

Mental Health and Addiction Workforce Action Plan 2017–2021

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MANATŪ HAUORA



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Foreword

Tēnā koutou

The New Zealand Health Strategy highlights the importance of working differently to meet changing population health needs and to support New Zealanders to live well, stay well and get well. Everyone has a role in promoting and maintaining mental health and the mental health and wellbeing of individuals and communities is everyone's concern. Therefore we need to take a much broader approach to the mental health and addictions workforce that takes social determinants into account and is able to bring everyone together – across whānau, iwi, hapū, communities, social networks and agencies, and across government.

This workforce action plan has been in development for some time and arose from a specific action in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. As we sought to understand what workforce actions were needed to meet the needs of New Zealanders, many more questions arose. What outcomes are people expecting to see? What really matters to people? How can we predict what workforce might be needed in the future as we reshape our system? As we worked through these questions it became clear that this plan needs to be dynamic, continuing to develop and evolve as we reshape our approaches.

We are operating in a moving, working system made up of highly skilled and dedicated people working with people every day to make a difference to their lives. The plan identifies actions we need to take to continue to support and develop a workforce to centre on people and what matters to them. This is five year plan with a ten year horizon, signalling our commitment to better mental health and wellbeing into the future.

This plan is an important part of our ongoing commitment to improve the workforce in order to improve access to health services for people with mental health and addictions, to improve health outcomes and improve our understanding of how well the system is performing for people. It is another step towards building a collective view of our future and our commitment to investing in medium to long term outcomes.

Noho ora mai

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Executive summary

The purpose of the *Mental Health and Addiction Workforce Action Plan 2017–2021* (the Action Plan) is to identify the priority areas and actions required to develop an integrated, competent, capable, high-quality and motivated workforce focused on improving health and wellbeing. It will guide decisions about investment and resourcing for the next five years to ensure the workforce continues to develop and grow.

This Action Plan will contribute to achieving the vision of the New Zealand Health Strategy. That is, all New Zealanders live well, stay well and get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.

For the mental health and addiction workforce, contributing to this vision means enabling people to thrive and experience wellbeing wherever they live and whatever their circumstances.

This Action Plan recognises the importance of a life course approach and the combined effort to address the social determinants of health by working across health, justice and social sectors to achieve equitable positive outcomes for all New Zealanders. It includes actions to develop a workforce with the right skills, knowledge, competencies and attitudes to design and deliver integrated and innovative responses.

The workforce is the sector's most valuable resource and achieving the New Zealand Health Strategy's vision depends on having a capable and motivated workforce working with people, their families and whānau to get the best outcomes. This Action Plan identifies the actions required to develop primary, community and specialist workforces so that they are well equipped to support an outcomes approach and reshape the health system to centre on people and what matters to them.

The mental health and addiction workforce requires strong leadership, commitment to improving health and wellbeing, and the active engagement of the health, justice and social sectors.

Part 1 of the Action Plan outlines the current context and strategic priorities that we are working towards. These form the basis of planning to develop an integrated, competent, capable, high-quality and motivated workforce that meets New Zealand's current and future needs.

This Action Plan was created as a specific action in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. As the context has changed significantly during its development, it now encompasses a national outcome-focused approach and the goals of the Health Strategy, as well as emerging future priorities. It also covers a much wider scope and considers how to build capacity and capability not only of the mental health and addiction workforce but also across the overall health workforce to improve mental health and wellbeing.

Part 2 sets out the Action Plan itself. It identifies the actions required for the next five years to develop the mental health and addiction workforce and help reshape the system to centre on people and what matters to them.

The Action Plan is structured around the World Health Organization (WHO) definition of health workforce planning and development (WHO 2010):

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.

This definition includes the values and attitudes to instil a culture that values the consumer voice, the role of family and whānau, and what really matters to the people we serve. The Action Plan defines the national expectations and requirements and what we currently consider ‘right’ as we plan for the future. However, it is acknowledged that needs and priorities change. We must continue to plan ahead and revise and adapt our approach as the landscape changes.

The overall outcome of the Action Plan is that New Zealanders experience joined-up care from an integrated, competent, capable, high-quality and motivated workforce focused on improving health and wellbeing. The table below provides an overview of the Action Plan and the priority areas and actions to achieve those priorities.

Mental Health and Addiction Workforce Action Plan 2017–2021			
Four priority areas			
1	A workforce that is focused on people and improved outcomes	2	A workforce that is integrated and connected across the continuum
3	A workforce that is competent and capable	4	A workforce that is the right size and skill mix
Fourteen actions			
1.1	Implement an outcomes approach by commissioning workforce development in line with the New Zealand Health Strategy and national frameworks.	2.1	Enable a more mobile, responsive workforce that can adapt to new models of care.
1.2	Develop strong leadership programmes and pathways at all levels to support the changing environment.	2.2	Strengthen collaborative ways of working to deliver coordinated and integrated responses.
1.3	Use data gathered to revise and adapt the workforce development infrastructure (national, regional and local) to ensure expected outcomes are being met.	2.3	Facilitate health and other agencies to share information, knowledge and resources they can use to address the social determinants of health.
		3.1	Build capability across the health workforce to respond to mental health, addiction and physical health issues.
		3.2	Support the development of the primary and community workforce to respond effectively and facilitate access to appropriate responses.
		3.3	Strengthen and sustain the capability and competence of the mental health and addiction workforce.
		3.4	Strengthen the workforce's capability to work in multidisciplinary ways.
		4.1	Use workforce data to understand the current and future size and skill mix of the workforce.
		4.2	Grow and develop the Māori workforce.
		4.3	Develop recruitment and retention strategies to address shortages and grow the Pacific, peer and consumer workforces.
		4.4	Develop mental health and addiction career pathways both for those already working in health and social services and for new recruits.

To ensure that this Action Plan is dynamic, it includes review, monitoring and evaluation so that we can compare actual outcomes and results with what's expected and use this information to make decisions about workforce development into the future.

Part 1: Background

The future we want

This Action Plan contributes to the vision of the New Zealand Health Strategy: that all New Zealanders live well, stay well and get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system. For the mental health and addiction workforce, contributing to this vision means enabling people to thrive and experience wellbeing wherever they live and whatever their circumstances.

The mental health context

The contextual information in this section shows further efforts are needed to promote wellbeing and to prevent mental health problems. While most New Zealanders experience good mental health and wellbeing most of the time, all New Zealanders have times of mental distress. Issues such as discrimination, misuse of alcohol and drugs, poverty, unemployment, abuse and family violence are barriers to good mental health and wellbeing and must be addressed along with providing accessible, high-quality, effective support for people who are mentally unwell.

A person's mental health and wellbeing crucially affect their path through life and are vital for the healthy functioning of families, communities and society. Many people, whānau, organisations and communities contribute to improving and sustaining an individual's mental health and wellbeing so the individual can reach their full potential.

The evidence shows people's mental health and wellbeing is influenced by experiences earlier in life. It is now clear that early childhood is the critical period. Adverse prenatal, infant and childhood experiences contribute to a diverse range of poor health outcomes in adolescence and adulthood, including elevated rates of depression and conduct disorders (Gluckman 2011; Ministry of Health 2011).

Given that the experiences of infancy and childhood have a major impact on adolescent and adult mental health outcomes, this workforce action plan recognises the importance of a life-course perspective. This means that professionals such as midwives, Well Child / Tamariki Ora nurses (Plunket nurses), early childhood teachers and others have an important role in supporting parents, infants and children to live, learn and play in environments that promote mental health and wellbeing and prevent poor mental health outcomes.

Mental health and wellbeing are strongly influenced by social determinants: low income, unemployment and a low standard of living all contribute to poorer outcomes for those with mental health and addiction issues. The World Health Organization (WHO) considers that the 'responsibility for promoting mental health and preventing mental disorders extends across all sectors and all government departments' (WHO 2013, p 17). Understanding how social, economic and physical environments contribute to health and wellbeing is important to be able to intervene at critical points.

Mental illness currently accounts for 15 percent of the total burden of disease in the developed world. The WHO predicts that depression will be the second leading cause of disability in the world by 2020.

In New Zealand, about 1 in 5 people will have a diagnosable mental illness in the last 12 months; of these people, about 1 in 30 people experience severe mental illness and require specialist services. Many more New Zealanders will need help to manage distress at some stage in their lives. Over the last two years, the proportion of people seen by primary care with a diagnosed mental health issue has increased to 22 percent.

An estimated 12 percent of New Zealanders will experience a substance use disorder in their lifetime, of whom 70 percent will have a co-existing mental health issue. While alcohol remains the principal cause of substance addiction issues, New Zealanders are prepared to try and use a variety of other drugs, including cannabis, synthetic cannabinoids, opiates, methamphetamine and assorted others. Drug-using communities are often wary of approaching services, and issues of stigma and shame can be barriers to seeking help.

As our understanding of the interplay between mental health and physical health outcomes grows, it reinforces the importance of taking a holistic approach to improving health and wellbeing. New Zealand's experience mirrors the well-documented international trends that show people with serious mental illness and addiction have poorer outcomes. New Zealanders with serious mental illness and addiction have significant physical health needs and a reduced life expectancy (by up to 25 years) in comparison with the general population (Te Pou o te Whakaaro Nui 2014b). Addressing inequitable outcomes for those with mental health and addiction issues is a challenge for New Zealand.

Working towards equitable outcomes for Māori and other populations

The New Zealand Health Strategy acknowledges the special relationship between the Crown and Māori under the Treaty of Waitangi. It identifies Māori health as a priority.

Reducing the disparity of Māori mental health outcomes continues to be a priority for the Ministry of Health and is part of its commitment under the Treaty of Waitangi. As a population group, Māori experience the greatest burden due to mental health issues of any ethnic group in New Zealand. Māori are over-represented under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Notably Māori are 3.6 times more likely than non-Māori to be subject to a community treatment order, and 3.3 times more likely to be subject to an inpatient treatment order.¹

Māori make up approximately 16 percent of New Zealand's population, yet they account for 26 percent of all mental health service users.² *Te Rau Hinengaro* (Oakley Browne et al 2006) showed that Māori experience the highest levels of mental health disorder overall, are more likely to experience serious disorders and co-morbidities and have the highest 12-month prevalence of substance disorders.

Suicide rates are also higher for Māori than for non-Māori. Further, Māori often present later, entering directly into acute services, which indicates an opportunity for early intervention is being missed.

¹ These ratios are based on the age-standardised rates of the Māori and non-Māori populations.

² PRIMHD data, extracted on 10 June 2016. This applies to both voluntary service users and those treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Meaningful action across the system is needed to address the disparity of mental health outcomes for Māori in New Zealand.³ The workforce needs to understand and act on what matters to Māori to achieve better outcomes for them.

Pacific peoples, people with disabilities and refugees (among others) are population groups that experience inequitable outcomes. Pacific communities experience poorer health outcomes in New Zealand and often present late, entering directly into acute services. Pacific health status remains unequal with non-Pacific people across almost all chronic and infectious diseases, including mental health and addiction.

Underpinning all the actions in this Action Plan is a commitment to improving outcomes for Māori and other groups where disparity is evident. This Action Plan aims to build a workforce that is culturally responsive to all New Zealanders and reflects the population it serves.

Health loss in New Zealand

The recent Ministry of Health report, *Health Loss in New Zealand 1990–2013* (Ministry of Health 2016b), finds that long-term mental and physical conditions (non-communicable diseases) now cause 88 percent of health loss in this country. Neuropsychiatric⁴ disorders are the leading cause of health loss in New Zealand, accounting for 19 percent of total disability-adjusted life years (DALYs).

Mental health is the main health challenge for youth (15–24 years). Neuropsychiatric disorders accounted for over one-third (35 percent) of all health lost by this age group in 2013.

While New Zealanders are living longer, it is not always in good health. The health loss report identifies how the prevalence of multiple long-term conditions steeply increases as we age. A health system that is oriented to managing single diseases individually will struggle to cope with this trend.

Providing better care for people living with mental illness, addiction and dementia – including care for their physical health – is a growing challenge for the health and social sectors. The mental health and addiction workforce needs to be more responsive to people with multiple long-term conditions as preventing and better managing long-term conditions will bring significant benefits.

These trends need to be factored in to future workforce planning for the mental health and addiction sector and the wider health and social sector. This applies to both planning ways to recruit and retain the workforce and developing models of care.

The New Zealand Health Survey

The 2014/15 New Zealand Health Survey (Ministry of Health 2015a) highlights the following concerning trends in relation to hazardous drinking and levels of distress in our communities.

- Around 31,000 children (3.9 percent) aged 2–14 years had been diagnosed with emotional and/or behavioural problems at some time in their life. The percentage has increased from 2006/07 (when it was 1.8 percent).

³ This is a specific action outlined in *Rising to the Challenge* (Ministry of Health 2012). In addition, the number of Māori subject to section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 is now an indicator for reporting in the Māori Health Plans that the Ministry of Health requires every district health board to produce.

⁴ Neuropsychiatric disorders are defined as mental health, addiction and brain disorders for the purposes of the report.

