PSA

Submission on the draft Mental Health and Addictions Workforce Action Plan 2016 – 2020

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For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

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Introduction

Who we are

The New Zealand Public Service Association : Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand, representing 62,000 members who are taxpayers and users of the health system. We are a democratic organisation with members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities, state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

We have a large membership in both DHB and NGO mental health and addictions services

Of these members, around 17,000 work for DHBs as allied health, mental health and public health professionals and support workers, and as administration and clerical support. We also have around 6,000 members who work in community-based public services; they provide home support to elderly and disabled people, mental health and drug and alcohol services, and residential disability support services. They are employed by not-for-profit and private providers who are funded through contracts to DHBs and, in some cases, directly by the Ministry of Health.

We are the largest union in mental health, with members working as mental health nurses, alcohol and drug clinicians and counsellors, psychiatric assistants, occupational therapists, social workers, psychologists, community-based care and support workers and clerical and administration workers. This provides us with a unique whole-of-service perspective, rather than a specifically occupational perspective.

The PSA has an historic connection to the mental health service. Our membership in the sector goes back to the days when mental health services were delivered directly by the Department of Health and the range of our membership has expanded since those days. We have been actively involved in advocating for better mental health services for many years, and in the 1990s were part of a movement that led to the Mason Report and the publication of the original *Blueprint for Mental Health Services in New Zealand*.

Through the New Zealand Council of Trade Unions : Te Kauae Kaimahi (the CTU), we work closely with other affiliated health sector unions on matters of common interest. We support the submissions of the CTU, NZNO and ASMS. We are an associate member of AHANZ, the peak body for allied health professional

associations, and maintain close links with organisations and consumer groups in mental health. We participate in the Health Sector Relationship Agreement (HSRA) and the National Bipartite Action Group (BAG), which are national health consultation forums.

In developing this submission we sought the views of our Mental Health Committee

In developing this submission we have consulted our Mental Health Committee which comprises members working in mental health services in DHBs and in the community. We also attended one of the stakeholder meetings.

Executive Summary

In principle, we support the need for a strategic, system-wide workforce action plan for mental health and addictions. However, we believe that there are a number of weaknesses in this draft which need to be addressed in the final document. It is vague, and lacks detail and an evidence-based understanding of the issues for mental health workers. We would be happy to talk with the Ministry about these comments.

We recommend that:

- The Ministry should meet mental health and addictions workers to hear directly about their daily experiences; the PSA offers to facilitate a meeting with members.

- The final Plan must realistically address funding issues and the impacts of continued underfunding in the sector. This is a major deficit in the draft Plan, which cannot succeed otherwise. It also fails to address the issues of underfunding of contracted providers, which impacts on both service quality and on continued low wages for workers. The Plan should pick up the recommendations of the Ministry's health strategy supporting reports that the contracting model needs to be revisited.

- It must also acknowledge the pressures of high and unrealistic workloads and inadequate resourcing, and engage with unions on the issues.

- Putting greater emphasis on primary and community based services is sensible, but this must not be at the expense of secondary services. The primary and community workforces must be adequately trained and equitably remunerated; and whanau / family / volunteer supporters must not be seen as substitutes for the paid workforce.

- The role of unions as worker representatives is missing; the Plan should say how unions will be meaningfully involved in workforce development and planning, including on things such as high-performing workplaces and productivity improvement.

- Ensuring robust health and safety policies for the workforce, in consultation with unions, should be part of the Plan (both for physical risk and mental health).

- The Plan emphasises 'strong leadership'; we agree that good leadership is needed, but this must be consultative and facilitative, and engage constructively with the workforce. The role of union delegates as workplace leaders should be acknowledged and supported as part of a distributed leadership approach across the sector.

- Another omission in the Plan is any substantive discussion of the important role of allied health in the mental health and addictions workforce; this should be addressed in the final Plan.

General comments on the Workforce Action Plan 2016 -2020

The Plan lacks detail and evidence

In principle, the PSA supports the need for a strategic, system-wide workforce action plan for mental health and addictions services, and we note its alignment to the draft New Zealand health strategy[1]. Unfortunately the introduction to the mental health and addictions workforce action plan (the Plan) replicates many of the deficits of the draft health strategy: while the general direction is sensible; the lack of detail, assumptions unsupported by either evidence or an understanding of what is actually happening in the sector, and vagueness about both implementation and funding are all worrying.

