PROVIDING INPUT OR COMMENT

Towards optimal primary mental health care in the new primary care environment

Feedback due by 5 pm on Friday 19th February 2010.

Please detach and return

Please use the following detachable pages or copy and paste them electronically when providing feedback.

You do not have to answer all the questions or provide personal information if you do not want to.

This feedback was provided by:

The New Zealand Psychological Society

Address: (street/box number): **187 Featherston Street, Wellington**

(town/city): _____

Email: **executivedirector@psychology.org.nz**

Organisation: **As above**

Position: (if applicable): **Contact person-**
Dr Pamela Hyde, Executive Director

Are you submitting this feedback:
(tick one box only in this section)

As an individual (not on behalf of an organisation)	☐
On behalf of a group or organisation	X
Other (please specify)	☐

Please indicate which sector(s) your submission represents:
(you may tick as many boxes as apply)

Consumer	☐
Family/whānau	☐
Academic/research	☐
Māori	☐
Pacific	☐
District Health Board (DHB)	☐
Primary Health Organisation (PHO)	☐
Education/training	☐
Local government	☐
Provider	☐

Funder	☐
Non-government organisation (NGO)	☐
Prevention/promotion	☐
Professional association	X
Other (please specify)	☐

Please e-mail your feedback no later than 5 pm, Friday 19th February 2010 to:

sarah_dwyer@moh.govt.nz

Alternatively, you can post your feedback to:

Dr Sarah Dwyer
Feedback on primary mental health guidance paper
Ministry of Health
PO Box 5013
Wellington

If you have any questions about this guidance paper, please feel free to email or phone Dr Sarah Dwyer: sarah_dwyer@moh.govt.nz or (04) 496 2326.

Your feedback may be requested under the Official Information Act 1982. If such a request is made, the Ministry of Health will release your feedback to the person who requested it. However, if you are an individual as opposed to an organisation, the Ministry will remove your personal details from the feedback if you check the following boxes:

☐ I **do not** give permission for my personal details to be released to persons under the Official Information Act 1982.

FEEDBACK QUESTIONS

Stepped care approach

1. Do you agree with the proposed stepped care approach?

Yes X No ☐

Please see the attached document for issues of concern and areas the NZPsS considers need more consultation and discussion

2. This discussion paper describes 13 key areas of focus for translating stepped care into practice and moving towards optimal primary mental health care (page 26). Are there other elements that are important for optimal primary mental health care that have been omitted?

Yes X No ☐

__We agree with these thirteen areas but consider that the following need to be included

- **Culturally appropriate models of mental health care**
- **Innovative service delivery models which make use of the mental health skills of the existing allied mental health workforce- in particular the large number of private practitioner psychologists**
- **Clear risk management processes to ensure patient safety**

Building workforce capacity and capability

3. The proposed core skills and qualities for practice staff and other primary mental health practitioners are listed on pages 44. Have any core skills or qualities been omitted?

Yes X No ☐

We would like to see the following skills and qualities included

- **Priority being given to professional supervision and skill maintenance and development**
- **Cultural competence**

Targeted approach to meeting the needs of vulnerable population groups

Māori

4. The requirements necessary for optimal service delivery for Māori are listed on page 60. Have any requirements been omitted?

Yes X No ☐

We believe that the Treaty of Waitangi needs to be recognised and acknowledged in this document as underpinning the provision of services to Māori. As noted above the importance of cultural competence needs to be emphasised for all those delivering services to Māori. This is in line with the HPCA Act S118.

Children

5. The requirements necessary for optimal service delivery for children are listed on page 61. Have any requirements for children been omitted?

Yes X No

It will however be important that those working with children have sufficient qualifications and experience to do so and as noted in the attached paper that there is a joined up approach with other agencies (e.g. education) in the management of child mental health issues.

Youth

6. The requirements necessary for optimal service delivery for youth are listed on page 63. Have any requirements for youth been omitted?

Yes X No ☐

As above re qualifications/competence and a joined up, collaborative approach

Older people

7. The requirements necessary for optimal service delivery for older people are listed on page 64. Have any requirements for older people been omitted?

Yes X No ☐

As above re qualifications/competence and a joined up, collaborative approach

Pacific peoples

8. The requirements necessary for optimal service delivery for Pacific peoples are listed on page 66. Have any requirements for Pacific peoples been omitted?

Yes X No ☐

We suggest consultation with Pasifikology for their response to this question see www.pasifikology.co.nz . We note the importance of recruiting and

retaining Pacific mental health workers including psychologists. A planned approach to workforce development for Pacific, Māori and other mental health workers is essential.

Asian, migrant and refugee peoples

9. The requirements necessary for optimal service delivery for migrant and refugee peoples are listed on page 67. Have any requirements for migrant and refugee peoples been omitted?

