

**Tauawhitia te Wero**

**Embracing the challenge**

**National mental health and addiction  
workforce development plan 2006–2009**

Citation: Ministry of Health. 2005. *Tauawhitia te Wero – Embracing the Challenge: National mental health and addiction workforce development plan 2006–2009*  
Wellington: Ministry of Health.

Published in December 2005 by the  
Ministry of Health  
PO Box 5013, Wellington, New Zealand

ISBN 0-478-29904-4 (Book)  
ISBN 0-478-29905-2 (Internet)  
HP 4208

This document is available on the Ministry of Health webpage:  
<http://www.moh.govt.nz/mentalhealth>



# Foreword

The workforce is at the heart of mental health and addiction services. When the Ministry published *Looking Forward: Strategic directions for mental health services* (1994) more than 10 years ago, it was quickly recognised that the goal of more and better mental health and addiction services required a parallel focus on the people who would deliver those services.

Services are now being delivered in a changed environment, reflecting the shift to community-based services and a focus on recovery and consumer-oriented services. The dynamic and evolving health environment, coupled with significant new social trends, means that service delivery is also likely to continue to change in the future. *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand mental health and addiction plan* (Minister of Health 2005) has set the agenda for action.

This National Mental Health and Addiction Workforce Development Plan supports the leading challenge for ‘Workforce and Culture for Recovery’ in *Te Tāhuhu – Improving mental health*. It also continues and develops the earlier work of the Health Funding Authority signalled in *Tuutahitia te Wero – Meeting the Challenges: Mental health workforce development plan 2000–2005* (2000), and consolidates the shift to a whole system approach to workforce development outlined in the *Mental Health (Alcohol and Other Drugs) Workforce Development Framework* (Ministry of Health 2002a).

*Tauawhitia te Wero* aims to reflect the needs of the current workforce, and to provide a strategic focus for changes required to achieve the workforce needed to deliver future mental health and addiction services. The next few years will be a period of consolidation, while laying the foundations to support our next 10-year plan. Although there is always uncertainty in what the future holds, there is also space for innovation and creativity, and we have set some ambitious goals and objectives to guide our way.

Janice Wilson (Dr)  
Deputy Director-General  
Mental Health



# Contents

- Foreword ..... iii
- Introduction..... 1
  - Defining workforce development ..... 1
  - Purpose of this document..... 1
  - Audience..... 2
- Planning for the Future..... 3
  - Principles for planning..... 3
- The Workforce..... 4
  - The workforce development framework..... 6
  - Funding and managing workforce development ..... 6
  - The workforce development environment ..... 9
- Future Services and Workforce ..... 11
- Our Vision..... 12
- The Plan ..... 13
  - Workforce development infrastructure ..... 13
  - Organisational development..... 16
  - Recruitment and retention ..... 19
  - Training and development ..... 23
  - Research and evaluation ..... 28
- Monitoring the Plan ..... 31
- Appendix A: Feedback on the plan ..... 32
- Appendix B: The strategic context for change ..... 34
- Appendix C: Planning cycles ..... 36
- Appendix D: Key organisations
- Glossary ..... 44
- References..... 47



# Introduction

## Defining workforce development

Simply put, the ultimate goal of workforce development in the mental health and addiction sector is to ensure that we have the right mental health and addiction practitioners and staff in the right place, at the right time, to treat, support and care for the users of mental health and addiction services.<sup>1</sup>

The traditional approach to workforce planning has been to assess workforce supply against future workforce demand, and then address any gap between the two through education and training. However, in recent years there has been a shift towards basing workforce development on a ‘whole system approach’. Instead of taking separate aspects of the workforce and studying them in isolation, a whole system approach focuses on how each part of the system interacts with the others. This means that education and training cannot be considered separately from, for example, recruitment and retention, leadership and management, and organisational culture.

Considered in this broader sense, workforce development is any initiative that influences entry to and exit from the mental health and addiction sector, movement within the sector, education, training, skills, attitudes, rewards and the associated infrastructure (Health Funding Authority 2000).

## Purpose of this document

This plan aims to provide a framework for the future by setting out key directions and actions that need to be led or contracted by the Mental Health Directorate, Ministry of Health, over the next four years.

It is also intended as a high-level ‘umbrella’ plan providing national direction on key issues for all other workforce planning in the mental health and addiction sector. It does not replace the more detailed workforce development and planning activities of the national mental health and addiction programmes and centres, District Health Boards (DHBs), non-governmental organisations (NGOs), and the regional mental health and addiction workforce co-ordinators.

This plan also links to and supports broader health workforce development plans, including the *Pacific Health and Disability Workforce Development Plan* (Ministry of Health 2004a), *Rāranga Tupuake: Māori Health Workforce Development Plan: Discussion document* (Ministry of Health 2005c), and the *Future Workforce 2005–2010* strategic framework and action plan (DHBNZ 2005).

---

1 In this document we refer to ‘service users’, but other common terms are ‘consumers’ and ‘tāngata whaiora’ (used especially when referring to Māori service users).

## Audience

The intended audience are those people who have a leadership and management role in mental health and addiction workforce development, including DHB and NGO chief executives, managers, clinical directors and service user leaders, together with key leaders from the education and training sectors.

# Planning for the Future

A plan sets out a range of different actions to be taken to achieve a goal or set of goals some time in the future. This plan sets out a framework for action over the next three to four years that incorporates a range of responses to current workforce development challenges, including:

- making the best use of current resources
- enhancing current resources
- innovative solutions
- strengthening inter-agency collaboration.<sup>2</sup>

This means that different actions have different timeframes.

We need to build on the excellent foundation of mental health and addiction workforce development while leaving breathing room for innovation. For this reason the plan is flexible. It recognises that further work will come out of the reviews and evaluations to be undertaken in the next few years, and that there will be changes to service models to meet the needs of service users.

Workforce development ideally requires at least a 10-year horizon given the lengthy training periods for some practitioners, such as psychiatrists. Therefore, this plan is already looking towards the next plan for 2010–2020. It includes important actions that we need to take in order to improve our workforce development planning processes, as well as projects that will form the foundation for future initiatives, such as the workforce redesign pilot projects.

## Principles for planning

The principles that have guided the development of this plan are that workforce development must:

- centre on the needs of service users
- respond to the diversity of service users and workforce, including Māori, Pacific peoples and Asian peoples
- be driven by leaders
- rely on networking and collaboration
- fit within the wider context of health and disability workforce development, including primary care.

---

<sup>2</sup> Adapted from Sainsbury Centre for Mental Health 2003.

# The Workforce

People in the mental health and addiction sector work in a wide variety of roles, and include:

- administrative staff
- addiction practitioners
- clinical psychologists
- counsellors
- family/whānau advisors
- funders and planners
- managers
- nurses
- occupational therapists
- psychiatrists
- psychotherapists
- service user advisors
- social workers
- support workers.

The main employers of the mental health and addiction workforce are DHBs and a range of NGOs.

Information about the number of people working in mental health and addiction services currently has to be gathered from a range of sources. One of the actions in this plan is to improve workforce information (see 'Research and evaluation'). The following table, though incomplete, gives an indication of the size of the workforce.

**Table 1: Selected mental health and addiction occupational group workforce numbers, 2004**

Occupational group	Total number	Māori	Pacific	Source
Addiction practitioners	950	22%	4%	Matua Raki 2005 <sup>a</sup>
Nurses (active registered)	3052	13.2%	2.7%	New Zealand Health Information Service Workforce Statistics 2004
Support workers	1423	33.0%	8.2%	New Zealand Qualifications Authority <sup>b</sup>
Psychiatrists and other medical practitioners working in mental health and addiction services	528	3.0%	0.4%	Medical Council of New Zealand Annual Workforce Survey 2003 <sup>c</sup>
Psychologists	1404	4.3%	0.2%	New Zealand Health Information Service Workforce Annual Survey 2004 <sup>d</sup>
Social workers	311	–	–	Hatcher et al 2005
<b>TOTAL</b>	<b>7668</b>			

- There are approximately 850 alcohol and drug workers, and 100 problem gambling practitioners.
- This is the number of graduates of the National Certificate in Mental Health Support Work. Note that not all mental health support workers have completed the National Certificate, and not everyone who has completed the Certificate is working in mental health.
- Includes specialists (288), medical officers special scale (65), registrars (166), and ‘other’ (5). Although the survey recorded no Pacific doctors working in psychiatry, this table includes two Pacific practitioners because there is at least one psychiatrist and one doctor training in psychiatry who would identify as Pacific.
- Of current surveyed registered psychologists (907), a total of 788 work in the fields of clinical psychology, rehabilitation, psychotherapy and counselling. The ethnicity percentages are from those surveyed psychologists.

Certain population groups continue to be relatively under-represented in the mental health and addiction workforce, particularly Māori, Pacific and Asian ethnicities. This is a concern in areas where there are high Māori, Pacific and Asian populations, because international and New Zealand evidence indicates that services delivered by providers and workers from the relevant communities are likely to be more effective than services delivered by members of other communities (Ministry of Health 2002c).

Other information about the workforce comes from one-off surveys. For example, a recent survey of the Māori mental health workforce (Tassell 2004) found that:

- Māori mental health workers work across a variety of service settings, with most working in NGO iwi and Māori health services, DHB community mental health teams, and DHB kaupapa Māori mental health services
- the majority have been in the mental health workforce for four years or less, and most have been in their current position for less than two years
- Māori are under-represented in clinical and professional occupation roles such as psychiatrists and psychologists, and are more likely to be employed in support roles.

