Opportunities and challenges for psychotherapy in Aotearoa New Zealand's new health system: A 2022 national District Health Board psychotherapy workforce survey and related discussions

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> We see psychotherapists playing an important role in the new [national health] system, bringing skills and experience into services across the spectrum of care. There is a huge opportunity to get involved, and we welcome ideas and initiatives to increase the number of psychotherapists and the promotion of psychotherapy across Aotearoa New Zealand. (Robyn Shearer, Deputy Director-General, Evidence Research and Innovation, Ministry of Health, 2022)[2]

Abstract

The dawning of a new national public health system in Aotearoa New Zealand offers opportunities and challenges for psychotherapists. This paper discusses these against three data sets, namely, a 2022 national District Health Board psychotherapy workforce survey, a video recording of the Psychotherapy and Public Worlds panel event at the 2022 New Zealand Association of Psychotherapists' (NZAP) conference, and psychotherapist registration statistics supplied by The Psychotherapists Board of Aotearoa New Zealand (PBANZ). The expansion of short-term, risk-based, manualised interventions during the former DHB era did not improve mental health at a community level (Mulder et al., 2022) nor promote equity and sustainability (Berg et al., 2022). Placing Te Tiriti o Waitangi, the Treaty of Waitangi (1840) (Te Tiriti) at the centre of the new health system suits psychotherapy,

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2 Personal communication (email) to author on 27 April 2022.

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whose wholistic worldview of health and wellbeing aligns with te ao Māori better than most other Western psychological approaches. Kōrero about the indigenising of psychotherapy in Aotearoa has been around since at least the 1980s. The Ministry of Health (the Ministry) has recently invited psychotherapists' advice on workforce policy development and how to promote psychotherapy in the new health system. This task will largely fall on the psychotherapy associations and some psychotherapy training organisations. A major challenge may be whether these entities can sustain the expenditure of human and other resources necessary to represent their memberships in continuing dialogue with the Ministry and its operational partners, Te Whatu Ora, Health New Zealand (Te Whatu Ora) and Te Aka Whai Ora, Māori Health Authority (Te Aka Whai Ora). Key opportunities include the recruitment of overseas psychotherapists and the greatly expanded provision of psychotherapy student placements in public health services to stimulate new psychotherapy training programmes and workforce growth.

Whakarāpopotonga

Kua wātea mai he huarahi ahu whakamua, whakaohooho ake ki ngā kaiwhakaora hinengaro i te pūaotanga ake o te pūnaha hauora hou ā-motu i Aotearoa. E whakawhitiwhiti kōrero ana tēnei pepa mai i ngā kohinga e toru, arā, he uiuinga a te Poari Hauora kaiwhakaora hinengaro ā-Rohe, he hopunga whakaata a te huinga paewhiri i te wānanga a te 2022 NZAP, me te tatauranga kaitohu kaiwhakaora hinengaro homaihia e te Poari o Ngā Kaiwhakaora Hinengaro o Aotearoa Niu Tīreni. Kāre i piki ake te oranga o te hauora hinengaro ā-hāpori (Murata etahi atu., 2022) kāre hoki i whakanuia te ōritenga me te toitūtanga (Pēke me ētahi atu., 2022) i te wā o te wā o te Poari Hauora Hāpori o mua. Ki te whakauruhia te Tiriti o Waitangi hei pūnaka pou tokomanawa mō te hauora hou ka hāngai ake ērā manawapā i ngā tirohanga whakaora hinengaro Whakatēuru. Nō te tau kotahi mano iwa rau waru tekau te pōtereterenga o te kōrero kia whakauruhia mai ki Aotearoa, te tūāpapa whakaoranga hinengaro a tangata whenua. No kō tata ake nei ka puta mai te pōhiri a te Minita Hauora ki ngā kaimahi whakaora hinengaro kia āwhinahia atu ki te whakatakoto whanaketanga kaupapa here, ā, me pēhea hoki te whakatairanga whakaoranga hinengaro ki roto i te pūnaha hauora hou. Ko te nuinga o tēnei mahi ka tau ki ngā rōpū whakaora hinengaro ko ētahi ki ngā rōpū whakangungu whakaora hinengaro. Ko te tino wero pea ko te wā taea e ngā rōpū te whakawātea kaimahi me ētahi atu rauemi hei kanohi kitea whakawhitiwhiti kōrero ki te Manatū me ana hoa kaimahi, a Te Whatu Ora me Te Aka Whai Ora. Ka uru mai ki ngā whiwhinga te rapu kaimahi whakaora hinengaro o tāwāhi me te whakawhānui whakaūnga nōhanga tauira whakaora hinengaro i rō ratonga hauora tūmatanui hei whakaohooho hōtaka whakangungu whakaora hinengaro hou me te whakapihinga kaimahi.

Keywords: Te Tiriti o Waitangi; public health workforce; mental health and additions workforce policy; DHB psychotherapy workforce survey; PBANZ registration statistics; NZAP conference panel; promotion of psychotherapy; health equity.

Whakapapa

The whakapapa of psychotherapy in the public health system of Aotearoa New Zealand is young compared to psychotherapy in the public health systems of older societies, such as in parts of Northern Europe, and consequently, the understanding and demand for psychotherapy in Aotearoa New Zealand is in a nascent phase.[3] This situation creates a psychological treatment vacuum that is currently being filled by the importation of contemporary public health discourses from overseas, largely centring on short-term cognitive approaches.

The whakapapa of this paper is Pākehā through its author's strong connection to te ao Pākehā, the Western worldview. If that whakapapa had included an equally strong connection to te ao Māori through an equitable partnership between Māori and Pākehā researchers, knowledge bearers, and co-authors, this paper may then have reflected the mana of those tangata whenua who have been kaitiaki to their people's mental health over many generations. Instead, its whakapapa is limited by the partial nature of the author's collaborations with Māori working in the new health system, in the former District Health Boards, in professional associations, regulatory and training organisations, and as practitioners.

The whakapapa of the author is Pākehā going back five generations in Aotearoa New Zealand to County Armagh, Ireland, on his father's side and two generations to southwestern Scotland through his mother. He grew up under the gaze of Pukemoumou in Te Awa Kairangi ki Uta, Upper Hutt, within the rohe of Te Rūnanganui o Te Āti Awa. Between 1991 and 2005 he worked in child and family mental health services at both the Wellington and Hutt hospitals, progressing to senior family therapist. Currently, he works part-time as the psychotherapy professional leader at Te Whatu Ora, Te Toka Tumai, Auckland, where Te Rūnanga o Ngāti Whātua are mana whenua, and in private practice as a psychodramatist, family psychotherapist, and educator.

Introduction

By the time this paper is published, the 21-year tenure of the 21 District Health Boards[4] (DHBs) established throughout Aotearoa New Zealand by the Fifth Labour Government in 2001 will be over. In their place, a bicultural organisational partnership is being steadily constructed comprising the Ministry and two new entities, Te Whatu Ora and Te Aka Whai Ora. On 1 July 2022, when this new structure took responsibility for the national health system, current clinical positions and services rolled over, including those in public mental health and addiction services where the majority of the registered psychotherapists employed by the DHBs are located.

In this exceptional moment, Te Tiriti takes its rightful place in the very heart of the

3 My thanks to Charmaine Gupta for this conceptualisation of psychotherapy in Aotearoa New Zealand (C. Gupta, Service Clinical Director, Te Whatu Ora, Te Toka Tumai, Auckland, in a panel discussion on the topic: "In times of high demand and stretched resources, what place does long-term psychotherapy have in the public health sector?" at the Opportunities for Psychotherapy in Te Whatu Ora, Health New Zealand, Professional Development Day for psychotherapy staff and students in Te Whatu Ora, Te Toka Tumai, Auckland and Waitematā, on 14 November 2022).

4 In 2001, the government established 21 DHBs; however, in 2010 the Otago and Southland DHBs merged to form the Southern DHB.

health system of Aotearoa New Zealand. The aim is for nothing less than improved and equitable health outcomes for Māori, which is something the DHBs did not achieve. DHB mental health and addiction services were dominated by medicalised, risk-based models of practice that encourage short term, individualistic, 'tick box' interventions to manage episodic care, often cyclically with the same tāngata whai ora (Durie, 1994), public health service users. These practices do not fit taha Māori understandings of health and wellbeing (Awatere, 1981; Durie, 1985; Keelan, 1986). Placing taha Māori understandings at the centre of mainstream services is one of the challenges the new health system faces. With challenge comes opportunity, and this is where psychotherapy has the potential to contribute equitable mental health and addiction solutions.

