Workforce stocktake

Final report to the Government Inquiry into Mental Health & Addiction, June 2018

New Zealand mental health and addiction workforce: challenges and solutions

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Evidence based workforce development

Part of the Wise Group

Te Pou o te Whakaaro Nui

Acknowledgements

Foreword

Over the last 30 years mental health and addiction services have dramatically changed with the closure of large institutions and delivery of increasing support to people in the community. It is now time to look at what is working, what no longer is, and what needs to change. Despite the discomfort change brings, we believe some things need to do be done differently. The current situation cannot be sustained. There is increasing demand for services and the current model of service delivery does not meet people's expectations. The workforce is also coming under increasing pressure and supporting more people who are experiencing intense and complicated mental health and addiction problems.

Currently about 8-9% of total Ministry of Health funding is spent on mental health and addiction services. These resources need to be used more efficiently and effectively to support improved wellbeing, resilience and recovery for people who experience mental health and addiction issues. This investment needs to be used to make a difference in people's lives and include a choice of effective service options that are informed and co-designed by people with lived experience and their whānau. Consumer leadership is imperative to the design of future services. This vision for services needs to be clearly outlined and based on an up-to-date understanding of people's needs.

To achieve change in the way services are delivered, consideration must be given to the workforce – this is our most costly and valuable resource within mental health and addiction services. Urgent prioritisation needs to be given to workforce planning, an evidence-based strategic process based on the future direction for service delivery and population health needs. Only by undertaking the workforce planning process at local, regional and national levels will we clearly understand how many workers will be required in the future, what type of knowledge and skills are needed, who is needed to undertake specific tasks, and how workers' knowledge and expertise can be utilised most effectively. The workforce needed to deliver mental health and addiction services in the future may look different and support people in a greater range of settings. Informed by workforce planning, priority areas for investment in workforce development should be identified, along with how and by whom these are best delivered.

To support change in practice and service delivery there is a need for strong and effective leadership by both the Ministry of Health and within services. Leadership is an imperative to achieving change and supporting cultures that make a difference to people accessing services and the workforce.

The Government Inquiry into Mental Health and Addiction is providing hope to people accessing services, and to the workforce, that things will change. It gives hope that models of service delivery will be reviewed to deliver more effective outcomes across the continuum of care for people, and that people who experience mental health and addiction issues will get their needs met no matter where they come into contact with services. That policy and service planning will also be undertaken across services in a coordinated and collaborative way to ensure investment is made where it matters most.

Robyn Shearer
Chief Executive, Te Pou o te Whakaaro Nui

Recommendations

Our recommendations for the Inquiry to consider in respect to key priority actions needed to deliver more effective services for people who experience mental health and addiction issues are outlined below. Without these actions being addressed, service delivery is unlikely to significantly change. This will impact on the wellbeing and resiliency of people accessing services.

1. Develop an evidence-based strategy that includes:
    a. how health services need to respond to mental health and addiction demand across population groups and government agencies that is co-designed with people accessing services and their whānau
    b. how people with lived experience can influence, design and work in services
    c. a population health study which determines the mental health and addiction needs of the population
    d. a mental health and addiction research agenda to ensure the availability of up-to-date New Zealand based evidence to inform service planning, design and delivery models
    e. population health approaches to ensure the effectiveness of services for people with a focus on responsiveness for Māori and other priority population groups
    f. a re-orientation of service design and the workforce to have an emphasis on the significance of the social determinants of health
    g. re-prioritisation of distribution of funding across DHB and community-based NGO services.

2. Invest in the urgent need for strategic workforce planning to address the current and future workforce priorities. This is required at a national and local level with a long-term approach. Key actions required include:
    a. review the way that Health Workforce New Zealand (HWNZ) prioritises workforce investment, so that it is based on strategic workforce planning and development
    b. national workforce planning requires long term investment via the workforce centres (currently Te Pou only has six months remaining for workforce planning in the current HWNZ work plan)
    c. investment in new roles that lead strategic workforce planning at a local level
    d. future workforce planning occurs alongside service design which focuses on workforce size, knowledge and skills, composition, and role clarity
    e. investments in workforce development consider the range of factors required for successful implementation and sustainable practice change (e.g., leadership, organisational cultures, systems and processes)
    f. effective strategies to address an ageing workforce.

3. Invest in targeted strategies to grow priority workforce groups such as the Māori, Pacific, support and peer workforces. These can be progressed through enhancement to existing scholarship programmes and workforce centres.

4. The Ministry of Health ensures DHBs and their contracted providers have clear expectations about the utilisation of the *Let's get real* framework so that practice consistently reflects the fundamental values, attitudes, knowledge and skills across all roles in health.

5. Provide the workforce with access to learning and development opportunities needed to build skills of the workforce as required in specific areas. These include talking therapies, coexisting problems capability, physical health needs, suicide prevention, trauma-informed care, cultural responsiveness and responding to population specific groups. Strategies to address these need to recognise the importance of organisational culture and leadership in supporting effective practice change.

6. Investment by Government agencies (via Tertiary Education Commission and Health) in career and education pathways to support growth of the peer and support workforce, and post-entry specialist training programmes. These can be progressed through the workforce centres in conjunction with relevant industry training organisations and education providers.

7. Invest in and prioritise workforce wellbeing. This requires multi-level strategies through workforce centres, DHBs and contracted providers to address workload and demand, monitoring (real time staff experience tools); recognising the role of trauma for the workforce, ensuring the importance and access to supervision, learning and development opportunities; role redesign and clarity.

8. Invest in building multi-level leadership capability across government, sector and services. This requires a review of current capability and future needs. This is needed to build effective organisational cultures that support the wellbeing of people accessing services, the workforce and effective implementation of change.

9. Build capability in continuous quality improvement methodologies via Te Pou o te Whakaaro Nui and Health Quality and Safety Commission.

Overview of findings

Workforce planning

The workforce needs to be the right size and skill mix to respond to people with experience of mental health and addiction issues. Currently, there are an estimated 12,500 FTE positions in Vote Health funded mental health and addiction services, including forensic services. About 14% of the workforce is located in infant, child and adolescent services. Three-quarters of workers are employed in the community, and 60% in DHB services.

There are challenges recruiting staff, particularly in child and youth services, and for some roles (e.g., psychologists, occupational therapists, and nurses). New Zealand also has a high reliance on overseas trained health professionals, including doctors and nurses (OECD, 2017). The Māori and Pacific clinical workforce is under-represented compared to people accessing services and expected population growth. To maintain the status quo and keep pace with population growth, the secondary mental health and addiction workforce may need to grow by 4,000-5,000 FTEs over the next 10 years, largely due to workforce ageing.[1]

Demand for mental health and addiction services is increasing and there is large unmet need in the community. *Towards the Next Wave* signalled the importance of growing the support workforce who currently make up about 60% of the NGO workforce and one-third of the overall workforce. To effectively respond to population demand, strategic workforce planning and development is required across multiple sectors, including secondary and primary health care, social services and other government agencies. A greater focus on worker wellbeing is also needed to respond to the increasing demand for services, risk of burnout and secondary trauma, experiences of intimidation and bullying, and the potential impact these have on people accessing services.

With new service delivery models emerging and to efficiently and effectively use the knowledge and skills of the workforce, it is important to consider the skills and roles required now and in the future. Currently, over three-quarters of the DHB workforce is comprised of clinical roles. Conversely, NGOs tend to employ a greater proportion of non-clinical staff who are primarily support workers.

In addition to the Vote Health funded workforce, primary care services and the Department of Corrections are among other key services supporting people who experience mental health and addiction issues. These services also require clinical and support roles and may create workforce competition.

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1 To keep pace with population growth, the workforce will need to grow by about 10% over the next 10 years. A large proportion of the workforce will also reach retirement age during this period. For example, half the DHB workforce is aged 50+, compared to 43% for all DHB staff.

Workforce development

Organisational development

The culture within services needs to promote wellbeing, resiliency and recovery for people who experience mental health and addiction issues. The workforce needs to reflect in their practice the essential knowledge, skills, values and attitudes outlined in *Let's get real.* These values include respect, manaaki, hope, partnership, wellbeing, and whanangatanga.[2] The attitudes include being compassionate, genuine, honest, open-minded and optimistic. The identification and implementation of strategies to support greater family and whānau inclusion are also required.

To support wellbeing and recovery, restrictive practices such as seclusion and restraint, which are highly traumatising for people, should be reduced and eliminated. The goal is for zero seclusion by 2020 (Health Quality Safety Commission, 2018). To achieve this, work is needed to further progress initiatives co-designed by people who access services; to support wider implementation of the *Six Core Strategies©* for reducing seclusion and restraint; and better understand and respond to the higher rates of seclusion for Māori and Pacific peoples.

Learning and development

The workforce needs to be competent and capable of responding effectively to the needs of people accessing services and their whānau. Learning and development activities based on key needs include access to talking therapies, implementing a systematic approach to trauma-informed care, and equipping workers in responding to long-term physical health problems. Suicide prevention is also a key area for development. Whilst there has been an increase in the number of providers supporting suicide prevention, there is no current suicide prevention strategy and staff in DHBs have told us they need upskilling in this area. Within services, the focus on building coexisting problems' capability and the provision of integrated care should remain a priority. Continued access to learning and development opportunities to build greater cultural responsiveness, and in responding to population specific groups is also required.

Adequate funding needs to be available to support learning and development, particularly within NGOs. Learning and development requires organisational commitment and leadership to ensure new knowledge and skills are embedded in practice. Training should not be undertaken without consideration of other factors required to bring about successful and sustainable change in practice e.g., leadership, organisational culture, systems and processes.

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2 Values included in the refreshed framework.

Recruitment and retention

To better meet the needs of Māori and reduce health inequalities, growing the Māori workforce remains a priority, particularly for clinical roles. Māori currently comprise 27% of people accessing mental health and addiction services.

There is a need to grow the Pasifika workforce, particularly the clinical workforce, to help reduce health inequalities and outcomes for Pasifika peoples. Pacific peoples often have high and complex needs and a higher risk of mental health and addiction issues, including suicidal behaviour, along with considerable unmet needs in the community (Faleafa & Pulotu-Endemann, 2017).

Growing the peer workforce (peer support and consumer advisors) is a priority. With effective training and supervision, the peer workforce use their lived experience to support and improve the wellbeing of people who are experiencing mental health and addiction issues. Currently there are estimated to be less than 250 peer support workers, who are mostly employed by adult NGO services. Strategic development of the peer workforce is required, including access to recognised NZQA qualifications and career pathways.

Information, research and evaluation

Up-to-date and relevant evidence is required to inform practice. For services to be responsive to population health needs, there needs to be an understanding of current mental health and addiction issues in the community. This is not adequately captured through the *New Zealand Health Survey*. The last population mental health survey was undertaken in 2006. Going forward, population level studies need to have a broader scope and include factors such as psychosis, discrimination, physical health and employment.

The collection of outcomes data helps services understand whether support provided is making a difference to people or if changes are required. Information collected also helps inform service delivery, and service planning at local, regional and national levels. The Ministry of Health must endorse and mandate the collection and use of people's experiences of service provision to encourage greater collection of information. All DHBs and NGOS must set expectations in annual plans of how they intend to incorporate the experience of people accessing services into service provision. Further progress is also required in outcomes data collection, particularly in NGO and primary mental health settings.

The development of a research and development strategy outlining priorities for clinical practice, particularly for priority population groups, is recommended along with mechanisms to better support the translation of evidence into practice.

Workforce development infrastructure

Currently $30 million is invested in workforce development activities by HWNZ, in addition to that invested by DHBs and others. There is a need to ensure that investment decisions are underpinned by evidence and a workforce planning approach so that investment is targeted to priority areas. HWNZ needs to ensure transparency in the decision-making process and how investment is applied across sectors. The absence of a governance structure that clarifies understanding of how funding is applied and how services are procured adds to unnecessary duplication of effort and activity. A stocktake is therefore needed to understand where workforce funding is applied and coordinated.

Strengthened leadership by the Ministry of Health is required to outline the future strategic direction for mental health and addiction services. Mental Health and addiction resources are now dispersed across the Ministry and coordination is not always evident. Leadership and governance capability within services also needs to be strengthened, including consumer leadership. Any change in practice requires effective leadership and building organisational cultures that support change, effective practice, and enhance outcomes for people.

To respond to the continuum and complexity of people's mental health and addiction needs, collaboration is required at both policy and service levels. Most people with mental health and addiction issues access primary health services and other community providers, such as social services. Prisoners have the highest rate of mental health and addiction issues in the population. The Ministries of Education and Social Development are among others providing support, particularly to children and youth. A whole of system approach needs to be taken to service planning, and in improving cross-service linkages and collaboration. To support this, new workforce roles may be required, along with the development of greater capability in collaborative ways of working. Workforce planning across sectors is required to determine these changes. We also need to be realistic that this will require a transition workforce – whereby we bring in new roles and review existing roles. This process needs to be well managed and coordinated nationally so that new roles are integrated well alongside existing roles.

To build the confidence of frontline health and other staff in responding to people who experience mental health and addiction issues, workshops like the MH101 and Addiction 101 programmes need to be available, alongside suicide prevention programmes.

