Fast Track

Discussion paper

CHALLENGES & OPPORTUNITIES FOR THE MENTAL HEALTH & ADDICTION COMMUNITY SUPPORT WORKFORCE

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Te Pou o te Whakaaro Nui

PLATFORM

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Support work has come a long way in a short space of time due to a receptive environment and people with a vision to see it as a discipline of the future, such as our own DHB whom we applaud for their far sightedness. Support workers now, more than any time in the past, need to get connected so that the future vision is there to see and that we are all singing off the same page.

Doug Alderson, support worker, Southern District Health Board

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1. INTRODUCTION

1.1 Introduction

This discussion paper is a companion paper to *On Track: Knowing where we are going* (Platform Trust & Te Pou o te Whakaaro Nui, 2015), which proposed a fundamental transformation of the mental health and addiction (MH&A) system.

Given the publication of the *Mental Health and Addiction Workforce Action Plan 2017–2021* (Ministry of Health, 2017), this paper draws together some of the available evidence on the MH&A NGO workforce and combines it with NGO sector intelligence to focus attention on those actions in the national *Mental Health and Addiction Workforce Action Plan* that will help grow and strengthen the community support workforce (including peer support workers).

1.2 Background

The community support workforce (CSW) is the focus group for this paper because it is one of the largest parts of the MH&A workforce and it has, arguably, the most significant role to play in implementing the policy shift towards a transformed MH&A system. If the MH&A sector is relying on a major contribution from CSWs in the delivery of community MH&A services in the future, there is a lot of groundwork to do to help prepare this workforce. In addition, there is a paucity of baseline information to inform any meaningful workforce planning activity. For example, very little is known about the composition of this workforce (eg age, gender, ethnicity, retention rates, etc.) and we need to better understand the core services that a CSW should provide to consumers, irrespective of service type and/or work setting.

Given that the MH&A sector is aiming to create a more integrated health and social system, then community support workers are uniquely positioned to make a valuable contribution to that objective, principally because they are one of the few workforce groups already working in almost every part of the wider community health and social system.

This paper outlines what needs to happen in order to help know, grow and develop this critical part of the MH&A workforce, so that it is better equipped to play its part in a responsive and effective health and social service system, both now and in the future.

1.3 Defining the community support workforce

DeSouza (1997, p3) has suggested that the role of the mental health support worker originally emerged in response to gaps in the provision of community care. More specifically, support workers were needed to staff community residential facilities that were opened in response to the deinstitutionalisation of the large psychiatric hospitals in New Zealand (Hennessy, 2015). A unique aspect of the addiction sector is that the workforce has always included people with their own experience of alcohol, other drugs and gambling related problems accompanied by a culture of "peers supporting peers" (Robertson, 2010). However, since the 1990's the support worker role in both mental health and addiction has continued to evolve in a multitude of ways, without shape or direction. This organic process has resulted in a role that is now multi-faceted and, as a consequence, is not well understood by the wider MH&A sector.

Whilst there are a plethora of job descriptions that describe different types of CSW, this paper focuses on two broad categories, as follows:

1. All mental health and addiction community support workers.
2. Specifically, peer support workers who are employed in roles where it is essential to be identified as someone who has personal experience of mental health and/or addiction.

One of the challenges for workforce planning is that these two categories of CSWs are not homogeneous. In many respects, the diversity of the work and the breadth of roles reflects the diversity and complexity of the local communities that CSWs operate within. In addition, community support work is not just a MH&A phenomenon. They can also be found in a wide range of working environments - including disability, aged care, social services, culturally specific services, as well as in the MH&A sector. For these reasons, the similarities and differences between the different types of CSWs in both categories will need to be teased out as part of a process of engaging with the wider sector.

The unifying feature that is common to all CSWs, in all work settings, is the distinctive nature of the relationship between the CSW and the consumer (Hennessy, 2015). This is especially the case for peer support workers where the values of mutuality and experiential knowledge are particularly important (Te Pou o te Whakaaro Nui, 2014a, p. 5).

1.4 National policy directions

There are a number of national strategic developments which have informed and shaped the MH&A workforce to date, including the role of the CSW. The most significant of these include:

- *Rising to the Challenge* (Ministry of Health, 2012), which emphasises the need to support people earlier in the life-course, with less intensive interventions, delivered through integrated community and primary services.
- *New Zealand Health Strategy: Future Direction* (Minister of Health, 2016), which outlines a strong commitment to changing the way the whole health system works to meet changing health needs and reaffirms many of the themes outlined in *Rising to the Challenge*.
- *The Mental Health and Addiction Workforce Action Plan 2017–2021* (Ministry of Health, 2017, p27), which confirms the key role that the primary and community workforce has to play in a combined effort across health, disability, justice and social sectors and makes commitments to grow this part of the workforce.

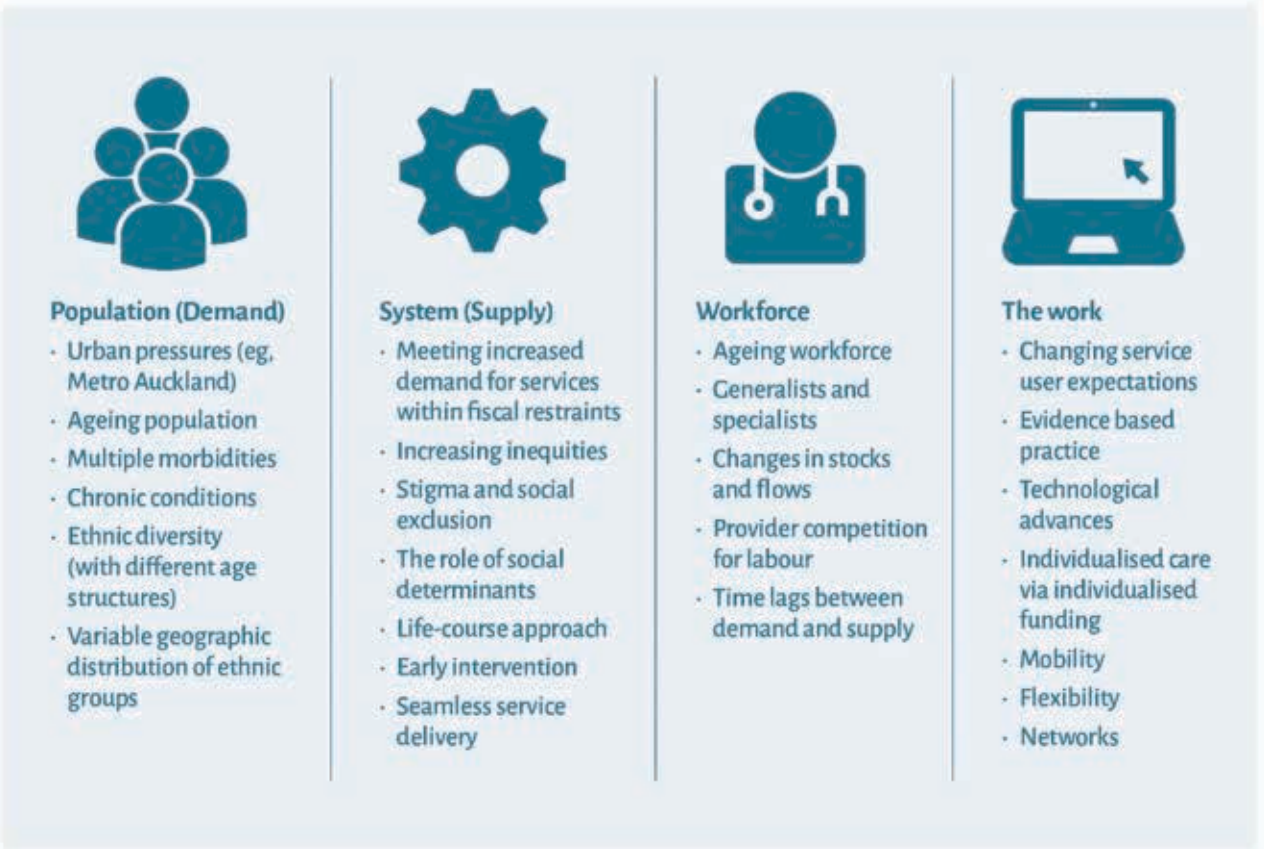
Note: Those actions from the national *Mental Health and Addiction Workforce Action Plan* (2017) that are relevant to the community support workforce are highlighted throughout this paper and summarised in Appendix one.