Psychotherapy does what clinical psychology and psychiatry — the dominant disciplines in public mental health and addiction services — generally do not do, which is to treat people as whole beings with interrelated mental, emotional, physical, relational, social, political, and spiritual realities. It builds a profound alliance between the psychotherapist and the person they are working with to enable broad, deep work, sometimes over lengthy periods, to achieve lasting change. It invites complexity, including the unconscious aspects of self, and seeks to integrate all parts of a person humanely rather than narrowing clinical focus to behaviours or cognitions to relieve symptoms.

The promotion of psychotherapy in Aotearoa New Zealand's new health system invites new policy work on the part of the Ministry. This paper aims to provide the Ministry and its operational partners, Te Whatu Ora and Te Aka Whai Ora, with perspectives from registered psychotherapists on how DHB mental health and addiction services have come to measure outcomes the way they do, how this influences the way services are provided, the difficulties and deficits that arise from such provision, and the opportunities psychotherapy provides should they choose to respond more wholistically to the challenges that our mental health system is currently facing.

In the remainder of this paper, I present data and or discussion on the following:

Section 1: A brief account of psychotherapy, including indigenous psychotherapies, and mental health and addiction services in Aotearoa New Zealand.

Section 2: A 2022 national DHB psychotherapy workforce survey.

Section 3: A report on the Psychotherapy and Public Worlds panel convened at the NZAP conference in 2022.

Section 4: Statistics and commentary on the psychotherapy workforce in Aotearoa New Zealand based on data collected by PBANZ.

Section 5: Opportunities and challenges presented to psychotherapy in Aotearoa New Zealand by the new health system.

Section 1: Psychotherapy in mental health and addiction services in Aotearoa New Zealand

Psychotherapy's heyday in Aotearoa New Zealand's mental health and addiction services probably occurs in the therapeutic communities nestled in large public mental hospitals between the 1960s and the late 1980s before a wave of deinstitutionalisation sweeps the Western world, bringing that era to a close by the early mid-1990s (Brunton, 2003; McNeish, 2017).[5] By then, the Fourth National Government is implementing a market-driven approach to the provision of health services by turning public hospitals into Crown Health Enterprises (CHEs) to be managed by business people whose salary bonuses are linked to the return of profit on the Crown's 'investment' in the health market (Cooper, 1994; Kelsey, 1995; Upton, 1991). With competitive market forces determining the viability of one service over another, individuals, organisations, and professions seek to position themselves to take advantage of market trends or, where possible, to directly influence those trends. In mental health, psychiatrists' medical primacy and legislative powers ensure they retain control in the clinical hierarchy, while among the allied professions clinical psychologists establish the New Zealand College of Clinical Psychologists in 1990 to formalise and expand their workforce's capacity to implement the emerging psychological paradigm of 'evidence-based practice'. This paradigm develops distinct theories, postulates, research methods, and standards for what constitutes legitimate contributions to clinical knowledge and practice, including the certification and credentialling of practitioners and the accreditation of training programmes in the mental health marketplace.

Despite the return to a not-for-profit national health system in 1997 and the subsequent establishment of 21 DHBs by the incoming Labour-Alliance Coalition Government in 2001, managerialist priorities that emphasise risk monitoring and 'tick box' outcomes predominate in the health system for the next 20 years, subjugating the health needs of the most vulnerable New Zealanders who cannot afford to access a wider range of services in the private sector. These priorities predispose DHBs to employing short-term, tightly focused, individualistic, manualised interventions, centred within the purview of clinical psychology, to meet the increasing demand for mental health services; however, "the expansion of those services and treatments is not leading to improvements in mental health at a community level" (Mulder et al., 2022, p. 90). This may be because evidence-based practice marginalises political context and produces healthcare models that fail to promote equity, sustainability, or to respond adequately to emerging healthcare challenges (Berg et al., 2022).

In the meantime, psychotherapists in Aotearoa New Zealand are being trained broadly in the amelioration and resolution of mental health problems, including psychiatric disorders, by bringing psychodynamic, wholistic, and systemic thinking, grounded in theories of human development, to bear on their clinical assessments, formulations, and practices (ADHB, 2020). Psychotherapists seek to integrate people's mental, emotional, and physical wellbeing, their wairua and spirituality, their relationships with whānau, family, friends, and nature, and their sociopolitical lives. By viewing people as embedded in these wide-ranging contexts, psychotherapists may orient to working for longer term, deeper change with people, which

5 In McNeish (2017), see chapter entitled: John Saxby (pp. 5-110) for descriptions of innovative psychotherapy developed and practiced within the therapeutic community at Tokanui Psychiatric Hospital during the 1980s.

may in turn lead to them being anecdotally critiqued as less time efficient than episodically focused treatments. Furthermore, with the current ideological focus on evidence-based practice "there has been a growing sense that psychodynamic[6] [psychotherapy] concepts and treatments lack empirical support or that scientific evidence shows that other forms of treatment for mental health issues are more effective" (Lummis, 2019, p. 1).

If this sense is real, then it is not accurate. Reputable research, including meta-analyses, finds psychotherapy to be as or more effective and efficacious over similar time frames as currently more favoured treatments, such as manualised cognitive approaches (see: Cuijpers et al., 2013; Gaskin, 2014; Leichsenring & Steinert, 2019; Mensi et al., 2021; Munder et al., 2019; Shedler, 2010), including, for example, the use of short-term psychodynamic psychotherapy to treat preadolescents and adolescents affected by psychiatric disorders (Mensi et al., 2021).

Kaupapa Māori psychotherapies

The adverse effects on Māori health and wellbeing resulting from the Crown's attempts to eradicate kaupapa Māori healers and their traditional health knowledges through the Tohunga Suppression Act (1907),[7] and other punitive assimilative strategies, are visible in the health inequities that persist in Aotearoa New Zealand today. During the Māori cultural renaissance of the early 1980s, the kōrero of Māori elders on marae around the country revived kaupapa Māori concepts of health, which Mason Durie documented as the four cornerstones of Māori health (1985) or Te Whare Tapu Whā (1994), namely, wairua (spiritual), whānau (family), hinengaro (mental), and tinana (physical). Other Māori psychotherapies also appear in the literature, including Whai Ora (Rankin, 1986), Powhiri Poutama (Huata, 1997), Te Wheke (Pere, 1997), Paiheretia (Durie, 2003), Whanaungatanga (Huriwai et al., 2001; Lyford & Cook, 2005), whānau-based interventions (Durie, 2005), the Meihana Model (Pitama et al., 2007), whakapapa narratives and whānau therapy (Swann et al., 2013), Whai Tikanga (McLachlan et al., 2017), and collaborative indigenous mental health therapies (NiaNia et al., 2017).

From these practices, the tikanga or correct procedures for psychotherapy from taha Māori perspectives can be seen to involve the following:

- Manākitanga: expressions of aroha, hospitality, generosity, and mutual respect build unity through humility and giving;

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6 "*Psychodynamic psychotherapy or psychoanalytic psychotherapy* [terms used interchangeably] refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than *psychoanalysis* proper. The essence of psychodynamic psychotherapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship. […] Seven features reliably distinguish psychodynamic therapy from other therapies, *as determined by empirical examination of actual session recordings and transcripts*" (Shedler, 2010, p. 99, emphases in original), namely: (1) focus on affect and expression of emotion; (2) exploration of attempts to avoid distressing thoughts and feelings; (3) identification of recurring themes and patterns; (4) discussion of past experience/developmental focus; (5) focus on interpersonal relations; (6) focus on the therapy relationship; and (7) exploration of wishes and fantasies (Blagys & Hilsenroth, 2000).

7 The tone of the Act is well represented in its opening statement: "Whereas designing persons, commonly known as tohungas, practise on the superstition and credulity of the Maori people by pretending to possess supernatural powers in the treatment and cure of disease, the foretelling of future events, and otherwise, and thereby induce the Maoris [sic] to neglect their proper occupations and gather into meetings where their substance is consumed and their minds are unsettled, to the injury of themselves and to the evil example of the Maori people generally" (p. 26). The Act is not repealed until 1962.

