Feedback from PSA Members working in Mental Health and Addiction on 'He Ara Oranga' Recommendations

Contents

Executive Summary

The PSA were invited by the Ministry of Health to gather feedback from PSA members working in mental health and addiction services on the Report of the Government Inquiry into Mental Health and Addiction, with a focus on the recommendations outlined in the report.

This feedback details the response to the recommendations outlined in the Mental Health and Addiction Inquiry report to the Government.

The content outlined was collected through 5 regional forums held across the country attended by over 60 individuals, over 95 members contributing to a Facebook discussion group, and 62 people filling out a comprehensive online survey. The focus of all modes of data collection was on the recommendations outlined in He Ara Oranga (see methodology, page 5).

Responses include prioritising of recommendations outlined in He Ara Oranga, identification of challenges that may hinder implication of recommendations, positives to be commended, and suggestions for the ideal implementation of recommendations. In addition, other key issues were identified that participants feel were not adequately addressed in He Ara Oranga.

Members do believe that the report presents an opportunity for long-overdue improvements to the system, although there is concern that implementation won't eventuate.

Overall, participants indicated mixed views to the recommendations. Some recommendations were considered to be of higher or lower priority than others, sometimes with a consensus and sometimes with a combination of priority levels being assigned.

Participants expressed concerns that some of the key messages in the report were not reflected in the recommendations, with specific concerns pertaining to shortcomings in addressing workforce challenges and limitations, with many participants expressing concern as to where the workforce to service the top 20% of those in need will come from considering the struggles to reach even 3%. Other concerns included fragmentation of current services, low staffing recruitment and retention levels, limited funding, and over-politicisation of mental health and addiction services and related matters.

Participants also emphasised the need to prioritise different recommendations, noting that "by acting on some recommendations directly, other recommendations will reap secondary or flow-on benefits."

The 10 key issues that need more attention

As part of the translation of the Mental Health and Addiction Inquiry into action, PSA Members working in Mental Health and Addiction want to see more focus on the issues listed here.
We have used the term tāngata whaiora to refer to people experiencing mental illness. A translation of this is a person on the journey to wellness.

- Address workforce issues
    - Address workforce shortages
    - Ensure safe staffing
    - Improve training and specialisation
- Emphasis on education
    - Improve awareness of services and pathways available to tāngata whaiora

    - Introduce education programmes regarding MH&A and suicide in school
    - Improve public awareness
    - Encourage open dialogue/national awareness of realities of MH&A
    - Reduce stigma associated with MH&A struggles and stigma associated with "speaking out"
- Defragmentation of services and agencies
    - Integrate services
    - Improve process of transitioning between different services
    - Promote awareness and understanding of pathways in primary health care providers, to best advise tāngata whaiora of their options
- Fostering support in the home and community
    - Develop (new and existing) community-based services
    - Promote and encourage peer support
    - Promote inclusion of family and whānau
    - Provide support for families of tāngata whaiora
- Alternative treatments
    - Place emphasis on offering variety of alternative therapies
    - Emphasise alternatives to medication
    - Recognise no "one-size-fits-all" model
- Recognise and reflect demographic and cultural diversity
    - Have services available that can cater to varying needs of individuals, for example different services and models for youth compared to elderly
    - Aim to have workforce matching demographics of population
- Energise Te Tiriti o Waitangi
    - Develop Māori for Māori solutions
- Consider consumer voice
    - Ensure people with lived experiences in mental health services are a strong component of mental health commission (or any other governing bodies)
- Develop cross-party support for the reforms
    - Promote transparency
    - Avoid risk of a change of government halting or reversing progress
- Improve resourcing
    - Increase availability of resources and facilities
    - Maximise efficiency of resource allocation

Order of priority

In addition to identifying regular themes in feedback, participants were also asked to indicate the level of priority each recommendation should be given. The priority assigned to the recommendations is as follows (from highest priority to lowest priority):

- Expand access and choice
- Establish a new mental health commission
- Take strong action on alcohol and drugs
- Prevent suicide
- Place people at the centre
- Enhance wellbeing promotion and prevention
- Transform primary health care
- Wider issues and collective commitment
- Strengthen the NGO sector
- Reform the MHA

Introduction

The PSA is the largest trade union in New Zealand and the largest trade union for mental health workers, with a long history of advocating for better mental health and addiction services.

Currently mental health and addiction services are in a crisis. This has occurred with the confluence of three elements: an increased demand for mental health and addiction services; a significant shift in the delivery of mental health treatment away from institutionalization without resources following; and a funding shortfall in health generally and mental health specifically.