We regret the non-engagement with unions; and offer to facilitate a meeting with mental health and addictions workers so that the final Plan can be informed by their experience

We regret that the Ministry and its contractors chose not to engage with health sector unions, who represent the mental health and addictions workforce, in developing the draft Plan. As far as we know, we were not notified directly about the development of the draft or about the workshops to discuss it, nor were other unions we have spoken to. We hope that the Ministry will rectify this omission before the final Plan is agreed and we would be happy to facilitate a meeting with PSA members working in mental health and addiction. A recurrent comment from members who have seen the draft Plan is that it lacks connection with the reality of their daily experience as mental health workers, and lacks awareness of the real issues of high workloads, long working hours, stressful work, workforce shortages – and of low pay for many workers, and inadequate terms and conditions.

The workforce will need to grow to cope with the expected doubling in demand

Given the expectation that there will be a doubling in demand for mental health and addiction services by 2020, our members understand that services will need to adapt to meet this demand; however, the Plan does not acknowledge that the workforce will also need to grow to cope with the demand. Our members in both DHB and community based services already experience high workloads and are acutely aware of current needs that they cannot meet, let alone meeting future needs. The assumption seems to be that a shift to primary and community based care, alongside using existing resources more effectively, will somehow resolve the issues. We doubt this.

[1] The PSA's submission on the draft New Zealand Health Strategy can be accessed here: https://www.psa.org.nz/dmsdocument/76346

The absence of any acknowledgement of the lack of funding in the sector is of concern

The absence of any real analysis of funding needs and pressures for mental health and addiction services is very concerning; without doubt it is the elephant in the room – the issue which we are all aware of, but which is not discussed. The document does not acknowledge the removal of the ring-fence on mental health funding and the impact of this on services.

Services will continue to struggle under pressure

Our observation is that any additional money that has been allocated to mental health and addictions is tightly targeted to specific services and outcomes, and is not for alleviating pressure on overall services. The proposed social impact bond for improving mental health through supported employment is a prime example of this approach. If the bond proceeds, the likely outcome is a well-funded and well-resourced project dealing with a defined problem, while other services continue to struggle to deal with the general demand and pressures within shrinking funding and resource.

The caveat at the end of each list of actions under the priorities is illuminating:

> *All actions in the draft are tentative. They are subject to costing, Budget processes, and consumer and sector feedback. Actions in the final Action Plan may be subject to further prioritisation, costing and funding availability over the five year period.*

The Plan seems to be set up to fail: it acknowledges that the desired actions may not be funded

Essentially the Plan acknowledges that it may not be possible to deliver on the actions it says are needed, which begs the question of whether it is being set up to fail from the outset. We understand the need for some flexibility to respond to changed priorities over the life of the Plan, and the wish to respond to feedback on the draft Plan, but it seems clear that the Ministry does not expect that government will deal with the core issue of underfunding of mental health and addiction services.

The role of unions as worker representatives is absent; there must be meaningful engagement with unions if the Plan is to succeed

The role of trade unions as worker representatives is entirely missing from the Plan: unions work closely with their members to support good work outcomes for them, and to support them to deliver good outcomes for service users and the employer. Collaboration and coordination across sectors must include engagement with the workforce and their unions. Meaningful engagement and collaboration with the mental health and addictions workforce through their unions must be included as a priority. The Plan calls for innovative approaches, for continuous improvement in services, and for new models of care – all of which are part of high performing workplace approaches.

PSA believes that unions are central to high-performing workplaces, and we

A high performing workplace is one where our members can mobilise their knowledge to improve the efficiency and quality of services and embed positive and productive workplace relationships and practices with a view to creating sustainable services, sustainable jobs, and productive workplaces.

want to be part of productivity improvements

The PSA believes that high performance workplaces can be achieved through a culture of engagement and collaboration by direct, meaningful and regular engagement with the workforce on all matters over which the workforce directly influences performance. This is essential for sustained high performance and for achieving the productivity gains that employers (and PSA members) seek in a time of scarce resources. In the highly unionised health sector, the union is central to innovation and improving productivity and the PSA wants to be involved.

