MatuaRaki
National Addiction Workforce Development

Mental health and addiction inquiry submission

Te Pou o te Whakaaro Nui

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Part of the Wise Group

Top five messages

- There is a looming mental health and addiction workforce crisis
- We need to change the composition of the workforce and the way it is educated and trained
- We need further investment in focused workforce development initiatives
- We need evidence-based approaches to workforce planning and development
- We need to support and look after our most important asset: our workforce

[1]What's working well?

Investment in workforce development

National investment in workforce development centres, like Te Pou o te Whakaaro Nui (Te Pou) and Matua Raki, allows for purposeful and focussed workforce planning and development initiatives to build the capacity and capability of the mental health, addiction and disability workforces. It also allows these centres to focus on providing mental health and addiction focussed workforce development solutions to the wider health and social care workforces.

There are several examples of successful workforce focussed initiatives that Te Pou has been involved in that have created systems change and paradigm shifts in the way mental health and addiction services operate. These include Te Pou's *Least Restrictive Practice* work aimed at reducing the use of seclusion and restraint, the Ministry of Health's *Let's get real*, the across workforce centre implementation of the Ministry of Health's *Supporting Parents, Health Children* (SPHC) and *Integrated Solutions* guidelines. The mental health and addiction workforce in Aotearoa New Zealand is also highly trained in the collection and use of relevant outcome measures and are regularly provided with reports which show aggregated outcome information at the team, service and national levels. Having a mandated and national approach to these programmes has made these types of initiatives particularly successful. For example, since 2009, the number of people secluded has decreased by 25%.

Skills Matter, a highly successful programme of work resourced and managed by Te Pou, funds education programme providers to deliver mental health and addiction post-entry clinical vocational training. *Skills Matter* funding is available for nurses, social workers, occupational therapists, addiction

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[1] This submission primarily focuses on mental health and addiction workforce issues

practitioners and other health professionals working in mental health and addiction services. The programme supports new entrants to develop the required clinical skills and knowledge to transition into practice in mental health and addiction and supports existing practitioners in mental health and addiction to develop advanced or specialist knowledge, skills and leadership in high priority workforce development areas. Evaluations of the *Skills Matter* programmes show they are contributing to knowledge and skill development in key areas and students are applying their learning into their clinical practice with support from supervisors, preceptors, work colleagues, course co-ordinators and fellow students.

Over the years we have gathered a number of other workforce focused stories of success. These include personal stories of professionals who have accessed the *Skills Matter* funding and organisations who have embedded *Let's get real* into the way they work. For example read about Moefilifilia Aoelua who accessed the new entry to specialist practice: mental health and addiction nursing programme, after graduating with a Bachelor of Nursing Pacific; and Odyssey House, Auckland, who embedded *Let's get real* into their organisation to support their values informed practice.

Equally Well is a group of people and organisations with the common goal of reducing physical health disparities for people who experience mental health and addiction conditions. Te Pou provide the 'backbone' function for *Equally Well*, however supporters span the health, mental health and social sectors, and include community organisations, mental health and addiction NGOs, primary care, district health boards, medical colleges and education providers. This is an excellent example where collaborative action is making a difference in the lives of people with mental health and/or addiction problems.

Investing in workforce development programmes has supported the continued development of international networks and collaborations that help us to identify meaningful international workforce development initiatives, for example the International Initiative for Mental Health Leadership (IIMHL) and the Global Addiction Academy Programme (GAaPP).

The workforce

The specialist mental health and addiction workforce are dedicated and highly skilled. The workforces consist of a broad and diverse range of people, including peer support workers, support workers,

consumer advisors and advocates, family and whānau advisors, psychiatrists, nurses, counsellors, addiction practitioners, social workers, psychologists, occupational therapists, psychotherapists, other allied health workers, and cultural workers (including kaumātua, mātua, and Māori, Pacific and Asian workers). Other people providing support include pharmacists, general practitioners, housing facilitators, primary care coordinators, suicide prevention coordinators, and training providers. The workforce also sits across the DHB and the NGO sector. For example, 52% of addiction services are provided by NGOs.

This diverse workforce means there is an array of support options from highly skilled personnel for people with mental health and addiction needs. This includes an increasing number of people working in roles that require a lived experience of mental health and/or addiction issues. There is also growing recognition of the role of other health and social care front line professionals in supporting people with mental health and/or addiction problems

Local initiatives

There are examples of good local programmes of work that are supporting national workforce development. For example, the Mid Central DHB SPHC toolkit for supporting parents who have a mental health and/or addiction problem and their children, that was developed and distributed by Mid Central DHB to DHB, NGO and Primary Health Organisation staff in their area to support implementation of the SPHC guidelines.

