model of care involving primarily psychologists embedded within teams and with some judicious use of external psychologists, be maintained. This is broadly in line with current operation. It is expected that the difficulties that proposed changes in this model were intended to address will be addressed by other recommendations made in this document.

### Psychology Practice Issues

#### Addressing Length of Care Issues

8. All psychologists (and other staff) utilise a regular outcomes measurement tool to evaluate progress in therapy. This may be session-by session measurement or less frequent, but should be at least every 5 sessions.
9. At regular intervals (e.g., every 10 sessions) these outcomes are considered with a small group of relevant MDT colleagues. If the client is not showing appreciable change, alternatives are considered, such as:
  - A further block of therapy sessions may be instituted.

<sup>8</sup> A study by one DHB showed that, over an nine year period, 79% of interns who were considered for employment were employed by the DHB for part or all of the following five years. In several of the remaining cases, a position in their area of specialty was not available.

- Assistance of a different kind (e.g., social work assistance with some social determinants of ill-health) that may be more beneficial at this stage may be initiated.

Less intensive supportive assistance, possibly involving consolidation of some aspects of therapy may be implemented by another staff member as part of an ongoing relationship. The psychologist would ideally be available to support the keyworker or other therapist to maintain this.

### **Assessments**

10. For formal assessments undertaken regarding specific conditions (e.g., Autistic Spectrum Disorder, Intellectual Disability) particularly if to facilitate or support access to other services, an agreed efficient and consistent approach to undertaking these assessments will as far as possible be used by all Lakes DHB psychologists. The process for establishing this approach would likely involve

- If the assessment is for use by other agencies, discussion and agreement with the agency to define the minimum reporting requirement that is fit for purpose to meet their needs.
- Development and agreement between psychologists of a consistent and efficient approach to achieving these assessments.

This approach would include (as far as possible) use of consistent measures and, if appropriate, a templated report structure.

### **Psychological Interventions for Axis II Disorders:**

11. Ensure as far as possible that all relevant services have psychologists and/or other clinicians who are trained in the assessment and use of evidence-informed therapies for Axis II disorders.

- This would include the delivery of DBT in both individual and group formats.
- These psychologists should be encouraged as appropriate to assist with upskilling other staff in the management and treatment of people with personality disorders.

### **Outcomes-Led Approaches**

12. All psychologists utilise an outcomes-led approach to gather information about their clients' therapeutic progress and utilise this information to guide therapeutic decision making.

13. The rest of the MHS consider and explore using appropriate outcomes information to guide clinical care.

### **Cultural Factors**

Ensure equity of access to psychological services for Māori clients of Lakes DHB mental health services. Strategies suggested by participants in this review to achieve this include:

14. Update and extend cultural training regarding Māori and other cultural groups for psychologists and other staff
15. Seek out opportunities for more Marae-based and similar initiatives that take psychological services "out of the clinic" and to Māori
16. Consider cultural assessment practices within the DHB services and how psychological assessment and intervention can dovetail with these to ensure psychological input is optimally contextualised regarding cultural factors.

## **Supporting Psychological Service Delivery by Other Staff**

### **Supporting Psychological Therapy Delivery by Other Staff**

17. Make supporting psychological therapy delivery by other staff a formal part of the role of all psychologists.
18. This may become a significant job component for some psychologists – may need to be recognised in the time allocation and job description.

## **Psychologist Participation in Team and Organisational Processes**

### **Psychologist Participation in MDT Discussions**

19. If an MDT discussion is being held about a client that a psychologist is working with, it become a standard and expected component of that discussion that the psychologist will briefly describe their perspective on the person’s difficulties (formulation), a brief description of the therapy process they are involved in, and any recommendations for action by other staff.

### **Changes to the Psychology Waitlist Processes:**

20. Routine involvement of a non-psychologist representative of the MDT in discussions of the Psychologists’ waitlist (e.g., discussions about who is on the waiting list, prioritisation, allocation, goals, etc. ) to assist with ensuring that the goals align with the MDT goals.
21. The Psychology Waitlist be stored in a form that is visible for staff of the relevant team (e.g., on a shared drive) so staff are able to check who is and is not on the list. Consideration be given to setting up a system to indicate the approximate time until when a client is likely to be seen.

### **Time and Workload Management**

22. All psychologists should aim to achieve an objective of 50% face-face contact time.
  - For most this may translate to achieving an average of four face-face contacts a day.
  - For psychologists with a large component of non-therapy oriented work (e.g., those frequently undertaking cognitive or ASD assessments), non-face-to-face but directly client-attributable time may be added as contact time at an agreed-on rate.
23. To make the above feasible, consideration should be given to making other MDT and service processes as time-efficient as possible.
24. Psychologists, particularly any who are concerned about their caseload becoming overwhelming, may wish to use the caseload tool developed by the former Psychology Advisor to assist them to evaluate and manage their caseload.

### **Keyworking**

25. Psychologists should not in general be involved as keyworkers for clients. The exception may be if they are effectively the only/main staff member working with the client, and the following conditions apply:
  1. There is a compelling clinical reason for them to be working with the client (not just “the next cab off the rank”).
  2. The psychologist is the only or main person working with the client at the time,
  3. If a situation that requires urgent attention but the psychologist is engaged in other activities (e.g., seeing scheduled clients) that precludes them from attending to the person’s needs, other staff will be prepared to address the issue.

