Health New Zealand
Te Whatu Ora

22 May 2025

s 9(2)(a)

Tēnā koe s 9(2)(a)

Your request for official information, reference: HNZ00084686

Thank you for your email on 5 April 2025, asking Health New Zealand | Te Whatu Ora for the following under the Official Information Act 1982 (the Act):

> *"I would like to make an OIA request for information in relation to the development of the associate psychologist role.*
>
> *Specifically including the names and occupations of all involved in the associate psychologist advisory group/ or any other group within HNZ that has had any dealings with this role and any documents, information, communications and any other information from this group regarding this role.*
>
> - *Please include information regarding the development of a training pathway*
> - *Please include any consultation undertaken with stakeholders in this role.*
> - *Please include any information regarding the impact on the workforce within HNZ,*
> - *Please include information on a pay scale or working conditions of this role.*
> - *Please also include any communications between HNZ and the Minister Matt Doocey or anyone from his office in the development of this role.*
>
> *I will require the documents via email and I am not open to a video call or summary or otherwise in relation to this request."*

Response

Please refer to **Appendix One** which provides our decision on the release of documents within scope of your request. The documents able to be released are attached as **Appendix Two**.

For the sake of clarity, I will address each question in turn.

> *"I would like to make an OIA request for information in relation to the development of the associate psychologist role.*
>
> *Specifically including the names and occupations of all involved in the associate psychologist advisory group/ or any other group within HNZ that has had any dealings with this role and any documents, information, communications and any other information from this group regarding this role.*

This part of your request is refused under section 9(2)(g)(ii) of the Act in order to maintain the effective conduct of public affairs through the protection of Ministers, members of organisations, officers, and employees from improper pressure or harassment.

We acknowledge that we do not believe harassment will be exercised on your behalf, although, as negative responses have been experienced by subject matter experts, as well as this response

being potentially proactively released for the public interest, there are concerns for such matters occurring from wider public. Therefore, as outlined above, refusal of this information has been made pursuant to section 9(2)(g)(ii) of the Act.

- *Please include information regarding the development of a training pathway*

As written in the Terms of Reference, the purpose of the Associate Psychologist Advisory Group (APAG) was to:

- Provide representative input from the perspective of a member's experience and expertise and where applicable their organisation, community, or institution and contribute towards any update, promotion or outcomes, as agreed within the meeting.
- Inform the project by identifying actions leading to an Associate Psychologist (AP) role, training pathway, and registration.
- Inform on practice, process and considerations that will impact the project.
- Contribute to and review solutions, and make recommendations to ensure solutions are maximally achievable, acceptable and contribute to the aim of the project.

The APAG met throughout 2024 to discuss important aspects of the role including but not limited to: the role description, place in the workforce, developing a training pathway, workforce support/supervision, employment settings, guidance for training methods and content, role development, cultural safety, te ao Māori perspectives on psychology, and any thoughts queries or concerns held**.** Please refer to **Appendix Two.**

Consultation on the draft role description went sector wide through the NZPB survey sent via Health New Zealand | Te Whatu Ora (Health NZ). Please refer to **Appendix Two.**

The AP programme will provide an opportunity for graduates from a 3-year undergraduate psychology degree (minimum), to enter a standardised training pathway that leads to a career as a registered health practitioner. This will allow MH&A teams to expand access to psychological support and increase the availability of regulated and supervised professionals in MH&A settings. It is intended that this role will be situated in Health NZ provided and funded clinical teams that provide for mental health and addiction care in both primary and specialist settings (including NGO's). It is also anticipated that other sectors will have an interest in the role.

The 4 years (minimum) of study including a 3-year undergraduate psychology degree (minimum) and 1-year postgraduate diploma including placement will equip APs to meet the competencies for registration that are being developed by the NZPB. These competencies will equip APs with skills to provide support to tāngata whai ora who seek low to moderate intensity psychological care.

APs will contribute to the provision of low to moderate intensity psychological care and will support the psychological functions of the MDT. In specialist services, this will compliment and support, but not replace, the care provided by registered psychologists for more complex needs. This will allow existing registered psychologists to focus on the more complex needs they're trained for.

The AP postgraduate diploma is level 8 on the NZQF (refer to **Appendix Two**) and with advice from stakeholders it was considered to be a relevant level of study for this role.

The newly developed Bachelor of Psychology/psychological science will provide an opportunity for pathways to professional practice to be developed that support more focussed acquisition of relevant competencies during undergraduate training. Tertiary education providers will consider how the AP qualification can pathway to further training and career opportunities in psychology. Priority will be given to ensuring the training and practice of AP's will be culturally safe, inclusive of Māori models of psychological care, and responsive across the diversity of Aotearoa New Zealand populations. This will be through the development of the training programmes, competencies and scope of practice. Supervision is intended to be provided by registered psychologists and the regulatory oversight of the NZPB and the HPCA Act will ensure safe practice. Health NZ will work on developing models and resourcing to enable supervision where it is not immediately available in

teams. In time, consideration will be given to a pathway for senior APs to develop the necessary competencies to supervise fellow APs.

As mentioned above, there are post-graduate training pathways available, as outlined in the below tables.

Table 1: Postgraduate training currently available

University of Canterbury	• HLTH430 – Motivating Behaviour Change I • HLTH431 – Motivating Behaviour Change II • PSYC442 – Clinical Practice Guidelines and Introduction to Cognitive Behavioural Assessment • PSYC443 – Cognitive Behavioural Therapy Case and conceptualisation and Intervention • PSYC446 – Frontiers of Cognitive Behavioural Therapy I • PSYC447 – Frontiers of Cognitive Behavioural Therapy • COUN681 – Solution Focused Therapies and Skills with Individuals and Groups • COUN682 – Focused Commitment and Acceptance theory
University of Auckland	• PSYCHIAT 769 – CBT with Children, Adolescents and their Whānau Part 1 • PSYCHIAT 770 – CBT with Children, Adolescents and their Whānau Part 2 • PSYCHIAT 766 – Youth Addiction and Co-existing Problems

Table 2: Skills Matter funding (via Te Pou) Postgraduate training

University of Auckland	• PSYCHIAT 740 – Child and Adolescent Psychopathology • PSYCHIAT 747 – Child and Adolescent Development • PSYCHIAT 768 – Assessment, Formulation and Treatment Planning in Child and Adolescent Mental Health • Assessment and Management of Co-existing Substance Use and Mental Health • Clinical Leadership in Nursing Practice
University of Otago	• Postgraduate Certificate & Diploma Courses in Cognitive Behavioural Therapy • Exploring Perinatal Courses for 2026 – online • Assessment and Management of Co-existing Substance Use and Mental Health

Auckland University of Technology	• New Entry to Specialist Practice – Allied Health
Multiple Tertiary Providers	• New Entry to Specialist Practice – Nursing

For all information around the MH&A targets refer to this link: [Achieving the mental health and addiction targets - High level implementation plans – Health New Zealand | Te Whatu Ora].

- *Please include any consultation undertaken with stakeholders in this role.*

Please refer to **Appendix Two.**

Please also see below a list of stakeholders involved in the conversations and feedback given throughout the creation of this role. It is important to note, this role continues to be shared as it progresses into training and employment.

- New Zealand Psychologists Board (NZPB)
- New Zealand Collage of Clinical Psychologists (NZCCP)
- New Zealand Psychological Society (NZPS)
- Ministry of Health (MoH)
- Mental Health & Addiction Lived Experience advisors
- Primary Health Organisations (PHOs)
- Non-Government Organisations (NGOs)
- Health New Zealand | Te Whatu Ora secondary services
- Health New Zealand | Te Whatu Ora Mental Health and Addictions DAHS
- Allied Health
- Hauora Māori services
- Māori psychologists
- Pacific psychologists
- Tertiary Education Organisations (TEOs) including Universities, Te Pukenga and Wānanga
- Professional bodies
- Workforce and sector service leadership
- Tertiary Education Commission (TEC)
- Deputy Vice Chancellor universities meetings
- University Planning committee meetings
- University professional leads/HODs
- Employment advisors

Consultation with representatives from these stakeholders and feedback provided by Associate Psychology Advisory Group (APAG) on various documents such as the draft role description and employment setting helped guide and shape the AP workforce (name to be decided by the New Zealand Psychologists Board NZPB). Stakeholders were sent the attached documents for information, feedback, consultation and discussion throughout the development of this role.

Health NZ engaged with representatives of these stakeholder groups, and an advisory group (APAG) was formed with representation from NZPB, NZCCP, NZPS, MH&A Lived Experience advisors, PHOs, NGOs, Health NZ secondary services, Māori and Pacific Psychologists and TEOs.

- *Please include any information regarding the impact on the workforce within HNZ,*

The AP role is one of many initiatives underway to provide support and grow the MH&A workforce. There have been increases planned for the clinical psychology training pipeline (that will amount to around a 50% increase since 2019), and investment that allowed for the centralisation of salary funding for the majority of Mental Health & Addiction (MH&A) clinical psychology internships with up to 70 centrally funded internships available in 2026. The Placement Project is designed to better

support students to complete their studies by facilitating placements matches with Health NZ and ensuring the required practical hours are met. Health NZ fund over 400 scholarships for people studying towards MH&A careers.

Across 2022–2023, Health NZ funded both the New Zealand Association of Counsellors (NZAC) and the New Zealand Christian Counsellors Association (NZCCA) to update their membership systems and to develop a co regulation model for experienced counsellors. This meant eligible counsellors could be employed in secondary and primary services, for example, the access and choice contracts in the role of a Health Improvement Practitioner (HIP).

With the Government's announcement of the Mental Health and Addiction targets there was a clear expectation for increased MH&A workforce development through the target of training 500 mental health and addiction professionals annually. To reach this target there are a number of initiatives underway including increased numbers of funded psychology internships. Additionally, there has been an increase in funded psychiatry trainees, better utilisation of the peer support workforce such as the new peers in Emergency Departments (ED), Multi-Disciplinary MH&A Teams and crisis café initiatives, and work to create innovative new roles.

Several meetings have been held with the Universities Deputy Vice Chancellors and Planning committees to discuss and encourage increasing the intake of clinical psychology programmes. The mental health and addiction target action is focused on increasing enrolments into clinical psychological training with an additional 10 places each year 2025 – 2027 inclusive. Each university is encouraged to increase their enrolments and in 2025 the University of Canterbury (UC) increased their intake by 10 clinical psychology students and intends to continue this for the next two years.

The 2025 target of training 500 mental health and addiction professionals includes training an additional 110 Social Workers, Occupational Therapists and Nurses to undertake New Entry to Specialist Practice (NESP) training. There will also be 22 annual tertiary nurse practitioner training places for Nurses working in Mental health and Addiction services, funded by Health NZ.

There is a professional development opportunity under development for experienced non-medical clinicians (Nursing and Allied Health) to develop the skills and competences needed to be appointed as responsible clinicians under the Mental Health Compulsory Assessment & Treatment Act by Directors of Area Mental Health.

See the Mental Health and Addiction Targets here Mental health and addiction targets – Health New Zealand | Te Whatu Ora.

Health NZ fund Skills Matter through Te Pou and other postgraduate training. This includes training for workforces in Health New Zealand | Te Whatu Ora funded MH&A services including talking therapies, training for Infant Child Adolescent Mental Health Services (ICAMHS) workforce, allied health training through NESP programme, and skills matter clinical leadership in nursing practice.

- *Please include information on a pay scale or working conditions of this role.*

Health NZ will begin preparing for sector specific aspects of employment such as pay scales. This will include, but not be limited to, the development of role descriptions, employer guidance, models of support/supervision, support for graduate entry to professional practice, career framework and ongoing competency/professional development.

This role will support equitable access to psychological care within MH&A teams that are well known to be in high demand and support existing registered psychologists to work at the top of their scope in the tasks which they have been trained. Increasing the MH&A workforce and reducing demand driven stress on currently practising psychologists is essential, to ensure the provision of a high-quality and sustainable MH&A workforce in Aotearoa New Zealand.

- *Please also include any communications between HNZ and the Minister Matt Doocey or anyone from his office in the development of this role.*

Please refer to **Appendix Two**.

As you may know, developing an AP pathway has previously been considered in Aotearoa.

- 2019 Ministry of Health-led psychology workforce taskforce developed a proposal for a similar but unregulated and lesser trained role modelled on the UK "psychological well-being practitioner." The role development did not progress at that time.
- 2021 the New Zealand Psychologists Board (NZPB) included an action to "explore the potential for a new psychology-related scope of practice, qualified to provide services for low-risk need" in their *Hauora for All* strategic document (2021-2025). This statement was reiterated in their briefings to the incoming Minister of Health and Minister of Mental Health (March 2024).
- 2022 The Ministry of Health (then the establishment of Health NZ commissioned Allen+Clarke to provide a feasibility analysis for a psychological Wellbeing Practitioner workforce. They interviewed a variety of stakeholders across mental health related sectors regarding the feasibility of establishing this workforce. Capacity to progress to developing this role was not available at the time.
- 2024 The Minister for Mental Health Hon Matt Doocey announced Health NZ would begin work on the development of the Associate Psychologist workforce with the goal of the first cohort of students beginning study in 2026.

There is a collective responsibility across Health NZ, the NZPB and Tertiary Education Organisations (TEOs) for delivery of aspects throughout the development of the workforce.

The AP workforce is being developed to address the ongoing substantial gaps in our mental health and addiction workforce which present a significant barrier to increasing access to services. Due to current demands on services, many people are waiting for psychological support in both primary and specialist services or are missing out altogether.

How to get in touch

If you have any questions, you can contact us at hnzOIA@tewhatuora.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Health NZ may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

Lisa Gestro
Director Mentally Well (Interim)
Planning, Funding and Outcomes

Appendix One

No.	Date	Title	Decision on release
1.	7 October 2022	A+C Feasibility report on psychological wellbeing practitioner - Final 07102022	Released in full.
2.	September 2024	Employment Setting AP role discussion document	
3.	23 September 2024	HNZ Te Whatu Ora Assistant Psychologist Project ('Assistant Psychologist (working title) project')	
4.	October 2024	Associate psychologist Workforce and role description guidance Feb 25	
5.	10 October 2024	Update from the AP project team 10.10.24	
6.	21 October 2024	HNZ Future Procurement Opportunity (FPO) Communications for Associate Psychologist	
7.	5 November 2024	HNZ Te Whatu Ora - Associate Psychologist RFP Communication to stakeholders	
8.	18 November 2024	HNZ Te Whatu Ora Associate Psychologist Project Update 18.11.24	
9.	16 December 2024	(Email Correspondence) IMPORTANT - NZPB survey Associate Psychologist	
10.	5 March 2025	Associate Psychologist Description and Vision Letter	
11.	N/A	APAG meeting 2-Summary of Role Description discussion Final	
12.	N/A	Background Information-HNZ-PF4H84AE	
13.	N/A	NZQF levels	

Feasibility analysis for a Psychological Wellbeing Practitioner Workforce

07 October 2022

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CONTENTS

GLOSSARY

Term	Definition
ACT	Acceptance and Commitment Therapy
ADHD	Attention Deficit Hyperactivity Disorder
CBT	Cognitive Behaviour Therapy
Dapaanz	Drug and Addiction Practitioners Association Aotearoa New Zealand
DBT	Dialectical Behaviour Therapy
HIP	Health Improvement Practitioner
HPCA	Health Practitioners Competence Assurance Act 2003
LiCBT	Low-Intensity Cognitive Behaviour Therapy
NGO	Non-Government Organisation
NSCBI	New Zealand Psychological Society National Standing Committee on Bicultural Issues
NZCCP	New Zealand College of Clinical Psychologists
NZPB	New Zealand Psychology Board
TEC	Tertiary Education Commission
TEO	Tertiary Education Organisation

Note on terminology

The terms 'clinical' and 'non-clinical' are used throughout this report to discuss the potential directions that a 'psychological wellbeing practitioner' could take.

In this report, the terms 'clinical' and 'non-clinical' relate to the current funding structure of mental health and addiction services in Aotearoa New Zealand.

A 'clinical' role requires formal registration with a Registered Authority to ensure compliance with the Health Practitioners Competence Assurance Act 2003 and is funded at a higher level. It captures much of the current mental health and addiction workforce, including psychologists nurses, occupational therapists, social workers, and accredited practice counsellors.

A 'non-clinical' role is a non-registered workforce such as support workers, kaiāwhina, and peer support workers. Their practice is in a supportive role rather than providing assessment, treatment, and diagnosis.

FEASIBILITY ANALYSIS FOR A PSYCHOLOGICAL WELLBEING PRACTITIONER WORKFORCE

In April 2022, *Allen + Clarke* was engaged by the Ministry of Health (later Te Whatu Ora Health New Zealand) to identify the feasibility of a new 'psychological wellbeing practitioner' workforce in Aotearoa New Zealand.

Individual and group interviews were held with people in the mental health and related sectors in Aotearoa New Zealand who shared their views on the feasibility of a 'psychological wellbeing practitioner' workforce. This included regulatory bodies in the health system, government agencies, education and training providers, and clinical psychologists working in a range of settings. For ease of reference, this report refers to the people that we spoke with as 'sector leaders'.