Strong leadership is needed; it must be broadly defined to include union delegates as workplace leaders

The Plan misses any focus on employment; it is about the workforce, but does not make the link between training and the availability of jobs once training is completed. Nor does it discuss the importance of having jobs that are fairly paid and satisfying. It is also largely silent on the importance of leadership and good management in the workplace (the draft New Zealand Health Strategy does address this to some extent) and on the role of leaders and managers in enabling and advocating for services and resources. Strong leadership is needed at all levels in the workplace, at the senior level and distributed throughout the organisation. PSA delegates have an important role as workforce leaders; they are trained to work with employers and members on getting good workplace and service outcomes. They are a resource for managers to work with to ensure good outcomes for the organisation and for service users.

The Ministry and senior leaders must talk with the workforce about their jobs

The Ministry of Health and health leaders must ensure that they have a good working knowledge of the mental health and addictions working environment, through talking with the workforce about their jobs and seeking their suggestions on how to do things better. This will inform good decision-making to provide the environment that will support better health outcomes for clients.

The Plan fails to address the issue of the underfunding of contracted services; and the impacts of this on the low-paid community based workforce

The Plan also misses any discussion of contracting to private and not-for-profit providers, who employ the community care workforce. As they struggle with their own deficits, DHBs have consistently underfunded contracted providers through mechanisms such as increasing service levels within the same (or decreased) funding or by dropping or lowering service requirements. Contracts are typically short-term, so there is no certainty of continued funding which makes it hard to retain workers and for employers to commit to training and workforce development. Wages in this sector are low, which also leads to high turnover and associated recruitment and training costs. Recent court cases, such as the in-between travel case and the Equal Pay Act case taken by aged residential care worker Kristine Bartlett, have highlighted the inadequate wages, training and other terms and conditions for community care workers and the need for government to act on improving wages and conditions.

Given the emphasis in the Plan on the role of the community care workforce, it is crucial that it is adequately funded, trained and supported to do the work. The Director General of Health commissioned two independent reports (on funding, and on capability and capacity) to support the draft New Zealand Health Strategy.

Both of these reports found that the current provider contracting model works against innovation and workforce development and recommended that there should be multi-year contracts to provide certainty and support forward planning – but the draft Health Strategy is silent on this, and so is the Plan.

Responses to the questions in the submission form

Q1: Does Part 1 of the Action Plan adequately describe the current and future state of the mental health and addictions workforce as part of an integrated health and disability system in the next five years?

The Plan acknowledges the major shifts that have taken place over the last two decades, and the move towards new models of care and different ways of working. However, it glosses over the challenges – particularly whether funding will be adequate to achieve the vision.

Training and career pathways must be developed to boost the Māori and Pacific workforce; there are also other areas of workforce need

The Plan notes the challenges of staff shortages and under-representation of Māori and Pacific health professionals, though the actions are generally vague (e.g. 'build capacity and capability'). Our members agree that Māori and Pacific mental health workers are under-represented and that training and career pathways must be developed; they also note increasing demand from migrants and refugees, where treatment and support often requires interpreters. Many refugees have experienced trauma and war in their home countries, and the workforce needs training to be able to assist their recovery. A member has also commented that in his DHB they are seeing some defence force staff returning from deployments with PTSD. Members also note increased demand for services from Asian and Chinese people, and see this as an insufficiently met workforce need. Their sense is that the system is not planning for future needs, but is only reacting. It needs to make use of data in a more sophisticated way, spotting trends and anticipating what will be needed. This is not just about analysing demographics; it needs a more holistic approach.

One member working in an NGO noted that in her region, there are very limited services for Pacific peoples but there are great needs among that community. She observes that Pacific peoples born in New Zealand can experience conflict between their two cultures, which leads to mental health service needs. For the Pacific mental health workforce, there can also be conflict about their career choice within the family – working in mental health can be seen as a stigma and is discouraged.

