Mental Health Sector Liaison Group Meeting

AGENDA

Date: Wednesday 24 June 2009 12.00pm – 5.00pm
Location: Shamrock House, Meeting Room 1, Ground Level
81 – 83 Molesworth St, Wellington

Attendees	**ACC:**	
	[redacted]	Manager Longer Term Programmes
	[redacted]	Programme Manager, Longer Term Programme
	[redacted]	Programme Manager, Early Interventions
	[redacted]	(Acting) National Manager, Rehabilitation Servic Development
	[redacted]	Manager, Sensitive Claims
	[redacted]	Manager Projects & Services, Sensitive Claims
	[redacted]	Manager, Customer Service Technical Support
	[redacted]	Team Administrator Longer Term Programmes
	[redacted]	National Advisor Psychology & Mental Health
	[redacted]	National Advisor Psychology & Mental Health
	External:	
	[redacted]	NZ Psychological Society
	[redacted] on behalf of	
	[redacted]	NZ College of Clinical Psychologists
	[redacted]	College of Psychiatrists
	[redacted]	Head of Psychological Medicine, University of Otago
Chair	[redacted]	ACC Senior Medical Advisor

Agenda Item	
1. Lunch	12.00 – 12.30pm
2. Welcome and Introductions	[redacted]
3. Minutes of previous meeting	[redacted]
4. Update on project to support Sensitive Claims Unit	[redacted]
5. Update on Neuropsychological contract	[redacted]
6. The assessment of symptom validity	[redacted]
7. Groupwork counselling	[redacted]
8. New Business: • Current issues about Fees • Re-registration for psychologists with SSU - double handling of documents. • Evidence based therapy	[redacted]

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MINUTES

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	External:	
	[redacted]	NZ College of Clinical Psychologists
	[redacted]	College of Psychiatrists
	[redacted]	Head of Psychological Medicine, University of Otago
Apologies	[redacted]	(Acting) National Manager, Rehabilitation Service Development
	[redacted]	NZ College of Clinical Psychologists
	[redacted]	NZ Psychological Society
Chair	[redacted]	ACC Senior Medical Advisor

1. Welcome and Introductions

New people:

[redacted] – attending on behalf of [redacted]

[redacted] – contracted to ACC Sensitive Claims Project

[redacted] – ACC Programme Manager with portfolios for DSAC, DATA, SAATS (Sexual Abuse and Treatment Services), Community & Residential Rehab Services for Sensitive Claims, Peer Review for Sensitive Claims, Groupwork Counselling Services, Telephone Support & Crises.

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2. Minutes of Previous meeting 25 March 2009 read and accepted.

Item 4 Update on Counsellor Review registration.

[redacted] updated group. Approximately 1000 letters and review forms have been sent out and to date we have received about 180 back with the due date being 26/6/09. There have been some questions from psychologists who were concerned that they were required to provide the information asked for. There has also been backlash from psychotherapists because they have just been through a similar process for the Psychotherapy Board.

Item 8. Access to clinical records during audit.

Action point "ACC will follow up about informed consent and resourcing the sanitising of notes as this is a very time intensive job."

This is an ongoing active process, the Sensitive Claims Unit is very aware of this and there have been no breaches in last 6 months.

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3. Update on Clinical Framework project to support the Sensitive Claim Unit (SCU)

Presentation by [redacted] (PowerPoint Handout – please keep confidential as still in draft).

The completion of the project is scheduled for 31 August.

ACC have taken the opportunity to establish a clinical framework which sets the standards and principles under which the Unit manages clients' needs. From the framework the project will develop clinical pathways and best purchasing for outcomes.
[redacted] has been leading the development of the clinical framework. Clinical Services Directorate, including [redacted], are involved and will be signing this off before ACC adopts the framework. Concepts were presented to group and [redacted] asked for feedback about principles and key messages.
Group discussion, main points raised were:

- Principle 3 "Measurable treatment effectiveness must be demonstrated" – One of biggest issues is endless ongoing treatment, so how will this be measured? Timeframe of treatment needs to be included.
A: Measurements will form part of the clinical pathways and clients' needs will be matched to the pathway and the pathway must have a focus on regular assessment of the effectiveness of the intervention and a drive towards recovery.

- "More is less". Difficult to get treatment providers to understand that the more they do the worse a client can get. Can be a difficult transition for the therapist to decrease treatments.
- Belief system ingrained that sexual abuse equals the need for counselling.

- Packages of Care (PoC) suggested as way to help establish expectations for client.
A: It will be challenging but important to use the PoC approach and identify the options for the best outcome for a client.