Summary of key findings

There was cautious support for the development of a new 'psychological wellbeing practitioner'[1] workforce

Sector leaders recognised the need to strengthen the mental health workforce in Aotearoa New Zealand. Overall, sector leaders indicated that the development of such a workforce was feasible, or at least worth exploring in further detail. However, they also emphasised the importance of several factors to ensure the success of a new practitioner workforce. These factors included:

- ensuring the practitioner workforce is developed to embed Te Tiriti o Waitangi in all areas
- developing a very clear scope of practice, so that it is clear what practitioners could do and what responsibility they could hold
- ensuring there is strong support in place for practitioners, including access to registered psychologists and cultural experts for mentoring and supervision
- having a strong focus on practical training following a theoretical foundation
- ensuring there is clear oversight of the workforce to help keep both the practitioner and people receiving care safe
- promoting education and awareness about the role, particularly among registered psychologists, employers, and the public to promote understanding of the purpose and scope of the practitioner workforce.

[1] *'Psychological wellbeing practitioner' is a draft working title only. Sector leaders raised concerns with this name, including that it could be confused with registered psychologists. Further work is required on the name of this workforce if it is to proceed. For ease of reference in this report we have referred to this role as 'practitioner workforce'.*

Views were mixed regarding whether the 'psychological wellbeing practitioner' workforce should work in clinical or non-clinical roles

Sector leaders shared differing views on whether the practitioner workforce should be developed to work in clinical roles or non-clinical roles.

Training practitioners to work in non-clinical roles could be a way to quickly develop an additional pool of support workers focused on wellbeing in community settings. This practitioner workforce could utilise the knowledge of existing graduates of psychology and related degrees and introduce additional training focusing on practical skills necessary for working with people and acquiring a strong foundation in mātauranga Māori. As this role would not be practising clinically, formal registration (and subsequent requirements) would not necessarily apply. This could enable a wider range of people with relevant lived or work experience to be eligible for such a role. However, there were comments that such a practitioner would duplicate existing support worker or kaiāwhina roles, and that working in non-clinical roles would not have much impact in the short term to ease the burden on a stretched psychological workforce. It would also be essential to consider a different name for practitioners working in non-clinical roles to ensure that 'psychological' is not included in the title.

Developing practitioners to be a registered workforce employed in clinical roles could provide support to ease the burden on the existing psychological workforce, depending on the activities included in their scope of practice. However, it may take longer to mobilise this workforce. Development of a clinical role would need to be done carefully. It should include engagement with the sector on the direction of the role and clear scope of practice, and may also need to consider creative solutions to supervision issues.

For this practitioner workforce to work in clinical roles, registration through the New Zealand Psychology Board will be essential

Sector leaders expressed significant caveats would apply to the practitioner workforce should this be developed to work in clinical roles in mental health and addiction services. It was clear that formal registration would be essential if practitioners were to provide psychological assessments, therapies, or interventions. This would be important to ensure that both the practitioner, and people receiving care, are kept safe.

The New Zealand Psychology Board Te Poari Kaimātai Hinengaro o Aotearoa (NZPB) is the regulatory body responsible for overseeing psychologist scopes of practice. As it would be significantly costly and time-consuming to establish a new regulatory body to oversee this practitioner workforce, the New Zealand Psychology Board was considered the most logical regulatory body to proceed with for registration.

Registration under the NZPB will likely come with a number of requirements in order for practitioners to become registered. For example, in addition to the specific training developed for this workforce, the NZPB would require a psychology undergraduate degree in order to consider registration of this workforce. It would not be possible to consider lived experience or other undergraduate degrees for this role due to the way the NZPB undertakes accreditation. Therefore, the existing pathways to registration limit the eligibility of this workforce to psychology graduates if pursuing a clinical role.

Further work will be required to identify training pathways that could be utilised for this practitioner workforce

Discussions with sector leaders indicated that there could be a range of opportunities for utilising existing or developing bespoke training programmes for the additional practical training component for the practitioner workforce. Further work is required to determine exactly how this should be done in parallel with determining the scope of practice.

As part of the New Zealand Psychology Board registration process, current psychology scopes of practice must complete training courses through an accredited educational provider. For the additional training component of the practitioner workforce, a new training programme may need to be developed, which could draw on existing accredited training programmes, but be adapted to deliver brief, targeted training, depending on the knowledge and skills included in the scope of practice. While in development it will be important to ensure that understanding of Māori models of health and wellbeing are fully integrated and cultural competency components of training are strengthened. Developing a new programme alongside sector leaders in indigenous psychology or hauora Māori providers could support this. There was also comment that, for training to be appropriate for Aotearoa New Zealand, it would need to be delivered by providers who have a firm understanding of the sector and Māori health.

Some learnings can be drawn from the successes and challenges of overseas models; however, caution should be exercised when considering what might apply in the Aotearoa New Zealand context

A variety of roles in different forms have arisen in other jurisdictions, demonstrating the similar workforce demand challenges faced and the interest in respective sectors for additional career pathways in this space. Psychological Wellbeing Practitioners (PWPs) in the United Kingdom (UK) have experienced some issues with employee retention. This highlights the importance of clear pathways for progression so that practitioners can see options for how they can continue to grow skills and progress in their career, and also ensure there are appropriate places for this practitioner to work.

Some criticism of alternative clinical roles in similar jurisdictions includes the risk of ‘therapeutic drift’ whereby the practitioners begin to deliver interventions they are not trained to deliver, or do not maintain their practice within the limits of their training. This highlights the importance of a clear scope of practice and appropriate supervision. Models in other jurisdictions where registration is required of the role place a strong focus on clinical supervision. This is an already identified challenge for Aotearoa New Zealand and may require creative solutions, such as considering the place of group and peer supervision to complement formal supervision, or models such as case management supervision as used in the UK.

Although there are some lessons that can be drawn from overseas models, it was clear from discussions with sector leaders that any new workforce developed for Aotearoa New Zealand needs to be developed from the bottom up, specifically for Aotearoa New Zealand. Any attempt to ‘lift and shift’ a model from other jurisdictions is unlikely to be successful or replicable here.

INTRODUCTION

Structure of the report

The report is divided into four sections:

- **Section 1: Introduction** – This section outlines the scope of the review, describes the work undertaken and outlines the purpose of the report.
- **Section 2: Interviews with sector leaders** – This section outlines the views of sector leaders regarding the feasibility of a 'psychological wellbeing practitioner' workforce.
- **Section 3: Next steps –** This section outlines the recommended next steps regarding the feasibility of a 'psychological wellbeing practitioner' workforce.
- **Appendices –** the attached appendices outline a range of frameworks mentioned in discussions with sector leaders, a brief comparison of workforces in Aotearoa New Zealand, and brief overview of similar workforces in other jurisdictions.

Report purpose

This report provides Te Whatu Ora Health New Zealand (Te Whatu Ora) with key findings from the feasibility analysis on the potential for a 'psychological wellbeing practitioner' workforce in Aotearoa New Zealand. The report does not make specific recommendations, rather, it seeks to present and provide analysis on the findings. It is intended to assist Te Whatu Ora with considering next steps in determining whether to further explore the development of such a new workforce, and the opportunities and risks in doing so.

Background

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) in December 2018 called for the transformation of Aotearoa New Zealand's approach to mental health and addiction. The development of a resilient, diverse, and skilled workforce is crucial to delivering this vision.

The idea of a 'psychological wellbeing practitioner' workforce was previously raised by the Psychology Workforce Taskforce Group in 2019. However, a range of concerns were raised with the proposal, and the idea was not progressed at that time. This report does not seek to respond to, or address the concerns raised about the Psychology Workforce Taskforce Group 2019 proposal.

In April 2022, *Allen + Clarke* was engaged by the Ministry of Health to take a fresh look at the feasibility of developing a new 'psychological wellbeing practitioner' type workforce in Aotearoa New Zealand. However, this review was not intended to continue on with the same proposal raised in 2019. Rather, the feasibility review considers the potential of developing such a workforce from a blank page. This work later moved across to Te Whatu Ora.

A large programme of work is underway to grow and upskill the mental health and addiction workforce. This includes work to develop pathways for workforces to safely and effectively

work or practise in mental health and addiction settings. Considering the feasibility of a 'psychological wellbeing practitioner' workforce is intended to complement other ongoing initiatives in this area.

The development of any new workforce is not intended to pull from already stretched existing workforces, but to draw on untapped potential to add to the workforce, for example, graduates with the appropriate skills but who are not registered in health professions. There is a desire to provide an additional option for people who do not wish to enter or are not accepted for clinical or other psychology post-graduate programmes, without drawing on or limiting options for people who would potentially enter these workforces.

Scope of the review

In scope for the review is the feasibility of a 'psychological wellbeing practitioner' workforce. The review does not include changes to the current pathway, training, or workforce for current psychology professions.

To inform the review, *Allen + Clarke* scanned the approach taken to similar workforces in other jurisdictions. This is briefly captured in the appendices.

Note on terminology

'Psychological wellbeing practitioner' is a draft working title only used for the purpose of this review. It does not refer to the proposal of the same name by the Psychology Workforce Taskforce Group in 2019. Sector leaders raised concerns with this role title, including that it could be confused with registered psychologists. The 'psychological/psychology' component of the name would only be able to be used if practitioners were to be a registered workforce employed in clinical roles in mental health services and had a minimum of an undergraduate degree in psychology. Further work is required on the name of this workforce if it is to proceed. For ease of reference in this report we have referred to this role as the 'practitioner workforce'.

Methodology

This feasibility review has been undertaken in three phases:

- Phase 1: Project inception and planning
- Phase 2: Engagement and research
- Phase 3: Development of report on feasibility (this report).

Limitations of this report

This report has primarily focused on the views of experts in the psychology sector, including Māori and Pacific experts. It is recommended that for any further stages of this work, greater engagement is carried out with a wider group of people, including further Māori and Pacific experts, representatives of potential service users, people who may be interested in being part of a new workforce, advocates of people with lived experience, and a wider range of people who support people in distress.

INTERVIEWS WITH SECTOR LEADERS

The project team conducted 16 interviews between 19 April and 9 August 2022 with several experts and representatives with connections to the psychology workforce in Aotearoa New Zealand. This included regulatory bodies in the health system, government agencies, education and training providers, and clinical psychologists working in a range of settings. These people are referred to as 'sector leaders' throughout this report.

Interview participants were identified initially by the Ministry of Health/Te Whatu Ora, and throughout the project based on referrals from others interviewed. This allowed the project team to discuss sector leaders' views on the feasibility of a new workforce, including the opportunities and risks in establishing such a workforce.

A separate hui was held with members of the New Zealand Psychological Society National Standing Committee on Bicultural Issues. A separate summary paper has been developed to capture the kōrero shared during this hui. It is intended that this report be read in conjunction with the separate paper capturing the hui kōrero.

Questions centred on opportunities and risks, as well as what aspects such as training, registration, supervision, models of employment, and ongoing professional development of a new practitioner workforce could look like.

Interviews were held with the following people and organisations:

Interviews
New Zealand Psychological Society National Standing Committee on Bicultural Issues (NSCBI)
• New Zealand College of Clinical Psychologists (NZCCP)
Te Rau Ora
Te Pou
Whāraurau
Le Va and Pasifikology
Otago University Senior Lecturers and clinical psychologists
Tertiary Education Commission (TEC)
Health Improvement Practitioner (HIP) Programme
Health Coach Programme
DHB Psychology Professional Leads (x 2 meetings)
New Zealand Psychologists Board (NZPB)
Ara Poutama Aotearoa New Zealand Corrections Service
Healthcare New Zealand/Explore
Group of Clinical Psychologists

1.1 The need for this role and where it could fit in the sector

Most sector leaders agreed that a new practitioner role could be valuable given the strong demand for mental health services currently being experienced. Sector leaders shared a range of ideas on how such a practitioner workforce could add value and where practitioners could fit into the sector.

1.1.1 How a practitioner workforce could add value

Views were mixed on whether this practitioner workforce would better suit a clinical or non-clinical role. However, sector leaders mostly discussed the practitioner as being developed to work in clinical roles.

Non-clinical roles

There was some discussion among sector leaders that the practitioner workforce could add value to the sector by taking on activities and workloads that are non-clinical in nature. For example, sector leaders saw value in practitioners providing support to target the social determinants of mental health, wellbeing, and social cohesion, such as community exercise groups and social connection groups. This would involve a focus on walking alongside and 'doing things' with people.

Clinical roles

Most sector leaders that we spoke with tended to discuss the potential for this practitioner workforce as working in clinical roles. It was not always clear whether this was because sector leaders saw this role as needing to be clinical, or because some sector leaders were speaking from the context of their own professional environment (typically clinical-focused, registered professionals).

As part of these discussions, some sector leaders noted that there are important aspects of registered, clinical roles which do not necessarily require a registered psychologist or other allied health professional to do. It was suggested that there is potential for practitioners to relieve the burden on registered psychologists and other allied health professionals by covering some aspects of their workload. This would enable those specialist professionals to focus on what they are trained in and operate at the top of their scope. Sector leaders shared their views on what tasks or activities practitioners in clinical roles could usefully do to ease the burden on the existing workforce. These included:

- helping registered psychologists to understand the priority of their client list (by triaging and completing assessments to support prioritisation)
- providing aspects of talking therapies for people with mild to moderate conditions. This might include mindfulness, Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), and Acceptance and Commitment Therapy (ACT)
- behavioural activation techniques for anxiety, depression and emotional distress
- providing or supporting group therapy which can be more efficient than one-on-one. For example, group therapy could be based on interventions such as CBT and DBT or skills

to manage anxiety and depression based on prescribed models. This could be delivered in a group setting and follow a strict manual to ensure fidelity with the respective model

- therapeutic case management and coordination. There were mixed views on this, with some considering it was better to solely focus on providing targeted psychological interventions. A mixture of therapy and case management could include for example:
    - assessing a person's needs and providing therapies
    - providing information, helping people to navigate the system, and providing referrals to other services
    - supporting people with the determinants of mental health such as employment, housing, and preventing loneliness.

While it was considered useful to enable specialists to operate at the top of their scope, one caveat was raised. If a practitioner were to take on lower-level aspects of a specialist's workload, there was concern around the risk of burnout where specialists only work with people who have high and complex needs.

1.1.2 Where a practitioner could fit in the sector

Views were mixed around where practitioners could best be based to add value. It is likely that this would be determined by whether practitioners are intended to work in clinical or non-clinical roles. Sector leaders provided various examples of the work practitioners could usefully do across a range of settings. A practitioner performing a clinical role could be based in primary care, secondary care, or in educational settings. Whereas a practitioner performing a non-clinical role may be best based in community settings, such as in NGOs and marae-based services.

Some sector leaders suggested that practitioners may need to be assigned to a specific setting in the sector, such as primary or secondary care. This could help provide clarity around the practitioner's scope. It was also emphasised that where in the sector practitioners are based should be dependent on where they can most usefully add value.

However, sector leaders noted that it will also be important to ensure that there are places for a new practitioner role to work. This included considering both the physical places that could accommodate an increased workforce, and how the health system would need to expand to enable practitioners to have somewhere to work.

For practitioners intended to work in clinical roles regardless of setting, sector leaders were of the view that practitioners should not provide care independently without close support or supervision of a registered professional.

Primary care

Some sector leaders saw primary care settings, such as GPs and Primary Health Organisations, as logical places for a practitioner to be based. It was suggested that practitioners could work most effectively in multi-disciplinary teams in this space. This could include working in an allied health environment, alongside others such as social workers and occupational therapists.

However, it was also noted that recent workforce developments including Health Improvement Practitioners (HIPs) and Health Coaches are also based in such primary care settings. The inclusion of the practitioner workforce may create confusion without a clear scope of practice and understanding of the role the practitioner plays relative to other roles in primary care. One point of difference is that HIPs draw from an existing pool of health professionals registered under the HPCA. A practitioner workforce would be able to contribute additional people to a primary care setting without drawing from existing registered workforces.

It is worth noting that some primary care settings operate with smaller teams. Working in a multi-disciplinary environment in primary care may require the practitioner to be flexible and mobile, such as joining a pool of workers who rotate between regions, sharing workforce resources.

Secondary care

Some sector leaders noted that there is significant demand for a practitioner workforce developed to take on clinical roles in hospitals and specialist services. The current secondary care psychology workforce is stretched and experiencing heavy workloads. A clinically oriented practitioner could be based in this space to help ease the workload burden. This could include undertaking assessments or providing brief or interventions in CBT or DBT.

Given the stretched nature of the existing psychological workforce (and availability of supervisors) in secondary care, practitioners would likely need to work in multi-disciplinary or team settings and not provide care independently. This would ensure that the practitioner had access to a registered psychologist and a wider team for support, mentoring, and supervision. An example of this model was that of dental hygienists working in the same setting as dentists, who they could draw from as nearby support and supervision as required. Although in these instances it will be essential that the practitioner has a clear grasp of when care needs escalating to a registered psychologist.

However, some sector leaders cautioned that it would not be appropriate or helpful for practitioners to provide brief interventions in the secondary care space, as people seeking help in this space are often at the high and complex end of the spectrum, requiring the expertise of fully qualified registered psychologists.