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Background

This workforce stocktake was undertaken to inform the 2018 Government Inquiry into Mental Health and Addiction. It summarises workforce information and consultation feedback provided in two earlier reports (May and June 2018), and incorporates up-to-date NGO and DHB workforce data in Vote Health funded mental health and addiction services.

The purpose of the workforce stocktake is to describe:

a) current mental health and addiction workforce planning and development
b) workforce challenges, future directions and solutions.

The workforce stocktake primarily focuses on Vote Health funded mental health and addiction services, including forensic services. This includes non-government organisation (NGO) and district health board (DHB) community and inpatient mental health and addiction services. Where information is readily available, primary mental health and Department of Corrections services have been included.

Workforce planning and development

The workforce is critical to achieving the future vision for mental health and addiction services. Any change in the way services are delivered in the future needs to be underpinned by strategic workforce planning. The goal of workforce planning and development is having 'the right number of people with the right skills, in the right place, at the right time, with the right attitude, doing the right work, at the right cost with the right work output" (World Health Organization, 2010, p. 1).

The World Health Organization promotes strategic workforce planning based on population health needs as the gold standard for the management and development of the health workforce internationally. Workforce planning involves the systematic identification, analysis and planning of future workforce needs based on population health needs and priorities (Te Pou o te Whakaaro Nui, 2017c), see Figure 1. The workforce planning process used to inform the development of this report included:

- examining the future direction as outlined in the *Mental Health and Addiction Workforce Action Plan*, other actions plans, and strategic documents
- gathering data to understand population needs
- examining the size, composition, knowledge and skills of the workforce
- identifying key gaps and priority areas.

Workforce development should be driven by, and be the output of, strategic workforce planning. Workforce development should address specific gaps identified through the workforce planning process and ensure the workforce is best able to deliver future services (International Organization for Standardization, 2016). As described in Table 1 below, there are five domains of workforce development and activities across multiple domains are often required to bring about sustainable and effective change in practice. For example,

learning and development is most likely to be effective when guided by a strategic workforce planning process and consideration is given to the organisational culture, systems and processes needed to support practice change.
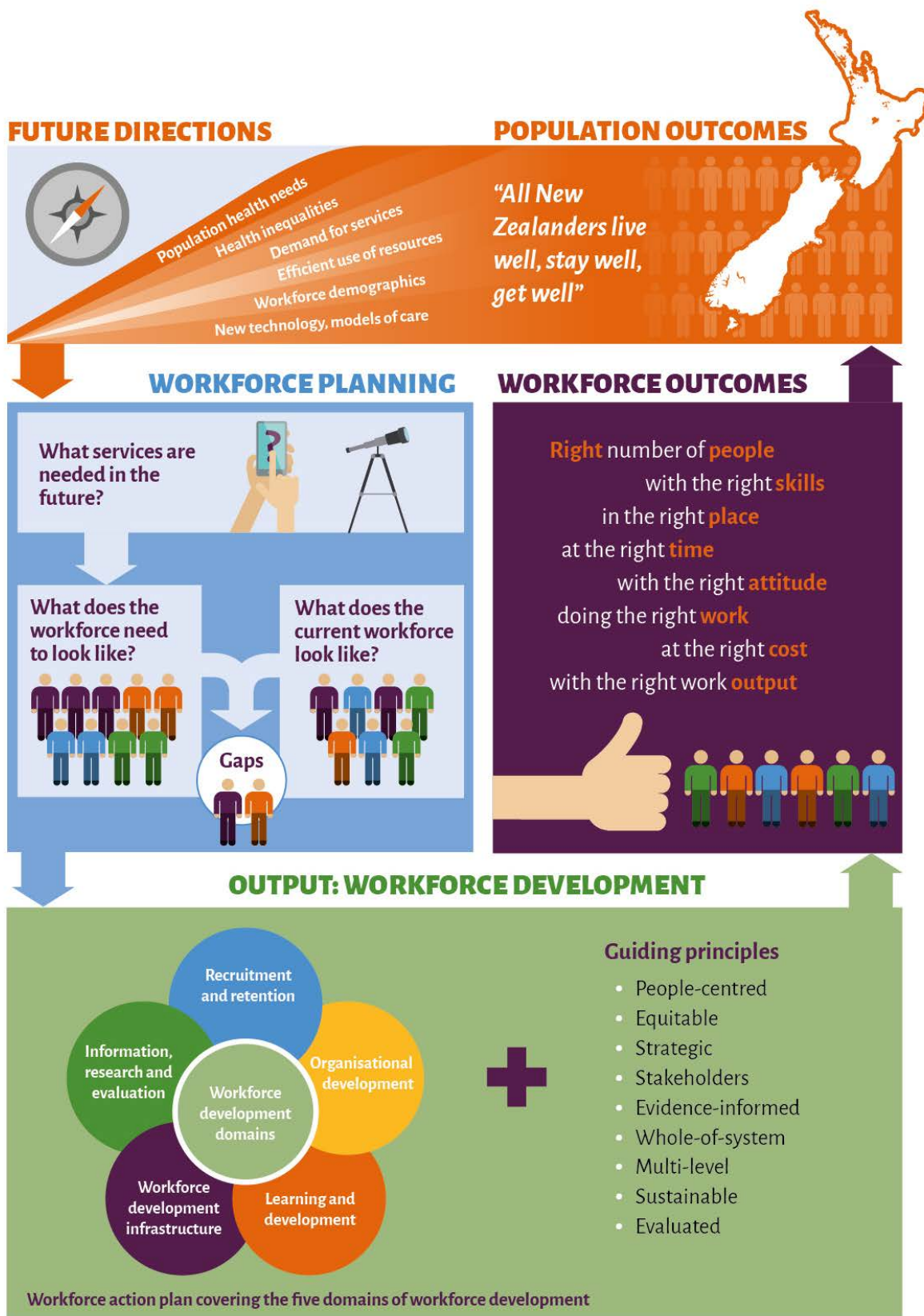
Figure 1. **Workforce planning and development process (Te Pou o te Whakaaro Nui, 2017c).**

Document structure

The structure of this document is based on workforce planning, and the five domains of workforce development as outlined in Table 1.

Table 1. *Workforce Planning, Domains of Workforce Development and 10 Key Future Directions**

Domain	Future directions
Workforce planning	1. Workforce with the right size and skill mix to respond to population needs, underpinned by strategic workforce planning 2. Workforce wellbeing and career pathways
Workforce development • Organisational development • Learning and development • Recruitment and retention • Information research and evaluation • Workforce development infrastructure	3. Building a culture that supports wellbeing and recovery 4. Workforce responds effectively to people and their whānau 5. Growing the Māori workforce 6. Growing the Pacific workforce 7. Growing the peer workforce 8. Evidence-informed practice and continuous quality improvement 9. Policy and funding supports workforce development 10. Working collaboratively with others

Note. * based on a review of the *Mental Health and Addiction Workforce Action Plan,* other action plans and strategic documents.

Key findings

Workforce planning

Each year about 1 in 5 adults experience mental health and addiction issues, most of which first occur early in people's lives (Oakley Browne, Wells, & Scott, 2006). Most people experiencing issues with their mental health or addiction do not access secondary mental health and addiction services.

Last year nearly 175,000 people accessed secondary mental health and addiction services (including 41,500 people aged under 18 years), reflecting 3.7% of the population.

Over the last five years there has been a 12% increase in the total number of people accessing services. The largest growth however, has been in access to only NGO services.[3] Approximately 30% of funding for secondary mental health and addiction services goes toward NGO services, and 70% towards DHBs.[4]

Workforce with right size and skill mix to respond to population needs

The workforce in Vote Health funded mental health and addiction services is currently estimated to reflect 12,500 full-time equivalent (FTE) staff, including about 1,000 FTEs in forensic services, see Figure 2. The mental health and addiction workforce represents about 12% of the DHB workforce.[5] About 14% of the workforce is located in infant, child and adolescent services;[6] 83% in adult services; and 3% in older adult mental health and addiction services.[7]

Figure 2. **Estimated workforce (employed and vacant) in mental health and addiction services.**
Note. Rates vary for specific services, such as infant, child and adolescent services, see Appendix A.
Source: Te Pou o te Whakaaro Nui (2015); Werry Workforce Whāraurau (2017).

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3 There has been a 34% growth in people accessing only NGO services over the last five years.

4 Source: Ministry of Health Price Volume Schedule 2016/17 for adults and older adults and Werry Workforce Whāraurau (2017).

5 There are 7,859 FTEs estimated to be working in DHB mental health and addiction services (see Table 7, Appendix C), and 60,546 FTEs reported as working in DHBs as at 31 March 2018 (see https://tas.health.nz/strategic-workforce-services/health-workforce-information-programme-hwip/)

6 Who receive about 12-13% of the overall funding.

7 The older adult workforce is lower given not all DHBs have mental health services for older people. In some DHBs, support for older people with mental health and addiction issues is provided within older adult health services.

Workforce data for infant, child and adolescent services indicates the DHB inpatient workforce has remained relatively static over the last 10 years, see Figure 3. The largest growth has occurred in the DHB community and NGO workforces (about 38% over the last 10 years).[8]
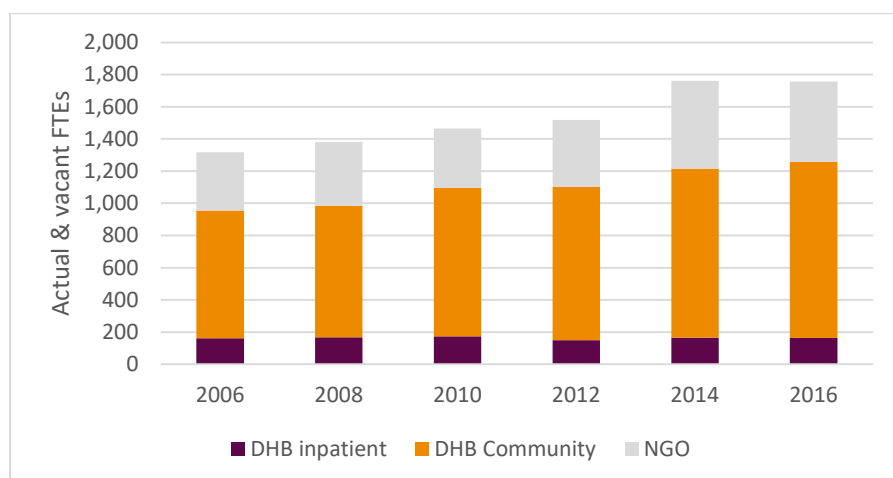
Figure 3. **Infant, child and adolescent workforce FTEs (employed plus vacant), 2006-2016, by service type.**
Source: Werry Workforce Whāraurau (2017).

Challenges growing the workforce

The demand for mental health and addiction services is increasing significantly relative to the workforce. Between 2006/07 and 2016/17 there was a 73% increase in people accessing services, and a corresponding 40% increase in funding, see Figure 4. For infant, child and adolescent services specifically, funding increased by about 60% over the same period, with the number of people accessing services more than doubling and the workforce growing by only one-third (Werry Centre, 2007; Werry Workforce Whāraurau, 2017). In recent years there has been a distinct flattening in the workforce size compared to the growth in demand for infant, child and adolescent services. This means workers are increasingly supporting a larger number of people. Future increases in the number of people seen will place further pressure on the workforce and impact on the quality of services. This situation cannot continue.

Recruiting qualified and experienced staff in mental health and addiction services is a key workforce issue. NGO services experience high workforce turnover rates compared to DHBs.[9] Across services, vacancy rates are high for some allied health roles (e.g., psychologists, occupational therapists) and nurses, particularly in forensic settings.[10] Perceived future shortages have also been identified for addiction and coexisting problem practitioners, nurses, psychiatrists, and psychologists (Te Pou o te Whakaaro Nui, 2015). There are challenges recruiting staff in infant, child and adolescent services in particular. For example, the overall vacancy rate in 2016 was 9% and 1.5 times higher than adult services.

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8 Growth between 2012 and 2016 for DHB community and NGO workforce was 15-20%.

9 For example, in 2016 the DHB turnover rate for infant, child and adolescent services was 13% compared to 28% for NGOs (overall rate=16%).

10 The overall vacancy rate for psychologists is estimated to be 12%, 9% for occupational therapists, and 7% for nurses. In 2016, vacancy rates were also high for psychiatrists (10%) and social workers (8%) in infant, child and adolescent services.