## The workforce development framework

The *Mental Health (Alcohol and Other Drug) Workforce Development Framework* (Ministry of Health 2002a) signalled a shift to a whole-system approach to mental health workforce development. A key part of this shift was the introduction of five strategic imperatives:

- workforce development infrastructure
- organisational development
- recruitment and retention
- training and development
- research and evaluation.

*Tauawhitia te Wero* maintains the emphasis on a systemic approach to mental health and addiction workforce development and contains goals and objectives across all of these five strategic imperatives.

## Funding and managing workforce development

The Mental Health Directorate in the Ministry of Health has a national allocation of funding for mental health and addiction workforce development. In addition, the Clinical Training Agency (CTA), a business unit of the Ministry, purchases mental health and addiction post-entry clinical training (PECT) programmes on behalf of the Directorate, as well as purchasing other mental health, addiction and psychiatry training programmes from its own funding stream. (See 'PECT' in the glossary on page 45 for the list of PECT criteria.)

**Table 2: Mental Health Directorate and Clinical Training Agency funding of mental health and addiction-related training and workforce development, 2002/03 to 2004/05<sup>a</sup>**

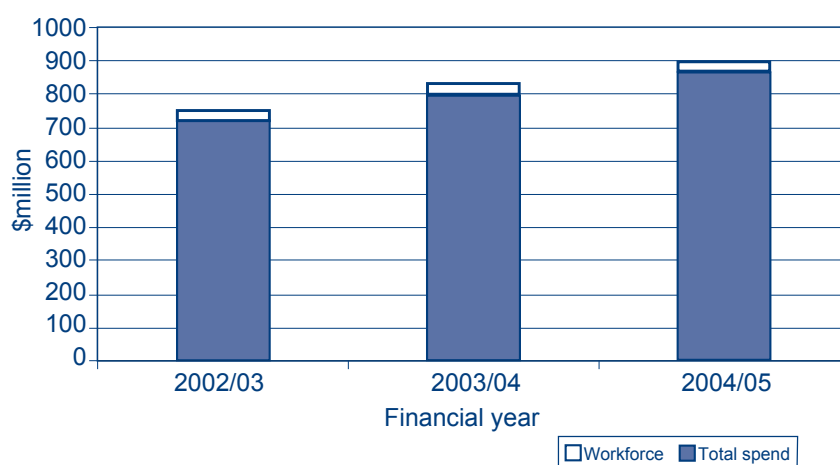
	2002/03 (\$million)	2003/04 (\$million)	2004/05 (\$million)
Clinical Training Agency:			
Mental health and addiction programmes	1.15	1.15	0.60
Psychiatry programmes	6.37	6.68	8.25
<b>Clinical Training Agency total</b>	<b>7.52</b>	<b>7.83</b>	<b>8.85</b>
Mental Health Directorate:			
Mental health and addiction PECT programmes (contracts managed by CTA) <sup>b</sup>	5.81	6.07	5.92
Mental health and addiction workforce development	9.00	11.00	11.00
<b>Mental Health Directorate total</b>	<b>14.81</b>	<b>17.07</b>	<b>16.92</b>
<b>Total Budget</b>	<b>\$22.32</b>	<b>\$24.90</b>	<b>\$25.77</b>

a. Budget figures are baseline budget figures for financial years and are GST exclusive.

b. This funding was initially known as Mason funding, being specified funding set aside for mental health in response to the Mason report (Mason 1988). It is now derived from the Mental Health Directorate national allocation, and managed by the CTA.

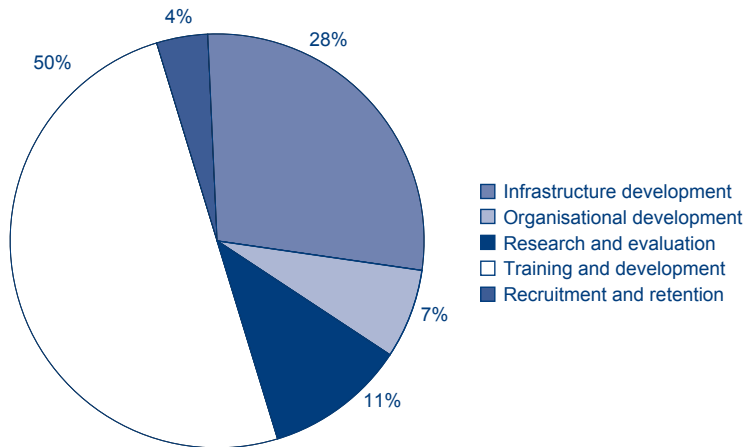
The national allocation of funding for workforce development is a small, but important, proportion of overall funding for mental health and addiction services (see Figure 1). Note that the latter ‘Total spend’ includes regional and local-level workforce development.

**Figure 1: Mental health and addiction workforce development national allocation of funding (including CTA-managed contracts) as a proportion of total mental health and addiction spending**



Aside from CTA-managed training contracts, the Mental Health Directorate national allocation of funding for workforce development is split across the strategic imperatives as follows.

**Figure 2: Mental health and addiction workforce development funding, 2004/05 (excluding CTA-managed contracts)**



Note: Contracted budget amounts for the year (GST exclusive) are in some cases estimates, because bids are often spread over more than one financial year for a centre or programme.

During 2000–2005 four national centres and programmes have been established to focus on priority areas of the workforce:

- the Werry Centre for Child and Adolescent Mental Health
- Te Rau Matatini (Māori mental health and addiction workforce development)
- the Mental Health Workforce Development Programme (covering adults, older people, service users, families/whānau and NGO issues)
- Matua Raki (an addiction treatment sector workforce development programme).

A significant proportion of the national allocation of funding is now managed by these organisations, which undertake a range of activities to address training and development needs, recruitment and retention issues, and organisational development of mental health and addiction services, as well as research to support mental health and addiction workforce development. The foundational work of the centres and programmes is informing the development of their long-term strategic plans. Te Rau Matatini has finalised its strategic plan for 2005–2010 (*Kia Puāwai te Ararau*), Matua Raki is consulting on its plan for 2005–2015, and the Werry Centre is also in the process of developing a long-term strategic plan for the child and adolescent mental health and addiction workforce.

Some of the other significant mental health workforce development initiatives contracted by the Mental Health Directorate are:

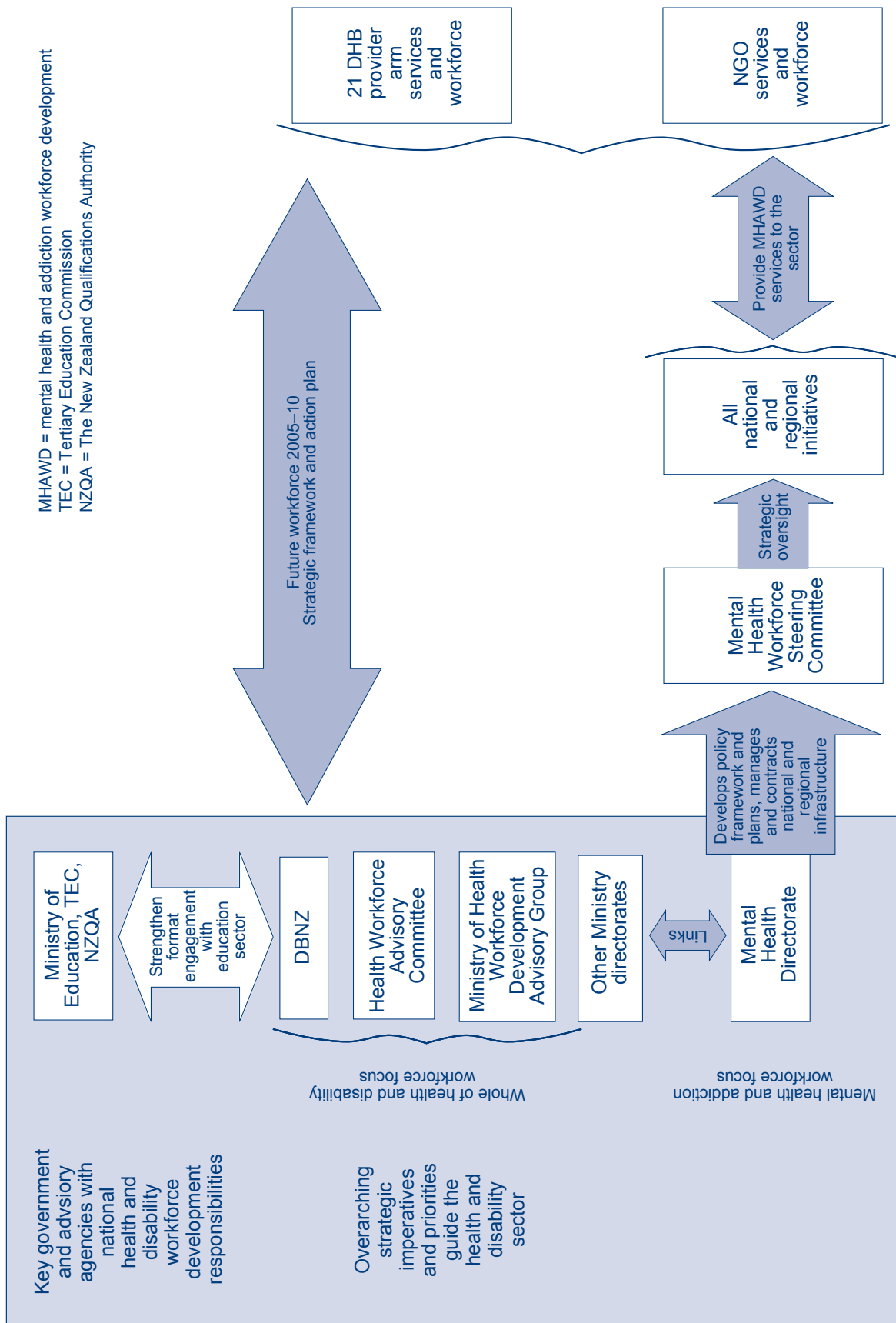
- the Mental Health Workforce Steering Committee, whose function is to have strategic oversight of all mental health and addiction workforce development
- Pacific mental health and addiction workforce training, research and feasibility studies conducted by Pava (an NGO health strategy organisation concerned with the impact of health-related problems in New Zealand for Pacific peoples)
- four regional mental health and addiction workforce co-ordinators (Northern, Midland, Central and South Island (for more information see Appendix D)
- the Henry Rongomai Bennett scholarships and leadership programme
- Te Rau Puawai Workforce 100 (scholarships and mentoring)
- Pacific Mental Health Workforce Awards (scholarships and mentoring)
- the Community Support Services Industry Training Organisation – setting standards for community support workers
- support worker training grant administration by NETCOR (New Zealand Education and Tourism Corporation)
- Knowing the People Planning, an approach to planning mental health services
- the University of Auckland Chair of Mental Health Nursing
- the Self Harm and Suicide Prevention Collaborative Project.

