Te Kaitātaki Oranga
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Future Workforce Development Needs

A brief overview of what changing environments mean for mental health and addiction workforce development.

Prepared for the Mental Health Commission by Acqumen
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Commissioner's Foreword

The functions of the Mental Health Commission are listed in the Mental Health Commission Amendment Act 2007. One of the functions is to support policy-makers and the funders and providers of mental health and addiction services in developing integrated, effective and efficient methods of providing care that meet the needs of their communities. Key to providing this care is the workforce, and therefore the Commission maintains an interest in the people who work in mental health and addiction services.

There are organisations that focus on the health workforce, including Health Workforce New Zealand and the four mental health and addiction workforce centres funded by the Ministry of Health (the Werry Centre, Te Pou including Le Va, Te Rau Matatini and Matua Raki). The Commission enjoys good relationships with these organisations and this report seeks to provide a brief supplement to their work.

Through this brief survey the Commission sought to provide an overview of the future development requirements of the mental health and addiction workforce in the context of changing modes of service delivery, including the growing role of primary care.

One of the most significant developments is that of the peer workforce. At the time of undertaking the survey for this report, Te Pou was looking at issues relating to the peer workforce in mental health and Matua Raki in addiction services. so the Commission did not intend to include this. However, it is a sign of the significance of, and support for, this development that most respondents referred to the peer workforce, so it is mentioned at the end of the report. The Commission will continue to advocate for peer support services as a mechanism to deliver effective and quality recovery-oriented services.

With the increasing need to focus services on both ends of the life-cycle, we support workforce development that prepares people to work with infants, children, adolescents and the increasing population of older adults. The Commission values families/whånau highly, whether they are a service user's chosen support network or their relatives. It is essential that the workforce is skilled in working with families and that service users and families are involved in workforce development.

This review suggests that a strategic and overarching view is needed for workforce development in the mental health and addiction sector. There will need to be strong leadership to ensure the workforce is responsive and flexible and delivers recovery-focused services to service users and families.

The Commission hopes that you find this report useful and we welcome any feedback to info@mhc.govt.nz.

Ray Watson
Acting Chair Commissioner

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1 Introduction

This report provides an overview of workforce development requirements in the next five to 10 years within the context of changing modes of service delivery, including the growing role of primary care in the whole spectrum of community, secondary and specialist mental health and addiction services.

1.1 Strategic context

Key Ministry of Health documents related to workforce development are *Te Tāhuhu – Improving Mental Health 2005-2015* (2005) and its action plan *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* (2006), *Te Puawaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015* (2008) and *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Plan 2006-2009* (2005).

Te Tāhuhu broadens the interest in mental health to cover not only people who are severely affected by mental illness but all New Zealanders. It has 10 challenges, including:

> *'Building a mental health and addiction workforce – and fostering a culture amongst providers – that supports recovery, is person centred, is culturally capable and delivers an ongoing commitment to assure and improve the quality of services for people' (p.12).*

Te Tāhuhu acknowledges that, while significant developments and the expansion of the mental health and addiction workforce have occurred, there is an ongoing need to assess and respond to workforce needs and to ensure alignment with service developments.

Te Kōkiri provides further direction for service and workforce development through to 2015. Actions relate to: developing and implementing policy frameworks to further support workforce development; developing and implementing specific workforce plans to respond to various populations and types of need; building collaboration at a number of levels, including national, regional and across stakeholders; and continuing to build leadership across all services.

Tauawhitia te Wero provides the national framework for workforce development and maintains an emphasis on a systemic approach across five strategic areas: workforce development infrastructure; organisational development; recruitment and retention; training and development; and research and evaluation.

Te Puawaiwhero builds on developments in oranga hinengaro − Māori mental health and addiction – and provides guidance on the interdependence of this approach with whānau ora. It is 'a resource to be used to inform those implementing the actions in *Te Kōkiri*' (p.iii).

1.2 Definition

For the purposes of this report the term 'workforce development' includes:

- professional development options and career paths for staff
- the accessibility, availability and affordability of relevant education and training
- the systems that ensure the competence of the workforce.

1.3 Scope

The project scope includes health practitioners and other staff working in the mental health and addiction sector. Services across primary, community, secondary and specialist settings are considered.

At the time of writing this report Te Pou was leading work on the development of the peer workforce, and therefore this project did not intend to look at the peer workforce. However, all participants referred to this, so it is mentioned.

1.4 Method

The method used for this project has two components:

Document review

A review of key documents that set the scene for this project.

Survey

A small survey of people from the mental health and addiction workforce centres, training organisations, Ministry of Health, District Health Board (DHB) Planning and Funding, Platform, non-government organisations (NGOs), primary and mental health clinicians, and service users and families was undertaken. The survey was completed using three methods:

- 14 face-to-face or phone interviews
- four written responses
- one focus group with the Waikato Local Advisory Group, with 10 participants.