The PSA has canvassed members who work in mental health and addiction services, led by the Mental Health and Addiction Committee, about whether they think the recommendations outlined in the Inquiry Report to the Government will make a desirable difference to these services. We also asked for suggestions on what implementation of the recommendations could look like.

Purpose of feedback

In the lead up to the general election the PSA campaigned strongly for a mental health and addiction inquiry. Following the success of this campaign, the PSA and PSA Youth network (PSAY) both prepared submissions to the inquiry panel, and we participated in national and regional meetings with the inquiry panel.

The Mental Health and Addiction Committee of the PSA submitted that the problems in service delivery of mental health and addiction services (and the consequences of these failings) are well traversed. We have focused on solutions – what would improve services, and, where possible, examples of these approaches.

The purpose of this feedback is to acknowledge that the work conducted in the inquiry will have revealed the problems and considered these in preparation of the recommendations. Thus this document is instead designed to focus on solutions.

In this round of engagement with members the focus was to gather feedback on the recommendations outlined in the report and whether they should or should not be implemented, the key challenges likely to be encountered in implementation, and whether or not the recommendations will create the desired changes in the landscape and effectiveness of mental health and addiction services in New Zealand.

Mental health services and the PSA

The PSA has an historic connection to mental health services. 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 and addiction 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.

Feedback to He Ara Oranga recommendations was gathered from members working in mental health in a wide range of settings, including DHBs and core public services. Roles represented include: Nurses, social workers, navigators, case managers, consumer evaluators, support workers,

therapists, taiohi ora wellness leaders, psychiatric assistants, kaihaumanu, peer support specialists, addiction practitioners, probation officers, AOD clinician, nurse educators, amokaiora matua, family therapists, diversional therapists, dual diagnosis clinicians, youth substance abuse counselors, recovery facilitators, clinical psychologists, corrections officers, programme facilitators, intervention coordinators, residential managers, administrators, health and safety advisors. The depth of experience is reflected in the range of time PSA members have worked in mental health: from four months to 47 years.

Over 200 members contributed to this feedback, and their responses were comprehensive.

Methodology

Data was collected via a combination of modes. Regional forums were held across the country in Auckland, Hamilton, Wellington, Nelson, and Christchurch, inviting PSA members working in mental health and addiction services to discuss and reflect on the recommendations.

A survey was also sent to PSA members working in mental health and addiction services, offering members the chance to response directly to each individual recommendation.

Finally a Facebook group was created to promote discussion, with a group membership 95 PSA members working in mental health and addiction services.

Recommendations were “posted” on a regular basis, inviting discussion between members.

Feedback sought focused on the recommendations outlined in He Ara Oranga, the priority of each recommendation, implementation (whether it should or shouldn’t be, and what implementation could look like), positives of the recommendation, and challenges or concerns (including barriers to implementation).

Summary of Findings

Findings were gathered in relation to specific recommendations and/or categories of recommendations in He Ara Oranga.

Findings will be presented first by addressing the challenges and recommendations of the key issues identified, followed by a prioritised assessment of the recommendations set out in He Ara Oranga.

NOTE: Quotes from members are *italicised* and in **bold** throughout this document.

Main themes emerging from feedback

The following table outlines the main themes identified in feedback, along with suggestions for overcoming barriers and links to relevant he Ara Oranga recommendations influenced by themes identified, with reference to recommendations where relevant.

Main Theme	Challenges and Concerns	PSA Member Recommendations	He Ara Oranga Recommendations

Address workforce issues
• Address workforce shortages
• Ensure safe staffing
• Improve training and specialisation
	• A theme that emerged **across all recommendations** is the concern that we currently have a workforce shortage
	• Low recruitment and retention coupled with staff burnout and concerns for staff safety were reported regularly
	
	"There aren't enough mental health workers to provide the services that communities and whānau currently seek and need, and this demand is expected to grow with increasing population growth and disaffected individuals and communities."
	
	• Further criticism emerged regarding the current state of training for working in MH&A services, for example limited mental health training for trainee nurses
	• Lack of opportunities to upskill
		• Increase funding
		• Incentivise careers in MH&A
		  ○ Improve conditions
		  ○ Improve pay
		  ○ Improve training
		• Include frontline staff in every step of mental health and addiction service decision making
		
		"We are overworked and need more support in the frontline. Our caseloads are unmanageable at times. We typically find ourselves doing so much admin work. More support workers are needed so that Practitioners have more time for one-on-one interactions."
		
