Developing sustainable interprofessional practice in mental health and addiction services

A brief literature review
July 2019
Acknowledgements

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Executive Summary

The World Health Organization (WHO) recommend interprofessional education and collaborative practice in health systems to address the growing shortage of health workers and to better manage people’s unmet health needs (WHO, 2010). This is call to action is relevant for New Zealand, as the mental health and addiction workforce is ageing and expanding at a slower rate than the population (Te Pou o te Whakaaro Nui, 2015, 2019). Building a mental health and addiction workforce that is more integrated and connected is in line with He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (Government Inquiry into Mental Health and Addiction, 2018) and the Mental Health and Addiction Workforce Action Plan 2017-2021 (Ministry of Health, 2017).

This literature review was undertaken to provide information about how interprofessional practice is currently being implemented nationally and internationally for the purpose of informing the sustainable development of this approach in New Zealand mental health and addiction services.

Key objectives included developing a better understanding of:

1. definitions used to describe interprofessional practice and education and how they are implemented, including the benefits, enablers and barriers
2. activities currently being undertaken nationally and internationally to promote the sustainable development of interprofessional practice across various health settings
3. future activities needed to enable the sustainable development of interprofessional practice in New Zealand’s mental health and addiction services.

Interprofessional practice

Interprofessional practice is a type of collaboration between health workers from different professional disciplines. This involves both clinical and non-clinical health roles working together to make shared decisions and provide care (WHO, 2010). In New Zealand, interprofessional practice has been defined by the National Centre for Interprofessional Education and Collaborative Practice (NCIPECP, part of Auckland University of Technology) as:

When all members of the health service delivery team participate in the team’s activities and rely on one another to accomplish common goals and improve health care delivery, thus improving [people’s] quality experience. IPP [interprofessional practice] is enhanced when it is supported by interprofessional learning experiences. (NCIPECP, n.d)

Substance Abuse and Mental Health Services Administration (SAMHSA) have emphasised the importance of interprofessional collaboration between the mental health, addiction and primary health workforces (including general practitioners and practice nurses) (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). In mental health settings, interprofessional teams may consist of people from medicine, nursing, allied health (including psychologists and social workers) and support work (including peer workers) (Victorian Mental Health Interprofessional Leadership Network, n.d).
What is involved in implementing interprofessional practice?

Collaboration is a key component of interprofessional practice. The WHO describe a collaborative-ready worker as “someone who has learned how to work in an interprofessional team and is competent to do so” (WHO, 2010, p. 7). An important component in preparing health workers for collaborative practice is known as interprofessional education. Interprofessional education “occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” and is shaped by mechanisms related to the education providers and curricula (WHO, 2010, p. 13).

For interprofessional knowledge and skills to transfer into practice settings, a whole-of-system approach is required that focuses on organisational and leadership support, and working culture and environment (WHO, 2010). Research highlights the importance of organisational factors such as partnership with people, whānau, and consumer roles; values and attitudes; shared leadership; champions; co-location or proximity; and structure of the team. New Zealand stories of interprofessional practice (Flood, 2017) describe successful teams as having:

- shared goals of addressing the needs of the person and delivering the best service possible
- mutual respect and trust in the expertise of each team member
- openness and flexibility in sharing roles and activities
- awareness of own professional limitations and strengths of other team members
- opportunities for face-to-face genuine dialogue
- opportunities to develop relationships between team members.

What are the benefits of interprofessional practice?

In practice settings, working in interprofessional teams can positively influence mental health workers’ participation in decision making, knowledge integration, mutual trust, team commitment, professional diversity, organisational culture and job satisfaction (Körner, Wirtz, Bengel, & Göritz, 2015; Ndibu Muntu Keba Kebe, Chiocchio, Bamvita, & Fleury, 2019a). Compared to conventional training, research shows interprofessional education for undergraduate students has a greater influence on knowledge and skills related to collaborative practice and positive attitudes towards other professions (Marcussen, Nørgaard, & Arnfred, 2019). For example, interprofessional training for health students that had a focus on substance use has been shown to help improve awareness of substance use problems and interprofessional aspects of management strategies (Brooks, Holm, Thomas, & Rich, 2017; Monteiro et al., 2017).

For people accessing services, interprofessional practice provides holistic support for health and wellbeing, and may help improve social functioning, life satisfaction, and reduce stigma and discrimination (Carpenter, Barnes, Dickinson, & Woot, 2006; Happell et al., 2019; Maranzan, 2016; Tippin, Maranzan, & Mountain, 2016). While the quality of evidence needs to be strengthened using more robust research and evaluation designs, research shows interprofessional education can lead to improved outcomes for people accessing services (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013).
Activities undertaken nationally and internationally to promote the sustainable development of interprofessional practice

Sustainable interprofessional practice requires effective interprofessional education and supporting factors that enhance a whole-of-system approach. Table 1 summarises current activities identified in this literature review, which helps support the sustainable development of interprofessional practice.

In New Zealand, interprofessional practice is supported by national mental health and addiction workforce planning; professional bodies for nursing, social work, psychology and occupational therapy; and district health board services and tertiary education providers. As a result, activities such as education programmes, research, conferences, competencies, and recruitment processes have been developed to support interprofessional collaboration among health workers. For many of these local activities, however, the involvement of mental health and addiction workers is unclear.

Internationally, a wide range of activities are currently utilised to support the development of interprofessional practice. Most notably, education providers in other countries offer specialised interprofessional mental health or social work programmes. The literature shows interprofessional education is also supported by champion roles and networks, professional development for existing health workers, and online resources.

Table 1. Activities that Support the Sustainable Development of Interprofessional Education and Practice in New Zealand and Other Countries

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Recommendations for interprofessional practice in mental health and addiction services

Recommendations for the sustainable development of interprofessional practice in mental health and addiction services are outlined below.

1. Examine the involvement of mental health and addiction professions in interprofessional activities currently available in New Zealand to better understand what improvements or actions are required to support the workforce. This may involve building collaborative relationships between education providers and mental health and addiction services to ensure future students are well-supported to transfer their interprofessional skills to collaborative practice.

2. Increase the amount of interprofessional collaboration activities that involve mental health and addiction students and professionals. In New Zealand mental health and addiction settings, interprofessional education is relevant for people who work in medicine, nursing, allied health (including psychologists and social workers), support work (including peer workers), and cultural and whānau roles or advisory groups. As above, promoting interprofessional practice may involve building collaborative relationships between health services, education providers, and professional bodies.

3. Investigate the cultural and whānau factors that are essential for the culturally effective implementation of interprofessional practice to support New Zealand’s diverse population. This may involve examining the impact of cultural support roles and whānau advisor roles in interprofessional mental health and addiction teams.
Background

The World Health Organization’s (WHO) *Framework for Action on Interprofessional Education and Collaborative Practice* (WHO, 2010) highlights the growing shortage of health workers and need to better manage people’s unmet health needs. The implementation of interprofessional education and collaborative practice in health systems has been recommended as a solution to this widespread issue. The desired outcome is the development of interprofessional teams that “understand how to optimise the skills of their members, share case management and provide better health-services to [people] and the community” (WHO, 2010, p. 10). This *call to action* was aimed at policy-makers, decision makers, educators, health workers, community leaders and global health advocates (WHO, 2010).