2. THE CHANGING NATURE OF THE WORK

Realistic workforce planning must take into account the fact that the nature of work is rapidly changing. MH&A staff will always rely on the use of the therapeutic self in their interactions with consumers, but new technologies and consumer's expectations around personalised responses (Kendrick, 2009) will influence how services are delivered in the future. This is already evident in the aged care sector where healthcare robots have been trialled in Auckland and are already being used in Gore. Among other tasks, the healthbots check blood pressure and heart rate, automatically transfer test data to clinicians and caregivers, monitor for falls, trundle around the room and provide people with some degree of companionship.[1]

Figure 1 captures some of the changes in the actual work, and situates these alongside some other change pressures. The response from the MH&A service delivery system cannot be more of the same. Services run the risk of being overwhelmed or becoming irrelevant unless they start to think and act differently.

Figure 1: Summary of change presssures



Source: Platform Trust & Te Pou o te Whakaaro Nui (2015). *On Track: Knowing where we are going*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.

[1]NZ Herald (2013). http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10860599

3. THE CURRENT COMMUNITY SUPPORT WORKFORCE

Workforce planning relies on good information about the composition of the current workforce in order to identify the size of the gap between the current and desired future state. Although *The adult mental health and addiction workforce: 2014 survey of Vote Health funded services* (Te Pou o te Whakaaro Nui,2015a), commonly known as *More than numbers*, and the *2014 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand* (The Werry Centre, 2014) provide a useful starting point for understanding the current CSW workforce, there is a need to have better information for workforce planning purposes. Additional information would include more detailed demographic data such as age, gender and ethnicity of staff, as well as information on work-related factors such as job retention.

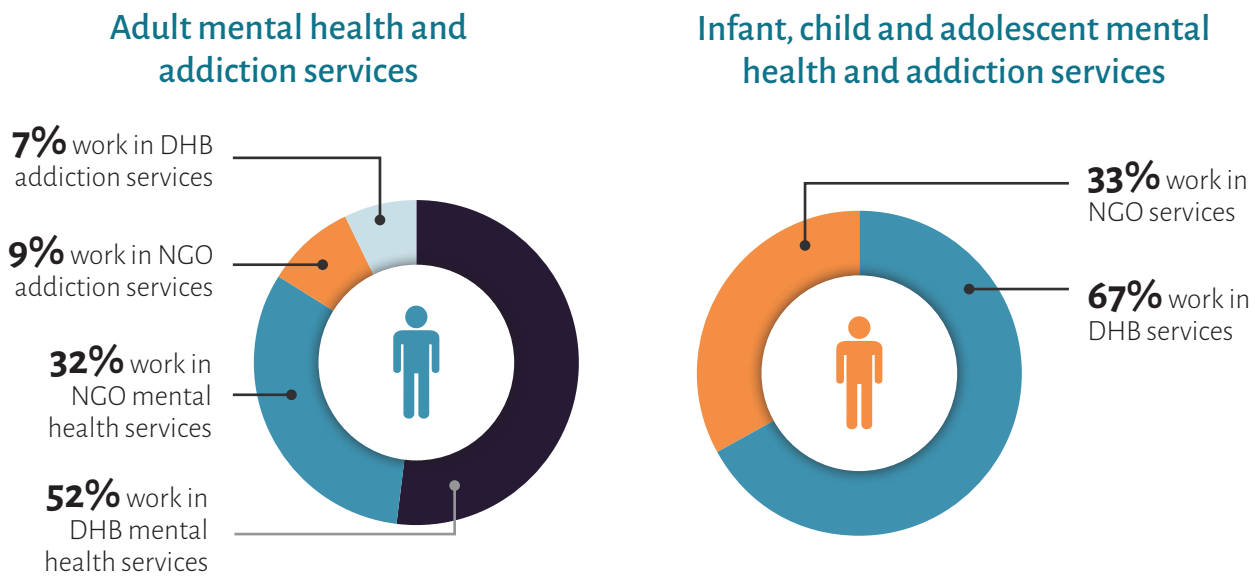
Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017) signals a clear intention to collect this type of workforce data. Refer to action 4.1 in Appendix one.

3.1 Total FTEs in the mental health & addiction workforce

In 2014 there were approximately 9,500 Vote Health funded full-time equivalent staff (FTEs) working in adult mental health and addiction services. Of this workforce, 84 per cent were working in mental health services and 16 per cent were in the addiction sector (Te Pou o te Whakaaro Nui, 2015a).

At June 2014 there were approximately 1,618 FTEs working in infant, child and adolescent mental health and alcohol and other drug services (The Werry Centre, 2015). Figure 2 shows how the funding is distributed across DHB and NGO MH&A services.