In addition, some projects are funded in partnership with other organisations (eg, universities and DHBs). For example, the University of Auckland Chair of Mental Health Nursing will be fully funded by the University in the fourth and fifth years.

## **The workforce development environment**

A range of agencies are involved in workforce development for the whole of the health and disability workforce. The way they influence and link to workforce development in the mental health and addiction sector is shown in Figure 3.

**Figure 3: Workforce development relationships**



# Future Services and Workforce

Mental health and addiction workforce development in New Zealand has moved into a new strategic phase with the release of *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand mental health and addiction plan* (Minister of Health 2005). The introduction to *Te Tāhuhu – Improving Mental Health* outlines recent developments in the health sector as well as major social trends that will continue to affect the way mental health and addiction services are delivered. *Te Tāhuhu – Improving Mental Health* sets out 10 leading challenges or action priorities for the development of future mental health and addiction services over the next 10 years.

All the leading challenges have significant workforce development aspects, but there is one specific workforce challenge: ‘Workforce and Culture for Recovery’. The challenge is to:

Build a mental health and addiction workforce – and foster a culture amongst providers – that supports recovery, is person centred, culturally capable, and delivers an on-going commitment to assure and improve the quality of services for people.

The immediate emphasis is on:

- building a workforce to deliver services for children and young people, Māori, Pacific peoples, Asian peoples, and people with addiction
- supporting the development of a service user workforce
- creating an environment that fosters leaders across the sector
- developing a culture amongst providers of involving whānau/families and significant others in treatment and recovery
- fostering a culture among providers that promotes service user participation and leadership
- developing a culture of continuous quality improvement in which information and knowledge are used to enhance recovery and service development.

This plan supports the leading challenge of ‘Workforce and Culture for Recovery’ in *Te Tāhuhu – Improving Mental Health*.

# Our Vision

He roopu kaimahi whanui tonu mo te hauora hinengaro, hei tautoko, hei tauawhi i nga momo tu ahuatanga o nga tangata e whai ana te oranga mo ratou, me o ratou whānau tuturu, whānau whanui hoki; tu rangatira to ratou tu i runga ano i te huarahi o te oranga nui. Koia nei te moemoea o te kaupapa, *Tauawhitia te Wero*.

The vision of *Tauawhitia te Wero* is a diverse mental health and addiction workforce:

- responsive to the needs of service users, their families/whānau and significant others
- confident in their positive and unique contribution to the journey of recovery.

This vision for the mental health and addiction workforce relates specifically to the Government's policy to address the needs of the 3 percent of the population who are most severely affected by mental illness.

# The Plan

## Workforce development infrastructure

### Definition

Workforce development infrastructure, in the context of this plan, refers to the set of:

- national centres and programmes
- regional co-ordinator positions
- education and training positions and programmes
- research and policy organisations and groups
- scholarships and governance bodies

which all have a role to play in developing the mental health and addiction workforce. All are funded directly or indirectly by the national allocation of funding managed by the Mental Health Directorate.

Other organisations, such as tertiary education and training providers, are also an important part of the network of infrastructural relationships in the sector, although they are most often funded from other allocations. The importance of strengthening relationships between the mental health and addiction, and education and training, sectors is discussed in the ‘Training and development’ section of this plan (below).

### Actions

Over the past five years the four national centres and programmes have established an excellent foundation for strategic planning and further development of the sector. There now needs to be a period of consolidation and alignment. Each centre/programme is at a different phase of establishment, and some contracts for work that could be undertaken by a centre or programme are still held directly by the Mental Health Directorate.

To determine what further actions are required, the Mental Health Directorate will review and evaluate the national infrastructure. The ultimate goal is for most of workforce development funded via the national allocation to be undertaken by the national centres and programmes.

There is also a need to ensure that current communication, networking, co-ordination and collaborative activities are strengthened between centres and programmes, with wider health workforce development stakeholders, and with DHBs and NGOs at local and regional levels. The role of the Mental Health Workforce Steering Committee also needs to be evaluated.

We can already anticipate the need for actions to align the contracts of the centres and programmes so that there is more national consistency, as well as actions to bring into line planning cycles across the sector. Although planning cycles have not been fully aligned this year, we anticipate that from 2006 the national plan will lead and guide the development of other plans with a mental health and addiction workforce development focus.

Finally, to support the development of the next 10-year plan, a set of formal national indicators needs to be developed. These will be linked to the current Key Performance Indicators (KPI) project and the Nationwide Mental Health Service Framework (Ministry of Health 2001), currently under review. Although existing information such as growth in workforce numbers, workforce full-time-equivalent (FTE) positions, and vacancy rates can all inform workforce development to a certain extent, improving the quality of information and formalising a set of national indicators will allow the state of mental health and addiction workforce development to be assessed consistently. Examples of the quantitative and qualitative indicators that could be developed include staff turnover, retention rates, and staff satisfaction surveys.

**Goal 1: To ensure that national and regional infrastructure supports the ability of DHBs and NGOs to progress workforce development**

Objective	Action	Responsibility	Completion timeframe
<p>1.1 To ensure that the mental health and addiction workforce development infrastructure is well co-ordinated; allows effective communication and information sharing, networking and collaboration (where appropriate); and reduces unnecessary duplication and inefficiency</p>	a. Review and evaluate national workforce development infrastructure, including recommendations for change and implementation	Mental Health Directorate	December 2006
	b. Increase communication activities to services to raise awareness of workforce development tools and techniques	Mental Health Workforce Development Programme, with the support of the other national centres and programme	Ongoing
	c. Align planning cycles	Mental Health Directorate	December 2006
	d. Align contracts	Mental Health Directorate	June 2007
	e. Implement the national infrastructure review recommendations	Mental Health Directorate, and all national centres and programmes	December 2007
<p>1.2 To further develop and co-ordinate a set of national indicators for mental health and addiction workforce development, including specific indicators for the Māori, Pacific, child and adolescent, and addiction workforces</p>	a. Integrate the set of formal national indicators with the Key Performance Indicators (KPI) project and Nationwide Mental Health Service Framework (under review)	Mental Health Directorate, and all national centres and programmes	June 2009

# Organisational development

## Definition

Organisational development is probably one of the least understood aspects of workforce development, yet it is vitally important if development of the workforce is to maintain momentum and achieve significant improvements. Organisational development aims to help services develop the culture and systems necessary to support and sustain their staff. It is strongly linked to recruitment and retention, as well as training and development.

Organisational development includes a range of inter-related topics. Here are some of the more important ones in the mental health and addiction context.

- *Culture* – the norms, customs, values, beliefs and attitudes by which an organisation functions. For example, what attracts Māori staff and keeps them working in an organisation is their ability to work ‘in a Māori way’, within a kaupapa Māori framework (Te Rau Matatini 2005).
- *Leadership* – including both the process of leading, and the people, groups of people and organisations that have a leadership role. Leadership can be defined and practised in a variety of ways. In the context of this plan, it involves influencing people, networks, groups and organisations to strive to achieve the vision for our mental health and addiction workforce.
- *Management* – planning, leading, organising and controlling defined aspects of an organisation. For example, Knowing the People Planning (KPP) is a management tool that allows services to identify long-term service users and their needs more effectively. One outcome of KPP has been a significant reduction in admissions to some services, thus reducing staff caseloads.
- *Design* – the structure, relationships, teams and hierarchies within an organisation.

## Actions

In this plan, leadership development is a key ongoing initiative supported across the mental health and addiction sector. Leadership development incorporates leadership training, mentoring, and management skills and tools that support leadership.

In relation to management, there is a need to investigate and support links across current initiatives such as Knowing the People Planning (KPP) and the National Resource Group (NRG) Service Improvement Model, both of which enable positive change management that has significant impacts on services and the workforce. Both are inclusive processes that bring together service users, families and whānau, significant others, and staff to work on service improvement.

NRG also has the potential to investigate and strengthen the links to be made with primary care. For example, the Auckland DHB Pacific mental health service, Lotafale, has experienced positive change as a result of participating in a pilot project for NRG. Involvement has led to improvements in service delivery, as well as the creation of new positions, all of which have been successfully filled.

This plan also supports the development of organisations so that they are better able to attract and retain staff. There are a number of possible existing and emerging organisational improvement models. For example, the magnet hospital model consists of a set of principles focused on attracting and retaining nursing staff to hospitals through:

- payment by salaries, rather than hourly rates
- giving staff the freedom, responsibility and authority to act autonomously
- minimum layers of management and bureaucratic procedures
- visionary and enthusiastic leadership
- employing workers who are clinically competent
- synthesis of the above five factors into an integrated, workable organisation (Ashton et al 2004).