Changes influencing service delivery since 2014

73% Access increase

40% Funding increase
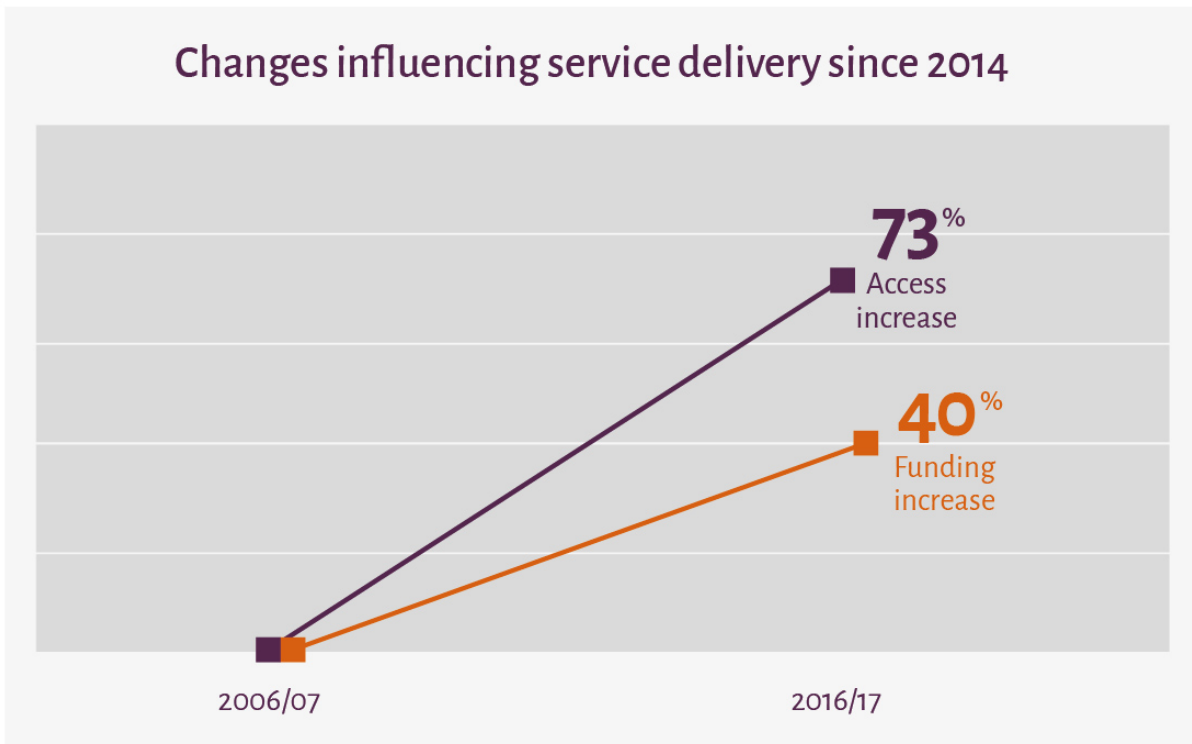
2006/07   2016/17

Figure 4. **Changes in service access and funding between 2006/07 and 2016/17.**
Source: Ministry of Health (2018c).

Another key challenge is maintaining a sufficient workforce due to workforce ageing. For example, about half of the DHB mental health and addiction workforce will reach retirement age within the next 15 years, see Figure 5. The population is also expected to grow by 10% over the next 10 years, see Figure 6. Based on this growth and workforce ageing, an estimated 4,000-5,000 FTEs will be required over the next 10 years to maintain the status quo of the secondary mental health and addiction workforce.

50%

Half the DHB MH&A workforce is aged **50 +**
Compared to 43% of all DHB employees

43%

Figure 5. **DHB mental health and addiction workforce age compared to the overall DHB workforce.**
Source: Te Pou o te Whakaaro Nui (2017a)

Population growth 2018 to 2028

Legend:
- Total population
- Māori
- Pasifika
- Asian

Total population: 10%
Māori: 18%
Pasifika: 18%
Asian: 38%
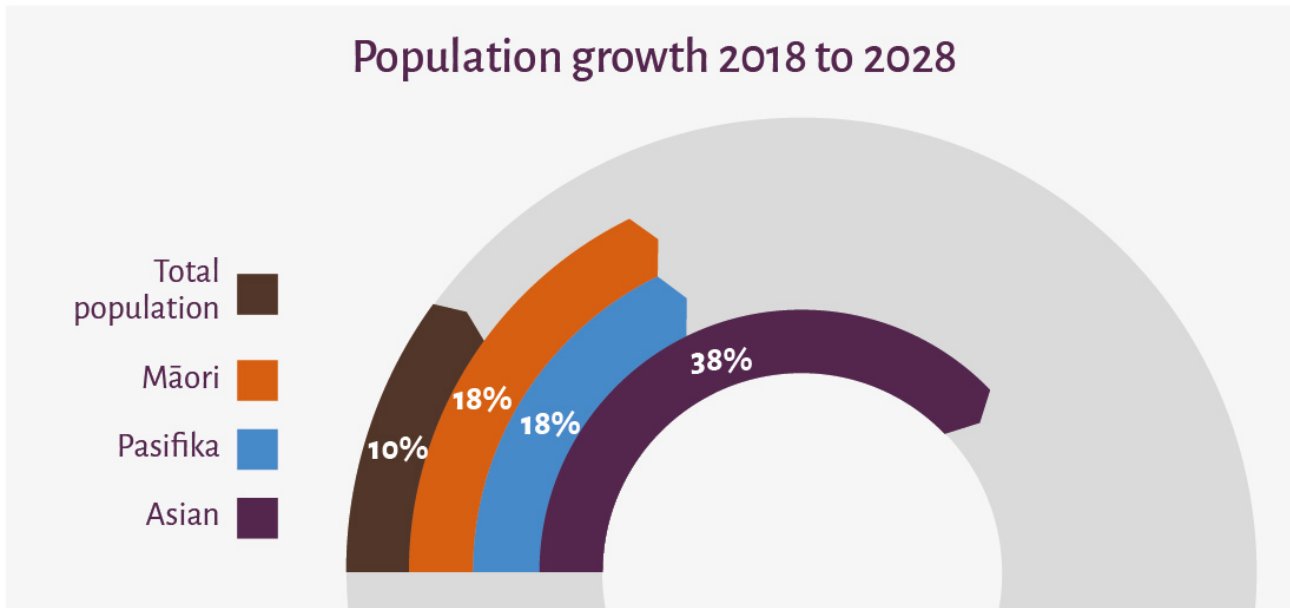
Figure 6. **Projected growth by population growth to 2028.**

Source. Statistics New Zealand (2017).

Some workforce planning has been undertaken and tools and resources have been developed to support this.[11] There is a need to ensure the development of local and regional workforce plans remains a priority, particularly where changes in models of service delivery are indicated. Proactive planning is required to address future workforce gaps. Workforce development initiatives need to focus on the development of effective workforce recruitment strategies, including strategies to help retain an ageing workforce, and consider more flexible working arrangements.

Workforce data needs to continue to be available to underpin workforce planning and for people with lived experience to be part of the workforce planning process. Workforce planning relies on good quality information about the population, people accessing services, and the workforce. Workforce information showing long term trends for infant, child and youth services is well established. However, for adult services, this information is still in development.[12]

Currently there is no national requirement to undertake workforce planning for mental health and addiction services within the health sector nor across other government sectors. Workforce planning needs to be undertaken across sectors, amongst key services providing support to people with experience of mental health and addiction issues given the rapidly changing workforce providing support. This should consider the primary health and secondary mental health and addiction workforces, including forensic services, along with the workforce supporting people in the community and in prison. Further consideration should be given to how services can be delivered in innovative ways and ensuring adequate funding is available to meet future demand.

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11 See https://www.tepou.co.nz/resources/getting-it-right-workforce-planning-guide/489

12 This is available for child and youth services and has been for some time through the Werry Workforce Whāraurau stocktakes. Workforce information about adult and older adult services has been collected in 2014 and 2010 respectively, and again in 2018.

Ensuring the workforce has the right skill mix

DHBs and NGOs currently employ a range of clinical and non-clinical roles as summarised in Table 2. While over three-quarters of the DHB workforce have clinical roles,[13] NGOs tend to employ a greater proportion of non-clinical staff who are primarily support workers. Within NGO settings, adult mental health services employ fewer clinical, and more non-clinical, staff than infant, child and adolescent, and alcohol and other drug services (see Appendix B for further details). In 2014, it was estimated that DHB FTEs were funded about 60% more on average than NGO FTEs (Te Pou o te Whakaaro Nui, 2015).

With new models of care emerging and being developed, it is important that workforce planning considers the tasks and functions required to support people, the associated skills and competencies, and then the types of roles required. Reviews of community mental health teams have already been undertaken in some DHB mental health teams to help support this. It would be useful to capitalise on this experience and knowledge to support other DHBs to do the same.

Table 2. *Estimated Workforce (Employed and Vacant) in Clinical, Non-Clinical, and Admin/Management Roles*

Workforce group	DHB 7,859	NGO 4,747	Total 12,640
Clinical workforce, including:	77%	25%	57%
• **Nursing** e.g., registered nurses, nurse practitioner, nurse specialist, nurse educator, enrolled nurse, other nursing professionals			
• **Allied health** e.g., social workers, addiction practitioner/clinician, clinical psychologist, occupational therapist, coexisting problems (CEP) clinician, counsellor, educator/training, other psychologist or allied health			
• **Medical and other professionals** e.g., consultant psychiatrist, psychiatric registrar, medical officer, liaison/consult liaison, other medical professionals			
Non-clinical workforce, including:	13%	62%	32%
• **Support workers** e.g., residential support workers, healthcare assistants, psychiatric assistants, peer workers – consumer and service user, family support worker, community development worker, employment worker, peer support – family and whānau, other support workers			
• **Cultural advice and support** e.g., Kaumātua, Kaiāwhina, Traditional Māori health practitioner, cultural supervisor, Kuia, Pasifika cultural advisor, Matua			
Administration and management:	10%	13%	11%
• For example, administrative/technical support, service manager, team leader, senior manager, consumer advisor/consumer leader, professional leader, clinical director, family/whānau advisor, other administration and management			

Source: Te Pou o te Whakaaro Nui (forthcoming, 2018) and Werry Workforce Whāraurau (2017)

Note. Percentages vary for specific services such as infant, child and adolescent services, and alcohol and other drug services. See Appendix B for details.

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13 The term clinical is used here to describe health professional roles such as doctors, psychiatrists, nurses, psychologists, addiction practitioners, social workers and related allied health roles (see Table 2 for further details).

With a greater focus on wellbeing, resiliency and recovery, new roles may be required to complement the secondary mental health and addiction workforce including health/lifestyle coaches, digital support mentors for children and youth, and more employment specialists.[14] About 1 in 5 people accessing adult inpatient services have problems with accommodation, employment and/or activities of daily living.[15] These activities can be supported by suitably qualified non-clinical staff, freeing up clinical workers to use their specialist skills elsewhere (Te Pou o te Whakaaro Nui, 2014). A review of scopes of practice to support the workforce working to top of scope is needed e.g., for nurses and support workers, and exploring the keyworker/case management model used in DHBs.[16] By effectively collaborating and working to top of scope, the skills of the workforce can be used more efficiently to fundamentally support people with experience of mental health and addiction issues and their wider family and whānau. There is however a need for role clarity across all roles.

For the small and specialised infant, child and adolescent workforce there is a need to find innovative ways to keep experience and expertise contributing to support the development of colleagues and services. This may require the development of new types of roles in the sector to support supervision, mentoring/coaching and training. Currently this is limited by narrow job descriptions and funding constraints.

Support workers (including youth workers and peer support workers) currently make up about 60% of the NGO workforce.[17] With a greater focus on community services it is anticipated that this workforce will require the greatest growth and development in the future.[18] The importance of growing this workforce has been signalled by *Towards the Next Wave* and is reflected in the recent pay equity settlement announcement for an estimated 5,000 mental health and addiction support workers across multiple sectors.[19] Growing the support workforce will require national investment and a long-term approach including: strategic workforce planning, career progression, career and education pathways, raising the profile and value of the support workforce, and greater recognition of how these roles can work alongside other workers to support working to top of scope. Currently, the only investment for mental health support workers is in the Level 4 National Certificate in Health and Wellbeing through Careerforce, while in addiction there are Level 6 and 7 qualifications. There is a need for this education pathway to be addressed alongside career pathways for support workers.

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14 There is also a need for more generalists than specialists to meet current needs (e.g., whānau ora navigators), and to develop nursing specific roles and job descriptions (e.g., clinical roles for the CAMHS pathways) rather than using senior medical officers.

15 While employment specialists are primarily employed by MSD, employment workers reflected 1.7% of the NGO adult mental health and addiction workforce in 2014 (Te Pou o te Whakaaro Nui, 2015). These are also issues for young school leavers and disenfranchised you.

16 There is a need for clarity on the role of keyworkers and to ensure this is useful to people accessing services. Coordination of care may be better led by primary care services or support workers with clinician backup. See https://www.health.govt.nz/system/files/documents/pages/mental-health-workforce-service-review.pdf

17 Support workers primarily employed within NGO services include residential support workers and peer support workers. Support workers make up about 10% of the DHB workforce primarily in health care assistant and psychiatric assistant roles. For infant, child and adolescent services specifically mental health support workers and youth workers, make up 2.6% of the DHB workforce, and 34% of the NGO workforce.