- Boys were 2.5 times more likely to have ever been diagnosed with emotional and/or behavioural problems as girls, after adjusting for age differences.
- Māori adults have higher rates of most health risks and higher rates of psychological distress than non-Māori adults.
- The percentage of adults who are hazardous drinkers has increased to 18 percent. This represents a return to 2006/07 levels, following a low of 15 percent in 2011/12.
- An estimated 636,000 adults (17 percent) had been diagnosed with a mood disorder and/or anxiety disorder at some time in their life.
- An estimated 225,000 adults (6 percent) had experienced psychological distress in the past four weeks (that is, they had scored 12 or more on the Kessler Psychological Distress Scale).
- Pacific adults experienced relatively high rates of psychological distress (that is, they were 1.6 times more likely to experience it than other adults) but relatively low rates of diagnosed mood and/or anxiety disorders (8 percent).

Adults living in the most socioeconomically deprived areas had significantly higher levels of most health risks, including hazardous drinking. They also had higher rates of psychological distress, diagnosed mood and/or anxiety disorders, and chronic pain.

The growing New Zealand population

The New Zealand population is growing. In the fiscal year to June 2016, the estimated resident population recorded the largest ever annual growth of 97,300 (2.1 percent) to reach 4.69 million (Statistics New Zealand 2016). New Zealand's population is predicted to continue to increase, reaching between 4.89 and 5.14 million by 2020 (Statistics New Zealand 2016).

Over the last two decades, the age structure of New Zealand's population has also changed significantly. Between 1996 and 2016, data shows increases in the population of:

- children (aged 0–14 years) by 7.2 percent
- younger working-age adults (aged 15–39 years) by 10.4 percent
- older working-age adults (aged 40–64 years) by 47.7 percent
- adults aged 65 years and over by 62.4 percent.

The demand on health services will increase in the future because New Zealand's population is both growing and ageing. The health workforce is also ageing: 40 percent of doctors and 45 percent of nurses are aged over 50 years, and mental health and addiction nurses in particular are older than the average age of nursing staff.

In addition, New Zealand's population is becoming more ethnically diverse. In Auckland, for example, around 39 percent of residents were born overseas and one in four are Asian (Statistics New Zealand 2016).

The Māori ethnic population is growing at a faster rate than non-Māori across most areas of New Zealand. Depending on future trends in birth rates, the Māori population could account for nearly 20 percent of New Zealand's population by 2038 (1–1.8 million), and nearly one-third of New Zealand's children (Statistics New Zealand 2016). To honour the Treaty of Waitangi, the mental health and addiction sector needs to continue to work in partnership to develop workforce strategies to improve health outcomes for Māori.

The Māori, Asian and Pacific populations will all become a higher proportion of the total New Zealand population by 2038 because they will grow at higher rates than other groups in the population (Statistics New Zealand 2016). To meet the needs of these populations and ensure a

culturally competent workforce, we need to upskill and grow the workforce to respond to and more closely reflect the communities it serves.

The government context

The Government is focused on improving the lives and wellbeing of New Zealanders, and on developing a better-performing public sector. To deliver better public services that meet the needs of New Zealanders, government agencies must be innovative and responsive and take a whole-of-government approach to achieving these outcomes. This Action Plan builds on and incorporates the focus of this broader work and contributes to the goals of the New Zealand Health Strategy.

Addressing the needs of children and youth at high risk of poor social outcomes continues to be a key Government priority. An essential part of improving their outcomes is to build resilience and to identify and provide effective intervention for mental health and behavioural problems. Priorities are to: improve assessment and care for children; improve core services for those aged 0–5 years who are at risk, along with their family and whānau; and prevent child conduct disorder.

Some of the many examples of cross-agency initiatives that are contributing to improving mental health and wellbeing are: housing and addiction support for pregnant women and families with new infants (Ministries of Social Development and Health), Alcohol and Drug courts (Ministries of Justice and Health), Earlier Mental Health Response project (NZ Police and Ministry of Health) and the Prime Minister Youth Mental Health Project (Ministries of Education, Health and Development, and Te Puni Kōkiri).

The New Zealand Health Strategy

The New Zealand Health Strategy (the Strategy) outlines a strong commitment to changing the way the whole health system works to meet changing health needs into the future (Minister of Health 2016a, 2016b). We need to think and act differently and focus more strongly on people and what they need. We need to emphasise maintaining health, being health literate and preventing illness whenever possible so that New Zealanders can live well, stay well and get well.

The Strategy outlines a high-level direction for New Zealand's health and disability system over the next 10 years. Its two parts are 'Future direction' and the 'Roadmap of actions 2016'. It describes new ways of working so that:

all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system (Minister of Health 2016a).

The first principle of the Strategy acknowledges the special relationship between Māori and the Crown under the **Treaty of Waitangi**. The principles of partnership, participation and protection underpin the relationship between the Government and Māori.

- Partnership involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- Participation requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- Protection involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

The Government is taking a social investment approach to improve the lives of New Zealanders. The social investment approach is about applying rigorous and evidence-based investment practices to social services and understanding the wider impact of government services on people's lives. It involves being very clear about who we need to get better long-term results for and the best way to get those results. This Action Plan allows for a social investment approach and challenges us to demonstrate that we have achieved results.

The Strategy and this Action Plan sit within Government priorities such as Delivering Better Public Services; cross-government strategies, including Whānau Ora and the Children's Action Plan; and population and other health strategies, such as *He Korowai Oranga: Māori Health Strategy* (Ministry of Health 2014b), *'Ala Mo'ui: Pathways to Pacific health and wellbeing* (Ministry of Health 2014a), *Healthy Ageing Strategy* (Associate Minister of Health 2016), *Primary Health Care Strategy* (Minister of Health 2001), *Rising to the Challenge: The Mental Health and Addiction Service Development Plan* (Ministry of Health 2012) and *Living Well with Diabetes* (Ministry of Health 2015d).

Rising to the Challenge

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health 2012) set the direction for mental health and addiction service delivery across the health sector over the five years from 2012–2017. *Rising to the Challenge* envisages a future where all New Zealanders will have the tools to weather adversity and support each other's wellbeing, and rapidly access interventions needed from a range of effective, well-integrated mental health and addiction services. In this vision, people will also have confidence that publicly funded health and social services are working together to support the best possible outcomes for those who are most vulnerable.

We must build on the gains made by *Rising to the Challenge* by continuing to ensure services are best placed to respond to the changing needs of the populations they serve. A capable and motivated workforce will be needed to take New Zealand into the future and ensure people are thriving and experience wellbeing.

Blueprint II

The overarching vision for *Blueprint II* is that 'Mental health and wellbeing is everyone's business'. Taking a broad view, it considers the roles of not only health services but also social services (Mental Health Commission (MHC) 2012a). *Blueprint II* is made up of two companion documents. The first, *How Things Need To Be* (MHC 2012a), sets out the broad view of the changes that are needed within the mental health and addiction sector. The second, *Making Change Happen* (MHC 2012b), is directed at people working in the sector and provides a more practical guide to implementing the changes. This Action Plan picks up many of the priorities highlighted in *Blueprint II*.

National Drug Policy 2015–2020

In 2015 the New Zealand Government launched its revamped National Drug Policy (Inter-Agency Committee on Drugs 2015). The *National Drug Policy 2015–2020* sets out the Government's approach to alcohol and other drug issues, with the overarching goal of minimising alcohol and other drug harm, and promoting and protecting health and wellbeing. It is the guiding document for policies and practices responding to alcohol and other drug issues. Its aims are to guide decision-making by local services, communities and non-governmental organisations (NGOs), to improve collaboration and to maximise the effectiveness of the system as a whole.

The Inter-Agency Committee on Drugs oversees the implementation of the National Drug Policy. It brings together the Ministries of Health, Justice, Social Development, and Education, the New Zealand Police, the Department of Corrections, and the New Zealand Customs Service, while the Accident Compensation Corporation, National Drug Intelligence Bureau, Health Promotion Agency and Te Puni Kōkiri also participate. Through the involvement of this collection of agencies, the delivery of this policy is integrated with broader social sector objectives.

The National Drug Policy takes practical health-based actions to address substance abuse. It reinforces and complements *Rising to the Challenge* by placing addiction treatment services within a wider context of alcohol and other drug harm-minimisation, which also covers prevention, early intervention and harm reduction.

He Korowai Oranga

He Korowai Oranga, New Zealand's Māori Health Strategy, sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It was refreshed in 2014 so that it continues to be relevant and builds on the initial foundation of whānau ora (healthy families) to include mauri ora (healthy individuals) and wai ora (healthy environments) (Ministry of Health 2014b).

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018

'Ala Mo'ui (Ministry of Health 2014a) is a four-year plan that provides an outcomes framework for delivering high-quality health services to Pacific peoples. The long-term vision of *'Ala Mo'ui* is: 'Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili (family) experience equitable health outcomes and lead independent lives'.

The four priority outcome areas are that:

- systems and services meet the needs of Pacific peoples
- more services are delivered locally in the community and in primary care
- Pacific peoples are better supported to be healthy
- Pacific peoples experience improved determinants of health.

The mental health and addiction sector

Over the last few decades, the Government has made significant investment in mental health and addiction services to support the move from an institutional base to a strong community base. This investment has allowed the sector to develop a wide range of community services and take more innovative approaches, as well as to further develop specialist and acute services. The Government has also invested in a range of promotion and prevention initiatives.

In the year ending June 2016, a record number of people (167,840, or 3.6 percent of the New Zealand population) accessed specialist mental health and addiction services, an increase consistent with international trends. Of these people, 48,105 accessed alcohol and other drug services across New Zealand. This exceeds the 3 percent target (as set out in the first *Blueprint*, MHC 1998) for access for the adult population and demand continues to increase.

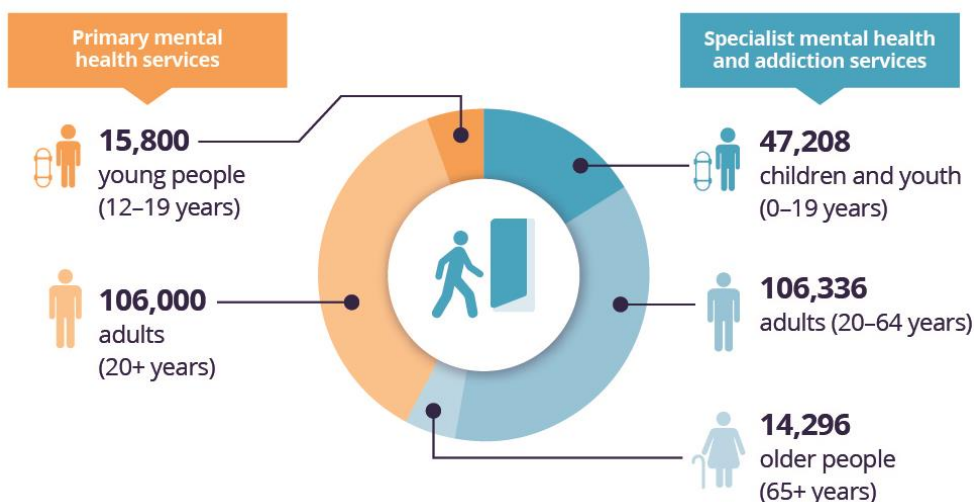
Of the total number who accessed specialist mental health services in the year ending June 2016, 47,208 were children and youth (aged 0–19 years). For this age group, the rate of access to mental health services has gradually increased over the last 10 years, from 1.7 percent in 2005/06 to 3.8 percent in 2015/16.

Specialist mental health services saw 14,296 older people in the year ending June 2016. This represents 2 percent of the population over 65 years.

Most people access mental health services in the community. In 2015, almost 91 percent of specialist service users accessed only community mental health services. Less than 1 percent accessed only inpatient services and the remaining 9 percent accessed a mixture of inpatient and community services (see Figure 1 and for more information, see Ministry of Health 2016c).

In addition to those using specialist mental health and addiction services, in the year ending June 2016 an estimated 106,000 adults and 15,800 of those aged 12–19 years olds were seen by primary mental health services across New Zealand for mental health and addiction issues. This represents 3.1 percent of the adult population and 3.2 percent of the population aged 12–19 years.

Figure 1: The number of people who accessed specialist and primary mental health services from 1 July 2015 to 30 June 2016



Sources: PRIMHD and Ministry of Health

While this increase in access is a positive sign that more New Zealanders are seeking and receiving mental health care, it places more pressure on services and the workforce to meet the demand. We need to rebalance the demand pressures across the continuum. Critical to the success of this task is to develop the primary and community care workforce.

Through the New Zealand Health Strategy, the Government has made a commitment to changing how the health sector works and to establishing a health sector that understands people’s needs and enables equitable outcomes. Mental health is an area that continues to see poorer outcomes and more than twice the mortality rate of the general population so efforts need to focus on improving this.

Taking an outcomes approach is part of reshaping the health system to focus on improving health and wellbeing and achieving better outcomes for all. This reshaping links population health with high-quality service delivery and a life course approach. It also takes into account the impact of social determinants throughout our lives.