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



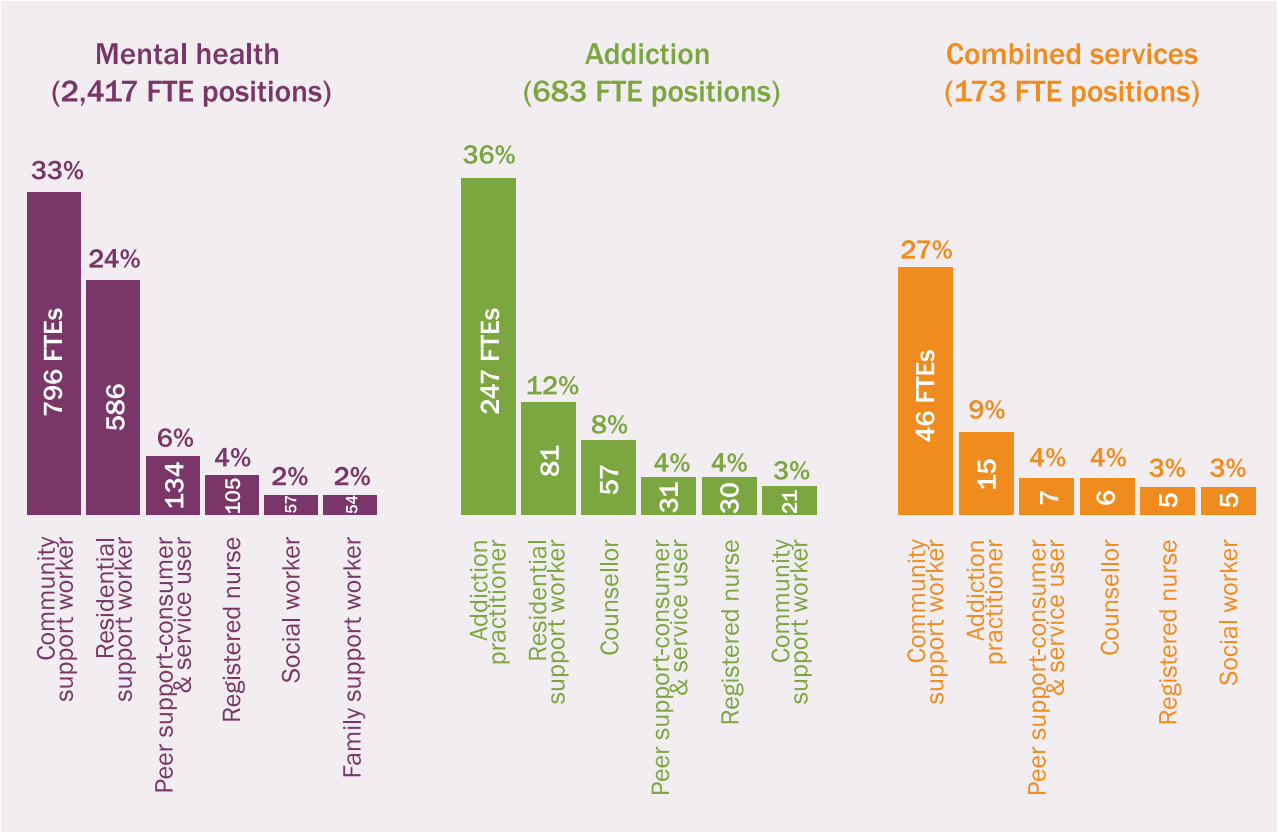
Source: Ministry of Health (2017). *Mental health and addiction workforce action plan* (p. 12).

3.2 The community support workforce

3.2.1 Adult MH&A community support workforce

Support workers comprise 31 per cent of the adult mental health and addiction workforce (2,988 FTE positions). Whilst 21 per cent of community support workers worked within DHB MH&A services, 72 percent (2,142) are employed by adult mental health NGO services and 7 per cent (209) are employed by adult addiction NGO services (see figure 3). The difference between mental health and addiction services can be explained by the number of staff working in addiction services who are now classified as Dapaanz addiction practitioners.

Figure 3: Adult MH&A NGO service delivery roles by workforce number in each service group

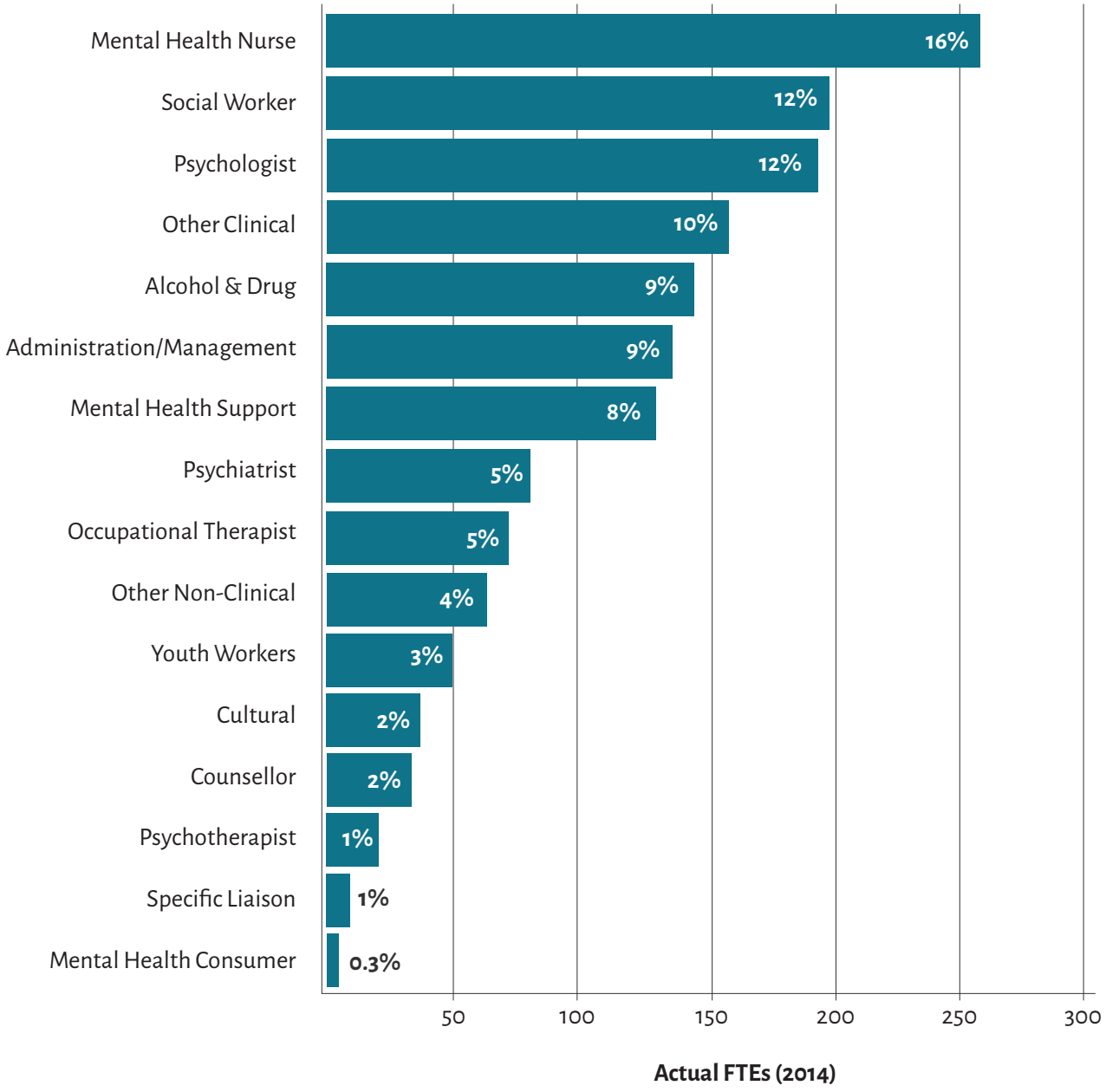


Source: Te Pou o te Whakaaro Nui (2015b). *NGO adult mental health and addiction workforce: 2014 survey of Vote Health funded services*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.