- Will the clinical pathway be closely linked to the Massey guidelines or will it be alluded to as the over-arching document?
A: Massey guidelines alone are the standard used to drive the thinking and create the framework and pathways. It is important to provide guidelines on what is necessary and appropriate treatment on evidence. This will be part of the Communications strategy.

- Clinical Framework messages to Clients & Providers no. 2 "Effective decisions on rehabilitation and treatment takes account of resources". What do you mean by that?
A: Resources issue is about matching client need with the interventions, and some interventions are more cost-effective than others (from the client perspective).

- "Habilitation" versus "rehabilitation". Taking into account the younger population there are two different aspects there. In sensitive claims many have never had the skills and it might be timely to send key messages to providers as rehabilitation is giving them skills they never had and ACC can't resource this. We need to habilitate not rehabilitate.
A: Acknowledge what is meant by habilitation but we need to pick a word to convey meaning and rehabilitation fits with the rest of ACC. This point will be taken into consideration.

- In the clinical pathways will there be arrows pointing to the interface where people need mainstream mental health services. Need to improve the process of people sharing the knowledge and treatment of clients than what happens now. Need to improve education of and communication with Mental Health Services.
A: This is addressed under principle 7 "We share responsibilities for injured clients with the wider community". In the purchasing framework and policy is emphasis on the relationship with mental health services, education services, CYFS and other providers who can be involved in shared arrangements. It is important to build these partnerships to deliver better services and outcomes to our clients.

- All Medical Practices have three stages 1. Simple - where people are treated and leave, 2. Complex – where extra input is required 3. Harm minimisation strategy. The clinical pathways seem to make a presumption that all cases will be simple. How will clients be categorised?
A: Exactly the way described. The pathway is not a straight line and clients will be assessed. Discussions will have very clear decision points.

- There needs to be some sort of forum/panel for complex case review where flags can be raised and discussed. The assessors need to know how to escalate these cases to ACC.
A: At present assessors can approach [redacted]. Will work closely with SCU to develop a clinical panel to assess these cases and plot the correct risk management strategy. There will definitely be a support framework built into the clinical pathway.
ACC will also need to inform assessors on ways to escalate cases. Possible entry points are via Clinical Services Directorate, Programme Manager, Case Manager, Branch Psychology Advisors (BAPs), or through SCU.

- A Panel approach was endorsed as it will help the client see that it is not just one provider's opinion. Can cases be reviewed on a regular basis?
A: SCU currently have a panel with the unit clinical psychologist and Branch Medical Advisor (BMA) every Thursday where Case Managers can bring complex issues.

ACTION: ACC [redacted]
Circulate contact information of BAP's, SCU and BMA's - phone numbers and email addresses (email addresses may be best as BAPs are part-time)
Clinical Services Directorate can be contacted if no response.

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4. Update on Neuropsychological contract

Contract went live on 1st June. To date ACC have approximately 60 providers approved under this contract and vendor coverage across NZ.

- The new contract has a standard (capped 7 hrs) or complex assessment (capped 12hrs) whereas the old contract only had a standard assessment.
- Complex assessment will be for cases more difficult to assess than normal (all specified in contract), e.g. children, co-morbidities, brain injury.
- Branch Psychology Advisors (BAPs) will make the decision on whether assessments will be Standard or Complex. Reports will be sent back to the BAPs who will advise Case Managers.
- Effort testing is mandatory.
- Included criteria to be a neuropsychologist as there are no standard criteria available (as there are for clinical or educational psychologists). Must be a clinical psychologist with 2 years neuropsychological experience and training. Have included a grand-parenting clause for some providers who have experience but not formal clinical scope.
- Trainee neuropsychologist component – At present only universities qualify, but ACC are looking into allowing some large establishments to become an alternative non-University training base.
- Trainee supervisory standards clarified.

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5. The Assessment of Symptom validity

ACC is looking at including Assessment of Symptom Validity in a number of contracts because it is known that the base rates of malingering and exaggeration are very high in a compensation environment. Mandatory effort testing was introduced in the Neuropsychology contract and will be gradually introduced into other contracts as they roll over:

- Psychological Services
- Clinical Psychiatry
- Pain contracts
- Mild – Moderate TBI
- IMA/VIMA

There is a role in assessing effort in order to make a valid diagnosis as there can be contributing factors. This isn't aiming to take people off the scheme but to identify reasons why they are exaggerating symptoms and treat those reasons. People have many different reasons why they exaggerate.
ACC have yet to establish what the process will be when we get reports back that indicate exaggeration, however BAPs' will be heavily involved with this.