To improve mental health and wellbeing, the health and disability, justice, corrections and social services workforces will need to make a combined effort in a whole-of-government response, recognising the social determinants of health. Broader society must also contribute: inclusive communities, supportive employers, people, families and whānau who support one another. In

addition, individuals themselves must play an active role in preventing and recovering from mental health and addiction issues through self-management.

Compelling evidence shows early adverse environments can have lifelong effects on the emergence of conduct disorder, substance abuse, and physical and mental health problems in later life (Ministry of Health 2012). A significant proportion of mental health and addiction issues starts to develop before the age of 25 years; adolescence is a particularly sensitive period of development.

Experiencing poor mental health early in life can have lifelong negative consequences, including diminished participation in the future workforce as well as enduring disability and/or poor family and social functioning (Gluckman 2011; Holt 2010; McGorry et al 2007; Ministry of Health 2011). Intervening effectively from the perinatal period through to childhood, adolescence and early adulthood can significantly improve longer-term outcomes and reduce future dependence on the health and social system.

The importance of prevention and early intervention applies equally to all people across the life course; both in terms of early in people's lives as well as earlier in the course of developing issues and illness. Work in three priority areas contributes to this approach.

- 1 Primary prevention: Prevent health issues by sustaining health and wellbeing and preventing illness whenever possible. Primary prevention and promotion of wellness involve working with iwi leaders, marae trustees and community leaders to alleviate risk, build resilience, strengthen whānau and facilitate collaboration. This area encompasses the *Five Ways to Wellbeing* (Mental Health Foundation 2016), which promotes building the following five actions into our day-to-day lives.
 - a. Connect, me whakawhanaunga.
 - b. Give, tukua.
 - c. Take notice, me aro tonu.
 - d. Keep learning, me ako tonu.
 - e. Be active, me kori tonu.
- 2 Early intervention: Effectively manage health issues early so that the person recovers rapidly with fewer complications. Secondary prevention and promotion of wellness involve Whānau Ora collectives, NGOs, general practices and recognising the signs, knowing how to respond appropriately and achieving results.
- 3 Tertiary prevention: People with long-standing disabilities are able to actively participate at home or in their community. Tertiary prevention and promotion of wellness involve NGOs, community agencies, rehabilitation centres, whānau, supporting positive attitudes, helping people to become part of the community, and working with whānau to raise expectations.

The workforce is expected to intervene early and respond to a range of issues as they occur. It needs to be well equipped and competent to work in this way. Given the increasing focus on improving quality, the workforce also needs to be able to use quality improvement methodologies and approaches. Related to that is the need to strengthen leadership at all levels in the system.

The workforce plays a vital role in encouraging and empowering people to be more involved in managing their own mental health and wellbeing. Another essential role is to build health literacy so people can make informed decisions and lead their recovery journey with their family and whānau.

The Ministry is committed to improving health literacy. It has released *A Framework for Health Literacy* (Ministry of Health 2015b) and *Health Literacy Review: A guide* (Ministry of Health 2015c) to support the health system and workforce to become health literate.

Related priorities

The following table lists the current active initiatives that are related to this Action Plan. However, new priorities and directions will emerge as the Action Plan progresses. This Action Plan will be reviewed and updated regularly throughout its life cycle to incorporate such changes.

Related initiatives	Relationship to this Action Plan
Commissioning Framework for Mental Health and Addiction	To implement this framework successfully, those responsible for commissioning must have the right skills and knowledge to develop integrated and innovative approaches.
Fit for the Future	The Ministry of Health is leading the 'Fit for the Future' project to develop system-wide solutions that address the increasing demand on the mental health system, particularly at the higher end of primary and community care. This involves looking at models and workforce initiatives to improve responses and outcomes for the group of people whose mental health and addiction needs are not easily met in primary care, but who do not meet the threshold for specialist care.
Forensic services	The increase in the prison muster is predicted to increase demand for forensic services. These trends will increase the demands on the existing workforce and will also require increased workforce capacity.
Health Workforce New Zealand Strategic Plan	Long term strategic framework that is to be developed in collaboration with the consumers and the sector. It will guide future decision making and investment on agreed priorities that are reviewed and updated annually.
He Tāngata: the draft Mental Health and Wellbeing National Population Outcome Framework	Part of implementing this framework successfully is to identify desired outcomes for the population and the sector and reflect these in this Action Plan.
Healthy Ageing Strategy	This strategy presents the overarching direction and action plan for healthy ageing over the next 10 years. It takes a life-course approach that seeks to maximise health and wellbeing for all older people. This strategy will impact on workforce requirements for those working with older people.
Investing in Children	Improving outcomes for vulnerable children is a Government priority. As the Ministry for Vulnerable Children develops, the impacts will become clearer. Service provision may change, which in turn will change the capability and capacity requirements of the workforce.
Joint work between Ministry of Social Development and Ministry of Health	These Ministries are working on cross-agency solutions to address and understand the number of people receiving income support due to mental health issue or substance abuse.
Kaiāwhina Workforce Action Plan	This action plan focuses on the development needs of the Kaiāwhina workforce as a valued members of an integrated team in the health, mental health, aged care, public health and disability services sector.
Methamphetamine Action Plan	The plan focuses on increasing the alcohol and other drugs (AoD) workforce capacity and capability to respond effectively to methamphetamine.
Misuse of Drugs Amendment Act 2016 Mental Health (Compulsory Assessment and Treatment) Amendment Act 2016	<p>These amendment Acts have been passed and will begin on a date yet to be decided. With both, it will be possible to use the trained health workforce more effectively and improve health care access.</p> <p>Under the Misuse of Drugs Amendment Act, authorised nurse practitioners, registered nurse prescribers and pharmacist prescribers, in addition to authorised medical practitioners, will be able to prescribe and treat addiction.</p> <p>Under the Mental Health Amendment Act, changes to sections 8B, 9, 10 and 11 will increase flexibility in the services to ensure the most qualified available health practitioner undertakes these functions.</p>

Related initiatives	Relationship to this Action Plan
Pharmacy Action Plan	Focus area 2 of the Pharmacy Action Plan is about medicines adherence and optimisation to help people understand their medication, ensuring the best combination of medication for them and making better use of our pharmacist workforce. Mental health is a priority area.
Prime Minister's Youth Mental Health Project	This four-year project is expected to continue to build on the gains made, develop the workforce to deliver youth-focused services and make these services sustainable.
Programme for the Integration of Mental Health Data (PRIMHD)	The national data set needs to be able to capture measures related to this Action Plan.
Rural Mental Health	This initiative supports mental wellbeing in rural communities through prevention and early intervention. It focuses on boosting the skills of health professional such as general practitioners, nurse practitioners and pharmacists working in rural areas.
Substance Abuse Compulsory Assessment and Treatment Bill	Planning for implementing this Bill is under way. It will have significant implications for the addiction workforce, including through changes to expectations and legislative requirements.
Suicide Prevention Strategy and Action Plan	The development of the next strategy will include workforce development initiatives that are linked with the Mental Health and Addiction Workforce Action Plan.
Supporting Parents, Healthy Children	This guideline aims to better identify, protect and support children and their families and whānau. Implementing this guideline includes embedding systems, policies and practices to identify and address the needs of children of parents with mental health and addiction issues.
Whānau Ora	The Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development are jointly implementing this key cross-government work programme. It places whānau at the centre of service delivery, supports knowledgeable whānau through health literacy and addresses the determinants of health by working for a collective impact and collaborating across sectors, iwi and NGOs.

By continuing to align with these initiatives, the mental health and addiction workforce will be equipped for the future and able to deliver people-powered, culturally appropriate and community-supported services that are effective and efficient.

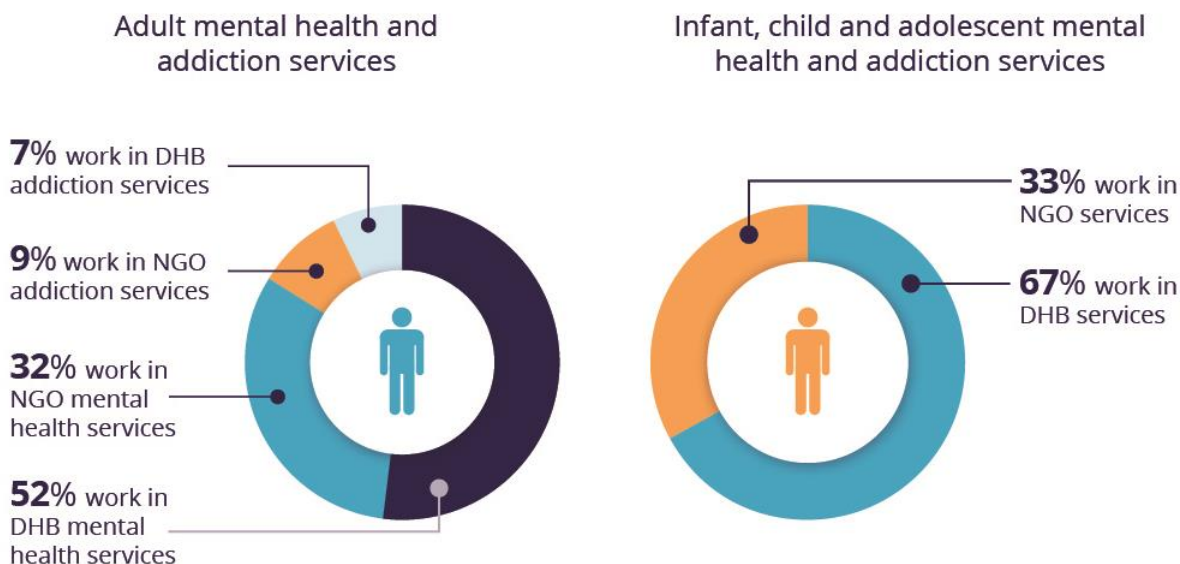
The workforce

At June 2014, 1618.7 full-time equivalent staff (FTEs) were working in infant, child and adolescent mental health and alcohol and other drug services; the vacancy rate was 8 percent. Of these FTEs, 1086 (67 percent) were in district health board (DHB) services and 532.37 were in NGO services. This workforce increased by 13 percent overall between 2012 and 2014; the NGO workforce, which increased by 29 percent, was mainly responsible for this growth (The Werry Centre 2015).

The adult mental health and addiction workforce represents approximately 7 percent of the total adult health workforce. At March 2014, over 11,000 people were working in this area in an estimated 9071 FTE positions; an additional 437 FTEs (5 percent) were reported vacancies (Te Pou o te Whakaaro Nui 2015a). Of this workforce, 84 percent were working in mental health services and 16 percent in the addiction sector (see Figure 2).

More than half (52 percent) of the workforce is working in DHB mental health services, 32 percent in NGO mental health services, 7 percent in DHB addiction services and 9 percent in NGO addiction services (for more information, see Te Pou o te Whakaaro Nui 2015a).

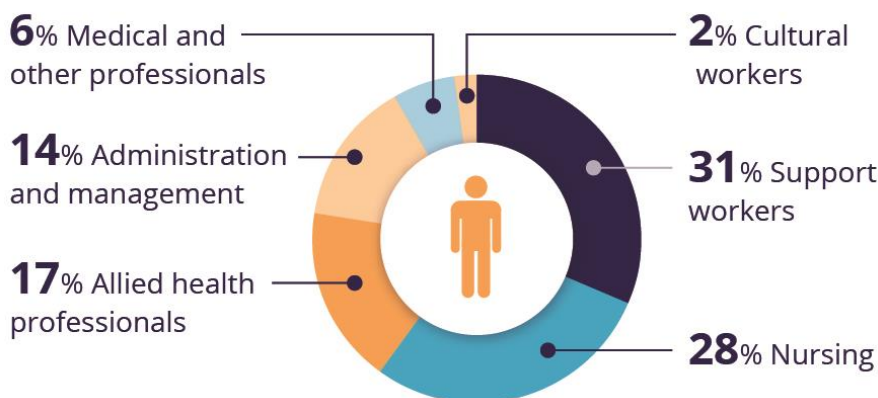
Figure 2: The percentage of FTE positions across DHB and NGO services



Source: Te Pou (2014) and Werry Centre (2014)

The mental health and addiction workforce consists of a broad and diverse range of people working in a number of different settings. This includes peer support workers, support workers, consumer advisors and advocates, family and whānau advisors, psychiatrists, nurses, counsellors, social workers, psychologists, occupational therapists, psychotherapists, pharmacists, other allied health workers, general practitioners, cultural workers (including kaumātua, mātua, and Māori, Pacific and Asian workers), housing facilitators, primary care coordinators and training providers. Others working in the field of mental health and addiction include organisations responsible for workforce development, managers and others in organisations supporting the mental health and addiction workforce. Other workers not traditionally seen as part of the mental health and addictions workforce such as midwives, Well Child / Tamariki Ora nurses (Plunket nurses), school nurses, and early childhood teachers have important roles in promoting mental health and wellbeing.