The development of interprofessional education and practice is relevant to the context of New Zealand’s mental health and addiction services. New Zealand’s mental health and addiction workforce is ageing and expanding at a slower rate than the population (Te Pou o te Whakaaro Nui, 2015, 2019). It is an estimated an increase of 4,000–5,000 full time equivalent (FTE) workers will be required to maintain the status quo of the secondary mental health and addiction workforce over the next 10 years (Te Pou o te Whakaaro Nui, 2015). Interprofessional practice is key to enabling the transformation of services as recommended in the recent Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, and applies across primary and secondary district health board (DHB) and non-government organisation (NGO) services (Government Inquiry into Mental Health and Addiction, 2018). Sustainable interprofessional practice will help support the Inquiry recommendations around placing people at the centre, transforming primary health care, strengthening the NGO sector, and taking a whole-of-government approach to wellbeing. Prior to the Inquiry, the *Mental Health and Addiction Workforce Action Plan 2017-2021* (Ministry of Health, 2017) recommended the development of “a workforce that is integrated and connected across the continuum” (p. 25). This will involve providing “platforms, such as interprofessional training, to increase understanding of the roles and responsibilities of workforce across the sector” (Ministry of Health, 2017, p. 26).

Aim and objectives

This literature review was undertaken to inform the sustainable development of interprofessional practice in New Zealand mental health and addiction services by providing information about how this approach is currently being implemented nationally and internationally.

Key objectives included developing a better understanding of:

1. definitions used to describe interprofessional education and practice and how they are implemented, including the benefits, enablers and barriers
2. activities currently being undertaken nationally and internationally to promote the sustainable development of interprofessional practice across various health settings
3. future activities needed to enable the sustainable development of interprofessional practice in New Zealand’s mental health and addiction services.
Method

A brief literature scan was undertaken through EBSCO, Google and Google Scholar. Key words included:

- interprofessional practice, interprofessional learning, interprofessional education
- collaborative practice, competencies, capabilities, roles, teams
- health professionals, mental health professionals, addiction.

The search involved literature published since 2008 and included key review articles, highly cited articles, leading professional networks/centres, online resources and information, and conference presentations. Where possible the searches included a focus on New Zealand, Australia, the UK and US. Both quantitative and qualitative studies were included in the review.

Accessible information was obtained and reviewed to identify key factors in relation to each research question. Key findings were discussed in relation to the Getting it right workforce development process (Figure 1), which categorises workforce development activities into five domains (Te Pou o te Whakaaro Nui, 2017b).

![Figure 1. Getting it right workforce development process. Source: Te Pou o te Whakaaro Nui (2017b).](image-url)
Key findings

What is interprofessional practice?

A model of collaboration between health workers

The World Health Organization (WHO, 2010) defined interprofessional collaborative practice as:

> when multiple health workers from different professional backgrounds provide comprehensive services by working with [people], their families, carers and communities to deliver the highest quality of care across settings. (WHO, 2010, p. 13)

Interprofessional practice is a type of collaboration between health workers from different professional disciplines. Collaborative practice is being utilised in health systems to increase consistency in professional practice and improve the quality of health care for people accessing services, see Figure 2. This involves both clinical and non-clinical health-related roles working together to make shared decisions and provide support (WHO, 2010).

![Figure 2. Improving health outcomes via interprofessional collaborative practice with support from health and education systems. Based on the WHO’s Framework for Action on Interprofessional Education and Collaborative Practice (2010, p.18).](image)

In New Zealand, interprofessional practice has been defined by the National Centre for Interprofessional Education and Collaborative Practice (NCIPECP, which is part of Auckland University of Technology) as:

> When all members of the health service delivery team participate in the team’s activities and rely on one another to accomplish common goals and improve health care delivery, thus improving [people’s] quality experience. [Interprofessional practice] is enhanced when it is supported by interprofessional learning experiences. (NCIPECP, n.d)

Interprofessional collaboration is different from *multidisciplinary* and *interdisciplinary* models of collaboration. Interprofessional teams are expected to communicate frequently and work together to share decision-making and provision of care for people accessing services, see Figure 3. Interprofessional practice focuses on integrating professional practice, while *interdisciplinary* collaboration focuses on the integration of knowledge and may lead to the development of new disciplinary areas (D’Amour & Oandasan, 2005). Whereas *multidisciplinary* teams consist of
professionals from different disciplines who often “work in silos” and make decisions specific to their own area of care (Gougeon, Johnson, & Morse, 2017; Körner, 2010).

![Diagram of Interprofessional and Multidisciplinary Teams](image)

**Figure 3.** Decision-making and provision of support within interprofessional teams and multidisciplinary teams in health services.

Substance Abuse and Mental Health Services Administration (SAMHSA) have emphasised the importance of interprofessional collaboration between the mental health, addiction and primary health workforces (including general practitioners and practice nurses) (Hoge et al., 2014). Interprofessional mental health and addiction teams may consist of people from medicine, nursing, allied health (including psychologists and social workers) and support work (including peer workers). In Australia, this type of interprofessional team has been implemented by the Victorian Department of Health and Human Services (Victorian Mental Health Interprofessional Leadership Network, n.d).

**Developing a “collaborative practice-ready” health workforce**

The WHO has described a collaborative-ready worker as “someone who has learned how to work in an interprofessional team and is competent to do so” (WHO, 2010, p. 7). Interprofessional education is the critical component needed to prepare health workers, and “occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (WHO, 2010, p. 13).¹ This is different from traditional health education which often focuses on preparing workers for specific professions, such as medicine, nursing, allied health, or social work. Interprofessional training has been found to have a positive impact on students’ self-reported readiness for interprofessional collaboration in mental health settings (Marcussen, Nørgaard, Borgnakke, & Arnfred, 2019).

¹ In addition, the term ‘interprofessional learning’ is used to encompass interprofessional education and interprofessional practice as a philosophical stance (National Centre for Interprofessional Education and Collaborative Practice, n.d).
Mechanisms that shape interprofessional education

New Zealand was part of an international environmental scan undertaken by WHO to determine the status and best practices in interprofessional education. The scan indicated nearly one-quarter of training in interprofessional education was provided by universities (WHO, 2010). Other common training providers included teaching teams/interprofessional education committees (19 per cent) and health professionals or therapists (12 per cent).

The WHO’s environment scan identified key educator and curricular mechanisms that shape interprofessional education (WHO, 2010, p. 24).

- **Educator mechanisms** involve the roles of policy-makers, managers, educators, and curriculum developers. Sustaining interprofessional education requires:
  - supportive institutional policies
  - managerial commitment and worker enthusiasm
  - champions to coordinate education activities
  - shared vision and understanding of the new curricula
  - identifying and eliminating barriers to progress.

- **Curricular mechanisms** involve the structure of the learning and assessment. Effective interprofessional education requires:
  - willingness to update, renew and revise existing curricula
  - willingness to change the culture and attitudes of health workers
  - well-constructed learning outcomes
  - applying principles of adult learning and learning methods that reflect real-world practice
  - encouraging interaction between participants
  - identifying and reducing logistical challenges and other barriers for participants.