## **Psychology Career Development**

### **Career Pathway**

26. Establish the use of the Senior and Consultant Psychologist terms as defined in the APEX

MECA. Mechanisms for evaluating suitability for these scales are well-developed in several DHBs and could be obtained and utilised by Lakes DHB.

27. Utilise the non-clinical skills that many psychologists bring, related to research, training, service design and evaluation, and leadership and consider creating opportunities for them to formally contribute these skills to the benefit of the organisation and its clients.

## **Use of External Psychologists**

### **External Psychologists**

28. There is a place for careful use of external (contracted) psychologists in the provision of psychological services within Lakes DHB, although the number of additional benefits that accrue from having internal psychologists who can support other staff and service functions in a way that external psychologists are unlikely to be able to do suggests that internal psychologists should remain the main approach.
29. A hybrid model which allows for primarily internal psychologists and careful use of external psychological for undertaking specific tasks is recommended. The kinds of tasks the external psychologists may particularly (but not exclusively) focused on include.
- Specialist Assessments (ID, ASD, Somatoform disorders) where there is not the internal resources of skill and time to do these resources
  - Brief therapeutic interventions (specialist areas and to reduce waiting lists e.g. panic disorder, adjustment disorders)

## **Psychology Advisor Role**

### **Psychology Advisor Role**

30. Increase FTE associated with Psychology Leadership either by Increasing the FTE for the Psychology Advisor role or by establishing one or two Associate Psychology Advisor roles to assist with performing the various functions of this role.
31. Maintain the Psychology Advisor as part of the Senior Management Group and ensure that they are involved in planning and service development in as many levels of the DHB and sector as is feasible.
32. Review and perhaps strengthen the mandate by with the Psychology Advisor and other Professional Advisors can influence professional practice issues, either by facilitating changes in psychological systems and practice, or at the individual clinician level.
33. Some of this work would be undertaken in collaboration with the service managers and the processes for how this is undertaken may need to be addressed. For example, in concert with managers, Psychology advisor has a role in ensuring that reasonable expectations for psychologists, such as those described above, are achieved.

## **Future Directions for Psychological Services at Lakes DHB**

### **Future Directions for Psychological Services at Lakes DHB**

34. Consideration be given to increasing the psychologist resource available in the Lakes DHB mental health and physical health services.
- The areas for expansion could be prioritised, and business cases built for expansion in those areas adjudged as most likely to contribute substantial gains for the population and to overall service effectiveness and cost-effectiveness.



## References

- Duncan, B.L., Miller, S.D., Wampold, B.E., & Hubble, M.A. (Eds.) (2010). *The heart and soul of change: Delivering what works in therapy*. (2<sup>nd</sup> Ed). Washington, D.C.: American Psychological Association.
- Early Psychosis Prevention and Intervention Centre. (2001). *Case management in early psychosis: A handbook*. Melbourne: Author
- Haggerty, J.L., Reid, R.J., Freeman, G.K., Starfield, B.H, Adair, C.E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *British Medical Journal*, *327*, 1219–1221
- Harnett, P., O'Donovan, A., & Lambert, M.J. (2010). The dose response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist*, *14*, 39-44.
- Lakes DHB Mental Health and Addictions Services (2017). *Lakes DHB; Community mental health and addictions service (Rotorua) Findings and Recommendations*. Rotorua; Author
- Leichsenring, F., Rabung, S. & Leibling, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Archives of General Psychiatry*, *61*, 1208-1216.
- Midland District Health Boards (2015). *Regional Services Plan 2015-2018*. [www.midlanddhbs.health.nz](http://www.midlanddhbs.health.nz)
- Ministry of Health (2014). *National Cancer Programme Update, July 2014*. Wellington: Author.
- Mental Health Commission (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Wellington: Author.
- Mental Health Commission. (2012). *Blueprint II. Improving mental health and wellbeing for all New Zealanders. How things need to be*. Wellington: Author.
- Mobray, D. (1988). *MAS review of clinical psychology services* (For the National Health Services/ Department of Health Manpower Planning Advisory Group). Cheltenham, England: Management Advisory Service.
- New Zealand Guidelines Group. (2002). *Best practice evidence-based guideline: Cardiac rehabilitation*. Wellington, New Zealand: Author.
- Stewart, M.W., Bushnell, J., Hauraki, J., & Roberts, M. (2014). Evidence and wisdom: The role and value of psychologists in healthcare. *Journal of the New Zealand College of Clinical Psychologists*, *24*(1), 3-14
- Stewart M.W., Fontanilla, I.S., Morunga, E., & McGuigan, K. (2016). Psychology for the enhancement of physical health in Aotearoa New Zealand. In J. Rucklidge, W. Waitoki, J. Feather, & N. Robertson (Eds.) *Professional Practice of Psychology in Aotearoa New Zealand*. Wellington: N.Z. Psychological Society.
- Stuart, S. & Robertson, M. (2003). *Interpersonal psychotherapy: A clinician's guide*. London: Arnold