		• Give more emphasis to mental health and addiction training for nurses
			• Expand access and choice
			• Enhance wellbeing, promotion and prevention
			• Place people at the centre
			• Prevent suicide
			• Reform the MHA
			• Establish a new MHWC
			• Wider issues and collective commitment
			• Strengthen the NGO sector

	• Lack of ability/opportunities to specialise (for example in non-traditional treatments) • Recruiting non-specialised nurses for MH&A roles • Lack of an adequate workforce impairs staff safety ***"Training needs to include trauma-informed care in Year 1 - not as an add-on."***	***"We need more intensive nursing undergraduate training - as even if the nurses don't choose to work in Mental Health, they will be working potentially with at risk clients in other settings."*** ***"As a point of focus, comprehensive Mental Health training could be factored into curriculums at tertiary level and for across MHA."*** • Improve GP training in identifying mental health risks *and* options for treatment • Consider evidence-based use of or alternatives to seclusion, to best balance the safety and rights of staff and patients • Strive for better staffing levels to accommodate services, resulting in improved client/staff health and safety ***"It's just not realistic to expect GPs to deal with exacerbation of mental illness past a certain stage."***	
Emphasis on education • Improve awareness of services and pathways available to tāngata whaiora • Introduce education programmes regarding MH&A and suicide in school • Improve public awareness • Encourage open dialogue/national awareness of realities of MH&A • Reduce stigma associated with MH&A struggles and stigma associated with "speaking out"	• In addition to improving training of MH&A service providers, a strong emphasis was placed on introducing more education about MH&A (and suicide) to schools at primary and secondary levels, and also as community programmes • A need for increased awareness of services available and treatment options may encourage more to seek help • Teaching resilience young as lack of resilience was noted in many patients • Teaching people to support one another and/or to identify problems in community and/or family environments ***"Education for families is vital to help them understand the role they play in caring for members in need."***	• Introduce mental health and addiction education to primary and secondary schools • Promote mental health and addiction awareness in public • Promote education for new parents, especially regarding the importance of attachment in infancy • Introduce resilience teaching to schools ***"In most of my case load, clients have little or no resilience. They believe they must have everything by 21 years old. I believe social media, TV, and movies have influenced this over time. We need to be changing this message people are seeing everywhere."***	• Expand access and choice • Transform PHC • Enhance wellbeing, promotion and prevention • Place people at the centre • Take strong action on alcohol and drugs • Prevent suicide • Wider issues and collective commitment • Reform the MHA
Defragmentation of services and agencies • Integrate services	• Services are fragmented with minimal communication between agencies	• Standardise access to experienced or trained staff in mental health at medical centres	• Access and choice • Put people at the centre

• Improve process of transitioning between different services • Promote awareness and understanding of pathways in primary health care providers, to best advise tāngata whaiora of their options	• Lack of standardisation in mental health services leads to repetition of questions at different services ***"I've had clients who are emotionally drained and no longer wishing to get help, after having to repeat the same background information to upwards of four specialists. Making vulnerable people forcibly revisit traumatic experiences while we decide a place for them seems cruel, and I've seen patients drop out of the system for this reason alone. Why aren't our records being shared, to save this experience?"*** • Lack of communication and integration between services hinders patient ability to continue to access help in case of moving ***"Lack of integration in services means transient people are unable to be followed up for treatment and lost to services."***	• Introduce a checklist of questions to be standardised across NZ and services to eliminate repetition of questions at each service • Have mental health clinicians working in GP practices to improve primary access to counsellors and psychologists • Creating specialist teams with strong communication may prevent loss of knowledge ***"Improve the link between DHBs, NGOs, GPs, and other agencies and/or services providers, have standardised systems, and introduce across-the-board records to ensure nobody gets lost in the cracks in the system."*** • Introduce an across-the-board system that will help gather more accurate statistics and other information about mental health in New Zealand ***"The problem now is that agencies (Govt, NGOs) compartmentalise based on contractual agreements - leading to waitlists, people becoming more unwell and more distressed family/ whānau."***	• Transform PHC • Strengthen the NGO sector • Establish MHWC • Enhance wellbeing, promotion and prevention • Wider issues and collective commitment • Strengthen the NGO sector
Fostering support in the home and community • Develop community-based services • Promote and encourage peer support • Promote inclusion of family and whānau • Provide support for families of tāngata whaiora	• It's not uncommon for family and friends of tāngata whaiora to experience stress and other issues as a result of supporting their loved ones • We need to be supporting family and whānau with evidence-based care • Many victims of suicide have never utilised services for mental health and addiction, so there need to be more community based solutions to catch those outside the system. • Need to increase capability of our work force to support the families and clients of communities ***"There are so many of my clients who feel they need a place to go and feel part of a community and to be able to do things like art or music to keep them in a stable wellbeing place. More wellbeing centres are needed."***	• Introduce a wellness benefit to fund GP or other medical visits and prescription costs for high needs tāngata whaiora • Introduce a benefit to support family and/or peer carers of high need tāngata whaiora ***"Communities prevent suicide – including support people (not just family)."*** • Promote and encourage youth groups to talk about positive and negative emotions, with an emphasis on teaching youth to talk to people when they're in need. • Introduce community wellbeing centres • Hold community events using the different services throughout communities, involving people in the community. Use these events to promote community interaction, and to teach people about the support network options available	• Expand access and choice • Enhance wellbeing, promotion and prevention • Prevent suicide • Establish MHWC • Place people at the centre • Wider issues and collective commitment • Reform the MHA