3.2.2 Child and youth MH&A community support workforce

In 2014, community support workers comprised 8 per cent of the total Infant, child and adolescent mental health/alcohol and other drug (ICAM/AOD) workforce (see figure 4). Of this total (141.7 actual FTEs), NGO ICAMH/AOD services employed 81 per cent of this particular occupational group (115.1 actual FTEs).

Figure 4: Total ICAMH/AOD Workforce by Occupational Group (2014)



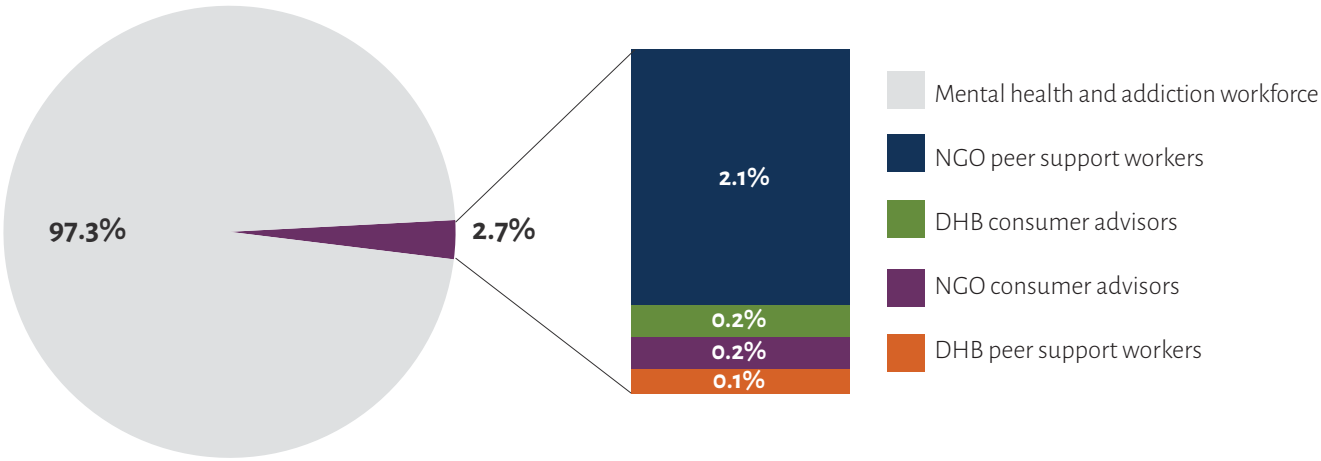
Source: The Werry Centre (2015). *2014 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand.* Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development. (p. 29).

3.3 The peer support workforce

For workforce planning purposes, the peer support workforce refers to staff who are specifically identified as providing dedicated peer support services (rather than staff with their own experience of MH&A problems who are employed in mainstream roles). The peer support workforce includes several other roles and job titles with similar functions, such as peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist (Te Pou o te Whakaaro Nui, 2014b, p5).

Whilst peer support workers have been identified as a priority for workforce development in *Rising to the Challenge* (Ministry of Health, 2015), the total number of peer support workers in adult mental health and addiction NGO services is low - ie; 202 FTEs or 5 per cent of the NGO workforce (Te Pou o te Whakaaro Nui, 2015b), reflecting low numbers across all services (see figure 5).

Figure 5: Peer workforce percentages as a proportion of the adult MH&A workforce[2]



Data source: Te Pou o te Whakaaro Nui (2015a).

I'm thinking, sitting in a park with a couple of consumers on a beautiful winter's day. They have all organised the day out. It was meant to be a lunch in the park. They organised it. I just showed up. They got there under their own steam. It was like a day in the park with any community group, and sitting next to a particular person who said, "You know what I was told when I was in the forensic unit that I would never work again because I had a diagnosis of schizophrenia and that I'd probably never be able to live independently. Do you know what? I made it to this picnic here today under my own steam. I've got a part-time job, and finding peer support is probably the most enlightening thing that has happened to me in my career as a service user".

Source: Platform Inc (2008), *Performance Story Report*: 2007 National Support Work Summit

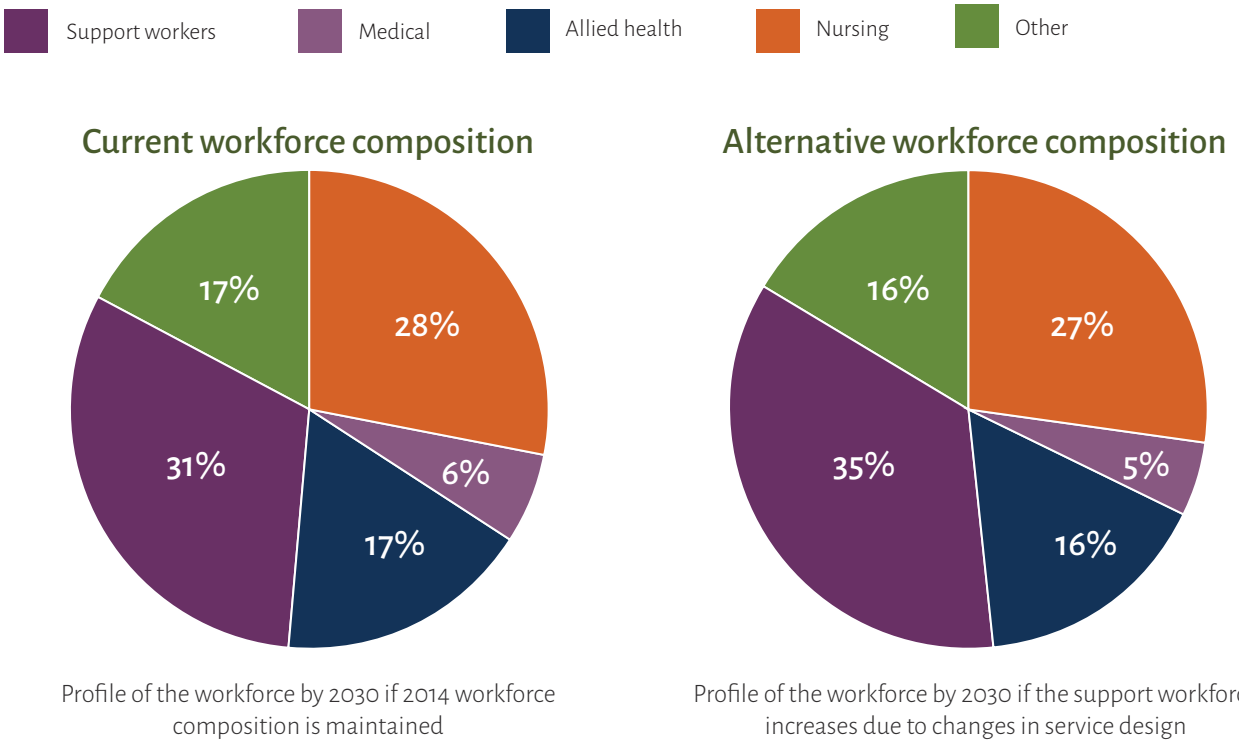
[2]This data was sourced from Te Pou o te Whakaaro Nui. (2015a). *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services.* Auckland: Te Pou o te Whakaaro Nui. It includes an estimate of 'missing' peer workforce FTEs due to the fact that not all NGOs responded to the survey – see footnote 4. Therefore, the figures in this graph are subject to the limitation that the method of allocation assumes that NGOs who did not report to the survey have the same workforce configuration as those that did report.

