

# **Review of Mental Health Post Entry Clinical Training Programmes**

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## Executive Summary

This project reviews post entry clinical training programmes currently funded by the Ministry of Health and managed by the Ministry's Clinical Training Agency for mental health nurses, occupational therapists, social workers, and other health professionals. The goal of this project is to determine the training and fiscal value of post entry clinical training. This project was initiated by the Mental Health Workforce Development Committee to ensure the success of a nationally coordinated approach to clinical training in mental health. The final report will contribute to a national training and development plan for mental health.

This review considers eight mental health post entry clinical training programmes including: New graduate mental health nursing; advanced mental health nursing; forensic mental health care; child and youth; dual diagnosis; cognitive behavioural therapy; new entry allied health; and Māori mental health.

Multiple methods were used for data collection. Semi-structured interviews were undertaken with key stakeholders, questionnaires were distributed to the 2003 graduates of post entry clinical training programmes, two focus groups were facilitated with former mental health service users, and discussions took place at two meetings with the Mental Health Directors of Nursing. Data collection took place between October and December of 2004 with a total 146 participants.

Overall the responses relating to both the training and fiscal value of post entry clinical training were positive. Participants reported advantages to the mental health sector from having ring-fenced funding for mental health workforce development but recommendations were made as to how funding for post entry clinical training could be improved.

A consistent theme focused on whether the Ministry of Health, with the responsibility for ensuring appropriate health services are provided for all New Zealanders, should be involved in purchasing education programmes. Participants in this study argued that the Ministry of Education should be responsible for funding educational programmes and the Ministry of Health should be responsible for increasing access for the health workforce. Funding currently used to purchase post entry clinical training programmes could be used to provide training for greater numbers of trainees, fund training to Postgraduate Diploma level with an exit point at Postgraduate Certificate level, and provide more appropriate funding for release time, clinical supervisors, additional clinical experience, and travel and accommodation for trainees. It was acknowledged that such changes would require policy amendments for both Ministries and it is not the Clinical Training Agency's responsibility to instigate this.

Other areas of concern included: The substantial costs for both clinical and education providers; post entry clinical training programmes not being appropriate for the majority of the Non-Government Organisations workforce; the programmes should include a focus on primary health care and a recovery approach; the requirement for a 0.8 clinical workload is discriminatory for women; regular consultation should take place with the broader mental health sector; and longer-term contracts with providers should take place well ahead of the beginning of the academic year.

Many of the results from this review reiterate findings in earlier reports related to post entry clinical training (Clinical Training Agency, 2004a; Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004; Health Workforce Advisory Committee, 2002; Hodges & MacDonald, 2000; Matenga & Honeyfield, 2003; Mauri Ora Associates Limited, 2003). It is imperative therefore that the recommendations of this review are taken into consideration when the national training and development plan for mental health is developed.

## Recommendations

- The Ministry of Health should review, with the Ministry of Education, current policy related to the split in funding for postgraduate education for nurses, occupational therapists, social workers and other health professionals working in mental health. The Ministry of Education should fund the programmes and the Ministry of Health should fund support for trainees in terms of scholarships for greater numbers of trainees, travel and accommodation, clinical mentors, release time and additional clinical experience.

Until the above comes into effect the following should be considered:

- Longer-term contracts with post entry clinical training providers should be developed;
- Funding for release time and clinical mentors should be increased;
- The Clinical Training Agency should provide funding for travel and accommodation for all trainees living at a distance from their education providers;
- The Clinical Training Agency should purchase Postgraduate Certificates and Postgraduate Diplomas to enhance the knowledge and skill level of mental health professionals;
- A pilot study should be established to evaluate a 0.6 clinical workload for trainees;
- The Clinical Training Agency should undertake more extensive, and ongoing consultation with the broader mental health sector;
- Programme specifications should reflect Māori and Pacific mental health issues, primary health care, health promotion, a recovery approach, and community development strategies;
- Specifications for the advanced mental health nursing programme should be reviewed; and
- A strategy for the development of all levels of the mental health workforce, including non-registered mental health workers should be developed.

# 1. Introduction

The Ministry of Health is committed to workforce development for the mental health sector. The partnership forged between District Health Boards (DHBs) and the Ministry of Health aims to ensure a nationally coordinated approach to mental health workforce development. Its operational arm is the Mental Health Workforce Development Programme (MHWDP). This project was initiated by the Mental Health Workforce Development Committee (MHWDC) to ensure the success of a nationally coordinated approach to clinical training in mental health. The final report will contribute to a national training and development plan for mental health.

The project reviews post entry clinical training (PECT) programmes currently funded by the Ministry of Health and managed by the Clinical Training Agency (CTA), an agency within the Ministry. PECT programmes are purchased for mental health nurses, occupational therapists, social workers, and other health professionals<sup>1</sup>. The project's purpose is to evaluate whether the \$5.8 million currently invested in PECT programmes for mental health professionals is meeting sector and policy requirements. There are six objectives for the project:

1. Review strategic documents and identify any relevant references that prescribe requirements for this project;
2. Develop performance indicators to assess PECT training programmes;
3. Utilise and evaluate existing PECT reviews;
4. Determine the fiscal and training value of PECT programmes for the sector;
5. Review and incorporate results of the 'Intermediate Level Training Evaluation' project; and
6. Provide a final written report, which includes recommendations on the way forward.

The overall goal is to utilise the information from this review to build upon the strengths and address the limitations of PECT.

This chapter provides a contextual overview of mental health workforce development and existing PECT programmes available for mental health nurses, social workers, occupational therapists and other health professionals in New Zealand. The chapter concludes with an overview of the structure of the report.

## 1.1 The Global State of Mental Health Workforce Development

The World Health Organisation (WHO) states that mental disorders account for nearly 12% of the global burden of disease and estimate that this burden is likely to increase in the coming decades (World Health Organization, 2003a, 2003b, 2003c). It is estimated that in the United States (U.S.) alone, the annual direct treatment costs for mental illness total US\$148 billion, which accounts for 2.5% of the gross national product (World Health Organization, 2003b, p14).

The WHO suggests that there are significant discrepancies between the burden of mental disorders and the resources dedicated to mental health services, and the provision of an educated and skilled workforce in mental health is limited throughout the WHO member states (World Health Organization, 2003a, 2003b). The 'Atlas: Mental Health Resources in the World' (2001) provides comparative data from WHO member states on the mental health workforce. This

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<sup>1</sup> Throughout this report 'alcohol and other drug' and 'cognitive behavioural therapy' health professionals and their PECT programmes will be included under the term 'mental health'. These programmes are multidisciplinary and may include doctors and psychologists.

document states that 45.7% of the countries, constituting 43.8% of the world's population, have access to less than one psychiatric nurse per 100,000 population (World Health Organization, 2001, p30). Although 88% of countries have Non-Government Organisations (NGOs) in the mental health sector, information on the type and quality of mental health services is not available (World Health Organization, 2001, p38).

## **1.2 Context for Mental Health Workforce Development in New Zealand**

New Zealand has a history of problematic and inadequate mental health services. The shift away from institutional care to the provision of mental health services within the community created significant resource implications (Ministry of Health, 1994, p1). Planned workforce development has not been set in place to support the on-going restructuring and growth of mental health services (Ministry of Health, 2000, p22).

Two national strategic plans (Ministry of Health, 1994, 1997) were developed to guide the development of the workforce as the mental health sector moved from an institution-based service setting to a community-based setting and outlined the need for *more*, as well as *better*, mental health services. Supplementing these strategies was the 'Blueprint for Mental Health Services in New Zealand' which provides a guide for all current service development (Mental Health Commission, 1998). These strategic developments have led to crucial changes to the mental health workforce, including a major increase in services and reorientation of the types of workforce required (Health Workforce Advisory Committee, 2002, p110).

## **1.3 National Agencies Involved in Workforce Development**

The following national agencies are involved in the development of the mental health workforce.

The 'New Zealand Health Strategy' (2000) established a partnership between the Ministry of Health and DHBs to ensure a nationally coordinated approach to mental health workforce development (Ministry of Health, 2002a, p6). The Health Workforce Advisory committee (HWAC) was developed in 2001 and provides strategic advice to the Minister of Health on the health and disability workforce (Health Workforce Advisory Committee, 2003). HWAC independently assesses the current workforce capacity and identifies future workforce needs to meet the objectives of the New Zealand Health and Disability Strategies. District Health Boards New Zealand (DHBNZ), representing the DHB Chief Executive Officers, is also concerned with workforce development and in July 2003 published its 'Workforce Action Plan' for the sector. The Mental Health Directorate has the overall responsibility for maintaining a strategic overview of the mental health workforce development and advising the Ministry of Health.

The Ministry of Health and the Mental Health Commission (MHC) have addressed the need to develop the mental health workforce by establishing the Mental Health Workforce Development Committee (MHWDC) (Mental Health Workforce Development Programme, 2003). The MHWDC is comprised of representatives from DHBs, NGOs, service users and their families, Māori, Pacific, MHC representatives and clinicians. The Committee advises on health and disability workforce issues and coordinates initiatives within the Ministry of Health and externally to ensure an integrated, consistent approach and efficient use of resources (Ministry of Health, 2002a, p6). The committee's purpose is to take responsibility for national coordination and leadership of mental health workforce development and to set targets, priorities and directions.

Te Rau Matatini, the National Māori Mental Health Workforce Development Programme funded by the Ministry of Health, was established in 2001 to strengthen the Māori mental health

workforce. Te Rau Matatini aims to provide sector leadership and advocacy for Māori mental health needs through the provision of analysis, evaluation and strategic development initiatives (Hirini & Durie, 2003, p3).

The other national mental health workforce development centres are the Werry Centre (National Child and Youth Mental Health Workforce Development Centre) and the National Addictions Workforce Development Programme.

## **1.4 Mental Health Education and Training in New Zealand**

To work in the mental health sector, health professionals undertake undergraduate and postgraduate education. Currently, nurses entering mental health register with an undergraduate nursing degree. Nurses registered before the introduction of the degree programme must hold a Nursing Council approved qualification, RCpN or RPN, to work in mental health. Over 18 polytechnics and universities in New Zealand offer comprehensive nursing courses at an undergraduate level. Although these programmes may differ in structure, they are required to meet the national standards set by the Nursing Council of New Zealand, the New Zealand Qualifications Authority (NZQA) or the Committee of University Academic Programmes (CUAP). All undergraduate programmes must provide 1500 hours of clinical experience in a variety of settings that include mental health, acute hospital services, general practice and community services (Ministry of Health, 2004, pp5-7). In order to practise in the mental health sector, it is recommended that nursing graduates or those re-entering the workforce complete a 10-month new graduate programme. Advanced mental health nursing programmes are also available for experienced mental health nurses.

Social workers are required to attain a diploma or degree in social work to practise in the mental health sector. Occupational therapists are required to complete a three year undergraduate course to obtain a Bachelors Degree. Specific training for alcohol and drug workers is relatively new and still developing. The minimum qualification required for these workers is at certificate level. Bachelor Degrees and postgraduate certificates and diplomas are also available.

### **1.4.1 The Development of PECT Programmes**

The CTA on behalf of the Ministry of Health is responsible for the funding and training of health professional's clinical training after they have gained their professional qualification. In response to the Mason Report (Mason, 1996), the government set aside specified funding ('Mason money') for mental health. Mason money funds the majority of mental health clinical training programmes. This funding is supplemented by a second CTA funding stream (Clinical Training Agency, 2001, p4). Table 1 illustrates the PECT mental health programmes purchased by the CTA in 2001 and the funding source for each of the programmes.