If whanau and families are to play a greater role, they must be adequately supported

The opportunities include the goal of providing 'care closer to home' in 'one team'. Is the meta-language here indicating that there is going to be a greater responsibility placed on families to care for their members who have mental health and addiction problems? If this is the case, then there needs to be adequate support systems in place for family members who to take on this responsibility and ready access to respite services for those times when the degree of risk or acuity is

more than can reasonably be expected to be coped with by family members. The Plan seems to assume that the family and whanau are actually part of the workforce for these purposes. They are not workers, and should not be seen as such. They are crucially important for support and recovery, and must be fully involved and supported; but must not be seen as a no-cost substitute for professional mental health workers in an over-stretched health system.

There is a place for telehealth; but it is not a substitute for face-to-face contact and therapies. Some groups may not have access to telehealth

The Plan sees the use of telehealth as a way forward; we agree up to a point, but urge caution in seeing telehealth as the answer to overstretched resources. It is a tool that can be effective in certain situations, but will not work in others. Mental health and addictions work is very much based on face-to-face contact (especially the Te Ao Māori perspective), and on talking therapies. Teleheath should not be seen as the replacement. We also point out that self-management via telehealth approaches requires both good health literacy and computer literacy, as well as access to computers and devices. Many people, particularly those on benefits or on low wages or who are older, will not have either the literacy or the access and they must not miss out.

A more integrated system, and one using telehealth and electronic approaches, will require more sharing of service users' information across agencies. Protecting privacy and ensuring that information is kept confidential is particularly important in mental health and addictions because of the stigma and attitudes in the wider community.

Thinking about health and safety – both physical risk and the mental health of the workforce – is a major omission in the Plan.

Ensuring and protecting the health and safety of the workforce is absent from the Plan, and we see this as a major omission. Our members often work in extremely difficult situations with highly stressed and unwell people who can be violent and unpredictable. They are trained to manage and de-escalate difficult situations, but we would like to see more emphasis in the Plan on keeping the mental health and addictions workforce (and patients and service users) safe and well. Health and safety is not just about managing physical risk; the mental health of the workforce must also be supported by the employer through active and comprehensive health and safety policies that involve workers, through their union, in their development and application. The Plan sees a greater role for whanau / family / volunteers in supporting people with mental illness in their communities, and in principle we support this. But their health and safety must also be ensured as part of a comprehensive approach in the sector.

Part 2
Priority One – Workforce development in primary health and community care

The focus on primary health care must be adequately

The make-up and capability of the primary health level workforce who provide interventions given to people who have mental health and addiction problems needs to be clarified, so that the workforce development needs of these particular

supported with training

people can be better understood – and also that the people working at the primary level front line need to be provided with appropriate training and development in order to ensure that the care they provide is robust and sufficient to meet the needs of this client group at the primary health level.

There are wider issues to consider in relation to what constitutes appropriate primary health level care for people who have mental health and addiction problems, because mental health and addiction problems do not exist in isolation from other general health issues. Specifically, the impact of the metabolic syndrome (which has been widely reported in the literature) and the training and ability of primary level practitioners to (i) screen and identify the issues in relation to the metabolic syndrome, and (ii) to provide appropriate intervention at the primary health level to minimise the impact in relation to the metabolic syndrome.

The primary and secondary workforces must have equitable remuneration

At the moment the primary and secondary workforces are remunerated very differently, however the degree of undergraduate education required to work in both sectors is equivalent – and the quality of work achieved in relation to the health care of people with mental health and addiction problems is equivalent across both sectors. Therefore, remuneration for occupational classes across primary and secondary level should be the same. There are also considerable gaps between the wages paid by DHBs and NGOs for some occupations in mental health and addictions. This is a fairness and equity matter and it is also about recruitment and retention. Workers who feel undervalued and overstretched leave their jobs for higher paid work, which adds to costs for the employer and problems for co-workers having to manage vacancies. Having a stable and adequately remunerated workforce supports better workforce, employer and service user outcomes.

Members working in community based care say that their role can be very wide – for example, providing transport, being an administrator, doing social work, in addition to the core community support worker role. They do this because the employer expects them to cover roles beyond their main scope, which makes it hard to provide the quality of care.

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

The practice nurse credentialing project is an example of innovation and good practice

The Plan asks for examples of innovations and good practice. The practice nurse mental health credentialing project (developed in collaboration with the New Zealand College of Mental Health Nurses) which was started in Northland a few years ago needs to be rolled out throughout the country. By giving practice nurses more education and experience in working with people who have stable enduring and low-risk mental health problems will enhance the overall capacity of that sector to deal with these particular service users, and so secondary mental health services are not being overburdened by inappropriate referrals back to secondary

level services for intervention which can be appropriately provided at the primary level.