In total 32 people participated in the survey. The list of participants is in Appendix 1.

2 Changing Environments

Survey participants were asked to describe the changes they have seen in the needs of people with mental health and addiction disorders and their families, whānau that might impact on workforce development in the next five to 10 years. This section provides a summary of the responses.

2.1 Increasing expectations

Overall there was agreement that clinical presentations have changed little. The major theme from all responses was that people's expectations of services and how they should respond to needs are greater.

Most participants made comments along the following lines:

> *'People now want to be active partners in service delivery. They want to have a say and make decisions about their lives and this changes how we need to work.' Ross Phillips, Pathways*

Some people now have 'individualised funding' – they receive a funding allocation to purchase the services they choose, and it is a method for enabling people to have greater control over their lives. Some participants see that inevitably people will want to control resources, and interest in this type of model will grow.

With the development of web-based technology, people are increasingly knowledgeable about mental health and substance abuse disorders and clinical treatment options and are less reliant on professionals as a sole information source.

> *'Families want some of the clinical language as part of finding a way to understand what's happening. But it's contradictory – they want the language but as time goes on they're likely to reject the labels.' Hugh Norriss, Mental Health Foundation*

Attitudes toward mental illness are slowly changing and, combined with the development of primary mental health care and increased screening, all participants agreed that demand for services will continue to grow.

> *'Publicity and things like the Like Minds campaign mean people are more comfortable putting up their hands and saying they want help.' Emma Wood, Te Pou*

Some participants thought that increasing recognition of the prevalence of mental illness and the success of de-stigmatisation programmes could mean that employees are more likely to disclose mental illness and have higher expectations of support from their employers.

2.2 Different population groups

Infants, children and young people

Twenty-eight percent of New Zealand's population are 0-19 years of age and they receive 11% of mental health funding (Statistics New Zealand, 2010). Several

participants acknowledged that the workforce for infants, children and young people needs to be significantly different from that for adult populations.

> *'Adult mental health services need some upskilling to better be able to meet the relevant developmental needs of young adults' Shona Clarke, Werry Centre*

> *'Māori are a younger population but there is a dearth of infant, child and youth and whānau services for them and not a workforce to match. We need to develop models for tamariki and rangatahi – not just impose adult models on them.' Kirsty Maxwell-Crawford, Te Rau Matatini*

The issues are similar for Pacific children, and along with culturally specific services there is a need to enhance and improve the responsiveness of mainstream services – given that the majority of Māori and Pacific children and youth are seen in mainstream services.

Older adults

The overall population will reach five million by the mid-2020s and one in five New Zealanders will be aged 65 years or older. Overall there was agreement on the need to further prepare the workforce to meet the growing needs of older people.

> *'Although this is recognised as a priority area, investment in the [mental health of older people] workforce has been limited and requires attention.' Emma Wood, Te Pou*

Māori

Te Rau Hinengaro: The New Zealand Mental Health Survey indicates that the prevalence of mental illness among Māori (29.5% in the past 12 months) and Pacific people (25% in the past 12 months) is higher than it is among other population groups and they are less likely to make contact with mental health and addiction services (Oakley Browne et al 2006).

> *'At this point while some gains have been made the needs of Māori haven't changed. They're still slow to access services, arrive in a crisis – meaning there's not enough opportunity for early intervention.' Kirsty Maxwell-Crawford, Te Rau Matatini*

Shortages in the number of Pacific and Māori in the workforce have been noted and services are seeking ways of improving responsiveness. For example, Blueprint for Learning (a training agency) reports increasing demand for practice-based training on the Treaty of Waitangi; workers want training on how to put the Treaty of Waitangi into practice.

Services aimed at meeting the needs of Māori are evolving to increase access and responsiveness. In some models (eg, Hutt Valley DHB) services for Māori are being integrated into mainstream mental health and addiction services with the aim of strengthening the overall response to Māori. In Hawke's Bay services have been devolved from the DHB and developed within an iwi-based organisation, and Te Taiwhenua o Heretaunga now provides mental health services alongside various other health, education and social services. Early feedback from those working within the

model has been positive and hopefully it will improve the recruitment and retention of the Māori workforce.

Te Rau Matatini sees that the development of Whānau Ora may be an opportunity to think about a national Māori health professional body to provide leadership for the workforce, including support workers.

2.3 Importance of families and whānau

Families and whānau have a valuable role in providing support to their family members, and some participants suggested that as demand for services grows and funding constraints continue there will be an increasing need to rely on them for this support.

> *'New service specifications encourage flexibility and for alcohol and drug services the boundaries between residential, respite and community services will change and this will make it more client-centred ... hopefully avoiding the bottleneck at beds. This will have an impact of the workforce – they'll need to be much more flexible and involve families and communities more.' Raine Berry, Matua Raki*

The needs of families and whānau should be recognised and responded to in a number of ways, including providing them with quality information and other support to maintain them in their role. They need the opportunity to take breaks by using respite services, particularly where their family members are children or young people. Several participants commented on the 'loss' of family therapy skills and the need to rebuild these; however, there are barriers, including a current lack of family therapy training in New Zealand at a postgraduate Masters level.

