New Zealand Nurses Organisation

Submission to the Ministry of Health

On the

Mental Health and Addiction Service Development Plan (Draft paper for stakeholder engagement)

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ABOUT NZNO

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 45 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Ministry of Health's Mental Health and Addiction Service Development Plan and appreciates the extended submission date until the end of the week.

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of the Mental Health Nurses Section (MHNS), the College of Primary Health Care Nurses (CPHCN), Te Runanga and professional nursing, policy, research, legal and industrial advisers.

3. NZNO supports the general direction of the document aimed at early intervention and holistic, integrated care.

4. NZNO would like further involvement as the Plan is operationalised, since the quality and efficiency (i.e. cost related to health outcomes) of service delivery is highly dependent on what services are delivered, where, and by whom.

5. To that end we recommend that education, training and qualifications for mental health and addiction service workers, are consistent with (and not separate from, or additional to) health care regulation, training and qualifications in other areas of health, to ensure appropriate clinical input, particularly where there are co-morbidities.

6. We draw your attention to Addiction Specialty Nursing Knowledge and Skills Competency Framework, developed by the Drug and Alcohol Nurses of Australasia (DANA), and also to previous NZNO submissions on this subject including on Civil Commitment for Drug and Alcohol addiction (NZNO, 2010).

7. We note the potential impact of:

   - the advancement of the date for the disestablishment of the Mental Health Commission, whose functions will be transferred to the Office of the health and Disability Commissioner;

   - the creation of a health promotion agency taking over the functions of the Alcohol Advisory Council of New Zealand (ALAC), the Health Sponsorship Council (HSC) and relevant functions of the Ministry of Health; and

   - the Mental Health Workforce Service Review

8. We note that the latter was undertaken by a team selected by Health Workforce New Zealand, not a representative team, and, accordingly, *may* not reflect the views of the sector.

9. We welcome the commitment to build on previous documents particularly the *Blueprint for Mental Health Services* and *Te Tahuhu: Improving Mental health* 2005-2015 (2005) and to undertake a review of the literature.

10. A brief discussion of the Plan is followed by our response to the questions given for consideration.

DISCUSSION

11. Regulated registered and enrolled nurses (RNs and ENs) and nurse practitioners (NPs), and unregulated community mental health workers and health care assistants (HCAs), are at the frontline of the delivery of care for both addiction, and the health conditions underlying and/or associated with drug and alcohol addiction. They work in a wide range of health settings, providing primary, secondary and tertiary care.

12. Nurses' clinical training is evidence-based and the profession has an holistic focus on 'wellness', in line with the Te Whare Tapa Whā model of health equally supporting mental physical, spiritual and whānau health (Durie, 1995).

13. We believe there is a strong need a need for clinical input even in community/ self help/ e-therapy settings. The increase in diabetes, for example, may significantly impact mental health and addiction services. Distinguishing that underlying symptoms, such as drowsiness, are due to blood sugar levels rather than addiction, requires clinical expertise and radically different treatment. Diabetes is also a high risk factor with the long term use of some mental health medications.

14. We are aware, however, that there are a number of community mental health support workers who are not clinically trained and that this can present problems. Indeed there is a general lack of consistency in training available for mental health support workers (Pace, 2009) which is of concern to our members.

15. NZNO has on several occasions, for example, pointed out the inconsistency of training for unregulated mental health team leaders at level 6 on the New Zealand Qualifications Framework, above the level 5 Diploma for Enrolled

Nursing, which encompasses 18 months of clinical training and is a regulated role. We believe that lack of clinical training at this level of authority may constitute a significant public health threat to those whose mental illness makes them particularly vulnerable and who cannot rely on either the clinical or ethical standards demanded by regulated HPs.

16. We draw your attention to the expanded scope of practice for enrolled nursing and recommend that much more extensive use of this regulated well educated workforce is made at all levels of mental health care.

Draft goals

17. We support the draft goals, though we question what is meant by "effective self care"; we would be very concerned if that translated in practice to less robust or frequent monitoring, or a diminution of clinical support.

18. Similarly, while we strongly support equipping "the workforce at all levels to function efficiently and strategically", we need to be assured that the criteria for measuring "efficiency" includes improvement in long term health outcomes, not simply reduced costs.