	• Some may benefit from a whānau ora/brokering approach to assist families to navigate the systems	• Recognise the success of existing models and promote development and expansion of these, e.g. whānau ora	
Alternative treatments • Place emphasis on offering variety of alternative therapies • Emphasise alternatives to medication • Recognise no "one-size-fits-all" model	• An overreliance on medication means many tāngata whaiora may not be accessing more suitable solutions • Medication can be unhelpful and even counterintuitive to many • Lack of culturally aligned therapy options limits access for many and is a disincentive to getting help • We need to recognise that challenges experienced by different demographics can vary greatly • Offering a variety of treatments will increase likelihood of appealing to the individual needs to tāngata whaiora	• Introduce services to provide alternative therapies such as music therapy, art therapy, equine therapy, and others. • Introduce culturally aligned therapy options immediately ***"Emphasis on increased "talk therapies" severely limits alternative evidence based therapies available too, e.g. adventure therapy, music, art, equine, yoga, occupational, vocational, I feel that PSA represents numerous professions under Allied Health Collective our voice needs to be heard. There's no mention in He Ara Oranga of occupational therapy for example!"***	• Expand access and choice • Enhance wellbeing, promotion and prevention • Transform PHC • Place people at the centre
Recognise and reflect demographic and cultural diversity • Have services available that can cater to varying needs of individuals • Aim to have workforce matching demographics of population e.g. proportionate Māori care providers for Māori patients • Expand service access to all locations in New Zealand, specifically rural regions with limited service availability.	• Culturally aligned services need to be more widely available, and not considered token or niche • Have services available that can cater to varying needs of individuals, for example different services and models for youth compared to elderly • The demographics of service providers needs to match the demographics of consumers. • Currently, specific cultural services are limited and can take only a small number of clients ***"It's essential for a cultural transformation in mental health and addiction services in order to truly partner service users and whānau at every level."*** • It's vital that whether it be the MHWC or any other governing leadership body, that there are representatives of all demographics and cultures. • Hard-to-reach areas need to stop being "written off"	• Expand cultural services • Develop a budget to make "talk therapies" and other treatment more culturally aligned and more widely available • Expand service access to "hard-to-reach" areas such as rural regions. Ensure services are catered to the specific needs of each region. ***"We should consider a strong focus on flexible services to reach the socio-economically deprived population who are most at risk – empower the workforce to do what is necessary e.g. provide transport, food, housing."***	• Expand access and choice • Establish MHWC • Place people at the centre • Enhance wellbeing, promotion and prevention

Energise Te Tiriti o Waitangi • Develop Māori for Māori solutions	• Te Tiriti o Waitangi needs to be recognised and honoured, not treated as a token commitment ***"Why is there no commitment to the Articles of Te Tiriti o Waitangi in any of the recommendations?"*** • Commit to representing and supporting Māori at all levels of the Mental Health and Addiction system, including more Māori in management roles ***"We need more support specifically for Māori and specifically for Pacific Islanders – and more than that, we need to stop putting all non-Pakeha cultures in the same boat!"***	• Ensure the views of are Māori recorded and addressed • Ensure the future work force will meet the needs of Māori and whānau • Address and combat Māori overrepresentation in mental health services • Utilize Kaupapa Māori approaches in treatment ***"Sometimes it feels like the creation of separate Māori organisations is just to allow 'mainstream' organizations to wash their hands of responsibility."***	• Expand access and choice • Establish MHWC • Place people at the centre • Enhance wellbeing, promotion and prevention
Consider consumer voice • Ensure people with lived experiences in mental health services are strong component of mental health commission (or any other governing bodies)	• The consumer voice and the voice of lived experience needs to be consulted in all decision making • Consumer voice needs to be considered as relevant a stakeholder as NGOs, whānau participation, primary and secondary care representatives, and cultural advisors • Consumers don't always feel practitioners adequately understand what the consumer is saying, yet practitioners are regularly used in lieu of a consumer voice ***"Experience <u>with</u> consumers is different to the experience <u>of</u> consumers."*** • Appealing to consumer voice and providing consumers greater choice in turn gives consumers a greater sense of ownership and empowerment	• Include consumer voice and lived experience in decision making • Include members with lived experience in establishment of the MHWC or any other governing bodies • Remember that the voice of a practitioner speaking on behalf of consumers may vary from the voice of consumers themselves • Utilise consumers with lived experience who want to help other tāngata whaiora ***"Consumers are an untapped workforce. Partner with peer support, volunteers, etc – so clinicians can focus on the clinical work."***	• Place people at the centre • Enhance wellbeing, promotion and prevention • Establish MHWC
Promote cross-party support for reforms • Promote transparency	• Many participants expressed concern that a change of government could halt or even reverse any progress made by the current government • Participants also expressed concern that politicising of mental health and addiction services hinders	• Ensure sustainable, long-term funding for NGOs and remote competitive tender process. • Implement pay structure for NGO staff comparative to DHB scales • Include cross party and cross sector leadership	• Establish MHWC • Take strong action on alcohol and drugs • Strengthen the NGO sector