Education settings

Sector leaders suggested the practitioner workforce, in clinical roles, could add value as a bridge between a school counsellor and registered psychologist. This could involve practitioners providing support to students in the interim until they are able to see a registered psychologist. For example:

- working with students with anorexia, ADHD, and autism including completing observations and assessments and providing findings to a registered psychologist
- talking with parents and teachers and providing interim support with challenges faced
- providing behaviour support for disabled people, and autism education and parenting education post-diagnosis.

Community settings

Sector leaders suggested the practitioner role could add value by working in community health services, marae-based services, and other community settings such as providing support to parents. This could also include providing behaviour support and behavioural activation groups within the community to support the social determinants of health and wellbeing, such as exercise groups or social connection opportunities.

Sector leaders noted that there are existing non-government organisations (NGOs) in the community space that take on people with psychology undergraduate qualifications or other relevant work/lived experience to work in behavioural support. Working in a community setting in such a way was considered the likely place for practitioners to be based if performing a non-clinical role.

1.2 Registration

The following was explored in discussion with sector leaders:

- whether or not the practitioner workforce needs to be a registered role
- what registration under the NZPB looks like
- other registration or regulation options for the practitioner workforce.

1.2.1 Does the workforce need to be registered?

If pursuing a clinical role for the practitioner workforce, it was largely considered essential that this workforce be registered. Registration provides a range of benefits, including ensuring the practitioner operates within a prescribed scope of practice, upholds ethical and legal standards, and provides employers and the public with an indication of competence.

Registration may not be necessary for practitioners if they perform a non-clinical role.

Although there were some mixed views, most sector leaders considered it necessary for this practitioner workforce to be registered, particularly if practitioners were to practise clinically. The following benefits were cited as part of registration for a clinical role:

- ensuring the practitioner remains strictly within a prescribed scope of practice and does not work with people they do not have the training to deal with
- ensuring practitioners have regard to ethical, legal, and Board-prescribed standards, including competence and cultural competence
- opening employment opportunities for practitioners to be seen as legitimate by employers
- providing public confidence that the role is being regulated to help to ensure quality and safety of care
- ensuring practitioners follow the Code of Ethics for Psychologists working in Aotearoa New Zealand, Te Tikanga Matatika: Mā ngā Kaimātai Hinengaro e mahi ana I Aotearoa[2]
- ensure practitioners have completed accredited courses of study or supervision-to-registration programmes[3]
- provide a reference point for determining complaints, competence, and fitness matters[4]
- provide a clear pathway and status for the practitioner role.

Some sector leaders viewed registration as unnecessary or were undecided on whether registration was necessary. When considering registration as potentially unnecessary, it was

[2] New Zealand Psychological Society. (2012). *Code of Ethics for Psychologists Working in Aotearoa New Zealand.* https://www.psychology.org.nz/members/professional-resources/code-ethics
[3] New Zealand Psychologists Board. (2021) *Annual Report* (pp. 13-14). https://psychologistsboard.org.nz/wp-content/uploads/2022/07/Psychologists-Board-Ann-Rprt-2021-E-online.pdf
[4] New Zealand Psychologists Board. (2021) *Annual Report* (pp. 16-17). https://psychologistsboard.org.nz/wp-content/uploads/2022/07/Psychologists-Board-Ann-Rprt-2021-E-online.pdf

noted that practitioners employed as part of the non-clinical workforce would not necessarily need to be registered as there would be less of a need for strict monitoring of standards and practice. This could provide a quicker route to establish the practitioner workforce.

Others pointed to existing models of service that allow for the flexibility of having non-registered professionals operate in the mental health space, such as the co-facilitator model currently utilised in Ara Poutama Corrections. In this model, a 'co-facilitator' provides a level of psychological therapy in a corrections context but is not required to be registered. Sector leaders noted, however, that this model sits within the context of a wrap-around structure of fully registered supervisors. Without this supporting structure of supervision by registered professionals, for example if a non-registered practitioner was to operate independently in private practice, there could be a public safety risk.

1.2.2 Registration with the New Zealand Psychology Board

A practitioner workforce that provides psychological therapies would fall under the responsibility of the NZPB to register. In this instance, eligibility to become a practitioner would be limited to those who have a formal psychology qualification due to the nature of the NZPB registration process.

If proceeding with registration, most sector leaders saw it as logical for this workforce to be registered with the NZPB. This is the existing regulating body for any role formally identified as a 'psychologist' or providing psychological therapies. The NZPB is responsible for the registration of a range of current psychology scopes of practice.[5]

Sector leaders suggested that if the new practitioner workforce were trained to provide psychological therapies and be expected to be employed in clinical roles, then this workforce would require registration with the NZPB.

As the NZPB registration process is based on accreditation of formal psychology qualifications[6], the NZPB would be unable to consider people who have alternative experience (such as lived experience) or qualifications other than psychology. This would limit the eligibility of those entering the practitioner workforce.

Other regulatory options that result in registration through the NZPB includes supervision-to-registration schemes, such as those provided by Ara Poutama and Te Ope Kātua O Aotearoa the New Zealand Defence Force. These schemes involve an 18-month programme of supervision and training of people with Master's degrees in psychology to full registration with the NZPB.

[5] Existing scopes are intern psychologist, trainee psychologist, clinical psychologist, psychologist, educational psychologist, counselling psychologist, and neuropsychologist.
[6] A list of current accredited training programmes can be found on the New Zealand Psychology Board website https://psychologistsboard.org.nz/for-education-providers-and-students/accredited-training-programmes/

Further information relating to NZPB registration

The Health Practitioners Competence Assurance Act 2003 requires the Board to prescribe the qualifications required for each scope of practice within the profession, and to accredit and monitor educational organisations and courses of studies. The Board's Annual Report 2020-2021 notes that there is a comprehensive set of standards and procedures for accreditation of qualifications leading to registration as a psychologist. These standards ensure that the training and practice of psychologists in Aotearoa reflect the paradigms and worldviews of both partners to Te Tiriti o Waitangi. [7]

1.2.3 Other registration options

Concerns were raised that exising regulatory organisations do not provide oversight and governance that is fit-for-purpose and reflects the needs of the communities the wokrforce would serve. While there was appetite for a different approach, establishing a new regulatory body was considered a long and costly exercise. Other options for regulation of the practitioner workforce could include certification (rather than full registration).

Oversight by a different body

Some sector leaders expressed concern with pursuing registration of the practitioner role through the NZPB. They cautioned that current regulatory organisations do not fully recognise Māori worldviews and models of health and wellbeing when considering requirements for registration in psychology.[8] It would be essential that the registration process for a practitioner workforce fully recognises the importance of cultural competency and practising in a culturally safe way.

When considering registration options, there was an appetite for a different approach. One option could be to establish a new regulatory body.

However, in discussing the potential to establish a new regulatory body for this role (for a clinical role), most sector leaders considered this would be a large, expensive, and long process. In their view a new body was not required given that the NZPB already exists.

There were concerns that if a practitioner workforce was not regulated or was regulated under a different body, they may be perceived as not having enough oversight. Any model of oversight and governance of the practitioner workforce would need to be developed to ensure it is fit-for-purpose and reflects the needs of the communities that the practitioner would be serving.

[7] New Zealand Psychologists Board. (2021). *Annual Report* (pp. 12 – 14) https://psychologistsboard.org.nz/wp-content/uploads/2022/07/Psychologists-Board-Ann-Rprt-2021-E-online.pdf

[8] For further information and commentary on this issue, refer to the separate *Summary of kōrero with NSCBI members on the feasibility review* paper.

Other options

Sector leaders raised another option for regulating a new practitioner workforce. This included pursuing a semi-regulated workforce, such as a process providing certification or credentialling rather than full registration. Certification could include comprehensive criteria, with a supervisor signing out that the individual is competent after they have completed specified training courses or other forms of professional development. Requirements would also likely include a minimum number of supervised hours of work.

1.3 Scope of practice

Sector leaders held a strong view that for any new practitioner role it will be essential to have a very clear scope of practice that practitioners are operating within. This would be important to keep both practitioners and the people receiving care safe. It would be a success factor for the role.

Development of a scope of practice would need to include a strong framework to ensure practitioners remain within their scope to avoid a drift of practice. This framework or scaffolding would mean that if there was a complaint, it would be clear what the practitioner was trained in and whether or not they had operated within their scope.

1.3.1 Risks of operating outside the scope of practice

The potential to operate outside of their scope of practice was a key risk raised, particularly if practitioners practise clinically. This could have a negative impact on public perceptions of the effectiveness of pscyhological care, generally. A strong and clear scope of practice, and an appropriate role title for the practitioner, will be essential to mitigate risk.

Sector leaders raised strong concerns with the risks of an unclear scope of practice and potential for practitioners to operate outside of their scope, particularly if performing a clinical role. This could negatively impact on the safety of both people receiving care, and the practitioners providing care. Key concerns raised included:

- the risk that employers could push practitioners to take on work outside of their scope of training due to increasing workload demands on the wider workforce
- that practitioners may perceive themselves as being capable of taking on more complex cases than they have been trained to provide care for or providing treatment options that they have not trained fully to deliver.

A strong and clear scope of practice was seen as critical to mitigate these risks.

Sector leaders were also concerned about the potential reputational risks to psychology with the introduction of a new practitioner workforce in a clinical capacity. They were concerned that, should a practitioner stray outside of their scope of practice and provide inadequate care, those receiving care may then associate ‘psychological wellbeing practitioners’ with ‘psychologists’ as a whole. This could result in a loss of trust in psychological therapies. Sector leaders raised this risk as part of the concern with the title ‘psychological wellbeing

practitioner'. Care would need to be taken to develop an appropriate role title for practitioners to mitigate this risk.

1.3.2 How the scope of practice should be developed

The NZPB determines the scopes of practice and core competencies for psychologists in Aotearoa New Zealand. Development of a scope of practice for a practitioner workforce would also need to be completed via the NZPB if this workforce is intended to practice clinically. Development of a scope of practice will need to fully integrate Māori models of health and wellbeing and will require consultation within the sector.

Sector leaders emphasised that thought would need to be given to an appropriate scope of practice and core competencies for 'psychological wellbeing practitioners'. This would then determine what training would be required for such a practitioner and may guide where in the sector practitioners could be based.

Currently, the NZPB determines the various **scopes of practice** for registered psychologists in Aotearoa New Zealand. The NZPB also sets the core competencies for the practice of psychology in Aotearoa New Zealand.[9] Development of specific core competencies would be required for any new practitioner workforce that intends to provide psychological therapies.

Ensuring that Māori models of health and wellbeing are fully integrated into any scope of practice and core competencies developed for this practitioner role will be essential.

We heard from sector leaders that the development of an appropriate scope of practice for a practitioner workforce may take time and would require significant consultation within the sector. Development of a scope of practice would likely need to include the NZPB, the New Zealand College of Clinical Psychologists, the New Zealand Psychological Society and NSCBI, He Paiaka Tōtara, Pasifikology, cultural experts and others in the sector working together.

Sector leaders also indicated that having Tertiary Education Organisations (TEOs) involved in the process and concurrently considering what the training for an agreed scope of practice could look like might help the practitioner workforce role 'go to market' faster.

[9] New Zealand Psychologists Board. (2018). *Core Competencies for the Practice of Psychology in Aotearoa New Zealand*. https://psychologistsboard.org.nz/wp-content/uploads/2021/06/Core_Competencies.pdf

1.3.3 Promoting understanding and value of the role

Engagement and clear communication with the sector on the defined scope of a practitioner workforce will be important to avoid confusion and misunderstanding. This will be particularly important if practitioners are intended to perform a clinical role.

Sector leaders considered that communicating and demonstrating the clear and distinguishable role that practitioners would play, and the value they would add to the overall workforce, will be a critical success factor.

For some newer roles in the sector, such as HIPs and Health Coaches, sector leaders noted that there was initially some confusion about what role they play, and what their scope is. This could be an issue for 'psychological wellbeing practitioners' if the role and scope are not clearly communicated to the sector or area of practice.

Sector leaders also noted that the development of a new practitioner intended to provide psychological therapies may receive resistance from the existing psychological workforce. This resistance may stem from the view that a practitioner workforce would not be adequately trained to provide psychological care and should not proceed. Sector leaders commented that substantial education and socialisation of the practitioner workforce would be needed with the existing psychologist workforce to ensure the purpose and scope of the practitioner is clearly understood.

Education on the practitioner workforce would also be important for employers to understand the scope of practice.

1.4 Training pathways

Sector leaders discussed two main areas in relation to what training could look like:

- undergraduate and postgraduate degrees and minimum requirements, and
- additional training required for a 'psychological wellbeing practitioner' workforce.

Ideas regarding funding of training, pathways for Māori and Pacific students, and ongoing professional development were also discussed.

1.4.1 Undergraduate and postgraduate degrees, and minimum requirements

Views were somewhat mixed regarding qualification requirements. If practitioners are intended to work in clinical roles, then a degree in psychology will be a minimum requirement (as this is needed for registration with NZPB). Specified papers may be necessary to ensure those with a psychology degree come equipped with the theoretical foundation needed for further training in clinical practice.

People with relevant lived, work, or cultural experience can bring excellent interpersonal skills and knowledge on how to practically support people in distress and could be considered a good fit for the practitioner workforce. However, due to the way the NZPB undertakes accreditation for registration, people with lived or other experience would be precluded from performing clinical roles. People with lived and other experience could only be considered as eligible for this workforce if practitioners are intended to work in non-clinical roles.

Bachelor's degree as a minimum requirement

Most sector leaders indicated that a bachelor's degree would likely be a minimum requirement or necessary starting point as part of training pathways for practitioners.

However, this requirement may deter some people and limit access to the practitioner workforce for those who do not have bachelor's degrees. For example, some sector leaders noted that there is significant untapped potential in people who have completed diplomas relating to mental health care (but not yet gone on to complete a bachelor's degree) who demonstrate a keen interest in working in the mental health space. The practitioner role could be explored as a pathway for these people to continue training. However, there are also other pathways that could be relevant for this group of people, such as support worker and kaiāwhina roles.

Some sector leaders noted that there is a large group of people with psychology undergraduate degrees who do not go on to complete formal registered psychology qualifications. There was a desire to utilise the skills of these graduates and a sense that the practitioner workforce could be a good option for these people if developed to be an unregistered workforce intended to work in non-clinical roles.

Overall, there were mixed views among sector leaders on whether a psychology degree would be a necessary minimum requirement for this practitioner role, and whether other relevant bachelor's degrees or experience could be suitable.

Psychology degree and specific papers as a minimum requirement

Some sector leaders were in favour of having a psychology degree as a minimum requirement. This was particularly the case if the practitioner workforce is intended to work in clinical roles. A psychology degree was seen as providing a grounding in psychological theory and a foundational understanding of behaviour that other degree pathways may lack. It was assumed that this would be a logical and useful starting point.

However, there were also concerns that psychology undergraduate degrees as they currently stand may not be sufficient to indicate whether an undergraduate is ready or suitable to progress. Screening of personal qualities, suitability, and fitness for practising in the mental health space will likely be necessary for this practitioner role.

Qualification requirements for registration with the NZPB

It is important to note that, should this practitioner workforce be developed to work in clinical roles, registration with the NZPB will be required, and having an undergraduate degree in psychology is a minimum requirement for registration of practitioners with the NZPB. Most current psychology scopes of practice require a Master's degree in Psychology from an accredited educational organisation.

In addition, sector leaders noted that due to the inconsistency of university programmes and pre-requisite courses for psychology qualifications across the country, not everyone who completes a psychology undergraduate degree will have covered the same content. For example, some universities already include papers based on talking therapies and applied experience; some universities require students to complete a paper on kaupapa Māori models of health and wellbeing as a pre-requisite but others do not.

Required papers

One mitigation could be to require certain papers to be completed as part of an undergraduate psychology degree before being accepted into further training. This could help ensure students are proceeding with the right foundation of theory prior to further training in practical skills. These papers might include:

- mental health-based papers, such as abnormal psychology or other mental health and wellbeing papers, including a clinical paper
- papers on mātauranga Māori concepts of health and wellbeing, and Pacific models of health and wellbeing.

It was considered essential that learning and training on kaupapa Māori and Pacific models of health and wellbeing are integrated into undergraduate study (and beyond) for those interested in practising in the mental health and addiction space. Sector leaders emphasised the need for this learning to be fully embedded, and not seen as an 'add-on'. Examples were raised of recently introduced courses in some universities, such as the kaupapa Māori minor

in psychology at Waikato University[10] that could be explored further as part of a model for required papers.

A dedicated undergraduate pathway

While out of scope for this review, sector leaders noted frustration with how psychology students are unable to do meaningful practical work until near the end of a post-graduate qualification for psychology, sometimes taking seven to eight years. Being unable to undertake practical work until late in the training pathway was considered a barrier to students such as Māori and Pacific students, who are drawn to this field of work so they can be out helping their communities.

An idea raised was to develop a dedicated psychology undergraduate pathway for those wanting to pursue a practicing clinical career in the mental health space. This pathway would outline a clear structure of required papers from the first year of study and could also include brief placements as early as first year so that students gain exposure to practical learning. Having practical exposure at an early stage of training was also considered useful in helping students understand whether such a career would be the right fit for them.