A more recent example is the New Zealand Needle Exchange Programme who are supporting their peer support staff to complete the Level 4 Certificate in Health and Wellbeing by offering in house work-based mentoring and support.

We also feel encouraged by workplace wellbeing schemes, for example the cross DHB wellbeingforhealth.nz website.

What's not working well?

Workforce crisis

Based on projected population increases, and the size and average age of the current workforce, the adult mental health and addiction workforce would need to increase by at least nine per cent (estimated 856 FTEs) by 2030 to meet current service demand. These projections do not take into account the aging workforce and assume that the current workforce and service delivery is meeting current consumer demand. However, policy direction signals that there are likely to be substantial changes to how and where services are delivered, therefore a much larger increase in workforce is likely to be required (Te Pou o Te Whakaaro Nui, 2015).

The vacancy rate in adult mental health and addiction services was 8% in 2014. Vacancy rates for infant, child and adolescent services are increasing – from 6% to 8% between 2014 and 2016. Vacancies in DHB adult services in 2016 were largely for clinical roles (nurses, psychologists, psychiatrists, and social workers). Overall, DHB mental health and addiction employees had an FTE turnover rate of 12% for the year ended 30 June 2017 (similar to all DHB employees of 11%). Infant, child, and adolescent mental health and addiction services had an annual turnover of 16% (mainly for clinicians), which was higher in NGOs (28%) compared to DHBs (13%) (Te Pou o Te Whakaaro Nui, 2015).

We also have an aging population. The average age of DHB mental health and addiction staff is just over 48 years of age. Half of employees were aged over 50 years of age, 36% are over 55 and 20% are over 60. (Te Pou o Te Whakaaro Nui, 2017).

These workforce planning, recruitment and retention concerns signal a mental health and addiction workforce crisis is looming, and that substantial investment must be made to incentivise people to enter and remain in these specialist workforces. Workforce strategies must also focus on workforce planning across services at regional and local levels and be long term to provide certainty to the sector. The evidence on this looming crisis has been presented to Health Workforce New Zealand and the Ministry of Health by Te Pou for a number of years.

While training is a core workforce development tool, further investment needs to be made to support training implementation, and a range of other complementary workforce development initiatives. For example, investing in workforce initiatives that focus on infrastructure and organisational change, as well as other innovative workforce practice that make the most of the limited workforce resource available. Where workforce strategies are implemented, those whose responsibility it is to implement them need to be held to account for their success. For example, DHBs should be required to do workforce planning as part of District Annual Plans. This could be supported with technical advice from Te Pou. Having an emphasis on the need for strategic workforce planning to support any service planning is essential to bring about the required workforce and practice change. For more information about evidence-based workforce planning and development please see here.

Currently there are a range of ways for registered health professionals to access funding through Health Workforce New Zealand and DHBs for post clinical training such as new entry to specialist practice (mental health and addiction) and new entry to practice (other nursing fields), psychiatry and psychology. It would assist with future workforce planning and development for all of this funding to sit in one area. Currently there is not one central place that captures funding or outcomes of training for post clinical training. By having funding sitting in one centralised place, it would also provide an opportunity to ensure evidence-based funding processes are used, and the ability to track training outcomes more cohesively across the sector.

Workforce wellbeing

In the recent addiction worker wellness survey by Matua Raki, 46% of respondents reported a high caseload, 56% reported spending 1-10 hours more a week at work than contracted, 57% reported being understaffed, 53% reported having a stressful job and 13% report being regularly bullied or intimidated. Research suggests New Zealand's mental health nurses are frequently subjected to abuse and violence from people accessing services (Baby & Carlyle, 2014). Similarly, new graduate nurses working across the health sector frequently experience violence from either colleagues or people accessing services (McKenna et al., 2003ab).

Recent studies indicate bullying is prevalent among workers in the medical profession generally. Up to half of those surveyed by the New Zealand Medical Association reported experiences of bullying (World

Federation for Mental Health, 2017). The extent of bullying within New Zealand is reinforced by a 2017 survey of senior doctors and dentists (Association of Salaried Medical Specialists, 2017). More than one-third (37 per cent) reported being bullied, and over two-thirds (68 per cent) witnessing colleagues being bullied. Much of the bullying was between medical colleagues. Other senior medical staff were frequently cited as perpetrators (53 per cent overall), followed by non-clinical managers (32 per cent), and people in clinical leadership positions (25 per cent). Similarly, new graduate nurses working across the health sector frequently experience violence from either colleagues or people accessing services (McKenna et al., 2003ab).