• Avoid risk of a change of government halting or reversing progress	frontline efforts as time and resources are consumed by higher level management. ***"We know that not all parties hold mental health with as much importance. We need security that a change of government – whether soon or later – doesn't undo all this work."***	• Recognise the danger of commercial and corporate influence on health decisions, for example by reducing the voice of commercial interest in decisions around alcohol and drugs. These are health problems, not commercial opportunities. • Remove political bias to decentralise the process and avoid political influence.	
Improve resourcing • Increase availability of resources and facilities • Maximise efficiency of resource allocation	• Participants noted the regularity with which facilities are closed or resources are reduced. ***"Smaller facilities are regularly closing as they become uneconomic. We are literally assigning a value to the wellbeing of our people – and not a high one. Every time a facility is closed, it is telling all those on the waitlist that their wellbeing isn't valuable enough. Obviously, this only makes them feel worse."*** • Resources need to be recognised for their true value rather than their dollar value. For example, the follow on benefits of resources include staff safety and wellbeing, in turn improving staff retention. ***"Already thinly spread resources are becoming so thinly spread that staff leave and the services become more broken than currently."*** • Optimise allocation of resources to avoid a "top heavy focus" of more management and less front-line spending	• Introduce more detox and rehabilitation units with quicker access and reduced waiting times ***"We need a facility available in the North Island for people to go who have been placed under the Drug and Alcohol Act. There is currently only one, a 9 bed facility in Christchurch."*** • Improve funding and efficiency of operations to prevent closing facilities ***"Smaller residential facilities are closing as they become uneconomic and choice is actually reducing to the point where we will only have the major retirement village providers left and they do not always provide a good fit for individuals with MH problems."*** • Introduce day services and community services with adequate staffing and resources • Build on the success of pilots and other trials for mental health and addiction services, such as the "Youth On Top Shop"	• Expand access and choice • Prevent suicide • Reform the MHA

Prioritising Recommendations by Category

The following table elucidates on the priorities assigned to the recommendations outlined in He Ara Oranga, as well outlining the positives of each category of recommendations, challenges for implementation, and linking these to the themes previously outlined.

Recommendations (In order of priority)	Positives	Key Challenges	Regular themes
1) Expand access and choice Why? • Need to expand choices as "one size doesn't fit all" e.g. alternative therapies • Current access and choice are limited • Many people in distress turned away from services due to limited resources • Lacking culturally diverse treatment options	• Greater access and choice will improve wellbeing • Expanding treatment variety will cater to diverse needs • Potential to redefine "mental health" • "A cornerstone for all recommendations" ***"Current access is long, costly, often causes more distress. By the time people are seen they have often got worse or have given up."***	• Current workforce cannot handle current demand • Staff burnout • Low staff recruitment and retention • Where is money going to come from to fund? • Cost • Concern about increased fragmentation between already "silo-ed" systems	• Workforce issues • Workforce training • Resources • Education • Cultural diversity • Alternative treatments
2) Establish a new mental health commission Why? • Could remove political bias dominating all decisions in MH&A • MHC could be a body to oversee all other recommendations • Could offer transparency to the public, improving public faith in MH&A services	• Provides oversight for the sector • Will encourage/mandate quality services • Covers multiple recommendations	• Concern this could morph into another agency lacking any real influence • Concern that more clinicians will leave services to work in commission • Needs to incorporate **all relevant stakeholders** • Risk of overarching activities not reaching the "coal face" • Need to ensure a balance of disciplines and demographics in commission ***"Attention to different ideologies operating in mental health has previously been poor. Need to get this right otherwise whatever is agreed for***	• Cultural diversity • Cross-party support • Family support • Demographic diversity