Several participants commented on the shortage of family-led service provision and saw this as a gap. The Werry Centre has guidelines for child and adolescent mental health services (CAMHS) that have or are seeking to develop both youth consumer and family/whānau advisor roles. They have found family/whānau advisor roles to be more difficult to establish than youth consumer advisors for a range of reasons, including limited understanding of how the roles might work in practice and potential benefits.

Most participants felt that within services there has been a bias against engaging with families, who may be seen as problematic to a person's treatment and recovery for a range of reasons, and that this has resulted in the failure to build some skills. While there will always be people who do not want their families involved, there is a wider need to 'shift the balance and attitudes' and ensure that workers can respond appropriately to families in a range of settings. From a different perspective, adult services often have no knowledge of whether a service user is a parent and what impact adult issues are having on their children.

2.4 Primary mental health

Workforce development needs were highlighted by a University of Otago evaluation of the primary mental health initiatives developed by primary health organisations (PHOs) for people with mild to moderate problems (Dowell, et al 2009). The initiatives created new roles and positions in primary care, mainly a primary mental health co-ordinator (usually a nurse or social worker), mental health nurse or a primary mental health

clinician. How the work was shared between existing primary care staff and newly created roles differed between the initiatives, depending on the skills and experience of the primary care teams.

Areas for skill development were identified through the evaluation. These included assessment, the use of outcome tools, brief interventions and talking therapies, motivational interviewing, self-management and medication use. A common learning need for those with backgrounds in mental health services was a greater understanding of the nature of primary health care service delivery. Existing primary care staff favoured mentoring and case-based learning approaches. The evaluation noted the need to increase workforce capacity to meet demand, formalise training expectations and requirements, and broaden the skill set to ensure that 'any door is the right door'.

Primary mental health is expected to help reduce the stigma associated with accessing secondary and specialist services. Several participants saw that there will be a growing resistance amongst service users to any service that is considered to be stigmatising.

> *'Young people don't want to rock up to a door that says "mental health services" now and this attitude will only continue to grow.' Marion Blake, Platform*

As part of the development of primary mental health services, a 'culture clash' with secondary and specialist services is expected. Most participants saw this as an inevitable part of developing relationships and an understanding of each other's philosophies and approaches, and that addressing this is just as important as any skill development.

> *'Primary and secondary services need to understand each other's roles and cultures and focus away from the service boundaries to a person's needs. This means shifting attitudes and learning new ways of working and collaborating with different groups.' Marie McKay, Wairarapa DHB*

2.5 Secondary and specialist services

The increased capacity of primary mental health is expected to prompt some realignment and adjustments in secondary and specialist mental health and addiction services over time, although demand for these services is not expected to reduce owing to increased screening and referrals from primary care. There is a continuing need to develop the capacity and capability of this workforce to ensure that people with severe and acute mental health and addiction needs receive responsive and highly skilled secondary and specialist services.

Areas for consideration include the future role of the community mental health teams, including case management and other services for people with long-term conditions, and the delivery of some interventions. Overall this was seen as a positive development and several participants made comments along the following lines:

> *'Let specialist services be specialist services and support them to be really good at their job.' Emma Wood, Te Pou*

Some participants thought there would be a need to increase specialisation in some areas, and areas commonly identified included:

- short-term and intensive interventions
- addiction services
- acute services

Secondary and specialist services will also need to develop skills for collaborating with a wider number of agencies.

> *'Potentially secondary services will be on an island surrounded by primary and community services. This would change the dynamics and hopefully provide more incentives to build relationships to avoid this.' Kirsty Maxwell-Crawford, Te Rau Matatini*

The development of primary mental health may increase calls for more locally delivered secondary and specialist services, including respite and acute home-based treatment and crisis and recovery house options.

2.6 NGOs

Historically, NGOs have aligned with secondary and specialist mental health services and this was expected to change. Participants agreed that the roles of NGOs and their increasingly able workforce should be expanded to include working alongside primary care in the delivery of personalised care and supports. This could occur in a number of ways, such as being contracted by Integrated Family Health Services to meet social needs, although funding would need to be allocated for this.

> *'A person may not even need to see the GP. A practice nurse could refer someone who is depressed and unemployed to a support service to hook them into local supports and help them find a job.' Ross Phillips, Pathways*

Some participants considered that as NGOs are focused on providing direct support to people in a range of settings, they are non-threatening to the other groups involved and this can be an advantage.

> *'NGOs have an important role in bridging the gap between primary and secondary services and can provide continuity to service users – they can also be the glue in the partnership.' Paul Ingle, Pathways*

One of the workforce groups most commonly identified as missing out on workforce development opportunities was workers employed by smaller NGOs.