- Whanaungatanga: rights and reciprocal obligations that recognise, bind, and affirm individuals and their contributions to collective interdependence;
- Kaitiakitanga: spiritual and cultural guardianship of te ao Māori, and active responsibility for resources and people that promotes growth and development;
- Rangatiratanga: the attributes of rangatira, including leadership with humility, generosity, altruism, diplomacy, and the promotion of self-determination;
- Wairuatanga: belief in a spiritual existence alongside the physical, with connections to atua Māori maintained through daily practices in the everyday lives and worldview of Māori. (Drawn from Mikahere-Hall et al., 2019)

The growing body of literature generated by Māori psychotherapists and based on kaupapa Māori research methods, locates kaupapa Māori psychotherapies deeply within te ao Māori (Fleming, 2018; Hall, 2013; Mildon, 2016; Morice & Fay, 2013), where:

> The need for a Māori psychotherapy is relatively obvious to anyone who is Māori. The purpose of a Māori psychotherapy is no different from the purpose of Pākehā psychotherapy for Pākehā or tau iwi. However, as long as psychotherapy remains monocultural, it will remain unable to meet the needs and aspirations of Māori practitioners and Māori clients. (Morice, 2009, p. 15)

The reality for psychotherapists working in the DHBs

Psychotherapists employed in DHB mental health and addiction services are generally required to be generic keyworkers who are allocated caseloads of service users and who work in clinical teams predominated by other generic keyworkers, and this situation may lead to frustration at not being able to practise the discipline for which they have trained. Specialist psychotherapy services have been closed or 'reformed' around the country. In some DHBs, child psychotherapists are not offered supervision with another child psychotherapist (J. Bruce, Treasurer, New Zealand Association of Child and Adolescent Psychotherapists (NZACAP), personal communication, September 7, 2022). As pressure mounts on services to reduce waiting lists, imported clinical management systems, such as CAPA,[8] direct clinical focus onto short-term interventions that aim to turn the majority of service users around near the door. Subsequently, psychotherapists either adapt by genericising their work and utilising prescribed evidence-based practices, such as, cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), acceptance and commitment therapy (ACT), or mindfulness processes, or they step away into private practice.

With the advent of a new national health system in Aotearoa New Zealand on 1 July 2022, the Ministry is now "stepping into a stronger national leadership role for mental health and addiction workforce development" (R. Shearer, personal communication, April 27, 2022). It may assist the design and commissioning of mental health and addiction services to have accurate baseline data on how many registered psychotherapists are employed in DHBs throughout Aotearoa New Zealand immediately prior to the health system change. The following national DHB psychotherapy workforce survey is an attempt to provide that data.

8 CAPA: Choice And Partnership Approach (Fuggle et al., 2016; Pajer et al., 2022). Also, see: https://wharaurau.org.nz/CAPA for a New Zealand perspective.

Section 2: 2022 national DHB psychotherapy workforce survey

Survey method

The survey utilises six quantitative questions and one qualitative question to ask:

1. How many registered generic psychotherapists are employed in each DHB?
2. What is the total FTE of registered generic psychotherapists employed in each DHB?
3. How many registered child and adolescent psychotherapists are employed in each DHB?
4. What is the total FTE of registered child and adolescent psychotherapists employed in each DHB?
5. In what services are registered psychotherapists employed in each DHB?
6. How many psychotherapy students are on placement in each DHB this year?
7. What comments do respondents wish to make about psychotherapy in their DHB?

A significant limitation of the survey, pointed out to me by a Māori colleague (personal communication, November 7, 2022), is the non-collection of data on ethnicity that might have indicated the level of lived Māori experience in the national DHB psychotherapy workforce and the likelihood of tāngata whai ora being exposed to cultural inequities. Such data might also assist the gauging of the success of any subsequent recruitment initiatives.

Implementing the survey involves contacting each DHB by phone to ascertain who the relevant person or persons might be to undertake or delegate its completion. This is most often the allied health director or equivalent, though professional leaders of psychotherapy and/or psychology, a mental health service manager, a nurse manager, and a social worker are also nominated by their respective DHBs. The survey is available for completion online via Google Forms, though half of all respondents reply via email or phone.

Survey results

Eighteen completed surveys covering all 20 DHBs[9] are received between the third week in February and the first week of March 2022, some four months before the arrival of the new health system. Thirteen DHBs make zero returns, meaning they do not currently employ any registered psychotherapists, and seven choose not to comment on psychotherapy in their DHB.

Questions 1–5: Registered generic psychotherapists and child and adolescent psychotherapists

The entire DHB psychotherapy[10] workforce in Aotearoa New Zealand is 20.6 FTE, the equivalent of one fulltime registered psychotherapist per DHB. This total breaks down to 11.1 FTE of registered generic psychotherapy (RP)[11] working in adult services (including one FTE

9 Capital and Coast DHB, Hutt Valley DHB, and Wairarapa DHB were collectively represented by MHAID, the regional Mental Health and Addiction, Intellectual Disability service launched in 2015 (Fairley, 2015).

10 This workforce comprises persons employed as registered psychotherapists. There are approximately six other DHB employees who qualify to apply for registration as psychotherapists but who are employed under another profession and associated registration framework, such as, in addiction services through the Addiction Practitioners' Association of Aotearoa New Zealand (DAPAANZ), or in social work through the Social Workers Registration Board (SWRB).

11 In this survey a registered generic psychotherapist (RP) refers to a psychotherapist registered by PBANZ under either the Psychotherapy Scope of Practice or the related Interim Psychotherapy Scope of Practice,

of vacancy) spread over 13 employees, and 9.5 FTE of registered psychotherapy with child and adolescent specialism (RPCA) over 14 employees. These results are tabulated below in Figures A and B, respectively.

Figure A: Registered generic psychotherapy FTE (with number of RPs) in all DHBs in Aotearoa New Zealand

DHB	FTE (Number of RPs)
Auckland	5.2 (7 RP)
Waitematā	3.0 incl. 1.0 vacancy (2 RP)
Southern	1.6 (2 RP)
Canterbury	1.0 (1 RP)
Capital & Coast, Hutt Valley, & Wairarapa	0.3 (1 RP)
Bay of Plenty	0
Counties Manukau	0
Hawkes Bay	0
Lakes	0
Nelson-Marlborough	0
Mid-Central	0
Northland	0
Tairāwhiti	0
Taranaki	0
South Canterbury	0
Waikato	0
West Coast	0
Whanganui	0

and who is working in adult mental or physical health services; whereas a registered child and adolescent psychotherapist (RPCA) refers to a psychotherapist registered by PBANZ under either the Psychotherapist Scope of Practice with Child and Adolescent Psychotherapist Specialism or the related Interim Psychotherapy Scope of Practice, and who is working in child and adolescent/youth mental or physical health services. Psychotherapists can be registered under an Interim Scope of Practice for up to five years while they complete 900 hours of postgraduate supervised clinical practice with weekly face-to-face clinical supervision for the first 24 months of practise and at least fortnightly thereafter, plus 120 hours of personal psychotherapy to complete full registration. In this survey, no differentiation is made between full and interim registration.