Figure 3: The percentage of each professional group working in Vote Health funded adult mental health and addiction services



Source: Te Pou, More than numbers workforce stocktake 2014

Multidisciplinary teams need to recognise the experience, history and unique insight that family and whānau bring and the importance of resourcing them in their role of supporting recovery and wellbeing. Staff also have a role in recognising, supporting and protecting children of parents with mental health and addiction issues, along with their wider family and whānau, by

working proactively to intervene early, support strengths and address vulnerabilities (see Ministry of Health 2015e).

Recent trends have been towards prevention and early intervention and the development of culturally specific services, a strong non-governmental organisation (NGO) sector, and involvement of people and their family and whānau in service planning and delivery. The mental health and addiction workforce is expected to partner with consumers and their family and whānau, who bring experience and perspectives that help staff to understand what really matters to people. The health sector is expected to work in a more holistic way with a focus on family and whānau, particularly to support parents with experience of mental illness and addiction and to improve outcomes for parents and vulnerable children.

The mental health and addiction workforce has had to adapt in this changing environment so that it improves services to meet the needs of people and their family and whānau. If the sector is to 'transform our model of care towards an integrated primary/community based response that leverages our hard won but limited capacity in specialist care' (HWNZ 2011, p 8), then services need to be designed in a quite different way.

In the workforce service review, *Towards the Next Wave of Mental Health and Addiction Services and Capability*, Health Workforce New Zealand (HWNZ) recommended several specific areas for development (HWNZ 2011). These included taking a whole-of-system and person centric view, adopting a wider scope to recognise social determinants and the whole-of-life course and strengthening the focus on primary responses, children and youth and the elderly. These themes feature throughout this Action Plan. The need to increase the range of responses available through primary and community care remains a priority.

The Ministry of Health's thinking has changed on the percentage increase in the workforce that is required. The actions in this Action Plan now include using data to better understand workforce development needs and the importance of aligning the workforce with the model of care. Since 2011, the workforce has developed a number of innovative ways of working that can be expanded and built on and will inform the development of new models of care.

The composition of the workforce will change with a stronger emphasis on support in the community and the capability to respond effectively to people in non-hospital settings. This will mean growing the primary and community care workforce, including the support worker workforce, navigator and coordinator roles, peer and consumer roles and family- and whānau-focused roles.

Challenges

New Zealand's health workforce is highly skilled and professional but faces staff shortages. The design of roles is important to use specialist roles effectively. To design roles well, it is important to gain a better understanding of 'breadth of scope' and what it means to work at 'top of scope' (see Te Pou o te Whakaaro Nui 2015b).

Among all specialty areas, psychiatry has the second highest percentage of international medical graduates, who make up 59 percent of the psychiatry workforce (based on registration data). This impacts on continuity of care as turnover for international medical graduates is higher than for those who are New Zealand trained. It also limits the impact of New Zealand training and development programmes as reshaping these programmes in line with an outcomes approach will have limited benefit for international medical graduates.

The ethnic distribution of the health workforce, in particular the under-representation of Māori health professionals, is another issue. International evidence shows access to services and health are improved for indigenous communities when the workforce reflects the local community. Pacific health professionals are also under-represented. Improving the representation of both Māori and Pacific peoples is particularly important for the mental health and addiction workforce due to the prevalence of mental health issues among Māori and Pacific communities.⁵

In the 2014 survey *More than Numbers* (Te Pou o Te Whakaaro Nui 2015a), three-quarters of respondents identified a need to increase their cultural competence for working with Māori, Pacific and Asian ethnic groups.

Critical specialist areas are experiencing shortages and for others shortages are anticipated in the future; some rural and provincial areas are also experiencing ongoing challenges to meet demand. The mental health and addiction sector needs to use population and workforce data to understand these issues in order to address them. The actions in this Action Plan will help with this task.

The number of people with long-term conditions and co-morbidities is increasing, impacting on what and how health care is delivered. The disparities in physical health outcomes between people who experience mental health and addictions and the general population has recently been highlighted in New Zealand. Further, children who have a parent with mental health and addiction issues are at increased risk of poor outcomes, including developing mental health and addiction issues themselves.

Opportunities

Responding to current challenges requires a strong and capable primary health workforce and an enhanced community workforce to support a greater government focus on prevention, self-care and care closer to home.

The specialist workforce will need to work differently and develop different skills so that it can provide a range of evidence-based interventions (including trauma informed care and talking therapies). It will also need to reorient to work more closely with primary care and align with effective models of care that are integrated, holistic and responsive.

A workforce that is confident and competent to work in a family- and whānau-focused way, and acknowledges and supports cultural diversity will contribute to the goal of delivering person-centred services closer to where people live, learn, work and play.

The workforce has an opportunity to work with a broad range of agencies in the health, social, education and justice sectors, supporting a range of government initiatives. This cross-sector work can be an important factor in improving outcomes for vulnerable children, their family and whānau. Greater leadership at all levels can strive to understand the way in which the system is travelling, support this commitment and build on the progress that has already been made.

The draft *Mental Health and Wellbeing National Population Outcome Framework* identifies important factors for mental health and wellbeing as: healthy, safe and secure homes; financial security and living standards; participation in education and employment; and physical health. To address these determinants of health, it is necessary to take a cross-government and cross-agency approach and to work collaboratively across the health and social sectors at national, regional and local levels.

⁵ In the 2012/13 New Zealand Health Survey, rates of psychological distress in the last four weeks were significantly higher among Māori adults (10 percent) and Pacific adults (9 percent) than in the general population (6 percent).

Evolving clinical practice and scientific and technological advancements will support new models of care that are integrated across settings and a people-powered approach. New technologies will help people be more involved in their mental health as well as driving innovative ways of working. Efficiencies can be gained by enhancing existing workforce roles as well as by redesigning roles to best use skills and expertise and by working in multidisciplinary teams. Good information technology platforms will help structural integration of services and workforce models.

Improving health outcomes is the responsibility of both primary and specialist workforces. There is an opportunity to build everyone’s capability: the mental health and addiction workforce can develop its skills with physical health issues, while the general health and disability workforce can learn more about dealing with mental health and addiction issues.

Identifying outcomes

This Action Plan contributes to the vision of the New Zealand Health Strategy and the vision of enabling people to thrive and experience wellbeing wherever they live and whatever their circumstances.

The following table is organised into the four priorities of the Action Plan. It shows the expected outcomes for mental health and addiction under each priority and how these outcomes align with the New Zealand Health Strategy.

1 A workforce that is focused on people and improved outcomes	2 A workforce that is integrated and connected across the continuum	3 A workforce that is competent and capable	4 A workforce that is the right size and skill mix
Expected outcomes: What do we want by 2021?			
<ul style="list-style-type: none"> Workforce centres and programmes are aligned to the New Zealand Health Strategy and lead the way as new priorities and models are developed. Leadership capacity is strong across the continuum, supported through programmes and mentoring for both current and emerging leaders. Outcome measures and results are monitored and data is used to revise and adapt the workforce development infrastructure (national, regional and local) to ensure expected outcomes are being achieved. 	<ul style="list-style-type: none"> Collaborative ways of working and care planning are clearly reflected and aligned at national, regional and local levels (from policy to practice). The workforce is mobile, is integrated with communities and primary care and has strong links with a number of different agencies, sharing skills, knowledge and resources. The mental health and addiction workforce is regularly working with welfare, justice, corrections and education. Understanding of how each contributes to wellbeing has increased. 	<ul style="list-style-type: none"> People with long-term conditions, including mental health and addiction issues, have improved health outcomes (reduced health loss). The workforce has a good understanding of people-centred and strength-based practice, which is part of all health training and development programmes. The workforce is culturally competent. Competency frameworks form the basis for all recruitment, training and professional development. Multidisciplinary teams are well-established and include both the regulated and kaiāwhina health workforce. 	<ul style="list-style-type: none"> Predictions of future needs and models of care determine the required size and skill mix of the workforce. Dynamic modelling is used to understand current and future requirements as new models and priorities emerge. The workforce is culturally diverse to reflect the population, particularly Māori and Pacific peoples. The workforce reflects the diversity and experience of service users, and works in collaboration with the service user and their family and whānau.

1 A workforce that is focused on people and improved outcomes	2 A workforce that is integrated and connected across the continuum	3 A workforce that is competent and capable	4 A workforce that is the right size and skill mix
	<ul style="list-style-type: none"> Agencies are working together to coordinate care and improve wellbeing at national, regional and local levels. 	<ul style="list-style-type: none"> Members of multidisciplinary teams work to the full breadth of their scope of practice. They value their contribution to improving health and wellbeing. 	<ul style="list-style-type: none"> Decisions about the right size and skill mix of the mental health and addiction workforce are based on an understanding of the contribution of the health workforce across the continuum as well as the contribution from other agencies.

Alignment to expected outcomes from the New Zealand Health Strategy: what 'great' would look like in 2026

<p>People-powered</p> <ul style="list-style-type: none"> Everyone who delivers and supports services in the health and disability system understands the needs and goals of the individual they are supporting as well as their family, whānau and community and focuses on the person receiving care in everything they do. <p>Value and high performance</p> <ul style="list-style-type: none"> All involved in delivering and supporting services strive for excellence and improvement, supported by evidence, research and analysis. <p>One team</p> <ul style="list-style-type: none"> The system has competent leaders who have an unwavering focus on its goals, and a culture of listening carefully and working together in the interests of people's ongoing wellbeing. <p>Smart system</p> <ul style="list-style-type: none"> A culture of enquiry and improvement exists throughout the health system, which has seamless links to research communities. The system learns and shares knowledge and innovation rapidly and widely. 	<p>Closer to home</p> <ul style="list-style-type: none"> The health system works effectively with other agencies to improve outcomes in areas such as housing, social development and corrections for all children and young people, and particularly those at risk. It works through strong community links with early childhood centres, schools, marae, churches, local authorities and other social service agencies. <p>One team</p> <ul style="list-style-type: none"> New Zealanders experience joined-up care that clearly shows different organisations and professionals are working as one team. 	<p>Closer to home</p> <ul style="list-style-type: none"> Our workforce in primary and community-based services has the capability and capacity to provide high-quality care as close to people's homes as possible. <p>One team</p> <ul style="list-style-type: none"> The health system is more than a sum of its parts, with each part clear on its role and working to achieve the aims of the system as a whole. <p>Smart system</p> <ul style="list-style-type: none"> The quality of health care is high as health workers spend quality time with people, make fewer errors and make better decisions. 	<p>One team</p> <ul style="list-style-type: none"> New Zealand offers coherent pathways for developing leadership and talent that inspire and motivate people already working in the health system, and those considering health as a career. We invest in the capability and capacity of our workforce, including in NGOs and the volunteer sector, and make sure that investment fosters leadership, flexibility and sustainability. <p>Smart system</p> <ul style="list-style-type: none"> Data is used consistently and reliably, with appropriate safeguards, to continuously improve services.
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Developing this Action Plan involved sharing a range of ideas and experiences from people right across the mental health and addiction sector and the wider health sector. People communicated a shared goal of improving outcomes for people with mental health and addiction issues, and a consistent view of what constitutes high-quality support and services. These services are person-centred, are integrated across the continuum of care, recognise and include family and whānau, are focused on early intervention, can support self-management and recovery, and are focused on local delivery with specialist support.

The sector also communicated a range of ways of developing the workforce to better meet people's mental health and addiction needs. These include:

- improving collaboration across the different layers of the mental health and addiction sector and the wider health sector
- collaborating across sectors, with a mental health and addiction workforce that works effectively with infant, child and youth services, social services, schools, justice, corrections and other social care services
- developing education, justice and social systems to have core mental health and addiction competencies to provide equitable and supportive services
- conducting workforce planning at national, regional and local levels
- having capable leadership at all levels to promote and support the necessary changes
- aligning the workforce more closely with service needs, including access and improved outcomes for vulnerable groups provided within multidisciplinary team environments
- promoting mental health and addiction career opportunities that are seen as an attractive career choice
- providing fit-for-purpose learning and development opportunities, with a focus on cultural competence
- improving information sharing and use of new technologies.

The Action Plan incorporates these themes and organises them in line with the WHO definition of health workforce planning and development (see 'Four priorities' in Part 2 for this definition).

Five domains of workforce development

A sector-wide commitment to improving workforce development infrastructure, organisational development, retention and recruitment, learning and development, and research and evaluation will ensure that the right people with the right skills are in place to support successful workforce development.

These five domains of workforce development are threaded through each of the Action Plan's priority areas and inform the actions.

