Mental Health and Addiction Workforce Action Plan

Submission to the Ministry of Health

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

OVERVIEW

Introduction

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Mental Health and Addiction Workforce Action Plan ("the Plan").

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of NZNO's Enrolled Nurses Section (ENS), Mental Health Nurses Section, the College of Primary Health Care Nurses, Te Rūnanga o Aotearoa and professional nursing and policy advisers. NZNO supports the separate submission of the ENS.

3. NZNO represents nurses and health care assistants working across the full range of public and community mental health services throughout Aotearoa New Zealand.

4. NZNO is an affiliate of the New Zealand Council of Trade Unions, Te Kauae Kaimahi (NZCTU) and participates in a number of health union fora including with government and district health boards (DHB) via the National Bipartite Action Group and the Health Sector Relationship Agreement.

5. As the leading professional representative of nurses, NZNO is also a key participant in national nursing and health sector fora, such as the senior nursing leaders group NENZ (Nurse Executives of New Zealand) and the General Practice Leaders Forum. We regularly

engage with, and submit to, the Minister, Director-General of Health, Chief Nurses Office and government agencies on health and health workforce issues.

6. NZNO has been a vociferous critic of the Ministry of Health's lack of long term health workforce planning for several years. We have challenged Health Workforce New Zealand's (HWNZ) 'scattergun' approach which has centred on narrowly focused 'innovation' in specialist fields, rather than comprehensive planning for a self-sustainable, flexible workforce, and note in particular its failure to progress the development of the Māori health workforce or increasing dependence on immigration. However, we note that HWNZ's future is not clear at this stage of the high-level reorganisation of the Ministry following the refreshed health strategy.

7. NZNO spearheaded the establishment of care capacity demand programmes in DHBs to underpin to "safe staffing and healthy workplaces" and has also supported the development of assessment tools such as InteRai.

8. NZNO has been and remains a strong advocate of fair pay and safe working conditions for all workers.

9. NZNO supports the NZCTU's submission and those of the Public Service Association, and the Association of Salaried Medical Specialists.

OVERVIEW

10. We applaud the Ministry of Health for pulling together a draft Action Plan for the Mental Health and Addiction (MH&D) workforce and in particular for its concise identification of a number of systemic MH&A workforce issues which, apart from specialist workforce gaps, have not all been as clearly articulated previously. These include:

    - increasing reliance on internationally trained health practitioners;
    - the need for a workforce that reflects the population, especially Māori as consistent with te Tiriti obligations;
    - ongoing education and training opportunities for specialist clinicians;
    - training needs for working in multidisciplinary teams (MDT);
    - nationally and regionally co-ordinated recruitment, retention and (long-term) workforce planning.

11. However, the Plan is less clear about specific actions to address these issues and, with the ubiquitous disclaimer for every "priority" ("all actions in the draft are tentative ...subject to costing etc), it is difficult to be sanguine about how, or if, the Plan will be operationalised.

12. We endorse the health and workforce outcomes outlined in the section on "The future we want" (p 9), and particularly support the primary health care focus on holistic (mental and physical health) care early intervention, supported self-management and recovery. This approach is consistent with the health priorities identified in Nursing Matters, 2014 (New Zealand Nurses Organisation, 2014).

13. We are also pleased to see acknowledgment of:

    - the increased risk for children of parents with MH&A issues;
    - the disparities in physical health outcomes of people with MH & A issues; and
    - the disproportionate effect this has on Māori and Pacific people who are high users of MH&A services, a pattern which reflects structural discrimination in health and social services (Human Rights Commission, 2012) and inequity in general (Marmot, 2008). The Plan comes admirably close to recognising and addressing this with its focus on the need for a diverse, culturally competent and representative workforce.

14. However, the Plan falls short of meeting the expectations for workforce development foreshadowed in *Rising to the Challenge, The Mental Health and Addictions Service Development Plan 2015-2017*, ("*Rising to the Challenge*").

15. *Rising to the Challenge* specifically required Health Workforce New Zealand to develop a national Workforce Plan that would identify "the workforce, skills and competencies needed to deliver on this Plan, taking into consideration;

    - new ways of working to make best use of the workforce;
    - new roles to complement existing staff groups;
    - future services, changing demography and future demand for services;
    - education, training and development required;
    - strategies to recruit and retain people in the workforce, including strategies to address any specific workforce shortages; and

- mechanisms for the Ministry of Health to track progress in implementing the workforce development plan (Priority Action 8.2, p 57)."

16. The Plan *describes services*, rather than identifying the workforce required to provide them and thus fails to pass the first test of what is required ie a national workforce plan which maps out "the workforce, skill and competencies required".