Figure B: Registered psychotherapy with child and adolescent specialism FTE (with number of RPCAs) in all DHBs in Aotearoa New Zealand

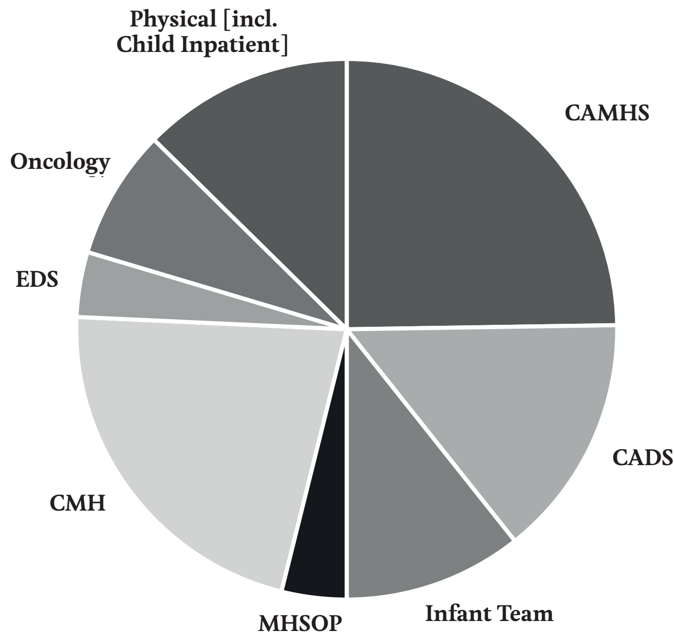
DHB	FTE (Number of RPCAs)
Waitematā	4.1 (5 RPCA)
Auckland	3.8 (6 RPCA)
Capital & Coast, Hutt Valley, & Wairarapa	1.6 (3 RPCA)
Canterbury	0
Bay of Plenty	0
Counties Manukau	0
Hawkes Bay	0
Lakes	0
Nelson-Marlborough	0
Mid-Central	0
Northland	0
Tairāwhiti	0
Taranaki	0
South Canterbury	0
Southern	0
Waikato	0
West Coast	0
Whanganui	0

On the following page, Figure C depicts the distribution of the 20.6 FTE of registered psychotherapy across services located in the five DHBs that report employing registered psychotherapists.

Question 6: Psychotherapy students

Only two DHBs provide clinical placements for psychotherapy students, namely, Auckland with 12 students and Waitematā with two. These DHBs are the most proximate to Auckland University of Technology (AUT) — though Counties Manukau DHB is also located within Auckland City and does not employ psychotherapists nor take psychotherapy students — whose Master of Psychotherapy is the only psychotherapy training programme in Aotearoa New Zealand seeking placements in the DHB context.

Figure C: Location of 20.6 FTE of psychotherapy by DHB service in the five DHBs who report employing registered psychotherapists



Question 7: Comments about psychotherapy made by DHB respondents

Comments by survey respondents about psychotherapy in their DHB fall into three main categories, namely, the need for more talking therapies[12] in both mental and physical health services, the widening of the pool of practitioners who can provide talking therapies beyond psychotherapists and psychologists, and the lack of awareness about how the psychotherapy workforce might be utilised in contemporary mental health and addiction services.

Presently, Covid-19 in both its short and long forms is focusing attention on the need for psychological services across the whole health sector, including physical health services.

> Long Covid, which has elements of ongoing anxiety and fatigue, alongside other physical manifestations, will put demand on a health service which is already stretched.

12 Talking therapy is a generic term for a variety of interpersonal methods that utilise speaking, listening, discussion, reflection, etc, to assist people to understand and make changes to their thinking, behaviour, and relationships in order to relieve distress and improve wellbeing.

> We need to be thinking what other services are required within the physical health space to work alongside clinicians when patients and whānau present with an array of symptoms. (Allied Health, Scientific and Technical Officer #1)

Increasing pressure on service provision is leading to practitioners not traditionally associated with talking therapies to train in DBT, CBT, ACT, mentalization-based therapy (MBT[13]), or single session therapy (SST), to work with individuals or lead therapy groups in mental health and addiction services.

> We have five nurse therapists working in our […] programme. This team treats people with borderline personality disorder […] and these nurses have been trained in [a group psychotherapy model] but are not registered psychotherapists. Another of our specialty services also employs a social worker, occupational therapist and two nurses [who] have training and experience in CBT but they are also not registered psychotherapists. Plus we have nurses trained in Maudsley Family-Based Therapy working in our Eating Disorders Service. (Psychology Professional Leader #1)

It seems counter-intuitive that broadening the capacity of mental health and addiction services to deliver talking therapies might marginalise the role of registered psychotherapists, yet this may be the case.

> We have in the past employed psychotherapists at the DHB; however, [we] have recently moved away from that. I think the issue around psychological support services to our community needs a complete revamp and we need to explore all options and opportunities and not just work with the current options, as the demand [for services] will never be able to be met by how we operate currently. I think it needs to extend beyond psychotherapists and psychologists, and include other mixes and options, including options tried elsewhere, like the UK. There is great opportunity, also, to upskill the wider workforce. Co-design with the community as well. (Allied Health, Scientific and Technical Officer #2)

Reference to the UK likely points to their Improving Access to Psychological Therapies (IAPT) programme (Clark, 2022) which began in 2008, a younger cousin to Australia's 2006 Better Access programme (Services Australia, 2022), with both national initiatives aiming to improve the treatment and management of mental illness through a network of trained talking therapy practitioners working at a local community level. Aotearoa New Zealand is also creating its own Big Community approach to wellbeing and community, as conceptualised in the Wellbeing Manifesto within *He Ara Oranga, Pathways to Wellness*, the report of the Government Inquiry into Mental Health and Addiction (2018, pp. 36–37, 90) and funded through the Labour Government's (2019) *Wellbeing Budget*.

"A key workstream in this [resulting] Access and Choice work programme is the

13 MBT is an integrative form of psychotherapy bringing together aspects of psychodynamic, cognitive-behavioural, systemic, and ecological approaches. See Bateman and Fonagy (2013) and their subsequent publications.

Integrated Primary Mental Health and Addiction (IPMHA) service [… that] provides easy access to mental wellbeing support in GP sites across the country" (Ministry of Health, 2021, np). Such support is to be provided by a new primary care workforce of Health Improvement Practitioners (HIPs) (Te Pou, 2022),[14] whose task is to help 325,000 people per annum with mild to moderate anxiety and depression by 2024 — approximately 6.5% of population coverage (Bastiampillai et al., 2019) — via brief-intervention consultations 'on the spot' as people present to GP practices. HIPs are practitioners registered variously under the Health Practitioners Competence Assurance Act (2003) (HPCAA) or by SWRB, DAPAANZ, or NZAC, and while registered psychotherapists are eligible via the first of these four broad gateways, the training experience in psychotherapy for thousands of other eligible registered practitioners could conceivably amount to the four days of face-to-face or eight half-days of online training required to begin practising as a HIP.

When we have an expanded workforce capable of delivering talking therapies, will we have lost sight of what psychotherapy offers that is distinct from the short-term, manualised, evidence-based practice so popular in medicalised and managerialised health services?

> [We] did have two [psychotherapists] several years ago in CAFS [Child and Family mental health Services] for 2-3 years but they struggled to work under our generally time limited model of care. Currently, [we] have two social workers with psychotherapy training working in CAFS as social workers. (Psychology Professional Leader #2)

It is as if there is no bona fide home for psychotherapy in the DHB mental health and addiction workforce because those services are controlled by medical doctors whose expertise is medication; patients are predominantly managed by nurses, occupational therapists, and social workers as generic keyworkers; clinical psychologists are the recognised specialists of talking-therapy treatments in the form of DBT, CBT, mindfulness and mentalisation; and psychotherapists do not easily fit into any of the above. Instead, they are often seen as offering a specialist 'procedure' within a rigid framework — such as when a child psychotherapist works in a playroom or an adult psychotherapist pursues medium- to long-term humanistic goals — rather than possessing a general knowledge that easily translates into a variety of skills fit for episodic care.

Perceptions of psychotherapists as lacking adaptability or needing more time than the health system can afford to undertake their specialist procedures, point to a lack of awareness or understanding about how the psychotherapy workforce could add value to contemporary mental health and addiction services.

> We see this [survey] as an opportunity to consider registered psychotherapists to be employed in our DHB. Ongoing shortages of clinical psychologists are problematic and the need for talking therapy is increasing. (Nurse Manager)

> We need to consider how we diversify our workforce to be able to provide choice and

14 Te Pou is a not-for-profit national workforce centre for mental health, addiction, and disability in Aotearoa New Zealand.

> increase capacity for the delivery of psychological therapies. (Allied Health Director)
> There needs to be greater awareness of the role of psychotherapists and how this workforce can be utilised. (Allied Health, Scientific and Technical Officer #3)

Diversification of the mental health and addiction workforce and the role of psychotherapy in the new health system are also matters of concern for NZAP members as they gather online — due to Covid-19 — for their annual conference from 1–3 April 2022. To stimulate informed thought and debate, a Psychotherapy and Public Worlds discussion panel is convened for an hour on the Saturday afternoon, with the invited inclusion of Robyn Shearer, the Ministry's Deputy Chief Executive and Deputy Director General of DHB Performance and Support.