Greater collaboration with universities would be required to establish a consistent, dedicated undergraduate pathway for this practitioner role. Sector leaders suggested exploring how the TEC could play a role in influencing how a dedicated degree pathway is structured consistently across all universities for this role.

However, it is noted that this option is something that could be explored further as part of a longer-term programme of work. Amending the university undergraduate pathway is largely outside the scope of this review.

Other degrees and/or lived or work experience

Some sector leaders saw value in considering people with other relevant undergraduate degrees, people with lived experience, or people with diverse work experiences in the wider health and social services sector. This was particularly the case for people who demonstrate excellent skills in emotional intelligence and the ability to work with people and communities.

Being a good fit for practising in the psychology space is an important consideration, and some people with relevant lived and work experience can offer a wealth of knowledge to practically support people in distress. This included the benefit that those with a strong understanding and background in kaupapa Māori models of health and wellbeing could bring to their communities. Enabling people with other degrees or lived/work experience could increase the number of people able to take up a ‘psychological wellbeing practitioner’ role.

However, issues were also raised about considering those with lived experience or those with degrees other than psychology. For those with lived experience, it was noted that registering individuals based on lived experience would not be possible and that a different model may be required to certify or regulate practitioners. Therefore, if the practitioner workforce is to

[10] University of Waikato. (2022). *Kaupapa Māori Psychology.* https://www.waikato.ac.nz/study/subjects/kaupapa-maori-psychology

utilise people with lived or other experience, it is likely that this could only be the case if practitioners were intended to be a non-registered workforce employed in non-clinical roles.

For those with other degrees, there was a view that other degrees would likely not bring a foundation of psychological theory to this practitioner role, which would be important if practitioners were to operate clinically. In relation to other specialist trained professions (such as nurses or occupational therapists) it was considered more important for them to focus on operating at the top of their scope, rather than broaden their scope to provide psychological therapies. Another risk is that people from other workforces could potentially be less likely to retain fidelity to specific psychological therapies or models of care over time and could revert to previous habits.

1.4.2 Additional training

An additional 12 months of targeted practical training would be necessary for this practitioner workforce. Regardless of whether clinical or non-clinical, core skills should be captured in additional training, such as interpersonal skills, a foundation of mātauranga Māori, and a thorough understanding of professional practice.

For a practitioner intending to work in a clinical role (with subsequent registration with the NZPB) additional training will need to be through a defined course delivered by an accredited educational provider. A non-clinical role will likely have greater scope to develop a fit-for-purpose training programme, which could utilise existing block courses from a range of providers.

Most sector leaders commented that an undergraduate qualification alone, in its current form, would be insufficient to prepare people to work or practise clinically in the mental health and addiction space. Additional training or bridging courses that focus on practical skills were seen as essential, regardless of whether the practitioner workforce is intended to work in clinical or non-clinical roles.

Most sector leaders suggested that this practitioner workforce could receive an appropriate amount of initial practical training in around 12 months.

The opportunity to undertake an additional year of targeted training would also be necessary for those entering the role with other levels of qualifications (such as diplomas) or lived/work experience.

What additional training should cover

Sector leaders noted that it was difficult to recommend exactly what additional practical training should cover as this will largely depend on the chosen scope of practice and where the practitioner role is intended to fit into the sector.

For example, if the practitioner's scope of practice included providing brief interventions through CBT, then targeted additional training would need to focus on delivering interventions within a CBT model. If providing coaching, then training would likely need to involve motivational interviewing skills.

Core skills

Some core skills and areas of knowledge were considered essential to be trained in regardless of where the practitioner role sits in the sector and what their scope of practice might be. These included:

- interpersonal and soft skills for working with people – such as the ability to listen, interact with people, build rapport, keep emotions in check, provide therapeutic engagement, and have strategies to deal with the impact of what they are hearing
- a basic foundation of mātauranga Māori and an understanding of Te Tiriti, Māori and Pacific models of health and wellbeing, and how to practise in a culturally safe way
- a thorough understanding of ethics, professional boundaries, and the practitioner's scope of practice – including the ability to identify warning signs and when care requires escalation.

Other aspects of training

Some sector leaders suggested additional training programmes draw on existing frameworks such as the 'Let's get real' framework for health care services and the Takarangi competency framework.[11]

It was also noted that it is important to consider the learner when developing additional training options. This should include considering what a learner would find interesting, rewarding, and economically sustainable.

How training could be delivered

Sector leaders raised some suggestions for what a year of additional training could look like regarding how training is structured and delivered. These suggestions included:

- the development of a bespoke/suitable training programme by developing new or utilising existing block courses. These could be university-run (likely necessary for a clinical role) or through other training providers such as workforce centres (potentially for a non-clinical role)
- that training programmes for a clinical role involve a rotational, on-the-job learning aspect so that learners are exposed to how people are supported and cared for across the continuum of mental health and addiction challenges, for example, gaining exposure in the community space right through to acute care
- training programmes delivered in an apprenticeship/internship practicum model. This could involve a student placement acting in a supporting role, gaining specialist knowledge through active on-the-job learning. Having strong support from employers would help to provide an environment that is conducive to training and good supervision.

Some sector leaders suggested that it would be important that practical learning involves simulation/role play, reflective practice, and videoing sessions and reviewing performance in

[11] See Appendix A for further information.

videoed sessions. These components of learning were regarded as effective and necessary to develop practical skills in psychological care.

Internship programmes – an example from the addiction workforce

Sector leaders described the success that some workforce centres have seen in internship programmes they offer. For example, one such programme run by Te Rau Ora provides host funding to employ a new person interested in working in the drug and addiction space for a year-long internship. This person does not necessarily need to have a qualification such as a bachelor's degree, but rather most come with lived experience. Through the internship, the person is exposed to practical care in the addiction space. As part of their internship, they complete their training and accreditation with Dapaanz. It was noted that sometimes candidates become sustainable employees and most continue on to postgraduate education. They have found that this targeted investment works to builds the addiction workforce.

Who could deliver training

Sector leaders generally indicated that a range of options are available regarding who might deliver necessary additional training. This included delivery of additional training courses and programmes via universities, workforce centres, hauora Māori providers, and government agencies, or a combination of options.

Workforce centres currently offer a range of training and internship programmes and noted that it could be possible to build a bespoke training programme for practitioners based on block courses.

Sector leaders also shared examples of university-run courses that target specific skills such as CBT which could be drawn from, depending on the scope of practice for the practitioner role, and whether the workforce pursues a clinical pathway.

Qualification requirements for registration with the NZPB

It is important to note that should this practitioner workforce be developed to work in clinical roles requiring registration with the NZPB, qualification and training programmes would need to be delivered by an accredited educational organisation. At present, this includes a range of both university post-graduate qualification courses and supervision-to-registration schemes.

1.4.3 Funding for training

Ensuring equitable access to funding for training programmes was considered important for students. The TEC could provide support on what funding could look like for university-run courses. Utilsing alternative training programmes may require a different funding mechanism.

Securing equitable funding was considered an important factor to consider as part of the development of this practitioner workforce. Sector leaders commented that, at present, different levels of funding are available depending on the programme or course of training. For example, some programmes have funding available for fees-only, while others may include accommodation and travel grants. It would be important to ensure equity of funding access for practitioner training to support affordability for students.

Sector leaders indicated that pursuing funding for the training of a practitioner role would be possible provided the psychology sector largely supports the idea. Te Whatu Ora provides funding for a range of existing post-graduate and other training courses that could inform the develop of such a training programme for the practitioner workforce, such as the New Entry to Specialist Practice course and the HIPs programme.

What this funding might look like could also be explored further via the Tertiary Education Commission (TEC). However, it is worth noting that the TEC largely monitor university-run courses and training programmes. Additional or alternative funding mechanisms may need to be explored where alternative training providers are utilised and where these providers are not already NZQA approved training providers.

1.4.4 Pathways for Māori and Pacific students

While the practitioner workforce could provide a broader range of pathways for Māori and Pacific students interested in the mental health space, there will always be a need for highly skilled, fully registered Māori and Pacific psychologists. Students should be appropriately supported regardless of the pathway they choose, and cultural worldviews and models of health and wellbeing should be fully integrated in both academic and practical training programmes.

Māori and Pacific psychologists are under-represented in psychology. Less than 1% of psychologists are Pacific and 6% are Māori.[12] However, Māori experience significantly higher

[12] LeVa. (2019). *Strategies for Increasing Pasifika Psychologists in the Workforce.* https://www.leva.co.nz/wp-content/uploads/2019/12/LV-190405-Growing-the-Pasifika-Psychology-Workforce-KeyFindings-final.pdf
Ware, S. (2022, Jun). *World-first Māori psychology learning coming to Waikato University.* https://www.stuff.co.nz/waikato-times/300624095/worldfirst-mori-psychology-learning-coming-to-waikato-university

rates of mental illness than non-Māori. Pacific peoples are also more likely to experience mental distress than the total population.[13]

Sector leaders indicated that this practitioner role, and the ability to complete an additional year of practical training in order to begin practising, could provide a greater range of pathways for Māori and Pacific students interested in practising therapeutically in the mental health space.

A key challenge for Māori practitioners as mentioned above, is that Māori seeking care tend to experience more serious / severe mental health challenges. Thus, there will always be a need for highly skilled Māori practitioners and registered psychologists to support Māori seeking care and provide appropriate treatment options.

It will be important for all Māori and Pacific students to be appropriately supported throughout academic studies and training, regardless of the pathway chosen to practice in the mental health space. It is also important that Māori and Pacific students see cultural worldviews and models of health and wellbeing integrated as part of any academic studies and training. As mentioned earlier, sector leaders suggested having Māori and Pacific experts deliver parts of theory and/or practical training. Workforce centres and hauora Māori providers could support this.

For Māori in particular, sector leaders described challenges retaining Māori psychology students due to the curricula not being relevant for the needs present in their communities. Further, for Māori first entering employment in psychology, they often face employment settings with limited access to cultural supervision and limited opportunities to strengthen cultural competency. For further context and detail on these issues, refer to the separate *Summary of kōrero with NSCBI members on the feasibility* review paper.

While some sector leaders suggested mātauranga Māori be woven throughout academic studies and training, others highlighted the need for training to be delivered by Māori for Māori. There is an opportunity for existing hauora Māori providers to support provision of training and supervision to help ensure that the practitioner workforce is equipped to meet the needs of communities it would serve.

[13] Government Inquiry into Mental Health and Addiction Oranga Tāngata, Oranga Whānau. (n.d.) *Inquiry Report* (3.2 Our conclusions).
https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/chapter-3-what-we-think/3-2-our-conclusions/

1.4.5 Ongoing professional development

The existing structured professional development processes of the NZPB could be utilised if practitioners are intended to work in clinical roles requiring registration through NZPB. Regardless, incorporating a focus on cultural competency and culturally safe practice into ongoing development, and ensuring that professional development continues consistently beyond the first year of practice will be essential.

Sector leaders noted that it would be important to build in ongoing professional development to maintain high standards of care. This should be focused on ensuring practitioners are continually improving and maintaining fidelity to their scope of practice.

If the practitioner workforce is developed to work in clinical roles requiring registration under the NZPB, then sector leaders noted that ongoing professional development could draw on existing models for continued competence through the NZPB structure.

Professional development could be delivered through online and/or group learning. Sector leaders also suggested that a continual focus on building cultural competency and culturally safe practice is an essential part of ongoing professional development, regardless of the pathway chosen. It was also considered essential that there are structured plans for any ongoing professional development to continue beyond the first year of practice.

Sector leaders commented that it will be important to articulate or develop pathways so that it is clear how practitioners can continue to upskill or progress from this role should they wish to do so. This could include the ability to progress on from the practitioner role (for example, being able to move into other registered scopes of practice) or take on leadership roles with greater remuneration.

1.5 Supervision

It was agreed that supervision would be an essential requirement for the new 'psychological wellbeing practitioner' workforce. Most sector leaders considered that an additional year of training (as mentioned above) combined with the supervision of a registered professional would provide practitioners with the right skills and knowledge to succeed in this role.

The key challenge would be the availability of supervisors to enable sufficient supervision, particularly for clinical roles. Sector leaders commented that registered psychologists are already stretched and being required to supervise a new workforce would create additional pressure. A traditional one-to-one supervision model may not be feasible for this workforce.

1.5.1 Supervision models and formats

Regular, formal one-to-one supervision will be an essential component of supervision for practitioners if working in clinical roles, however supplementing with peer or group supervision could support feasibility. Group and peer supervision may be sufficient for practitioners if intending to be a non-registered workforce employed in non-clinical roles.

Sector leaders suggested that appropriate supervision for this practitioner role could be set up in a range of ways, including hybrid models of different types of supervision, depending on the scope of the workforce. They considered that the types of supervision could include group and peer supervision alongside one-to-one options.

Effective supervision could be delivered in a variety of ways, such as in-person, phone, and video conferencing. Sector leaders highlighted how, during the COVID-19 pandemic, supervision of psychologists delivered remotely worked well and provided a way of maintaining networking and collegiality across the country.

Regardless of the overall method, it was recommended that supervision include review of video or audio recordings of sessions, as evidence has shown that this is an essential aspect of effective supervision and learning.

Traditional one-to-one supervision

Sector leaders considered it important for practitioners to undergo formal supervision on a regular basis. The frequency of formal one-to-one supervision was recommended to be between every 1-4 weeks, depending on the level of experience of the practitioner or scope of practice.

It is likely that regular, formal, one-on-one supervision will be necessary should the practitioner workforce intend to work in clinical roles. The model of one-on-one supervision could thus draw from existing models for supervision in a clinical setting.

As mentioned above, a critical success factor for the development of the practitioner role will be the availability of supervisors. Sector leaders suggested that to support greater availability, supervision expectations would need to be built into employment models and job descriptions, and supervisors funded to provide this aspect of their role. Incorporating a form of incentive

(such as being paid specifically for supervision duties) for senior practitioners to provide supervision may be required.

Group and peer supervision

Sector leaders saw some merit in group supervision for this practitioner workforce as this was a more resource-efficient method of supervision.

Peer supervision was also regarded as a model worth considering. This could involve practitioners with 3-4 years' experience playing a role in supervising new practitioners, based on fellow practitioners "walking alongside" each other.

It is likely that group and peer supervision could be sufficient should the practitioner workforce be developed as a non-registered workforce employed in non-clinical roles. However, group and peer supervision would likely need to be used in tandem with formal one-to-one supervision for any clinical roles.

Requirements of supervisors

Sector leaders generally suggested the need for some form of minimum requirements and competence in the area that the practitioner role is focused on. Training for supervisors of practitioners was also considered necessary as part of developing the new 'psychological wellbeing practitioner' workforce. It was considered important that all supervisors have a foundational background in kaupapa Māori.

Supervisors would ideally need to have experience working in the same setting or model of care as the practitioner, if performing a clinical role. For example, if the practitioner role involved providing brief CBT interventions, it would be expected that supervisors were also appropriately trained in CBT and had experience practising competently before being able to consider a supervisor role.

1.5.2 Examples of existing supervision frameworks

There are some existing supervision frameworks which are working well and could be drawn on for a 'psychological wellbeing practitioner' workforce.

In one example, under an established supervision framework, a supervisor must be a registered health professional who is practising competently and has at least three years of practice. Once supervisors are well established, they start to lead their colleagues. New recruits have a line manager and clinical manager, access to peer supervision, and a professional development framework including cultural competency.

Another example involved practitioners providing group-based care. Supervisors for these practitioners generally had some experience in the wider sector, and some form of bachelor's or Master's degree (psychology is preferred but not essential). Supervisors attend a week-long intensive training before being able to supervise. Supervisors assume their role for a set period and do not practice while supervising. After this time, supervisors cease supervisory duties and return to a practicing role. Peer supervision is utilised under this supervision framework, whereby a senior practitioner attends all group sessions for the first year after a

practitioner's training. After one year, the second practitioner attending the group sessions does not have to be senior. All practitioners have a cultural supervisor, line manager, and supervisor. All sessions are video recorded and every quarter the one videoed session is discussed during supervision.

NEXT STEPS

Overall, there was a general sense from sector leaders that there is value in pursuing further consultation on the development of a 'psychological wellbeing practitioner' workforce. Although there was also a clear message that if this new workforce is to be pursued, it would need to be done well, particularly if this workforce is intended to be a registered workforce employed in clinical roles.

While there was interest in moving forward with development, sector leaders also emphasised that the development of a new practitioner workforce could not be considered a 'silver bullet' or solution to current mental health and addiction workforce challenges on its own. Ongoing development of the wider mental health and addiction workforce, such as improvements to training for existing registered psychologist scopes and continued investment into boosting numbers of registered psychologists, will continue to be necessary alongside the introduction of a new practitioner workforce.

Some sector leaders saw that if done well, this practitioner workforce developed to work in clinical roles would be an attractive alternative career option for those who want to practise at a therapeutic level in the mental health and addiction space but choose not to pursue the lengthy training options that lead to the current NZPB registered scopes of practice.

Others viewed a non-clinical role as being ideal to utilise the skills of current psychology graduates through a faster route. Although there was concern that such a practitioner workforce developed to work in non-clinical roles would be very similar to existing support worker roles in practice and may simply duplicate this workforce.