Promoting participation in interprofessional education involves support from both health and education systems. Australian university perspectives identified the following barriers and challenges to enhancing interprofessional learning and preparing students for multidisciplinary mental health placements (Morrissey et al., 2011):

- insufficient support (financial and administrative) and resources from universities to encourage cross-disciplinary education
- insufficient support from schools (psychology, nursing, medicine, social work etc.)
- insufficient support from professional accreditation bodies
- curriculum crowding and rigidity
- lack of incentives
- faculty attitudes
- absence of clear guidelines, philosophical underpinnings, and suitable curriculum approaches.
Similarly, clinical perspectives highlighted barriers around perceived lack of support within universities and insufficient preparation of students (Morrissey et al., 2011). The importance of services being involved in interprofessional education initiatives and formal evaluation of these initiatives were also emphasised by clinical perspectives (Morrissey et al., 2011).

**Competency frameworks**

Competency frameworks have been developed to guide the implementation of interprofessional education and curricula (see Appendix for a list of example frameworks). This includes SAMHSA’s *Core Competencies for Integrated Behavioral Health and Primary Care* (Hoge et al., 2014). SAMHSA’s competency framework emphasised that working in interprofessional teams involves finding a common language and having an integrated set of competencies across disciplines (Hoge et al., 2014).

The WHO study group identified and examined 88 documents related to learning outcomes, competencies, capabilities and assessments (Thistlethwaite & Moran, 2010). Internationally, competency and capability frameworks often consist of the following six core themes.

- **Teamwork**, such as knowledge and skills about sharing goals, accountability, team dynamics and meetings.
- **Roles/responsibilities**, such as knowledge and understanding of different roles, professional boundaries, philosophies of care, and the health system.
- **Communication**, such as shared decision-making, negotiation, conflict resolution, handover, and awareness of different discipline languages.
- **Learning/reflection**, such as transferring learning to clinical settings, identifying future learning needs, and reflecting critically on team relationships.
- **Person-centred care**, such as understanding the person’s perspective, safety issues, and developing partnerships.
- **Ethics/attitudes**, such as respecting the views and ideas of other professionals, understanding ethical issues, and ability to cope with misunderstandings.

There is a need for more competency frameworks that can help guide interprofessional collaboration across a broader range of practice areas. For example, Hilty and colleagues (2017) found different health disciplines varied in e-therapy competencies, suggesting there is a need for a new competency framework that can support a wider scope of practice to enable interprofessional collaboration in e-mental health.

**What is involved in implementing interprofessional practice?**

In practice settings, interprofessional collaborative practice is shaped by mechanisms related to institutional support, working culture and environment (WHO, 2010). These mechanisms, outlined below, help to support the transfer of knowledge and skills from interprofessional education into practice settings, and ensure the goals of health workers and needs of people accessing services are met (WHO, 2010).
• **Institutional support** includes:
  o governance models and structured protocols to support collaborative practice and shared responsibility
  o personnel policies that recognise collaborative practice and equitable remuneration
  o shared operating resources
  o supportive management practices.

• **Supportive working culture** includes:
  o opportunities for sharing ideas and decision-making
  o routine meetings and regular communication between team and community members
  o conflict resolution policies
  o structured information systems
  o effective communication strategies.

• **Environmental support** includes physical space design (eg. the arrangement of resources and equipment), facilities and built spaces to help facilitate communication and enhance collaborative practice.

Similarly, recent case studies involving local mental health service networks in Quebec, Canada found interprofessional collaboration in mental health teams is strengthened by the following supporting factors (Ndibu Muntu Keba Kebe, Chiocchio, Bamvita, & Fleury, 2019b):

• positive team climate
• knowledge sharing and knowledge integration
• professional and team identification
• team commitment
• team autonomy.

**What are the benefits of interprofessional education and practice?**

**Health workers**

Overall, the effectiveness of interprofessional education and practice is still under investigation, due to the need for more ‘good quality’ research (Reeves, Boet, Zierler, & Kitto, 2015; Reeves et al., 2016; Reeves et al., 2010). A systematic review found interprofessional education has a greater influence on knowledge and skills related to collaborative practice and positive attitudes towards other professions compared to conventional training in mental health for undergraduate healthcare students (Marcussen, Nørgaard, & Arnfred, 2019). As shown in Figure 4, several studies have found interprofessional education positively impacts on health students’ perceptions and attitudes; knowledge and skills; behavioural change; and organisational practice (Reeves et al., 2016).
When interprofessional collaboration occurs in the workplace, it can positively influence mental health workers’ participation in decision making, knowledge integration, mutual trust, commitment to the team, professional diversity, organisational culture and job satisfaction (Körner et al., 2015; Ndibu Muntu Keba Kebe et al., 2019a).

**People accessing services**

Whilst the quality of evidence needs to be strengthened using better research and evaluation designs, studies show interprofessional education can lead to improved outcomes for people accessing services (Reeves et al., 2013). Interprofessional support in community mental health services can help improve people’s social functioning, life satisfaction, and symptoms compared to pre-treatment (Carpenter et al., 2006; Tippin et al., 2016). Interprofessional collaboration involving a range of health professionals is desired by people who experience mental health problems who seek holistic care for physical health and wellbeing (Happell et al., 2019). There have been suggestions that interprofessional practice may also have the potential to reduce stigma and discrimination for people with mental health and addiction problems, and support shared care models (Maranzan, 2016).

**What types of activities are currently being undertaken nationally and internationally to promote the sustainable development of interprofessional practice?**

Activities supporting the sustainable development of interprofessional practice are outlined in this section in relation to the five domains of workforce planning and development: workforce development infrastructure; organisational development; learning and development; recruitment and retention; and information, research and evaluation.
Workforce planning

Support for interprofessional practice through workforce planning

In New Zealand, there has been support for interprofessional practice in workforce planning at both national and DHB levels. Nationally, the Mental Health and Addiction Workforce Action Plan 2017-2021 (Ministry of Health, 2017) supports the development of collaborative practice and provision of interprofessional education.

There is also support for interprofessional education and practice in DHB-level workforce plans. For example, the Waitematā DHB Workforce Strategy 2012-2016 (Waitemata DHB, 2012) highlighted the role of interprofessional education in improving responses to people with long term health problems. 

Our focus in this workforce development plan must be on reforming and reshaping the training of the next generation of health care providers as well as refocusing current health care planning on excellent interprofessional, community based responses to long term conditions. (Waitemata DHB, 2012, p. 26)

Workforce development infrastructure

Support from professional bodies and networks

In New Zealand, professional bodies relevant to mental health and addiction have promoted the implementation of interprofessional education and collaborative practice. For example, the Nursing Council of New Zealand’s standards recommend the inclusion of interprofessional competencies in nursing education programmes and curricula.