Section 3: Psychotherapy and Public Worlds panel, NZAP conference, April 2022

The abstract for the panel session printed in the conference programme reads: "Psychotherapy exists in a rapidly changing mental health environment. This panel [...] discusses its impact on our prospects, vitality and livelihood" (NZAP, 2022a, 6). In addition to the constant stress of an evolving Covid-19 pandemic, that rapidly changing mental health environment includes the gathering pace of generational change in the national health system. On 1 July 2022, 15 months of intensive planning — mostly undertaken away from the glare of detailed public scrutiny due to the pandemic — takes effect when the existing 20 DHB regional governance structure is superseded by a new "single service" organisational partnership between the Ministry, as chief steward and kaitiaki, and two new entities: Te Whatu Ora, who take over the day-to-day services and functions of the DHBs, and Te Aka Whai Ora, who work alongside Te Whatu Ora "to improve services and achieve equitable health outcomes for Māori" (New Zealand Government, 2021, np).

Robyn Shearer represents the Ministry on the panel, whose roles in the new health system are policy, strategy, regulation, and monitoring, without the responsibility for funding and managing contracts. The other panellists are all NZAP members: Alayne Mikahere-Hall (Ngāti Whātua, Te Rarawa, Tainui, and a founding member of Waka Oranga National Collective of Māori Psychotherapy Practitioners), Kyle MacDonald, myself, and the panel Chair, John Farnsworth, who is also Chair of the NZAP Public Issues Committee.

John introduces the panel session by predicting it will be "pragmatic and outward looking, and concerned with the larger world in which psychotherapy takes its place", and Robyn's response, as the first invited speaker, is to affirm the roles of the Ministry and NZAP as partners in support of mental wellbeing in Aotearoa New Zealand at a time when the Ministry's health reforms "are focused on equity, person-centred care, increasing choice, and many more community solutions" (NZAP, 2022b).

Robyn gives an overview of the Access and Choice service delivery programme, noting that by the end of its roll-out approximately 60% of its workforce will be non-clinical, enabling the Ministry "to grow more options for people, have better reach out, and ultimately respond better to people's needs" (NZAP, 2022b).

In relation to the future of the current mental health and addiction workforce, Robyn

foresees new opportunities for psychotherapists in supporting emerging workforces associated with expanding the provision of talking therapy, for example, through training and supervision, "so you will play a pivotal role, and I'm looking forward to hearing from you about what opportunities you think exist in that regard and what part psychotherapists play in the [health] system now and going into the future" (NZAP, 2022b).

When the panel is invited to respond to Robyn's address, Kyle MacDonald advocates for expediting the recruitment of overseas trained psychotherapists and psychologists via immigration so that when Te Whatu Ora expands the talking therapy workforce it does not trade workforce quality for speed of establishment. Robyn confirms that the Ministry recognises Aotearoa New Zealand does not have the ability to grow its own workforce of mental health clinicians, which is why they are on the priority list for immigration; however, she does not know whether this goes beyond nurses and psychiatrists to include allied health and, specifically, psychotherapy.[15] She notes, as a related matter, the lack over many years of a "good workforce policy and having that longer term view of how we grow our capacity and capability across the sector." As Te Whatu Ora takes responsibility for the day-to-day issues in the new health system, the Ministry expects "to be able to focus on 'where are we going in the future', look at trends, look at what's happening internationally to help inform tertiary education and things like immigration as an opportunity" (NZAP, 2022b).

Alayne Mikahere-Hall also raises the issue of workforce development by acknowledging that Te Rau Ora [16] "has been working consistently hard in this space for a long time now," and asks Robyn what investment the Ministry will make towards the development of training for Māori and, potentially, for Māori psychotherapists. Robyn affirms the work of Te Rau Ora and the existence of funds in the Ministry's budget for such training, while also emphasising the importance of Te Whatu Ora investing in the Māori clinical workforce as part of its Te Tiriti partnership obligations rather than leaving that to Te Aka Whai Ora. In relation to Te Whatu Ora's kaupapa to pursue diversity in the mental health workforce, Alayne cautions that this may compound the existing problem of Māori voices [17] not being heard, though she welcomes the inclusion of Te Aka Whai Ora in this regard (NZAP, 2022b).

My [CW] questions for Robyn [RS] are informed by the 2022 national DHB psychotherapy workforce survey presented in Section 2 of this paper, and how the situation of psychotherapy might change under Te Whatu Ora.

CW: I'm aware of a survey I made recently around the 20 DHBs and there are 20 FTE of psychotherapy in the total DHB workforce, and they are in five DHBs only, so 75% of DHBs don't have a psychotherapist employed. Only two DHBs have a psychotherapy student. [...] My question to you is what will be the role of

15 See the subsection on overseas recruitment in Section 5 of this paper.

16 Te Rau Ora is a kaupapa Māori organisation dedicated to transforming Māori health and social service workforces to improve Māori health and wellbeing.

17 Mikahere-Hall adds that "the Māori voice is often the last or final voice at the decision making table. We should be there from the outset and consulted with independently as Māori, in a respectful Te Tiriti based engagement, irrespective of what our NZAP colleagues regard as best psychotherapy practice. [... T]he decision for NZAP to become a registered health profession was not inclusive of Māori. We were barely considered in the process. We had just arrived at the NZAP Council table to speak to Māori development within the professions and the establishment of Waka Oranga, when important decisions were being made about our professional future" (A. Mikahere-Hall, personal communication, December 15, 2022).

psychotherapy in Health New Zealand when the DHBs are gone, and [there is] that great need — as you say — for diversity, for person-centredness, and choice, yet there is an idea that psychotherapists have got to adapt to a new world, when actually we are relevant in the wider world currently, and will continue to be relevant. Really, I am wondering, in terms of the design of services and the commissioning of services, where the Ministry sees psychotherapy placed given those statistics?

RS: I think this is a longstanding issue about educating the people who are recruiting into those roles about the opportunities. [...] I think there's still a fairly traditionalist element in the recruitment of roles in many of the mental health services [...] where it tends to be nursing and psychiatry and some allied health, but dominated by nursing and psychiatry, and I think there is an opportunity for us [the Ministry] to be giving better guidance around: "If you have a vacancy, look for your opportunity to consider psychotherapy in the mix of people who could support communities or be part of a multi-disciplinary team approach." [...] I think there's a lot of policy work to do around that. In my view, it's still a shift we need to make around the type of roles in specialist mental health services that could be broadened out that are more helpful, and perhaps also, the enhancement of the community aspect, so [as] more people[/service users] are being driven out to the community, there needs to perhaps be a re-balancing of how many people[/clinicians] are employed in specialist mental health and how many are employed in primary [care in the] community. That's not going to be an easy thing because there's always lots of anxiety about [there being] not enough specialist mental health services. We have lots of vacancies, so it feels like there's a whole piece of work that needs to be done from a — if you like — a policy and innovation research perspective.

CW: Could I just follow that up with another comment, which again comes through the survey. There is quite a lot of hope for diversity [among survey respondents] and there are nurses, occupational therapists, and social workers being employed to run all sorts of mental health services: mentalisation, DBT, CBT, etc; so that when it comes to advertising for a mental health professional there is often, these days, quite a broad category of people who could fit in. [...] My concern is that there is a genericising of roles and what psychotherapy offers gets lost. So, [in relation to] the education of those in recruitment roles, it feels like there has already been education around diversity and somehow psychotherapy gets lost in that because there are all these other options.

RS: In response to that, if there's any advice or promotion from you as a network that could help us in describing and promoting the role, [...] Really happy to take that up because I do think it's about profiling what psychotherapy does, what's unique, and how you support people in their journeys, and the type of roles you are doing. I think it's really a great opportunity if we could work together on that — knowing

> that we're going through a whole lot of reform work [at the moment], but it would be really good, I think.[18]

Robyn's invitation for psychotherapists to advise the Ministry on policy matters relating to the role of psychotherapists in the mental health and addiction workforce creates opportunities for increasing both the presence of psychotherapy and the quality of public health in Aotearoa New Zealand. This paper is a response to that invitation. It attempts to contextualise the inherited DHB mental health and addiction workforce in terms of its ideological premises, practices, and pitfalls, and to promote psychotherapy as a Te Tiriti-honouring, culturally relevant, efficacious, effective, and humanising psychosocial treatment practice. In these respects, psychotherapy easily integrates within the cultural values emerging from the new health system.