It is likely that a 'psychological wellbeing practitioner' workforce would benefit from being implemented in a small number of regions rather than being fully rolled out nationally from the beginning. This would enable aspects of the role, such as the scope of practice and how it fits into the system, to be tested and refined where necessary. Sector leaders suggested that such a roll out should be in areas where there is significant interest in the development of the practitioner workforce as it will require dedication to get 'off the ground'.

A key success factor moving forward will be engagement. If continuing with further development of the workforce, there will need to be strong engagement with the sector to help determine the direction of development. This will likely include (but not be limited to) He Paiaka Tōtara, Pasifikology, and other key cultural groups; existing psychology organisations (NZPB, NZPS); tertiary education organisations, and workforce centres.

APPENDIX A: USEFUL FRAMEWORKS AND COMPARISON WITH OTHER WORKFORCES IN AOTEAROA

Frameworks and Māori models of health

There are a number of existing Aotearoa-based frameworks which may be useful when considering the development of a practitioner role in Aotearoa. There are also various Māori models of care such as Durie's (1994) model *Te Whare Tapa Whā* which can be drawn on.

Kaupapa Māori models of psychological therapy and mental health services - a literature review found that there are a considerable number of models proposed by the literature. The most frequently mentioned was Durie's (1994) model *Te Whare Tapa Whā.* A second model that was regularly referenced was Pere's (1991) model *Te Wheke,* which uses an analogy of an octopus to represent total wellness. Themes expressed by both *Te Wheke* and *Te Whare Tapa Whā* include the concept of holistic wellbeing emphasising the whole person and an understanding of the impact of spirituality and collective identity on health.[14]

Let's get real is a framework that describes the values, attitudes, knowledge, and skills required for working effectively with people and whānau experiencing mental health and addiction needs, developed for all healthcare services. The intent of *Let's get real* is to have shared values and attitudes when working with people and whānau with mental health and addiction needs and to develop the knowledge and skills of the workforce described in the seven Real Skills.[15]

Real Skills Plus Seitapu is a framework describing the essential and desirable knowledge, skills, and attitudes to engage with Pasifika peoples. [16]

Let's get talking is a toolkit to support mental health and addiction services to increase access to evidence-based talking therapies in Aotearoa. There are a range of resources as part of the toolkit. The *Let's get talking: Therapy* tool is designed to support best practice delivery of talking therapies using a stepped care approach. The tool provides information on the evidence base for various talking therapies in order to assist practitioners with matching a therapy(s) to a person's presenting need(s).[17]

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[14] Wratten-Stone, A., Te Whānau o Waipareira Trust. (2017). *Kaupapa Māori Models of Psychological Therapy and Mental Health Services – A Literature Review* (pp. 8-9). https://www.waipareira.com/wp-content/uploads/2017/11/W8.Kaupapa-Maori-Models-of-Psychological-Therapy.pdf

[15] Te Pou. (n.d.). *Let's get real*. Te Pou. https://www.tepou.co.nz/initiatives/lets-get-real

[16] Whāraurau. (2021). *Real Skills Plus ICAMH/AOD Competency Framework – Personal Development.* Whāraurau. https://realskills.wharaurau.org.nz/personal-development

[17] Te Pou. (n.d.). *Let's get talking toolkit.* Te Pou. https://www.tepou.co.nz/initiatives/talking-therapies/lets-get-talking-toolkit

Te Whare o Tiki is a framework describing the knowledge and skills required by the mental health and addiction workforce to be able to effectively respond to the needs of people with co-existing problems and their family/whānau.[18]

Takarangi Competency Framework provides a pathway to develop cultural competence, enhance cultural fluency, and analyse workforce needs relating to Māori responsiveness and monitor quality assurance. [19]

He rongoā kei te kōrero talking therapies for Māori – a wise practice guide for mental health and addiction services is a guide to enhance and sustain engagement in, and delivery of, talking therapies with Māori who access services as individuals or as whanau.[20]

Other workforces in Aotearoa

Health Coaches

The **Health Coach** is a new workforce that has been established in Aotearoa to support people to meet their health and wellbeing needs. Health coaches are part of a non-registered workforce from diverse backgrounds although some will likely have certification or qualifications. They may have lived experience although this is not essential.[21] The core components of the role are: supporting wellbeing; accessibility and responsiveness; seamless delivery; and training, skills and knowledge.

Health coaches focus on behavioural change for their clients. They create action plans and follow up with areas such as managing stress, eating well, taking medication, and exercising. We heard from sector leaders that when health coaches are supported by the right team and have clear scope and fidelity to the model, it can be safe and work well.

Health coaches mostly work in primary care and can also work in the community as part of an integrated team. They receive training in three phases based on set learning outcomes.[22]

One of the challenges with the health coach workforce is that supervision is not funded and can be difficult to provide. Health coaches have not received the same level of base supervision that would have occurred with people registered under the HPCA, such as Health Improvement Practitioner (HIPs).

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[18] Whāraurau. (2021). *Real Skills Plus ICAMH?AOD Competency Framework – Personal Development*. Whāraurau. https://realskills.wharaurau.org.nz/personal-development

[19] Whāraurau. (2021). *Real Skills Plus ICAMH?AOD Competency Framework – Personal Development*. Whāraurau. https://realskills.wharaurau.org.nz/personal-development

[20] Te Pou o Te Whakaaro Nui. (2010). *He Rongoā Kei Te Kōrero – Talking Therapies for Māori.* https://d2ew8vb2gktr0m.cloudfront.net/files/resources/Talking-Therapies-for-Maori.pdf

[21] Further information is available at: https://d2ew8vb2gktr0m.cloudfront.net/files/events/IPMHA-Health-Coach-Profile-November-2020.pdf

[22] Further information is available at: https://www.tepou.co.nz/initiatives/integrated-primary-mental-health-and-addiction/health-coaching

Health Improvement Practitioners (HIPs)

Another similar workforce that works as part of an integrated team in GP clinics is the **Health Improvement Practitioner (HIPs)** workforce.[23] HIPs have a focus on primary care, behavioural health and introducing brief behavioural change. They mostly provide brief CBT interventions and group sessions. They have a very clear scope.

There is an established training framework in place, which includes observations. HIPs are required to meet data metrics on the number of people they meet with. They complete reflections and attend peer supervision and webinars.

Some sector leaders questioned the need for both HIPs and the introduction of a new practitioner role. They emphasised the need to clearly articulate the value that practitioners would bring if this workforce was intended to be separate from HIPs. The main difference is that HIPs are people who must already be registered under the HPCA, Dapaanz or the Social Work Registration Authority (SWRB). Sector leaders expressed concern that HIPs are pulling from an already stretched workforce pool. They are from a range of disciplines and are often used to doing psychological work. They do not necessarily have a psychology background in their training, or a grounding in behavioural psychology.

Could the HIPs programme be expanded to include unregistered people?

One idea raised was to expand the HIPs programme to include unregistered people, to enable them to register upon completion of their training. This would have the benefit of providing a pathway into a monitored and registered health professional role. There is existing well-established training that could potentially be strengthened to meet standards for registration.

However, there were concerns that the status and quality of HIPs could be compromised with unregulated people coming into the HIPs training programme. There may be resistance from existing HIPs that the programme would be diminished if unregistered people can enter.

Another area that would need to be addressed if the programme is expanded would be increasing the number of HIP trainers. If NZPB registration was required for 'psychological wellbeing practitioners', the existing HIP training programme would not be sufficient to meet the required standard for NZPB registration. Training would need to be significantly expanded and provided through accredited organisations if this was required. NZPB registration would only apply to people with psychology degrees.

While HIPs work as part of a team in a general practice, there is no supervision component for HIPs at present, as they are already registered. However, supervision would need to be in place for practitioners. HIPs currently only work in general practice, whereas there is wider demand for practitioners in a range of settings.

[23] Further information is available at: https://www.tepou.co.nz/initiatives/integrated-primary-mental-health-and-addiction/health-improvement-practitioners-in-new-zealand and https://www.tepou.co.nz/resources/hip-training-evaluation-jul-to-dec-2021

APPENDIX B: COMPARISON WITH WORKFORCES IN OTHER JURISDICTIONS

UK IAPT model

Improving Access to Psychological Therapies (IAPT) was introduced in the UK in 2008 for the treatment of depression and anxiety.[24] The UK has taken a centralised approach administered by the National Health Service (NHS). This has been critical for the introduction of IAPT as a stand-alone program, with a purpose-built workforce, tight monitoring to standards, and clear evidence of results across a number of system indicators. Pre- and post-measures of symptoms are collected at every session and reported monthly through NHS digital on a district basis. Clear targets were set at the outset, including reach, wait times and recovery rates. The programme is free at the point of delivery.[25] IAPT up skilled an IAPT specific workforce, to increase the overall workforce and to maintain tight control over fidelity to evidence based approaches, its distinct program identity, and its stepped care model.[26] There is also a separate Children and Young People's IAPT programme which includes a community and schools based workforce.[27]

IAPT Services are characterised by:

- **Evidence-based psychological therapies**: with the therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimise outcomes.
- **Routine outcome monitoring**: so that the person receiving therapy, and the clinician offering it, have up-to-date information on an individual's progress.
- **Regular and outcomes focussed supervision**: so that practitioners are supported to continuously improve and deliver high quality care. [28]

The IAPT workforce includes low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate and severe depression and anxiety, operating within a stepped care model. Psychological Wellbeing Practitioners (PWPs) deliver low intensity interventions for people with mild to moderate depression and anxiety.[29]

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[24] NHS Health Education England. (n.d.). *Adult Improving Access to Psychological Therapies (IAPT).* https://www.hee.nhs.uk/our-work/mental-health/improving-access-psychological-therapies
[25] Mental Health Commission of Canada. (2018). *Expanding Access to Psychotherapy: Mapping lessons learned from Australia and the United Kingdom to the Canadian Context*, August (pp. 2-13)
[26] Mental Health Commission of Canada. (2018). *Expanding Access to Psychotherapy: Mapping lessons learned from Australia and the United Kingdom to the Canadian Context*, August (pp. 2-13)
[27] Ludlow, C., Hurn, R., Lansdell, S. (2020, Feb). *A Current Review of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) Program: Perspectives on Developing an Accessible Workforce*. https://doi.org/10.2147/AHMT.S196492
[28] NHS Health Education England. (n.d.). *Adult Improving Access to Psychological Therapies (IAPT).* https://www.hee.nhs.uk/our-work/mental-health/improving-access-psychological-therapies
[29] The National Collaborating Centre for Mental Health. (2021, Aug). *The Improving Access to Psychological Therapies Manual.* NHS. https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/

To enhance access and help patients from different backgrounds engage with these interventions, PWPs can provide face-to-face, online or telephone-based support, or support direct to other agencies such as GP practices, health care or community settings.[30]

Two PWP training routes are available, both accredited by the British Psychological Society. Apprenticeships are available for those without an honours degree[31] with relevant life experience, or university programmes.[32] PWPs who have completed their BPS accredited PWP training programme have a preceptorship year which is a structured period of transition for newly qualified PWPs, during which they are supported by an experienced practitioner to develop their confidence and refine their skills.[33] There are also opportunities for continuing professional development during and beyond the preceptorship year. Professional registration is with the relevant professional body following training.[34]

There have been some issues with retention of PWPs. Suggestions to improve retention include working to create a diverse workforce, supporting part-time training and working, effectively integrating PWPs into the team, ensuring a wide range of development opportunities, receiving adequate support, developing 'champions' such as champions for youth to enhance and widen PWPs skill sets, and providing career development opportunities such as senior, lead, and supervisor PWP positions.[35]

Australia's NewAccess early intervention program

Australia has adapted the UK's model and established a NewAccess early intervention programme. Adaptation to the Australian context included aspects such as geographical isolation and infrastructure of the healthcare system.[36] NewAccess has Access Coaches trained in low-intensity CBT (LiCBT) to guide problem solving and skills building for those with low to moderate depression and anxiety.[37] Coaches undertake twelve months of training, starting with a six-week intensive that then moves to practical learning. This involves managing clients and an ongoing curriculum under specialist supervision. A clinical supervision framework sits across the service and workforce, ensuring that NewAccess Coaches are never without clinical supervision. NewAccess is funded by the Commonwealth Department

[30] Psychological Professions Network. (n.d.). *Psychological Wellbeing Practitioner (PWP).* https://www.ppn.nhs.uk/resources/careers-map/career/psychological-wellbeing-practitioner
[31] Apprenticeships are open to applicants with academic qualifications at Level 5 in the UK system.
[32] Psychological Professions Network. (n.d.). *Psychological Wellbeing Practitioner (PWP).* https://www.ppn.nhs.uk/resources/careers-map/career/psychological-wellbeing-practitioner
[33] https://www.yhscn.nhs.uk/media/PDFs/mhdn/Mental%20Health/Senior%20PWP%20Network/22.01.19/5.%20Guidance%20on%20Preceptorship%20and%20Continuing%20Professional%20Development%20for%20PW....pdf
[34] The National Collaborating Centre for Mental Health. (2021, Aug). *The Improving Access to Psychological Therapies Manual* (pp. 16). NHS. https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/
[35] The National Collaborating Centre for Mental Health. (2021, Aug). *The Improving Access to Psychological Therapies Manual* (pp. 23). NHS. https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/
[36] Cormarty, P., Drummond, A., Francis, T., Watson, J., Battersby, M. (2016, Mar). *NewAccess for depression and anxiety: adapting the UK Improving Access to Psychological Therapies Program across Australia*. https://doi.org/10.1177%2F1039856216641310
[37] Ernst & Young. (2015). *New Access Demonstration Independent Evaluation – Summary of Findings* (pp.6). Beyond Blue.

of Health and Aged Care via Primary Health Networks (PHNs) across Australia, who commission service providers to deliver NewAccess in their region.[38]

An evaluation of NewAccess in 2015 found that the program was appropriate and effective in the Australian service delivery environment. It showed that evidence-based guided self-help for anxiety and depression could be delivered by trained and supervised community members, who were not necessarily mental health professionals. The programme was designed to fit within a system of stepped care, so that there was a clear process to step up those requiring more intensive services. The key elements of the program were that it was no cost, immediate and convenient access (phone or face-to-face).

Critical success factors for the program included:

- embedding the program within the health and social care systems and locating it in easy-to-access venues (for example using universities, health and NGO infrastructure)
- ability to self-refer and the low stigma associated with the program
- recognising the place of the program in a stepped care mental health system
- maintaining current processes to support fidelity and manage clinical risk, including a client information system and monitoring through supervision of coaches, fidelity audits of client sessions and monitoring of supervisors.
- positioning the Access Coach in the Australian mental health workforce, accrediting training and developing career pathways to support workforce sustainability
- selecting a capable regional body to commission and monitor the program
- commissioning arrangements to support clinical risk management, implementation fidelity and quality management. This includes an effective, systematic approach to clinical governance in service providers, well defined performance expectations, and ongoing monitoring, performance management and quality management of service providers
- continuing to use a wide range of marketing modes to promote the program
- socialising the public and existing service providers to this new model of care.[39]

A further evaluation commissioned by the Australian Department of Health and Aged Care was underway at the time of writing.[40]

[38] Beyond Blue. (n.d.) *About NewAccess.* https://www.beyondblue.org.au/get-support/newaccess/about-newaccess
[39] Ernst & Young. (2015). *New Access Demonstration Independent Evaluation – Summary of Findings* (pp.7 - 16). Beyond Blue.
[40] Australian Department of Health and Aged Care. (2022) *Better Access initiative*. https://www.health.gov.au/initiatives-and-programs/better-access-initiative

Assistant psychologists (UK)

The idea of assistant psychologists was raised by some sector leaders, with this role being common in the UK. Assistant psychologists are under direct instruction from a clinical psychologist who would usually retain clinical responsibility for patients and service users.[41] This would not appear to be feasible in the Aotearoa New Zealand context as there are limited numbers of registered psychologists available for supervision and limited capacity to manage a new workforce in a direct one-to-one supervision model. However, there could be potential for a workforce involved in assistant psychologists and other health professionals in team or group settings.

To become an assistant psychologist a degree in psychology is usually required, ideally one recognised by the British Psychological Society.

Medical assistants (US)

Another example given (outside of psychology) was the medical assistant workforce in the United States, which was seen as improving efficiency. Medical assistants complete administrative and clinical tasks in hospitals, offices of physicians, and other healthcare facilities.[42] This could include carrying out a full history of the person and blood tests, prior to nurses and physicians interacting with the person. Medical Assistants can be certified by the American Association of Medical Assistants.

[41] NHS. (n.d.). *Assistant psychologist.* https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles/assistant-clinical-psychologist

[42] American Association of Medical Assistants. (n.d.). What is a Medical Assistant? https://www.aama-ntl.org/medical-assisting/what-is-a-medical-assistant

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Discussion document: Defining Assistant Psychologist[1] (AP) place in workforce

The following has been written to provide a foundation for further discussion around the place of APs in the workforce and the levels of support that will be required. What is presented below is a draft list of ideas, that were brought up by the AP Advisory group in response to prompting questions.

We recognise that describing the place of the AP role in the workforce is inextricably tied to understanding the role description, who this role will be supporting and what gaps it seeks to close, training content, process, structure, and location, and models of supervision. As these aspects evolve, the understanding of the parameters that will support the role in the workforce will also evolve.