In 1995, the government split funding for health education between Vote Health and Vote Education. This meant that the Ministry of Education would fund all pre-entry qualifications and postgraduate qualifications with less than 30% clinical component. The Ministry of Health would fund all PECT programmes with 30% or more clinically-based components (Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004, p9).

**Table 1. PECT mental health programmes purchased in 2001.**

<b>Mental Health</b>	<b>Total Mason</b>	<b>Total CTA Base</b>
Forensic Mental Health Care	-	43
Dual Diagnosis	19	20
Psychiatry in General Practice <sup>2</sup>		12
Child and Youth Mental Health	68	-
Cognitive Behaviour Therapy	37	-
New Graduate Mental Health Nursing	88	-
Advanced Mental Health Nursing	115	-
Māori Mental Health Nursing	43	-
<b>Total Mental Health Programmes</b>	<b>370</b>	<b>92</b>

Source: CTA, (2001) 'Purchasing Intentions Plan 2001/02', p37.

The CTA stipulates that PECT training is:

- **Vocational** – rather than academic training or research;
- **Clinical** – clinically-based, with a substantial clinical component where employment in a clinical setting is integral to the completion of the qualification;
- **Post entry** – occurs after entry to a health profession, so that a person is eligible to practise in a particular occupation;
- **Formal** – a trainee is formally enrolled in a training programme that leads to a recognised qualification;
- **Six months** – the training programme is equivalent to a minimum of six full-time months in length; and
- **Nationally recognised** – recognised by the profession and/or health sector and meets a national service skill requirement rather than a local employer need (Clinical Training Agency, 2003).

This review considers eight mental health PECT programmes available to nurses, social workers, occupational therapists, and alcohol and other drug workers. These include, new graduate mental health nursing, advanced mental health nursing, forensic mental health care, child and youth, dual diagnosis, cognitive behavioural therapy, new entry allied health and Māori mental health. Medical graduates also undertake the PECT multidisciplinary programmes such as dual diagnosis, cognitive behavioural therapy and forensic mental health.

#### **1.4.2 Current Profile of Mental Health PECT Programmes**

The CTA produces two annual reports that provide a profile of current mental health PECT programmes (Clinical Training Agency, 2004a, 2004b). The first report provides data on the demographics of trainees who completed the programme in a specific year (Clinical Training Agency, 2004a), the second report summarises the feedback from trainees and clinical supervisors (Clinical Training Agency, 2004b).<sup>3</sup> Between 2000 and 2003, the CTA's total

<sup>2</sup> The Psychiatry in General Practice PECT programme is not covered in this review.

<sup>3</sup> The CTA's report that summarised the feedback from trainees and clinical supervisors is considered in chapter two.

purchased volumes of mental health PECT programmes decreased by 13%. The largest decrease was in advanced mental health nursing and the forensic programme. From 2001-2003, the total proportion of New Zealand European trainees increased from 56% to 65%, however, over the same period, the proportion of Māori trainees decreased from 21% to 17%. The proportion of Pacific and Asian trainees remained relatively stable at 3% and 2% between 2001 to 2003 (Clinical Training Agency, 2004a).

Table 2 illustrates the actual average monthly purchased and contracted volumes of trainees for each mental health PECT programme between 2000 and 2003.<sup>4</sup> The actual purchased volumes of trainees for new graduate programmes have remained relatively stable from 2000 to 2003. In contrast, actual purchased volumes for advanced mental health programmes have decreased since 2000 by 25%. Both the contracted and actual volumes purchased for forensic mental health programmes decreased by 50% between 2001 and 2003. Actual volumes for child and youth programmes purchased remained relatively stable between 2000 and 2003, however there was a substantial discrepancy between contracted and actual volumes for this programme, with contracted volumes decreasing by 34% in 2004. This was attributed to a large number of trainee withdrawals from the programme. The number of dual diagnosis programmes have slightly increased since 2000, with actual purchased volumes increasing nearly 30% between 2000 and 2003. Actual purchased volumes of trainees of cognitive behavioural therapy programmes have remained stable between 2000 and 2003, with thirty-four trainees the average monthly volume. Contracted volumes for allied health decreased from twenty to sixteen in 2004. The numbers of contracted volumes for Māori mental health training have fluctuated between 2000 and 2004. In 2001 there was a 136% increase in actual purchased volumes of trainees, whereas in 2003 actual purchased volumes dropped by 60% (Clinical Training Agency, 2004a, p17).

**Table 2. Average monthly purchased and contracted volumes of mental health PECT programmes (p = purchased c = contracted).**

Programme Type	2000		2001		2002		2003	
	p	c	p	c	p	c	p	c
New Graduate Mental Health Nursing	84	84	77	86	87	95	81	84
Advanced Mental Health Nursing	109	114	102	116	85	110	84	96
Forensic Mental Health Care	36	39	28	33	25	39	15	18
Child and Youth	54	72	46	68	44	63	56	67
Dual Diagnosis	20	21	27	39	24	39	26	35
Cognitive Behavioural Therapy	36	37	33	35	35	40	33	35
New Entry Allied Health	-	-	-	-	-	-	13	20
Māori Mental Health	14	20	33	43	30	39	12	12
<b>Total Mental Health PECT Trainees</b>	<b>353</b>	<b>387</b>	<b>346</b>	<b>420</b>	<b>330</b>	<b>425</b>	<b>320</b>	<b>367</b>

Source: Adapted from CTA (2004) 'Analysis of Mental Health Trainee Data', p5.

<sup>4</sup> The CTA provides two different sets of data in relation to volumes of trainees. Actual purchased volumes refer to the numbers of trainees that received funding by the CTA and contracted volumes describe the numbers of trainees contracted at the beginning of the training year. Statistics for contracted volumes are given up to 2004, whereas actual purchased volumes stop at 2003.

## **1.5 Structure of the Report**

This chapter provided the context for the project and chapter two presents a literature review outlining the current national issues for the mental health workforce and international best practises for mental health education and training. The literature review informed the evaluation process. The methodological approach to this study is discussed in chapter three. Existing reviews of national PECT programmes are discussed in chapter four and the results of this research are then presented in chapter five. Following this, the conclusions and key recommendations from this study are presented in chapter six.

## 2. Literature Review

Traditionally workforce issues have been neglected in the development of mental health services. This has created major deficiencies in skills in the mental health workforce (Ministry of Health, 1997). For example, insufficient numbers of staff; unsatisfactory skill mix; inappropriate training to deal with a changed delivery environment; challenges in Māori, child and youth, and, Pacific people's mental health areas (Mental Health Workforce Development Programme, 2003, p7). As the skills, values, morale, and attitudes of the mental health workforce have an enormous impact on the cost, quality and efficacy of mental health services, workforce development needed to be addressed (Ministry of Health, 2000, p22). The following reviews the policy background and workforce issues identified by key stakeholders and considers specific issues recognised by CTA that need to be addressed to progress the mental health workforce. The chapter concludes with a presentation of international 'best practice' in health education within the United Kingdom (U.K.) and Australia.

### Literature Search Process

The articles examined for this review were mainly accessed through on-line searches using the Internet search engine 'Google' ([www.google.co.nz](http://www.google.co.nz)) and manually on the Ministry of Health ([www.moh.govt.nz](http://www.moh.govt.nz)), Mental Health Commission ([www.mhc.govt.nz](http://www.mhc.govt.nz)), District Health Boards New Zealand ([www.dhbnz.org.nz](http://www.dhbnz.org.nz)), Mental Health Workforce Development ([www.mhwd.govt.nz](http://www.mhwd.govt.nz)), Te Rau Matatini ([www.matatini.co.nz](http://www.matatini.co.nz)) and World Health Organisation ([www.who.int/mental\\_health](http://www.who.int/mental_health)) web pages. The articles accessed from these searches were utilised for the contextual and political background found in the beginning of this review. Articles focused on New Zealand PECT and international literature were accessed through computer searches of a number of medical and nursing databases. The University of Auckland's Philson Medical School Library was used for all manual searches and articles were found in PsychInfo, Web of Science, Medline and CINAHL databases. Several key words were used in these searches, including 'mental health'; 'workforce'; 'education'; 'mental health nurses'; 'social workers'; 'occupational therapists', 'post entry'; 'graduate'; 'postgraduate'; 'retention'; 'recruitment'; 'clinical supervision'; 'competency'; and 'career pathway'. For inclusion in this review, articles had to purposively examine mental health workforce issues and/or initiatives in education for mental health nurses, social workers, occupational therapists, and alcohol and drug workers. Only articles discussing the mental health workforce post 1998 were considered.

### 2.1 Mental Health Workforce Development Policy Background

The 'Blueprint for Mental Health Services in New Zealand' (1998) was intended to guide all current service development (Mental Health Commission, 1998). The 'Blueprint' introduced the 'recovery approach' to be used in all mental health services. HWAC defines 'recovery' as happening when "people can live well in the presence or absence of symptoms of mental illness" (Health Workforce Advisory Committee, 2002, p110). For mental health workers, this involves working in partnership with clients to promote their full participation in society, protecting their rights, and helping to create supportive environments, as well as providing diagnosis and illness treatment services. The 'Blueprint' outlined the MHC's plans for the development of a well-functioning mental health workforce that could adequately and appropriately support the needs of those affected by mental illness in New Zealand. The MHC's vision of a successful workforce includes:

- A workforce sustained to respond to the needs of mental health service users;

- A workforce confident in its positive and unique contribution to the journey of recovery; and
- DHBs and NGOs owning and driving workforce development (Mental Health Commission, 1998).

In response, the Ministry of Health and the Health Funding Authority introduced strategies to develop and improve the skills of community mental health support workers and traditionally educated mental health workers such as nurses, occupational therapists, social workers, psychologists and psychiatrists. Current workforce development is guided by the following three strategic documents. 'Towards Better Mental Health Services' (1996) identified strategies for: Retention and recruitment; communication within the education sector; investment in training; mental health research; destigmatisation of service users; service provider responsibility; management practice; and organisation change (Ministry of Health, 1996). 'Developing the Mental Health Workforce' (1999) focused on the development of workforce competencies, organisational effectiveness and specialised services for child and youth, Māori and Pacific peoples (Mental Health Workforce Development Co-ordinating Committee, 1999). A programme for spending on workforce is directed by 'Tuutahitia Te Wero (2000), Mental Health Workforce Development Plan' (Health Funding Authority, 2000). This document planned workforce development for the specific needs of Māori, children and young people, and Pacific peoples (Ministry of Health, 1997, p31). More recent strategic initiatives developed for specific areas introduced by the Ministry of Health are included in 'Mental health (alcohol and other drugs) workforce development framework' (Ministry of Health, 2002a), 'Te Puawaitanga: Māori mental health national strategic framework' (Ministry of Health, 2002b), 'New Zealand Health Strategy 'DHB toolkit: Mental health, to improve the mental health status of people with severe mental illness' (Ministry of Health, 2001a); and, 'Mental health standards framework' (Ministry of Health, 2003).