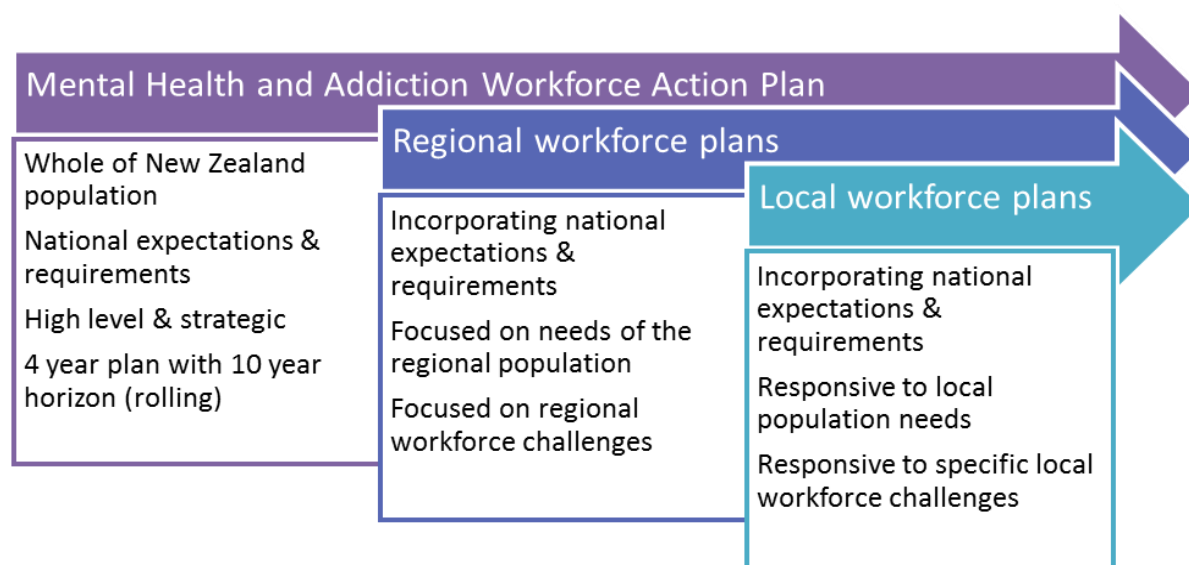
- 1 **Workforce development infrastructure:** Workforce development infrastructure involves a whole-of-system approach. This requires national and regional coordination to develop an efficient and integrated workforce.
- 2 **Organisational development:** Successful organisational development is centred on strong leadership, engaged management and effective organisational design to develop service culture and systems. To achieve the best outcomes for people, the workforce needs to be responsive and well-aligned to the needs of the local population. In practical terms, it works with innovative models of care that are integrated across settings to better serve people's needs, along with well-designed new roles and team structures.

- 3 **Recruitment and retention:** To achieve the goal of increasing the capacity and capability of the workforce, recruitment and retention need to be coordinated nationally and regionally. Recruiting and training under-represented workforce groups, improving and clarifying role design and strengthening support systems will help to retain staff. Promoting careers in mental health and addiction will support a sustainable workforce for the future.
- 4 **Learning and development:** To ensure that people with mental health and addiction issues receive high-quality care and support, a well-trained workforce that responds to service and population needs is required. The workforce needs to have clearly articulated training pathways, and training that builds capability for working in multidisciplinary teams and providing holistic care that is culturally appropriate.
- 5 **Information, research and evaluation:** It is necessary to make best use of information systems to improve access to training and effectiveness of service delivery, particularly to population groups that have a higher prevalence of mental health and addiction issues or are hard to access. Collecting data to give a national picture of mental health and addiction, along with analysis and feedback to the regions and services, will help with workforce development and local service delivery suited to the population's needs.

National, regional and local workforce planning

This Action Plan is a high-level national plan to inform effective workforce development at national, regional and local levels. It provides the national expectations and requirements that inform and support regional and local workforce planning (see the diagram below).

A whole-of-system approach to workforce development is needed to make the actions of this Action Plan an everyday part of national, regional and local activity. To successfully develop the workforce and achieve the actions outlined in this Action Plan, dedicated resource is required at each of these levels.



Part 2: The Mental Health and Addiction Workforce Action Plan

Introduction

This part is the Action Plan itself. It identifies the actions required for the next five years to develop the mental health and addiction workforce in ways that help reshape the mental health and addiction system to become one that centres on people and what matters to them. The actions identify what we need to do to achieve the desired future state under each of the priorities in five years' time.

Four priorities

This Action Plan is organised into four priorities, which are structured around the World Health Organization (WHO) definition of health workforce planning and development (WHO 2010):

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.

The table below shows the four priorities, what each one covers and how it aligns with the WHO definition.

Priority – A workforce that is:	What it covers	How it aligns with WHO (2010) definition
1 Focused on people and improved outcomes	<ul style="list-style-type: none"> • How do we know that what we are doing is working? • How do we measure performance and outcomes and ensure equitable outcomes for all? 	Right work output
2 Integrated and connected across the continuum	<ul style="list-style-type: none"> • How we work – our approach is linked up, cross-agency and holistic, has collaborative care plans, includes social determinants and reaches across addiction, mental health and the broader health sector. • Where we work – we are in different locations, are more mobile, share records and plans, and have the right tools (for example, mobile technology, cars). 	Right place, right time and right work
3 Competent and capable	<ul style="list-style-type: none"> • What we do – we undertake interventions, do comprehensive and holistic assessments, use Māori cultural models, use Pacific cultural models, respond in culturally and linguistically diverse ways, work at top of scope and with breadth of scope, effectively use scope of practice, use technical skills and respond to co-existing problems. • What competencies we need and how interventions are delivered – these include cultural competence, strength-based practice, planning for wellness. • How we develop a personal and workplace culture that values the consumer voice and world view, the role of family and whānau and what really matters to the people we serve. 	Right skills and right attitude
4 The right size and skill mix	<ul style="list-style-type: none"> • What does the workforce need to look like to meet our future needs? • Based on above, what will be the skill mix of clinicians, allied health, support staff (including peer and cultural) and primary care? Need to design roles to effectively use scope and expertise. • How do we develop an ethnically diverse workforce that reflects the population it serves? • Data – what do we know about the current workforce? How do use modelling for future years based on training numbers, expected shortages and other important influences? 	Right number, right cost

Mental Health and Addiction Workforce Action Plan: Intervention logic

New Zealand Health Strategy: All New Zealanders live well, stay well, get well in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.

People are thriving and experience wellbeing

Outcomes: What are our goals for New Zealanders?

New Zealanders experience joined-up care and support delivered by an integrated, competent, capable, high-quality and motivated health workforce focused on improving health and wellbeing

Pae ora – healthy futures

Mauri ora (healthy individuals)

Whānau ora (healthy families)

Wai ora (healthy environments)

Impacts: What difference will it make?

1	A workforce that is focused on people and improved outcomes	2	A workforce that is integrated and connected across the continuum	3	A workforce that is competent and capable	4	A workforce that is the right size and skill mix
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Outputs: What actions are we taking?

1.1	Implement an outcomes approach by commissioning workforce development in line with the New Zealand Health Strategy and national frameworks.	2.1	Enable a more mobile, responsive workforce that can adapt to new models of care.	3.1	Build capability across the health workforce to respond to mental health, addiction and physical health issues.	4.1	Use workforce data to understand the current and future size and skill mix of the workforce.
1.2	Develop strong leadership programmes and pathways at all levels to support the changing environment.	2.2	Strengthen collaborative ways of working to deliver coordinated and integrated responses.	3.2	Support the development of the primary and community workforce to respond effectively and facilitate access to appropriate responses.	4.2	Grow and develop the Māori workforce.
1.3	Use data gathered to revise and adapt the workforce development infrastructure (national, regional and local) to ensure expected outcomes are being met.	2.3	Facilitate health and other agencies to share information, knowledge and resources they can use to address the social determinants of health.	3.3	Strengthen and sustain the capability and competence of the mental health and addiction workforce.	4.3	Develop recruitment and retention strategies to address shortages and grow the Pacific, peer and consumer workforces.
				3.4	Strengthen the workforce's capability to work in multidisciplinary ways.	4.4	Develop mental health and addiction career pathways both for those already working in health and social services and for new recruits.

1

A workforce that is focused on people and improved outcomes

- How do we know that what we are doing is working?
- How do we measure performance and outcomes and ensure equitable outcomes for all?

We need an appropriate workforce development infrastructure to help implement an outcomes approach and build a **people-powered** health system. A whole-of-system approach to workforce development needs to be taken so that national, regional and local activities reflect national expectations.

For mental health and addiction, **He Tāngata** (the draft *Mental Health and Wellbeing National Population Outcomes Framework*) and the **Commissioning Framework** provide the national guidance for regional and local responses. Both frameworks will shape the national measures and key performance indicators (KPIs), which will include using data to inform and adapt workforce development activity. All data will be collected, analysed and reported by ethnicity so it is possible to monitor progress towards equitable outcomes.

Guided by the **Triple Aim** framework (see the Health Quality & Safety Commission's website),⁶ we have added the fourth aim of **workforce wellbeing**. We can use data to measure success against this Action Plan and answer the following key questions (based on results-based accountability):

- 1 How much? This question addresses the Triple Aim goal of '**best value for public health system resources**'. In relation to workforce development, this is a measure of the things we can count: workforce numbers, number of trainings delivered, number of people who attended training etc. Most of the system's current data systems are set up to capture this kind of quantitative data but this only gives part of the picture.
- 2 How well? This question is concerned with the quality of the approach taken and addresses the '**improved quality, safety and experience of care**' goal of the Triple Aim. Its answer needs to be continually reviewed as part of a continuous improvement cycle. Current measures include feedback from consumers and their families and whānau, staff feedback and satisfaction, incident and complaint reporting, audit results, and seclusion and restraint data.
- 3 Is anyone better off – did it work? This question addresses the '**improved health and equity for all populations**' goal of the Triple Aim. Identifying outcomes at both the individual level and the population level is a key part of an outcomes approach and the key result areas of the draft *Mental Health and Wellbeing National Population Outcomes Framework* will provide this information. Agreed outcome measures must take account of the social determinants of health and will be made up of several contributing measures.
- 4 Is the workforce well, engaged, developing and confident with strong leadership? This question addresses the fourth aim of **workforce wellbeing**. Agreed outcome measures will take account of staff engagement, development and leadership.

⁶ Health Quality & Safety Commission, www.hqsc.govt.nz

A capable and confident workforce that is highly functioning, person-centred, and fully integrated needs to be supported by effective and **strong leadership** at all levels. This kind of leadership is critical to give the system an outcome focus. Leadership and management across the system – working in many different organisations that are providing mental health and addiction services – will be expected to lead change towards the future that this Action Plan is seeking. Part of this work is to build capability to collect and use client and population outcome data to improve outcomes. Using outcome data to measure the impact of interventions and improve responses is critical to the task of determining if what we are doing is making a real difference for people.

If leaders are to achieve this change, the workforce must share the vision and be heading in the same direction. They must know what is expected of them and how their performance will be measured. Performance measures at the system level need to translate to individual performance measures and clearly show all those working across the system how they are playing an important role in improving outcomes for people.

Effective Māori leadership is critical to setting the foundation for Pae Ora and Māori health outcomes into the future. A vital step in fostering effective Māori leadership is to invest in building the capacity and capability of the Māori health workforce.

As part of enabling excellence in clinical care, effective Māori leadership is required to support health services to be accountable for continuing quality improvement. It supports services to deliver culturally responsive health care for Māori and safeguards high standards of care. Although Māori leadership in health is essential, improving Māori health is the responsibility of everyone working in the health and disability sector.

Growing Pacific leadership in the workforce can help to retain Pacific staff, establish culturally appropriate models of service delivery and improve outcomes for Pacific peoples. From the traditional viewpoint of how individuals progress in their careers (i.e. pipeline), once Pacific peoples are in the workforce, they must have the opportunity to advance into leadership positions if they are to influence moves to reduce disparities for Pacific peoples.

Peer and consumer leadership is another priority area. Strengthening this workforce provides significant opportunities to build capacity across the entire workforce.

What do we want in five years?

- Workforce development and programmes are aligned to the New Zealand Health Strategy and lead the way as new priorities and models are developed.
- Leadership capacity is strong across the continuum, with support from programmes and mentoring for both current and emerging leaders.
- Outcome measures and results are monitored and data is used to revise and adapt the workforce development infrastructure (national, regional and local) to ensure expected outcomes are being achieved.

Action 1.1	Implement an outcomes approach by commissioning workforce development in line with the New Zealand Health Strategy and national frameworks
1–2 years	<ul style="list-style-type: none"> • Commission workforce development and programmes to deliver on this Action Plan. • Use outcome agreements that allow for regional and local innovation and flexibility as new priorities and models are developed. • Co-design and deliver workforce development initiatives to build on the gains of <i>Rising to the Challenge</i> and implement the national mental health and addiction frameworks: He Tāngata (the draft <i>Mental Health and Wellbeing National Population Outcome Framework</i>) and the Commissioning Framework.
3–4 years	<ul style="list-style-type: none"> • Work with workforce centres, professional bodies and education providers to align training, competencies and registration requirements with future direction, priority areas and evidence-based approaches.
Action 1.2	Develop strong leadership programmes and pathways at all levels to support the changing environment
1–2 years	<ul style="list-style-type: none"> • Grow clinical leadership across the sector and across professions to support multidisciplinary teams and training initiatives. • Identify people with leadership potential within and across organisations to advance change models that are people-centred and strength-based. • Develop professional development programmes for existing leaders. • Facilitate liaison between education and training providers and the mental health and addiction sector by actively engaging with the two groups and providing opportunities for them to come together.
3–4 years	<ul style="list-style-type: none"> • Grow Māori leadership capacity and capability by providing culturally relevant upskilling and developing clear pathways into leadership positions. • Grow Pacific leadership capacity and capability by providing culturally relevant upskilling and developing clear pathways into leadership positions. • Develop leadership capability in under-represented workforce groups, peer-led groups and newly emerging workforce groups. • Make commitments to workforce development a regular part of planning, funding, delivery and policy activities and organisational culture.
Action 1.3	Use data gathered to revise and adapt the workforce development infrastructure (national, regional, local) to ensure expected outcomes are being met
1–2 years	<ul style="list-style-type: none"> • Develop agreed measures of results (including outcomes) and define feedback mechanisms to share and review.
3–4 years	<ul style="list-style-type: none"> • Work in partnership with providers to revise and adapt outcome agreements to ensure expected outcomes are being met.