If psychotherapists are to play a larger role in public health, the ongoing development of their workforce is required to ensure a sufficient number of practitioners are trained locally or imported from overseas and professional standards maintained. Statistical data on the psychotherapy workforce between 2008 and 2021 is presented in the following section, together with descriptions of initiatives that address issues relating to future workforce development.

Section 4: Psychotherapy workforce in Aotearoa New Zealand

The first attempt to formally organise psychotherapists in Aotearoa New Zealand into a workforce — in a broad sense of that term — goes back to the founding of NZAP in 1947 (Manchester et al., 1996). Over 60 years later, members of that Association "ceded our autonomy and self-determination to Government" regulation under PBANZ, "the regulatory authority and registration body for psychotherapists" (Fay, 2013, p. 32), as set out in Section 118 of the HPCAA. Since its inception in 2008, PBANZ has collected statistics on the national psychotherapy workforce and these are summarised overleaf.

Figures D and E depict the number of psychotherapists registered by PBANZ each year from 2008 to 2021. Starting with existing members of the profession who take up the opportunity for registration during the first two years, new registrations have steadied to between 21 and 37 per annum for the past decade. Notably, the number of registrations in the child and adolescent psychotherapy scope of practice are modest, with only nine new registrants over the past ten years, which is due to there being no training programme for a number of years. The existing programme at AUT is small and "should have greater [Government] support to ensure the longevity and success of the training, to increase the numbers of child psychotherapists who can potentially work and supervise clinicians in public mental health services" (J. Bruce, Treasurer, NZACAP, personal communication, September 7, 2022).

18 Also, see the appendix for additional notes provided by Robyn Shearer, dated 27 April 2022.

Figure D: Line chart of psychotherapists registered each year by PBANZ 2008-2021

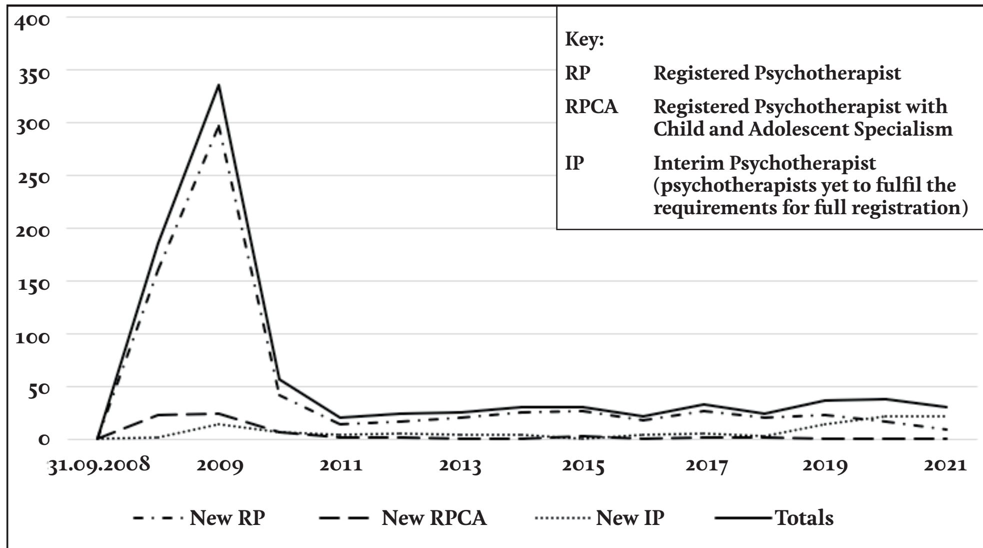


Figure E: Table of psychotherapists registered each year by PBANZ 2008-2021[19]

Year	New RP	New RPCA	New IP	Totals
Up to 31.09.08	0	0	0	0
01.10.08 – 31.12.08	161	23	1	185
2009	297	24	14	335
2010	42	7	6	56
2011	14	2	3	19
2012	16	2	5	23
2013	20	0	4	24
2014	25	0	4	29
2015	26	3	0	29
2016	18	0	3	21
2017	26	1	5	32
2018	20	1	2	23
2019	23	0	13	36
2020	16	0	21	37
2021	9	0	21	30
Totals	**713**	**63**	**102**	**879**

19 Data gratefully received from Janet Hay, PBANZ Kairēhita/Registrar, and her team in May 2022. Figures D, E, and F relate to each calendar year rather than PBANZ's Annual Practising Certificate year from 1 Oct to 30 Sept.

Figure F: Broad categorisation of qualification pathways for PBANZ registration 2008–2021[20,21]

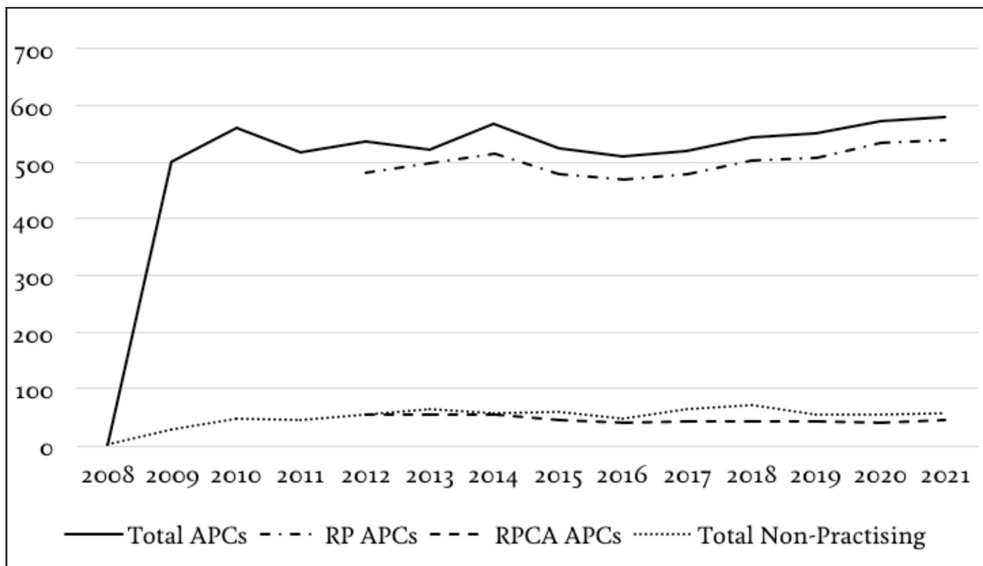
Qualifications	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Totals
PBANz	38	93	17	6	5	9	7	8	4	11	4	4	6	5	**217**
AIT/AUT Dip	36	73	9	-	1	-	-	-	-	-	1	-	-	-	**120**
ANZAP Dip	13	10	2	1	-	-	4	1	-	-	-	-	1	-	**32**
Ashburn Clinic	3	1	1	-	-	-	-	-	-	-	-	-	-	-	**5**
AUT MHS/MP AP	17	36	9	4	12	9	9	9	13	12	12	13	13	14	**182**
AUT MHS/MP CAP	2	-	-	1	-	-	-	1	-	-	-	2	6	5	**17**
Bioenergetics	1	2	1	-	-	1	-	-	-	2	-	-	1	1	**9**
Gestalt	9	23	5	4	3	1	4	5	1	2	-	2	1	1	**61**
Jungian	1	4	-	-	-	-	-	-	-	-	-	-	-	-	**5**
NZAP ACP	29	35	1	-	1	-	-	-	-	-	-	-	2	1	**69**
Psychoanalytic	1	3	1	-	-	-	-	-	-	-	-	-	-	-	**5**
Psychodrama	2	8	1	1	-	1	2	-	-	-	2	2	-	-	**19**
Psycho-synthesis	6	20	4	2	1	1	2	3	2	1	3	10	1	-	**56**
TA	17	19	1	-	-	2	1	2	1	4	1	3	6	3	**60**
UO PGDip CAP	10	8	3	-	-	-	-	-	-	-	-	-	-	-	**21**
UA PGC ICAMH	-	-	1	-	-	-	-	-	-	-	-	-	-	-	**1**
Totals	**185**	**335**	**56**	**19**	**23**	**24**	**29**	**29**	**21**	**32**	**23**	**36**	**37**	**30**	**879**