		change will 'default' into the medical model dominating, as has always been the case."	
3) Take strong action on alcohol and drugs Why? • Effects a large number of New Zealanders every day, both directly and secondarily • Treating A&D as health problems can help MHA services better respond • A&D issues are filling MH wards • Strong correlation between A&D and MH risks	• Focusing on the drivers of A&D problems is vital • Supporting justice clients with A&D background will reduce risk of reoffending • Improving education at an early age will raise awareness through life of the dangers of A&D	• Decriminalisation of cannabis is a potential time bomb, with evidence overseas finding increase in road deaths and teenage use • Desperately need more facilities ***"The Alcohol and Drug Act fails in the area between assessment and placement of the person under the act into <u>the one available facility if that facility is at full capacity</u>."*** • Commercial interest have too much voice in implementing A&D reform	• Education • Cultural diversity • Cross-party support
4) Prevent suicide Why? • Current statistics show this is a pressing issue, despite years of attempts to stem suicide rates • Suicide causes ongoing ripple effects, such as enduring intergenerational and extensive social/community harm • Need to focus on the at risk demographics	• Addressing the issue openly may help reduce suicide – instead of our current method of pretending it isn't happening • Increasing resources will save laves	• Suicide needs to stop being seen as a "dirty little secret" and instead be addressed as a major –and widespread – social issue • The need for education about suicide in school is reliant on fixing our current school system • All staff in MHA need intensive suicide prevention training • The role of socioeconomic drivers in suicide needs to be taken into consideration – and this is much harder to fix	• Education • Resources • Family support • Community support • Resources • Workforce
5) Place people at the centre Why? • The consumer voice needs to be valued more and less of a "token" input • Consumer voice and lived experience should be involved in the day-to-day decisions • People are the audience, so of course they should be the centre	• The system needs to meet the diverse needs of everyone – it can't do that without hearing from them • Could help supporting entire families, and avoid burnout • Could offer support to family systems • More cultural diversity in what's on offer can help a wider clientele ***"It's absolutely essential for culture transformation to truly partner with service users and whānau at every level."***	• We can often expect too much of families and whānau • We need to implement new thinking, not just tweak the status quo • Doesn't include how we can change/improve the system to be more person focused • Concern this will be an excuse to spend less on increasing facilities and workforce	• Consumer voice • Community support • Education • Family support • Workforce issues • Cultural diversity

• Need to offer more cultural diversity in options ***"Consumers are an untapped workforce - partner with peer support, volunteers, etc, so clinicians can focus on the clinical work."***			
6) Enhance wellbeing, promotion and prevention Why? • Prevention is key • Education via promotion is vital • Promotion could help change the stigma around MHA ***"A lot of younger people are coming into services with little to no resilience. The general population and the views of mental health come from the news or social media/TV - these views are either negative or misinterpreted. The only current education widely available is negative and stigmatising"*** • Whole-of-government approach key to wellbeing • Has all lacked funding for many years	• Promotion could help address lack of resilience • Effective implementation will reduce demand on acute services • Promotion could encourage a public discussion, changing the messages dominating and encouraging stigma in MHA ***"Overall - if children, adults, parents co-workers are being educated and supported, everyone is being validated, knows what to do and can get support"***	• Will require finally addressing our out-of-date education system • Will need to address the many socioeconomic drivers of inequality – and there are too many to count ***"Prevention and resilience building probably sits in education <u>and</u> primary health sphere - it will need to be adequately funded and staffed, and each area may need unique programmes/packages to suit population needs - this could become unwieldy and a money pit."***	• Education • Workforce issues • Fragmentation of system • Cultural diversity • Alternative treatments • Community support • Family support
7) Transform primary health care Why? • Is point of access for most people • Early intervention fundamental in MH treatment • Link between physical health and mental health often underrated ***"Investing well in primary care reduces the need for more costly interventions at tertiary and secondary specialist services."***	• Improving PHC may catch more suicide risk • Many suicide victims aren't in MH system • Could improve access • Potential to prevent crisis situations with early intervention • Transient people could be tracked across country/services	• Need standardisation of access – all MH&A staff at all MH&A centres need standard checklist to establish needs • Cost of GPs • Lack of awareness of what PHC encompasses • Funding and resources	• Workforce limitations • Funding • Improve training • Fragmented system