2

A workforce that is integrated and connected across the continuum

- How we work – our approach is linked up, cross-agency and holistic, has collaborative care plans, includes social determinants and reaches across addiction, mental health and the broader health sector.
- Where we work – we are in different locations, are more mobile, share records and plans, and have the right tools (for example, mobile technology, cars).

To promote good mental health and wellbeing and provide care **closer to home**, we need to be connected and work collaboratively across the continuum so that people experience joined-up care. Improving collaboration and coordination across the sector requires having a more integrated and cohesive **‘one team’** approach across our health and disability system, which improves the quality of services by working towards shared goals and beyond organisational boundaries.

Achieving this approach means building strong working relationships between primary and specialist mental health and addiction care as well as across the wider health and social system. By strengthening the way health, education, justice, corrections and other social services work together, we can support people to navigate across the public system to meet their needs and improve outcomes for our most vulnerable communities.

When the mental health and addiction workforce shares skills and knowledge, works together and supports one another, it can provide seamless, effective services for people experiencing mental health and addiction issues. We also need to build organisational capacity to work collaboratively and to align and strengthen work programmes to reduce duplication and fragmentation. A ‘one team’ approach includes strengthening the role of people with mental health and addiction issues, their families, whānau and communities, and having dedicated roles to support collaborative ways of working.

Our world is changing rapidly and with digital technology we can communicate in a range of different ways wherever we are. Now that people can be both mobile and connected, the way they interact with health services and their expectations have changed. The workforce needs to keep up with a fast-paced digital world, which offers many opportunities to connect and share information. We need to enable staff to use these opportunities to share their expertise, experiences and ideas to enhance service delivery in a considered way. With digital technology, consumers, family and whānau can also share their ideas and experiences and support one another.

What do we want in five years?

- Collaborative ways of working and care planning are clearly reflected and aligned at national, regional and local levels (from policy to practice).
- The workforce is mobile, is integrated with communities and primary care and has strong links with a number of different agencies, sharing skills, knowledge and resources.
- The mental health and addiction workforce has regular opportunities to come together with others working in health, welfare, justice, corrections and education. Understanding of how each contributes to wellbeing has increased.
- Agencies are working together to coordinate care and improve wellbeing at national, regional and local levels.

Action 2.1	Enable a more mobile, responsive workforce that can adapt to new models of care
1–2 years	<ul style="list-style-type: none"> • Provide regular opportunities for staff to share ideas about better ways of working based on their experience and to learn skills that enhance their expertise. • Provide opportunities to learn about developing mobile technology, shared records, collaborative care planning and developments as primary care models of care change and adapt.
3–4 years	<ul style="list-style-type: none"> • Provide opportunities for the workforce to co-design new models of care (including role design and reconfiguration) and lead change processes to make these models part of everyday practice.
Action 2.2	Strengthen collaborative ways of working across the continuum to deliver coordinated and integrated responses
1–2 years	<ul style="list-style-type: none"> • Provide opportunities for the community, primary, peer, family and whānau and specialist mental health and addiction workforces and the wider health and disability workforce to come together to share practice, innovation and new initiatives. • Provide platforms, such as interprofessional training, to increase understanding of the roles and responsibilities of workforces across the sector. • Facilitate the Pacific allied health and community workforce to engage with and develop Pacific integrated approaches for mental health and addiction.
3–4 years	<ul style="list-style-type: none"> • Increase training opportunities for the workforce in broader community-based services (for example, school-based counselling services, enhanced general practices and prison-based health services).
Action 2.3	Facilitate health and other agencies to share information, knowledge and resources they can use to address the social determinants of health
1–2 years	<ul style="list-style-type: none"> • Strengthen cross-sector engagement by providing opportunities to come together with other agencies to share new initiatives and current priorities. • Develop training and development programmes in collaboration with other agencies (health, welfare, justice, corrections and education) to increase understanding of how the social determinants of health interact with and impact on mental health and wellbeing.
3–4 years	<ul style="list-style-type: none"> • Provide training and development across agencies (health, welfare, justice, corrections and education) to increase understanding of how the social determinants of health interact with and impact on mental health and wellbeing.

3

A workforce that is competent and capable

- What we do – we undertake interventions, do comprehensive and holistic assessments, use Māori cultural models, use Pacific cultural models, respond in culturally and linguistically diverse ways, work at top of scope and with breadth of scope, effectively use scope of practice, use technical skills and respond to co-existing problems.
- What competencies we need and how interventions are delivered – these include cultural competence, strength-based practice, planning for wellness.
- How we develop a personal and workplace culture that values the consumer voice and world view, the role of family and whānau and what really matters to the people we serve.

To improve health outcomes, we need a highly competent and capable workforce that takes a holistic and **people-centred** approach.

The health workforce needs to have a good understanding of the impact of mental health on physical health and the importance of taking a **strength-based** approach to support the whole person and their recovery journey. Improving health outcomes is the responsibility of the workforce across the continuum (both primary and specialist). This Action Plan presents an opportunity to **build capability** in two directions: the mental health and addiction workforce can learn more about physical health issues; and the general health and disability workforce can increase their awareness, understanding and recognition of mental health and addiction issues.

Primary and community care providers are often people's first point of contact with the health system in New Zealand. Primary mental health care is an integral part of the continuum that covers health promotion, prevention, early intervention, and treatment for mental health and addiction issues. This continuum is based on a stepped care model of matching interventions to need so that the first response is the most effective, yet least resource intensive.

The Ministry of Health is committed to ensuring people can access a range of responses through their community when they need it, including through primary and community care. To develop a system that is **people-powered**, we need to support the primary and community sector to design and deliver integrated responses for those with mental health and addiction needs and build on existing successful models of care.

The **primary and community care workforce** has a key role in recognising distress, promoting health and wellbeing, conducting assessments, delivering primary mental health and addiction interventions and connecting with specialist care as required. We need to ensure that specialist mental health and addiction expertise is accessible and available to the primary health and community care workforce and to the wider health and disability workforce.

The kaiāwhina (or non-regulated) workforce plays a significant role in primary health and community care. It enables a holistic approach to self-management, **resilience and recovery** alongside the service user, their family and whānau and any other health or social services they need. The kaiāwhina workforce complements a service user's clinical care and makes it possible to take a stepped care approach to service provision.

The specialist workforce will also need to change and reorient to work more closely with primary and community care. To follow effective models of care, it will strengthen its focus on self-management and encourage consumers to be actively engaged in their recovery.

New models will be developed that support integrated approaches across the continuum, ensuring service users have access to a menu of options for effective self-management support. Specialist intervention needs to follow evidence-based models that clearly define expectations and pathways and to recognise that, once an individual no longer needs specialist care, primary and community care will take the lead.

The following principles need to underpin any model of care for mental health and addiction to ensure the success of services.

- Consumers and their family and whānau (including children) are at the centre of the model.
- A robust framework underpins service delivery, reflecting clinical and non-clinical aspects of care.
- The model focuses on resilience and recovery.
- The model reflects holistic practice that is focused on wellbeing and includes responses from outside the health sector.
- The model has a systemic focus.
- Responses reflect evidence of best practice (defined as dynamic, evidence-informed, innovative and open to change).
- Data is used to inform practice.
- The model is responsive to co-existing problems.
- Responses are culturally competent as well as clinically competent and reflect whānau ora.
- The model is part of a range of information used to develop funding models.
- The model can relate to other models of care within the district health board (DHB) and to models of care for regional services (eg, adult forensic mental health services).

A key focus of people-centred service delivery is to have a workforce that is **culturally competent** and well-placed to meet service needs. A workforce that respects diversity and demonstrates cultural competence can provide services that are culturally appropriate and personal for each individual and that connect with people, their families and whānau and the wider community.

A culturally competent workforce can use knowledge of tikanga, whānau ora and Māori models of care and can apply their cultural competence in working with Māori. Crucially, it also does not see cultural and clinical practice as distinct from one another.

The addiction workforce

Strengthening and sustaining the addiction workforce is a priority. The Ministry of Health recognises the importance of building organisational and individual capability and capacity to provide effective addiction treatment that meets current and future demand.

Addiction treatment services are preparing for the likely introduction of new substance addiction legislation by examining the model of care for service users. Delivering services using traditional models of care may cater well for the majority of service users, but we also need to develop non-traditional approaches. For example, many people are interested in self-managing their issues and do not want to try treatment in a formal setting.

Telehealth and web-based services are able to reach more people nationwide in a free, confidential way. Services need to be able to work with populations they may not have worked with before, such as gangs, so that they deliver services effectively.

Addiction workforce development must support the addiction workforce to take on new ways of working and to develop new skills to respond to changes. The workforce also needs to be **responsive** to the needs of over-represented groups with alcohol and other drug issues, including Māori and Pacific peoples.

A number of valuable addiction workforce strategies have been developed to help grow, strengthen and sustain the capacity and capability of those who work with people, particularly Māori, experiencing addiction-related harm. It will be important to continue delivering on the gains made through this Action Plan and other strategic documents.

Many people in the addiction workforce have lived experience of addiction issues, or experience of a family or whānau member with addiction issues. The addiction workforce fosters a people-centred approach with a focus on self-management, complementing clinical treatment and the recovery journey.

It is important that entry-level training pathways for the addiction workforce are meeting workforce needs. Specifically people must have equitable access to training opportunities throughout the country and have support to undertake the training at the NGO and primary care level.

Our existing addiction workforce – including alcohol and drug counsellors, peer and consumer roles, social workers and detox nurses – also need support to work to the top of their scope of practice in roles that integrate care pathways and ensure continuity of care.

In May 2016, the Ministry of Health published its *Strategy to Prevent and Minimise Gambling Harm* (Ministry of Health 2016d). That strategy includes a specific objective related to workforce development: ‘A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm’ (objective 6). It outlines the expectations in relation to health equity, cultural competency and health literacy focus.

Competencies

To reshape our system so that it takes an outcomes approach and focuses on improving mental health and wellbeing, we need the workforce to be equipped to work in new ways with new and shared competencies. It will also be important to link in with education so that these competencies become part of training and development programmes.

The Health Practitioners Competence Assurance Act 2003 provides a legislative framework for the professions that it regulates. Its main purpose is to protect the health and safety of the public. The Act includes mechanisms to ensure that practitioners are competent and fit to practise their professions throughout their professional lives. Under the Act, responsible authorities set qualifications and scopes of practice for health practitioners to ensure they practise competently and safely.

Although they are not regulated under the Act, addiction practitioners must be registered with the Drug and Alcohol Practitioners’ Association Aotearoa-New Zealand to practise.

All health professionals are also covered by the Health and Disability Commissioner Act 1994 (and Amendment Act 2003). The purpose of this Act is to promote and protect the rights of health and disability services consumers, and to help to resolve complaints about infringements of those rights in a fair, simple, speedy and efficient way.

The Health and Disability Commissioner Act 1994 underpins the Code of Rights, which establishes the rights of health and disability services consumers. The Code also sets out the obligations and duties of providers to comply with the Code, stating they must take ‘reasonable actions in the circumstances to give effect to the rights, and comply with the duties’ in the Code (see the Health and Disability Commissioner’s website).⁷

To achieve the goals of an inclusive, culturally responsive model of mental health care, service providers need to work to international human rights standards. As a member of the United Nations, the New Zealand Government is working towards meeting its obligations under various United Nations conventions and declarations. For mental health and addiction, relevant conventions and declarations include (but are not limited to) the:

- Convention on the Rights of Persons with Disabilities
- Declaration on the Rights of Indigenous Peoples
- Convention on the Rights of the Child
- Convention Against Torture and the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

These conventions and declarations underpin the people-powered approach. The workforce needs to have a fundamental understanding of how the human rights approach applies to their everyday practice.

In addition to the legislative framework, a range of competency frameworks are already in place. These provide national guidance and reflect the Ministry of Health’s expectations of the mental health and addiction workforce.

The Ministry of Health worked with the mental health and addiction sector to produce *Let’s Get Real: Real Skills for people working in mental health and addiction* (Ministry of Health 2008). This knowledge and skills framework describes the knowledge, skills and attitudes that are essential for all people working in mental health and addiction services in New Zealand.