### 2.1.1 Health Workforce Advisory Committee Workforce Issues

The HWAC (2002) identified issues that needed to be addressed to progress the mental health workforce:

- **National agencies' strategies for mental health workforce development need to be coordinated** – initiatives for developing the workforce are shared between a number of central agencies without coordination between agencies;
- **Retention and recruitment strategies need to be developed** – there are problems with retention and recruitment of Māori and Pacific mental health workers, and overall shortages in specific geographical locations and specialist areas;
- **Training for Māori needs to be implemented** – there is a lack of Māori representation in the mental health workforce despite educational developments;
- **Training for the Pacific workforce needs to be implemented** – there is a need for increased Pacific mental health workers with appropriate health qualifications and cultural knowledge;
- **Strategies for collating data need to be developed** – there is a lack of demographic information on the mental health workforce;
- **Competencies for community-based services need to be developed** – a new set of competencies 'in-line' with the cultural change from institutional approach to a community-based approach is needed. This includes re-orientating the workforce as well as modifying existing training and education curricula;

- **The introduction of standards requires structural support** – the introduction of new ‘Mental Health Standards’ (Ministry of Health, 2001b), which ensure mental health services in New Zealand offer the highest standard of treatment and support for those who use them, have required several changes in services and increased demand for workers. Consequently, a new workforce group has been developed that requires more structural support than is currently provided; and
- **Alcohol and drug competencies for the generalist health workforce need to be developed** – there is a general lack of adequate resourcing in this area and limited recognition of its importance by those responsible for training, and those who are funding training (Health Workforce Advisory Committee, 2002).

### 2.1.2 Māori Mental Health Workforce Development

Māori play a significant role in delivering mental health services in New Zealand, however there are many significant issues impeding progress for the Māori mental health workforce. Te Rau Matatini (2004) reported the key issues for the Māori mental health workforce, these included: The need for a nationally consistent workforce development and implementation and use of dual competencies; commitment to resources that support Māori mental health workforce development; and Māori provider development. Future priorities for Māori mental health workforce development identified were: Active recruitment based on improving the skill mix and experience of the workforce while fostering Māori values and enhancing cultural identity; effective and innovative recruitment strategies to attract Māori students; positive retention initiatives that support wider work influences; sustainable development of dedicated Māori DHB and NGO service providers; increased training and development opportunities in both clinical and cultural aspects of Māori mental health service delivery; improved information systems to better facilitate coordinated approaches at national, regional and local level; and inter-sectoral collaboration, particularly with the Education, Social Service and Justice sectors (Ponga, Maxwell-Crawford, Ihimaera, & Emery, 2004, p49).

The ‘Te Rau Whakaemi Project’ (2002) managed by Te Rau Matatini aimed to coordinate clinical training in critical areas of enhancement for current Māori mental health workers. Specifically, the project focused on extending knowledge and skills in both clinical and cultural aspects of Māori mental health service delivery (Maxwell-Crawford, Hirini, & Durie, 2002: 18). Part of this project involved a national survey to identify the training-needs of the Māori mental health workforce. The survey was conducted between August and September of 2002 and generated 586 responses. The survey content covered trainees’ perceptions of past training, their perceived adequacy of prior training, and current training priorities. The research findings indicate that most of the PECT graduates in the survey (91%) found the clinical training they received before entering the mental health workforce inadequate and failed to prepare them for the demands of their current roles. Respondents also reported on the cultural training they had received. In total, 70% stated that the programme they participated in covered some form of training in working with Māori mental health service users. The areas commonly covered were Tikanga Māori, Te Reo Māori, local tribal history, kawa and cultural assessment (Hirini & Durie, 2003, p14). Important themes that emerged from the survey included:

- The need for continuing education, and ongoing training in both the clinical and cultural areas;
- The need for clinical training that focuses on mental health clinical assessment, working with drugs and alcohol, and dual diagnosis;
- The need to obtain formal qualifications and training in administration, report writing, cognitive behavioural therapies and family therapies; and

- The need for training to cover Māori models of practice and theory, particularly Māori language and incorporating Te Reo and Tikanga Māori when practising mental health work (Hirini & Durie, 2003).

### 2.1.3 CTA funded Mental Health PECT Programmes

The CTA, as purchasers of mental health PECT programmes, has identified specific issues in relation to mental health PECT programmes. In April 2004, the CTA published ‘Analysis of Mental Health Trainee Data’ and ‘Review of 2003 Report 2 Responses’. Both these reports identified specific issues that currently exist for PECT programmes that need to be addressed to progress mental health service delivery in New Zealand.

- **Eligibility needs to be addressed:** A key issue identified by the CTA was a decrease in total purchased programmes because of the non-availability of eligible trainees. The report suggests that more needs to be done to attract potential trainees into these programmes.
- **Trainee support needs to be ensured by employers:** Trainees need to be ensured that they will be supported by their employers.
- **Appropriateness of PECT for Māori trainees needs to be considered:** The figures showed decreases in total Māori trainees and low pass rates for Pacific and Māori trainees. PECT programmes need to be more appropriately developed in relation to Māori and Pacific trainees.
- **PECT needs to be more available to trainees working in NGOs:** The numbers employed in NGOs who participated in PECT decreased from 2002 to 2003. PECT programmes should be made more available and relevant to NGOs.
- **Clinical workload needs to be considered:** Trainees of five different programmes stated that the clinical workload is too high to allow for time to attend formal teaching components.
- **Clinical placements:** Clinical placements need to offer a variety of cases/experience.
- **Support for clinical release by workplaces needs to increase:** Trainees need more support from their workplace to attend clinical supervision as well as attending classroom lectures.
- **Content of formal teaching component needs to be considered:** The trainees and clinical supervisors argued that the theoretical component of PECT programmes is too high and the time set aside for clinical placement was too low. Some clinical supervisors argued that the teaching/formal education component was not directly applicable to clinical settings.
- **Programme coordination needs to be addressed:** It was commented by both trainees and clinical supervisors that there was inadequate educational supervision and programme coordination of PECT programmes.
- **Clinical supervision needs to be improved:** Trainees of four programmes argued that there was inadequate clinical supervision due to acute wards being exceedingly busy. This issue was also raised by clinical supervisors of three of the programmes who argued that the ratio of trainees to supervisors is too high and there is a lack of support for clinical supervisors (Clinical Training Agency, 2004b, pp27-28).

## 2.2 International Best Practice Review

Mental health education and clinical training has become an important part of strategic workforce development internationally. The following presents ‘best practice’ examples of health education in the U.K. and Australia. The review considers programmes that have

impacted positively on consumer and family outcomes and increased the trainees' skill and knowledge base.

### **2.2.1 Mental Health Services in the United Kingdom and Australia**

The shift to community-based care has impacted on the practices of the mental health workforce in the U.K. and Australia (Shera, Aviram, Healy, & Ramon, 2002, p550). In the U.K., significant changes to mental health practices include a renewed interest in evidence-based health care, the provision of service user orientated practices, a shift from uni-disciplinary to multidisciplinary working, a move to primary care led services and priorities set according to the needs of those with serious mental illness (Hannigan, 1999). In Australia, mental health professionals are required to work autonomously and are expected to have a variety of skills that are shared by all mental health workers. Case management has become an essential part of service delivery (Lloyd, Bassett, & King, 2002, p88). In both countries, current models of practice emphasise the provision of both discipline-specific and generic work within multidisciplinary teams.

### **2.2.2 Education and Training Issues**

A review of current literature from the U.K. reveals limitations with the content, teaching and access of mental health education and training. The Sainsbury Centre for Mental Health report (2000) identified the depth and quality of content on cultural competency, health promotion and mental health in the primary setting as limited. The report argued that the content of the Diploma in Social work is limited in how well it equips social workers to deal with mental health problems. The centre also illustrated there is limited programmes that cover specific areas such as mental illness (Workforce Action Team, 2001, pp6-7). Bailey (2002) found gaps in the knowledge of drug and social workers dealing specifically with people with co-existing mental health and substance use illness (Bailey, 2002). The Sainsbury Centre for Mental Health report found that tutors of mental health programmes are not "up to speed" and have limited contemporary clinical or service experience (Workforce Action Team, 2001). Brooker et al. (2002) reported that educators find it difficult to encourage professionals, other than nurses, to participate in mental health training programmes. Clinical service providers argued that undergraduate education and training for most mental health workers is focussed on academic achievement rather than practical skills (Brooker et al., 2002). The SCMH reported that access to funding of new programmes is difficult and there is a lack of flexibility with education and training contracts (Workforce Action Team, 2001). Brooker argues that access to mental health programmes is limited to mainstream mental health professionals, thus the training needs of non-professionally affiliated staff are often neglected (Brooker et al., 2002, p111).

Clinton and Hazelton (2000) provided a snapshot of the education and training programmes for mental health nurses available in Australian Universities. The report found that the Bachelor of Nursing curriculum is generic with minimal mental health content present, and clinical placements in mental health services were severely limited in university-based mental health programmes. Students' clinical experience within mental health services was also limited by a lack of coordination between universities. The report illustrated that in New South Wales (NSW), universities often compete for placements rather than cooperate. Wynaden et al.'s (2000) research showed that undergraduate nursing programmes do not prepare students to function as beginning practitioners in the mental health area (Wynaden et al., 2000, p143). Students suggested that the expertise of their lecturers was limited, with some not being able to provide current information on the mental health sector. Clinton and Hazelton (2000) also argued that specialist preparation for mental health nurses at a postgraduate level is inadequate. Their report illustrated employers' concerns that graduates from these courses are inadequately prepared to practice unless they have had prior mental health experience. Further, the limited

number of nurses with a mental health background employed for teaching meant that most universities do not have the capacity to offer postgraduate programmes (Clinton & Hazelton, 2000).

## **2.3 Examples of 'Best Practice'**

The literature from the U.K. and Australia exemplifies innovative clinical training programmes that have developed in response to policy changes and the consider some of the current issues outlined above. Generally, they focus on undergraduate programmes as, for example, few nurses in the U.K. have a degree and the majority of their ongoing education is at undergraduate level. Five areas of training are discussed: Consumer orientated training; multidisciplinary team training; primary health care training; clinical placements; and rural and remote area training.

### **2.3.1 Service User Involvement**

Increasing value has been placed on involving service users in the education and clinical training of mental health workers in the U.K. (Frisby, 2001, p663). Frisby (2001) discusses the work of service users, students and lecturers in mental health pre-registration education that focuses on client assessment. Service users involved in this programme were required to evaluate students' client review presentations. In the presentation, individual students critically reflected on a mental health assessment of a client in which they had participated. The results of this programme were largely positive. Service users reported a strong sense of empowerment and encouraged other colleagues to undertake this work in the future. The students thought the format of the programme was constructive. Service user involvement enabled students to hear from the 'voice of experience' and obtain a deeper understanding of how interventions have a real effect on clients' issues. Students developed their confidence to examine real life clinical incidents and the programme encouraged reflective learning. The students stated that discussions in the classroom were significantly enhanced by the presence of the service users and they enhanced their development of assessment skills (Frisby, 2001).

Mental health policy in Australia stipulates that service users should be actively involved in the design, delivery and evaluation of mental health services (Happell, Pinikahana, & Roper, 2003, p67). Happell et al. (2003) conducted a survey of nursing students who had completed a postgraduate programme that involved a consumer academic. The results indicated that student approval ratings of service users' participation in mental health service management, treatment, planning and service delivery had increased following exposure to the consumer academic. The research also showed students' increased support for the involvement of a consumer academic in psychiatric nursing education (Happell et al., 2003, p74). Clinton (1999) reports on the effectiveness of consumer orientated education and training for breaking down stereotypical thinking about people with a mental illness. The study reports on a programme offered by the Queensland University of Technology for undergraduate students that was organised to facilitate collaboration between students and service users. The results of the study indicated that this kind of approach to training seemed effective in assisting undergraduates to develop more positive attitudes towards people with mental illness (Clinton, 1999, p103).