Yes X No ☐

As above there is a need for a planned approach to workforce development in relation to the mental health workforce for migrant and refugee communities. There is also a need to develop models of practice which are suitable for use with specific migrant and refugee populations.

People with disabilities

10. The requirements necessary for optimal service delivery for people with disabilities are listed on page 69. Have any requirements for people with disabilities been omitted?

Yes X No ☐

As above re workforce development and the joining up of services and support

People with alcohol and/or other drug problems

11. The requirements necessary for optimal service delivery for people with alcohol and/or other drug problems are listed on page 69. Have any requirements for people with alcohol and other drug problems been omitted?

Yes X No ☐

It is important that primary care mental health workers have appropriate training to work with clients with alcohol and drug problems. These problems are often complex and require a coordinated approach which centres on the family/whanau as well as the individual.

People with comorbid physical and psychological problems

12. The requirements necessary for optimal service delivery for people with comorbid physical and psychological problems are listed on page 72. Have any

requirements for people with comorbid physical and psychological problems been omitted?

Yes X No ☐

As above re workforce development and a joined up approach

Prison population

13. The requirements necessary for optimal service delivery for the prison population are listed on page 74. Have any requirements for the prison population been omitted?

Yes X No ☐

As above re workforce development and a joined up approach

People in low socioeconomic groups

14. The requirements necessary for optimal service delivery for people in low socioeconomic groups are listed on page 75. Have any requirements for people in low socioeconomic groups been omitted?

Yes X No ☐

The issue of access is important for this group and the importance of a joined up approach is particularly important in relation to poverty, education and justice issues.

General

15. Do you have any other comments or feedback about what is required to achieve optimal primary mental health care in the new primary care environment?

Yes X No X

Please see attached document

The NZPsS believes that effective delivery of optimal primary health care needs to ensure that

- **the model for delivery of care is not solely doctor/nurse centred and that the skills of the wider mental health workforce are acknowledged, developed and utilized- e.g. psychologists who are registered mental health professionals and those in education**
- **those providing primary mental health services are appropriately qualified, receive supervision and professional development**

- **treatments are evidence-based in the context of the primary care model and continue to be so as research continues to provide up to date data**
- **mental health services are not delivered in isolation of other services being delivered to individuals and their families- e.g. a joined up approach. However it is important that services are streamlined and coordinated**

Please see the attached Appendix below for additional detailed comments

Appendix 1

Towards optimal primary mental health care in the new primary care environment: A draft guidance paper.

The New Zealand Psychological Society welcomes the Ministry of Health's initiatives with regard to the development of personalised and accessible mental health assistance for people through the primary health care system. We support the overall thrust of the initiative and believe that making localised and subsidised mental health care available to New Zealanders is an important step forward.

The draft guidance paper produced by the Ministry is a useful starting point for consultation and we welcome the opportunity to comment on areas where we have concern in the hope that these can be taken into account in the further development of this important initiative. In addition to our comments on the feedback questions we note in more detail below our concerns and suggestions

1. We are concerned at the suggestion that "talking therapists" who provide primary mental health packages of care should generally be expected to meet the needs of most clients within 4-6 sessions." While there is evidence that it is possible to produce some improvement within this limited timeframe, working within a very particular model and for a carefully selected group of clients, this is unlikely to be true for "most" people with mild to moderate mental health problems. A key text in psychotherapy summarising the research on psychotherapy duration notes that in general, ten sessions would probably be the minimum number required for some kind of therapeutic change and that with less than 20 sessions, 50% of clients would probably not achieve a substantial benefit from therapy (Lambert, 2004).

   The updated 2009 version of the NICE guidelines which informed the Increasing "Access to Psychological Therapies" in the UK 2009 (a similar plan to that being suggested here) recommended 16-20 sessions plus follow-ups as the dosage for effective treatment of depression (in comparison to the 2004 NICE guidelines you quoted in the draft guidance paper). The latest recommendations on anxiety are due out this year, but in 2004 their recommendation was 8-10 sessions for anxiety conditions such as GAD and Panic Disorder (McIntosh et al., 2004). It may be the 4-6 sessions recommended in the paper are a product of financial necessity but it is important that this is not presented as the optimum treatment dose for mild to moderate mental health problems – a representation which may deny people further treatment when they need it and lead to unrealistic expectations amongst service providers and clients. The limitations of the 4-6 session intervention suggests that intervention strategies may have to be radically transformed (rather than just using 'slimmed down' versions of conventional practices) to produce change in this time period. Further research is needed to establish an evidence base for practices specifically used in the PHO context.