Interprofessional health care and quality improvement: co-ordination of health consumer care within the health care team including discharge planning, interprofessional collaboration and communication; advocacy for the nursing contribution; respect for all members of the health care team; quality improvement and research activities; leadership; teaching and mentoring within the team. (Nursing Council of New Zealand, 2010, p. 7)

The New Zealand Psychological Society have outlined a position statement for workforce development, which includes “recognition of the contribution that psychologists can make to interprofessional delivery of services especially in conjunction with general practice” (The New Zealand Psychological Society, n.d). Similarly, Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa (2012) published a position statement supporting the WHO’s call to action for interprofessional education and practice.

In other countries, interprofessional education and practice are supported by professional associations or networks, such as Australasian Interprofessional Practice and Education Network (AIPPEN) and Canadian Interprofessional Health Collaborative (CIHC). More examples of interprofessional associations in other countries are outlined in the Appendix. In New Zealand, this type of support is currently provided by the National Centre for Interprofessional Education and Collaborative Practice, which aims to lead, facilitate and promote collaborative practice, education and research (NCIPECP, n.d).

**Organisational development**

**Organisational support and team structure**

Sustainable interprofessional practice involves a shift from the traditional hierarchy structure to a shared leadership approach. Thus, organisations need to be willing and committed towards new ways of working. Health professionals indicate interprofessional teams need to be supported by the organisational vision, and require designated time for meetings and reflection, use of technology, and a good understanding and navigation of the health system (North West Local Health Integration Network, 2009). For example, the uptake of interprofessional practice in community mental health settings can be constrained by limited involvement of medical professionals and senior management in organisational support (Reeves et al., 2006).

In New Zealand, local stories of interprofessional practice from a range of health professionals (Flood, 2017) indicate organisations need to support interprofessional teams by:

- establishing a shared vision and expectation for interprofessional practice
- undertaking intentional workforce development and funding for interprofessional practice
- providing designated time, physical space and travel expenses for teams to have face-to-face meetings
- including interprofessional knowledge and skills in recruitment strategies
- helping teams to manage external forces or demands that favour professions working in silos.

Research shows team location and physical environment can impact on interprofessional collaboration. Karam and colleagues (2018) examined interprofessional collaboration within the same organisation compared to inter-organisational collaboration. Health professionals’ indicated collaboration across organisations faced greater challenges, including establishing a sense of belonging among professionals working in different organisational cultures; geographical distance; the multitude of processes; and the need to formalise roles, responsibilities and channels of communication (Karam et al., 2018). Co-location of youth mental health teams was associated with positive perceptions of interprofessional practice, as it makes specialised resources more easily accessible and enables team members to be in frequent contact with each other (Rousseau, Pontbriand, Nadeau, & Johnson-Lafleur, 2017).
Team structure and effective communication are important components of interprofessional practice. New Zealand-based stories of interprofessional practice (Flood, 2017) describe successful teams as having:

- shared goals of addressing the needs of the person and delivering the best service possible
- mutual respect and trust in the expertise of each team member
- openness and flexibility in sharing roles and activities
- awareness of own professional limitations and strengths of other team members
- opportunities for face-to-face genuine dialogue
- opportunities to develop relationships between team members.

Team members value having face-to-face time with the person accessing services, as well as being in close proximity with other team members (Flood, 2017).

When I originally started work here, the social workers had separate offices. We have had changes and all the rehab wards now have an interdisciplinary model of working. We have moved into an interdisciplinary office with the other disciplines and everybody sits together and I find that it’s much more conducive to working as an interdisciplinary team. Because there are those casual conversations about a client that just happen during the day. Discussions with the occupational therapists for example about ‘What’s happening with their weekend leave?’; ‘Is there equipment?’; ‘Where are they going to go?’; and it works much better now we’re sharing the same office. We get to know the OTs [occupational therapists], physios and other[s] better because we share the lunch room as well. It would probably be beneficial if we all had a shared lunch area. – Social worker perspective from Flood (2017, p. 164)

Teams are perceived to be working well when they understand each other’s role and skills, and are able to share responsibilities within reasonable scope (Flood, 2017).

Although we had set roles within the team, there was also a lot of crossover of our roles. We reached a point over a period of time where our roles were quite interchangeable... So for example the physiotherapist wouldn’t necessarily make recommendations about medications, that was perhaps more of what I do, however there came a point where she felt comfortable having talked to me so many times around this issue, to give certain advice to [people]. She would always communicate and check with me that the advice she was giving was right and we would communicate that way around... There’s not really any reason why these things couldn’t be shared if we support and learn from each other. Ultimately we want the best for the [person] so we don’t have to be too precious about these kinds of things. – Nursing perspective from Flood (2017, p. 162)
Partnerships with people and whānau

Barnes, Carpenter, and Bailey (2000, p. 199) state “the ultimate goal of interprofessional education must be the empowerment of [people]”. Their study showed partnerships with people who access services can add value to interprofessional education and practice as key stakeholders (Barnes et al., 2000). Moreover, partnerships with people who access services during clinical placements were perceived by students as a valued experience, which helps to improve their knowledge and attitudes about people who experience mental health problems (Carpenter et al., 2006).

Similarly, the Victorian Mental Health Interprofessional Leadership Network’s (VMHILN’s) approach to interprofessional mental health teams highlights the importance of having a team member with lived experience of mental health and addiction problems, such as peer support workers (Victorian Mental Health Interprofessional Leadership Network, n.d). Involvement of peer leaders and peer support workers as part of interprofessional practice can help support the co-design, co-facilitation and evaluation of education programmes, and recruitment interviewing.

Shared leadership

Committed and consistent leadership is a critical component in the implementation of health initiatives and programmes (Damschroder et al., 2009). The characteristics and actions of effective leadership in interprofessional health and social care teams were identified in a review by Smith and colleagues (2018), these are shown in Table 2.

Table 2. The Characteristics and Actions of Shared Leadership in Effective Interprofessional Teams. Source: Smith et al. (2018)

<table>
<thead>
<tr>
<th>Characteristics and actions of shared leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate shared leadership</td>
</tr>
<tr>
<td>Team-building and clear expectations</td>
</tr>
<tr>
<td>Support transformation and change</td>
</tr>
<tr>
<td>Ensure leadership clarity</td>
</tr>
<tr>
<td>Personal qualities and commitment</td>
</tr>
<tr>
<td>Direction setting and coordination</td>
</tr>
<tr>
<td>Goal alignment and provide feedback</td>
</tr>
<tr>
<td>Support external liaison</td>
</tr>
<tr>
<td>Support creativity and innovation</td>
</tr>
<tr>
<td>Ensure skill mix and diversity</td>
</tr>
<tr>
<td>Facilitate clear communication</td>
</tr>
<tr>
<td>Ensure clinical and contextual expertise</td>
</tr>
</tbody>
</table>

The literature describes new types of frameworks or leadership structures associated with interprofessional learning. In contrast to traditional leaderships models based on formal hierarchies, leadership within interprofessional teams and relationships is distributed among health professionals providing multiple sources of influence (Anonson et al., 2009; Dow, Appelbaum, & DiazGranados, 2015). Therefore, shared leadership is an essential part of effective collaboration (Anonson et al., 2009). In practice, shared leadership is dynamic; where team members provide leadership and respond to leadership from one another. This dynamic leadership depends on the needs of the person accessing the service and the profession that can best meet these needs. For example, physicians are likely to be the leader or key decision maker in emergency situations (Dow et al., 2015).
There has to be leadership but it doesn’t necessarily have to be one individual . . . it has to be who’s the best leader for the situation with the [person], and that’s [person]-focused care. . . . In every situation, there’s always someone who should be in charge, who knows more than anyone else (to deal with the [person’s] need). (Anonson et al., 2009, p. 21)