17. In this context, particular clarity is called for with regard to the clinical workforce regulated under the Health Practitioners Competence Assurance Act 2003 (HPCAA) because of the robust protection of public safety it affords through assurance of practitioners' ongoing competence and fitness to practice. The regulated workforce is the workforce that is both competent and responsible for the clinical assessment and treatment of both mental and physical illness.

18. The Plan must clarify the distinction between the regulated health workforce (health practitioners defined as "Health practitioner has the same meaning as in section 5 of the HPCA Act 2003") and care and support workers. We do not support the inferred distinction through use of the term 'specialist' workforce, which is open to varying interpretation depending on the context.

19. Lack of access to ongoing clinical assessment and care is a major factor in the continuing disparity of physical health outcomes for people with MH & A issues, and is also a key contributor to entrenched skills shortages and high turnover.

20. While much has, and will be gained from deinstitutionalising and devolving mental health services towards more integrated community-based social and health services, accompanying workforce changes have often led to diminished clinical roles, in both DHB and NGO services. For example, many providers have replaced regulated enrolled nurses (ENs) with health care assistants, and registered nurses (RNs) working in community health teams are sharing rosters with, and reporting to, non-clinicians eg mental health support workers, or social workers.

21. This can cause dangerous delays, sometimes for weeks, in giving essential medications such as intramuscular anti psychotics, and equally dangerous failures of recognising and treating adverse reactions or clinical conditions. Nurses reporting health concerns to managers/leaders with no clinical background are extremely distressed when their concerns are not taken seriously and ignored.

22. This management/workforce model is clearly unsafe, and a barrier to early intervention and health equity, yet it has been extended via DHB Aged Residential Care (ARC) Contracts to services for the fastest growing group of vulnerable New Zealanders. NZNO opposes the

diminution of clinical oversight as MH&A services transition into the community-based model.

23. We strongly recommend that, in addition to ensuring appropriate numbers and skill mix, the quality of MH & A workforce is assured through contracts that have robust requirements for safe staffing and auditing.

24. Significant changes to service provision, particularly in the current context of fiscal 'retreat' rather than restraint (Rosenberg & Keene, 2015), have had a significant impact on the sustainability of the MH&A and wider health workforce.

25. Inadequacies in staffing levels and skill-mix, substitution, dependence on internationally trained practitioners, fluctuating employment opportunities for new graduates, a confusing qualifications landscape etc. indicate the need for integrated education, employment and immigration strategies.

26. NZNO would be happy to discuss any aspect of this submission and subsequent development of the Plan.

27. The following responses to the consultation questions are primarily from the MHNS.

28. NZNO broadly supports the services the Plan describes, but **recommends** that a national workforce plan mapping out the workforce, skill and competencies is developed.

29. We also recommend you note previous submissions on the mental health workforce available from our website[1] and draw your attention to NZNO's nursing workforce research[2] and to our submission to the National Council of Women on the *White Paper on Enabling Women's Potential - the economic, social and ethical imperative for New Zealand* which covers some pertinent issues relating to Māori health workforce, violence, aging an retirement and gender equity[3].

CONSULTATION

Questions

Part 1

[1] http://www.nzno.org.nz/get_involved/submissions/
[2] http://www.nzno.org.nz/resources/research
[3] http://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2015-04%20NCWNZ%20Enabling%20women's%20potential%20NZNO%20response.pdf

Q1. Does Part 1 of the Action Plan adequately describe the current and future state of the mental health and addiction workforce as part of an integrated health and disability system in the next five years? If no, what is missing or needs to be added? (pages 5-12)

Yes √☐ No ☐

Additional comments:

See preceding overview. In general yes, though we question whether some of the advances indicated in this section have actually occurred in the sector to the degree represented.

There is a clear assumption that the mental health and addiction workforce needs can be addressed as one – currently these parts of the sector tend to act independently, often have differing philosophies and practices (e.g. there are separate competencies for mental health and addiction nursing) and therefore some work is still required prior to developing this workforce as a single entity.

Part 2

Priority One – Workforce development in primary health and community care

Q2. Do you agree with the actions in this section? (pages 16-19)

Yes √☐ No ☐

Additional comments:

See preceding overview and particularly our comments that the Plan does not set out a national workforce plan which maps out the workforce, skill and competencies required. The section 'What do we want in five years' under each of the priority areas, for example, describes a mix of services rather than the workforce required.

Note that access to primary health care and medication is unequal and that there is still considerable unmet need. A stepped care approach is supported as long as everyone can get on the first step; new "models of care" must be supported by new service models that allow alternate entry points to an integrated health system, rather than one moderated entirely by GP practice.

The meaning of the third paragraph is opaque and we suggest that the kaiāwhina workforce, contributes to a holistic approach to self –management rather than enables it. … "provision of effective care at lowest cost" reduces healthcare to a commodity. We suggest amending to "…least intensive, most efficient and safest way.