18 https://www.health.govt.nz/system/files/documents/pages/mental-health-workforce-service-review.pdf

19 See https://www.beehive.govt.nz/release/pay-equity-settlement-mental-health-and-addiction-support-workers

Workforce wellbeing and career pathways

Career pathways

Tertiary education programmes need to be fit-for-purpose and support the development of relevant knowledge and skills for people entering the mental health and addiction sector. For example, in working with population specific groups such as child and youth and people with coexisting problems. To further support mental health and addiction career pathways, there is a need to continue new graduate programmes, like Skills Matter, which support the transition to practice. Each year around 300 nurses and allied health professionals are funded through the Skills Matter programme (see Table 3).[20] The programme includes multiple components to support effective transfer of knowledge to practice. These include funding for preceptors and supervisors and release time, a requirement for clinical placements and organisational support for students, along with strong relationships with the sector to ensure programmes are relevant, current and reflective of workforce need. The Skills Matter programmes are in high demand and increased investment is required, especially for allied health programmes, given the drive to address social determinants of health. Longer-term funding is also needed to ensure these programmes can be designed to meet future workforce needs. The short-term funding contracts (currently annual from January to December) do not support innovation or adaptation of programmes.[21]

Table 3. *Skills Matter Funded Programmes, 2016–2018*

Programme	2016	2017	2018
Clinical Leadership in Nursing Practice	44	47	41
Coexisting Substance Use and Mental Health	29	25	24
Core Skills in Infant, Child & Adolescent Mental Health and Addiction	31	29	30
NESP Allied Mental Health and Addiction	28	29	36
NESP Mental Health and Addiction Nursing	163	171	161
PG Diploma in Cognitive Behaviour Therapy	18	21	16
Total number of students	**313**	**322**	**308**

Note. NESP = New entry to specialist programme. Source. Skills Matter data collected by Te Pou o te Whakaaro Nui.

In developing career pathways, there is a requirement for greater transparency of study and career pathways, and clearer expectations about what to expect when working in mental health and addiction services. Planned career promotion programmes are also needed to encourage young people into mental health and addiction earlier.

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20 In 2018, 16% identified as Māori and 8% Pacific.

21 Funding needs to consider the lead in time for DHBs who recruit new graduate staff in August and allocate places in September in the year prior.

Improved workforce wellbeing

A greater focus on the wellbeing of the workforce is required given the pressure on staff due to the increased demand for services, risk of burnout and secondary trauma, and experiences of bullying and intimidation (Te Pou o te Whakaaro Nui, 2018f).[22] Given the potential impact on people accessing services, there are recommendations to move from the Triple Aim to a Quadruple Aim that adds the goal of improving the work life of health care providers.[23]
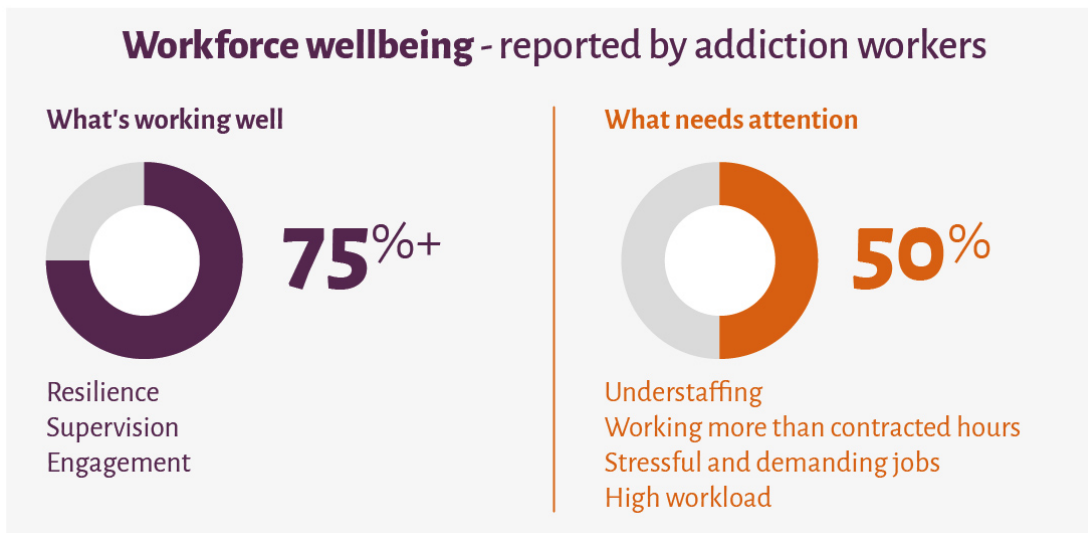
Figure 7. Workforce wellbeing among addiction workers in New Zealand.
Source: Matua Raki (2018); Roche et al. (2018)

Last year there was an amendment to the Hippocratic Oath sworn by all doctors to include the clause "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard". Until now, the declaration had no provision related to self-care. This year work was carried out to better understand the wellbeing of the addiction workforce (see Figure 7 for key findings), and in reviewing relevant literature and identifying tools and resources.[24] The Health Quality and Safety Commission are also undertaking the *Ngā Poutama Oranga Hinengaro* survey later this year focusing on factors affecting quality and safety within mental health and addiction services. Supervision guidelines also exist for nurses, addiction and family inclusive practitioners, and *Let's get real* includes a focus on maintaining professional and personal development as part of the Real Skills. Further work is required in monitoring the wellbeing of the workforce in different service settings, and building cultures in organisations that support wellbeing, and ensuring staff have access to regular supervision, mentoring, and other opportunities for professional development. In addition, capacity and demand tools (e.g., Choice and Partnership Approach [CAPA]) and

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22 For example, about 50% of medical professionals in New Zealand and Australia experience workplace bullying from peers (Rutherford & Rissel, 2004; Scott, Blanshard, & Child, 2008). About one-third of nurses experience inappropriate behaviours from people accessing services, with mental health nurses most at risk (McKenna, Poole, Smith, Coverdale, & Gale, 2003).

23 Triple aim includes Improved quality, safety and experience of care; Improved health and equity for all populations; and best value for public health system resources. See https://www.hqsc.govt.nz/news-and-events/news/126/. The Quadruple Aim adds the wellbeing of workers. See http://www.annfammed.org/content/12/6/573.full

24 As part of work on trauma-informed care.

roles, which have been used in infant, child and adolescent services, could be utilised more in adult services.[25]

Workforce development

Organisational development

Building a culture that supports wellbeing and recovery

Workforce has the essential capabilities to effectively respond to people and whānau

The culture within services needs to promote the wellbeing, resiliency and recovery of people accessing services. Two-thirds of adult services have identified the need for increased workforce capability in supporting self-managed care, using strengths-based approaches to enhance recovery, and in working with families and whānau (Te Pou o te Whakaaro Nui, 2015). To support this, it is important the workforce has the core knowledge, skills, values and attitudes outlined in *Let's get real*, and people accessing services are engaged and involved in decisions about their own care and treated with dignity and respect.

Over the last year, work has been undertaken to refresh the Ministry of Health's *Let's get real* framework (Te Pou o te Whakaaro Nui and Ministry of Health, 2018), see Figure 8. The focus of *Let's get real* is now broader and includes everyone working in health supporting people with mental health and addiction needs. The *Let's get real* framework, which is expected to be launched by the Minister of Health in October 2018, has a more people-centred approach based on wellbeing and strengthened cultural diversity. To support further implementation of *Let's get real* and building core capability of the workforce, clear expectations of the framework through contracting are required by the Ministry of Health. *Let's get real* needs to be reflected as part of DHB district annual plans and a requirement for DHBs to include this as an expectation in NGO contracting. For practice within services to reflect the refreshed *Let's get real* framework, further work is required to support organisations and the workforce to implement and embed this, along with frameworks developed for specific population groups.[26]

There have been calls for greater family and whānau inclusion in services and the identification and implementation of strategies to support this e.g., routinely undertaking family assessments; family inclusive online training; single session family consultation training; and the development of resources to support the *Let's get real* Real Skill of Working with whānau. Further training to support implementation of the *Supporting Parents Healthy Children Guidelines* (Ministry of Health, 2015) and adaptation of the 5-step method[27] to the New Zealand context is planned. Relevant training is needed to ensure these are applied appropriately.

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25 http://www.werryworkforce.org/CAPA

26 This includes *Real Skills Plus ICAMH/AOD*, *Real Skills plus Seitapu – Working with Pacific Peoples*, *Te Whare o Tiki* – for working with coexisting mental health and addiction, and *Takarangi Competency Framework* – to develop cultural competence in working with Māori.

27 Copello, Templeton, Orford & Velleman (2010).

Figure 8. Refreshed *Let's get real* framework.

Source: Te Pou o te Whakaaro Nui and Ministry of Health (2018)

Restrictive practices are reduced and eliminated

To support wellbeing and recovery, restrictive practices such as seclusion and restraint, which are highly traumatising for people, need to be reduced and eliminated. Since 2009 when policy was introduced there has been a reduction in seclusion, see Figure 9. However, 11% of people accessing services in 2016 were secluded and the rate of seclusion was twice as high among Māori and Pacific peoples compared to others. There is an aspirational goal that by 2020 there will be zero seclusion (Health Quality Safety Commission, 2018). Several initiatives have been undertaken to support reduced seclusion and restraint of people accessing adult mental health inpatient services. The *Six Core Strategies©* (National Association of State Mental Health Program Directors, 2008) is an evidence-based framework for reducing restrictive practice that has been adapted to the New Zealand context and support provided for implementation by Te Pou (Te Pou o te Whakaaro Nui, 2013). Services have also been provided sensory modulation training, and a review in 2017 helped identify future needs and areas for development (Te Pou o te Whakaaro Nui, 2017b). In addition, Safe Practice Effective Communication (SPEC) training has been made available and provides national consistency and best quality evidence-based therapeutic interventions for effectively reducing

seclusion and restraint.[28] Other work has involved monitoring seclusion data, undertaking research to better understand DHB variation in seclusion rates and risk factors based on routinely collected HoNOS scores, along with the Health Quality and Safety Commission's work on continuous quality improvement.[29]

To continue making progress in reducing seclusion and restraint it is important to further support co-design leadership, the use of *Six Core Strategies©* within services, monitoring seclusion use, and the implementation of SPEC training. Other measures include refreshing the sensory modulation knowledge and skills of the workforce, developing the knowledge and skills of the workforce to better manage the impact of substance use issues and withdrawal, supporting the development of a national restraint measure, and better understanding and implementing strategies to reduce the risk of seclusion for Māori and Pacific peoples. There are concerns however that PRN medication may be used as an alternative to seclusion and needs to be monitored. For example, New Zealand research indicates the amount of PRN medication nearly doubled in the years following the implementation of *Six Core Strategies©* (Wolfaardt, 2013).
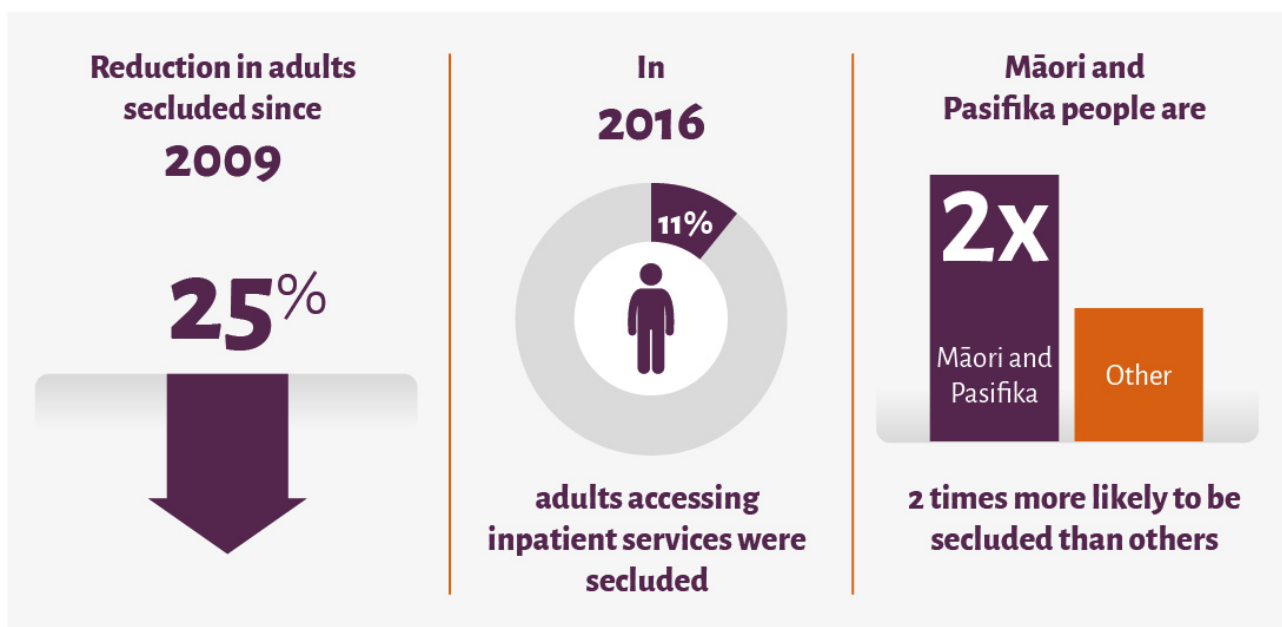
Figure 9. **Seclusion amongst adults accessing mental health and addiction inpatient services.**
Source: Ministry of Health (2017); Health Quality Safety Commission (2018)

In February 2018, the Substance Addiction (Compulsory Assessment and Treatment) Act (2017) came into effect. Training has been provided to introduce the addiction workforce to the criteria for the use of the Act, including capacity assessment, to ensure compulsion is only used as a last resort with people who have severe substance addiction and impaired capacity to make decisions about addiction treatment. Further learning and workforce development opportunities have been identified by the sector and the Ministry of Health, alongside challenges to current models of care.