20 Excludes supervised clinical practice and personal psychotherapy experience requirements.

21 Abbreviations: PBANZ — Final assessment accredited or set by PBANZ 2008-2010 and comparable overseas qualification assessments; AIT/AUT Dip — Auckland Technical Institute/Auckland University of Technology, Graduate Diploma of Psychotherapy; ANZAP Dip — Australia and New Zealand Association of Psychotherapy, Diploma of Adult Psychotherapy; Ashburn Clinic — Ashburn Clinic Certificate of Completion; AUT MHS/MP AP and AUT MHS/MP CAP — Auckland University of Technology, Master of Health Science (now Master of Psychotherapy), with Adult, and Child and Adolescent pathways respectively; Bioenergetics — Certified Bioenergetic Therapist; Gestalt — Diploma of Gestalt Psychotherapy; Jungian — Accredited Jungian Analyst with ANZSJA and/or IAAP; NZAP ACP — New Zealand Association of Psychotherapists, Advanced Clinical Practice; Psychoanalytic — Membership of the New Zealand Institute of Psychoanalytic Psychotherapy; Psychodrama — Australian and Aotearoa New Zealand Psychodrama Association, Certified Psychodramatist; Psychosynthesis — Diploma in Psychosynthesis Psychotherapy; TA — Certified Transactional Analyst; UO PGDip CAP — University of Otago, Postgraduate Diploma in Child and Adolescent Psychotherapy; UA PGC ICAMH — University of Auckland, Postgraduate Certificate in Health Sciences in Infant, Child and Adolescent Mental Health.

Figure F tabulates the number of registrants coming through each available qualification pathway between 2008 and 2021. “In these times of upheaval and existential crisis,” — states the NZAP Northern Branch’s advertisement for an address to be given by Elizabeth Day, Head of Department of the AUT psychotherapy training programme — “the escalation of mental ill-health calls for an exponentially larger workforce, trained to support people in ways that fit time and place” (Northern Branch NZAP, 2022). AUT’s response is to centre their work in Te Tiriti-honouring practices, draw on and broaden the research base of their training, and increase access to their programmes through nationalisation and by increasing student numbers at their Auckland base. The proposed nationalisation involves opening at least one new training site satellite to Auckland in 2024 for an additional 20–25 students, with clinical placements located around that satellite required by 2025. Current estimates for annually increasing student numbers for the next few years on the existing Auckland programme range from a 10% increase in the adult (generic) stream, to 20% in the child and adolescent specialism stream (E. Day, personal communication, August 22, 2022).

Figure G: Line chart of Annual Practicing Certificates (APCs) issued by PBANZ and non-practising registered psychotherapists 2008-2021[22]



The total number of APCs issued to registered psychotherapists and registered child and adolescent psychotherapists by PBANZ are shown graphically in Figure G. The net annual increase over the last 10 years is 75 (from 516 in 2012 to 581 in 2021), with the representation

22 Data on the total number of APCs issued and the number of non-practicing registered psychotherapists without an APC, is drawn from PBANZ’s Annual Reports (2008-2021) for the period 1 October to 30 September each year. Data on the split between RPs and RPCAs is provided by PBANZ; however, such figures were not available for the period 2008-2011.

of the child and adolescent specialism decreasing from 9.1% (n = 47) to 7.7% (n = 45) in the same period.

The 2021 figures roughly equate[23] to there being 11 registered psychotherapists per 100,000 New Zealanders, as compared to 74 registered general practitioners, 1100 registered nurses, 72 registered clinical psychologists, 58 counsellors,[24] and 8 registered psychiatrists, where each of these comparative professions is recognised as being in a mental health and addiction workforce crisis by the Association of Salaried Medical Specialists/Toi Mata Hauora (2021).

"To protect the health and safety of members of the public" (HPCAA, 2003, Sec. 3.1) PBANZ is at work on a five-year strategy to expand access and choice to mental health treatments in Aotearoa New Zealand. It identifies two main strategies for doing so, namely, (1) a commitment to PBANZ's work reflecting Te Tiriti and responsiveness to tangata whenua, and (2) the equitable access to, and availability of, psychotherapy through workforce development. With respect to Te Tiriti, PBANZ actively engages in considering the needs of both tangata whenua whānau and tangata whenua psychotherapists, and its aim is for 50% of Board members to be tangata whenua. With respect to the psychotherapy workforce, PBANZ is developing an accreditation process for psychotherapy training providers that will enable existing 'grandparented'[25] providers to have their programmes gazetted, and for new training programmes to emerge. PBANZ is also reviewing its psychotherapist scopes of practice to ensure that specialisms reflect the current profession and take into account the needs of the public, including those relating to public mental health and addiction services (PBANZ, 2022).

It can be seen from the various statistics and commentaries above that psychotherapy is a relatively small professional discipline in Aotearoa New Zealand, but one with opportunities to take and challenges to meet in the newly emerging bicultural health system, and these are discussed in the section below.

Section 5: Opportunities and challenges

The mana[26] of psychotherapy

The new health system presents a generational opportunity for public mental health and addiction services to shift away from the DHBs' ideological paradigm of cyclic, risk-based, episodic modes of care, to more equitable, person-centred, diversified, accessible, and sustainable healthcare practices. As the epigraph to this paper conveys, the Ministry foresees psychotherapists playing an important role in shaping and contributing to that system. That the Ministry invites input and advice from psychotherapists is an indication of the mana of the latter; and indeed, it is a significant event when a person's mental wellbeing is

23 These figures have been calculated from workforce data available online from relevant professional bodies and dated between 2018 and 2021.

24 Counsellors are not regulated by legislation in Aotearoa New Zealand. NZAC offers a registration "for members who meet our rigorous training, qualification and professional development standards" (see: https://nzac.org.nz/). The "per 100,000" figure given above is based on NZAC having around 3000 members.

25 Here grandparenting refers to an exemption for specific psychotherapist training providers, past and present, in recognition that their training courses meet the requirements for registration until such time as PBANZ develops a new accreditation process.

26 Mana: "Prestige, authority, control, power, influence, status, spiritual power, charisma. Mana is a supernatural force in a person, place or object" (Moorfield, 2011).

wholistically supported and restored, perhaps lastingly, which is how psychotherapy has gained mana in Aotearoa New Zealand through its appropriate use over many decades. Psychotherapists stand in their mana when forging partnerships with the Ministry through their professional associations, NZAP and NZACAP, or as workforce training providers. The challenge is whether the voluntary leadership teams of these entities can sustain the expenditure of human and other resources necessary to represent their memberships in continuing dialogue, not only with the Ministry but also with Te Whatu Ora and Te Aka Whai Ora as clarity is gained about which policy and operational responsibilities sit with each organisation.

Te Tiriti o Waitangi

Psychotherapy can assist the new health system to be a good Te Tiriti partner. It can do this because psychotherapy's worldview of people's health and wellbeing appears to align more closely with te ao Māori than the individualism of psychiatry and clinical psychology. In responding to the dearth of psychotherapists employed in DHBs (as depicted in Section 2 of this paper), Te Aka Whai Ora advocates for the long-term benefits of psychotherapy:

> It would seem appropriate for all DHBs to employ at least one (if not more) psychotherapists, as the support they can offer tāngata whaiora would be critical and beneficial to *longer-term* wellness and hauora (improved health). (L. Cassin, Clinical Director, Oranga Hinengaro, Te Aka Whai Ora, personal communication, August 10, 2022; emphasis added)[27]

Moreover, NZAP has developed deep relational roots with Iwi Māori during several decades of difficult discussion about psychotherapists' conscious and unconscious racism, and these roots sustain an ongoing Te Tiriti partnership with the Waka Oranga National Collective of Māori Psychotherapy Practitioners. The perennial challenge is decolonisation and Te Mana Motuhake o te Iwi Māori — self-determination and control for Māori over their health and wellbeing — which has implications for the legal status of current and future kaupapa Māori practice, training, and accreditation pathways. While meeting its Te Tiriti responsibilities is still very much a work in progress for psychotherapy, its partnership experiences and those of its regulatory authority, PBANZ — who have set a five-year strategy that includes tangata whenua comprising 50% of its Board's membership — may usefully inform their contributions to broader discussion on cultural equity in the health system.