Another model is the ‘learning organisation’, in which:

- education is flexible and dynamic
- retraining, re-certification, lifelong learning, inter-professional learning and organisational learning are recognised and developed
- health practitioners are research minded in their training and work roles, and organisations encourage this
- core learning organisation functions and cultures are recognised and included in training and development programmes (Health Workforce Advisory Committee 2005).

Choosing the right model for the New Zealand context is crucial, and the plan includes actions to:

- investigate the range of existing and emerging organisational improvement models suitable for the diversity of the New Zealand mental health and addiction sector, including kaupapa Māori and Pacific models
- develop appropriate guidelines for the adoption of one or more kinds of models adapted to the specific conditions of the New Zealand sector
- roll out pilot action research projects to implement the guidelines at a service level.

It will be important for these actions to take account of the recruitment and retention challenges facing the mental health and addiction sector, including recruiting and retaining the ageing workforce as well as young workers. (These are discussed further in the next section of the plan.)

The actions in this part of the plan can be aligned with the Priority I and II actions in DHBNZ’s (2005) *Future Workforce 2005–2010*, which relate to fostering supportive environments and positive cultures, and enhancing people. There are also synergies with the developing workforce/sector capability priorities, including actions to create organisations that recognise and support an ethnically and culturally diverse workforce, and to develop and support access to leadership development programmes for the Pacific health workforce (Priority VII).

**Goal 2: To assist mental health and addiction services to develop the organisational culture and systems necessary to sustain their workforce**

Objective	Action	Responsibility	Completion timeframe
2.1 To continue to build leadership capacity within all mental health and addiction services	a. Continue to provide leadership development to key personnel (clinical, management, service users)	Mental Health Directorate and all national centres and programmes	Ongoing
	b. Investigate whether current initiatives can be linked (eg, KPP and NRG)	Mental Health Workforce Development Programme; Mental Health Directorate	December 2006
	c. Implement recommendations of the above investigation	As above	June 2007
2.2 To build the capacity of mental health and addiction services to become organisations that are able to attract and retain staff	a. Investigate the range of current and emerging organisational improvement models suitable for the diversity of the mental health and addiction sector	Mental Health Workforce Development Programme, with the support of the other national centres and programme	June 2008
	b. Develop guidelines for organisational improvement models	As above	December 2008
	c. Pilot and then roll out an action research project on implementing organisational improvement models	As above	December 2009

# Recruitment and retention

## Definitions

Recruitment is about attracting and choosing people who are capable of performing well in an organisation. How an organisation recruits is just as important as the employment opportunities it offers. Recruitment cannot be separated from other internal human resource practices such as professional development policies, or the broader external environment such as labour market conditions; economic, social, industrial and technological factors; and legislative constraints on recruitment. Recruitment is closely linked to organisational development in that staff achievements, training and career guidance, and personal development are all factors that attract staff to work in an organisation (adapted from Hatcher et al 2005).

Retention is about making sure that staff stay with an organisation long enough to make an effective and valued contribution. It is about ensuring that staff are supported to grow and develop with the organisation. Then when it is time for staff to leave, it is about making sure that succession planning is in place. Like recruitment, retention is closely connected to organisational development. Working conditions are influenced and determined by an organisation's systems, management practices and culture, so they are a key factor in the decisions to leave an organisation (Ashton et al 2004). Many studies note that recruiting and retaining employees should be treated the same way (Hatcher et al 2005).

## Actions

In the 2004/05 financial year, 6898 full-time-equivalent (FTE) positions were contracted by DHB provider arm mental health and addiction services.<sup>3</sup> The national vacancy rate reported by the Mental Health Commission for the same year was 8 percent.<sup>4</sup> Vacancies are likely to be filled by temporary and casual staff until permanent staff can be recruited. Because the workforce is ageing, a key challenge will be to recruit and retain older workers while attracting younger workers in what is likely to be a very competitive labour market. The urgent need to attract and retain more staff to the mental health and addiction sector requires co-ordinated and integrated solutions that address these challenges.

The actions outlined below are intended to align with related actions in DHBNZ's *Future Workforce*, such as:

- Priority I, Action 5: human resources capacity and capability
- Priority II, Action 1: attracting and retaining older people
- Priority VI, Action 5: invest and develop Māori workforce capacity
- Priority VII, Action 3: action programme to promote the health and disability sector as a career option to Pacific peoples.

---

<sup>3</sup> This FTE figure does not include NGOs.

<sup>4</sup> Ministry of Health FTE figures are higher than the Mental Health Commission total FTE figure of 5157 because the Ministry's figures include administrative, management and support staff FTEs (1094), as well as locums (contractors), overtime, temporary and bureau staff FTEs (647).

Under *Tauawhitia te Wero*, there will be a national campaign promoting mental health and addiction as a career to school leavers, university students, adults and current health professionals. Although overseas recruitment has been – and will continue to be – a way to fill vacancies, in the longer term we need to focus on growing and sustaining a diverse New Zealand workforce.

It will be important for such a campaign to counter negative media portrayals and the stigma associated with working in the sector by emphasising the positive and rewarding aspects of a career in mental health and addiction. The campaign will build on key opportunities such as the relatively youthful Māori, Pacific and Asian populations, and the potential for more service users to participate as members of the workforce. The campaign will complement the Service User Workforce Development Strategy developed by the Mental Health Commission (2005), which will be implemented by the Mental Health Workforce Development Programme. As part of its work programme, Matua Raki will also be continuing to develop the addiction service user workforce.

The career promotion campaign will be further complemented by developing a national mental health and addiction recruitment website. The website will build on and co-ordinate the work already being undertaken by DHBs and NGOs. It will also support the nationwide implementation of successful recruitment strategies already employed by individual organisations. In addition, the website will be a demonstration project leading the development of a nationwide health recruitment website already signalled by the Minister of Health. Both the career campaign and the website align with DHBNZ's *Future Workforce* Priority III, Action 3: to develop a brand that increases the attractiveness of health sector careers.

Another key component of recruitment and retention is to build the capacity of services to attract and retain staff. This overlaps with organisational development initiatives discussed previously. Individual DHBs and NGOs have implemented some successful recruitment strategies that could be taken up more uniformly across DHBs and NGOs. We want to ensure that services are equipped with best-practice policies and management tools to enable them to attract and retain the best staff for their service. In the New Zealand context, it will be important to develop policies and tools that attract and retain Māori staff, as well as Pacific and Asian staff, particularly in areas with similar populations.

The survey data for the Māori mental health workforce, for example, suggest that retention is a significant issue for this part of the workforce given that most have been in the workforce for a relatively short period of time. For the Pacific workforce, there is a need to feel valued, and to participate more at all levels of organisations and in all workforce-related activities (Faleafa 2004).

**Goal 3: To develop a nationally co-ordinated response to issues of recruitment and retention**

Objective	Action	Responsibility	Completion timeframe
3.1 To reduce the stigma associated with working in mental health and addiction so that more health and non-health staff are attracted to the sector	a. Implement a national advertising campaign promoting mental health and addiction as a career option in a range of occupational roles	The national centres and programmes	December 2006
3.2 To ensure nationally co-ordinated recruitment to all mental health and addiction services, including locums and other temporary staff, which includes targeting under-represented groups such as Māori and Pacific workers	a. Develop a national website, with ongoing content and maintenance provided by DHBs and NGOs, and co-ordinated regionally, including an advertising campaign tied into the career promotion campaign (above)	The national centres and programmes, in collaboration with DHBNZ (to be confirmed), all four regions, and Platform <sup>1</sup>	December 2006
3.3 To build the capacity of all mental health and addiction services and related organisations to attract and retain staff	a. Ensure all services have in place policies and management practices that attract and retain Māori staff, especially in mainstream services where there are significant Māori populations	Te Rau Matatini and the Mental Health Workforce Development Programme; all four regions	December 2007
	b. Ensure all services have in place policies and management practices that attract and retain Pacific staff, especially in mainstream services where there are significant Pacific populations	Pava; all four regions	December 2007
	c. Ensure all services have in place policies and management practices that attract and retain Asian staff, especially mainstream services where there are significant Asian populations	Mental Health Workforce Development Programme; all four regions	December 2007

1 Platform represents NGOs who provide a range of community-based mental health services (see Appendix D) for further information).

Goal 4: To develop a regionally co-ordinated response to issues of recruitment and retention			
Objective	Action	Responsibility	Completion timeframe
4.1 To ensure that DHB regions co-ordinate recruitment and retention strategies and policies in partnership with NGOs	a. Ensure regional mental health and addiction workforce development co-ordinators work within annual district planning processes to develop co-ordination strategies	Mental Health Workforce Development Programme; all four regions	Ongoing
	b. Ensure the national recruitment website contains regional links (see above)	Mental Health Workforce Development Programme; DHBNZ (to be confirmed); Platform; all four regions; supported by the other national centres and programme	June 2007

# Training and development

## Definitions

Training and development includes all aspects of education and training focused on developing the knowledge, skills, and attitudes of people to work in mental health and addiction services, as well as ongoing training and development once people are working in the sector. It includes tertiary education in mental health and addiction, post-entry clinical training (PECT), and other training in aspects of mental health and addiction treatment, support and care.

## Actions

A key action in the plan is the development of a new framework of core dual (ie, clinical and cultural) competencies for mental health and addiction workers. This builds on earlier work, addresses outstanding issues, and links to the requirements of the Health Practitioners Competence Assurance Act 2003 (HPCA Act). The Act has changed the context for the education and training of mental health workers by requiring regulatory bodies of registered health professionals to ensure the safety of the public and the ongoing professional competence to practise. The new quality assurance provisions comprise mandatory ongoing competency requirements, competency-based practising certificates, and stronger accountability of these regulated professionals. The regulatory bodies also approve education programmes for their groups.