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28 https://www.tepou.co.nz/initiatives/safe-practice-effective-communication/225

29 https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/

Ensuring services are culturally responsive

To help address inequalities in health status, access and outcomes, mainstream mental health and addiction services need to be culturally responsive. Māori currently reflect 27% of people accessing services. While about one-third of Māori access kaupapa Māori services, the majority access mainstream services. Several tools and resources have been developed for working with Māori e.g., *Let's get real* tools and resources for Working with Māori,[30] *Takarangi Competency Framework* for Māori working with Māori, Working with Māori eLearning through the Matua Raki website, and *Te Reo Hāpai* – language resource to improve engagement with Māori.[31]

Conservative estimates indicate Pacific peoples reflect 6% of people accessing services.[32] There are also high unmet needs for Pacific peoples in the community. Like Māori, most Pacific peoples access mainstream services, with only about one-third accessing either Pacific or kaupapa Māori services. To enhance responsiveness to Pacific peoples, the *Real Skills plus Seitapu* framework for working with Pacific peoples has been developed, and the *Engaging Pasifika* cultural competency training programme has been completed by over 3,500 health workers, supported by tools and resources, including organisational cultural competency guidelines.[33]

Greater consideration needs to be given to the cultural responsiveness for Asian peoples given projected population growth of 38% over the next 10 years.

To support engagement and cultural responsiveness, talking therapy guides have been developed for Māori, Pacific, Asian, refugee and migrant communities.[34] Although developed a while ago, the College of Psychiatrists developed an online orientation package for overseas trained doctors. Further opportunities to build cultural responsiveness include strengthening the focus within Skills Matter funded programmes, developing Māori approaches to trauma-informed care (Waikato University's *He Oranga Ngakau* project is well underway to support Māori providers),[35] and providing opportunities for non-Māori and non-Pacific peoples to work in cultural services. Consideration should also be given to maintaining the ongoing need for ethnic specific services e.g., Māori for Māori, and Pacific for Pacific services, as well as Asian for Asian services.

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30 https://www.tepou.co.nz/initiatives/lets-get-real/107

31 https://www.tepou.co.nz/uploads/files/Te%20Reo%20Hapai%20booklet.pdf

32 Source: Ministry of Health, PRIMHD extract 9 April, analysed by Te Pou. Pacific peoples accessing services may be underestimated due to prioritised ethnicity.

33 https://www.tepou.co.nz/uploads/files/resource-assets/Lets-Get-Real-Real-Skills-Plus-Seitapu-Working-with-Pacific-Peoples.pdf

34 https://www.tepou.co.nz/initiatives/talking-therapy-guides/56

35 https://www.waikato.ac.nz/rangahau/research/well-being

Learning and development

Workforce responds effectively to people and their whānau

The workforce needs to be competent and capable of responding effectively to people with experience of mental health and addiction issues and their whānau. A key challenge for services is managing pressure on staff due to the increasing number of people accessing services with complex issues (Te Pou o te Whakaaro Nui, 2015). Significant problems among people accessing inpatient services are illustrated in Figure 10. In order to respond effectively to people's needs, workforce development activities are required in:

- upskilling staff in psychological therapies (e.g., talking therapies including work focused psychological therapies)
- continuing to build coexisting problems capability, reviewing *Te Ariari o te Oranga* and the companion *Integrated Solutions* guidance and providing more integrated care (e.g., for coexisting mental health and addiction problems)
- implementing a systematic approach to building trauma-informed capability (including recognition of historical and intergenerational trauma among Māori)
- equipping workers (particularly support and peer workers) in responding to long-term physical health problems.

People accessing mental health inpatient services

Children and youth

Significant problems with
- Trauma
- Emotions
- Relationships

Adults (aged 18 years +)

Significant problems with
- Trauma
- Depression and anxiety
- Relationships
- Delusions and hallucinations
- Alcohol and other drugs

Physical health

People who experience serious mental health problems

10-25 years shorter life expectancy than the general population

Main kind of illness: Cardiovascular diseases, respiratory and infectious diseases, diabetes, hypertension.

Figure 10. **Significant problems amongst people accessing mental health and addiction inpatient services.**
Source. Havens et al. (2012); Te Pou o te Whakaaro Nui (2018c, 2018d, 2018e, 2018f); World Health Organization (2014).

Many people accessing mental health and addiction services have significant problems with self-harm, see Figure 11. There is a need to develop a national approach to suicide prevention and post-vention for clinicians and support staff working in mental health and addiction services, as well as primary care, social services and general health workers. It is also timely to roll out and mandate the national suicide prevention

guidelines for emergency departments developed in 2016,[36] and to review and adapt national guidance on risk assessment and management – including crisis care and management. Any workforce development activities should be underpinned by a workforce planning approach and adequate funding needs to be available, particularly for NGOs, to support sustainable workforce training and development.

Figure 11. Significant problems with self-harm among people accessing mental health inpatient services.
Source.Te Pou o te Whakaaro Nui (2018c, 2018d, 2018e). See https://www.tepou.co.nz/resources/honos-reports-jan-2017-to-dec-2017/874

The workforce working with different population groups requires some specific knowledge and skills. This includes specific learning and development opportunities for working with child and youth; older people; people with coexisting disabilities and mental health and/or addiction issues; and for the addiction, youth and adult forensic mental health workforces. Frameworks have been developed to support engagement and responsiveness with some population specific groups including: *Real Skills Plus ICAMH/AOD* for working with child and youth, *Takarangi Competency Framework* – to develop cultural competence in working with Māori, *Real Skills plus Seitapu – Working with Pacific Peoples*, and *Te Whare o Tiki* – for working with coexisting mental health and addiction problems.

Recruitment and retention

Growing the Māori workforce

There is a need to grow the Māori workforce to better meet the needs of Māori. Currently the Māori workforce, particularly the clinical workforce, is under-represented relative to the proportion of Māori accessing mental health and addiction services, see Figure 12.

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36 https://www.health.govt.nz/publication/preventing-suicide-guidance-emergency-departments

Māori workforce under-represents people accessing services

27% people accessing services are Māori

26% non-clinical workforce are Māori

16% clinical workforce are Māori
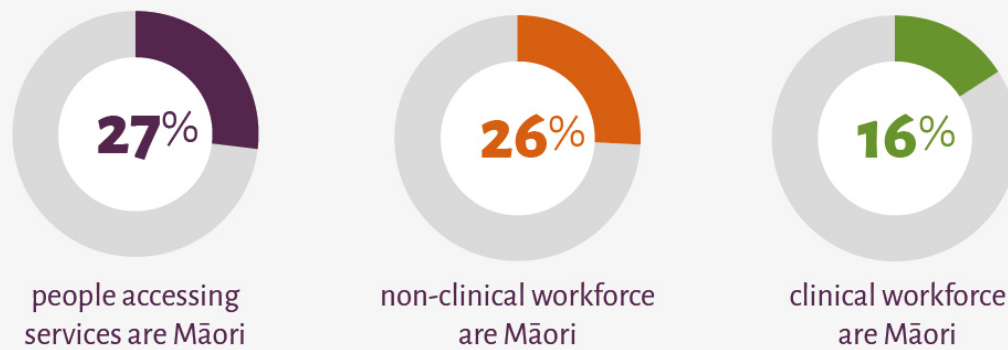
Figure 12. **Māori workforce compared to Māori people accessing mental health and addiction services.**

Source: Te Pou o te Whakaaro Nui (forthcoming, 2018); Werry Workforce Whāraurau (2017), Ministry of Health, PRIMHD extract 9 April, analysed by Te Pou.

Te Rau Matatini is the national workforce centre which leads Māori mental health and addiction workforce development, and there are scholarships available for Māori to access. For example, Te Rau Puāwai Workforce Development Programme provides bursaries and learning support for students seeking to commence or complete a Massey University qualification in the field of Māori mental health.[37] Addiction qualification scholarships available through Te Rau Matatini include Hoe Tahi and Hoe Rua.

While current programmes may need to be reviewed and refreshed, other potential strategies highlighted through feedback to grow the Māori workforce include: setting targets for Māori workforce representation; developing specific recruitment strategies targeting Māori; re-establishing funding for internship programmes for Māori and Pacific nursing and allied health staff; supporting the development of the Māori workforce and cultural advisors, including cultural staff in all DHB teams; sharing resources with other services (e.g., regional Māori health or kaupapa services); building relationships with tertiary institutions; and outreach into secondary schools to encourage Māori youth into tertiary education.

Growing the Pacific workforce

Growing the Pacific workforce remains a priority, particularly the clinical workforce. The Pacific workforce is currently under-represented compared to people accessing services and future population projections, see Figure 13. Pacific people often have high and complex mental health needs; a higher risk of mental health and addiction issues, including suicidal behaviour; along with considerable unmet needs in the community (Faleafa & Pulotu-Endemann, 2017).

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37 http://www.massey.ac.nz/massey/maori/maori_research/te-rau-puawai/te-rau-puawai_home.cfm

Pasifika clinical workforce under-represents people accessing services

6% people accessing services are Pasifika

7% non-clinical workforce are Pasifika

4% clinical workforce are Pasifika
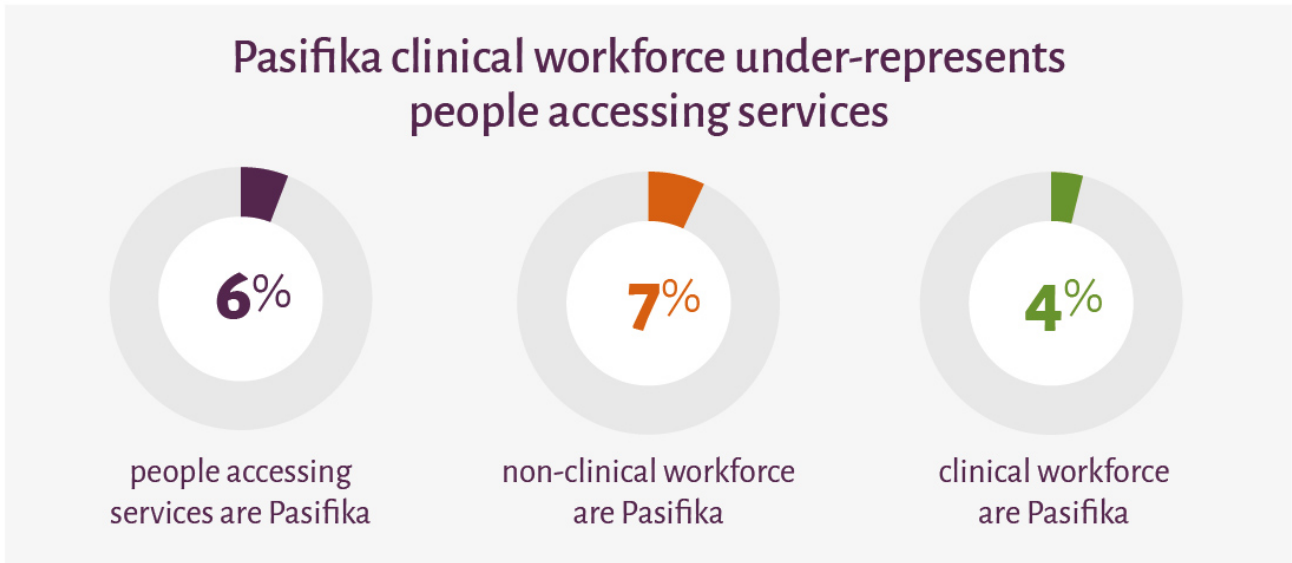
*Figure 13.* **Pacific workforce compared to Pacific peoples accessing mental health and addiction services.**
Source: Te Pou o te Whakaaro Nui (forthcoming, 2018); Werry Workforce Whāraurau (2017), Ministry of Health, PRIMHD extract 9 April, analysed by Te Pou.

Le Va is the national Pasifika Health workforce centre leading work on Pacific mental health and addiction workforce development and has drafted a Pasifika mental health and addiction workforce action plan. The fundamental key themes underpinning the plan are illustrated Figure 14. Workforce action plans have also been developed by Auckland and Waitemata DHBs for the nursing and allied health workforces. Le Va also contributed to the refreshed *Te Uru Kahikatea: Public Workforce Development Plan*.

Figure 14. **Pasifika mental health and addiction workforce action plan key themes.**
Source: Le Va

Among the programmes designed by Le Va to support Pacific mental health, addiction, and public health workforce development are the *Futures that Work* programme, designed to increase the number of students studying mental health and addiction tertiary subjects, ensuring a fit-for-purpose pipeline from the Pacific mental health and addiction workforce. Over 400 Pasifika people have completed the *Futures that Work* programme. Similarly, the *Le Tautua Pasifika Leadership* programme supports and equips Pasifika leaders in mental health, addiction, and public health services (Faleafa & Pulotu-Endemann, 2017) to rise higher within mainstream organisations. Other noteworthy targeted Pasifika workforce initiatives by Le Va include Pasifikology (clinical psychologists) and Pasifika Allied Health Aotearoa New Zealand (PAHANZ).