There’s no one designated leader, so that their decision making is shared and each profession makes decisions in consultation with the others but within the context of their scope of practice. (Anonson et al., 2009, p. 21)

**Champions in education programmes**

Interprofessional education benefits from supportive organisational leaders and establishment of champions. Since educators or trainers come from different professions, champion roles help to ensure the curricula is well-coordinated and reflects the learning needs of students. For example, the University of Nottingham’s Division of Nursing implemented interprofessional learning to support student clinical placements (Kelley & Aston, 2011). This involved the establishment of practice learning teams responsible for providing specialist learning clinical environments, and teams that were co-ordinated by a project or education lead and a champion to support sustainable interprofessional learning (Kelley & Aston, 2011).³ The University of Nottingham’s Division of Nursing also found shared leadership and accountability within learning teams can help to overcome the loss of a champion (Kelley & Aston, 2011).

Similarly, the University of Otago has established a ‘Champion Network’ to support learning (O’Brien, Pullon, & Skinner, 2015). This involves representatives from different professions taking leadership in developing and implementing opportunities for collaboration. Champions help to ensure local learning needs are met across the university’s campuses and the programme reflects interprofessional principles (O’Brien et al., 2015).

**Values and attitudes**

Interprofessional education programmes can positively influence students’ perceptions and attitudes towards interprofessional learning and teams (Darlow et al., 2015; Reeves et al., 2016). Collaboration is a key component of interprofessional practice, and Figure 5 illustrates the values and behaviours required to support collaborative practices (Te Pou o te Whakaaro Nui, 2018a).

In New Zealand, *Let’s get real: Real Skills for working with people and whānau with mental health and addiction needs* outlines the essential values, attitudes, knowledge and skills required to deliver effective services in partnership with people who have mental health and addiction needs (Te Pou o te Whakaaro Nui & Ministry of Health, 2018). The refreshed *Let’s get real* framework supports interprofessional collaboration and is relevant to all health workers across different settings (Te Pou o te Whakaaro Nui, 2018b). Values, attitudes, knowledge and skills can be utilised to map professional roles to specific workforce tasks, this is demonstrated in Figure 6 (Te Pou o te Whakaaro

³ The residential mental health teams consist of nurses, occupational therapists, clinical psychologists and workers in housing associations.
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Nui, 2017a). This helps identify and outline the different types of professional roles who have similar capabilities to undertake the same tasks.

**Figure 5.** Collaborative health workers’ values and behaviours. Source: Te Pou o te Whakaaro Nui (2018a).

**Figure 6.** An example of task analysis for future workforce requirements, adapted from Australian Public Service Commission (Te Pou o te Whakaaro Nui, 2017a).
Learning and development

New Zealand education providers

As mentioned above, an international scan found that nearly one-quarter of interprofessional education was provided by universities (WHO, 2010). In New Zealand, interprofessional education curricula or programmes are offered by tertiary education providers, including the University of Otago, Auckland University of Technology, University of Auckland, Whitireia and Wintec. However, information about the participation of mental health and addiction workers is limited, and there is a need to better understand whether these programmes have been adapted for students or professionals in mental health and addiction.

The Division of Health Sciences at the University of Otago has a strategic vision to become a national leader in interprofessional education in New Zealand (Division of Health Sciences - Centre for Interprofessional Education, 2017). Their approach to interprofessional education for health professional students is shown in Figure 7. The strategic approach shows the complexity of collaborative activities increases throughout the education programme; starting from minimal levels of interprofessional interaction between students to planned interactive activities or placements.

![Figure 7. The Division of Health Sciences (University of Otago) approach to interprofessional education. Source: O’Brien et al. (2015).](image-url)
The university’s Wellington campus has been offering an interprofessional education programme since 2011, which has expanded over time. In 2014, most of their participating students were from medicine, radiation therapy, dietetics and physiotherapy (Darlow et al., 2016). An evaluation found students who participated in the programme had better attitudes towards interprofessional learning and teams compared to students who had undertaken a discipline specific curriculum (Darlow et al., 2015). The students perceived the programme content as having long-term professional benefits and direct relevance to their future careers (Darlow et al., 2016). Opportunities for improvement identified by students included a stronger focus on student-led opportunities to learn about and interact with each other (Darlow et al., 2016), which further highlights the importance of face-to-face communication within teams.

Auckland University of Technology’s NCIPECP and School of Interprofessional Health Studies also focuses on providing research and learning opportunities to enhance collaboration and quality of care amongst health science students.  

**Education providers in other countries**

In other countries, specialised interprofessional mental health or social work programmes are available at both undergraduate and post-graduate levels. Examples of interprofessional mental health and addiction programmes in Canada, the US and UK include:

- Interprofessional Mental Health and Addictions Post-Degree Diploma at Camosun College (British Columbia, Canada), see [http://camosun.ca/learn/programs/interprofessional-mental-health-and-addictions/](http://camosun.ca/learn/programs/interprofessional-mental-health-and-addictions/)
- Interprofessional Mental Health Practice Certificate (online) at Thompson Rivers University (British Columbia, Canada), see [https://www.tru.ca/distance/programs/nursing/interprofessional-mental-health-practice-certificate.html](https://www.tru.ca/distance/programs/nursing/interprofessional-mental-health-practice-certificate.html)
- Interprofessional Health Education Graduate Courses at the University of Calgary (Alberta, Canada), see [http://www.ucalgary.ca/pubs/calendar/current/interprofessional-health-education.html](http://www.ucalgary.ca/pubs/calendar/current/interprofessional-health-education.html)
- Interprofessional Disabilities Services Minor (undergraduate) at the University of South Dakota (US) [http://catalog.usd.edu/preview_program.php?catoid=24&poid=3892](http://catalog.usd.edu/preview_program.php?catoid=24&poid=3892)

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In Australia, Curtin University offers an interprofessional education curriculum as part of the first-year health science programme to supplement students’ discipline-specific studies in psychology, social work, nursing, pharmacy, speech pathology, or occupational therapy.5 Curtin University uses real-world simulation training to help students experience share decision-making, role clarification, and conflict resolution. Such simulated learning experiences can improve students’ confidence, clinical skills, communication and ability to manage medical emergencies related to serious mental health problems (Attoe, Sherwali, & Jabur, 2015; Lavelle, Attoe, Tritschler, & Cross, 2017).6

Interprofessional education programmes that aim to improve responsiveness to people who experience substance use issues have been piloted overseas. Universities in the US have implemented interprofessional workshops or programs to help improve knowledge, confidence, and attitudes towards substance use, particularly opioid use, amongst students in health disciplines. Students reported high training satisfaction, increased awareness of substance use problems, understanding of interprofessional aspects of management strategies, and ownership of their role and the need to work as part of interprofessional teams to address substance use (Brooks et al., 2017; Monteiro et al., 2017).