4. THE FUTURE COMMUNITY SUPPORT WORKFORCE

4.1 Increased numbers of staff

More than numbers (Te Pou o te Whakaaro Nui, 2015a) estimated that large increases will be needed in the community support workforce in order to meet population growth, irrespective of whatever underlying model of care is adopted in the MH&A sector. Figure 6 below presents two possible forecasting scenarios taken from *Towards the Next Wave* (Health Workforce New Zealand, 2011) for the adult MH&A workforce.

Figure 6: Modelling of possible changes to the adult MH&A workforce



Profile of the workforce by 2030 if 2014 workforce composition is maintained

Profile of the workforce by 2030 if the support workforce increases due to changes in service design

Source: Te Pou o te Whakaaro Nui (2015a). *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services.* Auckland, New Zealand: Te Pou o te Whakaaro Nui.

The first scenario on the left shows the projected changes in occupation groups to meet population growth should the current composition of the workforce be maintained. Under this scenario, the projected increase in support workers is 9 per cent or **269 FTEs** by 2030.

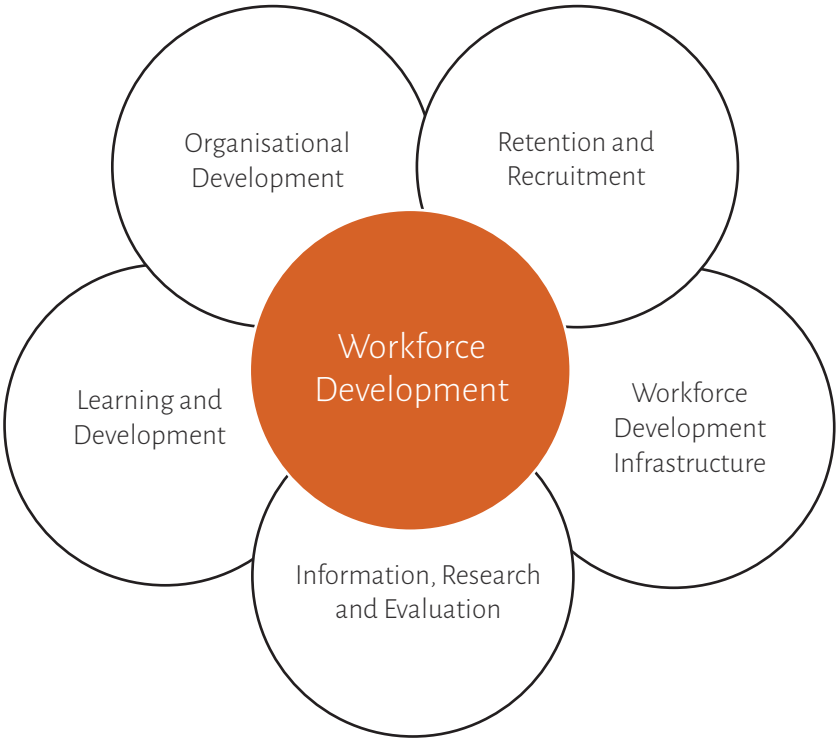
The second scenario on the right presents an alternative workforce composition (ie, roles and capabilities) based on major changes to the current model of care. These changes include a greater emphasis on early intervention by community and primary services as well as a greater utilisation of specialist services in a consult-liaison role. Under this scenario, the projected increase in support workers is 23 percent or an additional **685 FTEs** by 2030.

No such modelling work has been completed for the infant, child and adolescent MH&A services, but the Werry Centre (2015) in their stocktake states that "given that one quarter of all clients seen are by the NGO workforce, an increased focus on addressing the needs of the NGO sector is pertinent" (The Werry Centre, 2015, p. 7).

5. FUTURE WORKFORCE CAPABILITY

A systems-orientated approach to workforce development means that we appreciate that the work, the worker and the organisational environment are intricately inter-connected and that intervening in the system with a focus on the worker alone will be less than likely to be sustained over the longer term. For this reason, the Ministry of Health (2017) has developed a framework to help focus activity that was designed to build the capacity and capability of the MH&A workforce. The five domains of workforce development in this framework are outlined in figure 7.

Figure 7: Domains of workforce development



Source: Adapted from Ministry of Health (2017). *Mental Health and Addiction Workforce Action Plan 2017-2021*. Wellington, New Zealand: Ministry of Health.

This discussion paper addresses all five of the domains under the broad headings used in the Health and Disability Kaiāwhina Workforce Action Plan (see section 7).

Whilst all of these domains are important, the following section of this paper focuses on the area of learning and development as a direct response to the following most commonly expressed question.

- *How can we ensure community support workers are qualified to work in mental health and addiction, now and in the future?*

5.1 Learning and development

In the process of considering the many issues related to the learning and development domain, an approach was developed, which provides the following three dimensions:

(a) capabilities;

(b) an expanded scope of practice and;

(c) right mix of skills

This approach is a mental map and, as such, it is open to adaptation and modification based on sector feedback. It has been included here in order to stimulate debate.

The relationship amongst these three dimensions can be thought of as a rubric cube (see figure 8), with every part interacting with each of the others. An effective workforce learning and development strategy would take into consideration all three dimensions.

Figure 8: Three possible dimensions of workforce training and development activities

5.1.1 Capabilities dimension

The terms competence and capability are often used interchangeably when referring to the workforce. However, there are some distinct differences between the terms that are worth teasing out in order to avoid confusion.

- **Competence** can be broadly understood as the knowledge and skill required to undertake particular tasks.
- **Capability** enhances individual competencies with the values, attitudes, knowledge and skills needed to apply these competencies effectively in a variety of practice settings. Capability is about having the capacity to constantly improve through being receptive, reflective and adaptive to the environment.
- **Workforce capability**, from an organisational standpoint, is the collaborative process through which individual competencies in the workforce are applied or deployed.
- **Workforce composition** is the combination of roles and capabilities that make up the workforce.

A capability approach focuses on attaining the right combination of capabilities to deliver services rather than simply replicating current roles and functions.

There is a continuing need to build both individual and organisational capability with regard to the community support workforce. For example, recognising the role of values and attitudes as well as knowledge and skills. Te Pou on behalf of the Ministry of Health, is currently engaged in a refresh of the *Let's get real* framework (Ministry of Health, 2008) so that it can be used to influence future workforce development activities.

Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017, p. 30) reaffirms the place of *Let's get real* (Ministry of Health, 2008) as the foundation document for the MH&A workforce.

5.1.2 Expanded scope of practice

The introduction of the CSW role as part of the process of deinstitutionalisation offered the opportunity to provide a different model of service delivery that freed up other MH&A professionals to take on either additional or more specialist roles within the service continuum. Ironically, the increased pressure on MH&A services means that the CSW role now needs to be revised in order to meet the increased demand. In the process of developing new and revised CSW roles, it will be important to engage with other professional groups that might consider that CSWs are starting to impinge on their profession's scope of practice.