8) Wider issues and collective commitment Why? • Wellbeing starts at birth – if we adequately help people early on, fewer MH&A difficulties down the line • Could help overcome fragmentation of services	• Could promote/improve communication between various MH&A agencies • Relatively low cost intervention compared to inpatient admissions • Existence of leadership/watchdog role will keep governments "honest" • Reduced referrals to more expensive services	• Need to increase resourcing • Potential for the reallocation of funding within PHOs rather than additional staff funding	• Education • Community support • Fragmented system
9) Strengthen the NGO sector Why? • To take pressure off other services • NGO provision has been steadily reducing over the years ***"There has been a steady reduction in NGO provision over the years and they can provide really important services that can be more helpful than secondary MH services."*** • Increasing access will require improved services at all levels/sectors • NGO sector charged with delivering some vital MHA services	• Brings a recovery focus • Could enhance staff retention with support and training in place • Will shorten waiting lists • Will resolve crisis situations sooner	• MH&A overly politicised subject • NGOs not given the resources to support clients to benefit health and wellbeing • NGOs need to be more accountable • Strengthening of GP practices to offer the roles NGOs provide may be a better option to reduce fragmentation	• Cross-party support • Workforce issues • Education • Fragmented system
10) Reform the MHA Why? • Human rights are being violated • A number of people are involved in this both in acute and long term processes *Note: Participants demonstrated a wide variety of experiences with the MHA, with some feeling the current Act needs no change, and others indicating it needing an immediate reform.*	• Awareness of potential risk human rights violations occurring	• The problem is with community and inpatient services being inadequately resourced to safely manage demand • Some participants feel the current Act positively balances rights with risk/safety	• Resources • Workforce • Education

Workforce issues

In addition to the categories of recommendations set out in He Ara Oranga, participants were also presented with a category entitled “Do you think the recommendations outlined in He Ara Oranga adequately address workforce issues?”

While this category was left out of the table of priorities, participants strongly indicated that the recommendations do not adequately address workforce issues (such as shortages and low staff recruitment and retention rates), and that this category is one of the highest priorities to be addressed.

Conclusion

The vision of mental health and addiction services proposed in He Ara Oranga will require significant investment in expanding and upskilling the workforce, as well as a significant change to the public messaging around mental health and addiction.

Having addressed the categories of recommendations and identified a multitude of themes requiring attention and improvement, it is evident that addressing workforce issues is critical now.

There is an immediate workforce crisis and the transformation proposed in He Ara Oranga will only be possible with a future focused on workforce strategy.

As the primary union for mental health, the PSA will continue to participate in the process of ensuring mental health and addiction services met the needs of the people of New Zealand Aotearoa.

What is the takeaway?
What's our deliverable?

Is there any ongoing dialogue with the Director General promoting us as the go to group for the workers voice.

Some of it is a new direction from the Inquiry report recommendations. Will be challenge for them to move on from that. They're going to need extra support and sort of put it out there where theres support.

Appendix A

PSA Mental Health Committee

The Mental Health Committee of the PSA includes mental health workers from the community, from District Health Boards and from other government departments who have mental health workers in their workforce. Between them the committee has over 200 years' experience working in the field. A number of committee members also have lived experience of mental health and addiction challenges, either personally or within their whanau.

Andy Colwell – co-convener

Andy has worked in the mental health sector for 18 years as a qualified and registered social worker. He has extensive experience and knowledge working in the community as an allied health clinician. His roles have included continuing care, residential support, and assertive outreach. He currently works in a crisis team.

Pollyanna Alo – co-convenor

Polyanna is Samoan and has a social work postgraduate paper. She has worked as a health worker in the Mental Health Sector. Pollyanna has been in the health sector for 10 years, and prior to that was in the education sector for five years. She is passionate about Social Justice and Animal welfare, and continually strives to advocate for equality and fairness in the workplace.

Brent Doncliff - RN, MN (Hons), FCNA (NZ)

Brent has been a registered nurse since 1988. He holds a Master of Nursing degree, specialising in mental health. He is a Fellow of the College of Nurses Aotearoa (NZ). He has worked in clinical practice, nursing education and mental health service management. He has published several articles in professional nursing journals.

Tarn Evans

Professionally, Tarn has been a Mental Health Support Worker for 13 years in a variety of areas: youth respite; residential supported living; crisis respite; and community support. She is currently employed as a Housing Case Worker. Personally, Tarn has spent many years supporting family and friends at various times to navigate Mental Health services.