Clinical placements

Recently, the Centre for the Advancement of Interprofessional Education (England) developed guidelines to support organisations in commissioning, developing, delivering, evaluating, regulating and overseeing interprofessional education programmes (Barr et al., 2017). The guideline emphasises the importance of clinical placements in health services to help students apply their new knowledge into practice (Barr et al., 2017).

Interprofessional practice learning is more robust when universities and practice agencies enter into mutually beneficial agreements ensuring, on the one hand, that [interprofessional education] placement experiences are available in the necessary numbers to the required standard and, on the other hand, that practice educators are prepared, supported and valued. Teaching and learning in the classroom and on placements can then be two sides of the same coin. (Barr et al., 2017, p. 7)

A small US study incorporated interprofessional competencies into a post-masters mental health nursing practicum course. Students gained confidence in working within a team and communicating with other health professions, and improved knowledge of their own professional roles (Haefner, Filter, & McFarland, 2019).

A local example of interprofessional clinical placements is the partnership between Ko Awatea, Counties Manukau DHB and tertiary education providers.7 Together they developed and

6 Students were from medicine, nursing, and clinical psychology.
7 See http://koawatea.co.nz/cultivating-interprofessional-practice/
implemented an interprofessional education initiative in which undergraduate students participate in interprofessional workshops and placements with Counties Manukau DHB. Students reported improvements in communication and teamwork, interprofessional learning, and interprofessional relationships after attending two half-day interprofessional workshops (Flood, McKinstry, Friary, & Purdy, 2014). The participating students were from physiotherapy, occupational therapy, speech and language, nursing, pharmacy, and medicine (Flood et al., 2014).

Rural communities are a priority area for the implementation of collaborative practice. Health Workforce New Zealand funds the Rural Health Interprofessional Immersion Programme, which is open to students from various tertiary providers (Farry, Adams, Walters, Worley, & Dovey, 2010; Ministry of Health, 2014). The University of Otago leads a similar rural placement initiative called the Tairāwhiti Interprofessional Education (TIPE) programme. As part of these programmes, students from various health disciplines complete multiple 5-week rotations in rural communities and participate in learning activities to gain real-world experience in rural service settings and shared decision-making. Rural placements were perceived as a beneficial experience for students, as well as rural clinical providers (Boyes, 2015; Farry et al., 2010; Pelham, Skinner, McHugh, & Pullon, 2016). The placement programme included mentors from the rural communities’ mental health team (Farry et al., 2010).

**Competency framework for the New Zealand addiction workforce**

Matua Raḵi have outlined competencies around interprofessional health care and quality improvement within the *Addiction Specialty Nursing Competency Framework for Aotearoa New Zealand* (Matua Raḵi, 2012), see Figure 8. This was based on the Nursing Council of New Zealand’s competency guidelines and helps to set the expectation of interprofessional competencies across the addiction nursing workforce.
Professional development for existing health workers

Learning opportunities for existing health workers include participation in interprofessional training, supervision, network groups, e-learning and post-graduate courses.

Professional training and supervision

In New Zealand, research about interprofessional supervision has been undertaken at the University of Auckland with a focus on social work and psychology. Beddoe and Howard (2012) found interprofessional supervision was common in psychology and social work professions (Beddoe & Howard, 2012). Benefits of being supervised by someone from a different profession include learning the usefulness of different approaches, increasing knowledge, and facilitating creative thinking (Beddoe & Howard, 2012). Disadvantages include not meeting aspects of one’s own professional role, not being able to raise all issues with a supervisor, and lack of shared theories or language (Beddoe & Howard, 2012). Participants emphasised interprofessional supervision as not being suitable for new or inexperienced workers who do not have a firm grounding in their own profession, as well as health workers who have not yet received supervision in their own professional discipline (Beddoe & Howard, 2012). Similarly, policies from the Social Workers Registration Board and the Aotearoa New Zealand Association of Social Workers have expressed a preference for same-profession supervision before undergoing other types of supervision (Davys, 2017).
Simulation training is a key learning tool used in interprofessional education for existing health workers. Recent research involving community mental health workers, as well as medical and nursing and clinical psychology trainees, showed simulation training improved knowledge and confidence in team work skills (Attoe, Lavelle, Sherwali, Rimes, & Jabur, 2019; Piette, Attoe, Humphreys, Cross, & Kowalski, 2018). In addition, simulation training can help to improve workers’ knowledge, confidence and attitudes towards supporting people who experience mental health and physical health comorbidities (Fernando et al., 2017), and working with whānau and networks (Kowalski et al., 2018).

Professional network groups and e-learning

Network groups enable existing health professionals to connect, work together and share knowledge. An example of an interprofessional network group is the Victorian Mental Health Interprofessional Leadership Network, which was established in 2016. Prior to this, the initiative started as a leadership programme where Area Mental Health Services nominated interprofessional teams of four (one each from nursing, allied health, lived experience and medical) to participate in the programme.\(^8\) Network members meet every two-months to share ideas and knowledge and receive regular updates through e-newsletters. Members also benefit by being involved in interprofessional mental health collaboration, workshop events, increasing leadership capacity in their local area, and having the ability to contribute to the state’s policy reform, health initiatives and workforce strategies.

Also, in Australia, the Mental Health Professionals Network (MHPN) developed an interdisciplinary professional development platform for community mental health. This is a national initiative that supports and enhances collaborative care among workers in primary mental health services. MHPN had significant uptake across Australia, and has the potential to be adopted in other settings (Gibbs, Murphy, Ratnaike, Hoppe, & Lovelock, 2017). The MHPN model was easily accessible, cost-effective, and comprised of two key programmes: face-to-face network meetings and online webinars (Murphy, Hoppe, Gibbs, Ratnaike, & Lovelock, 2018). Recent evaluation of the model indicates the webinars increased health workers’ discussions about other disciplines (Murphy et al., 2018). People who attended the network meetings were likely to make practice changes relating to increased awareness of, and interaction with, professionals from other disciplines (Murphy, Gibbs, Hoppe, Ratnaike, & Lovelock, 2017). The MHPN initiative and model also supports health workers in Primary Health Networks (see http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home).

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\(^8\) See https://www.nwmh.org.au/interprofessional-leadership-development-program
The MHPN webinars can be accredited towards continuing professional development and provides learning outcomes, expert panellists, useful resources and attendance certificates. Examples of past MHPN webinar topics include:

- tips and strategies to enhance communication between medical and mental health professionals
- working collaboratively to manage comorbid mental health and methamphetamine use
- collaborative mental health care to support adults on the autism spectrum.

As part of the interdisciplinary networks, there are around 380 mental health networks established across Australia, many of which meet face-to-face on a monthly, bimonthly or quarterly basis (MHPN, 2017). Members of these networks include GPs, psychiatrists, psychologists, mental health nurses, social workers, occupational therapists and other health workers (MHPN, 2017). Some networks discuss a range of mental health topics in the local community, and others focus on key priority areas such as substance use issues, problem gambling, physical health, or suicide prevention.