### **2.3.2 Multidisciplinary Training in Primary Health Care**

Community Mental Health Teams are considered an essential aspect of community-based health care in the U.K. Bailey (2002) illustrated that at a micro level, it is difficult to design clinical training for groups of workers that are from varied backgrounds (Bailey, 2002, p573). Similarly, Trenchard et al. (2002) argued that the broad focus of programmes aimed specifically at nurses created a barrier to community mental health nurses sharing their learning with other

mental health professionals they would be working with (Trenchard et al., 2002, p259). The report identified the need for mental health nurses to have experience working alongside non-nursing mental health practitioners. Other programmes developed in the U.K. are multidisciplinary and focus on 'psycho-social interventions'. Trainees from diverse programmes participate in these programmes from undergraduate diploma through to Masters Degrees, including nurses, occupational therapists, psychologists and those who are not affiliated to professional groups (Trenchard et al., 2002).

The provision of child and adolescent mental health services in primary care have become a strategic priority in the U.K. Consequently, primary health staff training has become an integral aspect of service development. In response to the existing limited and fragmented training, an inter-agency child and adolescent mental health training programme for primary care staff has been set up as a component of service development within the U.K. (Sebuliba & Vostanis, 2001, pp191-192). The clinical training programme included social services teams, health visitors, school nurses, nursery nurses, voluntary sector workers, teachers and other educational staff, community paediatricians and general practitioners. Sebuliba and Vostanis' (2002) reported on 150 staff evaluations of the programme which involved the completion of a two-day introduction course followed by three training days on the assessment and management of children and their families. The aim of the programme was to "facilitate the interface between primary care and specialist child and adolescent mental health teams, by supporting primary care staff in acquiring skills in appropriate assessment, management or referral of cases" (Sebuliba & Vostanis, 2001, p199). Overall, the staff who participated in the programme rated their awareness of mental health issues significantly higher. Most participants commented on the importance of training with other professionals from different agencies because it increased their sharing of language, skills and knowledge of resources and how to access them (Sebuliba & Vostanis, 2001, p199).

### **2.3.3 Collaborative Approaches**

Literature supports the proposition that clinical placements are the most influential factor for choosing a career in mental health nursing (Charleston & Goodwin, 2004; Happell, 2001; Rushworth & Happell, 2000). Happell (2001) explored the impact of undergraduate programmes on nurses' career preferences. Questionnaires were given to students on commencement and completion of undergraduate nursing programmes. The results showed that following completion of the programme, the popularity of mental health nursing as a career preference increased significantly (Rushworth & Happell, 2000, p129). Charleston and Goodwin's (2004) research on preceptorship training for undergraduate nurses also indicated that graduates willingness to enter the mental health field increased since completion of training.

Arnold et al. (2004) exemplify how closer collaboration between health and education providers enhances clinical and educational experiences of nursing students. The authors discuss an innovative collaborative programme developed by the School of Nursing, University of Ballarat and Grampians Psychiatric Services. This programme involved mental health clinical staff providing student off-campus support as clinical supervisors and on-campus lecturers. The clinical staff members were supported by coordinators based at the university. The students' evaluations of the programme were positive, with most stating they were able to apply theory to clinical practice and they received accurate assessments. The students valued their relationship with the mental health nurse clinicians and found this central to the overall quality of the programme. The mental health nurse clinicians also stated that their involvement was positive and enabled them to refresh and/or increase their knowledge base (Arnold, Deans, & Munday, 2004, p66).

#### **2.3.4 Distance Education**

A particular problem in rural Australia is the limited availability of specialist mental health services. Nurses who lack the necessary qualifications and experience are relied upon to provide mental health services. Chang et al. (2002) described the development, implementation and evaluation of a mental health continuing education programme for nurses employed in rural and remote areas of NSW. The initiative saw the collaboration of the NSW Health Department, a rural university and several regional health service partners. A variety of distance education methodologies were utilised to disseminate information on each training module. The trainees of the programme rated it favourably. Chang et al. concluded that the programme represents a cost-effective, convenient method of enabling rural and regional nurses to develop their skills in mental health nursing (Chang et al., 2002).

This chapter considered the policy background and current workforce and education issues for the mental health workforce. The literature review also presented examples of 'best practice' clinical training programmes being offered in the U.K. and Australia. It exemplified that service user involvement, multidisciplinary training, collaborative approaches and distance education can increase trainees' skill and knowledge base, and improve consumer and family outcomes. This literature review provided the necessary background for the development of the methodological approach described in chapter three. The key issues will be addressed in relation to the results of this research in chapter six.

### 3. Methodology

The goal of this project was to review PECT programmes funded by the Ministry of Health and managed by the CTA. This project was overseen by a reference group representing education and clinical providers of PECT programmes, graduates of PECT programmes, Māori working in the mental health sector, and service users. A representative of Pacific providers was also invited to be part of the reference group.

#### 3.1 Study Design

The project was comprised of four main phases: The development of performance indicators; a literature review; data collection and analysis; and the development of a report.

##### 3.1.1 Phase One: Development of Performance Indicators

The performance indicators formed the basis of the methodological framework for the project. They were developed in consultation with an advisory group comprised of representatives from the Mental Health Directorate, the CTA, educational providers, mental health service providers, mental health service users and graduates of PECT. Relevant literature was gathered to provide the background for the development of the performance indicators. Table 3 illustrates the criteria developed for the performance indicators to determine the fiscal and training value of PECT programmes.

**Table 3. The performance indicator criteria.**

<b>Training Value</b>	<b>Fiscal Value</b>
Access to PECT programmes	Costs/Benefits for clinical providers
Trainees' skill and knowledge development	Costs/Benefits for education providers
Formal teaching component	Costs/Benefits for PECT graduates
Clinical component	Costs/Benefits for service users
Programme coordination	Costs/Benefits for Ministry of Health
Consultation processes	Costs/Benefits for professional groups
Content of PECT programmes	National approach to PECT programmes

##### 3.1.2 Phase Two: Literature Review

The first part of the literature review appraised the policy background and the current best practises in education and training available for mental health professionals in Australia and the U.K. The literature searching process is discussed in chapter two.

##### 3.1.3 Phase Three: Data Collection and Analysis

Multiple methods were used to gather information on the fiscal and training value of PECT for the mental health sector. Semi-structured interviews were undertaken with key stakeholders, questionnaires were distributed to the 2003 graduates of PECT programmes, two focus groups with former mental health service users were facilitated, and discussions took place at two

meetings with the Mental Health Directors of Nursing. Data collection took place between October and December of 2004.

Existing reports on CTA programmes and the report on 'Intermediate Level Training Evaluation' were evaluated in terms of the performance indicators.

#### **3.1.4 Phase Four: Final Report**

The findings from the previous three phases were analysed and summarised in this report, sent to reference group members for consultation, and submitted to the Health Research Council of New Zealand and MHWDC.

### **3.2 Sample**

The key stakeholders were identified by the research team in consultation with the MHWDP. The key stakeholders included representatives from NGOs, DHBs, the MHC, the Ministry of Health, the CTA, education and clinical training providers, professional colleges and unions, and mental health consumer and family/whanau advisors.

A purposive selection process was undertaken to determine a representative sample. The stakeholders were selected based on geographical, organisation and interest group representation. The research team also contacted two Heads of Schools with PECT programmes who wished to be interviewed and two others who approached the team via the CTA. The stakeholders were initially contacted by e-mail or telephone. One member of the research team attended two meetings with the Mental Health Directors of Nursing to discuss the project and record the feedback. A further four interviews took place with representatives of the Ministry of Health, MHC, MHWDC and the CTA.

Questionnaires were distributed to 2003 graduates of mental health PECT programmes via the education providers to maintain anonymity for the graduates. To generate service users' perspectives, the research team facilitated two focus groups with former mental health service users in Auckland and Christchurch. The participants for both focus groups were recruited by the consumer advisors identified in the stakeholder group.

### **3.3 Data Collection Methods**

#### **3.3.1 Structured Interviews**

The research team developed questionnaires focused on the performance indicators to guide their interviews with the key stakeholders. The questionnaires required the participants to strongly agree, somewhat agree, somewhat disagree or strongly disagree with the statements on PECT programmes using a Likert scale. There was space provided for comments on each statement and open-ended questions were included. The questionnaires were adjusted to accommodate the interests of the different stakeholder groups. The interviews were 30-60 minutes duration and took place between late October and early December, 2004.

Reliability of the data generated from the interviews was tested using triangulation. For the larger stakeholder groups, for example the education providers, data was compared with data generated from NGO and DHB clinical service providers and graduates to ensure that consistent themes were emerging.

### **3.3.2 Semi-Structured Interviews**

Interviews with consumer advisors and representatives from the CTA, Ministry of Health, and the MHC were based on open-ended, rather than closed questions, to allow participants the opportunity to expand on the topics. These interviews were approximately 30 minutes and took place in November.

### **3.3.3 Graduate Questionnaires**

The graduate questionnaires focused on the graduates' perceptions of the training and fiscal values they received from participating in the PECT programmes. The graduate questionnaires were based on the CTA's specifications of the trainee outcomes for these programmes, and respondents were asked to rate their experiences using a Likert scale.

### **3.3.4 Focus Groups**

The two focus groups with former service users were facilitated by an experienced mental health professional who was a member of the research team. The focus groups evaluated current PECT programmes from a consumer perspective.

## **3.4 Data Analysis**

The performance indicators developed in phase one were used as a basis for the coding and analysis of the data. The quantitative data were entered into the statistical package SPSS and analysed using descriptive statistics. The statistical analysis is presented in tabular format in the results section of this review. The comments and responses to the open-ended questions were analysed using a general inductive approach (Thomas, 2003). This information supplemented the quantitative data and often helped qualify and/or clarify the participants' responses.

## **3.5 Limitations of the Research**

Not all identified stakeholders were available for interviews and some of the participants were not well informed about the broader issues related to the PECT programmes.

In addition to coordinators of PECT programmes identified by the research team, several requests for interviews were received from university Heads of Schools and one Technical Institute responsible for the provision of PECT programmes. One methodological issue to consider in relation to self-selected participants is the possibility that these participants may not be representative of the population in general. Data may be skewed by these participants' enthusiasm for particular issues in regard to PECT programmes, while the rest of the sample may feel neutral about similar issues. When analysing the data resulting from these interviews, the self-selected participants confirmed rather than contrasted with responses from the other education providers.

## **3.6 Ethics**

The proposal was submitted to The University of Auckland Human Participants Ethics Committee and permission to proceed was provided prior to commencement of the data collection.



## 4. Existing Reviews of PECT Programmes

As required under the Terms of Reference, this chapter reviews the key findings and recommendations of the 'Evaluation of Intermediate Level Training' (2004) report to ascertain the report's contribution to understanding the fiscal and training value of PECT. It should be noted that Intermediate Level Training is not a PECT programme. The chapter also reviews the evaluations of all PECT programmes generated by Hauora.com and the Expert Advisory Group on Nursing PECT programmes. Specific PECT programme evaluations by Victoria University (allied mental health) and WINTEC (Māori mental health) are also considered. The chapter begins by describing the objectives of each report, then the key findings are examined in terms of the training and fiscal value of each programme.