Secondary traumatic stress, vicarious stress, or occupational burnout experienced by mental health and addiction workers have been shown to adversely impact on their wellbeing and interpersonal relationships, along with service delivery, treatment outcomes, and satisfaction amongst people accessing services (Byron et al., 2015; Bateman, Henderson, & Kezelman, 2013; Evans & Coccoma, 2014). Vicarious trauma not only affects health workers personally but can impact on relationships with other professionals, and significant others (Baby & Carlyle, 2014; Pack, 2013). The negative impact of vicarious trauma can include overextending, overindulging, avoiding situations, absenteeism, substance use, self-criticism, and experiencing intrusive thoughts (Rakei, 2016). A New Zealand study revealed mental health nurses felt unprepared for the possible negative impacts of trauma on themselves, such as vicarious traumatisation (Davies, 2009). Davies found caring-induced trauma often led to mental health nurses leaving the profession altogether, especially when they did not understand what was happening to them. We also know that that organisational systems can increase the risk of vicarious trauma among the workforce. We advocate for a national strategy that focuses on organisational and self-care of the mental health and addiction workforce; our biggest asset. Such a strategy is also likely to have positive impact on recruitment and retention into the mental and addiction sector.

Lack of agile systems

The current mental health and addiction system, especially that which sits within DHBs can produce barriers to transformative change. The mental health and addiction sector needs to be risk aware but also transformative, innovative, agile and responsive to community need and ongoing change. These services need to be co-designed and co-produced alongside those people likely to access and use the services, so they are focused on the needs of people and their whānau rather than the needs of the service.

Currently many services often have long wait lists, and response time can be slow, and when provided can be difficult to navigate. We need easy to access, crisis and low threshold services that are provided in the community and within people's own homes.

Non-government organisations, if adequately funded, may be more able to avoid the strict and rigid processes of larger government organisations. This may allow them, to be flexible and adaptable to implement workforce initiatives and in turn meet the needs of their communities. For example, systems that can respond to people, family and whānau experiencing co-existing mental health, addiction, disability and physical health problems will require systems and a workforce that can flex and innovate to meet need, rather than provide siloed organisation centred departmentalised services.

NGOs should be able to provide secondary mental health services with adequate funding models. This can only occur with independent third-party funding models, not the current situation of DHBs funding their own provider arm and external NGOs.

This type of transformative systems change will require focused and evidenced based workforce planning and development, so organisations and the workforce have the capability to provide the required agility and meaningful choices for communities who could choose the provider they wish to have support from. Changes to personalised budgets in the disability sector could be piloted in mental health and addictions. These types of options enable real choice for consumers and whānau.

Support for Leadership

Leadership in the mental health and addiction sector is critical. We need to understand and address the workforce needs of the leaders in the sector, because we know that the more capable the leader, the more potential there is for successful implementation and change. We need to focus on building and growing Māori, Pasifika and peer leadership. We need to nurture current leadership, and incentivise and support new and emerging leaders. We would like to see an in depth stocktake on the current capability of those in leadership positions, and a workforce strategy that focusses on building leadership capability and capacity at all levels of practice, including governance. This is critical for implementation of any new strategy.

What could be done better?

Values informed practice

There has been increasing recognition worldwide of the significance of values in the provision of healthcare, and in particular in mental health and addiction services. Values significantly influence and impact, both people accessing health services, as well as those working within services. Prioritising people's values also enables services to be more fully 'person-centred', with people and whānau who access services at the centre of the picture (Fulford, 2010). In these ways, values have a direct influence on the effectiveness and responsiveness (or otherwise) of mental health and addiction services.

Let's get real is a framework that describes the knowledge, skills, values and attitudes for people working with those experiencing mental health and addiction problems. In the recent work Te Pou has done on the *Let's get real* refresh we continue to hear that values and attitudes that underpin this framework are still at the heart of what we do, but that we still need to be doing this better.

Values informed practice involves two things.

- Recognising the impact of values – including the values of people accessing services, practitioners and organisations.
- Understanding how to work with values more effectively for better outcomes.

Simply put, values informed practice is about recognising values and understanding how to work with them. The ultimate aim of bringing values to the fore is to enable better ways of working and better outcomes for people accessing services, their whānau and for people working in services (Te Pou o te Whakaaro Nui, 2017).