Please consider the ideas below and provide comment, expanding on what is written, where needed and providing solutions. This may be shared with members of any network or group that you are representing on the APAG. All feedback is welcome – we will work to represent this in a final guidance document.

Our starting assumption (as outlined in the background document) for this discussion was that an Assistant Psychologist will be a registered mental health professional who undertakes assessment, interventions, and case management tasks for a specified range of conditions under the supervision of a registered psychologist. It is envisaged that it will be a condition of registration that individuals registered in this scope are not permitted to work in sole practice:

Prompting questions provided to APAG

What employment settings will the Associate Psychologist (AP) (working title) workforce be utilised in/trained for?

What level of support will be stipulated for this role, for example;

- *Will APs be required to work in partnership with a registered psychologist (scope defined?) in an MHA team supporting their workstream?*
- *Will APs be members of an MDT working under supervision of a registered psychologist?*
- *Will APs be members of an MDT working under supervision of a sufficiently experienced clinician?*
- *Will the support needs change with career progression (on acquisition of experience and/or further credentials?*

[1] The NZPB have indicated a preference for the name Assistant Psychologist over Associate Psychologist. We will therefore refer to this role as Assistant Psychologist until a name is chosen and formalised.

How will responses to the above question prompts ensure APs are available to areas that have high workforce needs and likely lower psychology workforce?

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Te Whatu Ora

The following themes emerged in response to these questions

Overseas models

Learning from overseas models, particularly the mistakes and restrictions can be helpful, however it is necessary to ensure the assistant psychologist's pathway is nuanced to the local environment, ensuring cultural perspectives, voices of tāngata whai ora and is outcomes driven.

Role support

We recommend that the proposed role will require supervision from a psychologist and that all scopes of psychologist working in MHA services could supervise and/or partner with AP's. Further discussion around supervision models will be ongoing.

APs will function as, and be supported by, members of an MDT.

APs will not be independent practitioners in sole practice. Further credentials may be identified that support progression to independent practice.

The support required will be reflective of the workplace environment and the people in those environments. Therefore, more than one model of supervision may be defined to ensure flexibility across clinical (primary, secondary, NGO) and geographical and cultural environments. This will be particularly important for ensuring rural communities, Māori and people with the highest needs are not excluded by an overly prescriptive model. Suggestions given:

- Utilisation of telehealth for supervision (with development of a competency around this)
- Being an 'assistant to the psychologist' i.e. working with directly delegated tasks that don't require the top of scope skills of a Psychologist (this model is favored by NZPB)
- Contracting supervision into teams
- Adapting the Intern Hub Service model to provide supervision for groups of APs
- Utilisation of group supervision

Example roles for APs

- For every individual and whanau that comes into services there is a stepped level of care required across their spectrum of complexity ie aspects of the issues may be minimally complex while other aspects may be of high intensity or complexity. Additionally, over time an individual may require different levels of support. Therefore, whatever the employment environment (secondary, primary or NGO), there will be low to moderate complexity needs that the AP role can contribute to.

- APs would be valued in a primary/first response area to compensate for the limited access to psychologists in certain areas around Aotearoa. The creation of a structured first response programme utilising APs could be developed for wide use throughout communities.

- Secondary services provide services at the highly complex severe level therefore the moderate/middle range may not make it to secondary services and are left to primary

services. The APs could sit within primary care delivering brief interventions or deliver manualised cognitive behavioural therapy (CBT) treatments, treatments for stress, anxiety, anger, AoD, amongst other psychological needs.

- As registered health practitioners APs could be trained to be in Health Improvement Practitioner roles.

23 September 2024

Health New Zealand
Te Whatu Ora

Assistant Psychologist (working title) project

Health New Zealand | Te Whatu Ora is developing a new psychology workforce Assistant Psychologist. This workforce will assist in increasing access to psychological services and support the current mental health and addictions workforce.

Limitations to the size of postgraduate psychology training programmes that equip students to be registered psychologists have resulted in a significant disconnect between the opportunities provided by universities and workforce needs. The proposed approach would provide an alternate pathway for the large numbers of psychology graduates who want to work in the mental health and addictions workforce but are currently unable to achieve entry into these highly restricted postgraduate training programmes.

The government announced the establishment of this new workforce in May 2024 and thus Health New Zealand | Te Whatu Ora and the Hauora Māori Service Group have established an advisory group (APAG) with wide representation to provide guidance and advice to the process. The advisory group is now meeting and while guidance on the role and training is developing, the vision is that Assistant Psychologists will be registered health professionals with regulatory oversight from the New Zealand Psychologists Board (NZPB). They will hold a postgraduate qualification, and will, under the supervision of a registered psychologist, undertake low intensity assessments, interventions and case management tasks for a specified range of conditions. The NZPB supports the development of this role and will work towards establishing the scope of practice, competencies and accreditation processes. It is Health New Zealand | Te Whatu Ora's intention that the training for Assistant Psychologists will begin in 2026.

Ngā mihi nui,

Health New Zealand | Te Whatu Ora,

Mentally Well, Enablement

Health New Zealand
Te Whatu Ora

Associate Psychologist

Workforce and role description

Guidance for development

October 2024

The following is provided as guidance to the development of the role and workforce parameters of associate psychologists. This document sets the suggested boundaries of the role within which job descriptions for specific workplaces can be described. As with all positions, it is anticipated that a workplace will provide job specific training within these boundaries to ensure the associate psychologist has the necessary skills to meet the needs of the population being supported. Section 7 of the Pae Ora (Healthy Futures) Act 2022 outlines the Health Sector Principles which describe key outcomes and actions intended to meet our responsibilities under the Articles of Te Tiriti O Waitangi, as articulated by the courts and the Waitangi Tribunal[1]. Te Tiriti o Waitangi principles and intentions underpin the development of this role and supports equity of mental wellbeing outcomes for Māori.

A. Workforce parameters

An associate psychologist is a registered health professional who supports and enhances psychological care within a service/team for tāngata whai ora who are experiencing mental distress and/or mental health and/or addiction conditions. This role is being developed for employment in the health sector (primary, secondary and NGO) and in sectors that utilise psychological services in mental health and addictions team environments. As a condition of registration associate psychologists are required to:

- work within a team environment where there are defined lines of clinical responsibility (ie not permitted to work independent of a clinical team environment)
  AND
- work with supervision from a registered psychologist or a senior associate psychologist

[1] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641; *New Zealand Maori Council v Attorney-General* [1989] 2 NZLR 142; *New Zealand Maori Council v Attorney-General* [1991] WL 12012744; *New Zealand Maori Council v Attorney-General* [1992] 2 NZLR 576; *New Zealand Maori Council v Attorney-General* [2013] NZSC 6; *The Ngai Tahu report 1991* (Waitangi Tribunal 1991); *Report of the Waitangi Tribunal on the Orakei claim* (Waitangi Tribunal 1987); *Report of the Waitangi Tribunal on the Muriwhenua fishing claim* (Waitangi Tribunal 1988).

To enable registered psychologists to work at top of scope, associate psychologist's may be employed to provide direct assistance to one or more registered psychologist/s by carrying out delegated tasks.

B. Supervision

Two issues requiring mitigation have been identified in relation to the diversity of services that have expressed a need for this workforce.

- the high level of need for mental health and addiction support, and the deficits in workforce, introduces a risk that the associate psychologist may experience pressure to engage in tasks that are beyond defined competencies.
  AND
- it is understood that an associate psychologist may be employed to a clinical team that does not have a registered psychologist on site **OR** registered psychologists on site do not have capacity to provide supervision.

Supervision has a supportive function as part of continuing professional development and life-long learning. For associate psychologists, supervision will also have a focus on support of work within identified competencies, and to identify and mitigated pressures to extend beyond these.

The minimum requirements for frequency of supervision will be identified by the NZ Psychologists Board as part of the development of the scope of practice and competencies for the role.

The associate psychologist role is intended to be supportive of registered psychologists, allowing them to work at top of scope on duties such as supervision. It is acknowledged however, that this new role may also place a demand on the supervisor capacity. The following will be required as part of the role development to increase acceptability and success by reducing this demand.

- For workplaces to identify a pathway on the psychology career framework for early career registered psychologists to provide supervision to associate psychologists.
- Enabling sufficiently experienced associate psychologists to develop the competencies required to provide supervision to senior associate psychologists (seniority to be determined by workplaces as part of their career frameworks).
- Requiring models for provision and resourcing of supervision to be developed by employers. This may include virtual or hub style supervision.

To support ongoing professional development the NZ Psychologists Board will identify what is required for an associate psychologist continuing competence programme.

C. Core skills and competencies

Cultural competency

- A foundation of mātauranga Māori and knowledge of Pacific models of health, to ensure culturally responsive practices that acknowledge the unique cultural perspectives, histories, and challenges faced by Māori and Pacific communities.
- Familiarity with Te Tiriti o Waitangi and commitment to upholding its principles in practice.
- Understanding of culturally safe practice across the diversity of Aotearoa NZ's populations.

Understanding of ethics and reflective practice.

- Orientation to ethical practice with reference to (but not limited to) the NZPB code of ethics.
- Orientation to relevant legislation and associated obligations.
- Understanding the human rights as a foundation to a rights-based mental health system.
- Maintenance of professional boundaries.
- Consent, privacy and information safety.
- Working to core competencies and scope of practice including responsibilities/obligations as a registered health professional.
- Reflective practice skills and adherence to continuing competence programme.

Communication and relational skills.

- The practice of whakawhanaungatanga.
- Understanding of interpersonal skills (soft skills) for working with people – such as reflective listening, developing therapeutic engagement.
- Understanding diverse lived experience perspectives, CPSLE values and models.
- Orientation to team functioning and valuing the knowledge and experience of the diverse roles within the team and wider system.
- Systemic orientation to health, social services and other support sectors.

Basic psychological knowledge.

- Understanding human behaviour and development across the lifespan.
- Understanding social determinants of mental health/wellbeing/health, including cultural identity, discrimination, socioeconomic status, and other factors that disproportionately affect Māori, Pacific, and other communities.
- Theoretical framework of psychology, particularly in the areas of applied and developmental psychology.
- Foundation of understanding of the recovery model of mental health care and other dominant models including their value and limitations.

- Practicing from a trauma informed perspective that recognises the impact of historical, systemic, and intergenerational trauma on Māori, Pacific, and other communities.
- Supporting diversity.
- Basic understanding of commonly occurring mental health and addiction conditions.
- Understanding of the value and limitations of diagnostic classification systems.
- Understanding and responding to distress.

D. Responsibilities and tasks

Assessment and data collection from a culturally sensitive perspective, with an emphasis on understanding the cultural, social, and historical contexts that may shape a person's mental health and wellbeing.

- Supporting triaging and screening assessments to enable prioritisation.
- Psychometric assessments – administration and inputting data (not interpretation).
- Semi-structured history taking assessments.
- File reviews and gathering background information.

Therapeutic support including utilisation of Hauora Māori and Pacific models to guide culturally appropriate assessments, care plans, and interventions.

- Within team environment support planning and implementation of programmes of culturally adapted care and structured therapy for tāngata whai ora (individual and group) who have low/moderate intensity/complexity needs, or while on wait list e.g. protocol driven CBT, FACT.
- Complete components of assessment or therapy delegated by registered psychologist and/or endorsed by supervisor e.g. behavioural observations, in vivo exposure, mindfulness, mood recording.
- Provision of psychoeducation.

Therapeutically oriented case management and coordination.

- Supporting the development and implementation of Wellness Recovery Action Plans
- Provision of skills oriented strategies for self management.
- Providing a culturally responsive approach in step-up and step-down phases of therapy, recognising that transition periods may require additional support and resources for Māori, Pacific, and other identified service users to achieve sustainable outcomes.
- Support and psychoeducation for whanau.
- Interprofessional communication and service liaison (eg navigation and referrals).

- Supporting people by addressing broader determinants of mental health, such as employment, housing, social engagement, and loneliness, while considering community-specific barriers, such as lack of culturally appropriate services or language support.
- Monitoring, evaluating and communicating of progress/outcomes.

Administration.

- Preparing session materials and resources.
- Letters/ written summaries (checked and signed by clinical line management or supervisor).
- Information filing and management.

Research and quality assurance.

- Literature reviews and research.
- Audit/service evaluation.

Update from the Associate/Assistant Psychologist project team

Kia ora koutou 10 October 2024

Thank you all for your contribution to the latest Associate Psychologist Advisory Group meeting. We wanted to take the opportunity to update you about tasks that are proceeding, and to summarise the clarifications that your feedback has provided.

Firstly, for those of you who have not spotted it yet, the Mental Health and Addictions Workforce Plan released two weeks ago again endorsed the development of the AP role. Following release of this plan, and with the various communications that we have been organising, we are now seeing that it is being discussed widely. Judging by the letters and inquires we have been receiving, there is growing interest in its potential to both provide a career option for psychology graduates, and most importantly, to help the large numbers of people who currently have limited, or no access to mental health and addictions support. The good news for the existing psychologist workforce is that the Workforce Plan identified an agreement to seek a further 30 training positions in clinical psychology, and to and precede this with 30 additional funded internships over the next three years. This step in the direction of increasing the existing workforce has been a component to the puzzle of ensuring support for the AP role.

In recent weeks we have begun the processes that are required for procurement of both the NZ Psychologist Board and TEO's. Any information that is required for these processes, for example that a RFP has been placed on GETS, will be notified via communications that we provide. You will be the first to know about these so that you can share the messages, however, we also have a stakeholder communication list for information that is required nationally.

We are receiving some great feedback from members of the advisory group who have reached out to their membership/networks to gather commentary on the development of the role. Thank you for those who have got this to us so far. To date, this has been generally positive and aligned with the documents that we have circulated with some very helpful clarification and guidance on a range of details. As we have discussed, this information from your networks will be used to inform, or be provided alongside, the next steps that will be taken by the NZPB, TEO's and employers.

We understand from your recent feedback, and that which has been gathered previously, that there is general agreement that the AP role will;

- be to enhance the workforce of mental health and addiction services across both primary and secondary (including NGO) sectors and Kaupapa Māori services.
- be employable to psychological services within both mental and general health (health sector).
- be employable to mental health and addictions teams in non health sectors (eg, Ara Poutama, Oranga Tamariki).

- develop a workforce that will support communities and services that have significant workforce challenges.
- develop a Māori psychology workforce through partnering with Māori for the development of training and workforce parameters.
- be a regulated role via registration with the NZPB.
- have graduated from a yet to be established postgraduate qualification (i.e. diploma) that requires a combination of theoretical and practical learning, and includes perspectives from lived experience community.
- as a minimum require an undergraduate psychology (major) degree as a prerequisite for entry to training.
- identify a 'pathway to practice' (i.e. prerequisite papers) through undergraduate psychology that may benefit the work readiness of students entering post graduate training.
- have practical learning during training that may require collaboration/partnership with employers.
- have a clearly defined range of competencies that ensure AP's work to the level of their training and experience.
- be required to have clinical supervision by a registered psychologist or AP who has the requisite experience and training (to be defined) in supervision.
- have a career pathway developed that includes (but is not limited to) supervision of other AP's after a specified period of practice and training (to be defined).
- not be permitted to work in sole practice.
- be advantaged when rejoining the training pathway to higher-level psychologist qualifications.

These ideas about the role remain open for discussion across the next meetings with final guidance being provided to both NZPB and TEO's in October - November. These agencies will have the opportunity to conduct their own processes to refine and operationalise this guidance.

Two aspects have had some mixed feedback. First, the relationship of the role to registered psychologists. There is a range of opinion on whether this role exists solely as an 'assistant to' (in partnership with), a registered psychologist. In this model, AP's would conduct delegated tasks under the direct supervision of a psychologist and could only be employed to teams that have a sufficiently senior psychologist who is willing/employed to work in this way. The alternative is this partnership role, **as well** as AP's functioning as members of an MDT engaging with clients around a range of low intensity and complexity tasks (as defined by competencies) and receiving clinical supervision from a registered psychologist or sufficiently experienced AP. Please come to the next APAG meeting prepared to discuss the pros and cons of these models.

Another aspect of this role that we seek guidance on, is the name of the role. This now needs resolving as soon as possible. Both assistant and associate have been offered as a naming convention for registration purposes and we acknowledge the word 'psychologist' is required to be part of the title for it to be registered role with NZPB. We consider that Associate Psychologist is reflective of the registered roles elsewhere, whereas Assistant Psychologist tends to not be registered roles and denotes a role that is an assistant to 'someone'. We know there are a range of views and we look forward to discussing this at the next meeting.

In the next APAG meeting we will also be traversing the ways in which we can envisage support for this role. This is for both the practicum support that will be required during training, and for ensuring there are supervisors available for the role. This is something that we have acknowledged is a significant challenge to be overcome and may require some innovation of traditional models to achieve. We want to ensure that what we develop is acceptable to psychologists, is solution focused to ensure no additional burden to their workload, and is recognised and valued within their role description. We hope you have a chance to consider this in the next week or two and we look forward to discussing it at the next APAG meeting (21 October).