### 4.1 Intermediate Level Training

Intermediate Level Training (ILT) was a pilot programme managed by the DHBNZ on behalf of the Ministry of Health as part of the MHWDP. ILT was not CTA funded nor a PECT programme. The programme provided intermediate level training to 1400 trainees identified as community support workers, service users/tangata whaiora and their families, health professionals and DHB staff. The training took place in 2003 and was comprised of one national and four regional workshops. The evaluation of this programme was achieved through 90 qualitative and quantitative interviews with training participants, training providers, consumer and NGO representatives, DHB and Ministry of Health staff (Curtis, 2004, piv).

### 4.2 Hauora.com

Hauora.com produced two reports that review Māori post entry clinical training. First, the 'Scoping Report for a Way Forward in Māori Post Entry Clinical Training' (2000) summarises the key findings and recommendations from a larger investigation commissioned by Te Ohu Rata Aotearoa to increase the numbers of Māori participating in PECT training (Hodges & MacDonald, 2000, p1). Second, in 2003 the CTA contracted Hauora.com to conduct a cultural audit of PECT providers' implementation of the CTA requirements related to Māori Health and support for Māori trainees.

The scoping report's purpose was to present an environmental scan of health workforce training opportunities and issues for Māori, not just in mental health. Four areas were covered in the environmental scan, these included: Trends and influences on Māori workforce development; Māori workforce profile; policy and funding context; and current Māori workforce development activities. From this situational analysis the report recommended a way forward for Māori PECT training.

The second project utilised a cultural audit tool, developed by the CTA and Hauora.com, to review CTA contracted providers' compliance with their contracts. The tool embedded five broad categories and 19 criteria aligned to clauses contained within the contracts. Non-compliance was identified and improvements were suggested using mutually agreed 'Action Plans' (Mauri Ora Associates Limited, 2003, p2). The project aimed to: Provide a strategic overview of Māori PECT activity and address any gaps in the CTA's purchasing priorities that may have emerged as a result of audit findings; ascertain where there can be improvements in the delivery of PECT programmes to Māori and work with providers to improve delivery; and, understand the level of provider compliance against Māori specific clauses in CTA contracts.

### **4.3 Expert Advisory Group on Nursing PECT Programmes**

In June 2001, the Ministry of Health established the Expert Advisory Group on Post Entry Clinical Nurse Training Programmes. The groups' purpose was to advise on the national purchasing and prioritising of PECT programmes for nurses. This resulted in a report, 'Towards a National Strategy for Purchasing Post Entry Clinical Nurse Training Programmes'. The expert panel reviewed the current problems, issues and barriers in relation to the purchasing and prioritising of post entry clinical training for nurses. The report also provided recommendations for future purchasing and prioritising of clinical nursing education (Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004, p3).

The Expert Advisory Group employed a variety of methods to generate information that could be utilised to inform the development of the national strategy. Extensive literature reviews were undertaken, DHB Directors of Nursing were surveyed and background information from tertiary institutions was located to inform the report.

### **4.4 Allied Mental Health, Victoria University**

Completed in July 2004, this report evaluates the Postgraduate Certificate in Allied Mental Health offered by the Graduate School of Nursing and Midwifery, Victoria University of Wellington in terms of the programme's ability to fulfil the CTA's requirements outlined in their specifications.

### **4.5 Tihei Mauri Ora – Māori Mental Health Nursing, WINTEC**

This report was produced by the education provider for the CTA and provided an evaluation of the Diploma in Māori Mental Health Nursing offered at the Waikato Institute of Technology. The report covered the contracted period from August 2001 to July 2003 and includes comments from preceptors, the clinical coordinator, tutorial staff and trainees' perceptions of preceptor effectiveness (Matenga & Honeyfield, 2003, p1).

### **4.6 Training Value of PECT**

Hauora.com (2000) report that access to existing PECT programmes is not flexible enough to allow training opportunities for the Māori health workforce. It was argued that the CTA's access criteria favours medical occupational groups where there are few Māori health professionals. The authors argue that community health workers play a major role in the provisions of health services that have an impact on Māori health status (Hodges & MacDonald, 2000, p2). Hauora.com's (2003) cultural audit also revealed that a large proportion of the providers were unaware of specific Māori Support and Access funding provided by the CTA for PECT trainees. Further, those who had experience with this funding found the application process difficult and confusing in respect to how the funding could be applied (Mauri Ora Associates Limited, 2003, p5). The cultural audit also reported that this has limited the support provided for Māori trainees and hinders recruitment of Māori into PECT programmes. Māori trainees cannot always be identified and offered targeted specific assistance in training which in turn limits workforce planning (Mauri Ora Associates Limited, 2003, p4).

Māori participants in the ILT evaluation reported limited utilisation of a Kaupapa Māori-based framework in the workshops. One participant argued that the community support worker model was derived from a Kaupapa Māori model and therefore Māori frameworks should have been used in the delivery of these workshops. In general, the participants in the workshops had an

expectation that the ITL trainers would acknowledge the Māori health and wellbeing paradigm that included Māori knowledge, skills and beliefs (Curtis, 2004).

In contrast, the cultural assessment of WINTEC's Diploma in Māori Mental Health Nursing programme revealed that graduates gained knowledge and understanding in several aspects from a Māori World view (Matenga & Honeyfield, 2003). It was reported graduates of this PECT programme had an increased knowledge of Te Reo, their personal attributes/whakapapa, the support systems both within and outside their work systems, a Māori view of healing and the needs of other cultures. Trainees also had an increased level of confidence to pursue higher learning (Matenga & Honeyfield, 2003). Hauora.com predicts that Tikanga and Te Reo as well as Māori models of health care will become a normal part of publicly funded health systems. It was argued that the health system will need to "tap the potential of larger numbers of young Māori set to enter tertiary education and the workforce" (Hodges & MacDonald, 2000, p2). Essentially, this means increasing Māori participation in PECT through building the numbers of graduates at pre-entry level.

The majority of trainees in the ITL evaluation valued the networking and information sharing that the programme facilitated, however, this was often dependent on the mix of individuals in the regional workshops as trainees reported tensions between funders and workers, and clinicians and service users in some workshops (Curtis, 2004, p23). The trainees and education providers reflected that the broad range of groups attending the sessions were often too diverse, with some arguing that the material was simplistic and others that it was too difficult (Curtis, 2004, p23).

Trainees of the allied health programme reported their clinical workload was not reduced enough to enable them to study sufficiently and their workplaces were unable to replace them while they attended their study days. It was also reported that some clinical service providers did not foster a 'learning environment' (Curson & Wilson, 2004, p3).

Hauora.com's cultural audit reported limitations with current Māori advisory units. The report stated that most DHBs have a Māori health unit led by a member of the senior management team who reports to the CEO. However, the audit revealed that in most DHBs the Māori health unit staff members were not consulted about issues in relation to the CTA or PECT training. The audit made clear that more involvement of Māori health unit staff in the development and planning of PECT and support programmes for Māori trainees would increase the responsiveness to training (Mauri Ora Associates Limited, 2003, p3).

#### **4.7 Fiscal Value of PECT**

Hauora.com's cultural audit reported the cost of providing replacement staff during trainees' release time as a major barrier for smaller Māori NGO clinical providers. Similarly, DHB clinical providers of the allied health programme reported that more resources are needed to be able to fund the recommended one day per week study leave. The Expert Advisory Group report suggested that increased clinical workloads to cover workplace shortages had led to reductions in the number of experienced staff participating in PECT (Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004, p11). The evaluators of the allied health programme argued that DHB clinical providers do not understand the funding they have received from the CTA and the commitment they should make to support trainees within the programme. It was not always clear to the education providers of this programme whether the funding devolved to DHB clinical providers was used to support the students (Curson & Wilson, 2004, p9). Ministry of Health funded Māori providers revealed other barriers to accepting trainees include lack of space, and sufficient qualified staff and supervisors (Mauri Ora Associates Limited, 2003, p4).

Hauora.com's cultural audit recognised that PECT eligible Māori trainees were likely to be women with family and community commitments on top of their job, or trainees who live in rural or provincial areas that have limited access to academic support or appropriate mentors. For eligible trainees such as these, PECT creates additional costs such as time off work, time away from family and other commitments, and travel, accommodation and communication costs (Mauri Ora Associates Limited, 2003).

Current policy splits funding for clinical training between the Ministry of Health (via the CTA) and the Ministry of Education. The Expert Advisory Group on PECT nursing programmes argued that the current funding arrangements are a major barrier to the facilitation of effective postgraduate education. This report suggested the Ministry of Health and Ministry of Education review their current policies relating to the funding of postgraduate education for nurses, suggesting the Ministry of Education should fund PECT programmes and the Ministry of Health should fund fees and support for trainees, clinical supervision and mentoring (Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004, p23).

Hauora.com's cultural audit reported the different funding streams available between and within sectors are not nationally coordinated. It was argued that coordination between sectors in respect to national strategies and local needs pre-entry and post entry funding needs to be addressed (Hodges & MacDonald, 2000, p3).

## 5. Results

This chapter presents the results from the Likert scales and comments on the training and fiscal value of mental health PECT programmes generated from the semi-structured interviews, graduate questionnaires and service user focus groups. They will be presented under the performance indicators and their criteria.

### Sample

A total of 146 people participated in this research. They included: Twenty-one participants representing consumers and family advisors and NGO clinical providers; eighteen education providers of PECT programmes; six DHB clinical provider representatives; five representatives from professional groups; one representative from the Mental Health Directorate and the CTA; and a Ministry of Health advisor. Two meetings were also held with twelve Mental Health Directors of Nursing. Eighty-one respondents completed the graduate questionnaires, 75% were female and 25% male. This gave a response rate of 30%. Sixty-four per cent of the respondents were New Zealand European, 10% Māori, 6% Asian and 3% Pacific. Forty-two per cent were between 41-50 years, 22% 31-40, 21% 51 or over and 15% 21-30. Most of the respondents (32%) completed advanced mental health nursing programmes, followed by new graduate (17%), child and youth (15%), cognitive behavioural therapy (11%), dual diagnosis (10%) and new entry allied health (9%). No completed questionnaires were received by graduates of Māori mental health PECT programmes.

### 5.1 Training Value

Participants were asked to rate the mental health PECT programmes in terms of their training value. This section illustrates the key stakeholders', graduates' and service users' perceptions of the training value of PECT.

#### 5.1.1 Access to PECT Programmes

Trainees entering the new graduate mental health PECT programmes are required to be Registered Nurses or allied health professionals who have practised in mental health for no longer than six months and are employed by a Ministry of Health funded service.

A CTA representative explained that new graduate nursing programmes are also available to experienced Registered Nurses who have only worked in mental health for up to six months. The Ministry of Health advisor contended that in contrast to the original intentions for the programme, the Nursing Council of New Zealand and the CTA, without consulting the mental health sector, decided this would help alleviate the shortage of mental health nurses.

The CTA's specifications for all PECT programmes stipulate that eligible trainees must hold a 0.8 or greater position within a Ministry of Health funded mental health service and have a minimum of two full-time years experience in the mental health sector.

Table 4 illustrates the education providers' responses to the CTA's criteria for eligible trainee selection for PECT programmes. In total 66% reported the CTA's selection of trainee requirements were appropriate.