Action 1- sounds great but the reality is that mental health and addiction service users often have complex family environments and communities. The resourcing of this inclusion needs to be mindful of a highly skilled approach to this support – both cultural and mental health specialist sector knowledge.

Action 2 – Excellent but need to increase employment as well training opportunities.eg there have been limited employment opportunities for Nurse Practitioners (NPs) and ENs and appropriately supported opportunities for new graduates. (We note Voluntary Bonding Scheme opportunities but do not support these in mental health and aged care unless new graduates are properly mentored through a Nurse Entry to Practice (NEtP) programme.

Ensure workforce is SAFE – Note the significant violence that health workers and mental health workers in particular are subject to; they must be appropriately trained to deal with this and be assured of adequate protection.

Good to have training opportunities for primary health nurses across all these priority areas – should enhance the responsiveness and hopefully reduce the stigma. BUT this should not be seen as an alternative to skilled mental health care, but as a way of improving the general health services provided to service users. Is there some suggestion that primary health nurses have "down time" which can be used cost effectively? If not, then the more appropriate solution for people experiencing mental illness/addiction would be providing a mental health and/or addiction health worker at the point of contact e.g. GP practice, PHO – for example, the Mornington Health Centre where two mental health nurses provide early /brief intervention support to patients within this service – thus receiving skilled care which is prioritised rather than the service of a generalist.

Action 3 – agree with the "closer to home "approach but not if this results in a diluted approach to mental health service provision and ongoing clinical assessment. If this is not a cost cutting exercise, it would be preferable to place highly skilled mental health and addiction workers in schools GP practices and prisons rather than attempting to upskill already busy health staff. The use, for example, of online learning does not take into account the highly interactional nature of mental health and addiction services. Recruitment may be targeted eg towards health practitioners, kaiāwhina, particular groups; new recruits need proper support programmes eg NEtP. Retention programmes for Internationally qualified practitioners are important.

Action 4- use of the peer/consumer competencies needs to be more widespread if this is to be effective.

'Priority Two – Developing the workforce to improve integration between primary and secondary care

Q3. Do you agree with the actions in this section? (pages 19-22)

Yes √☐ No ☐

Additional comments:

Strongly support enhanced referral pathways (note that Health Practitioners (Statutory References to Medical Practitioners) Amendment Bill when enacted will remove barriers and facilitate this. Pleased to see need to recognise coexisting mental and physical health issues. It would be a positive step to improve service integration and accessibility and to strengthen the confidence and capability of the primary health and community care workforce.

Would like to see safety and quality mentioned. Services need to be safe for both consumers and the workforce. Eg not fair for health workforce to be responsible for service failures- for the regulated workforce this is a significant risk. Services also need to be high quality – i.e. accessing safe, quality services

Action 5 – sharing could also include health promotion Examples of successful integrated models needed for a) and for i) key health issues (eg suicide?) Important action but also very expensive e.g. 5 (b+c) supervision and mentoring programmes – supervision is a major issue currently within the sector, let alone across services.

Action 6 – great to remove barriers but are we looking at more skill dilution? Would we consider such an extensive approach to generalism in other sectors or is the mental health sector is more vulnerable?

Action 7 – Consultation liaison – is this a coordinating clinician? A navigator? Good to see NPs and allied health. We agree with the aim of improving workforce alignment but note that there have been interdisciplinary training programme initiatives for decades – has there been a substantial improvement in the mental health sector as a result of these programmes? Do we have evidence that, post-programme, these initiatives improve collaboration and ultimately the service user experience? Have we asked the people including family) who experience this multidisciplinary approach whether it works?!

How is 7 (a) going to be achieved? There has not been a great interest in mental health and addiction Nurse Practitioners status. Peer support programmes have been limited – will there be increased funding? The generic nature of the Kaiāwhina workforce remains a concern for the mental health and addiction sector. Care and support workers are integral to the health care team, but their knowledge and skills cannot be substituted for those of a health practitioners. Clinical oversight is required to provide a quality service for people experiencing mental illness and addiction.

Priority Three – Specialist workforce capacity and training pathways

Q4. Do you agree with the actions in this section? (pages 22-25)

Yes √☐ No ☐

Additional comments:

The regulated workforce (we **do not support** the use of 'specialist' to denote regulated) is aging but there are many ways in which expertise can be retained and utilised eg through mentoring, flexible hours, shared jobs. We draw your attention to NZNO's research and peer reviewed papers on retirement and aging of nurses available online http://www.nzno.org.nz/resources/research

Sustainability, should be modified to self-sustainability and accompanied by a clear commitment to reducing overreliance on overseas recruitment. Note the WHO's draft Global Strategy for Human Resources in Health recommended middle and high income countries target of 90% self-sustainability. Currently over 25% of our nursing workforce comprises internationally qualified nurses (IQN).