The values informed practice that underpins the *Let's Get Real* framework supports the knowledge and skills that are also required for people with mental health and addiction problems. There are seven Real Skills for the mental health and addiction workforce. Each skill can be achieved at an essential, practitioner, or leader level.

1. Working with service users
2. Working with Māori
3. Working with family/whānau
4. Working within communities
5. Challenging stigma and discrimination

6. Law, policy and practice
7. Professional and personal development

Let's get real provides a context for consistent application of values, attitudes, knowledge and skills, which otherwise can be applied variably across services and around the country.

Responding to disabled people and taking a human rights approach to working with co-existing issues

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recognises that disability as an evolving concept and arises from the interaction between the person with an impairment and attitudinal and environmental barriers that hinder full and effective participation in society on an equal basis with others.

Its purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity. The rights enshrined in the UNCRPD apply to people who have long term physical, mental, intellectual or sensory impairments. All people experiencing distress and seeking support are entitled to the enjoyment of all rights described in the UNCRPD, but there are some specific barriers that people with other impairments face. People with an intellectual impairment or neurodiversity such as autism may be subject to diagnostic overshadowing and be at greater risk of restrictive practice. Miscommunication, misunderstanding, misdiagnosis and inappropriate environments and responses can also arise for Deaf people due to a lack of New Zealand Sign Language interpreting and capability within the workforce.

Taking a human rights centred approach to workforce initiatives for working with co-existing issues[2] would be an effective way to:

- break down funding and professional silos
- promote understanding of the social model of disability and the way in which exclusionary barriers impact on wellbeing
- promote understanding of the right to cultural identity and culturally appropriate support
- promote understanding of right to universal access

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[2] Co-existing issues might include mental health, addiction, physcial health and disability. For example deaf mental health or FASD and problematic subtance use.

focus support on the ultimate outcome of universal access, full citizenship and self-determination for all people experiencing distress.

Kia Noho Rangatira Ai Tātou Human Rights and UNCRPD is a highly effective education programme developed by Te Pou o te Whakaaro Nui and the Disabled Persons Assembly. It is currently available to disability support services but equally applicable and essential to mental health and the wider social and state service sector.

Aotearoa NZ practice and evidence

While there has been some improvement in access to and delivery of culturally responsive services, there is much more that needs to be done to improve the ability of the workforce to provide both culturally and clinically responsive services. Investment into research and evaluation of te ao Māori ways of working with mental health and addiction issues is required, using appropriate methodology, so we develop a body of evidence of effective indigenous models.

We also require a focussed approach to recruitment of people into the workforce from a variety of diverse cultures and backgrounds, to ensure our workforce better reflects the people who access services and can respond to them effectively.

Investment in the peer and lived experience/consumer workforce

The peer workforce plays a vital role in effectively supporting people accessing mental health and addiction services, and their family and whānau. The peer workforce includes all roles that require personal lived experience of addiction and/or mental health problems, for example peer support and consumer advisor roles.

Further investment is required in growing and diversifying the peer workforce, for example to include Deaf peers. This will require a regulatory framework and the development of career pathways. Ongoing evaluation of peer support models and roles within the mental health and addiction system will also help to make sure these roles are embedded, meaningful and respected. Increased participation of peers will in turn positively influence service design and delivery.

Understanding social determinants of health and trauma.

Understanding people, family and whānau in their context is critical to providing services to meet their needs. Currently the mental health and addiction workforce tends to be focussed on psychiatric diagnoses and individual pathology. While this is crucial, there is an increasing need to understand and be able to work with the social determinants of mental health and addiction and/or the impact of trauma; and recognise the importance of family, whānau and social supports in ongoing recovery and wellbeing. This is largly due to the way mental health and addiction professionals are trained and how systems have developed over time. Those involved in mental health and addiction would benefit from interprofessional education and an understanding of each others professional training and expertise. This requires the workforce to be both configured and trained differently.

Working with children, older people, family and whānau

The workforce needs to be able to be more responsive to children, family and whānau. This requires a paradigm shift in the way professionals are trained and how services operate. Family and whānau should be involved in services alongside their family and whānau members, but also need to be offered support and services in their own right. Professionals needs to be trained to work with family and whānau groups. Professionals also need to be more aware of the children and other dependants in the lives of the people they work with and feel comfortable discussing parenting and caring, as well as assessing risk.

The workforce will need increased understanding and skill in working with older people with mental health and addiction problems. There is considerable evidence that with an aging population there will be more problems associated with dementia and other conditions. Currently this is seen as highly specialised work, however there will be an expectation that all the wider workforce has some understanding and skill in this area.