**Table 4. Education providers' responses to the appropriateness of trainee selection criteria.**

<b>Very appropriate</b>	<b>Somewhat appropriate</b>	<b>Not very appropriate</b>	<b>Not appropriate</b>
22%	44%	17%	17%

The education providers agreed that trainees in the programmes other than new graduate programmes do require substantial experience in the mental health sector prior to participating in PECT programmes. They argued however that greater flexibility was required in terms of the requirement for two years experience as some potential trainees were denied access due to a shortfall of a few weeks. One education provider stated that the two-year clinical experience requirement has meant that some mental health professionals, for example nurses, have to wait two years before continuing with postgraduate education. It was argued that this is inconsistent with the philosophy underpinning professional education. Another education provider reported that for some programmes a shorter clinical experience in a relevant speciality area, for example alcohol and drug services or forensic mental health, would be more beneficial than two years in general mental health. Professional group representatives and Mental Health Directors of Nursing also reported that the criteria for entry into PECT programmes are too tight in relation to the clinical experience needed. It was argued that the small percentage of allied health professionals in mental health needs to be taken into consideration when reviewing this criterion.

The specifications require all trainees to be New Zealand citizens or hold a New Zealand residency permit. Since many mental health managers in New Zealand recruit from overseas, it was argued that some trainees may not be eligible for PECT programmes until they have met the residency requirement and this disadvantages them.

The CTA requires PECT trainees to hold a recognised health professional qualification. Some education providers (34%) reported that this requirement reduces the breadth of students allowed to take part. One education provider argued that this requirement does not allow for those working at senior levels who are not registered health professionals to participate in PECT training. Non-registered health workers comprise a large percentage of the alcohol and drug workforce. It was argued that PECT programmes are inappropriate as a workforce development strategy for this group. Similar comments were made by an education provider of a cognitive behavioural therapy programme. They argued that the workforce is older and unqualified. It was also stated that this requirement disadvantages Māori and Pacific. A large percentage of the Māori and Pacific mental health workforce do not have an undergraduate or tertiary degree.

NGO clinical providers also reported that the CTA's criteria for entry denies their workforce's ability to access PECT programmes. They explained that the core of the NGO workforce is comprised of support workers who do not have the necessary qualifications to access PECT programmes. Although NGO services do attract workers with some form of qualification, they do not have the clinical qualifications required to participate in PECT programmes. It was argued that the Ministry of Health needs to provide further funding for the National Diploma for Mental Health Support Workers.

Some NGO representatives suggested that there is reluctance by the government to support the development of community mental health support workers. Although there are degrees for mental health support workers, it was argued that these need to be funded by the CTA. They argued that PECT programmes need to bring service users, support workers and traditional health professionals together to break down divisive values and attitudes within the mental

health workforce. A Ministry of Health advisor maintained that access to new graduate programmes should be extended to the NGO and Primary Health Organisations sector.

Representatives of the Mental Health Directorate and the CTA explained that the CTA’s mandate is to purchase post entry clinical training for health professionals. They are not mandated to provide training for the whole sector. The CTA is responsible for purchasing programmes on behalf of the Mental Health Directorate who direct purchasing of programmes according to the government’s priorities. The CTA, therefore, is constrained by statutes dictating what it can purchase and any changes to broaden the role of the CTA would require a cabinet mandate.

Several stakeholders, including education providers, representatives from the Mental Health Directorate and Ministry of Health, argued that the programmes should be funded by the Ministry of Education and the CTA should fund access to the programmes in terms of clinical scholarships, mentorship, travel and accommodation. It was recognised policy changes would be required and that it would not be the role of the CTA to undertake this.

The Ministry of Health advisor argued that PECT programmes should be provided by universities with research expertise and clinically skilled educators. They suggested polytechnics should not be teaching PECT programmes.

### 5.1.2 Knowledge and Skill Development

To complete mental health PECT programmes successfully, the CTA requires trainees to demonstrate particular skills and knowledge. DHB clinical providers of mental health services commented on PECT graduates’ competency in each of the outcome areas. Table 5 summarises the responses of the DHB clinical providers in relation to PECT graduates’ increased knowledge and skills.

**Table 5. DHB clinical providers’ perceptions of PECT graduates’ increased knowledge and skills.**

<b>PECT graduates have increased</b>	<b>Strongly agree</b>	<b>Somewhat agree</b>	<b>Total % of respondents</b>
Knowledge of speciality area	33%	67%	100%
Assessment skills	33%	67%	100%
Referral and liaison skills	33%	50%	*83%
Risk management	16%	67%	*83%
Knowledge of intervention models	67%	16%	*83%
Inter-disciplinary teamwork skills	50%	33%	*83%
Clinical leadership skills	67%	33%	100%
Autonomous working skills	33%	67%	100%
Flexibility and scope	33%	67%	100%
Reflective practise	83%	17%	100%

\* Percentages less than 100% indicate nil responses due to the non-applicability of the question for particular respondents.

All the DHB clinical providers argued that PECT graduates have increased speciality knowledge. These stakeholders reported that PECT has led to graduates taking on increased responsibility in the workplace, further postgraduate study and has developed graduates' competency to perform leadership roles. One DHB clinical provider stated that PECT programmes are a catalyst for graduates to move into leadership roles, especially for those staff members with many years experience.

Most DHB clinical providers agreed that graduates of PECT have competency in assessment skills, referral and liaison, and risk management. However, some DHB clinical providers recognised that graduates' competency in these skills can vary across programmes and successful implementation and further development of these skills often depends on workplace support. It was noted that clinical service providers do not always allow graduates to put their new skills into practice.

Over half (67%) of the DHB clinical providers only somewhat agreed that PECT develops graduates' ability to work autonomously. These stakeholders suggested that the development of autonomous working skills could be limited by the teamwork practices that characterise mental health services.

Most DHB clinical providers reported PECT graduates are more flexible to move between different areas of work as a result of their increased knowledge and skill. All the stakeholders argued that reflective practice is emphasised in PECT programmes.

The Mental Health Directors of Nursing were positive about the training value of the mental health nursing PECT programmes. They reported that PECT advances nursing practice and new graduate programmes have influenced nurses' progression into clinical leadership roles and increased their awareness of postgraduate education and CTA processes. The value of Māori and Pacific mentorship was stated and leadership was emphasised as an important component of nursing PECT programmes.

One consumer advisor was positive about new graduate mental health PECT programmes and reported that PECT reinforces the partnership role and addresses the stigmatisation and discrimination of mental health service users. As a result, this has a positive impact on service users and reinforces their roles as professionals, and increases the recovery principle of 'partnership'.

The professional groups agreed that graduates of mental health PECT programmes have increased knowledge and skills. All reported that PECT is appropriate for their association's members and for client health outcomes. Representatives of professional groups were less positive about the appropriateness of PECT for improving Māori and Pacific health outcomes. It was argued that the Māori specific PECT programme is the only one that is appropriate for Māori. They argued the generic programmes' inclusion of Māori and Pacific health perspectives was poor and while PECT graduates are aware of the socio-political context of care their knowledge is not necessarily in-depth.

Table 6 summarises the trainees' perceptions of their increased knowledge and skills since completing PECT programmes. The results were mainly positive, with most trainees strongly agreeing or somewhat agreeing that they had increased knowledge and skills as a result of participating in the programme. In contrast to the DHB clinical providers' perceptions of graduates' increased knowledge and skills, a minority of the graduates' reported they either somewhat or strongly disagreed that their knowledge and skills had increased.

**Table 6. PECT graduates' perceptions of their increased knowledge and skills.**

<b>Competency Area</b>	<b>Strongly agree</b>	<b>Somewhat agree</b>	<b>Somewhat disagree</b>	<b>Strongly disagree</b>
Assessment skills	65%	26%	6%	3%
Referral and liaison	56%	33%	7%	4%
Culturally appropriate care	48%	40%	10%	4%
Clinical leadership	46%	41%	10%	4%
Risk management	54%	38%	5%	3%
Knowledge of speciality area	54%	37%	4%	4%
Multidisciplinary teamwork	49%	35%	7%	5%
Autonomous work	59%	26%	9%	4%
Understanding of intervention models	46%	37%	9%	4%

Note: Due to rounding and non-applicability, some percentages may not total 100%.

### **5.1.3 Formal Teaching Component**

Seventy-two per cent of the education providers agreed with the CTA's requirements that the PECT programmes be offered at Level 8 on the National Qualifications Framework. Some education providers had concerns about moving new graduate programmes to Level 8 in terms of trainees' ability to cope with the pressure of studying at postgraduate level.

The vast majority of the professional group representatives supported all PECT programmes being Level 8 on the National Qualifications Framework. One representative suggested that Level 8 for new graduate programmes was inappropriate as not all new graduates are ready to study at postgraduate level. This representative reported that the deficits in undergraduate mental health education need to be addressed. The Mental Health Directors of Nursing agreed with all PECT programmes being Level 8 on the National Qualifications Framework, however they also explained that new graduate trainees find it hard to meet the clinical workload and theoretical components at this level.

There was some discontent about new graduate and advanced mental health nursing programmes both being at postgraduate certificate level. The CTA representative explained that while it was recognised that new graduates and mental health nurses with at least two years experience are at very different levels clinically, both groups are entering postgraduate education at the same academic level.

### **5.1.4 Clinical Component**

Trainees of PECT programmes are required to work at least 0.8 (four days a week) in a mental health clinical setting as well as undertaking the academic component of their PECT programme. Seventeen per cent of the education providers stated that the CTA's requirements for clinical workload were very appropriate, 50% somewhat appropriate, 22% not very appropriate and 11% not appropriate. The education providers reported that this requirement denies access to many potential trainees and is discriminatory against females with family commitments and those who may want to work part-time. As these demographics are characteristic of a large percentage of the mental health workforce, this requirement denies

access to a group of people who could benefit from the programmes, and has implications for the quality of care provided to service users. Most education providers argued that CTA needs to be flexible in relation to trainees' individual circumstances and several argued for the requirement for clinical workload to be changed to 0.6 employment. It was also argued that 0.6 employment would allow trainees more time to complete the academic component of the programmes. This would benefit trainees with family responsibilities. The CTA representative argued that before a change from 0.8 to 0.6 could take place there would need to be evidence that trainees could receive the necessary clinical experience during that time.

Most of the education providers (88%) reported that the CTA's requirements for clinical supervision were very appropriate. As for clinical workload, some education providers reported that the CTA needs to be more flexible with the quantity of clinical supervision (20 hours) required and focus on the quality of the supervisors. Graduates were questioned on the appropriateness of the clinical supervision they received. The results were mostly positive with 52% claiming that the clinical supervision was very appropriate, 35% somewhat appropriate and 5% not very appropriate. A small percentage (7%) did not receive any clinical supervision.

### **5.1.5 Programme Coordination**

The CTA specifications require programme coordinators to convene an advisory group, which includes representation from service users, Māori, Pacific Island people, trainees, mental health services and education institutions. This group oversees the programme and identifies any issues that need to be addressed. Approximately half (56%) of the education providers stated that the CTA's requirements for convening an advisory group were appropriate. Seventy-two per cent agreed that the CTA's requirements for liaison with the clinical workplace were very appropriate.

There were some concerns voiced by the education providers in relation to the advisory groups for PECT programmes. Although the CTA's requirements state that the advisory groups should include representation from a variety of groups, one education provider reported that limited consultation with Māori takes place. Others argued that liaison with DHB clinical providers was difficult when trainees are drawn from four to five DHBs. Geographical distance between members of the group constrained attendance at meetings and involvement with the programmes.