A core dual competencies framework will build on the recent work of the national programmes and centres, and DHBs and NGOs, including:

- a continued focus on dual competencies for working in community-based mental health and addiction services and recovery-based models of care
- a continued development of cultural competencies – both as part of a dual competencies framework for Māori staff (building on Te Rau Matatini’s work), and for all staff in mental health services who work with Māori, Pacific and Asian service users
- dual competencies for providing care and treatment for older people, because there is a long-term trend for the proportion of older people in the total population to increase
- greater consistency in dual competencies such as collaborative teamwork in multidisciplinary teams and communication skills – these competencies are important not only within mental health and addiction services, but also in the interface with primary services (eg, in rural areas)
- dual competencies in basic information management skills, including the analysis of Māori mental health information for the benefit of Māori (linking to the *National Mental Health Information Strategy 2005–2010*, Ministry of Health 2005b).

A core dual competencies framework will be implemented in part by a national training plan, in part by strengthening experiential learning such as clinical placements. This latter work will be co-ordinated with work already undertaken by the Werry Centre, Te Rau Matatini and the Drug and Alcohol Practitioners’ Association Aotearoa-New Zealand.

A new core dual competencies framework will contain the detail needed to assist the development of undergraduate educational curricula, professional development and training recommendations, and performance appraisals. For those workers in mental health and addiction who are not regulated under the HPCA Act, work on core dual competencies will provide the ability to be consistent in competency with other workers. Employers will therefore have a greater role in ensuring that competencies are met.

The new core dual competencies framework will also be able to be linked into national, regional and sectoral planning processes. It could, for example, be used as part of a best-practice planning process (see ‘Research and evaluation’ below). Once core dual competencies are established, they will inform the development of a national training plan.

Each year approximately 650 students complete their studies in mental health and addiction education courses, and more than 250 mental health workers participate in post-entry clinical training as part of their ongoing professional training and development. But changes in mental health and addiction care and treatment have been outpacing changes in training. There is a recognised need for education and training specifications to be reviewed and updated to reflect current practice and models of care.

A key part of developing a national education and training plan will be a review of undergraduate education. Submissions on the draft Second National Mental Health Plan called for more links to tertiary institutions to improve mental health and addiction education (Ministry of Health 2005a). In practice, some CTA PECT programmes fill the gaps in the mental health and addiction content of undergraduate programmes. A greater mental health and addiction component of courses at undergraduate level would, however, have a positive effect on the core dual competencies of new mental health and addiction workers, is likely to have a positive effect on recruitment, and will improve the ability of workers in primary care to care for and treat people with mental illness. Evidence suggests that a basic understanding of mental health breaks down workers’ ignorance and the stigma associated with mental illness, both of which have been identified as barriers to service users’ interactions with general practitioners (Lester et al 2005). An important opportunity arises from the high Māori participation in tertiary education, now proportionally higher than non-Māori in most age groups (Ministry of Social Development 2005).

The training plan could include initiatives such as:

- more and better basic training in mental health and addiction in undergraduate programmes for doctors, nurses and other health professionals
- changes to the content of CTA PECT specifications recommended by the recent review
- arrangements to permit accreditation of in-service training programmes, as well as prior learning and experience for people wishing to move between occupations and practice areas
- improved access to training by workers in DHBs and NGOs, particularly those in rural areas

- training for case workers and managers, which could provide substantial improvements in workforce efficiency and productivity
- training in supervision and mentoring
- more training for family/whānau advisors and support workers, as well as service user peer support models
- more cultural training and cross-cultural communication training across all occupational roles
- reciprocal arrangements so that culturally competent workers share their knowledge with mainstream services
- a Māori programme for community support workers, supported by a career pathway for community support work
- training for a range of Pacific workers, such as matua, interpreters and cultural advisors, together with formal recognition of roles
- training mental health workers in addiction competencies, and vice versa, because of the high prevalence of dual diagnosis, including joint training programmes for mental health and addiction services staff
- leadership development training
- training for funders and planners
- training for the workforce in information use, particularly outcomes data, to improve and support evidence-based best practice.

We recognise that existing and new programmes will need to be carefully co-ordinated because the sector is already at capacity in terms of taking up training, including increased mandatory training requirements.

Both the core dual competencies framework and the national training plan will support the shift in focus from information collection to information use, signalled in the *National Mental Health Information Strategy 2005–2010* (Ministry of Health 2005b), as well as the challenge to develop a culture of continuous quality improvement in which information and knowledge are used to enhance recovery and service development (*Te Tāhuhu – Improving Mental Health*, Minister of Health 2005).

The core dual competencies framework and the national training plan also align well with the DHBNZ *Future Workforce* Priority III, Action 5, whereby DHBs agree that competencies should become portable across DHBs and disciplines. The framework will also enable links to Priority V, Action 1: to develop primary health models that explicitly recognise the range of competencies and skills that provide for the diverse needs of the population.

There is a need to strengthen the national co-ordination and leadership of education and training for the workforce, both before and after they enter the sector. Work is already under way on the wider health workforce, such as the qualifications supply analysis (Tertiary Education Commission 2004). The development of the core dual competencies framework

and the national training plan will include formal consultation and co-ordination with the education, wider health and employment sectors, and that process of engagement is also included as a separate and ongoing action of this plan. We need to understand the barriers and incentives for universities, other tertiary education providers and other training organisations in order to align education and training with our goals and vision for the workforce.

Formal consultation and co-ordination with the education and training sectors will also align with DHBNZ's plan to:

- formally engage with the education sector on workforce issues (Priority III, Action 1)
- facilitate a round-table discussion with education, health sector, professional organisations, etc, to redesign health education in New Zealand
- engage with the Tertiary Education Commission to increase successful Māori participation in health and disability education and training, including developing kaupapa Māori programmes (Priority VI, Action 2)
- create incentives for the education sector to ensure a greater proportion of Pacific students complete their courses (Priority VII, Action 4) (DHBNZ 2005).

The work on core dual competencies and a national training plan will provide the foundations for the further development of clinical career pathways, building on the recent work of the centres/programmes and DHBs. Such work, while strongly linked to education and training, is also an important part of ensuring that graduates are attracted to and retained by the mental health and addiction sector. This work also aligns with DHBNZ *Future Workforce* Priority II, Action 2: to establish alternative career pathways/opportunities across all health and disability professions, both vertical and lateral.

Other essential ongoing training is training in Māori and Pacific models of care, particularly for workers providing care, treatment and support to Māori and Pacific service users. Such training will be important in districts and regions with significant Māori and Pacific populations. It will also align with DHBNZ Priority IV, models of care, as well as Priority VI, Action 4: to ensure access of Māori and non-Māori clinicians and staff to Māori health/hauora competency development and training opportunities (DHBNZ 2005).

**Goal 5: To align pre-service entry, orientation and ongoing development of mental health and addiction workers with service provision requirements**

Objective	Actions	Responsibility	Completion timeframe
5.1 To ensure that educational and training programmes meet the current and future needs of the mental health and addiction workforce and mental health and addiction services	a. Develop a core dual competencies framework, including an implementation plan	Mental Health Directorate, supported by the national centres and programmes, and Pava	December 2007
	b. Develop a national training plan, including a review of the mental health and addiction component of undergraduate health training, and of clinical placements	Mental Health Directorate, supported by the national centres and programmes, and Pava	December 2008
5.2 To ensure that education and training leads to careers that attract and retain more staff	a. Further develop clinical career pathways for nurses, occupational therapists, social workers and community support workers, particularly in child and adolescent services	Mental Health Workforce Development Programme, all four regions, supported by the other national centres and programme, and Pava	June 2009
5.3 To ensure that all mental health and addiction workers caring for and treating Māori service users are familiar with Māori models of care	a. Provide training as needed for workers, including clinicians, in all mental health and addiction services	All national centres and programmes; all four regions	Ongoing

**Goal 6: To co-ordinate the education, health and employment sectors**

Objective	Action	Responsibility	Completion timeframe
6.1 To ensure that mental health and addiction education and training is co-ordinated with work in the wider health, education and employment sectors	a. Establish a formal consultation and co-ordination group with relevant health, education and employment state sector services and agencies, as part of the development of the national training plan	Mental Health Directorate, supported by the national centres and programmes	Ongoing

# Research and evaluation

## Definitions

Research in this context means investigating aspects of the mental health and addiction sector in order to add to our knowledge and understanding of the workforce and workforce development. It may involve a range of methodologies, including survey questionnaires, in-depth interviews or participatory action research.

Evaluation is about assessing the effectiveness of an initiative or project in achieving its stated aims. Evaluation may not always be necessary, particularly if a project is based on solid evidence. On the other hand, an innovative training programme, for example, may require an earlier and more rigorous evaluation. An evaluation may recommend changes that could range from ending the initiative, to major or minor adjustments to the project design and implementation.

## Actions

As we have seen, the size of the workforce is difficult to describe accurately. Information systems to collect workforce data require further development. The development of DHBNZ's Health Workforce Information System (HWIS) will allow annual workforce data collection to inform the next plan. In the meantime, two key initiatives are an NGO mental health and addiction workforce stocktake, to be followed closely by an equivalent DHB workforce stocktake. The NGO stocktake will take place first because there is currently little robust information available about this part of the sector. A standard data template, linked to HWIS templates, could be integrated into all NGO and DHB information systems to allow consistent collection of information for the stocktakes and in the future. The stocktakes will also inform the next National Mental Health and Addiction Workforce Development Plan 2010-2020.