Hennessy (2015) has identified some of the problems with expanding the boundaries of practice, including occupational conflict (Abbott, 1988). However, as other health professionals continue to increase their scope of practice (eg, nurse prescribers), this will leave room for community support workers to do the same thing. Duckett (2005) is of the view that even small shifts in scope "will yield a substantial increase in the supply of services". Refer to section 7.1.2 of this paper for further commentary about role redesign.

Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017). Action 2.1 - Provide opportunities for CSWs and the peer workforce to co-design new roles and lead change processes.

5.1.3 Right mix of skill levels in response to increasing complexity & intensity

Whilst support workers are very proficient at responding to the unique aspirations of individual consumers, they may not be so proficient in dealing with the projected increase in multiple health and social needs, particularly at the high and complex end of the continuum.
The Centre for Workforce Intelligence (2015) has estimated that 86 per cent of the projected demand for skills in healthcare in the United Kingdom will be due to increasing numbers of people with both physical and mental health long term conditions. The projected increase in demand can be broken down and considered in terms of skill level, which categorises the workforce according to increasing levels of education, training and legal responsibilities. The skills of support workers are projected to grow the fastest to account for a significant increase in additional paid hours by 2035. What do these sorts of estimates mean for the growth and development of the community support workforce in New Zealand?

Anticipated changes to the model of service delivery will, increasingly, require community support workers to become more proficient in a number of areas, including the following:

- early intervention;
- working with people from different cultural groups;
- addressing the social determinants of health at both individual and community levels and;
- communicating and collaborating across teams/ organisations/sectors.

In order to meet the future demand for MH&A services, all parts of the MH&A workforce will need to be capable of responding in a more holistic way to the diversity, complexity and intensity of people's needs, as described in figure 9 on the following page.

Staff will also need to be able to operate together in a much more integrated way (possibly as members of a virtual trans-disciplinary team) to provide consumers and their families/whānau with the right set of skills, at the right time and in the right place.

Figure 9: Holistic, integrated service provision focused on the needs of consumers and their family/whānau.

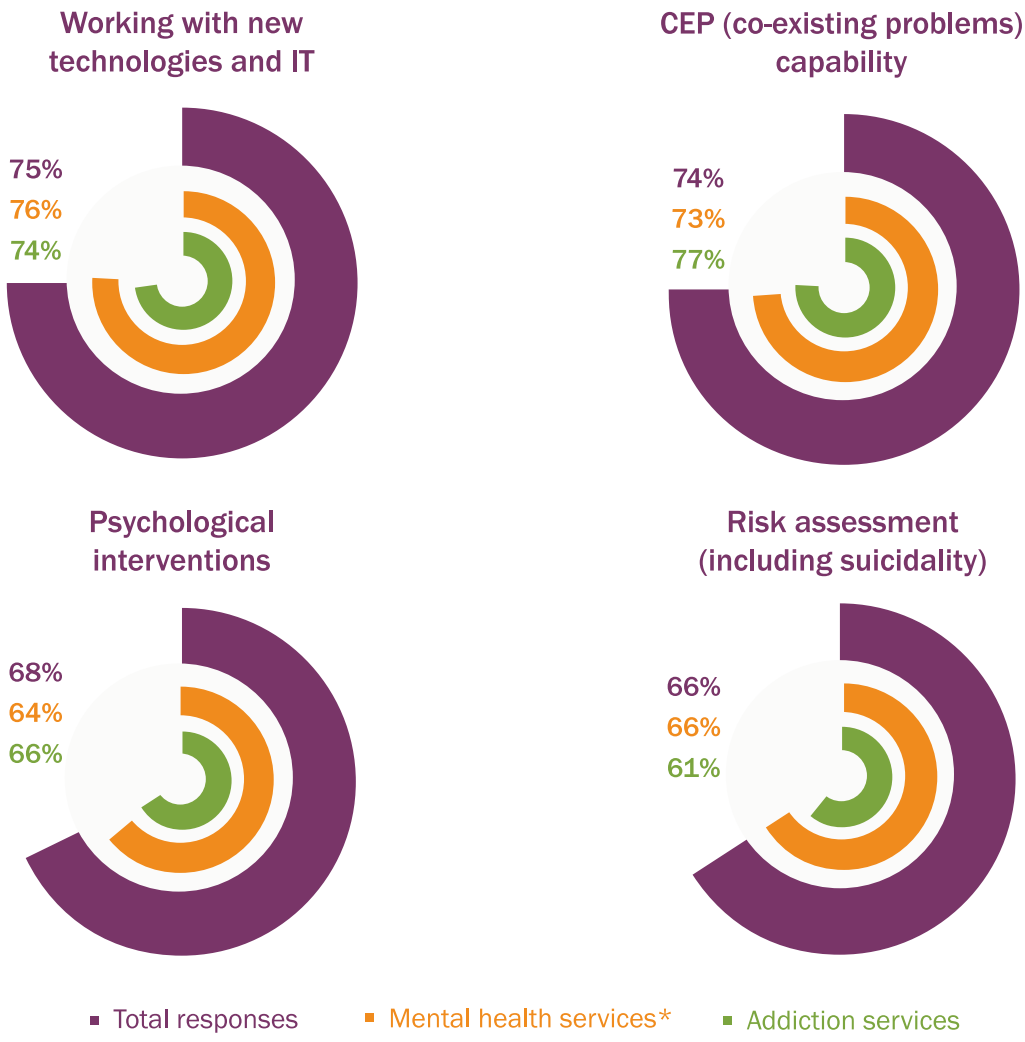
Source: Gaines, P. (2017) Adapted from Platform Trust and Te Pou o te Whakaaro Nui. (2015). *On Track: Knowing where we are going*. Auckland, New Zealand: Te Pou o te Whakaaro Nui (p. 44).

Note: This diagram offers a few of the possible service responses to the wide range of problems that are known to have a negative impact on a person's mental health and wellbeing. They are included here as a representation of the increased scope of practice for the MH&A workforce and are not intended as an exhaustive list of interventions. In addition, this diagram should not be interpreted as meaning that all staff should be everything to everyone, more that people's MH&A problems are situated within a wider social context and should be addressed as such.

5.2 Current knowledge and skill development needs

In addition to the areas covered in this paper, the staff of adult MH&A NGO service providers have expressed some clear skill development needs as part of the *More Than Numbers* survey undertaken by Te Pou in 2014. Figure 10 below captures the top four areas as identified by NGO respondents.