Richard Hemingway

Richard works as a Rehabilitation Assistant at Stanford House, a 15 bed inpatient medium secure forensic unit on the Whanganui District Health Board campus. He has been working in this area of mental health since 1996 when he commenced work at the National Secure Unit (maximum security) at Lake Alice. He currently holds a National Certificate in Mental Health (Mental Health Support Work) Level 4 and recently commenced the Diploma of Health and Wellbeing (Applied Practice) Forensic Inpatient Level 5 and has completed training in Social and Therapeutic Horticulture.

Yvette Faass

He tamaiti o Te Ati Haunui a Paparangi, he whangai ahau, me he tamaiti o Kāi Tahu whanau tuturu.

Yvette works at Purapura Whetu Trust Ltd. She has worked in the specialised Kaupapa Māori Mental health field for the past 10 years after working in the Domestic Violence field. She has a BA double major in Psychology and Education, and is a qualified Registered Social Worker. Her other qualifications include a Dip MH Support Worker and Heke Rongoaa (Diploma in Natural Māori medicine) from Te Wananga o Raukawa. She has participated in numerous Kaupapa Māori modalities of practice trainings and courses to assist her provide effective best practice.

Personally, Yvette was born into a whanau as the child of parents with MH issues, domestic violence and alcoholism, with a pattern of intergenerational comorbidity. She has experienced clinical depression and through counselling and personal development of strategies and skills has learnt to manage her depression. Involved in Te Ao Māori and practices to nourish mana ahua ake have enabled Yvette to support others to also reach their goals and dreams.

Billy West

Billy started working in the 1980s in Disability support at the time people were beginning to be moved from Hospitals into the Community. He returned to the Mental Health and Disability field in 2005. He has worked for several organisations, including “Youth Horizons”, P.A.R.S (Mt Eden Prison special unit). Richmond-Wellink (Emerge Aotearoa), Day Services in Henderson and Onehunga, ACC, Rehabilitation unit (Auckland Wide). Youth Justice (Pakuranga), Odyssey House (Drug and alcohol) Recovery Facility and School, Spectrum Health Care, and Pathways Health Limited. He is currently a Support Worker (Navigator) in the Mobile Team at Pathways.

Billy completed Pre- Degree course in Youth work at B.M.E.T.S Then a Degree at Auckland University in Social Services with a Major in Youth Work and a minor in Disability and Mental Health. He has a level 4 National Certificate in Mental Health and Addictions.

Amanda Martin

Amanda is a Senior Recovery Facilitator in the Crisis Assessment Team (CATT) and Home Based Treatment (HBT) Team with Mental Health NZ and Healthcare NZ. She has a National Certificate Mental Health Support Worker, Diploma in Pastoral Care and a Diploma in Counselling. Amanda has worked in the mental health and addictions field for the last 25 years. Her experience includes: Supportive Accommodation; Alcohol & Drug Services; Prison/Forensic; Court Support; Acute/Crisis Respite; Planned Respite; Facilitator - Psycho-Social Counselling, Rwanda & Burundi Genocide Survivors; Community Support; and Counselling.

Nancy Dally

Nancy has been nursing since 1969. She has been working in the mental health sector since 1974. Nancy worked in the Māori unit and the acute ward at Kingseat Hospital until it closed and then went to Tiaho Mai at Counties Manakau DHB, where she is now. Nancy is an enrolled nurse.

Allan Franks

Tena Koutou, tena Koutou,
He mihi, he mihi
Ko Allan Franks tenei. Ko Ngaapuhi, Ngaati Maniapoto Ngaa Iwi

Allan has worked in Māori Mental Health Services at Te Korowai Atawhai (CDHB) as He Pukenga Atawhai; and Manawanui (ADHB) as Kaiatawhai. He is presently employed at Te Whetu Tawera Adult Inpatient Services. Allan trained as a Psychiatric nurse in the '70s. He has been He Kaimahi for Hauora Māori for 20 years.

Allan's whanau has had links with Te Rau Matatini, Māori Mental Services at Tokonui Hospital, and Carrington Hospital.

Vicki Lewis

Vicki is a Registered Social Worker and has worked in secondary mental health services for 24 years. Previous roles have included provision within the acute inpatient setting, iCAMHS and adult services. She is currently working in a crisis team.

Megan Barry

Megan has been working as a Registered Mental Health Nurse for 7 years. In this time Megan has worked as a youth representative in many arenas. She is a convenor for PSAY, the PSA youth network, a youth representative for the DHB sector, and a youth representative on the PSA Executive Board.

She is currently working at Counties Manukau DHB.

Joseph Waru

Joseph has over 30 years of experience as a social worker, working with Māori communities.

For the last 6 years he has worked as a cultural advisor to the Auckland DHB CAMHs service.