DHBs and NGOs require incentives to plan and to plan well. There is a need to strengthen workforce development and planning best practice. A key action in the plan is the development of a locally tested workforce development planning guide, perhaps modelled on the *Planner's Guide* developed by the UK Sainsbury Centre for Mental Health (2003). The local National Resource Group (NRG) Service Improvement Model has already been having a positive impact on aspects of workforce development where it has been piloted. That work could form the basis of a planning guide based on relevant New Zealand kaupapa and principles.

In the longer term, there is a very strong likelihood that the mental health and addiction workforce, working in the current way, will be unable to meet future demand for services created by an ageing population (see, for example, New Zealand Institute of Economic Research 2004). This, and the shift to service-user-focused care based on a recovery approach, strongly suggests that services need to find ways of working better and more efficiently within current human resource levels.

A more productive and efficient workforce could be achieved by actions such as:

- defining the role of psychiatrists
- expanding the scopes of practice for non-psychiatrists, including the nurse practitioner role
- considering ways in which more psychologists could work in services
- strengthening the role of family/whānau advisors
- reducing the administrative burden on clinicians and support workers
- increasing peer support worker roles.

Such changes to practice roles and workforce design will likely have other benefits, such as increasing job satisfaction. Significant research and evaluation will be required, along with a long time frame for implementation. The Mental Health Workforce Development Programme will be developing a range of workforce redesign pilot projects, following the recommendations of *Improving Recruitment to the Mental Health Workforce in New Zealand* (Hatcher et al 2005). This work will then form the foundation for further development and roll-out of workforce redesign to be undertaken in the plan for 2010–2020.

These workforce redesign actions will align with DHBNZ's models of care Priority IV (DHBNZ 2005), in particular Action 1: to incentivise innovative models of care that support job redesign, team building and shared competencies development within the HPCA Act; and Action 4: to fund initiatives to encourage the introduction of new models of team-working which are health-outcome focused.

Goal 7: To ensure there is information available to the sector to inform workforce development			
Objective	Action	Responsibility	Completion timeframe
7.1 To ensure that robust and uniformly defined data are collected across the whole of the mental health and addiction workforce to allow better workforce development planning, service quality improvement and forecasting	a. Carry out a stocktake of the NGO mental health workforce using a common data template	Mental Health Directorate, supported by the national centres and programmes	June 2007
	b. Carry out a stocktake of the DHB mental health workforce using a common data template	Mental Health Directorate, supported by the national centres and programmes	June 2008
7.2 To develop mental health and addiction workforce development and planning capability across the sector	a. Develop a locally tested best practice workforce planning and development guide appropriate for a diverse workforce	Mental Health Workforce Development Programme, supported by the other national centres and programme; all four regions	December 2008
7.3 To utilise the current workforce in innovative ways to address staff shortages	a. Set up pilot workforce redesign projects, including kaupapa Māori, Pacific, and child and adolescent pilots	Mental Health Workforce Development Programme, supported by the other national centres and programme	December 2009

# Monitoring the Plan

It will be important to monitor the plan with a variety of quantitative and qualitative measures. This plan will be monitored by the:

- Mental Health Directorate, via its workforce and services contracts management and reporting system – the Directorate monitors contracted services against *Blueprint* levels and reports on gaps
- Mental Health Workforce Steering Committee, as part of its strategic overview role
- review process for DHB regional strategic plans
- six-monthly Mental Health Commission DHB provider mental health workforce monitoring reports
- NGO and DHB stocktakes, undertaken as part of this plan.

The Mental Health Directorate is also working with the DHB Funding and Performance Directorate (Ministry of Health) to establish a mental health workforce database to improve the monitoring of projects and to enable better co-ordination and networking in relation to the Ministry's workforce development responsibilities.

The monitoring function of the Mental Health Workforce Steering Committee will be reviewed as part of the general review of the national mental health and addiction workforce development infrastructure.

# Appendix A:

## Feedback on the plan

The Ministry of Health presented the draft plan to a range of sector groups and organisations around the country, as follows:

- addiction training providers
- Central Regional Mental Health Network
- Consumer Addiction Network
- Directors of Area Mental Health Services and Managers (DAMHS)
- Health Workforce Advisory Committee
- Mental Health Advisory Coalition
- Mental Health Commission
- Mental Health Workforce Steering Committee
- Mental Health Workforce Development Committee (Mental Health Workforce Development Programme)
- Midland Regional Mental Health Network
- Moana Pasifika
- Ministry of Health Workforce Development Advisory Group
- National Addiction Centre and Matua Raki
- NGO Reference Group (Mental Health Workforce Development Programme)
- Northern Network Coalition
- Pava
- Royal Australian and New Zealand College of Psychiatrists
- South Island Regional Mental Health Network
- Supporting Families
- Werry Centre.

At each presentation meeting, verbal feedback on the draft plan was noted. All attendees were invited to give further written or verbal feedback to the Ministry. In addition, the Ministry circulated the draft to sector contacts as widely as possible. The following 15 organisations gave additional feedback via written letter, tracked changes to the draft plan, email or written feedback using the feedback form, or further verbal feedback either by phone or in additional meetings:

- Bay of Plenty DHB Māori Health Planning and Funding Unit
- Bay of Plenty DHB Mental Health Services
- Clinical Training Agency
- DHBNZ
- Knowing the People Planning
- Moana Pasifika
- Mental Health Workforce Development Programme
- New Zealand College of Clinical Psychologists
- Otago DHB – Mental Health and Disability Services
- Pava
- South Island Regional Mental Health Network
- Supporting Families
- Te Rau Matatini
- Waikato DHB
- Werry Centre.

## Appendix B: The strategic context for change

Workforce development is undertaken bearing in mind the principles of the Treaty of Waitangi. Commitment to the Treaty is reinforced by the New Zealand Public Health and Disability Act 2000.

Three key documents form the Mental Health and Addiction Strategy:

- *Looking Forward: Strategic directions for mental health services* (Ministry of Health 1994)
- *Moving Forward: The National Mental Health Plan for More and Better Services* (Ministry of Health 1997b)
- *Te Tāhuhu – Improving Mental Health 2005-2015: The second New Zealand mental health and addiction plan* (Minister of Health 2005).

*Looking Forward* confirmed the strategic commitment to the shift from institution-based to community-based delivery of services, backed up by sufficient inpatient services for acute care. *Te Tāhuhu – Improving Mental Health* has established a set of 10 leading challenges for the mental health and addiction sector to be implemented by a detailed action plan.

It is Government policy to fund and implement the Mental Health and Addiction Strategy through the *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998). The *Blueprint* is a national mental health and addiction service development plan that includes detailed resourcing guidelines for the level of mental health and addiction service delivery.

Another relevant framework is *Te Puāwaitanga Māori Mental Health National Strategic Framework* (Ministry of Health 2002b). This builds on the work in *Looking Forward* to provide DHBs with a nationally consistent framework for planning and delivering services for tāngata whaiora and their whānau, so they can meet the Government's mental health and addiction policy objectives for Māori for the period 2002–2007.

Within the broader health and disability sector, key health strategies provide higher-level direction to health and disability sector workforce development, including mental health and addiction workforce development. Relevant strategies are:

- *The New Zealand Health Strategy* (Minister of Health 2000)
- *The New Zealand Disability Strategy: Making a world of difference – Whakanui oranga* (Minister for Disability Issues 2001).

Specific population and service strategies are:

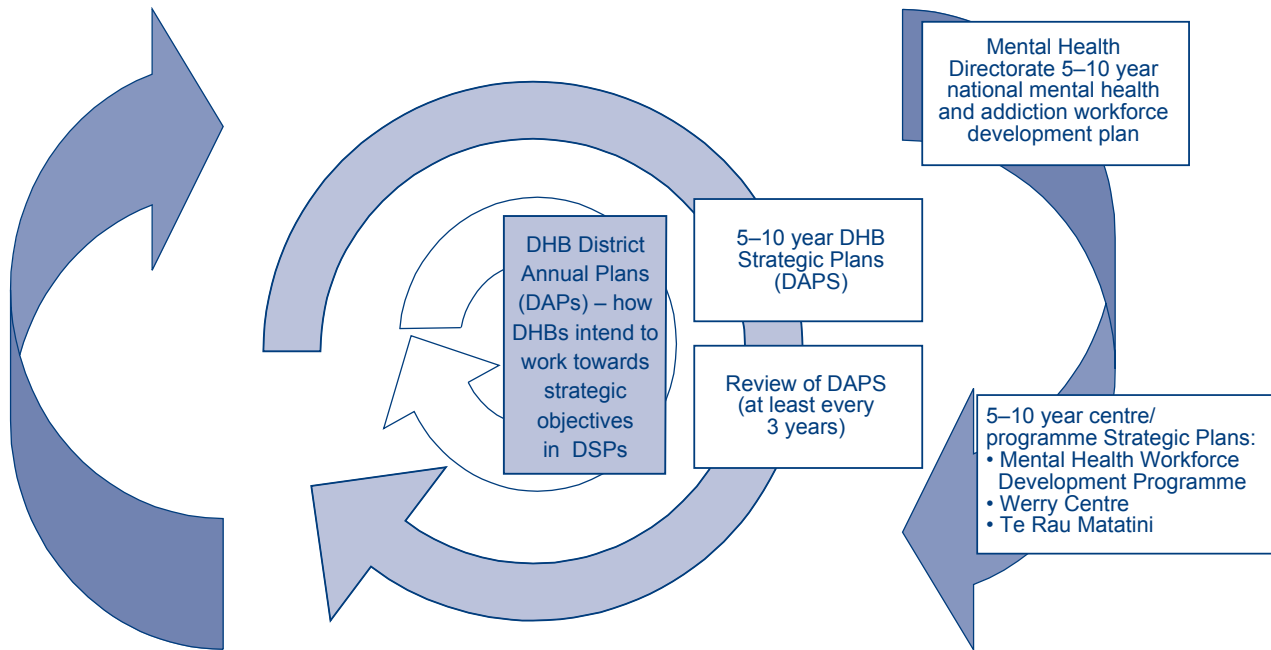
- *The Primary Health Care Strategy* (Minister of Health 2001)
- *He Korowai Oranga: The Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002)

- *Making a Pacific Difference: Strategic initiatives for the health of the Pacific people in New Zealand* (Ministry of Health 1997a).