Future strategies identified through feedback to grow the Pasifika workforce include:

- undertaking a gap analysis to support development of the Pacific non-regulated workforce
- developing digital space skill sets (see Digital Space: Australia)
- re-establishing funding for the internship programme for Pasifika nursing and allied health staff
- developing national recruitment strategies targeting Pasifika people
- linking with local Pasifika groups and building networks
- undertaking qualitative work to better understand the impact of cultural values within the workforce and on outcomes for people and their families.

Growing the peer workforce (peer support and consumer advisors)

Growing the peer workforce (peer support, consumer advisors, including youth consumer advisors) is a priority. With effective training and supervision, the peer workforce use their lived experience to support the wellbeing of people who experience mental health and addiction issues. Peer support has been found effective in supporting people's recovery and offers a potential strategy for addressing workforce shortages. Despite being a priority area, there are estimated to be less than 250 peer support workers employed in adult mental health and addiction services, and these are mostly in NGO services (Te Pou o te Whakaaro Nui, 2015).[38] Strategic development of the peer workforce is required. Work has been undertaken to outline the competencies and values required for the peer workforce.[39] There are also a number of consumer advisory groups and peer led services. Strategies recommended to grow the peer workforce include: improving awareness and knowledge of peer worker roles and models; increasing stakeholder commitment to growing the peer workforce (e.g., within NGOs and DHBs to support people accessing services to link into the community pre and post treatment); supporting organisations to build a culture where peer workers thrive; and ensuring peer workers are involved in all levels of service delivery (e.g., strengthening Standard 2.5 - Consumer Participation, within the Health and Disability Services Standards).

Investment in workforce development for the peer workforce is required. Currently there is no recognised NZQA Level 4 qualification to train as a peer worker. Without this, peer support workers will trail behind colleagues in pay equity. Investment is also required focusing on research on peer roles and services; providing national networking opportunities; enabling peer supervision capability and capacity development; and describing top of scope for peer roles. There is also a reported need for a professional body with a code of ethical practice for peer support workers, which dapaanz[40] is currently in the process of developing for addiction peer support workers. Finally, there is a need to grow peer services and look at models such as Tupu Ake - a peer-led acute alternative mental health service (see Appendix D).[41]

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38 Including family/whānau peer support workers. The peer support workforce reflects less than 2.5% of the overall adult mental health and addiction workforce.

39 https://www.tepou.co.nz/initiatives/peer-workforce-competencies/23

40 The professional association for people working in addiction treatment.

41 See Appendix D.

Investment is needed in the family and whānau workforce. Family advisors need access to adequate supervision and training gaps addressed. Family advisors should also be employed within NGOs, and DHBs need to fill their vacancies for these roles. The lack of specific addiction service family and whānau advisors is a significant issue for all addiction services and DHBs and NGOs need to prioritise employing people in this role.

Information, research and evaluation

Evidence-informed practice and continuous quality improvement

Up-to-date evidence to inform practice and translate into practice

To achieve better outcomes for people accessing services, it is important that up-to-date evidence is available to inform practice, and that evidence is translated into practice. The Mental Health Commissioner recently published a report on mental health and addiction services (Mental Health Commissioner, 2018), and annual reports are undertaken by the Director of Mental Health (Ministry of Health, 2017). The Key Performance Indicator (KPI) programme provides up-to-date information about acute inpatient mental health services on an online dashboard.[42] The Programme for Integrated Mental Health Data (PRIMHD) and Mārama (real time service user and whānau feedback) also provide data to inform practice.[43] Each year, the *New Zealand Health Survey* captures self-reported data on mental health and addiction issues, service access, and barriers (Ministry of Health, 2018b).[44] There are a few key universities and services which have also undertaken research relevant to mental health and addiction services, and in 2017 the Health Research Council funded another seven relevant projects.[45] Guidelines have been established in some areas which help translate evidence into practice and support more consistent service delivery e.g., for cardiovascular disease risk assessment and the management of psychosis.

Continued availability of up-to-date and quality data to inform service, workforce and individual care planning is required. Currently the value of PRIMHD data would be strengthened by Ministry of Health leadership. The reconvening of the PRIMHD governance group is urgently needed to ensure transparency of service provision and outcomes for people accessing services. The last mental health and addiction population survey, *Te Rau Hinengaro* (Oakley Browne et al., 2006)*,* was undertaken in 2006. This requires updating with a broader scope to examine factors such as psychosis, discrimination, physical health and labour force status[46] to better understand current population needs. Up-to-date data is urgently needed to inform service planning and determine the corresponding workforce needed to respond to population health needs. The potential to use the information data infrastructure (IDI) data offers new possibilities to explore the aetiology and outcomes of mental health and addiction issues. Continued testing of new

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42 https://www.mhakpi.health.nz/

43 https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

44 https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey

45 http://www.hrc.govt.nz/funding-opportunities/recipients

46 Labour force status examines whether a person is employed (full or part-time), unemployed (looking for full or part-time work) or not in the labour force.

technology and ways of working is also required. E-therapies for example, potentially offer an alternative and/or adjunct to face-to-face support for 'mild-to-moderate' mental health and addiction issues. The development of a research and development strategy outlining priorities has been recommended, along with mechanisms to support more effective translation of knowledge into practice. To achieve this there is a need for sufficient research and evaluation capacity in the sector.

Ensuring services are making a difference to people

Services need to know they are making a difference to people accessing them. The *Commissioning Framework for Mental Health and Addiction* (Ministry of Health, 2016) and *He Tāngata: The Draft Mental Health and Wellbeing National Population Outcome Framework* support an outcomes approach.[47] The Health of the Nation Outcome Scales (HoNOS) family of measures and the Alcohol and Drug Outcome Measure (ADOM) have been mandated for collection in DHB mental health, and adult community alcohol and drug services respectively into PRIMHD. Training, tools and resources have been developed to support the collection of these outcome measures. Outcome measures can inform individual care assessment, planning, and allocation of referrals at the clinical level. This information can be further used to inform workforce planning, service development, research and policies at team, service, and national levels (Te Pou o te Whakaaro Nui, 2016), see Figure 15. Work is also being undertaken on the collection of feedback from people accessing services and whānau through Mārama (real time feedback).[48] Further progress in outcomes data collection is required e.g., a self-rated tool within DHBs, continuing to align outcome measures in the NGO sector,[49] and reviewing the use of outcome measures in primary mental health services. This information needs to be more actively used in service provision. The Ministry of Health must endorse and mandate the collection and use of information about the experience of people accessing services. All DHBs and NGOS must set expectations in annual plans of how they intend to incorporate the experience of people accessing services into service provision.

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47 https://www.matuaraki.org.nz/news/the-mental-health-and-wellbeing-outcomes-framework/780 and
https://www.matuaraki.org.nz/uploads/files/resource-assets/Outcomes_Framework_Rachel_Haggerty_Kevin_Harper_MoH.pdf
48 See http://hdcrtf.co.nz/
49 NGOs and PHOs are not currently mandated to collect outcomes data. However, some NGOs use WHO-QOL, Kessler-10 or other measures. ProCare also uses Kessler-10 for talking therapy sessions.
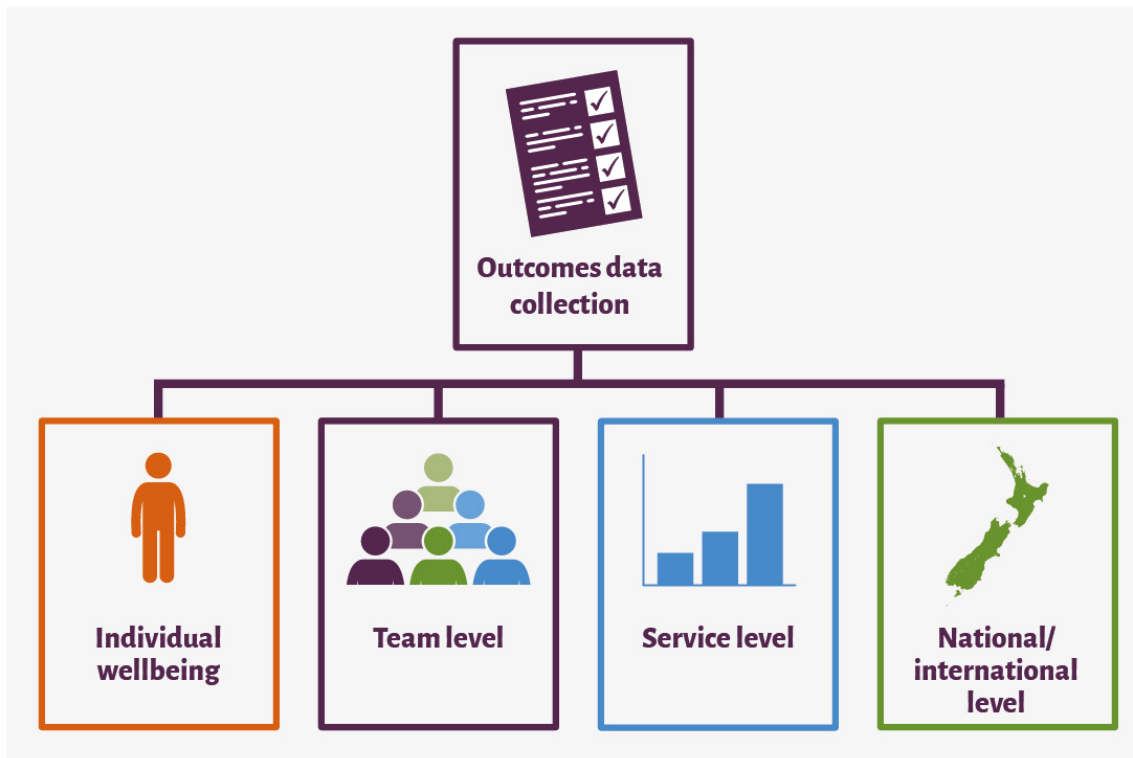
***Figure 15*. Utility of outcomes data collection.**

Quality improvement

Opportunities for quality improvement need to be tested and evaluated within mental health and addiction services. The Health Quality and Safety Commission's quality improvement training for mental health and addiction staff will assist with this. Also required is greater capability in implementing and sustaining change, as well as the use of evidence-based approaches to support successful implementation of workforce development initiatives. The latter for example is influenced by a range of factors including: the activity; workforce capability, beliefs and readiness; organisational factors (e.g., culture and learning climate, readiness and resources); the needs of people, social and political factors.[50]

Workforce development infrastructure

Policy and funding supports workforce development

Policy and funding is required to support workforce development. While the *Mental Health and Addiction Workforce Action Plan 2017-2021* was released last year (Ministry of Health, 2018a), the Ministry of Health needs to urgently outline the future strategic direction for mental health and addiction services. This needs to be co-designed with people accessing services. There needs to be adequate resourcing and planning for implementation of the *Workforce Action Plan.*

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50 https://www.tepou.co.nz/resources/getting-it-right-developing-your-workforce/810

New Zealand Mental health and Addiction Sector Workforce Action Plan Enablers

Service providers

Health

District Health Boards, Primary Healthcare Organisations, Non-Government Organisations

Ministry of Health

Health Workforce New Zealand

Ministry Advisory Group

(MOH appointed agencies)

Te Pou

Le Va

Te Rau Matatini

Werry Workforce Whāraurau

Te Rau Puawai

Careerforce

Professional bodies
Regional Authorities
DAPAANZ
Colleges
Societies
Unions

Government Agencies
Health Promotion Agency
Health and Disability Commissioner
Mental Health Commissioner
Health Research Council
Health Quality and Safety Commission
Ministry of Social Development

Training/Education
Universities (includes Wānanga)
Technical institutes
Industry training organisations
New Zealand Qualifications Authority
International trainers
Tertiary Education Commission
Independant trainers
Private training establishments

Advocacy groups
Mental Health Foundation
Drug Foundation
Alcohol health watch
Platform

Figure 16. **New Zealand mental health and addiction sector** *Workforce Action Plan* **enablers.**

New Zealand is well placed with workforce agencies to have the infrastructure to support implementation of the *Workforce Action Plan*, which needs to be supported by strong leadership by HWNZ. Currently $30 million is invested in workforce development by HWNZ. This funding includes approximately $14 million annually for the workforce centres, and $16 million in workforce training and development activities, such as psychiatry training, Skills Matter, psychology internships, and scholarships. To ensure available funding is being used most effectively in priority areas, it is important that investment is informed by a strategic workforce planning approach, and considers investment across sectors (e.g., education, industry training organisations, and DHBs). To support this, a stocktake of current funding and activities across sectors is required.