19. It is not clear from points 10 and 11 whether the intention is to respond more effectively to needs of Māori and other ethnic groups on *cultural* grounds, or because those particular groups are disadvantaged. We recommend a recommitment for mental health services to:

    - reducing health disparities;
    - providing culturally appropriate services; and
    - honour the principles of te Tiriti of Waitangi.

Emerging Trends and priorities in the provision of MHAS

20. We reiterate our concerns about "effective self care and e-therapies": access to them should not preclude access to face to face care.

21. Otherwise however, NZNO strongly supports this impressive list of priorities for mental health and addiction services and in particular clauses (b) and (e) - i.e. promotion of positive mental health (which should include public education), early intervention, focus on youth, better integration and addressing some of the social determinants of mental health.

22. We are also impressed to note the inclusion of services in Corrections facilities: NZNO has repeatedly drawn attention to the lack of support for vulnerable children as a key factor in our abysmally high incarceration rates for young people, and the opposing responses to alcohol and drug abuse by the Justice and Health systems[1] are counterproductive and perpetuate intergenerational harm. A reduction in prisoners with mental health problems could be a useful measure of the Plan's effectiveness. We also suggest that a practical way to strengthen the provision of assessment services in the criminal justice arena would be to have court-based specialist clinicians to screen, assess and advise those on alcohol and drug related charges.

23. We trust the intention will be followed with the significant resourcing of people and places that it needs to develop a fully integrated and safe mental health service. This will require coordination of education and training - we note for instance, that the while the DHBs are offering CEP education to their clinicians, it is not available outside the DHBs to primary mental health workers.

24. In this context we also note the MHNS's imperative that provision is made for primary mental health workers and facilities *in addition* to, not instead of, existing secondary services in the DHBs which are critically in demand. They are concerned that there will be an unbridgeable gap, if secondary services

[1] i.e. The response to alcohol-related harm, for example violence, drunk driving, addiction, cancer, heart disease, differs from treatment for a clinical condition in the health system (the client is sick) to punishment by the criminal justice system (the client is bad).

which currently enable a GP to refer a patient back to when primary health care, for whatever reason, has failed, are not available.

25. However, appropriately staffed community facilities offer a very good opportunity to address the lengthy waiting lists for residential rehabilitation beds for extended stays which are mainly restricted to urban areas.

Emerging themes and potential barriers

26. Sector wide engagement is necessary to address workforce deficiencies since to some extent they have developed outside the mainstream of health workforce development. The need to provide safe holistic care will require robust standards of training and education, and clinical supervision.

27. We strongly recommend that the expectation for support workers in mental health is for a regulated, clinical role for positions requiring an educational level of five on the NZQF or above.

28. We also note the excellent work that is being done in many areas of mental health - the brief intervention programmes in Southland for instance, which are readily accessible at primary care level.

QUESTIONS FOR CONSIDERATION

Questions for consideration

1. *Do you support the directions and priorities*?
   Yes

2. *If not, what changes do you recommend?*

3. *What are the priorities for action?*
   Upskilling the workforce
   Utilising EN workforce (as formerly)

4. *What specific actions are needed to achieve these aspirations/goals?*
   Wide sector engagement and 'buy-in' before changing of current systems- clear understanding of what current situation is regarding workforce, available facilities and therapies - "self care" and "e-therapies" need careful explanation (and in the case of e-therapies, robust communications systems). Also need good public engagement and clear articulation of roles, qualifications and responsibilities for different levels of care e.g. families, non-clinical support workers etc should not be

put in the position of undertaking care for which they are not trained and qualified to give, and must be kept fully informed.

5. *Are there barriers to achieving these actions?*

   - *If so, how can they best be addressed?*

   Lack of consistency between mental health services and between DHBs
   Lack of consistent education/training
   Lack of appropriate facilities in a range of locations

6. *Which areas of service need better integration and how can this be achieved?*

7. *How will we be able to measure whether we are achieving these goals?*

   - *Specific targets and timeframes?*

8. *What are existing strengths that shouldn't be lost?*

1. Brief interventions in Southland. - Need to consult with primary mental health nurses.

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REFERENCES

Durie, M. H. (1994). *Whaiora: Māori Health Development*. Auckland: Oxford University Press.

Pace, B. D. M. (2009). Organisational views of the Mental Health Support Worker role and function. *International Journal of Psychosocial Rehabilitation.* 14;1. 29-33