2. The recommendation that each practice team have knowledge and skills across a "range of core areas" may not be realistic unless further specialised training and on-going supervision in these areas is provided. Some of the recommended "core areas"(e.g. relaxation strategies, stress management) may be dealt with reasonably well by a practitioner without extended and specific psychotherapy training but others are less 'simple' (such as solution focussed counselling or exposure techniques) and require considerable skill, experience and supervision to undertake safely and effectively. We acknowledge that the document does pay significant attention to

training and workforce development issues, but we would recommend that there be a more careful differentiation of 'simple' strategies from more complex interventions in order to ensure that primary health care staff members do not undertake work for which they are not qualified.

3. The suggested range of "more intensive" therapy options is too narrow to reflect the number of treatment approaches that currently have a strong evidence base. There are a number of other suitable short term models that have good research evidence for their efficacy, for example, Process Experiential (Emotion Focussed) Therapy, Short Term Psychodynamic Therapy, Cognitive Analytic Therapy, and Commitment and Acceptance Therapy amongst others. Furthermore as new models are developing all the time – and the evidence for existing models changing and growing –it is important that there is space in the policy to accommodate these as they become available (the recent APA update on the evidence base for psychodynamic therapy is a case in point)[1]. We endorse the suggestion that there could be "some flexibility to include other interventions" but we would suggest that it is not sufficient to leave the decision about the use of alternative models to those specified in the hands of each "region" as these may be limited by the preferences, training or knowledge base of the regional coordinating body. While we would generally recommend that the range of therapies available be expanded from the current list, we do have some reservations about 'e-therapies' which have not, as yet, been well evaluated.

4. A recommended referral pathway that through general practitioners may not always be the best option as GPs have been recognised to have, for a variety of reasons, difficulties in identifying mental health issues in their patients (Ormel et al., 1990). Your document suggests that it may be possible to also allow other more direct routes of referral of mental health problems to relevant providers. We endorse this suggestion and ask that further consideration be given to how this process might work.

5. There are also concerns amongst our members about the process of consultation in relation to this document. While some recommendations are taken from the consultation undertaken by Peters (2007), the Society recognises that there are limits to the "snapshot" overviews which individuals may have of the 'talking therapies'. We note the importance of involvement of one of the larger group of psychologists involved in the provision of psychotherapy i.e. those in private practice. Given the scarcity of mental health resources, it is important to include this group more actively in the consultation process and also to explore ways in which their experience and knowledge can be used more effectively as a resource in the delivery of primary mental health services.

6. There would appear to be a risk in the "collaborative" model proposed in the document in that that too many clinicians could be involved in the stepped care process. Research recognises the importance of the therapeutic relationship (a trustworthy connection with one person) as fundamental to good therapy outcomes (Lambert, 2004). This would also work against the intention which is to provide "more personalised care" to patients. It would be important to develop guidelines and procedures which recognise and balance the need for conducting psychological interventions within the framework of an established relationship, with the need for collaboration. It may be that a therapeutic relationship is less significant in the

[1] The APA released the following press release on psychodynamic therapy in January this year: http://www.apa.org/news/press/releases/2010/01/psychodynamic-therapy.aspx

context of brief, practically focussed interventions but further research would be needed here.

7. We are concerned that the extended 15 minute consults provided by a GP/practice nurse might not be effective as there is very little that can be achieved in terms of psychological intervention in this short space of time. It may be more cost effective to put the money involved with such consults towards funding a clinician who can provide a more substantial and effective service.

8. We note that risk assessment does not seem to be directly addressed in the document. We believe this area needs to be given more emphasis. Some clients whose needs are being addressed through the primary health care initiative are likely to be at increased risk for harm to self or others relative to the general population of a GP practice, it would be important to ensure that there is a brief but effective mechanism in place to monitor and manage this.

9. We are a little confused by the apparent blurring of the 'definitions' of practitioner vs. team vs. providers (of packages of care) and we would like to have more clarity on the different roles in the system.

10. We are concerned that the document would seem to suggest that “every primary health practitioner” is expected to be skilled in mental health diagnosis. Practitioners may or may not have the training or the ‘right’ to diagnose mental health problems. It would be important to specify those professions where diagnosis is a recognised part of training and scope of practice.

11. Whilst the paper acknowledges youth and children as important population groups for intervention, it would be useful to give this aspect of primary health care further attention. With the value of early intervention/prevention well recognised, it is cost effective to put energy into the psychological well-being of young people. In particular, it would be useful to explore ways in which the primary mental health system might interact with services of the Ministry of Education – as schools are often the site in which most children and young people are first identified as having psychological difficulties. We believe that this “joined up” approach should occur as frequently as possible.

12. Private practitioner psychologists can offer support at all levels of the “stepped care” approach. This includes psychological interventions on the mild/moderate level of severity (e.g. strength and solution focussed interventions) and in relation to secondary level client needs. Psychologists are also able to act as patient advocates. In addition psychologists have the knowledge and experience of theoretical models which inform practice and have the skills to train and supervise other professionals involved in the stepped care approach.

References

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