Figure 10: Service & policy areas needing some or large increase in workforce skills and knowledge

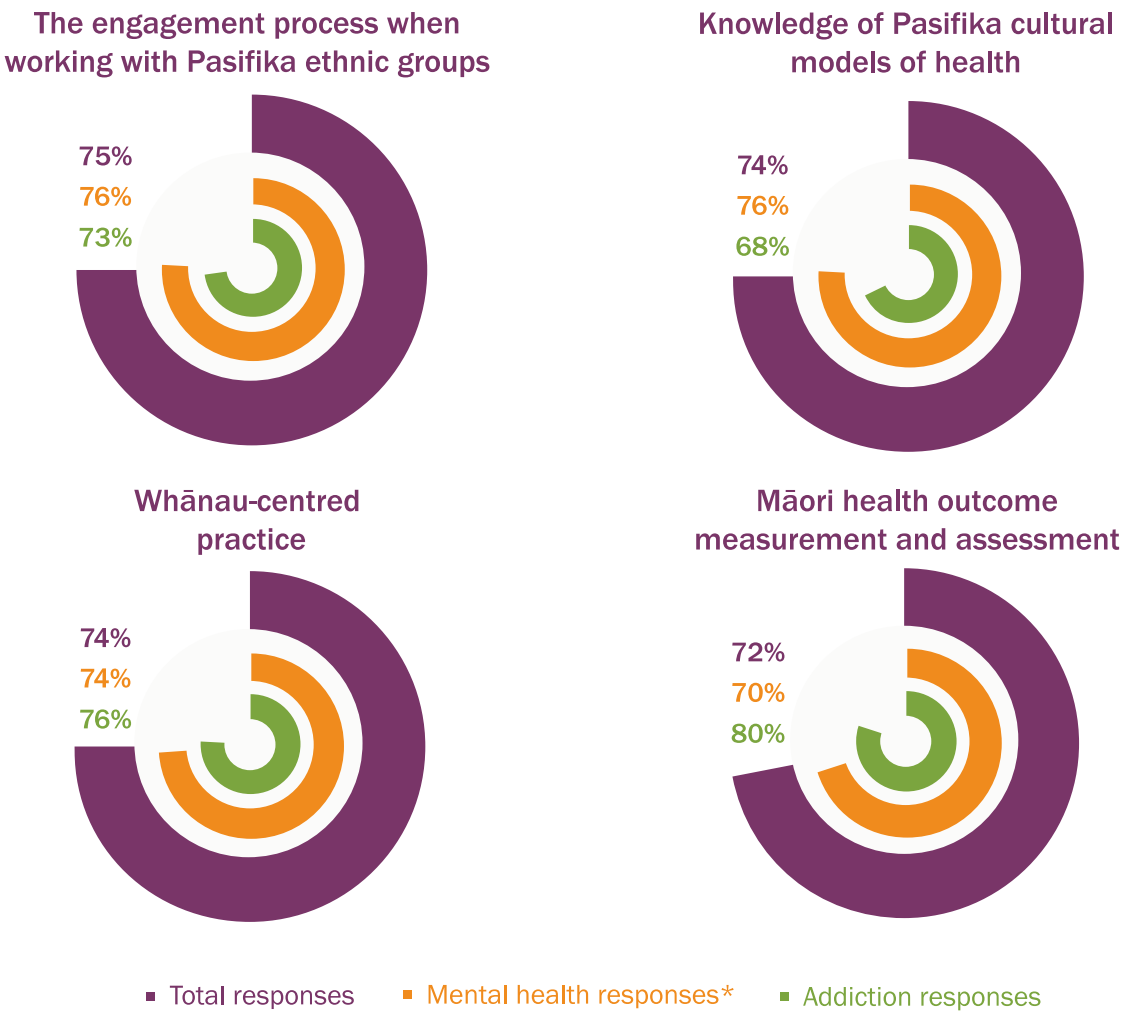


*Mental health includes responses from both the mental health and the combined services groups.

Source: Te Pou o te Whakaaro Nui (2015b). *NGO adult mental health and addiction workforce*: 2014 survey of Vote Health funded services. Auckland, New Zealand: Te Pou o te Whakaaro Nui (p. 19)

In addition, a large proportion of survey respondents indicated the workforce needed to increase cultural competence for working with Māori, Pasifika and Asian ethnic groups. Figure 11 shows the four cultural competency-related knowledge and skill areas that respondents most commonly identified as skills that the workforce needed to increase.

Figure 11: Cultural competence areas most often identified by NGO MH&A respondents



*Mental health includes responses from both the mental health and the combined services groups.

Source: Te Pou o te Whakaaro Nui (2015b). *NGO adult mental health and addiction workforce*: 2014 survey of Vote Health funded services. Auckland, New Zealand: Te Pou o te Whakaaro Nui. (p. 14)

6. CULTURAL CONSIDERATIONS

6.1 Māori

A representative and culturally competent workforce is required to support the goal of improving outcomes for Māori, Pasifika, Asian and other ethnic groups. This is particularly important for Māori because a greater proportion of consumers attending NGO services are Māori compared to DHBs. In 2013, thirty per cent of all consumers seen by adult mental health NGOs were Māori, compared to 22 per cent seen by DHBs. Similarly, for NGO AOD services, 40 per cent of consumers were Māori, compared to 29 percent of those seen by a DHB (Te Pou o te Whakaaro Nui, 2015b, p14).

Survey results indicate that the proportion of Māori in the overall workforce (19 percent) under-represents the proportion of Māori who are accessing MH&A services. Adjusting for service non-responses suggest that Māori staff make up 25 per cent of the reported non-clinical workforce with the majority being employed by kaupapa Māori teams (Te Pou o te Whakaaro Nui, 2015a p62).

Table 1: Proportions of reported Māori FTEs and Māori consumers – adults only

	Mental Health		Addiction	
	Proportion of Māori staff (%)	Māori access to services (%)	Proportion of Māori staff (%)	Māori access to services (%)
DHB	12.4	22	15.9	29
NGO	27.0	30	27.5	40
Total (%)	18.7		22.6	

Data source: Te Pou o te Whakaaro Nui (2015a, 2015b).

The results of the survey also suggest that coordinated strategies are needed to improve Māori uptake of careers in MH&A services in the Northern and South Island regions in particular.

Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017). Refer to Actions 1.2, 3.2, 3.3 and 4.2 regarding strategies to grow the Māori CSW and peer workforce.

6.2 Pasifika

Nationally, Pasifika representation in the NGO workforce was higher than, or consistent with, Pasifika representation as consumers of services. However, as most DHB areas will see an increase in the Pasifika population of somewhere between 20 and 70 percent, the survey results suggest that ongoing strategies to encourage mental health and addiction careers among Pasifika people will help prevent an imbalance occurring in the future (Te Pou o te Whakaaro Nui, 2015b, p. 17).

Table 2: Proportions of reported Pasifika FTEs and Pasifika consumers – adults only

	Mental Health		Addiction	
	Proportion of Pasifika staff (%)	Pasifika access to services (%)	Proportion of Pasifika staff (%)	Pasifika access to services (%)
DHB	2.8		6.4	
NGO	7.6	6	5.9	5
Total (%)	4.9		6.1	

Data source: Te Pou o te Whakaaro Nui (2015a, 2015b).

Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017). Refer to Actions 1.2, 2.2, 3.2, 3.3 and 4.3 regarding strategies to grow the Pasifika CSW and peer workforce.

7. OTHER KEY ISSUES

This section of the paper outlines other key issues identified in relation to the development of the community support workforce. The issues and some of the implications have been organised under the broad headings used for *The Health and Disability Kaiāwhina Workforce Action Plan Framework* (Careerforce, 2015).