> *'Smaller NGOs seem to miss out on training, especially training related to individual needs. The main problem is affordability and that they don't seem to have enough budget to be able to slip in any extras.' Marie McKay, Wairarapa DHB*

A second group that may currently miss out are workers in rural and remote areas; the development of work and web-based options is expected to meet some of their needs.

2.7 Integration and collaboration

A major theme from the survey was that improving responsiveness to service users and families will require collaborative approaches between services to be developed on two levels:

1. Further developing integration between primary care, NGOs and secondary and specialist mental health and addiction services, and with disability and age-care services.
2. Building collaboration with the broad range of community, social, housing, education, justice and other agencies.

Progress has been made in some areas and needs to be extended. Workforce development is a component of this.

Integrated services

Growing recognition of the complexity of some needs and co-existing disorders (including mental health and addiction, mental health and intellectual disabilities, physical health and age-related needs) and population changes will increase the need for integrated responses from a wider range of services.

> *'As the population ages, greater ability for services to manage personal health needs or integrated services that bring [a] broader range of skills to address needs – nursing, OT [occupational therapist], psychologist, psychiatrist and co-ordinated needs assessment – will be required.' Mary Wills, Hawke's Bay DHB*

Although the *Better, Sooner, More Convenient* strategy is focused on primary care, some participants saw that it might provide a platform for local community development and wider collaboration between services.

> *'We should aim for one-stop shops, both physical and virtual, with a wider group of community service agencies able to meet a range of needs. The concept would be similar to Integrated Family Health Centres but have an even broader membership and purpose.' Paul Ingle, Pathways*

> *'We've been aware of the enormity of the problem for some time so this isn't new knowledge, but it has taken time to get direction and to act on this.' Raine Berry, Matua Raki*

Collaboration

Integration within the health and disability sector can be achieved by developing integrated systems and aligning contracts and funding incentives, but broader collaboration with a wider range of social and other agencies requires a different approach.

> *'We may want communities to provide resources and jobs for example, but it can be difficult. We need to think about how we engage communities and other services to make this happen.' Marie McKay, Wairarapa DHB*

'We could support integration by helping people to understand the benefits, giving skills and knowledge, and help with problem solving. There need to be incentives – workers have to see the benefits, but they also have to have the capacity to [work collaboratively]. And there have to be consequences if they don't.' Sue Treanor, Werry Centre

To truly enable the delivery of personalised services, joined-up workforce development approaches are required. Mental health and addiction workers will need to understand the roles of the various agencies and how they relate to people and families' needs. They will also need skills for working collaboratively, including relationship development and problem solving.

'Our staff will need to be more health and social service literate and contribute and expect more from the relationships.' Marion Blake, Platform

There is also some need to consider workforce development practices that could reinforce the silos between different occupational and service groups. For example, currently the Ministry of Health funds the Mental Health Support Workers Grant and this is available to those working in services contracted through Vote: Health. Support workers employed in vocational or supported employment services funded by the Ministry of Social Development are not eligible for the grant and either the worker or the employer must pay the fees.

'The impacts of poverty and unemployment are barriers to recovery and as a sector we're not doing enough to address this. We need to get better at helping people find work.' Paul Ingle, Pathways.

People will be increasingly frustrated with the boundaries between services and the number of workers with whom they have to deal, and they will want to see wider integration and connections between mental health and addiction services and other health and social service agencies.

'Professionals may want to isolate needs and symptoms and focus on a psychosis. But a person sees many more factors in their lives like poverty and unemployment and they will want to address these.' Marion Blake, Platform

'We need to be able to see needs holistically. Historically contracts and service specifications prevent this so with Whānau Ora leading the way hopefully we can resolve this. The national direction needs to catch up with what some NGOs and providers have been trying to do.' Kirsty Maxwell-Crawford, Te Rau Matatini

3 Future Directions for Workforce Development

This section looks at how the changes in needs and service delivery may impact on the workforce in the next five to 10 years.

3.1 Strategic direction

Most participants commented on the 'myriad of workforce activities' that have occurred to date, and overall there was agreement on the need to examine progress and reset strategic goals and priorities.

> *'Developing primary care, NGOs, specialist services – none of these are the holy grail. This is about strength of approaches – the strengths of NGOs, of DHBs, etc. Building on these strengths should be the focus for service and workforce development.' Hugh Norriss, Mental Health Foundation*
>
> *'Agree on a few national priorities and then implement well.' Mary Wills, Hawke's Bay DHB*
>
> *'We need to get good direction on the priorities.' Robyn Shearer, Te Pou*
>
> *'We need to shift the training supply paradigm we're working with – there are lots of options but where's the plan? Employers ultimately decide what training a worker will do but we need more consistency in expectations.' Marion Blake, Platform*
>
> *'The issue is do we aim to have more workforce or to have the workforce we need? We come from a history where if you talk problems up then you get rewarded and this perpetuates a crisis mindset. We need to reframe the rewards. [Currently] workforce initiatives can work against that by focusing on the individual rather than on our customer and the community.' Hugh Norriss, Mental Health Foundation*
>
> *'The focus on recruitment hasn't worked and we need a more balanced approach that is based on service user needs and links to service design and workforce development.' Sue Treanor, Werry Centre*