AP Project Team

Health New Zealand
Te Whatu Ora

21 October 2024

Tēnā koe

Health New Zealand | Te Whatu Ora (Health NZ) are developing a new psychology workforce role - the Assistant/Associate Psychologist (Working Title). This new workforce will help grow access to psychological services and support the current mental health and addictions workforce.

Health NZ | Te Whatu Ora (Health NZ) is finalising an open procurement process for the development of a new Associate Psychologist training programme. Health NZ intends to procure with Tertiary Education Providers for the development of a postgraduate diploma programme for training the Associate Psychologist workforce. It is intended the training will be reflective of the skills, knowledge, attributes and application relevant to psychological practice in health settings and mental health and addictions settings across sectors including kaupapa Māori services, primary and secondary MH&A services, and NGOs.

Health NZ have placed a Future Procurement Opportunity (FPO) on the Government Electronic Tender Service (GETS) for interested tertiary education providers to subscribe to this FPO. This FPO indicates to the market that a Request for Proposal (RFP) will follow.

GETS | Health New Zealand (Te Whatu Ora) - Development of a Post-graduate Diploma Programme for Associate Psychologists

Further communications will follow as procurement progresses and the development of the Associate Psychologist continues.

Ngā mihi nui

Enablement Team
Mentally Well

Health New Zealand
Te Whatu Ora

5 November 2024

Tēnā koe

The development of the associate psychologist role is progressing. The project has reached its next milestone procuring a tertiary provider to develop the associate psychologist training programme.

Applications opened 1st November 10.30am for tertiary education organisations to seek Government funding for the development of New Zealand's first postgraduate diploma programme for associate psychologists.

Investment in the development of this new training pathway supports the Government's target to grow the psychology workforce and improve people's access to psychological services. The Minister of Mental Health announced this update. Applications now open for new training pathway | Beehive.govt.nz

The first cohort of at least 20 students are expected to start the one-year postgraduate programme in 2026.

The Request For Proposals (RFP) for funding to develop this new training programme opened 1st November on the New Zealand Government Electronic Tenders Service (GETS). GETS | Health New Zealand (Te Whatu Ora) - Development of Post-graduate training for Associate Psychologist workforce

The deadline for proposals is midday 12pm 28 November 2024.

The development of the associate psychologist training pathway will align with the competencies and scope of practice which the New Zealand Psychologists Board, the regulator for the psychology workforce will develop.

The associate psychologist training programme will provide a new pathway for psychology undergraduate students who want to work in mental health and addictions and undertake postgraduate studies leading to roles as registered psychologists but are unable to because of the very restrictive postgraduate pathways.

The associate psychologist will hold a postgraduate qualification and be a registered health professional who under supervision will support and enhance psychological care within a service/team, working with tāngata whai ora who are accessing services.

This new role will allow capacity for registered psychologists to focus on more complex cases and use their full scope of practice.

We want to encourage tertiary education organisations to take up this excellent opportunity to offer this new training programme for undergraduate psychology students and to help grow access to services for tāngata whai ora.

Ngā mihi nui

Enablement team,

Mentally Well

Health New Zealand
Te Whatu Ora

18 November 2024

Tēnā koe

The Health New Zealand | Te Whatu Ora Mental Health and Addictions Workforce Plan 2024 - 2027 highlights the importance of increasing access of psychological services for tāngata whai ora. From 2027 associate psychologists will contribute to this target. Health New Zealand | Te Whatu Ora are excited to be moving forward with this project with the responsible agencies to reach the Minister for Mental Health's goal for associate psychologists to be in training by 2026.

A broad range of sometimes highly varied views have been gathered in establishing the title of the role, understanding the knowledge and skills that will be required, and in considering how and where it will be established in the workforce. We thank everyone who has contributed to the conversation and in particular our Advisory Group and their associated networks who generously provided their time and expertise. This project now moves to the New Zealand Psychologists Board (NZPB) who will consider this information in the development of the regulatory aspects.

As indicated in our previous communications the project has also progressed to procuring tertiary providers to develop a postgraduate diploma for training this new workforce. The RFP currently on GETS will close 28 November. We look forward to the programmes being developed and ready for enrolments in 2026

Progress on this project will also focus on the employment aspects of the role. The associate psychologist role is being developed for employment in health services (primary, secondary and NGO) and in sectors that utilise psychological services in mental health and addictions environments. We are looking forward to ensuring that this workforce is developed to be supportive of regions that have shortages in their workforce. Part of this will be to explore the models and resourcing of the supervision required for training and ongoing support of the role.

To keep up to date with this project you can find information on the Health NZ | Te Whatu Ora website. Associate psychologist training programme – Health New Zealand | Te Whatu Ora

We want to thank our stakeholders for their continued engagement and support during this project. We will continue to provide further updates as these milestones progress.

Ngā mihi nui

Enablement Team,

Mentally Well,

Health New Zealand | Te Whatu Ora

Document 9

From: Sue Dashfield <Sue.Dashfield@TeWhatuOra.govt.nz>
Sent: Monday, 16 December 2024 2:06 pm
Subject: IMPORTANT - NZPB survey Associate Psychologist

Tēnā koe

Just a reminder to please complete the New Zealand Psychologists Board survey on the new Associate Psychologist role description. The feedback gathered is important to ensure the associate psychologist helps increase access to psychological services for tāngata whai ora, supports the work of registered psychologists and the whole mental health and addictions workforce.

Here is the link
https://www.surveymonkey.com/r/LGLVYB3

The survey closes **Tuesday 24th December**

Ngā mihi nui

Sue Dashfield
Group Manager Enablement
Mentally Well
Planning, Funding and Outcomes

Health New Zealand
Te Whatu Ora

Health New Zealand | Te Whatu Ora

Health New Zealand
Te Whatu Ora

5 March 2025

Update on the associate psychologist training programme

Tēnā koe

The project to develop an associate psychologist[1] workforce continues to progress. This document provides an update on the work underway, with a bit more information about some of the drivers of the project.

Defining scope and competencies
The New Zealand Psychologists Board (NZPB) is continuing to work on the regulatory aspects of the role. The scope and competencies are expected to be outlined by the end of April so that a qualification can be developed ready for a 2026 intake. NZPB remain committed to the project timeframes, while all acknowledge that this is a complex piece of work, occurring in a context of potential changes to health workforce regulation.

Developing the tertiary qualification
The procurement process is nearly complete to select the first two tertiary providers to develop the associate psychologist qualification. Contract discussions are being finalised, and announcements will follow of the successful providers. There was a lot of interest in the project and other tertiary providers may also join the work to develop the qualification in future.

Workforce solutions to meet the needs of New Zealander's
One of the greatest risks to the public in our mental health and addiction system is the scarcity of workforce to provide the support and treatment required across the spectrum of care. The introduction of the associate psychologist role will help to grow the mental health and addiction workforce and aims to enhance equitable access and outcomes for people requiring services.

The notion of developing a multitiered psychology workforce to address the broad spectrum of needs of people with mental health and addiction issues in Aotearoa New Zealand is not new. While the psychology profession here has observed and waited with some hesitancy, most other countries have moved ahead. While we can learn from these, a New Zealand approach needs to be uniquely responsive to our diverse cultural perspectives, geographical reach, and the clinical and emotional support needs of tangata whai ora and their whānau.

There are multiple complexities in developing this role and we acknowledge the caution that the psychology profession and others are advising. This has included the need for training to prioritise Māori focused course content, the potential that the associate psychologist workforce may have demands placed on it that exceed competence, and that cultural and clinical supervisory support may be stretched. We are committed to finding solutions to these and other challenges. We are also focused on maximising the contribution this workforce can make to ensure that tāngata whai ora and their whānau have access to care that meets their needs.

[1] The title of the role has not yet been finalised.

The vision for the associate psychologist role

The training and practice of associate psychologists will be culturally safe and responsive across the diversity of Aotearoa New Zealand populations.

It is intended that the training will reflect the skills, knowledge, attributes, and application relevant to psychological practice in health settings and mental health and addiction settings, including Kaupapa Māori services, Pacific services, primary and secondary Mental Health & Addiction services, NGOs, and across sectors. Foundational competence in te Ao Māori models and concepts, as well as knowledge of Pacific health models and their integration within practice, will be a cornerstone of training. Additionally, the training will focus on the development of knowledge and application of competencies when working with the diversity of cultures in Aotearoa New Zealand.

It is acknowledged that clinical and cultural competence is not a destination but a commitment to lifelong learning. This will be a key message in the requirements for professional development, as well as supervision.

Associate psychologists will be supported to deliver psychological services in mental health and addiction teams across our communities. To ensure safe practice in areas with limited psychology resources, employment guidelines, a career framework, and clinical and cultural supervision models will be developed and funded.

While some associate psychologists may be employed as assistants to psychologists and work on delegated and directly supervised tasks, it is anticipated that others will be employed as practitioners within multidisciplinary MH&A teams in primary, secondary, and NGO services. This message of unmet need has been received clearly and emphasises that the associate psychologist role is eagerly anticipated in communities with the greatest gaps in access to psychological services, particularly in rural areas and in NGOs.

Deploying an associate psychologist workforce to teams with the greatest need raises a challenge: these services may lack the infrastructure for supervision and other supports. There may be instances where there are no other psychologists in the service, and as a new workforce, employers will require guidance on how to optimally define and support the role to ensure they work within the safe boundaries of their competency. Added to this is that the existing demand for clinical and cultural supervision will increase as this workforce grows and as the intake to training for other scopes increases.

To address this, the NZPB's regulation of the associate psychologist role, and employment guidelines from Health New Zealand | Te Whatu Ora (Health NZ), will clearly define the graduate competencies that provide the boundaries of entry to the role. Work is underway to progress the models and resourcing of clinical and cultural supervision, as well as the expectations for professional development and career progression that will sustain and grow skills.

The vision is for the psychology workforce to be multitiered, with a range of scopes utilising complementary skill sets (from low to high intensity), providing for the spectrum of needs within MH&A services.

One aspect of the vision for introducing associate psychologists to the mix of psychological scopes is to help bring more cohesion to the profession overall. The vision is of a multitiered

workforce that's able to offer support based on complementary skills, covering everything from early assessment/intervention to formulating and treating complex, high-intensity issues. This approach not only spans different levels of service—community, primary, and specialist care—but also caters to the range of needs of each person/tangata whai ora and their whānau. This is especially true for those dealing with more complex mental health and addiction needs. In such scenarios, associate psychologists may play a supportive role for intensive psychological work while also addressing the lower-intensity aspects of care, ensuring a well-rounded approach for those who need it.

Currently, many roles in the mental health and addiction workforce are filled by allied professionals, such as social workers and occupational therapists. While these professionals may not have come from professions trained specifically for mental health, they have stepped up to meet the demand for mental health care, including psychological therapies, thanks to training often funded by Health NZ. The psychology profession now has an opportunity to grow and respond to some of these workforce needs.

Training and regulation of psychologists will be responsive to the needs of the workforce and tangata whai ora. The associate psychologist training model will ensure growth and allow adaptation.

The role of psychologists in public mental health and addiction services, along with the model of training and the size of the psychology workforce, has seen little change over the years despite the well-known and long-standing shortage in this workforce. Adaptation and evolution will be necessary to respond to these challenges.

Over the past few years, several universities have introduced restructured undergraduate psychology programmes, presenting a prime opportunity to create a more focused and tailored training pipeline for a new generation of students who are eager for a psychology career. The addition of associate psychologist training adds another crucial piece to this puzzle. It is intended that this role will be a step on a staircase to other scopes of practice and initiate a more flexible pathway of career progression.

The challenge now lies with tertiary providers and employers to leverage these opportunities, adapting training and workforce structures to ensure that the psychology profession can grow, evolve, and lead in meeting the increasing demand for mental health and addiction care.

We'll continue to update you as this project progresses - read more here.

Ngā mihi nui

Group Enablement

Mentally Well

Health New Zealand | Te Whatu Ora

The following has been written to provide a foundation for further discussion around the place of APs in the workforce and the levels of support that will be required. What is presented below is a draft list of ideas, that were brought up by the AP Advisory group in response to prompting questions.

What is the need that the Associate Psychologist (AP) role can fulfil?

Increased access to care for Tangata Whaiora

- There are currently large equity concerns in regards to access to psychologists for Māori and whānau, despite having the most need.
- Build capacity and capability in communities, not just in larger services centres

Service needs

Significant gaps in the workforce across **all sectors**. In MHA the need most pronounced in

- NGO sector
- Step up and down from primary to secondary services
- Support for psychologists to work top of scope in secondary sector
- Providing an option for people on wait list, earlier screening/triage

Career options

- Undergrads get lost and don't have the ability to progress on the training pipeline
- Opportunity for a place to stop and earn money and progress career later
- Encouragement of Māori, pacific, lived experience and disabled to do this role.

What skills and knowledge will this role need to support people/communities/workforce/services?

- Clear boundaries and definition of the role as well as the support required. Risk of expectation inflation especially in areas with limited workforce.
- Need strong cultural competency.
- Lived experience competency and models (how would this be evaluated?)." LE need to be part of the educational process, not just in the universities. How do you get access to the LE grass roots perspective. How to be connect the LE and the Psych that will be the only way to meet the needs of LE."
- Not just academic research knowledge - practical experience is essential to the training.
- Understanding of conditions, diagnoses, assessments,,case formulations
- Trauma informed
- Te Whare Tapa Wha / Human Behaviour Models
- De-escalation skills
- Lived experience workforce knowing about the MDT work force
- Therapies, CBT and Case worker responsibilities
- Question – clear with the expectations of the role.

Answers to questions about the skills and knowledge/role description will be informed by understanding more about the place of the role in the sector(s) and the process and content of training that is envisaged. Please continue to consider what skills and knowledge may be needed for this role.

What questions need to be addressed to guide and develop a role description?

Registration

- Broad agreement that the role should be registered
- Protection of the public is valued
- Flexibility may be required to accredit different training models.

What will the training be?

- One year post graduate
- Prerequisites within the undergraduate degree prior to entry to postgraduate
- Could there be consideration of base training then several streams leading to work in different sectors.
- Courses enrol both AP and non-AP students to increase volume and reduce costs to TEO's. Practical component unique to AP
- Training needs flexibility – consider training model that supports training all around the country. Criteria for training is freely available so community services could take that criteria and deliver it themselves. TEO's support with their resources.
    - Could this model be created so that others such as Wananga, Iwi or other health professionals could take the criteria and deliver it themselves. This would allow movement into the communities that need such as helping to grow the support in rural areas. Examples like Hauora Waikato.

      "There are models for how that may be. Here is the basic criteria, her is how to do it and agencies could apply. Basic knowledge is freely available. Hoping clin psych moves into the community that people want them. Uni's use their resource to help support that growth. Rural, small town access".
- Practical community/service based training is as important (more) as academic.
- Consider an indigenous scope, (and remember people who could deliver this are the ones who are already overworked)
- Be creative with developing a new framework/model for training. NZ Psychologist Board need to be alongside with different models.
- Need consideration of how to support those who already have a degree to upskill/ gain qual
- AP training is a step on a training pathway. Having this qual gives time off/advantage for taking the next step to training for other scopes. Ie pathway to other scopes is shortened by having experience as AP

Supervision/support

- This role is intended to work as associate/assistant to registered psychologists? Is this all psychologists? All who work in MHA? What about other non MHS scopes? How flexible can the training get?
- Can this role function if there is no partnership with a psychologist? What about in an MDT?
- Supervision models need to be examined to ensure blockages are not created.
- Need to increase the workforce to ensure support for the role.
- Can supervision be delivered remotely? National supervision? Potentials for rural/remote communities.
- Lived experience supervision should be provided and valued
- Can non psychologists supervise these APs?
- Positive for Māori to manage risks and explore supervision models

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Developing an Associate Psychologist Workforce in New Zealand

Background

The reasons for considering creation of an associate psychologist workforce

Ongoing substantial gaps in our mental health and addiction workforce present a significant barrier to increasing access to services and providing optimal models of care. The In the vacancy rate for psychologists in HNZ Te Whatu Ora is around 22%.

Due to current demands on services, many people are waiting for psychological services or are missing out altogether. Establishing effective, appropriate frameworks/models of delegation would enable registered psychologists who are employed in mental health and addictions settings to most effectively utilise their full scope of practice.

The proposed establishment of an associate psychologist role will allow individuals with a suitable undergraduate qualification to enter a further period of training (proposed to be a one year post graduate diploma) so they may be registered with the New Zealand Psychologists Board (the Board) and employed in roles that provide support to the delivery of psychological services.

Restrictions and barriers on psychology postgraduate training course numbers means there is a very significant disconnect between the opportunities provided by universities and workforce needs. The proposed approach would draw on the large numbers of psychology undergraduates who are interested in working in health but who do not achieve entry into the currently available highly restricted training that leads to registration as a psychologist. It is envisaged that the psychology training pipeline could be restructured to allow the associate psychologist role to be both a career opportunity and a step towards more flexible training in other registered scopes of psychology. This would include engagement toward a Māori pathway, which can then scaffold toward a whole of pipeline approach to Te Ao Māori models within the profession of psychology.

Note: Associate Psychologist is a placeholder name and has not been confirmed.

What is a 'psychology associate'?

An associate psychologist is typically a qualified mental health professional who, under the supervision of a registered psychologist, undertakes assessment, interventions, and case management tasks for a specified range of conditions.