Group discussion. Main points are:

- What tools are available as to use for assessments?

A: The Medical Symptom Validity Test – Green was adapted for medical practitioners in the US .It is a variation of the Green Word Memory Test and is a 10 minute computer based tool that nurses can use. Fee for tool is $100 per annum.
Another tool looked at in forensic psychology and psychiatry settings is the Structured Interview for Reported Symptoms.

- Important to formally assess symptom validity as subjective clinical opinion has not proved to be particularly accurate. If clients and providers know that assessment of symptom validity is an expected part of the whole assessment process, there is less resistance to the concept and practice.
- ACC will need to provide training/education for providers so that they can diagnose and report the various options as to why the exaggeration is happening, not just assume it is malingering. Need to start training before putting in contracts.

- Need to sell it to providers as helping people by making the correct diagnosis, not just trying to catch clients out. If you diagnose someone as needing help they will start to act in accordance with the diagnosis – self-fulfilling diagnosis.

- Is this tool used in overseas workers compensation jurisdictions? And how successful is it in terms of predicting outcomes

A: The Green tools are used in Canada and have been found to be very valid. Green's measures can be used for anyone claiming concentration or memory problems and can be used for a range of diagnoses, PTSD, Pain, Depression, Brain injury. These are very easy tests made to look more complicated than they are - forced choice format. There are norms for all ages, from 5 years up.

- Suggestion that this should be captured as an outcome measure in EOS. Would be a great opportunity to get base rates and provide an excellent database in 12 -18 months time.

ACTION: ACC [redacted]
Look at how to put this into place on EOS.

- The ideal place to introduce concept to sector would be at the RANZCP NZ Conference, 14-16 October.

- How will the success of this tool be monitored? Suggestion that Long Term Claims would provide a good pool to measure. Discussion on how to implement, possibly ask the Workers Comp scheme in Canada for some benchmarks for comparison.

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6. Groupwork counselling discussion

The Groupwork Counselling contract is due to expire on 31/8/09. [redacted] sought feedback from group.

Overview:
This contract is for Sexual Abuse victims and originally provided group support ad infinitum. Approximately 2 years ago the service was re-designed to have three stages. Stage 1 & 3 are Skills Acquisition groups (moods, communication, anxiety management, resilience etc). Stage 2 is a psychotherapy group (exploring feelings, reaction to the abuse, perceptions etc). Clients can move through stages or stages can be standalone. Stage 1 is 12 weeks max, Stage 1 & 2 is a max of 16 weeks. Participants can continue to have 1:1 counselling during groupwork.
ACC want to extend term of contract for another 6 months in order to assess service and change the way in which we pay for the groups, possibly to per client per session and would also apply a DNA rate.

ACC Issues:

- ACC require a readiness assessment but we do not pay for it.
- The 1:1 counsellor and the group facilitator must sign off a referral for ACC. There is a perverse incentive in that a counsellor who refers can also run groups.
- Are we getting the right people into the right groups? At present groups must be min 6, max 10 and 50% of group must be ACC clients in order to be funded.
- Potentially providers can make up group numbers from own practice.
- ACC pays 2 facilitators to run group.

Questions for discussion:

- What is a reasonable number of DNA's over an 8 – 12 week period? If DNA's continued it could indicate that the group was not appropriate.
- Skills Acquisition group – what is a normal period of time per session?
- Safety issues – with 2 facilitators what is the optimal therapeutic or clinical minimum number of participants.

Main points discussed:

- Concern that the 1:1 counsellors are allowed to also be group facilitators. MBT (Mentalization-based Therapy) states this is destructive because it sets up jealousies between own clients and others. Can be very damaging for the clients, having to "share" their confidant with a group of people. Backed up by DBT, MBT, Anthony Bateman.

- Problem with limited vendors; facilitators need at least 12 months experience of facilitation of groups. Therefore is difficult to have 1:1 counsellors separate from group facilitators.

- It is important to check Massey Guidelines to see what they say about groups, we know it definitely says that groups need to be of longer duration – need to cite where Massy Guidelines gets this from.

- ACC needs to fund the readiness assessment as is important to know clients are ready to join group. Suggestion that ACC should have certain criteria that need to be met before client can be referred to group.

- Serious concern about stage 2 groups - should not be run - potentially destabilising, can cause contamination, potential harm from group dynamics and transference. There must be experts available to facilitate or ACC could change it to "support" or "life skills" group options as part of treatment package.