An example of an approach that considers needs, systemic and organisational factors, and workforce requirements has been led by the Werry Centre and involves implementing the 'Seven Helpful Hints of Effective CAMHS' and the 'Choice and Partnership Approach'. These models were developed in the United Kingdom. They aim to improve access to services and the quality of responses through efficient flow management and referral processes, and by offering children, young people and their families and whānau choices in their dealings and relationships with CAMHS. The models aim to increase the capacity of services to meet needs, but not necessarily by increasing the number of positions. Implementation involves a combination of local service re-design and workforce development.

One participant valued this type of approach because:

> *'[It is] clear about what works nationally and what needs to be done locally.' Mary Wills*

It is also consistent with the need for clear direction and leadership of developments.

'The real drivers for change are more at an organisational level – it's about how an organisation articulates the bigger picture and understands needs, and then getting people on board and skilled to meet those needs.' Hugh Norriss, Mental Health Foundation

Connecting service and workforce development nationally, regionally and locally requires tools and other enablers to support these processes. It also requires strong relationships between the various groups involved.

'We need really good regional engagement and to respond to DHBs as stakeholders. [Engagement] has been patchier with NGOs and PHOs, but we need to stay and act together.' Debbie Tohill, Werry Centre

3.2 Leadership

Leadership is important to building shared visions and managing change.

'We need to think about how to develop leadership and shared visions across groups, including service users and families. We need to build a culture of debate and look at the values and tensions between the different groups, and not shy away from them.' Sally Pitts Brown, Blueprint for Learning

Efforts to build leadership have been underway for some time, and valuable programmes are available.

'We used to say passion was enough, but this isn't the case any more. We need really skilled leaders to take us through the next stage of development.' Kath Fox, Richmond NZ

Several participants noted gaps in clinical leadership, particularly for Māori. There are also leadership gaps amongst first-line managers, peer leaders, senior managers and planning and funding.

3.3 Core knowledge and skills

Participants suggested that all workers should have a set of 'generic' or 'core knowledge and skills', such as engaging well with service users, families and communities. The 'Let's Get Real'[1] (Ministry of Health 2008) framework aims to achieve this goal.

'"Let's Get Real' was developed with service users and families so it's based on what they want from services. It's about going back and getting basic skills right. This needs to happen before specialisation can occur.' Emma Wood, Te Pou

[1] 'Let's Get Real' is based on seven skills that should be shared by everyone working in mental health and addiction services: 1) working with service users, 2) working with Māori, 3) working with families and whānau, 4) working with communities, 5) challenging stigma and discrimination, 6) law, policy and practice, and 7) professional and personal development.

The framework was further developed in 2009 for child and adolescent services with the 'Real Skills Plus' competency framework (Werry Centre 2009). This has two competency levels – 'practitioner-core' and 'practitioner-specialist'.

Participants thought that over time the 'Let's Get Real' framework could evolve to include other competencies related to:

- personalised and service-user-centred care
- collaboration and working with other agencies
- community development.

This framework can be used to inform the professional standards of individual health practitioner groups, although groups such as mental health nurses and psychiatrists have independently developed their own standards.

3.4 Combined training opportunities

Currently there are variations in the training available to workers depending on their undergraduate training and employers. For example, a clinical worker employed by an NGO has less access to training than a DHB worker.

Several participants saw the value of taking cross-sectoral views of workforce development, and this included offering placements with and secondments to other organisations, and bringing together workers from a range of roles and employers for training and professional development. The value of this is greater than skill development and includes fostering an environment that expects collaboration.

> *'We need to look at different parts of the workforce together. The executive leadership and management programme [provided by Blueprint] does this and we need to do more in this way. We also don't do enough about multi-disciplinary teams and we need to change this for the same reasons – [different workers] developing skills together.' Emma Wood, Te Pou*

> *'Things like secondments and placements are invaluable to building shared understandings of the environments.' Kirsty Maxwell-Crawford, Te Rau Matatini*

Some participants saw that a focus on getting the best use of the whole workforce, no matter where they work, will be increasingly important.

> *'Global factors like the ageing workforce will mean we need to move more towards virtual teams and it should be less apparent who the employer is. [A benefit is that] this will lead to more integration and collaboration in real terms.' Kath Fox, Richmond NZ*

3.5 Flexibility

Ongoing efforts need to build on the skills and resources already in place, and fit with what works well within a primary care context.