To bring about change in practice and service delivery, effective leadership is required. Leaders need to be able to support and implement change, build organisational cultures to enhance the wellbeing of people accessing services and the workforce, and identify and implement opportunities for improvement. The current pathway to leadership positions does not necessarily equip people with the knowledge and skills required. To strengthen leadership capability, workforce planning is required. Based on an understanding of current capability and needs, a workforce development plan should be developed addressing recruitment, development and training needs.

Working collaboratively with others

While it is essential to maintain secondary mental health and addiction services, there is also a need for prevention and earlier access to services e.g., early intervention in psychosis services, increasing services supporting children aged under 5 such as parenting programmes and other early intervention initiatives, and good primary mental health and addiction initiatives in primary care. The critical importance and value of early intervention and parenting support as the solution to improving the transition to adulthood for young children is reiterated in many recent reports, including *Improving the Transition: Reducing social and psychological morbidity during adolescence* and *It's Never too Early, Never too Late: A discussion paper on preventing youth offending in New Zealand* by Professor Sir Peter Gluckman, Chief Science Advisor.

The types of services providing support to people with experience of mental health and addiction issues is rapidly changing with other agencies, such as the Department of Corrections, investing in services and support. Strategy, policy and funding needs to be aligned and integrated across sectors to effectively support people wherever they come into contact with services.

Primary care

More than 1 in 3 people accessing primary health services meet diagnostic criteria for depression, anxiety or problematic substance use each year (Bushnell, McLeod, Dowell, & Ramage, 2003). New Zealand research also indicates over 60% of people who die by suicide visit their GP within 6 months prior, and over one-quarter in the month prior (Didham, Dovey, & Reith, 2006).

In 2017, $32 million was invested in primary mental health initiatives, including extended consultations, assessments, brief interventions (including counselling), other psychological interventions and medication reviews – targeting Māori, Pacific peoples, youth and people on low incomes. Several programmes have been developed to support effective responses to people with experience of mental health and addiction issues in primary care settings including:

- *Closing the Loop* – outlining the future vision of primary care based mental health services to provide a holistic, person-centred, responsive system of care and support[51]
- Auckland Regional Health Pathways[52]

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51 http://www.closingtheloop.net.nz/#closing-the-loop

- Te Ao Māramatanga - College of Mental Health Nurses credentialing programme in mental health and addiction for primary care nurses

- *Te Hikuwai* - a brief intervention resource developed by Te Pou to support effective talking therapies for adults using a stepped care approach, which could be scaled up with further investment.

Other primary mental health initiatives include Beating the Blues – an online CBT programme for the treatment of depression, and the Fit for the Future project, which is currently undertaking pilots to address increasing service demand. The Green's youth mental health policy agreed in confidence and supply with the government, also includes free counselling for all people aged under 25. Despite this, primary mental health services continue to be under-resourced, primary addiction services are rare, and there needs to be a range of services available for people to access at the right level of care, that don't necessarily involve prescription, but a range of services and supports.

Department of Corrections

Any discussion on services for people with mental health and addiction issues should consider people in custodial settings. Prisoners have the highest rate of mental health and addiction issues in the population (Mental Health Commissioner, 2018).[53] The Department of Corrections has invested in drug treatment programmes within prison and community settings. Over the next four years it is also putting $11.6 million into developing a new prison-wide model of care to better meet the mental health and addiction needs of prisoners. A key component of the $300 million redevelopment of Auckland's maximum security facility is to better support people's mental health needs. As with any new initiative, there will be a significant impact on the availability of suitably qualified staff and a need to look at the knowledge and skills needed to work in that environment.

Other organisations

Other organisations supporting people with experience of mental health and addiction issues include, but are not limited to:

- ACC - counselling for people who have experienced sexual trauma or developed mental health issues as a result of injury

- Ministry of Education and Health collaborations including school-based services currently being piloted

- Ministry of Social Development employment support

- Oranga Tamariki – Ministry for Children support for children in care or with special needs

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52 A web-based information portal, has been developed to upskill and resource GPs in responding to people's needs and includes at least 20 clinical pathways, see https://aucklandregion.healthpathways.org.nz/
53 Indig et al. (2016) found prisoners were 3 times more likely to have been diagnosed with a mental health or substance abuse disorder and 4 times more likely to have thought or attempted suicide compared to the general population.

- Police – who may be required to provide initial responses to events involving people whose mental health and addiction issues render them a danger to themselves or others[54]

- Health and community services who are rolling out programmes and activities in schools, and online to improve the health and wellbeing of young people as part of the Prime Minister's youth mental health project[55]

- Other employment, training, education and accommodation services.

Whole of system, collaborative approach

A whole of system approach needs to be taken to service planning across community, primary and secondary services to support better integration of services across the continuum of care. To improve cross-service linkages, several strategies have been recommended including developing a shared clinical framework, improved service access pathways, ensuring greater consistency in DHB primary mental health plans, and developing one-stop-shops involving primary and secondary co-location and models of care. The workforce can also support this e.g., having peer support workers integrated within services to support linkages with the community, and including mental health consultants as part of home-based contracts such as Family Start. In addition, specialist and peer roles could work alongside others such as police, ambulance officers, and emergency department staff to support cross-service linkages. To support increased responsiveness in primary care services, health coach models could be used to work alongside GPs, along with an increased focus on upskilling practice nurses.

Literature has been reviewed to better understand collaborative ways of working, see Figure 17.[56] There is now a need to build greater capability in collaborative ways of working using multiple strategies e.g., role design recognising the time and capability needed for collaboration, and training and development in collaboration skills. Organisations need resources to support collaboration, and a supporting infrastructure e.g., integrated infrastructure between services, and a single national electronic file notes system. *Equally Well* is an example of a collaborative where over 100 organisations from various sectors have committed to improving the physical health outcomes for people with experience of mental health and addiction issues.[57] In addition, *Housing First* has been contracted to work within a collaborative impact approach to end homelessness.[58]

Building the capability of other health workers in responding to people with experience of mental health and addiction is needed. *Lifekeepers* suicide prevention training programme is available to those working in communities or frontline roles, including support workers and youth workers who do not already receive training. *Waka Hourua* deliver a national suicide prevention programme for Māori and Pasifika communities. In addition, there is currently a MH101 programme designed for frontline government and social service

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54 But this should not be the norm.

55 https://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project

56 https://www.tepou.co.nz/resources/collaborative-capability-in-the-mental-health-and-addiction-sector---literature-review/862

57 https://www.tepou.co.nz/initiatives/equally-well-physical-health/37

58 https://www.housingfirst.co.nz/

agencies, which could be developed for other health professionals.[59] Similarly, an Addictions 101 programme can be delivered to grow knowledge about addiction. The refreshed *Let's get real* framework also provides an opportunity to have targeted workforce development strategies across health, in addition to the *Real Skills Plus ICAMH/AOD*; *Real Skills plus Seitapu* and other related frameworks. This will however require a clear mandate from the Ministry of Health about the expectations of other health services.

What are the values and behaviours of collaborative workers?

Values

Collaborative workers are:

Humble, honest and kind

Committed to equity, openness, trust, respect and diversity

Committed to working with others for mutual benefit

Open to risk, innovation and change

Committed to enhancing people's rights

Behaviours

Collaborative workers are:

Able to connect with and work in partnership with people

Flexible and adaptable around:

- making decisions
- giving up autonomy
- accommodating different points of view and ways of working
- working in diverse community settings

Able to network and connect with colleagues within and across organisations

Able to communicate well

Figure 17. **Values and behaviours of collaborative workers.**

Source: Te Pou o te Whakaaro Nui (2018a)

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59 MH101 is a one-day workshop designed to increase the confidence of frontline government and social agency staff who encounter people with experience of mental illness and/or addiction.

Summary

The workforce is the most important resource within mental health and addiction services, and with the right leadership and workforce planning at local, regional and national levels, it will be critical to transforming the way services are delivered in the future. No change in service delivery will be achieved without the workforce. To understand what the workforce needs to look like in the future there needs to be a clear vision for service delivery and an understanding of population health needs. These two priority areas need to be urgently addressed. Once this information is available strategic workforce planning is required. This will help identify key gaps and priority areas where investment in workforce development is required. Currently it is unclear where investment is being made and if it is in the right areas.

Recommendations

Our recommendations for the Inquiry to consider in respect to key priority actions that need to be taken to support transformation of services and effective responses to people with experience of mental health and addiction and whānau are outlined below.

1. Develop an evidence-based strategy that includes:
    a. how health services need to respond to mental health and addiction demand across population groups and government agencies that is co-designed with people accessing services and their whānau
    b. how people with lived experience can influence, design and work in services
    c. a population health study which determines the mental health and addiction needs of the population
    d. a mental health and addiction research agenda to ensure the availability of up-to-date New Zealand based evidence to inform service planning, design and delivery models
    e. population health approaches to ensure the effectiveness of services for people with a focus on responsiveness for Māori and other priority population groups
    f. a re-orientation of service design and the workforce to have an emphasis on the significance of the social determinants of health
    g. re-prioritisation of distribution of funding across DHB and community-based NGO services.

2. Invest in the urgent need for strategic workforce planning to address the current and future workforce priorities. This is required at a national and local level with a long-term approach. Key actions required include:
    a. review the way that Health Workforce New Zealand (HWNZ) prioritises workforce investment, so that it is based on strategic workforce planning and development
    b. national workforce planning requires long term investment via the workforce centres (currently Te Pou only has six months remaining for workforce planning in the current HWNZ work plan)
    c. investment in new roles that lead strategic workforce planning at a local level
    d. future workforce planning occurs alongside service design which focuses on workforce size, knowledge and skills, composition, and role clarity
    e. investments in workforce development consider the range of factors required for successful implementation and sustainable practice change (e.g., leadership, organisational cultures, systems and processes)
    f. effective strategies to address an ageing workforce.

3. Invest in targeted strategies to grow priority workforce groups such as the Māori, Pacific, support and peer workforces. These can be progressed through enhancement to existing scholarship programmes and workforce centres.

4. The Ministry of Health ensures DHBs and their contracted providers have clear expectations about the utilisation of the *Let's get real* framework so that practice consistently reflects the fundamental values, attitudes, knowledge and skills across all roles in health.

5. Provide the workforce with access to learning and development opportunities needed to build skills of the workforce as required in specific areas. These include talking therapies, coexisting problems capability, physical health needs, suicide prevention, trauma-informed care, cultural responsiveness and responding to population specific groups. Strategies to address these need to recognise the importance of organisational culture and leadership in supporting effective practice change.

6. Investment by Government agencies (via Tertiary Education Commission and Health) in career and education pathways to support growth of the peer and support workforce, and post-entry specialist training programmes. These can be progressed through the workforce centres in conjunction with relevant industry training organisations and education providers.

7. Invest in and prioritise workforce wellbeing. This requires multi-level strategies through workforce centres, DHBs and contracted providers to address workload and demand, monitoring (real time staff experience tools); recognising the role of trauma for the workforce, ensuring the importance and access to supervision, learning and development opportunities; role redesign and clarity.

8. Invest in building multi-level leadership capability across government, sector and services. This requires a review of current capability and future needs. This is needed to build effective organisational cultures that support the wellbeing of people accessing services, the workforce and effective implementation of change.

9. Build capability in continuous quality improvement methodologies via Te Pou o te Whakaaro Nui and Health Quality and Safety Commission.

Glossary

Adult mental health and addiction services: provides support to adults aged 18–64 years.

Clinical roles: Primarily includes nursing, allied health (e.g., psychologists, social workers and occupational therapists), psychiatrists and other medical staff.

Co-design: designing services with people that use them and their whānau.

Community services: DHB and NGO services delivered in the community.

Consumer: A person who accesses mental health and addiction services (i.e. a "consumer" of services). The use of the term in this report is equivalent to the term "service user".

dapaanz: the professional association for people working in addiction treatment.

DHB: District health board.

FTE position: A full time equivalent (FTE) position is a unit of measurement of the hours spent in work as a ratio of the total possible hours in a typical role (i.e., 40 hours). An FTE of 1.0 equates to full time employment.

DHB: District Health Board. There are currently 20 DHBs in New Zealand.

NGO: Non-governmental organisation.

Infant, child and adolescent mental health and addiction services: provides support primarily to young people aged below 18 years, but can go up to the age of 20 when developmentally indicated.

Inpatient services: Services delivered within DHB inpatient units or NGO residential accommodation.

Kaupapa Māori services: a service based on Māori values and culture, that accepts and values cultural practices and aims to make a difference to the lives of tāngata.

Labour force status: examines whether a person is employed (full or part-time), unemployed (looking for full or part-time work) or not in the labour force.

Let's get real: *Let's get real* describes the essential values, attitudes, knowledge and skills required to deliver effective services in partnership with people who experience mental health problems and addiction. The refreshed version of *Let's get real* updates the 2008 framework and applies to everyone working with people who experience mental health problems and addiction wherever and whenever they are involved in, or are in contact with, health services.

NGO: non-government organisation.

Non-clinical roles: Primarily include support workers, youth workers, peer support workers, and cultural workers.

Older adult mental health and addiction services: provides support to adults aged 65+ years.