Health and disability workforce development strategy has been led by the Health Workforce Advisory Committee (HWAC). HWAC promotes a systemic, sector-wide approach to health workforce issues. It suggests that strategically framing workforce development requires approaches that are patient-centred, systemic and evolutionary (ie, incremental rather than forced and sudden). With the support and involvement of HWAC and the Ministry of Health, DHBNZ has been developing *Future Workforce 2005–2010*, a strategic framework and plan to guide DHB collaborative workforce activity for the next 10 years. Other relevant plans include the *Pacific Health and Disability Workforce Development Plan* (Ministry of Health 2004) and *Rāranga Tupuake: Māori Health Workforce Development Plan: Discussion document* (Ministry of Health 2005c).

# Appendix C: Planning cycles

The diagram below describes, in simplified terms, current planning cycles and their inter-relationships. One outcome of this plan is that planning cycles will become more aligned over time.



# Appendix D: Key organisations

## Central agencies

### Mental Health Directorate, Ministry of Health:

- maintains and articulates a strategic overview
- helps DHBs and NGOs to implement workforce development
- facilitates relationships of workforce development stakeholders within the mental health and addiction sector and across sectors
- helps in the development and funding of workforce development initiatives via the national allocation
- advises the Minister of Health about mental health and addiction workforce development.

Key contact: Robyn Shearer, Project Manager, Workforce

DDI: 09 580 9115

Email: [Robyn\\_Shearer@moh.govt.nz](mailto:Robyn_Shearer@moh.govt.nz)

Website: [www.moh.govt.nz/mentalhealth](http://www.moh.govt.nz/mentalhealth)

### Clinical Training Agency, Ministry of Health:

- purchases post-entry clinical training (PECT), including mental health and addiction.

Key contact: Heather Forsythe, Portfolio Manager

DDI: 03 372 3076

Email: [Heather\\_Forsythe@moh.govt.nz](mailto:Heather_Forsythe@moh.govt.nz)

Website: [www.moh.govt.nz/cta](http://www.moh.govt.nz/cta)

### DHB Funding and Performance, Ministry of Health:

- ensures mental health and addiction resources are used within each of the 21 DHBs in a manner that reflects identified community needs
- drives district and regional mental health and addiction planning
- funds service provision.

Key contact: Alar Treial

DDI: 04 470 0626

Email: [Alar\\_Treial@moh.govt.nz](mailto:Alar_Treial@moh.govt.nz)

Website: [www.moh.govt.nz/dhbfp](http://www.moh.govt.nz/dhbfp)

### **Mental Health Commission:**

- monitors and reports on workforce capacity
- works with key agencies to lift the image of the mental health sector as a career alternative
- addresses workforce issues through support and promotion of appropriate agencies and initiatives
- leads destigmatisation and anti-discrimination activities.

Key contact: Bernie De Lord, Senior Analyst

DDI: 04 474 8917

Email: bdelord@mhc.govt.nz

Website: www.mhc.govt.nz

### **Ministry of Health Workforce Advisory Group:**

- advises on the strategic overview of the contribution of the health and disability workforce to health and independence outcomes
- co-ordinates health and disability workforce issues and initiatives, both within the Ministry of Health and externally, to ensure an integrated, consistent approach and efficient use of resources
- identifies key workforce problems and makes recommendations on priorities
- recommends a set of principles to guide the development of the future health and disability workforce.

Key contact: Judy Glackin

DDI: 04 496 2195

Email: Judy\_Glackin@moh.govt.nz

## **Health Workforce Advisory Committee (HWAC)**

The HWAC is a statutory body established in 2001 under section 12 of the New Zealand Public Health and Disability Act 2000 to provide high-level strategic advice and policy guidance on any health workforce issues that the Minister of Health specifies by notice to the Committee. Specifically, the HWAC:

- independently assesses current workforce capacity and foreseeable workforce needs to meet the objectives of the New Zealand Health Strategy and the New Zealand Disability Strategy
- advises the Minister of Health on national goals and strategies for the health workforce
- facilitates co-operation between the health sector and workforce education and training agencies to ensure a strategic approach to health workforce supply, demand and development
- reports on the effectiveness of recommended strategies and identifies required changes.

Key contact: Dr George Salmond, Chair

Ph: 04 496 2125

Email: [hwac@moh.govt.nz](mailto:hwac@moh.govt.nz)

Website: [www.hwac.govt.nz](http://www.hwac.govt.nz)

## **Tertiary Education Commission (TEC):**

- is responsible for funding most post-compulsory education and training offered by universities, polytechnics, colleges of education, w nanga, private training establishments, foundation education agencies, industry training organisations and adult and community education providers
- oversees implementation of the Tertiary Education Strategy and the associated set of priorities
- facilitates collaboration and co-operation in the tertiary education system, and a greater system connectedness to wider New Zealand businesses, communities, iwi and enterprises.

Website: [www.tec.govt.nz](http://www.tec.govt.nz)

## **Ministry of Education**

The Ministry works in a strategic and facilitative role with the education sector. Its work is focused on three key areas or vital outcomes:

- effective teaching for all students
- family and community engagement in education
- quality providers.

Website: [www.minedu.govt.nz](http://www.minedu.govt.nz)

### **New Zealand Qualifications Authority:**

- provides an overarching role in quality-assured qualifications
- co-ordinates national qualifications in New Zealand.

Website: [www.nzqa.govt.nz](http://www.nzqa.govt.nz)

### **Department of Labour:**

- provides information, services and support covering almost every aspect of work
- helps businesses work better
- helps to meet New Zealand's skill needs and to improve the quality of New Zealanders' working lives.

Website: [www.dol.govt.nz](http://www.dol.govt.nz)

## **National mental health and addiction workforce development centres and programmes ([www.mhwork.org.nz](http://www.mhwork.org.nz))**

### **Mental Health Workforce Development Programme:**

- promotes a nationally co-ordinated approach that builds mental health and addiction workforce capacity and capability so that services meet the recovery needs of adult mental health service users
- informs evidence-based workforce development policy and implements workforce development initiatives
- provides systematic evaluation of workforce initiatives to promote effectiveness, efficiency and dissemination of information.

Key contact: Barry Foley, Manager

Ph: 09 300 6770

Email: [bfoley@hrc.govt.nz](mailto:bfoley@hrc.govt.nz)

Website: [www.mhwd.govt.nz](http://www.mhwd.govt.nz)

### **Te Rau Matatini:**

- ensures that Māori mental health service users (tāngata whaiora) have access to a well-prepared and well-qualified Māori mental health workforce
- contributes to Māori mental health workforce policy development at a national and regional level
- expands the Māori mental health workforce
- promotes rewarding career opportunities in mental health for Māori.

Key contact: Kirsty Maxwell-Crawford, Project Manager – Transition

Ph: 0800 MATATINI (0800 6282 8464)

Email: [k.maxwell-crawford@matatini.co.nz](mailto:k.maxwell-crawford@matatini.co.nz)

Website: [www.matatini.co.nz](http://www.matatini.co.nz)

### **Werry Centre for Child and Adolescent Mental Health:**

- undertakes research, consultation and needs analysis to support workforce planning
- undertakes projects to increase the capability of the workforce to provide effective, evidence-based treatment, to support consumer participation and student placements
- supports the delivery of education and training to the sector.

Key contact: Sue Treanor, Director

Ph: 09 373 7599 ext. 82 487

Email: [coordinator@werrycentre.org.nz](mailto:coordinator@werrycentre.org.nz)

Website: [www.werrycentre.org.nz](http://www.werrycentre.org.nz)

### **Matua Raki – Addiction Treatment Sector Workforce Development Programme:**

- aims to provide the encouragement, resources and rewards for excellence in the practice of addiction treatment
- delivers a range of training
- collaborates to run the NZ School of Addiction
- builds research and evaluation capacity.

Key contact: Ian MacEwan, Senior Project Manager

Ph: 04 499 3083

Email [ian.dapaanz@xtra.co.nz](mailto:ian.dapaanz@xtra.co.nz)

Website: [www.chmeds.ac.nz/departments/psychmed/treatment/natswdp.htm](http://www.chmeds.ac.nz/departments/psychmed/treatment/natswdp.htm)

# Regional mental health and addiction co-ordinators and networks ([www.mhwork.org.nz](http://www.mhwork.org.nz))

## Regional mental health and addiction workforce development co-ordinators

Established in 2004, the co-ordinators aim to:

- build strong relationships within and across the mental health and addiction sector
- facilitate uptake of national mental health and addiction workforce development opportunities
- increase regional feedback and participation with national, regional and district mental health and addiction workforce development planning
- ensure national centres and programmes are responsive to the needs of the mental health and addiction sector.



## **Regional mental health networks**

There are four regional mental health networks, which:

- represent regional mental health stakeholder groups, including DHB funders and planners, DHB providers, NGOs, tāngata whaiora/service users and whānau/families
- inform regional mental health planning.