The programme coordinators are required to complete several reports for the CTA, these include: Tenure of trainees in mental health services at the commencement of the programme; a summary of exit interview information from trainees leaving the programme; and a summary of the progress of the programmes. Education providers' responses to this requirement were varied. The qualitative material indicated that most education providers think that some form of reporting is important for good national standards, however, the methods and content included in the required reporting were criticised. It was argued the quantitative "tick box" methodology utilised by the CTA is ineffective and irrelevant to quality education outcomes. The common argument was that the statistical reports required by the CTA were not concerned with the quality of the programmes and it was reported education providers never see any feedback on the reports they submit to the CTA. The Mental Health Directors of Nursing voiced similar concerns. They argued that the CTA needs to ask more about the context of PECT programmes rather than what trainees passed or failed.

The professional group representatives generally reported coordination of PECT programmes to be appropriate. One representative argued that the interface between DHB clinical services and education providers needs to be addressed. This stakeholder argued that regions need to take control of determining their own needs and meet the needs of that region.

### **5.1.6 Consultation Processes**

Several stakeholders were “enormously frustrated” by the lack of consultation with Māori, Pacific and health professionals from other disciplines in relation to the directions of Ministry of Health funding. The CTA representative explained that consultation with the mental health sector takes place when developing specifications for new PECT programmes. It was reported that responses to the new specifications by the sector are evaluated by a clinical and academic expert panel and recommendations are made to the CTA Purchase Board.

### **5.1.7 Content of PECT Programmes**

The content of PECT programmes was criticised by all NGO clinical providers, family advisors and consumer advisors. It was argued that the content of PECT does not fit with the philosophical basis of NGO mental health services that includes primary prevention, ongoing social inclusion, and reflects the broad, bio/psycho/social, holistic approach to wellness and recovery. It was suggested that PECT programmes should be developed with a focus on primary health care, health promotion, the recovery approach and community development strategies. One NGO clinical provider argued that PECT perpetuates the “status quo” and does not take into account the move by current mental health providers who base their services on community recovery-based models. This stakeholder reported that although the model of care within the mental health sector has changed, it has not been included in the education curriculum for the workforce.

The NGO clinical providers stated that the Ministry of Health needs to consider developing PECT in relation to the needs of the NGO mental health workforce. The Mental Health Directorate representative suggested that because 30% of mental health funding is with NGOs and the CTA has not been mandated to purchase appropriate education for NGO workers, perhaps a new agency responsible for the training and development of the whole mental health workforce needs to be implemented. The Mental Health Workforce Development Programme is currently in the process of constructing a proposal for a national mental health workforce development plan.

Consumer and family advisors had concerns about the content of PECT programmes. Two family advisor representatives argued that trainees are not taught comprehensively about family inclusion in the mental health service processes. It was stated that apart from the Māori, and child and youth programmes, PECT programmes have an individualised focus. It was suggested that all PECT programmes need to emphasise health professionals engaging with support groups whilst planning care. A consumer advisor reported that the content of PECT programmes may not relate to the needs of Pacific service users. This representative also reported that service users relate well to support workers but are often in the care of “higher” status health professionals who think they know what service users need. They argued that PECT training needs to teach health professionals “how to relate” to service users as some nurses “fear” service users and react to them as if they are criminals. This representative argued that health professionals need to “step down from their pedestal” and treat service users as people. The same consumer advisor reported that PECT does not consider spiritual aspects of mental health. Pacific Island and Māori perspectives on health are different to a Western philosophy of care and PECT should acknowledge spiritual perspectives. Another family advisor reported that PECT programmes are limited in terms of mental health promotion. This representative argued that models that emphasise community strengthening and empowerment should be utilised in all PECT programmes.

The former service user focus group participants were positive about the training value of PECT programmes. They argued that the programmes have changed graduates’ attitudes to mental

health service users and the inclusion of service users in the programmes allows for trainees to hear real stories and experiences. It was argued that service user involvement in PECT allows trainees to hear different experiences that focus on ‘wellness’ as opposed to ‘sickness’. Former service users suggested that all PECT programmes should involve service users and families.

Representatives of professional groups reported that the content of PECT programmes do not prepare nurses for nursing in primary health care, particularly with wellness and health promotion approaches.

The Mental Health Directors of Nursing argued that the CTA’s specifications need to be reviewed in order to improve the content of PECT programmes. They argued that the specifications had not been reviewed since 1996 and no major reviews of advanced mental health nursing programmes have taken place since the programme was established in 1991. The Mental Health Directorate representative explained that the CTA has not been able to review and/or evaluate programmes due to the lack of resources. To do this they would need to apply for additional funding from the Mental Health Directorate.

It was also argued by the Ministry of Health advisor that the CTA should not determine the content of PECT programmes, instead their specifications should allow for education providers to develop programmes with clinical providers, service users and regulatory bodies. The Mental Health Directorate representative questioned the relevancy of PECT programmes for inclusion of the recovery approach as specified in the ‘Blueprint’. The CTA representative argued that the specifications are only the minimum requirement and do not restrict providers from including a recovery approach.

## 5.2 Fiscal Value: Costs/Benefits Analysis

This section presents the research findings relating to the fiscal value of PECT programmes. The findings were analysed in terms of the financial benefits and/or costs of PECT programmes and will be set out under the criteria of clinical providers, education providers, graduates, service users, Ministry of Health and professional groups’ representatives.

### 5.2.1 Clinical Providers

The majority of representatives of DHB clinical services and Mental Health Directors of Nursing were positive about the cost-effectiveness of PECT programmes. Table 7 illustrates the DHB clinical providers’ agreement with the cost-effectiveness of PECT in relation to clinical supervision, learning support and release time.

**Table 7. DHB clinical providers’ perceptions of the cost-effectiveness of PECT programmes.**

PECT provides...	Strongly agree	Somewhat agree	Somewhat disagree
Value for money	50%	50%	-
Cost-effective clinical supervision	83%	-	17%
Cost-effective learning support	17%	67%	17%
Cost-effective release time	50%	50%	-

Note: Due to rounding and non-applicability, some percentages may not total 100%.

All DHB clinical providers argued that PECT programmes provide value for money and the majority agreed that they provide cost-effective clinical supervision, learning support and release time. Both the DHB clinical providers and Mental Health Directors of Nursing argued that PECT contributes to increased retention of staff, decreased staff sickness and decreased incidents. One Mental Health Director of Nursing explained that retention has increased significantly as a direct result of PECT. These direct savings to mental health services in terms of avoiding turnover costs, have major financial implications for DHBs.

DHB clinical providers also reported that CTA funding does not cover all the costs of learning support and release time. They reported that release time creates costs to the service and to other staff members who have increased responsibility when replacement staff are not available. One representative stated that there is a constant tension between support for education and replacing staff attending teaching days.

Other DHB clinical providers explained that locations of PECT programmes were a major financial barrier for DHB staff living at a distance from the education provider. They reported that the CTA funding does not cover the cost of travel and this makes it difficult for trainees travelling long distances to gain clinical experience and attend the formal teaching programme. The Mental Health Directors of Nursing also reported that the cost to trainees for travelling from a distance to attend the formal teaching days needs to be addressed. Several argued that DHB clinical providers often cover this cost.

DHB clinical providers and Mental Health Directors of Nursing were critical of the CTA's timeframes for negotiating contracts. It was argued that limited flexibility with contracts was not the most efficient way to meet sector policy requirements. Both DHB clinical providers and education providers suggested that the CTA needs to expand their timelines for contract decisions and develop long-term contracts for periods longer than three years. Often contracts were not confirmed until November, or even February or March, leaving insufficient time to recruit trainees and clinical mentors. This creates a real problem for staff recruitment and retention.

For NGO clinical providers, the ability to provide clinical release time is limited. It was reported that even after receiving funding, clinical release time is made impossible by the lack of "support structure" to fill the trainees' role. It was argued that NGO services receive less overall funding from the government than DHB mental health services and this impacts on their ability to enable staff to participate in PECT programmes. They also reported that community services have no support structure to draw on for clinical supervision.

### **5.2.2 Education Providers**

Sixty-seven per cent of the education providers agreed that their organisation benefits from providing PECT programmes and 28% disagreed. They reported that the financial benefit of PECT programmes is dependent on the numbers of trainees enrolled in the programmes. Because programmes are funded in relation to the numbers of trainees, where there are low numbers education providers have to subsidise the programmes.

The education providers' responses in table 8 indicate the level of CTA funding encompassing clinical supervision, release time, learning support, education mentoring, learning resources, and selection and training for supervisors needs to be addressed. Education providers argued that CTA funding for release time often becomes absorbed in DHB general funds rather than being allocated to the specific units where PECT trainees need to be replaced while they attend the formal teaching programme, this was confirmed by the Mental Health Directors of Nursing. Participants suggested that the CTA needs to consult with the clinical providers to alleviate this

problem. Education providers also argued that the current tendering process for PECT produces too much uncertainty to ensure efficient continuity of programme delivery. As mentioned above, this has implications for the recruitment and retention of teaching staff as well as recruitment of trainees.

**Table 8. Education providers’ perceptions of the appropriateness of CTA funding.**

<b>Funding Area</b>	<b>Very appropriate</b>	<b>Somewhat appropriate</b>	<b>Not very appropriate</b>	<b>Not appropriate</b>
Clinical supervision	22%	28%	17%	17%
Release time	11%	11%	28%	28%
Learning support	22%	39%	22%	11%
Education mentoring	22%	33%	22%	17%
Learning resources	33%	22%	17%	17%
Selection/training of supervisors	6%	33%	17%	22%

### **5.2.3 Graduates**

To ascertain the indirect costs/benefits, graduates were asked if the PECT programme had equipped them for promotion to a new position. The response was mixed, with 42% stating yes, 22% no and 33% not sure. Over half (53%) of the graduates stated that they intended pursuing further postgraduate education following completion of their PECT programme. Only 6% of graduates stated they would not and 26% were not sure.

To determine the direct costs/benefits for trainees the graduates were asked whether they would have enrolled for a PECT programme if it had not been funded by the CTA. Eighty per cent stated they would not have and 17% agreed they would have. Graduates were also asked whether they were released from their workplace setting to attend teaching days. A large percentage (73%) claimed they were always released. Only 4% were sometimes or mostly released, and one graduate stated they were never released but had to take annual leave.

### **5.2.4 Service User Representatives**

Service user representatives reported that funding needed to increase to cover replacement of staff during release time.

### **5.2.5 Ministry of Health Representatives**

The Mental Health Directorate representative suggested it is time to question whether the investment in PECT is the right one considering the future workforce will be comprised mostly of Māori, Pacific and NGO mental health support workers who are currently not eligible for PECT programmes. The CTA representative argued that the limited budget pool and purchasing directions imposed by the Mental Health Directorate inevitably result in rationing and limited flexibility.

### **5.2.6 Professional Groups’ Representatives**

All representatives from professional groups reported that PECT provides value for money. These stakeholders had some concerns with the level of funding for clinical release and clinical

supervision. The representatives reported that the cost of clinical supervision and release time to mental health services makes it difficult for staff to access PECT programmes. Representatives explained that smaller, specialised and rural mental health clinical providers are disadvantaged. It was reported that the travel costs for trainees in distant areas are high and that these trainees need to be compensated, and that the percentage of CTA funding for mental health professionals in comparison with general medicine, is too low.