'We need to consider the structure of the [primary care] workforce – for example more nurse practitioners would be good but don't get in the way of people who currently do well and have good skills. Don't exclude people from primary care because the boxes aren't ticked. Build on generalist skills and focus on developing these with training and career pathways. Rigid systems won't work.' Helen Rodenburg, Compass Health

The role and utilisation of clinical staff working within NGOs could also be extended.

'Why couldn't a registered nurse employed by an NGO do a diabetes check on behalf of the primary care team?' Kath Fox, Richmond NZ

One of the challenges for planners will be the variation in delivery models and the range of skills and roles within primary care, and developing programmes to accommodate the range of needs.

'We have to look at the workforce as a team – there will be variation in the make-up of the teams, the skills will be different, and the skills of the person who takes the lead may differ, but the key thing is to ensure that overall the team can do what's required ... We need to offer training and professional development in areas like brief interventions and accept that take-up may vary due to the range of roles and abilities within the team.' Helen Rodenburg, Compass Health

Having a flexible system that provides clear direction for primary care skill development and co-ordinated activities was considered important to achieving national consistency in the quality of service provision.

'[We need] to ensure a baseline of mental health and addiction skills, [the] ability to deliver low-intensity interventions, and to refer on to more intensive interventions if required.' Jo Parangatai, Compass Health

'[Workers] will need to let go of some of the structures and ways of working they currently know and we need to teach them skills on how to manage change. This is part of resilience but it's also about teaching flexibility… We can't afford to have the workforce disengaging and need them to act as owners.' Sally Pitts-Brown, Blueprint

National consistency begins with undergraduate training and vocational programmes but may extend over time to the development of primary mental health competencies and scopes of practice aligned to 'Let's Get Real' and applicable to primary care practitioners.

3.6 General practice staff

A mental health and addiction skills baseline for general practice staff needs to be developed.

'Measures should be simple. For example every practice should be able to demonstrate that they have a "competent person" and if they don't have one they need to show how they link with a practice that does.' Sandra McDonald, ProCare

They need encouragement and incentives to ask questions and delve into problem areas, to engage with practice nurses and mental health co-ordinators, and to consider a broad range of treatment options.

A suggested model is to develop a career pathway that would enable general practice staff with a particular interest in mental health and addiction to develop their expertise. As well as having an opportunity to extend skills and knowledge, expert general practice staff could also be a resource for their practice groups.

> *'The tools can be really simple. [Our psychiatrist] does training and gives the nurses scripts – he just tells them to ask the person if they're feeling anxious. If they say yes tell them to lie down with their hands on their tummy and breathe etc. ... It's simple but gives the nurses confidence to ask the questions. It also shows that a lot of this stuff is common sense and that they do similar things in other parts of their practice.' Sandra McDonald, ProCare*

The whole general practice team is important in developing the capability to deal with mental health and addictions. The attitudes and approaches of receptionists can influence a person's willingness to attend and engage with a practice.

> *'The receptionist can make or break things. For Māori who may have avoided primary care and not be enrolled with a practice, if they feel the receptionist is judging them they'll head for the hills.' Kirsty Maxwell-Crawford, Te Rau Matatini*

ProCare has recently run focus groups with Māori and Pacific and the feedback confirmed the importance of the initial contact and the impact this has on engagement.

An area requiring further development is the relationship between primary care, NGOs and other community supports to address social and other needs. Suggestions include developing broker, co-ordinator or social work roles within practice teams to facilitate access to a wider range of supports and services.

3.7 Support workers

As the scope of NGOs develops, there is a need to reassess workforce requirements. Several participants said that the term 'support worker' was outdated and no longer reflected the level of skills required for some roles.

> *'It's a term that doesn't recognise the level of skill some have or their backgrounds – social workers and psychologists are being employed in some roles.' Sally Pitts-Brown, Blueprint*

Participants from NGOs saw the need to 'rebrand' the support worker role and to use language that better describes the types of work done. New titles and descriptions may need to reflect differences in the type of work being done.

> *'With so many NGOs delivering such a broad range of services there is a really long tail in terms of the range of support work responsibilities.' Paul Ingle, Pathways*

At one end of the spectrum a support worker might provide assistance with shopping and other daily activities, while at the other end of the spectrum a support worker may be providing intensive support to someone who is acutely unwell and receiving treatment in a crisis or recovery house.

'Many support workers articulate the desire to remain in the workforce but to be valued, and given the opportunities for meaningful professional development and for the opportunity to be contributing members of multi-disciplinary teams.' Chrissie Cope, Careerforce

There has been less investment in this workforce when compared with clinical services, and this may need to be reviewed to ensure training and development programmes are 'fit for purpose'. The current New Zealand Qualifications Authority certificates and diplomas have been useful but the limitations are becoming increasingly apparent as the shape of the workforce changes, the complexity of the work increases in some areas, and areas of specialisation become more apparent.

'Approaches are too broad brush – why would a psychology graduate do Level 4 training just because they're working in an NGO?' Marion Blake, Platform

There is a need to consider the next steps in line with the potential of this workforce and service developments. It also means ensuring that NGOs have sufficient funding to support workforce development.