It is envisaged that it will be a condition of registration that individuals registered in this scope are not permitted to work in sole practice but are required to work under supervision of either a registered psychologist or a mental health and addictions multi-disciplinary team.

There are a range of titles which describe similar roles internationally, including 'clinical associate psychologist,' 'psychological wellbeing practitioner' and 'assistant psychologist.'

Examining these does not suggest that the aim is replication, rather that the learning that has been done in other countries provides a perspective to be considered. A summary of these roles, the models they operate within, and outcomes is provided in **Appendix 1.**

Work to-date on the potential for this workforce.
Developing an associate psychologist workforce has previously been under consideration in New Zealand. In 2019, members of the Ministry of Health-led Psychology Workforce Task Group developed a proposal for a similar role of "psychological wellbeing practitioner," based on a United Kingdom model. This model received mixed reviews from the sector, particularly from Māori health leaders who had significant concerns that the English model did not include a Mātauranga Māori approach and would not be fit-for-purpose in New Zealand.

In 2022, the Ministry of Health (later Health New Zealand | Te Whatu Ora) commissioned Allen+Clarke to provide a feasibility analysis for a Psychological Wellbeing Practitioner Workforce. They interviewed a variety of stakeholders across mental health and related sectors regarding the feasibility of establishing this workforce and reported:
• cautious support for the development of this workforce
• the need to clarify whether the role would be employed to clinical or non-clinical FTE
• the need for the role to be registered through the Board in order to work in clinical roles
• the need for further work to identify training pathways that could support this workforce
• the importance of exercising caution in considering the application of similar overseas models within New Zealand
• that well executed engagement and consultation is essential in moving forward with developing this workforce.

Desirable characteristics for the role

If this role is to be introduced, some desirable factors (below) would need to be ensured.

• **The role attracts new people into the mental health and addiction workforce**
Competition between agencies and the private sector for the mental health and addiction workforce often sees the same people revolving between positions, with insufficient new entrants. Focusing on psychology graduates would ensure this proposed new workforce draws from a pool of people who often do not find an entry point into the health sector.

• **It is clearly distinguishable from the other mental health roles**
It is important that the public, health professionals and associate psychologists themselves, know where this role fits in the wider landscape. This workforce needs to be readily distinguishable from other mental health and addiction workforces. A clear scope of practice and associated competencies would be needed, and regularly reviewed guidance documents around the role description and expected standards for recruitment, employment, and support would need to be widely promoted.

• **It is clearly distinguishable from and supportive of registered psychology roles**

The Associate Psychologist role needs to be clear how it differs from, but can support, the role of existing registered psychologists. For example the role may include, and would not be limited to;

- supporting the less complex aspects of a psychologist's work by:
- triaging and undertaking screening assessments to support registered psychologists in prioritising clients
- providing aspects of evidence-based talking therapies for people with mild to moderate mental health and addiction conditions
- providing behavioural strategies for anxiety, depression and emotional distress
- providing or supporting group therapy, which can be more efficient than one-on-one
- undertaking therapeutic case management and coordination, including helping people to navigate the system and making referrals to other services.

Appendix 2 provides a broad comparison of the associate psychologist role to other mental health and addiction roles within New Zealand.

With a registered scope of practice and employment into clinical positions, associate psychologists will occupy roles that are distinct from other newly created/expanded roles such as health coaches, peer support/lived experience workforce. Clarification around the distinction from other workforces that engage in therapeutic case management and talking therapies for mild to moderate presentations will also be required.

• The level and type of training is suitable for the focus of the role

It is envisaged that training for the associate psychologist qualification will draw from students who have completed specified prerequisite undergraduate papers via a bachelor degree in psychology. University of Canterbury (UC) and Victoria University of Wellington (VUW) have both recently introduced new Psychological Science bachelor's degree programme's which have potential to support clearer pathways into the associate psychologist role as well as the existing registered scopes of practices. Both programmes offer a focussed psychology curriculum that allows students to choose psychology as both their major and their minor subjects. This foundation of skills and knowledge may provide an entry point to the role of associate psychologist. This does not exclude other undergraduate psychology degrees providing prerequisite pathways. As this workforce will require registration by the Board, other (non psychology) undergraduate degrees are not considered as prerequisite for entry.

Allen+Clark, writing before these new university developments, concluded that:

- a bachelor's degree would be a minimum entry requirement, desirably with practical exposure at any early stage of training
- specified papers may be necessary as prerequisites to ensure those with a psychology degree come equipped with the necessary theoretical foundation
- undergraduate training in kaupapa Māori and Pacific models would be essential, along with understanding of how to practice in a culturally appropriate way
- an additional 12 months of targeted practical training would be necessary (noting this was prior to development of the newly tailored undergraduate training programmes).

Our current view, to be confirmed through further consultation, is that post graduate training for associate psychologists would be via limited entry to a 1-year (post)graduate diploma

(120 points). The training will likely be derived from both existing, and yet to be developed papers within universities and/or Wananga. The intention is that training will include a Kaupapa Māori and non-Māori pathway.

It will be essential to prioritise practical learning provided alongside theoretical, to achieve the competencies that will be defined by the scope of practice. The support of Health and other sectors for practicum training and supervision will be needed to ensure the functioning of this role. This support may be developed in the form of a Memorandum of Understanding. Consideration will be given to this post graduate study being developed as an earn while you learn opportunity.

As associate psychologists will both train and work in partnership with registered psychologists, the role is dependent on growth of the existing psychology workforce.

• **There is strong oversight and ongoing development**
Allen+Clark found that most sector leaders believed it would be necessary for this workforce to be registered to ensure quality and safety of care, and appropriate role parameters. Logically registration fits with the NZ Psychologist Board, which would accredit training programmes, define the scope of practice and competencies, and ensure ethical and legal standards. Ongoing professional development would be necessary to maintain high standards of care, drawing on the Board's existing models.

Pathways for ongoing progression through the pipeline of training for registered scopes of practice would require development and articulation.

• **Summary**
The above points indicate a workforce that draws on psychology graduates with suitable training, who would work under the supervision of a registered psychologist or a multi-disciplinary team. They would have clinical roles that support registered psychologists, and would be registered with and have oversight from the Board.

Further development of this concept

The assumptions and considerations outlined above require closer examination and detailed targeted discussions with the Board, potential employers across multiple sectors, tertiary education providers, and peak professional bodies.

Tasks and barriers to be explored include:
• Education system implications – need to:
- determine financial and staffing capacity of tertiary education organisations to deliver training
- design and implement appropriately accredited training programmes
- engage early with Te Ao Māori training programmes

- Existing registered psychologist workforce implications – need to:
  - determine capacity to supervise placements as a requirement of the associate psychologist training practicum
  - establish effective frameworks for delegating tasks to psychology associates
  - manage ongoing supervision requirements for psychology associates

- Mental health and addiction service implications – need to:
  - ensure supervision of trainees and registered psychology associates under a registered psychologist
  - identify where psychology associates would work and integrate this role into service design and delivery

- Regulatory implications – need to:
  - define the role of the Board, including scope development/definition, agreement of competencies required for the role, training programme accreditation, registration and oversight
  - confirm the capacity for the Board to regulate this profession

- Implications for Māori – need to:
  - ensure the training for, and the practice within, this role is culturally safe and responsive
  - ensure these roles do not perpetuate inequitable access or outcomes for those who require mental health and addictions services
  - explore the development of Te Ao Māori training pathways to ensure this new role supports equitable workforce representation and the provision of culturally safe and responsive services.

- Health NZ Te Whatu Ora – need to:
  - lead engagement and provide coordination and oversight of the project
  - maintain responsibility for defining the associate psychologist's place in the MH&A workforce
  - establishment of heath sector practicum support and supervision
  - ensuring
  - ongoing support for the function of this workforce within MH&A services.

It is intended that the first intake into this training will begin in 2026, with the first qualified cohort entering the workforce in 2027. This is an ambitious target and will require a number of dependencies aligning.

An indicative project plan is included in **appendix 3**

Appendix 1: International Roles

Comparable role	Programme/model description	Outcomes, if known
Psychological Wellbeing Practitioners (PWPs) were specifically developed to work within IAPT services in the UK. They provide assessment and low intensity interventions for people with mild to moderate depression and anxiety. Training through an apprenticeship model (PWP trainees are employed through IAPT services) combined with an accredited post graduate qualification	**Improving Access to Psychological Therapies (IAPT) – UK:** Designed for the treatment of depression and anxiety. It is a stand-alone programme with a purpose-built workforce. It includes low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate and severe depression and anxiety.	Retention has been a reported issue with IAPT PWPs. Suggestions to improve retention include working to create a diverse workforce, supporting part-time training and working, effectively integrating PWPs into the team, ensuring a wide range of development opportunities, receiving adequate support, and providing career development opportunities such as senior, lead, and supervisor PWP positions.
Assistant Psychologists (UK) Work in the healthcare field, often for the NHS, however other opportunities for employment can also be found in human resources, education, forensic settings, and the non-profit sector. They work under supervision and complete tasks such as: • Preparing/administering psychological tests and assessments • Observing and recording behavioural observations • Implementing specific treatment and intervention programmes • Research and information gathering Assistant Psychologists must hold an undergraduate degree in psychology. They	Assistant Psychologists are not part of a specific delivery model in the UK.	No specific reported outcomes. The British Psychological Society reports that may Assistant Psychologists use their experience as a steppingstone towards becoming fully registered psychologists.

work under the supervision of a registered psychologist.		

Clinical Associate in Psychology (UK) Specialist mental health professionals whose duties include assessing, formulating, and treating clients within specified ranges of conditions and age, either in primary care/adult mental health settings or in a range of areas involving children, young people, and their families. Unlike registered psychologists, Clinical Associate practitioners can operate only within certain specialised areas and are required to work under the supervision of a fully qualified practitioner psychologist. Clinical Associate Psychologists must complete a BPS-accredited undergraduate degree (or conversion course) in psychology, followed by an MSc in either *Psychological Therapies in Primary Care* or *Applied Psychology for Children and Young People*.	This role was designed to support he **NHS Five Year Forward View** which called for a transformation of services for people with complex psychological needs seen in secondary care mental health services. Greater access to quality care for those with moderate to severe mental health difficulties was advised in community and inpatient settings. The plan also called for more patient choice in care and a reduction in waiting times.	No specific reported outcomes.
Access Coaches Access Coaches are trained in low-intensity CBT (LiCBT) to guide problem solving and skills building for those with low to moderate depression and anxiety. Coaches undertake	**NewAccess early intervention programme – Australia** Australia has adapted the UK's IAPT model and established a NewAccess early intervention programme. Adaptation to the	An evaluation of NewAccess in 2015 found that the programme was appropriate and effective in the Australian service delivery environment. It showed that evidence-based

twelve months of training, starting with a six-week intensive that then moves to practical learning. This involves managing clients and an ongoing curriculum under specialist supervision. A clinical supervision framework sits across the service and workforce, ensuring that NewAccess Coaches are never without clinical supervision.	Australian context included aspects such as geographical isolation and infrastructure of the healthcare system. Access Coaches were developed to support this model.	guided self-help for anxiety and depression could be delivered by trained and supervised community members, who were not necessarily mental health professionals. The programme was designed to fit within a system of stepped care, so that there was a clear process to step up those requiring more intensive services. A more recent evaluation published in 2022 highlighted concerns about equitable access. Better Access serves some groups better than others, and these gaps are widening. Of most concern, increases in utilisation over time disproportionately favour people on relatively higher incomes in major cities.

Appendix 2 –Comparisons between psychology associates and related roles in New Zealand

Role	Summary of scope & applied settings	Key differences from proposed associate psychologist role
Health coach	Health coaches are part of a non-registered workforce from diverse backgrounds although some will likely have certification or qualifications. They may have lived experience of mental health and addiction issues although this is not essential. Core components of the role are: supporting wellbeing; accessibility and responsiveness; seamless delivery; and training, skills and knowledge. They focus on behavioural change for their clients. Health coaches mostly work in primary care and can also work in the community as part of an integrated team.	Health coaches do not have a psychology degree, or a grounding in behavioural psychology. They are not able to undertake formal assessments or triage referrals.
Health Improvement Practitioner (HIP)	HIPs work in general practices as part of an integrated team, providing support for patients with mental health and addiction challenges. They mostly provide brief CBT interventions and group sessions. HIPs must already be registered under the Health Practitioners Competency Assurance Act2003, Dapaanz ,the Social Work Registration Authority or a Health New Zealand approved category within the New Zealand Association of Counsellors register.	HIPs are from a range of disciplines and are often used to Do mental health and addiction work, however, they do not necessarily have a psychology background in their training ,or a grounding in behavioural psychology.

Appendix 3: Associate Psychologist Implementation Year July 2024 to Dec 2026

Deliverables and Milestones (♦)	2024 Calendar year		2025 Calendar year				2026 Calendar year			
	2024/2025 Financial year				2025/2026 financial year				2026/2027 Financial year	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
HNZ Te Whatu Ora										
1. National Coordination and Governance										
Key stakeholders identified and contacted	♦·									
Governance structure established	♦·									
Internal project team established	♦·									
Advisory Group (planning) established with Terms of Reference	♦·									
Project scope, planned benefits and key outputs are agreed		♦·								
Process to establish implementation and associated procurement / commissioning identified.			♦·							
Timeline, budget, comms & engagement, risk & quality management are established			♦·							
Funding is confirmed			♦·							
Dependency to increase clinical psychology pipeline are actioned			♦·							
1st cohort enters workplace										♦·
2. Role Definition										
Title, role description, employment models, alignment with other sectors, boundaries with other disciplines are defined.			♦·							

3. Training Pathways										
Procure/ commission partnership organisations to collaboratively develop and implement role	♦									
1st cohort begin training							♦			
4. Workforce Support										
Funding model is confirmed				♦						
Supervision model is confirmed				♦						
Workforce support coordination is in place									♦	
5. Technology										
IT system requirements are identified		♦								
Link to Student Placement Project if Practicums are unpaid.				♦						
Procure development of IT system if required										

Deliverables	2024 Calendar year		2025 Calendar year				2026 Calendar year			
	2024/2025 Financial year				2025/2026 Financial year				2026/2027 Financial year	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Partnership organisation dependencies										
Tertiary education provider(s) (training)										
Increase in intake to existing pathways agreed										

Existing training pathways are developed to allow progression to further qualifications										
Policy on sector support required for training/practicums is agreed										
Qualification is defined										
Prerequisites for entry are identified										
Competencies are defined										
Qualification is developed, finalised, and notified										
NZ Psychologists Board (regulation)										
Competencies are defined and agreed										
Scope of practice is defined and established										
Accreditation requirements are defined										
Qualification accredited										
Unions APEX/PSA	TBC									
TEC and MoH	TBC									
NZQA	TBC									

NZQCF levels:

Level	Qualification	Credentials
1	Certificate	Micro-credentials
2	Certificate	Micro-credentials
3	Certificate	Micro-credentials
4	Certificate	Micro-credentials
5	Certificate Diploma	Micro-credentials
6	Certificate Diploma	Micro-credentials
7	Diploma Bachelor's Degree Graduate Certificate Graduate Diploma	Micro-credentials
8	Bachelor Honours Degree Postgraduate Certificate Postgraduate Diploma	Micro-credentials
9	Master's Degree	Micro-credentials
10	Doctoral Degree (PhD)	Micro-credentials

NZQCF Level descriptors

L	Knowledge	Skills	Application
1	Basic general and/or foundation knowledge	Apply basic solutions to simple problems Apply basic skills required to carry out simple tasks	Highly structured contexts Requiring some responsibility for own learning Interacting with others
2			
3	Demonstrate some operational and theoretical knowledge in a field of work or study	Select and apply from a range of known solutions to familiar problems Apply a range of standard processes relevant to the field of work or study	Limited supervision Requiring major responsibility for own learning and performance Adapting own behaviour when interacting with others Contributing to group performance
4			
5	Demonstrate broad operational or technical & theoretical knowledge within a specific field of work or study	Select and apply a range of solutions to familiar and sometimes unfamiliar problems Select and apply a range of standard and non-standard processes relevant to the field of work or study	Complete self-management of learning and performance within defined contexts Some responsibility for the management of learning and performance of others
6			
7	Demonstrate specialised technical or theoretical knowledge with depth in one or more fields of work or study	Analyse, generate solutions to unfamiliar and sometimes complex problems Select, adapt and apply a range of processes relevant to the field of work or study	Advanced generic skills and/or specialist knowledge and skills in a professional context or field of study
8	Demonstrate advanced technical or theoretical knowledge in a discipline or practice, involving a critical understanding of the key principles	Analyse, generate solutions to complex and sometimes unpredictable problems Evaluate and apply a range of processes relevant to the field of work or study	Developing identification with a profession and/or discipline through application of advanced generic skills and/or specialist knowledge and skills Some responsibility for integrity of profession or discipline
9	Demonstrate **highly specialised knowledge**, some of which is at the forefront of knowledge, and a critical awareness of issues in a field of study or practice	Develop and apply new skills and techniques to existing or emerging problems Mastery of the field of study or practice to an advanced level	Independent application of highly specialised knowledge and skills within a discipline or professional practice Some responsibility for leadership within the profession or discipline
10			