### **5.2.7 Stakeholders' Perceptions of a National Approach to PECT**

This section presents stakeholders' perceptions of the effectiveness and efficiency of the Ministry of Health's national approach to the funding, coordination and management of PECT programmes. These responses were made to an open-ended question. There was a major division between the education providers. Forty-five per cent of the respondents strongly agreed that a national approach to providing PECT is the best approach but they qualified this by stating there should be regional variations to recognise specific regional needs. In this way, PECT programmes should be aligned with, and reflect both national and regional plans. The CTA representative argued that the CTA is focused on developing a national workforce with transferable skills rather than focusing on local employer needs.

New graduate education providers were more positive about the current approach to the coordination and funding of PECT programmes. According to one participant, the current national approach is a "win-win" situation for both the employers of trainees and education providers. PECT for new graduates was considered by this participant to increase the retention of nurses considerably.

One NGO representative commented that it is important to have national consistency and to continue funding for PECT programmes.

## **5.3 Other Issues**

Participants were invited to report on 'other issues' related to PECT programmes. The CTA's role in the national coordination of PECT was discussed by the education providers. Some respondents argued that the CTA and Ministry of Health should not be responsible for the national coordination of PECT programmes. It was suggested by one respondent that the major university providers, such as the University of Otago and the University of Auckland, working closely with DHBs, could coordinate and take responsibility for the funding and management of PECT programmes. There was recognition from the Mental Health Directorate that the CTA does a good job "at what it does", and many positive comments were made in relation to the current CTA representative responsible for purchasing the mental health programmes.

Several education providers discussed whether PECT programmes should be Ministry of Health or Ministry of Education funded as currently Ministry of Health and Ministry of Education trainees study alongside each other in the same programmes. It was argued that funding for the programmes should be divided between the two Ministries, with the Ministry of Education funding the programmes and the Ministry of Health funding support for the trainees to access the programmes.

Another concern for DHB clinical providers and Mental Health Directors of Nursing was career pathways for mental health nurses. These stakeholders reported that CTA funded PECT programmes have promoted the profile of mental health as a career option. It was reported new graduate programmes have increased retention and recruitment of nurses into the mental health sector and there has been an increase in the number of mental health nurses with Masters Degrees since the introduction of CTA funded programmes. This suggests that mental health

nurses are now more enthusiastic about participating in postgraduate education. It was argued that funding now needs to be directed towards purchasing postgraduate diplomas and developing a clear pathway to mental health nurse practitioner roles.

Education providers and a Ministry of Health advisor argued that the mental health workforce needs up-skilling beyond Postgraduate Certificate level. These stakeholders also suggested that there should also be funding support for Postgraduate Diplomas and Masters as the graduates of these programmes would ultimately have a positive impact on developing the practice of other mental health workers and ultimately improving service user outcomes. It was argued that the advanced mental health nursing programmes need to be at Diploma level to fit with nursing career pathways.

The CTA representative explained that to date, the CTA has not received approval from the Mental Health Directorate to purchase beyond Postgraduate Certificate level but the CTA is currently considering this issue. It was also noted that the mental health workforce expects that all postgraduate programmes should be funded in contrast to other health professionals who fund their own ongoing education.

The Ministry of Health advisor suggested that because multidisciplinary programmes, for example forensic mental health, are not endorsed by the Nursing Council, nurses intending to proceed to Nurse Practitioner are unlikely to participate in these programmes.

## 6. Conclusions and Recommendations

Overall the responses were positive relating to both the training and fiscal value of PECT. Participants reported advantages to the mental health sector from having ring-fenced funding for mental health but recommendations were made as to how funding for PECT could be improved. The majority of participants agreed that PECT programmes increase graduates' knowledge and skills and enable them to take on more responsibility and leadership roles, and facilitate their flexibility in terms of working across various areas of their speciality. Some workplaces did not support the development of the skills and knowledge developed in the programmes by allowing graduates to utilise them in practice.

PECT programmes were considered important both for their content and for the retention of graduates resulting in lower costs of turnover. The vast majority of PECT graduates (91%) reported that the clinical training they received in their undergraduate programmes was inadequate and it failed to prepare them for the demands of their current roles.

PECT has promoted mental health as a career option for nurses in particular. It has also resulted in larger numbers of mental health nurses undertaking further postgraduate study, for example, 53% of graduates in this study intend to continue with further postgraduate education and the participants reported there are greater numbers of practising mental health nurses with Masters Degrees.

A consistent theme focused on whether the Ministry of Health, with the responsibility for ensuring appropriate health services are provided for all New Zealanders, should be involved in purchasing educational programmes. It was argued that the Ministry of Education should be responsible for funding educational programmes and the Ministry of Health should be responsible for increasing access for the health workforce. Funding currently used to purchase PECT programmes could be used to provide training for greater numbers of trainees, fund training to Postgraduate Diploma level with an exit point at Postgraduate Certificate level, fund student fees and provide more appropriate funding for release time, clinical supervisors, additional clinical experience, and travel and accommodation for trainees.

As suggested by the Ministerial Taskforce (Ministry of Health, 1998), The Expert Advisory Group on PECT nurse training programmes (Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004) and Hauora.com (Hodges & MacDonald, 2000), the current situation whereby funding for health professionals' postgraduate education is split between the Ministry of Health and the Ministry of Education is not in the best interests of the mental health workforce or service users. Presently health professionals funded by Ministry of Health and Ministry of Education study alongside each other in the same programmes. The difference between the two is that for Ministry of Health funded trainees, clinical supervision and mentoring is mandatory and when necessary additional clinical experience is organised to meet the requirement of the 30% clinical content. Comparatively, Ministry of Education funded students are also expected to be practising in clinical areas related to their study and are encouraged to have clinical mentors but there is no requirement that they be employed 0.8 and they are not funded for release time. These students are also required to pay their own university fees, approximately \$4000 for a full-time year. PECT money could be better used promoting access to programmes for trainees as suggested above. It was acknowledged that such changes would require policy amendments for both Ministries and it is not the CTA's responsibility to instigate this.

The results from this study confirmed the assertions stated by the Ministerial Taskforce (Ministry of Health, 1998) and Hauora.com (Mauri Ora Associates Limited, 2003) that trainees in rural and/or provincial areas are often at a real disadvantage in terms of additional travel and

accommodation costs, and lack of academic and clinical support. The policy changes suggested above would release additional funds for the trainees and training for their local mentors.

PECT programmes also result in substantial costs for both education and clinical providers. The former, in particular when there are low numbers of trainees in the programmes, and the latter due to the indirect costs related to release time.

The NGO arguments that PECT programmes are not appropriate for the majority of their workforce, comprised of mainly support workers, indicates there is some misunderstanding about the CTA's mandate. It also confirms Hauora.com's (2003) assertion that consideration needs to be given to the ongoing development of the NGO workforce which is mainly Māori and Pacific, most of whom do not have a health professional qualification. This argument applies to a broad range of workers including the specialties of alcohol and drug, and cognitive behavioural therapy. As intimated in Te Rau Matatini (Hirini & Durie, 2003) and supported by the Mental Health Directorate representative, a coordinated strategy for the development of all levels within the mental health workforce should be considered.

Where the small numbers of NGO health professionals do access PECT programmes, their workplaces struggle to provide replacements for their release time for the formal teaching days, and clinical supervision. Participants confirmed Hauora.com's findings that NGOs do not have the support structures in place to provide these (Mauri Ora Associates Limited, 2003).

The findings from this study confirmed Hauora.com's (Mauri Ora Associates Limited, 2003) assertions that the CTA's requirement for a 0.8 clinical workload is discriminatory for women with family and community responsibilities who usually work part-time and less than 0.8. Trainees who do meet this requirement, often struggle with juggling the academic and clinical workloads on top of their family responsibilities. Education providers argued that 0.6 clinical workload would still allow trainees to gain the necessary experience while undertaking the programmes. Another suggestion made was to extend the programmes over two years. Participants also reported there should be more flexibility with the two years clinical experience requirement.

NGOs, family advisors and consumer advisors argued that the content of the programmes does not fit with the philosophical basis of NGO mental health services. They suggested PECT programmes should be developed with a focus on primary health care, health promotion, a recovery approach and community development strategies.

Ongoing evaluation of programmes is essential to ensure quality and appropriate standards are maintained, and the programmes are relevant across the mental health sector for both DHBs and NGOs. Including service users in the planning, delivery and evaluation of programmes and assessment of trainees has proved to enhance the quality of programmes in New Zealand (O'Brien & Heron, 2005), Australia (Happell et al., 2003) and the U.K. (Frisby, 2001). Māori mental health PECT programmes were reported to increase trainees' knowledge and skill development within a Māori world view. The other programmes, it was argued, do not sufficiently reflect Māori and Pacific mental health approaches and issues.

Regular consultation with the broader mental health sector, including Māori and Pacific providers, service users and professional groups needs to take place on a regular basis, not only when specifications are being developed. This would ensure specifications remain relevant, the volumes of trainees in the various programmes are appropriate for the needs of the sector, and the most relevant programmes are available. Including clinical providers in the consultation process would ensure they have an understanding of their responsibilities in terms of supporting their students and the need to allow the funding they do receive to filter down to subsidise the

trainees' replacement while attending formal teaching days, and extra clinical experience (Curson & Wilson, 2004; Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004). Some DHB managers are unaware of the need for new entry social workers and occupational therapists to undertake postgraduate education.

A real concern was voiced about the timeframes in which the contracts for PECT programmes are negotiated. CTA contracts with PECT providers should be negotiated well ahead of the academic year and they should be for longer terms to allow for adequate recruitment of trainees and to ensure appropriate clinical supervisors and academic staff are available.

Many of the results from this review reiterate findings in earlier reports related to PECT (Clinical Training Agency, 2004a; Expert Advisory Group on Post-Entry Clinical Nurse Training, 2004; Health Workforce Advisory Committee, 2002; Hodges & MacDonald, 2000; Matenga & Honeyfield, 2003; Mauri Ora Associates Limited, 2003). It is imperative therefore that the recommendations of this review are taken into consideration when the national training and development plan for mental health is developed.

## **6.1 Recommendations**

- The Ministry of Health should review, with the Ministry of Education, current policy related to the split in funding for postgraduate education for nurses, occupational therapists, social workers and other health professionals working in mental health. The Ministry of Education should fund the programmes and the Ministry of Health should fund support for trainees in terms of scholarships for greater numbers of trainees, travel and accommodation, clinical mentors, release time and additional clinical experience.
- Undergraduate nursing and other health professional programmes should increase their mental health knowledge and skills component and increase the students' access to appropriate mental health and related specialty clinical placements.

Until the first recommendation comes into effect the following should be considered:

- Longer-term contracts with PECT providers should be developed;
- Funding for release time and clinical mentors should be increased;
- The CTA should provide funding for travel and accommodation for all trainees living at a distance from their education providers;
- The CTA should purchase Postgraduate Certificates and Postgraduate Diplomas to enhance the knowledge and skill level of mental health professionals;
- A pilot study should be established to evaluate a 0.6 clinical workload for trainees;
- The CTA should undertake more extensive, and ongoing consultation with the broader mental health sector;
- Programme specifications should reflect Māori and Pacific mental health issues, primary health care, health promotion, a recovery approach and community development strategies;
- Specifications for the advanced mental health nursing programme should be reviewed; and
- A strategy for the development of all levels of the mental health workforce, including non-registered mental health workers should be developed.



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