3.8 Recruitment, retention and career pathways

All participants saw that recruitment and retention are ongoing challenges. The most common comment was the need to attract young people into the workforce by promoting awareness of the different opportunities and the potential for job satisfaction within mental health and addiction services, and creating incentives where necessary. Participants gave information on some of the initiatives currently in place, including: work experience and gateway programmes where school students can earn National Certificates of Educational Achievement credits; expos and other promotion opportunities; and encouraging students to think about mental health as a career option and take science-related subjects at high school.

'We're not on their radar. Question is how do we get them by the nose and lead them into human services?' Steve Scott, Waikato Local Advisory Group

Waikato has a new graduate programme supported by its planning and funding team that takes a 'sector-wide view'. The programme began with nurses but has since been extended to include allied health graduates. The graduates are paid a wage and do placements in both DHB and NGO services. Initially there were not enough graduates for the number of placements available, but this has changed and the programme is now oversubscribed.

As the focus shifts towards more holistic views of wellbeing, the types of people being recruited into roles may need to change, including for NGOs.

'[Workers] should be successful in their own lives – be inspirational and aspirational and provide a good role model.' Ross Phillips, Pathways

Currently there isn't a national body for standards, or a nationally consistent pathway for support workers. Several participants saw the development of a national body as a key part of the next development stage for this workforce.

'Lack of central body and credibility ... this hinders recruitment and retention. There should be more focus on a pathway to the regulated [clinical] workforce.' Kirsty Maxwell-Crawford, Te Rau Matatini

3.9 Focus for tertiary education providers

There is an ongoing need to ensure that the content of undergraduate and postgraduate programmes and continuing education programmes is aligned with workforce requirements. Participants suggested that content could be more grounded in the World Health Organization's position that 'there is no health without mental health'.

Suggested improvements to undergraduate courses included:

- core skills related to family engagement
- human development and maturation – from a child and youth perspective
- first interventions
- alcohol and other drugs, including screening
- multicultural approaches.

Participants considered areas where improvements could be made in postgraduate programmes and these included:

- increased focus on mental health and problem solving
- primary care and brief interventions
- primary care.

A greater alignment between tertiary providers and service and workforce planners could potentially release some funding for investment in other workforce development priorities.

4 Delivering Training and Workforce Development Programmes

The survey included specific questions for the workforce centres,[2] training providers and service providers and these focused on gathering information on the challenges associated with workforce development from a provider perspective. Five common themes emerged from the responses.

4.1 Economic pressures

New Zealand has experienced a recession and this has meant a decrease in funding and other restraints on services. All participants noted the impact this has had on workforce development, including the willingness of employers to release staff and pay travel and other costs associated with training, even where there are no course costs involved. Workers may also be reluctant to be away from their jobs. The workforce centres and training providers accepted that part of the solution lay in finding economical ways of delivering training and development that reduced the cost to employers. However, there is a wider concern that priorities are being set with a short-term view and that there will be longer-term negative impacts on the capability of the workforce and organisational development.

> *'It will take time to see the impact of cutting back on training. We're just starting to see the benefits from training but [progress] is fragile.' Emma Wood, Te Pou*

4.2 Ease of access balanced with broader objectives

All of the workforce centres and training providers involved in the survey acknowledged the need to develop efficient delivery methods, including:

- further use of work-based options, including web-based learning and developing information, guidelines and other resources
- delivering block courses
- partnering with other training agencies
- providing training on a regional and local basis.

These initiatives are partly driven by current funding restraints, but there is also a growing expectation that training will be easy to access and locally relevant. All these participants made the point that there are advantages to work-based and web-based learning, but that it should be balanced with other objectives including peer learning, broadening understanding of different roles, developing relationships and the potential for collaboration between trainees. There continues to be wider economic value in the face-to-face delivery of training and professional development.

[2] There are currently four workforce centres contracted by the Ministry of Health: the Werry Centre, Te Pou (including Le Va), Te Rau Matatini and Matua Raki.

4.3 Information and outcomes

Several participants noted that it is difficult to measure training and development outcomes for a number of reasons.

> *'As an organisation we try to look at evidence-informed practice and outcomes achieved, but this is difficult as there isn't enough [information available] to support this ... It's also hard to align qualifications to this.' Kath Fox, Richmond NZ*

In the absence of evidence-based methodologies, workforce development agencies and services may take different approaches to measuring outcomes, and this will make it difficult to quantify the overall gains made from investment in the long term.

Also, information available for workforce planning is limited. The *Mental Health and Addictions Workforce Stocktake* (Ministry of Health, Population Health Directorate 2008) provides an overview of the demographic makeup of the workforce and gaps and this can be useful when developing recruitment and retention strategies, particularly when used in combination with the epidemiological information on mental illness provided in *Te Rau Hinengaro*. However, these information sources require updating and are not linked to service development.