Peer support workers: people who use their lived experience alongside specialist training and supervision to support the wellbeing, resilience and recovery of people with mental health and addiction issues. It is a person-centred approach underpinned by recovery and strength-based philosophies. 'Peer support workers' is an umbrella term for several other roles and job titles with similar functions, such as peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist.

PHO: primary health organisation.

Secondary mental health and addiction services: specialist mental health and addiction services funded by Vote Health funding.

Skills Matter: post-graduate clinical training programme for allied and nursing professionals to support the transition to mental health and addiction practice, and leadership development.

Tupu Ake: a ten bed seven night peer-led acute admission alternative service developed by Pathways in 2008. Tupu Ake is based in old Papatoetoe, and provides brief support to people requiring an acute level of care in a community setting. See https://www.tepou.co.nz/uploads/files/resource-assets/Tupu%20Ake%20Evaluation-Final.pdf

Quality improvement: The Health Quality & Safety Commission work towards achieving the New Zealand Triple Aim for Quality Improvement: i) improved quality, safety and experience of care; ii) improved health and equity for all populations; and iii) better value for public health system resources.

Vote Health funding: Funding associated with the Ministry of Health or DHB mental health and addiction service delivery contracts. This definition of health funding does not include Ministry of Health whānau ora or primary care funding.

Appendix A: DHB and NGO workforce

Table 4 summarises the workforce employed within different types of DHB and NGO services. This includes provisional adult workforce information and may differ from forthcoming published results.

Table 4. *Mental Health and Addiction Workforce (FTEs Employed plus Vacant) by Service Type*

	DHB inpatient	DHB community	DHB forensic	DHB total	NGO	Total
Infant, child and adolescent workforce (2016)						
Clinical [1]	137	916		1,053	265	1,318
Non-clinical [2]	19	63		82	205	287
Admin/management	8	115		123	29	152
Sub-total	164	1,094		1,258	499	1,757
%	9%	62%		72%	28%	100%
Adult mental health and addiction workforce (2018)						
Clinical [3]	1,546	2,749	677	4,971	922	5,893
Non-clinical [4]	266	474	239	979	2,728	3,706
Admin/management	208	370	75	652	631	1,284
Sub-total	2,021	3,592	990	6,603	4,280	10,883
%	19%	33%	9%	61%	39%	100%
Total	2,185	4,686	990	7,860	4,780	12,640
%	17%	37%	8%	62%	38%	100%
Adult alcohol and other drug workforce (2018) [5]						
Clinical [6]	8	494		542	479	1,021
Non-clinical [7]	2	19		21	276	297
Admin/management	5	54		60	111	170
Sub-total	55	567		622	866	1,488
%	4%	38%		43%	58%	100%

Source: Te Pou o te Whakaaro Nui (forthcoming, 2018); Werry Workforce Whāraurau (2017).

Note.

[1] Primarily includes mental health nurse, social worker, psychologist, and alcohol and drug practitioners, followed by psychiatrist, occupational therapist, coexisting problems (CEP) clinician, psychotherapist and other clinical.

[2] Primarily includes mental health support worker and youth worker, followed by cultural appointment, mental health consumer advisor, specific liaison, and other non-clinical support.

[3] Primarily includes nurses, followed by medical and other professionals, social workers, addiction practitioner/clinician, clinical psychologist, occupational therapist, dual diagnosis practitioner/CEP clinician, counsellor, and other allied health and clinical roles.

[4] Primarily include support workers. Support workers mostly reflect residential support workers, followed by healthcare assistants, peer support – consumer and service user, psychiatric assistants, and to a lesser extent, family support workers, community development workers, employment workers, and peer support – family and whānau. Non-clinical roles also include cultural advice and support e.g., Kaumātua, Kaiāwhina, Traditional Māori health practitioner, cultural supervisor, Kuia, Pasifika cultural advisor, Matua and other cultural advisors.

[5] Included within adult mental health and addiction workforce figures above.

[6] Primarily includes addiction practitioners/clinicians, followed by nurses, dual diagnosis practitioners/CEP clinicians, counsellors and social workers.

[7] Primarily includes support workers. Support workers mostly reflect residential support workers, and to a lesser degree peer support – consumer and service user, psychiatric assistants, family support workers, healthcare assistants, peer support – family and whānau and other support workers. Non-clinical roles also include cultural advice and support.

Appendix B: Clinical and non-clinical workforce

Table 5 summarises the proportion of the workforce employed in clinical, non-clinical, and administration or management roles for different types of services.

Within NGO settings, adult mental health services employ fewer clinical, and more non-clinical, staff than infant, child and adolescent, and alcohol and other drug services.

Table 5. *Clinical and Non-clinical Workforce (Employed plus Vacant) in DHB and NGO Services, by Service Type*

Service type	DHB			NGO			Total		
	Clinical	Non-clinical	Admin/ Mgnt	Clinical	Non-clinical	Admin/ Mgnt	Clinical	Non-clinical	Admin/ Mgnt
Infant, child & adolescent	84%	6%	10%	53%	41%	6%	75%	16%	9%
Adult mental health & addiction	75%	15%	10%	22%	64%	15%	54%	34%	12%
Alcohol & other drug services	87%	3%	10%	58%	29%	13%	70%	18%	12%
Total workforce	77%	13%	10%	25%	62%	13%	57%	32%	11%

Note. Based on information provided in Appendix A.

Appendix C: Occupational roles

Table 6 summarises occupational roles for the overall DHB and NGO workforce, by service type.

Tables 7 and 8 report these for DHB and NGO services respectively.

Table 6. *Occupational Groups and Roles (FTE Positions Employed plus Vacant) for DHB and NGO Services*

Roles and groups	Child and youth 1,757	Adult mental health 9,395	Adult AOD 1,488	Total 12,640
Clinical workforce				
Addiction practitioners	9.1%	0.2%	37.2%	5.7%
Psychologists	12.4%	3.1%	1.2%	4.2%
Social workers	12.8%	4.1%	8.0%	5.8%
Occupational therapists	5.2%	2.7%	0.6%	2.8%
Nurses	16.6%	33.2%	14.9%	28.8%
Medical professionals	5.8%	6.9%	3.0%	6.3%
Other clinical roles[a]	13.0%	1.6%	5.3%	0.8%
Total clinical workforce	**75.0%**	**51.8%**	**70.2%**	**57.2%**
Non-clinical workforce				
Support workers[b]	16.0%	33.5%	13.5%	28.8%
Other non-clinical roles[b]	0.3%	3.2%	4.5%	2.9%
Total non-clinical workforce	**16.3%**	**36.7%**	**18.0%**	**31.8%**
Admin & management	**8.7%**	**11.4%**	**11.7%**	**11.0%**

Source: Te Pou o te Whakaaro Nui (forthcoming, 2018); Werry Workforce Whāraurau (2017).

Note:

There are differences in reporting across the Werry Workforce Whāraurau 2016 stocktake (Werry Workforce Whāraurau, 2017) and the 2018 DHB and NGO workforce information collation undertaken by Te Pou (Te Pou o te Whakaaro Nui, forthcoming, 2018). This means that the distribution of roles in the table differs between child and youth services and adult services as described below.

[a] Other clinical roles for child and youth services includes non-psychiatry medical professionals, nurse managers, and allied health interns. For adult services this group includes a wide variety of roles with relatively small workforces such as psychotherapists, family therapists, needs assessment coordinators, and clinical liaison.

[b] Child and youth services support workers includes cultural support workers, youth workers, other non-clinical support for people accessing services. In adult services, support workers include community and residential support workers, psychiatric, nursing and healthcare assistants and various other non-clinical support roles including peer support roles.

[c] Other non-clinical roles for child and youth services include liaison and consumer advisor, non-clinical needs assessors and coordinators. In adult services, other non-clinical roles include consumer advisors and supervisors, health promotion officers, and non-clinical coordinators.

Table 7. *Occupational Groups and Roles (FTE Positions Employed plus Vacant) for DHB Services*

DHB roles and groups	Child and youth 1,257	Adult mental health 5,979	Adult AOD 623	Total 7,859
Clinical workforce				
Addiction practitioners	5.8%	0.0%	34.0%	3.6%
Psychologists	16.9%	4.6%	2.7%	6.4%
Social workers	14.2%	5.5%	10.7%	7.3%
Occupational therapists	0.0%	3.8%	1.0%	3.0%
Nurses	22.3%	49.6%	29.9%	43.7%
Medical professionals	7.8%	10.5%	6.5%	9.8%
Other clinical roles[a]	16.7%	0.0%	2.2%	2.9%
Total clinical workforce	**83.7%**	**74.1%**	**87.1%**	**76.6%**
Non-clinical workforce				
Support workers[b]	6.5%	15.9%	3.3%	13.4%
Other non-clinical roles[c]	0.0%	0.2%	0.0%	0.0%
Total non-clinical roles	**6.5%**	**16.0%**	**3.3%**	**13.4%**
Admin & management	**9.8%**	**9.9%**	**9.6%**	**10.0%**

Source: Te Pou o te Whakaaro Nui (forthcoming, 2018); Werry Workforce Whāraurau (2017).

Note:

There are differences in reporting for DHB workforce across the Werry Workforce Whāraurau 2016 stocktake (Werry Workforce Whāraurau, 2017) and the 2018 DHB workforce information collation undertaken by Te Pou (Te Pou o te Whakaaro Nui, forthcoming, 2018). This means that the distribution of roles in the table differs between child and youth services and adult services as described below.

[a] Other clinical roles for child and youth services includes non-psychiatry medical professionals, nurse managers, and allied health interns. For adult services this group includes a wide variety of roles with relatively small workforces such as psychotherapists, family therapists, needs assessment coordinators, and clinical liaison.

[b] Child and youth services support workers includes cultural support workers, youth workers, other non-clinical support for people accessing services. In adult services, support workers include community and residential support workers, psychiatric, nursing and healthcare assistants and various other non-clinical support roles.

[c] Other non-clinical roles for child and youth services include liaison and consumer advisor, non-clinical needs assessors and coordinators. In adult services, other non-clinical roles include consumer advisors and supervisors, health promotion officers, and non-clinical coordinators.

Table 8. *Occupational Groups and Roles (Employed plus Vacant) for NGO services*

NGO roles and groups	Child and youth 499	Adult mental health 3,416	Adult AOD 832	Total 4,747
Clinical workforce				
Addiction practitioners	17.5%	0.7%	39.5%	9.2%
Psychologists	1.2%	0.4%	0.0%	0.4%
Social workers	9.4%	1.8%	6.0%	3.3%
Occupational therapists	0%	0.7%	0.3%	0.6%
Nurses	2.5%	4.5%	3.7%	4.2%
Medical professionals	0.7%	0.5%	0.5%	0.5%
Other clinical roles[a]	22%	4.3%	7.5%	6.7%
Total clinical workforce	**53.1%**	**12.9%**	**57.6%**	**25.0%**
Non-clinical workforce				
Support workers[b]	41%	64.5%	21.1%	54.4%
Other non-clinical roles[c]	0%	8.7%	8.0%	7.7%
Total non-clinical roles	**41.1%**	**73.2%**	**29.1%**	**62.1%**
Admin & management	**5.8%**	**13.9%**	**13.3%**	**13.0%**

Source: Te Pou o te Whakaaro Nui (forthcoming, 2018); Werry Workforce Whāraurau (2017).

Note:

There are differences in reporting for NGO workforce across the Werry Workforce Whāraurau 2016 stocktake (Werry Workforce Whāraurau, 2017) and the 2018 NGO workforce survey undertaken by Te Pou (Te Pou o te Whakaaro Nui, forthcoming, 2018). This means that the distribution of roles in the table differs between childr and youth services and adult services as described below.

[a] Other clinical roles for child and youth services includes non-psychiatry medical professionals, nurse managers, and allied health interns. For adult services this group includes a wide variety of roles with relatively small workforces such as psychotherapists, family therapists, needs assessment coordinators, and clinical liaison roles.

[b] Child and youth services support workers are primarily comprised of support workers and youth workers, with small workforce in other non-clinical support for people accessing services. In adult services, this group is comprised mainly of support workers including community and residential support workers with a small workforce in peer support roles.

[c] Other non-clinical roles for child and youth services include liaison and consumer advisor, non-clinical needs assessors and coordinators. In adult services, other non-clinical roles include consumer advisors and supervisors, health promotion officers, and non-clinical coordinators.

Appendix D: Tupu Ake peer-led service

Tupu Ake is a peer-led mental health support service based in Papatoetoe, Auckland. The service was developed using a co-design process that included both people who access services (called guests) and DHB and NGO services.

Tupu Ake is a peer-led service delivering acute care and support in a homelike environment, to people who would otherwise require inpatient admission. Its design is unique in its intent to offer a community service for people requiring inpatient care that is led and staffed by peer support specialists, and that involves a highly collaborative working relationship between the DHB's clinical services and the NGO provider.

The main service provision is by peer workers, with clinical support available when required. Services are delivered in partnership with guests and their whānau, in an environment that aims to be non-stigmatising and led by guests' understanding of their own needs.

For more information and evaluation of Tupu Ake services, see
https://www.tepou.co.nz/uploads/files/resource-assets/Tupu%20Ake%20Evaluation-Final.pdf

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