As a core framework it complements other competency frameworks for specific mental health and addiction professions, such as for mental health nurses. With *Real Skills plus Seitapu* (Te Pou o te Whakaaro Nui 2009), the framework has been extended for Pacific mental health and for child and adolescent mental health. For a diagram showing how the competency frameworks relate to each other, see Appendix A.

As *Let’s Get Real* (Ministry of Health 2008) identifies, people working in mental health and addiction treatment services need to be:

- compassionate and caring – sensitive and empathetic
- genuine – warm, friendly, fun, and have aroha and a sense of humour
- honest – have integrity
- open-minded – culturally aware, self-aware, innovative, creative and positive risk-takers
- optimistic – positive, encouraging and enthusiastic

⁷ Health and Disability Commissioner, <http://hdc.org.nz>

- patient – tolerant and flexible
- professional – accountable, reliable and responsible
- resilient
- supportive – validating, empowering and accepting
- understanding.

Seven *Real Skills* apply to everyone working in mental health and addiction treatment services. Each has three sets of performance indicators – essential, practitioner and leader – and a broad definition as follows (Ministry of Health 2008).

- 1 **Working with service users:** Every person working in a mental health and addiction treatment service uses strategies to engage meaningfully and work in partnership with service users, and focuses on service users’ strengths to support recovery.
- 2 **Working with Māori:** Every person working in a mental health and addiction treatment service contributes to whānau ora for Māori.
- 3 **Working with families and whānau:** Every person working in a mental health and addiction treatment service encourages and supports families and whānau to participate in the recovery of service users and ensures that families and whānau, including the children of service users, have access to information, education and support.
- 4 **Working with communities:** Every person working in a mental health and addiction treatment service recognises that service users and their families and whānau are part of a wider community.
- 5 **Challenging stigma and discrimination:** Every person working in a mental health and addiction treatment service uses strategies to challenge stigma and discrimination, and provides and promotes a valued place for service users.
- 6 **Law, policy and practice:** Every person working in a mental health and addiction treatment service implements legislation, regulations, standards, codes and policies relevant to their role in a way that supports service users and their families and whānau.
- 7 **Professional and personal development:** Every person working in a mental health and addiction treatment service actively reflects on their work and practice and works in ways that enhance the team to support the recovery of service users.

Many of the elements of the seven *Real Skills* are reflected in the other professional competency frameworks. For working with Māori, for example, the Takarangi Competency Framework helps in developing competent practitioners who are working towards whānau ora.

Competency frameworks need to be kept up to date with changing practice. As we reshape our system, new competencies will be developed. Working across the continuum will require different competencies across the specialist and the primary and community workforces. It will also mean people working in mental health and addiction services may need new competencies to work in a more integrated and outcome-focused way.

These new competencies must align with an outcomes approach and the national expectations and requirements must be clear. It will also be important to recognise the supports and organisational structures that need to be in place to support change and make it part of everyday practice.

Multidisciplinary

A key focus for training and workforce development is building a multidisciplinary workforce across the continuum of specialist, primary and community services.

To work as **one team**, everyone has a vital role to play in working to their scope and breadth of practice and contributing to the overall outcome of improving mental health and wellbeing. This includes the specialist and regulated workforce, the kaiāwhina and peer workforce as well as the consumer and their family and whānau working towards shared goals.

Valuing the consumer voice of lived experience and incorporating it into practice and teams are important to instilling a culture that values people and the role of family and whānau.

Multidisciplinary teams need to recognise the experience, history and unique insight that family and whānau bring and the importance of resourcing them in their role of supporting recovery and wellbeing.

To understand different scopes of practice and use the workforce effectively, we need a well-designed and structured multidisciplinary team approach. This design will allow each member to best contribute their skills and expertise.

Among people with an addiction, 70 percent also have co-existing mental health issues. Those with co-existing problems have higher rates of hospitalisation and suicide, poorer general health, more offending, more financial problems and unstable housing. To focus on mental health and wellbeing, the workforce must consider factors that increase the risk of, or offer protection against, mental distress, illness and addiction.

Building capability across the continuum to recognise and respond to co-existing mental health and addiction issues is essential if we are to ensure that ‘any door is the right door’ for people needing help. A workforce that has co-existing problem capability means they have a particular ‘way of working’ rather than that they are providing a new or separate service. This way of working recognises the value of specialists and ensures that the team actively helps a person to access the most appropriate service. A multidisciplinary approach is needed to respond to co-existing problems, with an understanding of roles, responsibilities and professional development needs.

It is essential that specialist workforces have opportunities to include mental health and addiction modules in their training pathways so they are better able to respond to and treat people presenting with mental health and addiction issues. Such opportunities include internships across a range of settings, which may be facilitated by working closely with education providers.

To work as a multidisciplinary team, people need a good understanding of what it means to work to the full breadth of scope. In this way of working, those with the most ‘expert skills’ work with the most complex cases.

The vision of the *Healthy Ageing Strategy* (Associate Minister of Health 2016) is ‘Older people live well, age well and have a respectful end of life in age-friendly communities’. The following actions relate to mental health and addiction and the workforce has a critical role in supporting them.

- Action 9. Ensure that those working with people with long-term conditions have the training and support they require to deliver high-quality, person-centred care in line with a healthy ageing approach.

- Action 10. Enhance cross-sector, whole-of-system ways of working.
- Action 12. Better enable individuals and communities to understand and live well with long-term conditions and get the help they need to stay well.
- Action 18. Improve the physical and mental health outcomes of older people with long-term mental illness and addiction.

A specific focus of the forensic and youth forensic workforce is to change in the ways needed to support the Ministry’s development of youth forensic services. Specifically, these changes will include developing adequately trained staff, and improving training opportunities so that competency frameworks for this diverse workforce are consistent.

What do we want in five years?

- People with long-term conditions, including mental health and addiction issues, have improved health outcomes (reduced health loss).
- The workforce has a good understanding of people-centred and strength-based practice, which is part of all health training and development programmes.
- The workforce is culturally competent. Competency frameworks form the basis for all recruitment, training and professional development.
- Multidisciplinary teams are well established and include both the regulated and kaiāwhina health workforce.
- Members of multidisciplinary teams work to the full breadth of their scope of practice. They value their contribution to improving health and wellbeing.

Action 3.1	Build capability across the health and disability workforce to respond to mental health, addiction and physical health issues
1–2 years	<ul style="list-style-type: none"> • Develop programmes for the general health and disability workforce to increase their awareness, understanding and recognition of mental health and addiction issues.
2–4 years	<ul style="list-style-type: none"> • Implement programmes for the general health and disability workforce to increase their awareness, understanding and recognition of mental health and addiction issues. • Develop mental health literacy programmes that are culturally appropriate and form part of the curriculum for health professionals through formal training as well as programmes for the existing workforce. • Support the implementation of the relevant actions of the <i>Healthy Ageing Strategy</i>.
Action 3.2	Support the development of the primary and community workforce to respond effectively and facilitate access to appropriate responses
1–2 years	<ul style="list-style-type: none"> • Build the capacity of the community and primary health care workforce by developing training and development programmes to effectively recognise and respond to mental health and addiction issues at first point of contact (either by direct intervention or by connecting the person to an appropriate community or specialist service). • Provide specific training on priority areas including suicide prevention, Māori cultural models, Pacific cultural models, older people, youth mental health and at-risk children. • Increase access to training opportunities on primary-level interventions (including talking therapies, motivational interviewing, engagement, family interventions and self-management) for those engaging at first point of contact. • Facilitate sharing of mental health and addiction skills, knowledge and resources across community, primary and specialist care through collaborative forums, supervision and mentoring programmes. • Provide training and development on the consult-liaison function and roles that work across the continuum.
2–4 years	<ul style="list-style-type: none"> • Implement training and development programmes (including on-site, community and remote options) to effectively recognise and respond to mental health and addiction issues at first point of contact particularly for Māori and Pacific populations (either by direct intervention or by connecting the person to an appropriate community or specialist service).

Action 3.3	Strengthen and sustain the capability and competence of the mental health and addiction workforce
1–2 years	<ul style="list-style-type: none"> • Support the implementation of and deliver on the workforce requirements outlined in the <i>Māori Addiction Strategy</i> and revised <i>Pacific Mental Health and Addiction Plan</i>. • Support the implementation of and deliver on the workforce requirements (objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm) of the <i>Strategy to Prevent and Minimise Gambling Harm</i>. • Build on existing training and development programmes to build capability and competence in working with children, youth, families and whānau, including delivering trauma-informed care. • Develop training and development to address co-existing mental health and addiction issues to improve competence across the workforce. • Review the suite of competency frameworks and update them as required to follow an outcomes approach and include measures of effectiveness. • Develop new ways of training, support the workforce to undertake and complete education and training and support them to review and reflect on their learning and to make it part of their everyday practice. • Strengthen the workforce to translate knowledge, skills and competencies into routine practice through organisational development, supervision, mentoring, peer support and professional development. • Increase training opportunities focused on improving outcomes for those with co-occurring conditions, including mental health, addiction, physical health and disability. • Strengthen workforce development opportunities for the addiction workforce, including by increasing access to training and development for addiction medicine specialists. • Strengthen links between national and regional workforce planning and regional networks. • Develop shared learning opportunities for the workforce across the continuum to build their skills with and contribute to collaborative care planning.
2–4 years	<ul style="list-style-type: none"> • Provide training and development to improve competence across the workforce in responding to co-existing mental health and addiction issues. • Make these competencies part of recruitment, training and professional development and national accountability documents. • Develop networks for addiction education and tertiary training providers to build organisational capacity for workforce development and better coordinate training and education opportunities. • Increase access to addiction treatment training and education for the workforce, and in particular workers with lived experience (across the whole workforce, not only for those in designated roles). • Develop advanced training pathways for specialist areas – for example, youth forensic mental health.
Action 3.4	Strengthen the workforce’s capability to work in multidisciplinary ways
1–2 years	<ul style="list-style-type: none"> • Strengthen training pathways to develop an integrated workforce and meet people’s changing mental health and addiction needs. • Support multidisciplinary teams to deliver integrated responses by including the regulated and kaiāwhina workforce, family and whānau, and cultural aspects. • Increase the availability of multidisciplinary training and development programmes, including regular review, as teams adjust to more integrated ways of working.
2–4 years	<ul style="list-style-type: none"> • Work with health service and education providers to offer internships that expose interns to different workplaces, settings and roles and working in multidisciplinary teams.

4

A workforce that is the right size and skill mix

- What does the workforce need to look like to meet our future needs?
- Based on above, what will be the skill mix of clinicians, allied health, support staff (including peer and cultural) and primary care? Need to design roles to effectively use scope and expertise.
- How do we develop an ethnically diverse workforce that reflects the population it serves?
- Data – what do we know about the current workforce? How do use modelling for future years based on training numbers, expected shortages and other important influences?

As we reshape our system to take an outcomes approach, models will evolve and the needs and distribution of the population will change. The specialist workforce must adapt to meet the changing needs and expectations of people and their families and whānau.

Alongside the need to develop the primary health and community care workforce is a continuing trend of declining numbers in the specialist workforce while demands for it are increasing. Compounding this trend, the specialist workforce is ageing and New Zealand continues to rely on overseas trained health professionals. A key focus is to ensure a **sufficient and sustainable** specialist workforce.

The specialist workforce is dedicated to providing expert treatment for people experiencing mental health and addiction issues. Health Workforce New Zealand (HWNZ) provides funding for clinical training across several mental health and addiction specialty workforces, including psychiatry, clinical psychology, and mental health nursing.

All organisations across the continuum, at national, regional and local levels, need to undertake workforce planning. To understand the current and future requirements for the workforce, we need to use the available data and identify current trends. This involves dynamic modelling to track those in training through to when they join the workforce and looking at the effects of factors such as ageing, career breaks and overseas-trained specialists.

Available data shows that the medical workforce makes up 6 percent of the total full-time equivalent (FTE) mental health and addiction workforce. It includes consultant psychiatrists, psychiatric registrars and additional medical professional roles (Te Pou o te Whakaaro Nui 2015a).

HWNZ has developed a workforce modelling and forecasting tool that uses a range of data sources, including registration data, to develop future projections.

Based on a 2016 head count, 572 consultant psychiatrists are registered in New Zealand. Taking into account current training numbers, interns and those entering the workforce (both for the first time and as a re-entry), it is projected that 675 consultant psychiatrists will be registered by 2026. While the number of psychiatrists per 100,000 is projected to increase, if current trends continue we would expect that a significant number of these will be international medical graduates. Of the 39 psychiatrists that entered (or re-entered) the workforce in 2016, 34 were international medical graduates (based on registration data).

In 2014, nurses made up 28 percent of the total mental health and addiction workforce (Te Pou o te Whakaaro Nui 2015a). In 2016, 1893 FTE community nurses and 1723 inpatient nurses were registered. By 2026 it is projected that there will be 2010 community nurse FTEs and 1734 inpatient nurses. Based on these figures, we can expect the number of mental health nurses per 100,000 population to fall by 2026.