Technology

There will be a need for the workforce to understand and use technology to an increasing degree. Mental health and addiction services have generally been slow to adopt new technolgy but for the workforce to adequately respond to service user needs this will need to change. The workforce will increasingly need to use and work with clinical apps, e-learning and mobile technology. This will require the development of safe standards for the useof this technology, upskilling and considerable workforce development.

The wider workforce and collaboration

Who we consider as the mental health and addiction workforce needs to change. While the specialist workforce and the systems that they work in do require a transformative change, we also need to consider the wider health and social care workforce as part of the workforce who also currently work with people with needs as a result of their mental health and addiction issues. For example GPs, social workers, teachers and probation officers can be considered part of the workforce and need to be trained and upskilled accordingly. There would also need to be a focus on the ability to work collaboratively within and across systems, without the assumption that this be done automatically. Clear guidance, practical models and workforce initiatives that focus on how to collaborate well are required.

Early intervention approaches and talking therapies could be utlised across a range of health and social care professions in order to respond to distress in a timely way prior to the need for more intensive or specialist intervention. The need for this is especially evident in organisations such as Oranga Tamariki, where trauma, mental health and addiction problems are widespread across case loads, but where much or the workforce has little or no knowledge or training in working with these issues.

There would need to be a paradigm shift in the way these health and social care workforces view mental health and addiction, and in the way they are funded. They would need to be given both role adequacy (the ability to respond) and role legitimacy (the belief they have the right to respond).

Te Pou and Matua Raki have already been doing some of this work, for example with the provision of *MH101*, *Addiction 101 and Screening and Brief Intervention* workshops across a range of private and public community organisations. These workshops provide, education, insight and brief ways of responding to people presenting with mental health and/or addiction problems in front line health and social care environments. The recent refresh of ***Let's get real*** has also focussed on this, with the framework now applicable across the whole of the health sector. It supports health professionals to meet the needs of people with mental health and addiction issues wherever they present in the health system.

The *Mental Health and Disability Support Service Interface Project* developed by the South Island Shared Services Agency and the Ministry of Health identified a range of policy, process, and funding solutions to address the lack of integration between these services. For example, flexible funding, integrated approaches across special education, health, accessible services (some not physically accessible) including removing any skill or attitudinal barriers.

To this end, some specific workforce solutions included:

- development of qualifications, other training and online tools, focussed on co-existing issues
- glossary of language for both sectors
- psychiatric registrars to have disability placements
- advocate for a chair/Professorship in co-existing issues in academic institutions
- improve behaviour support skill holistically across education, whānau, health and disability.

Unfortunately personnel and resource changes meant none of the suggestions were pursued. We highly recomend that these workforce soultions be revisited.

What sort of society would be best for the mental health of all of our people?

Recovery lives in the community and requires an approach that works to increase recovery capital[3] for individuals, families and whānau. We believe that mental health and addiction are everybody's business and therefore we all have a responsibility for one another. We require a community approach to health and wellness with a focus on the needs of individuals, families and whānau, and a workforce development approach that includes both specialist workforces, and a variety of health and social care workers on the frontline. Reducing stigma, shame and discrimination so people experiencing mental health and addiction are supported in the community rather than excluded and ostracised is paramount.

Anything else you want to tell us?

Any and all changes made to the mental health and addiction system as a result of this inquiry will require a long-term vision. Transformative change will not happen immediately and continued, guaranteed and ringfenced investment in this area will be required for at least 15-20 years. This investment must be for both mental health AND addiction and must include a specific and targeted approach to workforce planning and development.

Investment in this area now is likely to lead to substantial savings across a range of government agencies in the long term (for example Corrections, Oranga Tamariki and general health) as we know the impact of unsupported mental health and addiction problems can have across a range of areas. Investment in this area should also improve the lives of children, individuals, families and whānau across the country if the investment strategy focuses on equity; that is with a focus on supporting fair access, fair chances and fair resource distribution to alleviate any disadvantage experienced by at-risk or vulnerable groups.

Te Pou o te Whakaaro Nui and Matua Ra<u>k</u>i are well equipped to support the process of transformative change that is required, with a focus on building the capability and capacity of the mental health and addiction workforces, as well as other front-line workers in health and social care.

3'Recovery capital' refers to the internal and external resources necessary to make change. Recovery capital recognises that a variety of elements can support or jeopardise 'recovery'; these include social networks, physical, human, cultural and community issues. Recovery capital differs from individual to individual and whānau to whānau and may change over time.