Networks can be contacted through the regional co-ordinators.

## **DHBs and NGOs**

### **DHBNZ:**

- provides an organisational infrastructure for workforce development activity within and across DHBs
- develops a national strategic plan for workforce development
- aggregates DHB demand for workforce development initiatives.

Key contact: Marilyn Rimmer

Ph: 04 473 5359

Website: [www.dhbnz.org.nz](http://www.dhbnz.org.nz)

### **Platform:**

- represents NGOs, which provide a range of community-based mental health services.

Key contact: Marion Blake

Ph: 04 385 0385

Email: [ceo@platform.org.nz](mailto:ceo@platform.org.nz)

Website: [www.platform.org.nz](http://www.platform.org.nz)

# Glossary

Action research	An inclusive, self-reflexive and cyclical social research methodology. In an ongoing process, participants' actions are studied, changed, and studied again as part of an action research project. Sometimes called participatory action research.
Children and adolescents	People aged 0–19 years (inclusive).
Competencies	The attitudes, skills, knowledge and behaviours of health practitioners and support workers that enable them to perform particular functions.
Consumer	A person who experiences or has experienced mental illness and/or addiction and who uses or has used mental health and addiction services. Other terms often used are service user and tangata whaiora.
CTA	Clinical Training Agency – a business unit within the Ministry of Health which funds post-entry clinical training (PECT).
DHB	District Health Board – the 21 DHBs are established under the New Zealand Public Health and Disability Act 2000.
DHBNZ	District Health Boards New Zealand (see <a href="http://www.dhbnz.org.nz">www.dhbnz.org.nz</a> ).
FTE	Full-time equivalent.
HPCA Act	Health Practitioners Competence Assurance Act 2003.
KPP	Knowing the People Planning – an approach to planning in mental health services (see <a href="http://www.kpp.org.nz">www.kpp.org.nz</a> ).
Matua	Parent (Samoan). This term has evolved in the health sector to describe a Pacific person, usually an elder, whose credibility in Pacific communities is due to their work for Pacific people, who is held in high regard, and who has expert knowledge of cultural beliefs and protocols.
Matua Raki	The Addiction Treatment Sector Workforce Development Programme, one of the four national centres and programmes (see Appendix D for further information).

Mental Health Workforce Development Programme	One of the four national centres and programmes for mental health and addiction workforce development (see Appendix D for further information).
NGO	Non-governmental organisation.
NRG	National Resource Group – responsible for facilitating and supporting the Service Improvement Model, run by the Mental Health Workforce Development Programme.
NZQA	New Zealand Qualifications Authority.
Pava	An NGO health strategy organisation concerned with the impact of health-related problems in New Zealand for Pacific peoples.
PECT	<p>Post-entry clinical training, funded by the CTA. A PECT programme is:</p> <ul style="list-style-type: none"> <li>• vocational – rather than academic or research based</li> <li>• clinical – clinically based, with a substantial clinical component where employment in a clinical setting is integral for completion of the qualification</li> <li>• post-entry – occurs after entry to a health profession, so that a person is eligible to practise in a particular occupation</li> <li>• a formal programme – participants are formally enrolled in a training programme which leads to a recognised qualification</li> <li>• six months minimum – the formal training programme is to be equivalent to a minimum of six full-time months in length</li> <li>• nationally recognised – recognised by the profession and/or health sector and meeting a national health service skill requirement rather than local employer need.</li> </ul>
Peer support	The coming together of people on a voluntary and equal basis for mutual aid.
Platform	An NGO that represents NGOs who provide a range of community-based mental health services (see Appendix D for further information).
Primary health care	Covers a broad range of services – although not all of them are

Government funded:

- generalist first-level services, such as general practice (GP) services, mobile nursing services, community health services, and pharmacy services that include advice as well as medications
- first-level services for certain conditions (such as maternity, family planning and sexual health services, and dentistry) or those using particular therapies (such as physiotherapy, chiropractic and osteopathy services, traditional healers and alternative healers)
- participating in communities and working with community groups to improve the health of the people in the communities
- health improvement and preventive services, such as health education and counselling, disease prevention and screening.

Recovery	Living well in the presence or absence of mental illness and the losses that can be associated with it.
Service user	A person who experiences or has experienced mental illness and/or addiction and who uses or has used mental health and addiction services. Other terms often used are ‘consumer’ and ‘tangata whaiora’.
Support worker	In mental health and addiction services, a non-clinician who works with people with mental illness and/or addiction.
Tāngata whaiora	People seeking wellness; mental health and addiction service users. (Singular: tangata whaiora.)
TEC	Tertiary Education Commission.
Te Rau Matatini	One of the four national centres and programmes, Te Rau Matatini focuses on Māori mental health and addiction workforce development (see Appendix D for further information).
Werry Centre	The Werry Centre for Child and Adolescent Mental Health Workforce Development, one of the four national centres and programmes (see Appendix D for further information).

# References

- Ashton T, King D, McRae S. 2004. *Labour Market Constraints Affecting the Mental Health Sector: Report to the Mental Health Commission*. Auckland: Centre for Health Services Research and Policy, University of Auckland.
- DHBNZ (District Health Boards New Zealand). 2005. *Future Workforce 2005–2010 (draft July 2005)*. Wellington: DHBNZ.
- Faleafa M. 2004. *A Pacific Perspective on Child and Adolescent Mental Health Services Workforce Development Needs: Report from the first national fono*. Auckland: Werry Centre for Child and Adolescent Mental Health.
- Hatcher S, Mouly S, Rasquinha D, et al. 2005. *Improving Recruitment to the Mental Health Workforce in New Zealand*. Auckland: Mental Health Workforce Development Programme, Health Research Council.
- Health Funding Authority. 2000. *Tuutahitia te Wero—Meeting the Challenges: Mental health workforce development plan 2000–2005*. Christchurch: Health Funding Authority.
- Health Workforce Advisory Committee. 2005. *Fit for Purpose and for Practice: A review of the medical workforce in New Zealand: Consultation document*. Wellington: Health Workforce Advisory Group.
- Lester H, Tritter JQ, Sorohan H. 2005. Patients' and health professionals' views on primary care for people with serious mental illness: focus group study. *British Medical Journal* 330: 11-22; originally published online 20 Apr 2005. Accessed at <http://bmj.bmjournals.com/cgi/reprint/330/7500/1122>.
- Mason KH. 1988. *Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients*. Wellington: Government Print.
- Matua Raki. 2005. *Matua Raki: The Addiction Treatment Sector Workforce Development Programme Plan for 2005–15: Discussion document*. Christchurch: National Addiction Centre.
- Medical Council of New Zealand. 2004. *Annual Report*. Wellington: Medical Council of New Zealand.
- Mental Health Commission. 1998. *Blueprint for Better Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission.
- Mental Health Commission. 2005. *Service User Workforce Development Strategy*. Wellington: Mental Health Commission.
- Minister for Disability Issues. 2001. *The New Zealand Disability Strategy: Making a world of difference –Whakanui oranga*. Wellington: Ministry of Health.
- Minister of Health. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health.
- Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health.
- Minister of Health and Associate Minister of Health. 2002. *He Korowai Oranga: The Māori Health Strategy*. Wellington: Ministry of Health.

Minister of Health. 2005. *Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health.

Ministry of Health. 1994. *Looking Forward: Strategic directions for mental health services*. Wellington: Ministry of Health.

Ministry of Health. 1997a. *Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand*. Wellington: Ministry of Health.

Ministry of Health. 1997b. *Moving Forward: The National Mental Health Plan for More and Better Services*. Wellington: Ministry of Health.

Ministry of Health. 2001. *Nationwide Mental Health Service Framework*. Wellington: Ministry of Health.

Ministry of Health. 2002a. *Mental Health (Alcohol and Other Drugs) Workforce Development Framework*. Wellington: Ministry of Health.

Ministry of Health. 2002b. *Te Puāwaitanga Māori Mental Health National Strategic Framework*. Wellington: Ministry of Health.

Ministry of Health. 2002c. *The Health and Independence Report*. Wellington: Ministry of Health.

Ministry of Health. 2004. *Pacific Health and Disability Workforce Development Plan*. Wellington: Ministry of Health.

Ministry of Health. 2005a. *Improving Mental Health: A draft second national mental health and addiction plan 2005–2015: Analysis of submissions*. Wellington: Ministry of Health.

Ministry of Health. 2005b. *National Mental Health Information Strategy 2005–2010*. Wellington: Ministry of Health.

Ministry of Health. 2005c. *Rāranga Tupuake: Māori Health Workforce Development Plan: Discussion document*. Wellington: Ministry of Health.

Ministry of Social Development. 2005. *The Social Report*. Wellington: Ministry of Social Development.

New Zealand Health Information Service. 2004. *The New Zealand Workforce Statistics: Nurses and midwives*. Wellington: Ministry of Health.

New Zealand Institute of Economic Research. 2004. *Ageing New Zealand and Health and Disability Services: Demand projections and workforce implications, 2001–2021: A discussion document*. Wellington: Ministry of Health.

Sainsbury Centre for Mental Health. 2003. *A Mental Health Workforce for the Future: A planner's guide*. London: Sainsbury Centre for Mental Health.

Tassell NA. 2004. *Workforce Profile II: An extended analysis of the mental health workforce*. Palmerston North: Te Rau Matatini.

Te Rau Matatini. 2005. *Kia Puāwai Te Ararau: Māori Mental Health Workforce Development Strategic Plan*. Palmerston North: Te Rau Matatini.

Tertiary Education Commission. 2004. *Qualifications Supply Analysis: The New Zealand health sector*. Wellington: Tertiary Education Commission.