National mental health and addiction workforce policy

The aims of the new health system — to achieve greater equity, diversification, and person-centred care in public mental health and addiction services — would be enhanced by providing the option of psychotherapy to more tāngata whai ora, thus giving Māori the choice to access psychotherapy if they want to. The Ministry is offering to guide health recruiters toward psychotherapy and it envisages roles for psychotherapists in training and supervising community-based HIPs under the Access and Choice scheme; however,

27 At the time this quote was made, the regional hospital and specialist service entities in Te Whatu Ora had superseded the DHBs.

recruiters do not design national workforce policy and there are good reasons why psychotherapists have shied away from public health under the DHBs.

This appears to be a Ministry workforce policy issue, and in recognising this the Ministry is inviting psychotherapists to provide them with ideas and advice about how to promote psychotherapy. In effect, this is an opportunity for psychotherapists to market psychotherapy through such means as disseminating eye-catching research unique to the Aotearoa New Zealand context in contemporary media, such as television, radio, and Twitter — like Kyle MacDonald[28] does — and in promotional videos and self-help apps that feature real life and digital/cartoon formats.

This mahi is likely to fall largely on the psychotherapy associations and psychotherapy training providers who depend on market growth for survival; however, the promotion of psychotherapy in Aotearoa New Zealand has not been a straightforward issue (Tudor, 2011, 2012). Despite being motivated to have more psychotherapists employed in the public sector when lobbying the Ministry for registration 20 years ago (Bailey & Tudor, 2020), the DHB psychotherapy workforce survey in Section 2 of this paper gives reason to wonder whether enough has been done to promote psychotherapy since. Among modality training, the gestalt, self-psychology, and psychosynthesis institutes are currently without sufficient faculty or trainees to be active; while practitioners newly certificated in psychodrama, transactional analysis, and bioenergetics do not necessarily seek psychotherapy registration. These dynamics present further challenges to public health policy; namely, to extend its diversification more widely so that these readily sought after modalities within the private sector *are also made available within the public sector.*

Other workforce-related opportunities include undertaking local mental health and addiction needs analyses to determine, among other strategic matters, whether a review of the widespread closure of specialist psychotherapy services around the country is required. For example, person-centred care means matching treatment with needs, which could include making greater provision for long-term, specialist psychotherapy with particular populations of service users. The provision of short-term psychotherapy in physical health settings, such as immunology, cardiology, and sexual health is another workforce diversification option.

Psychotherapy workforce development

"One of the obvious brakes on the number of psychotherapists available to work in [public health] is the very limited opportunities for training through current tertiary institutions" (L. Holdem, Past President, NZAP, personal communication, August 15, 2022). There are signs those brakes might be easing. PBANZ is developing training standards that provide opportunities for both current and new training providers. AUT aims to nationalise its psychotherapy training courses through satellite centres, the first opening in 2024. NZAP's Academy (NZAP, 2022) is almost ready to launch its online learning community, which will include training workshops suitable for HIPs and other mental health providers. The opportunities that new or expanded psychotherapy training programmes offer public

28 See Kyle's *New Zealand Herald* column, Mind Matters, at https://www.nzherald.co.nz/author/kyle-macdonald/, his co-hosting of The Nutters Club on Newstalk ZB at https://thenuttersclub.co.nz/tags/kyle-macdonald, and his Twitter feed at https://twitter.com/kylemacd.

health rely on the health system making psychotherapy student practicum placements and psychotherapy-trained placement supervisors readily available throughout the country to encourage training providers to set up around regional public health services. An incentive for the health system is that the recruitment of students into postgraduate public health career positions is enhanced through them bonding with the teams they complete their placements in. Alternatively, students could be paid a financial bond during their clinical placements to secure their services for a minimum time following the completion of their training.

Overseas recruitment

The former Long Term Skill Shortage and Essential Skills work visa schemes have been replaced in the past year by an Accredited Employer Work Visa framework. Positions must have been unsuccessfully advertised in Aotearoa New Zealand before being eligible for overseas recruitment. Psychotherapy is included with psychiatry, clinical psychology, nursing, occupational therapy, and general practice, as a Tier 1 Straight to Residence role among Immigration New Zealand's Green List roles.[29]

The Ministry of Health is currently developing a national Health Immigration Service, with close ties to Immigration New Zealand, to handle overseas recruitment for the whole health system. Given the traditional strength of psychotherapy in Australia, the United Kingdom, South Africa, the United States, France, Germany, and Canada — who are seven of the top ten sources of migration to Aotearoa New Zealand over the past ten years[30] — the odds are that there is a significant pool of experienced psychotherapists who are ready to bolster our local workforce.

Concluding comments

The opportunities and challenges highlighted in this paper are not exhaustive. They are intended to stimulate discussion and action to aid the expansion of psychotherapeutic services in Aotearoa New Zealand's new health system. In my opinion, it is no exaggeration to say that by looking back to the origins of our bicultural statehood to be able to see forward to the health of future generations — ka mua, ka muri — the Government's vision for equitable transformation in a constantly changing healthscape is remarkable. It is another significant step towards a more just society where the health and wellbeing of everyone living in Aotearoa New Zealand is of equal importance. And what role will psychotherapy play in this collective healing? We wait to see.

29 "Psychotherapy: ANZSCO 272314, Tier 1 role eligible for straight to residence. Industry: Health and social services. To be eligible you must be working for an accredited employer or have a job offer from one. If you meet all the visa requirements you can apply for a Straight to Residence Visa now. […] Qualifications, registration or experience required: You must have NZ registration with the Psychotherapists Board of Aotearoa New Zealand." See: https://www.immigration.govt.nz/new-zealand-visas/apply-for-a-visa/tools-and-information/work-and-employment/green-list-occupations

30 Source: http://infoshare.stats.govt.nz/#

Appendix

The following notes were provided by Robyn Shearer of the Ministry on 27 April 2022:

We need a robust, expanded, and diversified workforce to deliver initiatives to enhance mental wellbeing. As pointed out in *He Ara Oranga* [Government Inquiry into Mental Health and Addiction (2018)], "All the dreams of the Inquiry will come to naught if we don't have a workforce."

We've taken a "whole of workforce" approach focusing on growing the existing workforce, developing new workforces, and supporting and upskilling the current workforce. This applies to workforces in targeted prevention programmes, and both primary and specialist mental health and addiction services.

Some of the approaches we are taking are:

Strengthen the national strategic leadership

The Ministry's Mental Health and Addiction Directorate has stepped into a stronger national leadership role for mental health and addiction workforce development, working with other government agencies and also with the four national mental health and addiction workforce development centres.

Growing and upskilling mental health and addiction workforces

New investment includes a focus on expanding training and development, equity initiatives for people and groups which have poorer outcomes, and increasing the number of people entering the mental health and addiction workforce. Examples of these initiatives include:

- Increasing the number of clinical psychology interns from 12 to 28;
- Doubling the number of scholarships for Māori and Pacific studying towards a mental health and addiction career;
- Increasing the numbers able to access the New Entry to Specialist Training;
- The new MHA nursing campaign we launched recently.

We are also looking at upskilling opportunities for areas such as talking therapy — working with a wide range of providers, including the University of Auckland, the University of Canterbury, Te Rau Ora, and Te Pou to broaden the skillset of our existing workforce. We have funded ten post graduate courses covering talking therapies and brief interventions and a Kaupapa Māori talking therapies training.

Changing the workforce mix and models of care

Through the Access and Choice programme, we are embedding the support workforce, including peer support workers, cultural support workers, and health coaches, to work alongside the clinical workforce in primary mental health and addiction services.

By the end of the rollout, a significant percentage of the workforce delivering Access and Choice services will be non-clinical workers. This shift will help services to grow more quickly, reach more people, and ultimately better respond to people's needs.

New initiatives and innovations

We will continue to expand beyond traditional workforces, building understanding of mental wellbeing for staff across other government agencies. For example, we have a Request for Proposal on GETS at the moment for Maternal and Infant Mental Health Competency training for the broader workforce. This will be available to both mental health and addiction staff and to the wider workforce such as Whānau Ora.

We are working with the New Zealand Association of Counsellors on processes to accredit individual counsellors to work in MHA services, and hope for this to be in place later this year.

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