**Conferences and other networking opportunities**

Shared learning opportunities can be facilitated by conferences and other networking activities. All Together Better Health is a leading global conference for interprofessional education and collaborative practice. It is supported by The World Interprofessional Education and Collaborative Practice Coordinating Committee. Previous conferences were held in Japan, Australia, Sweden, Canada, the UK and US. The most recent *All Together Better Health* conference was held in New Zealand by AUT in September 2018. The next biennial conference will be hosted by Qatar University in 2020.

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* For example, members of the Royal Australian and New Zealand College of Psychiatrists can claim hours under Section 4: Self-Guided Learning.
in 2020. Such conferences provide health professionals and leaders a good opportunity to learn about interprofessional practice and the latest relevant research.\textsuperscript{10}

The \textit{All Together Better Health} conference in 2018 also hosted a Healthcare Team Challenge. This is an internationally recognised learning activity that simulates interprofessional teamwork and collaboration, which involves students and current healthcare professionals. The activity requires interprofessional teams to develop a plan for working with a case study scenario involving complex health needs.

In previous years, local education providers have hosted other interprofessional conferences and events. In 2016, AUT hosted the \textit{New Zealand Interprofessional Health Conference}, and in 2017, University of Auckland’s Centre for Medical and Health Sciences Education hosted a free \textit{Interprofessional Education Showcase}.

\section*{Recruitment and retention}

\subsection*{Role clarification and expansion}

SAMHSA’s \textit{Core Competencies for Integrated Behavioral Health and Primary Care} (Hoge et al., 2014) recommended the use of interprofessional competencies in the recruitment process and to update job descriptions. This requires having clear definitions for roles, such as peer support workers (Asad, 2015). For services with a strong focus on interprofessional collaboration, this will help to ensure candidates are well-suited to the position, understand the nature of the work, and identify future training or supervision needs.

Lack of role clarity is a prime driver of dissatisfaction with and turnover in healthcare positions. Greater clarity in job descriptions and job roles can help improve employee satisfaction and retention. (Hoge et al., 2014, p. 7)

An Australian case study in a youth mental health service showed workers collaborated across professions in their routine work and when there was uncertainty around decision-making (Pomare, Long, Ellis, Churruca, & Braithwaite, 2018). In contrast, less interprofessional interactions were observed when role confusion was present (Pomare et al., 2018). Good awareness and understanding of team member’s roles and responsibilities is a core competency for collaborative practice (Thistlethwaite & Moran, 2010). This involves workforce development and human resource processes to re-define, develop and expand roles (Te Pou o te Whakaaro Nui, 2018a). Interprofessional teams need to be able to clearly communicate each member’s role and responsibility to one another, and to people accessing services and whānau (Hoge et al., 2014). Clear roles help to support effective communication and shared decision-making, and minimises potential

\textsuperscript{10} To help promote the All Together Better Health conference, the New Zealand Nurses Organisation has shared details about the conference in issue 7 of their Library e-newsletter. The conference was also promoted on the Te Pou website and in the Health Quality & Safety Commission’s e-digest – Issue 84 [24 May–13 June 2018].
conflict and unrealistic expectations among team members (Canadian Interprofessional Health Collaborative, 2010; Whitehead, 2015).

**Recruitment activities to support interprofessional practice**

Organisational commitment towards developing interprofessional practice and competencies can be reflected in recruitment processes (Hoge et al., 2014). A local example from Bay of Plenty DHB demonstrates a role description that includes interprofessional competencies. Their recruitment listing for a specialist practice mental health & addiction nurse outlined ‘interprofessional health care and quality improvement’ as a principal accountability of the position. The description is outlined in Figure 10.

<table>
<thead>
<tr>
<th>Interprofessional Health Care and Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• With guidance collaborates and co-ordinates care with other health professionals to ensure a quality service</td>
</tr>
<tr>
<td>• Maintains and documents information necessary for continuity of care and recovery</td>
</tr>
<tr>
<td>• Develops a discharge plan and follow up care in consultation with the client, family and other health team members</td>
</tr>
<tr>
<td>• Makes appropriate referrals to other health team members</td>
</tr>
<tr>
<td>• Recognises and values the roles and skills of all members of the health care team in the delivery of care</td>
</tr>
<tr>
<td>• Develops a knowledge of community services and resources</td>
</tr>
<tr>
<td>• Participates in continual quality improvement activities to monitor and improve standards of nursing</td>
</tr>
</tbody>
</table>

*Figure 10. Interprofessional health care and quality improvement competencies from the recruitment advertisement for Specialist Practice Mental Health and Addictions Nursing roles in Bay of Plenty DHB.*

**Information, research and evaluation**

**Online materials that promote and support interprofessional education**

Online promotional and learning materials have been used to engage health professionals and attract future students. The *Journal of Interprofessional Care* has been sharing research notes and updates through an [online blog](#) and social media platforms such as Facebook and Twitter. Other interprofessional centres, such as the [Canadian Interprofessional Health Collaborative](#) and [Centre for the Advancement of Interprofessional Education (UK)](#) also uses Twitter to share information and connect with health professionals and students.

Western University (Ontario, Canada) provides a [one-stop website](#) for information about interprofessional education initiatives. This hub consists of interprofessional resources, case studies, online modules, practice tools, learning materials and information about local initiatives. Figure 11 shows the list of professional role descriptions that are available on the Western University website. These descriptions provide information about responsibilities, education, and registration/licensure.
to help workers learn about other professions or team members. Similarly, the University of Otago provides interprofessional resources and tools on their Division of Health Sciences website.

### Figure 11. List of role descriptions available on the Western University website.

To promote and support the development of interprofessional education, online videos have been used as media tools to explain interprofessional collaboration to future students. Locally, Ko Awatea and Counties Manukau Health produced a video to showcase the use of interprofessional collaborative practice at the National Burn Centre. Similarly, Curtin University in Australia uses online videos to showcase their interprofessional education programme and placements in age-care facilities.

Universities and professional bodies in the UK and US have produced online videos aimed at potential students. These videos explain the importance of interprofessional practice in health settings and showcase local success stories.

**Videos introducing interprofessional practice:**

- University of New England
- University of Leicester

**Videos that showcase the university’s programme, curricula and educators:**

- Middlesex University
- University of Kansas Medical Center
- Vanderbilt University

**Videos that share stories and examples of successful implementation of interprofessional practice:**

- American Speech-Language-Hearing Association and the California
- Interprofessional Education and Practice at the University of Arizona Health Sciences Center
Evaluation of interprofessional education initiatives

Evaluation helps to provide valuable information for stakeholders about processes and outcomes (Reeves et al., 2015). Reeves and colleagues (2015) published a guide to support high-quality evaluations of interprofessional education activities and initiatives. The key factors for a high-quality evaluation include:

- formation of clear and purposeful evaluation questions
- use of evaluation models and theoretically informed approaches
- advice about the selection of qualitative, quantitative and mix methods designs
- managing evaluation resources and funds
- disseminating evaluation results to the interprofessional education community.