> *'We've got gaps and the only way we can fill them is to do surveys on needs – we're doing one now on older people services. This is frustrating for the services and people we need to fill out those surveys but it's the only way we can get some information.' Emma Wood, Te Pou*

4.4 Māori workforce development

Te Rau Matatini was launched in March 2002 as an organisation focused on developing the Māori workforce with a mental health focus. However, this focus has since broadened and the organisation now aims to:

> *'... improve the quality, utility and relevance of health workforce development programmes, strengthen Māori health leadership development and, in doing so, strengthen the responsiveness of services for Māori. [It is] therefore committed to Māori health workforce gains inclusive of the continuum of population health and mental health encompassing primary care, public health, prevention, and treatment' (Te Rau Matatini, 2009, p.3).*

Te Rau Matatini works closely with tertiary education institutes; however, there are capacity issues and some struggle to attract and retain Māori staff to teach and lead programmes. To address this Te Rau Matatini is developing a private training enterprise (PTE) to enable it to deliver programmes.

4.5 Peer workforce

Many participants commented on the need to view peer workers as an intrinsic part of the wider mental health and addiction workforce, and to ensure that their development needs were not overlooked. This reflects a view that peer workers are one of the groups that may currently miss out on training owing to a lack of appropriate and available programmes and funding. Te Pou is currently heavily engaged in this area and is

working with members of this group on a range of mental health initiatives, such as supervision and leadership development and peer-led recovery learning packages.

People with lived experiences of mental illness are a growing part of the workforce and they are working in a broadening number of roles, including youth consumer advisors and peer support workers, and in project management, service development, management and leadership positions. This growth is attributed to a number of factors, including an increased appreciation of the value their experiences bring to services and the wider workforce.

> *'We've been doing some training with teams including nurses and psychiatric registrars, with a focus on engaging with people and developing therapeutic relationships – showing them that it's not all bad for people with mental illnesses and that practitioners can and do help. A lot of this is about asking them questions and affirming stuff they already know. I think it's important for retention – it gets the nurses interested and excited about being able to help.' Julie Kneebone, Waikato Local Advisory Group*

The Werry Centre has developed guidelines for youth consumer advisors, and although workers may share job titles, the types of role they are carrying out vary significantly. Some may be providing advice on how information (eg, pamphlets) and other services are delivered, and one youth advisor is currently the leader of a wider consumer advisor team. Current issues relate to ways of supporting and developing peer workers.

> *'There is currently no specific training available to youth consumer advisors, and some have difficulty accessing their service's training budget to attend conferences etc.' Shona Clarke, Youth Consumer Advisor Project Leader, Werry Centre*

Further work is required in a number of areas, and in a broader context participants saw that the lack of a career pathway for peer workers is an issue – often they follow a similar pathway to support workers but this limits scope as 'they are not just buddies or support workers with experience of mental illness'. Peer workers need ongoing opportunities to develop through training and career pathways that promote the range of roles available in different work settings and encourage role progression, and to ensure that the potential of the workforce is realised.

In the addiction area, peer roles may differ from those in the mental health area and a thorough consideration of the needs of these roles is required. Matua Raki has been doing some work in this area and will shortly produce a report on peer roles in addiction services.

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Appendix 1: List of Participants

Group	Agency	Contact person	Method
Workforce centres	Te Pou Werry Centre Matua Raki Te Rau Matatini	Robyn Shearer and Emma Woods Sue Treanor and Debbie Tohill Raine Berry Kirsty Maxwell-Crawford	Interview Interview Interview Interview
Ministry of Health	Primary mental health Health of older people	Sarah Dwyer Roz Sorensen	Interview Interview
Training bodies	Blueprint for Learning (PTE) Careerforce (ITO)	Sally Pitts Brown Chrissy Cope	Interview Written response
NGOs	Platform Richmond NZ Pathways	Marion Blake Kath Fox Paul Ingle and Ross Phillips	Interview Interview Interview
DHBs	Wairarapa DHB Hawke's Bay DHB	Marie McKay Mary Wills	Interview Written response
Cross-sector	Waikato Local Advisory Group	Lesly Bird (PHO) Julie Kneebone (consumer) Julie Fidoe (supported accommodation) Anne Grennell (family) Laurie Hakiwai (Māori providers) Steve Scott (AOD providers) Karen Covell (self-development providers) Carol Clarke (child and youth providers) Eileen Hughes (Health Waikato Mental Health and Addiction Services) Katherine Fell (Portfolio Manager, Mental Health and Addiction Planning & Funding, Waikato DHB)	Focus group
Primary care	Compass Health Compass Health ProCare	Helen Rodenburg Jo Parangatai and Mark Gingell Sandra Mc Donald	Interview Written response Interview
Other	Mental Health Foundation Werry Centre	Hugh Norriss Shona Clarke (Youth Consumer Advisor Project Leader, Werry Centre)	Interview Written response