It isn't clear why the youth forensic workforce is more diverse than the workforce in other services.

Action 8 – generally agree – especially with targeted recruitment and strengthening retention. Note also Aotearoa New Zealand's very poor retention of migrant health workers (Hawthorne, 2012) .

c) Include employment in developing demand models etc.

Action 8 (d) – emphasis should be on investigate here. There are huge role boundary issues with implications for service users in terms of the quality of their care. There needs to be an urgent investigation of the role of all health and support workers in terms of accountability, practice delineation. NGO's responsibilities and in employing this range if health workers needs to be clarified, as do respective professional accountabilities. For example, where an RN line-managed by a supervisor from a support worker background. Nursing Council competencies become compromised by such an arrangement.

Action 9 – good to see inclusion of trauma informed care; however this list could be more extensive.

c) Add Prescribing – addiction to prescription drugs is significant and poorly recognised. Should be included in workforce training.

Priority Four – Addiction treatment and recovery training pathways

Q5. Do you agree with the actions in this section? (page 25-27)

Yes √☐ No ☐

Additional comments:

We question and challenge why Māori are only mentioned in relation to addiction-related harm priority!

Support practitioners practicing to the full extent of their scope and strongly support "any door is the right door" approach as long as it is integrated with primary health care provision.

Strongly agree that there is a need to ensure that entry level training pathways for the addiction workforce are meeting workforce needs. The addiction area is not a strong one in most undergraduate nursing programmes.

Helpful to have increased training opportunities as long as these are adequately resourced and linked with employment. The focus on including training for people with lived experience is helpful.

Overarching priority areas for mental health and addiction workforce development

Q6. Do you agree with the actions in this section? (pages 27-29)

Yes √☐ No ☐

Additional comments:

Lack of information about re drug trends, violence

Action 12 – without defining the addiction workforce and care this is far too open. Actions 14 and 15 – this would be a helpful approach

Action 15 should include those affected by family violence – more training is needed for family violence screening – note NZNO's position statement on interpersonal violence. - http://www.nzno.org.nz/Portals/0/publications/Interpersonal%20Violence,%202012.pdf

Action 17 sounds good but would be a massive undertaking involving much consultation – sounds costly.

Action 18 – leadership appears to be an issue across the mental health and addiction sector. It would be helpful to develop both clinical and non-clinical leadership capability however there needs to be careful planning around what type of leadership training would best develop leaders who would make a big difference to the sector. Just sending someone to leadership training does not always make this difference. Perhaps some mental health and addiction sector leadership competencies against which leaders could be evaluated. How will these potential leaders be selected and funded?

Priority of Actions

Q7. If you had to prioritise the actions in the plan what would be your top five actions for implementing in the next five years?

Priority actions:

NZNO believe a comprehensive workforce development and action plan must be comprehensive and integrated. Prioritising a few actions and failing to act on the others will be counterproductive. We are particularly anxious about the disclaimer for every "priority" ("all actions in the draft are tentative ...subject to costing etc) which begs the question of how, or if, the Plan will be operationalised.

The MHNS ha identified the following priorities. Action s, 1, 8 and 9
Action 1

Q8. Are there any actions in the plan that you particularly agree with or disagree with, and if so why?

Agree	**Reasons**
Action 18	Think strong leadership is important however we have reservations about how this development would occur
Disagree	**Reasons**
Action 2	Agree with training primary health staff but not with using them as a replacement for mental health and addiction skilled workers

Q9. Are there any actions that you think have been omitted and should be included? If so what are they, and why should they be included?

Additional actions that should be included?	Reasons
Review of mental health and addiction knowledge and skills within undergraduate health professional education – similar to the (2001) KPMG strategic review of undergraduate nursing education in New Zealand. Mental health promotion for children. While we are relieved that the Plan is not as disproportionately focused on 'innovation' and digital technologies as others have been, there may be room for some investigation of access to and recording of mental health information which is sensitive. Note our comments above and in the preceding overview – we believe the Plan must ensure employment, education and immigration actions are linked.	Undergraduate training should be able to address the primary care knowledge deficit issues, without additional training, if the curriculum adequately addressed mental health and addiction knowledge and skills. The new entry health practitioner would also have a stronger base on which to develop specialist skills. It is a matter of prioritisation within the curricula.

Q10. We would like to include examples of innovative workforce approaches in the final version of this Action Plan. Are you are aware of any innovative workforce solutions currently being used, piloted or trialled in the sector**?**

Yes ☐ No ☐

We are still exploring this. There have been a number of primary health care initiatives which have had positive implications for mental health eg oral health programme in Waikato, WAVES, but these are incidental rather than specific.

If Yes – can you please briefly explain the innovative approach used, how and by whom (we would also like contact details of a key person we could follow up with):

Contact details:

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30. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the

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