Evaluation questions can be used to address the needs of local stakeholders and provide feedback about the learners’ attitudes, knowledge, skills and behaviours around collaborative practice. Figure 12 outlines the training evaluation method based on Kirkpatrick’s framework. Questions about attitudes, knowledge and skills are more commonly aimed at undergraduate students or new graduates, whereas questions about collaborative behaviours are more applicable to experienced health professionals and organisations (Reeves et al., 2015). This method has been used by Carpenter et al. (2006) to evaluate the outcomes of a post-graduate interprofessional programme for community mental health workers.

<table>
<thead>
<tr>
<th>Level 1 – Reaction</th>
<th>Learners’ views on the learning experience and its interprofessional nature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2a – Modification of attitudes/perceptions</td>
<td>Changes in reciprocal attitudes or perceptions between participant groups. Changes in perception or attitude towards the value and/or use of team approaches to caring for a specific client group</td>
</tr>
<tr>
<td>Level 2b – Acquisition of knowledge/skills</td>
<td>Including knowledge and skills linked to interprofessional collaboration</td>
</tr>
<tr>
<td>Level 3 – Behavioural change</td>
<td>Identifies individuals’ transfer of interprofessional learning to their practice setting and their changed professional practice</td>
</tr>
<tr>
<td>Level 4a – Change in organisational practice</td>
<td>Wider changes in the organisation and delivery of care</td>
</tr>
<tr>
<td>Level 4b – Benefits to patients/clients</td>
<td>Improvements in health or well-being of patients/clients</td>
</tr>
</tbody>
</table>

*Figure 12. Outcomes typology for interprofessional education. Source: Reeves et al. (2015, p. 306).*

Example evaluation questions from Reeves et al. (2015) are provided below.

What impact did the interprofessional education experience have on improving learners’ collaborative attitudes, knowledge, and skills outcomes? (Reeves et al., 2015, p. 306)
What effect did the interprofessional education activity have on affecting changes to collaborative behaviours of the learners? (Reeves et al., 2015, p. 306)

Specific to mental health settings, Tomizawa, Shigeta, and Reeves (2017) outlined a framework that can be utilised to assess and monitor the quality of interprofessional teamwork in services. The framework assesses the structure, process, and outcomes associated with interprofessional collaboration, see Figure 12.

**Figure 12.** Framework for the assessment of interprofessional teamwork from Tomizawa et al. (2017).

**Summary of interprofessional activities currently being undertaken**

This review identified a wide range of activities currently supporting the development of interprofessional practice in New Zealand and other countries.

In New Zealand, interprofessional practice is being supported by workforce planning at the national and local levels, professional bodies, and tertiary education providers. As a result, activities such as education programmes, research, conferences, competency frameworks, online materials and recruitment processes have been developed to support interprofessional collaboration among health workers. In New Zealand, targeted mental health and addiction activities include the Matua Rakhi addiction nursing competency framework, values and attitudes frameworks, inclusion of social workers in some education programmes, and nursing recruitment processes in DHBs.

For most other activities in New Zealand, however, the extent of involvement of mental health and addiction workers is unclear. Local interprofessional activities can sometimes involve social workers, occupational therapists and speech and language therapists. It is potentially a major barrier for interprofessional practice in the mental health and addiction workforce if these activities are not reaching other key professions, such as psychiatrists, psychologists, mental health nurses, support workers or addiction practitioners. Thus, there is a need to further understand the involvement of mental health and addiction professions in interprofessional activities and increase the availability of activities targeted to mental health and addiction professions. In addition, the literature search did...
not identify any research or activities around cultural and whānau factors, which are important to interprofessional practice in the New Zealand context.

In contrast, the involvement of mental health and addiction professions is clearer in other countries. International examples from Australia, the UK and US show the involvement of mental health workers in: interprofessional community mental health teams; champion roles to inform student clinical placements; specialised mental health and addiction interprofessional education programmes; webinars/e-learning resources; evaluation of implementation in mental health services; and interprofessional networking groups. Some of these international activities can be considered for development and implementation in New Zealand to support interprofessional collaboration in the mental health and addiction workforce.

**Future activities needed to enable the sustainable development of interprofessional practice**

Based on the information gathered in this review, recommendations for the sustainable development of interprofessional practice in New Zealand’s mental health and addiction services are outlined below.

1. Examine the involvement of mental health and addiction professions in interprofessional activities currently available in New Zealand to better understand what improvements or actions are required to support the workforce. This may involve building collaborative relationships between education providers and mental health and addiction services to ensure future students are well-supported to transfer their interprofessional skills to collaborative practice.

2. Increase the amount of interprofessional collaboration activities that involve mental health and addiction students and professionals. In New Zealand mental health and addiction settings, interprofessional education is relevant for people who work in medicine, nursing, allied health (including psychologists and social workers), support work (including peer workers), and cultural and whānau roles or advisory groups. As above, promoting interprofessional practice may involve building collaborative relationships between health services, education providers, and professional bodies.

3. Investigate the cultural and whānau factors that are essential for the culturally effective implementation of interprofessional practice to support New Zealand’s diverse population. This may involve examining the impact of cultural support roles and whānau advisor roles in interprofessional mental health and addiction teams.
Appendix: International associations and competency frameworks for interprofessional education and practice

List of international interprofessional education associations (taken from Australian & New Zealand Association for Health Professional Educators)

- **AfrIPEN**
  Africa Interprofessional Network
  [http://afripen.org/](http://afripen.org/)
- **AIHC**
  American Interprofessional Health Collaborative
  [www.aihc-us.org/](http://www.aihc-us.org/)
- **AIPPEN**
  Australasian Interprofessional Education and Practice Network
  [www.anzahpe.org](http://www.anzahpe.org)
- **ATBH**
  All Together Better Health
  [http://www.k-con.co.jp/atbh6.html](http://www.k-con.co.jp/atbh6.html)
- **CAIPE**
  the (UK) Centre for the Advancement of Interprofessional Education
  [www.caipe.org.uk](http://www.caipe.org.uk)
- **CIHC**
  Canadian Interprofessional Health Collaborative
  [www.cihc.ca/](http://www.cihc.ca/)
- **EIPEN**
  European Interprofessional Network
  [www.eipen.org](http://www.eipen.org)
- **JAPE**
  Japan Association for Interprofessional Education
  [www.jaipe.jp/](http://www.jaipe.jp/)
- **NEXUS**
  National Centre for Interprofessional Practice and Education
  [https://nexusipe.org](https://nexusipe.org)
- **NIPNET**
  Nordic Interprofessional Education Network
  [www.nipnet.org](http://www.nipnet.org)
- **Network TUFH**
  Network towards Unity for Health
- **SIF**
  Securing an Interprofessional Future for Australian IPE and Practice
  [sifproject.com](http://sifproject.com)
- **WCC**
  World Coordinating Committee
  [https://waipe.net/about-us](http://https://waipe.net/about-us)

Examples of competency frameworks for interprofessional education and practice.

- World Health Organization: Framework for Action on Interprofessional Education and Collaborative Practice
- Canadian Interprofessional Health Collaborative: A National Interprofessional Competency Framework
- SAMHSA - HRSA Center for Integrated Health Solutions: Core Competencies for Integrated Behavioural Health and Primary Care
- Interprofessional Education Collaborative: Core Competencies for Interprofessional Collaborative Practice
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