The Plan has a focus on prevention and early intervention and a stepped care approach. There is scope here for the development of a 'community of practice' model approach whereby regular trans-agency training and networking can facilitate shared-care models with the service user at the centre of development and delivery of wraparound care.

Both primary and secondary services must be in place and in balance so that so that clients get the levels of service they need

The Plan places considerable emphasis on providing for early intervention and community support so that there is less need for acute inpatient services. For this to be effective, the upstream services need to be in place and reducing the flow of people into acute and inpatient services before those services are reconfigured and the resources reallocated. And in the other direction, the primary and community based services also need to be in place to fully support recovery approaches after secondary care. Members observe that there are real capability and capacity issues for primary health organisations: GPs and practice nurses need upskilling in mental health issues and community health coordination services are required to help clients navigate and access the services they need. Primary care liaison nurses and allied health workers are needed in primary health care settings.

A member who is a community mental health nurse working in secondary care has concerns about the affordability of primary care and the unintended consequences for both the person and for secondary care:

Primary care must be accessible and affordable; if not, there are impacts on both the person and on the demand for secondary care

The provision of secondary mental health care has been restricted over the years and certainly more recently we are seeing people with significant mental health issues and those with less severe problems are being directed into the primary health sector. What we're seeing at the moment is a number of people who cannot afford to access primary mental health care and so are being deprived of early intervention when signs and symptoms are less severe and as a consequence the personal suffering and the degree of intervention required to alleviate this mounts up before they meet the entry threshold for secondary mental health care. The degree of fragmentation of the sector at the moment means that people who cannot afford to pay in some areas have a certain degree of access to free services – such as under the care plus scheme which is provided by some PHOs, but in other areas these schemes are not present and so free mental health care for those who cannot afford to pay is not being provided.

Acuity levels are increasing; so is complexity and co-morbidity.

PSA members report that acuity levels are increasing, as well as the demand for acute services. They see more complexity and co-morbidity, with the intersection of drug and alcohol addictions, mental health conditions and domestic violence. Other social and economic factors also contribute to stress and unwellness: unemployment, low pay and associated financial hardship, inadequate housing, family issues. They also note more people coming from the criminal justice system

Social and economic factors contribute to stress and unwellness

into the mental health system. The Plan acknowledges the need for the health system to work more closely with other sectors, and we welcome this, but have reservations about the sectoral leadership, capability and capacity needed to lead the necessary changes in practice in what is still a highly fragmented environment.

Considerable pressures remain in Cantrerbury

Our Christchurch members say that post-earthquake mental health needs are still emerging – and still remain – five years on, putting considerable pressure on their services, particularly for children and young people. Canterbury DHB highlighted the crisis in their mental health services in early 2015[2] and more recently early this year.[3] Yet the Plan has no action that will support the particular needs of the Canterbury mental health and addictions workforce, or its clients.

Priority Three – Specialist workforce capability and training pathways

The Plan needs more detail and thinking about the role of allied health

One area that we would like to see more fully developed in the Plan is the role of allied health professionals in the mental health and addictions workforce. Occupational therapists and social workers in particular are very much part of the multi-disciplinary recovery approach, providing the motivation and support alongside the clinical team. There is brief reference to allied health in the actions under this priority but we would like to see more focus on this.

Our members have commented on the need to strike the right balance so that services for people with enduring and stable mental illness are not provided at the expense of specialist services needed for people with acute and high-risk mental health conditions.

Priority Four – Addiction treatment and recovery training pathways

There is increasing complexity in addictions services; and work is needed to analyse drug trends to inform workforce planning

Our members working in addiction services note increasing complexity in their work, particularly around co-morbidities. Synthetic cannabis use is an issue, as is increased violence. They want to see more work done to analyse drug trends, which should then feed into workforce development and planning.

[2] http://www.stuff.co.nz/the-press/67799698/health-board-seeks-crisis-meeting
[3] http://www.stuff.co.nz/the-press/news/75161125/governments-dogged-determination-to-deny-mental-health-problem-in-canterbury