- ACC need to change way in which we purchase which can open up to DHB's as vendors.

- Could be part of NSIS – Supported living.
- ACC need to get at least 4-5 expert opinions. [redacted] offered DHB contacts (e.g. [redacted] Waikato DHB ph [redacted]
- [redacted] will look into stage 2 individual vs group. Refer to Bateman & Fonagy. Group and 1:1 therapists must be different and would expect skills groups would also be same.

ACTION:
Check against Massey guidelines – [redacted]
Send to RM re MBT – group vs individual treatment

NEW BUSINESS

(Items 7,8 & 9 were requested by [redacted] who was then not able to attend.)

7. Re-registration for psychologists with SSU - double handling of documents

Assume this was about the Counsellor Review and how it affects the Psychologists. There was some confusion because the original Counsellor Review letter was sent out to all Counselling providers including those under contract, to whom it didn't apply. A second letter was sent out explaining this.
Those who provide psychological services under contract do not need to reply as we already have information on file.

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8. Evidence based therapy

Possible concerns about the treatment modalities listed on the Counsellor Review form. The list is not definitive and there is an "Other" category to allow other modalities to be listed.

There have been some issues from Psychotherapists who want psychotherapy listed as a treatment modality, which it is not. There has been some difficulty in defining what psychotherapy is in NZ, appears to differ from other countries.
When you try to compare psychotherapies it is the non-specific factors of relationships that determine outcomes. Point made that while it can be difficult to judge relationships and therapies, ACC can definitely limit number of sessions. DBT and MBT both say 50 sessions + boosters are sufficient and going past that will cause problems.
After max of 50 sessions, treatment should change to monthly sessions and boosters. This needs to be included in clinical pathways.
Also need to see proper psychometric outcome measures. How are they getting better? What were the problems to start with and what is the response to treatment.

Q: What is the process for getting counsellors to follow evidence based practice?

ACC is waiting on outcomes of Counsellor review before making any decisions.
Best way will be through purchasing options such as:

- Put Sexual abuse counselling under contract
- Strengthen regulations- provide more monitoring and governance
- Clean up database

ACC will formulate criteria and put in place a communications plan to set expectations with tools behind it, monitoring, feedback, Massey guidelines emphasis and internal work - training etc.

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9. Current issues about Fees

New fee structure sent out. New fee for MHSLG will be $342.50.
Any issues please email [redacted]

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10. [redacted] replacement

[redacted] is no longer able to attend meetings, group asked for nominations or ACC can send out a suggestion list of candidates to group.

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11. Outlier Management – Report writing

[redacted] asked for group suggestions on what is needed improve the Peer Review process and providing feedback to providers who write reports. What feedback is required, what are the good bits, how can we strengthen it? One possibility is to provide comparisons within sector which is similar to our feedback process in other sectors.

ACC's focus is on "Appropriate assessment diagnosis to guide treatment"

- Self evaluation – assessors never receive feedback on whether report was okay and whether outcomes worked
- Guidelines are not sufficient; do not actually link to information being requested.
- Would be helpful to have standard request to specifically comment on malingering
- There needs to be consistency and standardisation across country
- Need ability to write shorter reports when necessary
- Needs to be guidelines for time allowed for writing reports – at present there seem to be no limits or understanding of what ACC is wanting.
- Set expectations – would be useful to send psychiatrists a distribution of the mean and median, range of hours spent on reports. ACC also needs to send out some benchmarking information and templates of best practice reports – good and not so good examples.
- Suggest 4 hours as standard time to write reports. Reports for courts etc would take longer.
- National Advisor wants psychology reports to be of similar standard to psychiatric reports but would need longer than the standard 3 hours.
- Helpful if referral is targeted; ie Requestor sets out scenario, what the problem is and what they are looking for.
- Need to get a way to modify emphasis on formula and symptom reality
- Case Managers need skill to ask the right questions – need to use Medical Advisors, ACC need to employ more clinical expertise.
- Treatment can be delayed while waiting on determination of causality.
- Need to organise a committee for rewriting reports

Summary:

- Emphasis on better decision up front which means asking the right questions in the right way from the right clinician.
- Ensuring at the branch level we are getting the support for the people requesting the decisions.
- May have to re-write the guidelines/referrals/psychiatric assessments, either with the MHSLG or a small panel/committee
- Educating providers – understand what range of contracts/services is available. Guide to what is available for recommendations.

Meeting closed at 4pm

Next meeting will be Wednesday 23 September, 12.30 – 4.30pm
ACC Shamrock House, 81-83 Molesworth Street, Wellington.