Allied health includes psychologists, occupational therapists, social workers, psychotherapists, alcohol and other drug practitioners, dual diagnosis practitioners, counsellors, dieticians and nutritionists. Allied health made up 17 percent of the workforce in 2014 with 680 FTEs working in addiction and 950 in mental health (Te Pou o te Whakaaro Nui 2015a). The 2848 registered psychologists in 2016 (head count) are projected to increase to 3687 by 2026. In particular, Māori and Pacific psychologists are under-represented.

While information is collected nationally for the regulated workforce, gathering this data for the kaiāwhina workforce is more challenging. Based on survey information from 2014, there were 2988 support worker FTE positions representing 31 percent of the workforce, 172 cultural advice and support positions and 1622 other positions (Te Pou o te Whakaaro Nui 2015a).

The information we currently use for this workforce comes from surveys. However, we need to be developing the infrastructure that can routinely collect and analyse this information.

We need a workforce that our population can relate to, one that reflects the diversity of the populations it serves and provides opportunities for under-represented groups to grow. International evidence shows that services with health professionals from indigenous and other minority groups can increase access to services and improve health for those communities.

Māori are significantly under-represented in the total health and disability workforce. While representation has improved in recent years, there is still work to be done. For example, the number of Māori nurses has increased from 780 in 1994 to 3510 in 2015. However, this represents 7 percent of the total nursing workforce whereas, if the figure is to match the percentage of Māori in the total population, it should be 14.9 percent (based on registration data). The Pacific nursing workforce is also under-represented.

In a culturally responsive workforce, Pacific peoples will be represented effectively to reflect the population that the workforce serves, and specialists will be upskilled to meet the needs of Pacific populations. Of the total estimated for the adult mental health and addiction workforce, 5 percent are Pacific workers (Faleafa and Pulotu-Endemann 2017).

Individuals in Māori and Pacific communities need to be able to see pathways for themselves and their families and whānau to enter the workforce. They also need to see career development pathways once they are part of the workforce.

Peer and consumer workforces

HWNZ recognises the value that people with lived experience bring and they have a role to play right across the continuum, not only in support roles. People in the peer and consumer workforce are advocates and role models and have a valuable role in shaping services and training and development of the mental health and addiction workforce as a whole.

We can strengthen the peer and consumer workforce in many ways. For example, we can effectively resource its development, meet the requirements of the peer competency framework and support the workforce's local and national networks.

Addressing current shortages will help meet future demand but we also need to develop a broader workforce to achieve our vision of people thriving and experiencing wellbeing. We need to understand how the **one team** approach can work in practice across sectors and how each sector contributes to achieving our vision.

What do we want in five years?

- Predictions of future needs and models of care determine the required size and skill mix of the workforce.
- Dynamic modelling is used to understand current and future requirements as new models and priorities emerge.
- The workforce is culturally diverse to reflect the population, particularly Māori and Pacific peoples.
- The workforce reflects the diversity and experience of service users, and works in collaboration with the service user and their family and whānau.
- Decisions about the right size and skill mix of the mental health and addiction workforce are based on an understanding of how both the health workforce across the continuum and other agencies contribute.

Action 4.1		Use workforce data to understand the current and future size and skill mix of the workforce.
1–2 years	<ul style="list-style-type: none"> • Match the workforce more closely to current and future needs by using dynamic modelling to provide regular insights on the current state and future projections. • Monitor areas of concern and use data to determine the success of different approaches, including ethnicity data to monitor equity. • Gather data to understand the role of different professional groups and how specialist, primary and community workforces – including allied health, peer and community support staff, enrolled nurses and wider general practice teams – complement each other. • Investigate methods to increase available data on the kaiāwhina workforce. • Investigate, identify and develop measures of workforce wellness. 	
2–4 years	<ul style="list-style-type: none"> • Use improved data on the kaiāwhina workforce to understand its current state and future projections. • Use data to inform planning and to revise and adapt workforce development initiatives, including designing the right roles. • Implement measures of workforce wellness. 	
Action 4.2		Grow and develop the Māori workforce.
1–2 years	<ul style="list-style-type: none"> • Prioritise Māori recruitment to and retention in clinical and non-clinical roles and implement strategies to address this priority. • Contribute to achieving the Māori workforce objective 2.3 of <i>He Korowai Oranga</i> – ‘to increase the number and improve the skills of the Māori health and disability workforce’ – in relation to mental health and addiction. 	
3–4 years	<ul style="list-style-type: none"> • Contribute to the Māori workforce goals (<i>Raranga Tupuake: Māori Workforce Plan 2006</i>, Ministry of Health 2006) of investing in Māori students, expanding the skill base and providing equitable access for Māori to training opportunities in relation to mental health and addiction. 	
Action 4.3		Develop recruitment and retention strategies to address shortages and grow the Pacific, peer and consumer workforces.
1–2 years	<ul style="list-style-type: none"> • Address known specialist shortages by implementing targeted recruitment, retention, learning and development strategies. • Prioritise Pacific recruitment to and retention in clinical and non-clinical roles and implement strategies to address this priority. • Increase recruitment and retention of the peer and consumer workforce by strengthening the infrastructure, providing effective leadership, management and supervision, and strengthening networks at regional and national levels. 	
2–4 years	<ul style="list-style-type: none"> • Embed strategies into national, regional and local workforce development. 	

Action 4.4	Develop mental health and addiction career pathways both for those already working in health and social services and for new recruits.
1–2 years	<ul style="list-style-type: none"> • Develop a marketing strategy to promote careers in mental health and addiction, focusing on reducing stigma and discrimination (for example, through core competency training) and attracting young people (for example, by developing and implementing online and school-based initiatives). • Increase training and career opportunities for the peer and consumer workforce, including by offering leadership programmes and meeting the requirements of the peer competency framework. • Grow the workforce for older people with mental health and addiction issues (for example, by developing workforce initiatives for workers in aged care facilities). • Investigate the role and workforce development needs of other workforce groups to complement existing mental health and addiction service delivery models, for example, Whānau Ora navigators. • Strengthen the family and whānau workforce (family advisors supporting services as well as family support staff and whānau peers working directly with whānau) and develop family and whānau participation models at regional and national levels. • Support and strengthen rural and regional recruitment and retention initiatives by developing career pathways that accommodate a more mobile workforce, enhancing professional networks to connect isolated health professionals and improving access to supervision, mentoring and professional development.
3–4 years	<ul style="list-style-type: none"> • Implement the marketing strategy to promote careers in mental health and addiction. • Develop career pathways for the support workforce to ensure its ongoing professional development.

Implementation

All people currently working in the mental health and addiction sector have a role to play in implementing this Action Plan and achieving the vision of all people thriving and experiencing wellbeing. Beyond the health workforce, achieving this vision will also need the combined effort of the social and justice sectors.

Through Health Workforce New Zealand, the Ministry of Health will provide overall leadership of the Action Plan and guide the strategic direction of workforce development to the sector with the support of the Regional Workforce Development Hubs. The Ministry also has a key role in leading the implementation of this Action Plan across the health sector, and working across agencies to take a whole-of-government approach.

District health boards, primary health organisations, workforce centres and non-governmental organisations also have a key role in implementing this Action Plan. They all need to demonstrate strong leadership to support the envisaged changes and make them part of everyday practice.

HWNZ will work in partnership with the sector and guide the implementation of this Action Plan. If the Action Plan is to be successful, efforts must focus on regional collaboration and planning, strongly engaging primary health and community care and facilitating engagement across community, primary and secondary care.

Another part of implementing the Action Plan successfully will be that multiple service providers and organisations, and multiple sectors, collaborate, coordinate and connect with each other and with family and whānau and people with mental health and/or addiction issues. A whole-of-system and people-centred approach is needed to work towards improving the health and wellbeing outcomes for people with mental health and addiction issues.

This Action Plan has relevance not only to all people working in the mental health and addiction sector, but across the overall health workforce to improve mental health and wellbeing. It will guide investment decisions and resourcing to enable the delivery of quality responses and services and, as a result, better outcomes for people with mental health and addiction issues.

Monitoring and reporting progress on the Action Plan

HWNZ will monitor the implementation of the Action Plan. It will report on progress to the HWNZ Board and the Ministry of Health Mental Health and Addiction Governance Group on a quarterly basis and to the wider sector annually on the Ministry's website.

HWNZ will use a variety of mechanisms to coordinate and communicate sector feedback on the implementation of the Action Plan, and feedback to mental health and addiction service providers.

This Action Plan will be a rolling plan, reviewed and adapted as it progresses. The agreed measures will be used to measure success and revise and adapt the Action Plan to ensure the expected outcomes can be achieved.

Glossary

Breadth of scope	Utilising the full range of knowledge, skills and services health workers are competent and permitted to perform to support people’s health, well-being and recovery.
Commissioning	The process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, ensure equity and enhance experience within the resources available.
Continuum	In this context, all health funded services that aim to improve outcomes for those with mental health and addiction issues. This includes community, primary, specialist and tertiary mental health and addiction services.
Cultural competence	An awareness of cultural diversity and the ability to function effectively, and respectfully, when working with people of different cultural backgrounds. Includes the attitudes, skills and knowledge needed to achieve this.
DALYs	Integrated measure of health loss. DALY is the sum of years of life lost (YLL) and years lived with disability adjusted for severity (YLD). So one DALY represents the loss of one year of life lived in full health.
DHB	District health board. The 20 DHBs across New Zealand are responsible for providing or funding the provision of health services in their district.
FTE	Full-time equivalent staff.
Health loss	The gap between the population’s current state of health and that of an ideal population in which everyone leads a long life free from ill health or disability. Measured in disability-adjusted life years (DALYs).
Health Quality & Safety Commission	An agency responsible for helping providers across the whole health and disability sector – private and public – to improve service safety and quality and therefore outcomes for all who use these services in New Zealand.
HWNZ	Health Workforce New Zealand.
International medical graduates	Doctors with an international postgraduate medical qualification who have obtained vocational registration to practise as a psychiatrist in New Zealand as they meet the standards of qualifications, training and experience set by the Royal Australian and New Zealand College of Psychiatrists.
Kaiāwhina workforce	An over-arching term to describe non-regulated roles in the mental health and addiction sector e.g. support worker, cultural advisors.
KPI	Key performance indicator. A measure used to evaluate the success of an organisation and/or of a particular activity in which it engages.
NGO	Non-governmental organisation. An organisation that is neither a part of a government nor a conventional for-profit business. Usually set up by ordinary citizens, NGOs may be funded by governments, foundations, businesses or private people.
Outcomes approach	An increased focus on measurable outcomes that matter to people and make a real difference to their lives. Measuring outcomes is part of measuring results and involves applying a balanced weighting to the three goals of the Triple Aim.

PHO	Primary health organisation. Funded by DHBs to provide essential primary health care services, mostly through general practices, to those people who are enrolled with the PHO.
PRIMHD	Programme for the Integration of Mental Health Data. A Ministry of Health single national collection of mental health and addiction information about service activity and outcomes data for health consumers. Data is collected from DHBs and NGOs.
Public sector	All public entities in central and local government.
QALYs	Quality-adjusted life years. A measure of disease burden, which considers both the quality and the quantity of life lived.
Strengths-based practice	A client-led practice theory that focuses on the strengths and resources of the person. It involves working alongside people to identify what is working well and building on it rather than focusing on problems and symptoms.
Top of scope	Utilising the highest level of knowledge, skills and services health workers are competent and permitted to perform to support people's health, well-being and recovery.
Triple Aim	A quality improvement approach that covers three goals: improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources.
Whānau	Extended family group. This concept includes physical, emotional and spiritual dimensions. It is based on whakapapa and can be multilayered, flexible and dynamic. Whānau is based on a Māori and a tribal world view.
Whānau ora	Healthy families – means Māori families supported to achieve their maximum health and wellbeing.
WHO	World Health Organization. Its primary role is to direct and coordinate international health within the United Nations' system.
Workforce centre	Ministry of Health appointed agents to deliver workforce-related services.

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Appendix A: How the competency frameworks relate to each other

Lead agency or agencies	Werry Centre	Te Pou o te Whakaaro Nui, Le Va, Ministry of Health	NZ College of Mental Health Nurses Inc.	Drug and Alcohol Practitioners' Association Aotearoa-New Zealand	Midland DHBs, Northern Regional Alliance, Te Pou o te Whakaaro Nui
Competency framework	Real Skills plus CAMHS*	Real Skills plus Seitapu Working with Pacific peoples	Standards of Practice for Mental Health Nursing in Aotearoa New Zealand	Addiction Intervention Competency Framework	Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce
Focus	Practitioner – specialist Practitioner – core	Specialist Advanced Core	Applies to all mental health nurses	Practitioner Essential	Peer leader Peer manager Peer practitioner Essential

Let's Get Real: Real Skills for everyone working in the area of mental health and addiction (Ministry of Health 2008)

Essential Let's get real (Knowledge, skills and attributes)	Practitioner Let's get real (Knowledge, skills and attributes)	Leader Let's get real (Knowledge, skills and attributes)
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PROFESSIONAL COMPETENCY FRAMEWORKS