Whilst the term kaiāwhina is not well known or utilised within the MH&A sector, the scope of the plan does cover the MH&A community support workforce.

Figure 12: The Health and Disability Kaiāwhina Workforce Action Plan Framework

Source: Careerforce Te Toi Pūkenga and Health Workforce New Zealand (2015). *The Health and Disability Kaiāwhina Workforce Action Plan*. Wellington, New Zealand: Careerforce Te Toi Pūkenga and Health Workforce New Zealand

Note that relevant actions from the *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017) have also been highlighted where appropriate.

7.1 Sustainability – sufficient numbers of staff to meet demand

Flexibility across community support worker roles is encouraged and supported by funding structures. Workplace conditions and human resource systems support staff, provide job security and system stability. As new models of service delivery emerge the contribution of support workers is integrated ***(www.workforceinaction.org.nz).***

7.1.1 Uncertain funding

Across the country, DHBs pay NGOs different prices for exactly the same purchase unit. For example, in 2014 the annual rate paid to an NGO to cover all costs (including staff wages, sick leave, annual leave, travel costs, training, administration and other overheads) associated with delivering a non-clinical community support service to adults with complex mental health needs ranged from $73,749 per annum at one DHB, to $96,550 at another (see figure 13 below). These differences in price for the same purchase unit are thought to reflect the historical purchasing practices of DHBs rather than being the result of any rigorous pricing methodology.

Figure 13: Variance in amounts paid by DHB for a range of purchase unit (PU) codes

Source: Fair Funding at https://www.fairfunding.org.nz/fairfunding

In addition, when DHBs do not pass on the annual Contribution to Cost Pressure (CCP) funding increase to NGOs[3], this directly impacts on the wages for community support workers. It is not fair to ask the lowest paid group of staff to see more people, increase the amount of time spent in face-to-face interactions, deal with more complex problems and be prepared to do so on less than the living wage[4].

> *"People never come to us with just one thing. There's usually a lot going on in their lives. We cover housing, addiction, diet, physical health,.....everything. Whatever people need"*
> A community support worker

If NGOs are required to operate to the same Nationwide Service Framework (NSF) and National Health and Disability Services Standards as DHBs, it's only reasonable to also have a nationally agreed pricing structure in place that enables NGOs to pay their staff a fair wage and to operate a high quality, sustainable business.

Implications

- Implement longer term contracts as successive one year contracts limit the NGOs' ability to plan ahead.
- Investigate the issue of pay equity - limited funding can also impact on the NGOs' ability to pay fair wages; which may result in staffing cuts and high-pressure working environments, that can, in turn, lead to poorer staff retention.
- Invest in NGO services - funding cuts to community services are unlikely to generate health savings, as people who are no longer able to access NGO services may become more acutely unwell and require more costly inpatient, police and/or emergency department services.
- Introduce a transparent pricing model – purchasing services based on historical prices will continue to perpetuate the current state, thereby undermining the ongoing sustainability of the NGO sector.

7.1.2 New service models and role redesign

While increasing the numbers and scope of community support workers in the workforce is a long-term solution to MH&A workforce shortages, there is also a need to redesign the role in response to new models of service delivery. Achieving the vision of *Rising to the Challenge* (Ministry of Health, 2012) and the *New Zealand Health Strategy* (Minister of Health, 2016) will depend, in large part, on recruiting and training staff in expanded and/or new roles, many of which will be situated in different working environments (eg schools, marae, community centres, etc.).

For example, whānau ora services and MH&A staff in primary care settings are illustrative of new services that have been developed to help meet the need for high-quality, lower cost care in the community. The development of the role of healthcare assistant, both here and in the United Kingdom, is an example of how the health sector has shifted some less complex tasks from registered nurses to a cheaper labour force, thereby freeing up specialist staff to work to top-of-scope and, at the same time, filling a perceived gap in service delivery (Spilsbury, & Meyer, 2005).

Implications

- Start a discussion with other professional bodies about how the CSW role might complement more specialist roles – ie, an expanded scope of practice is likely to create tensions with other health professions which might be worried that their professional role is being eroded, or encroached upon, by the 'non-regulated' workforce.
- Continue to support the refresh of the *Let's get real* (Ministry of Health, 2008) framework over 2017 so that it remains relevant.
- Consider any quality and safety issues associated with transferring some tasks currently undertaken by health professionals to the unregulated workforce.
- Investigate the impact of MH&A workforce redesign as a national research priority.

[3]https://www.fairfunding.org.nz/ccp
[4]http://www.livingwage.org.nz/what_is_the_living_wage

7.1.3 Peer support

Peer support workers were identified as a priority group for workforce development in *Rising to the Challenge* (Ministry of Health 2012). However, as previously noted, the total number of peer support workers in NGO services is low (202 FTEs, representing 5 per cent of the adult MH&A NGO workforce).

Strategies to grow this workforce should be considered alongside other strategies to develop effective peer support services – as described below:

Figure 14: Components of effective peer support services

Source: Mental Health Commission (2011). *Power of peer support services*. Wellington, New Zealand: Mental Health Commission.

Implications

- Develop strategies to grow the peer support workforce nationally, including workforce planning and development initiatives.

Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017) signals a clear intention to develop the peer support workforce. Refer to actions 1.2, 2.1, 3.1, 4.2 and 4.3 in Appendix one.

7.1.4 Specialisation

There is an ongoing debate related to the future of mental health and addiction roles with regard to the appropriate balance of mental health & addiction specialists and generalists. In addition, there are a number of different ways to define what is meant by specialist and generalists.

The model in Figure 15 was developed by Gerald Biala (2008) and considers staff specialisation to be on a continuum ranging from generalist to specialist.

In clinical terms, specialists are those staff that have extensive expertise and training in a specific area (eg psychiatry). At the generalist end of the continuum, clinical staff maintain competency in all cases and can respond to any case at any time (eg GPs).

What is often missed in this discussion is the fact that 21.6 per cent of the adult NGO MH&A workforce are clinical staff. This statistic challenges the traditional perception that NGOs only employ CSWs. They don't, but the workforce challenges for NGO clinical staff are different to those of their clinical colleagues in DHB settings. For example, they generally receive lower rates of remuneration, have variable access to clinical supervision and reduced access to professional development opportunities.

Figure 15: Specialisation continuum

Source: Biala (2008). Specialty staff versus generalists: How do ORs strike the balance? *OR Manager*, 24(8), 1, 12-14

In terms of the community support workforce, the specialists are those staff who work in specialist DHB MH&A services. The generalists are those people who work in the wider health and social sector without expertise and training in mental health and addictions, but who come into contact with people who have MH&A problems. Viewed from this perspective CSWs are situated somewhere along the continuum between the generalists and the specialists.

Implications

- Develop strategies to support clinical staff who are working in NGOs – ie, implement career pathways, clinical supervision and professional development.
- Explore the balance of specialists vs. generalists in a number of different community contexts and assess how the current composition of the workforce might need to change accordingly.
- Upskill the generalists that work in community settings (eg schools, marae, community centres, etc.) to identify and respond appropriately to people with MH&A problems.

One of the national workforce strategies is to better equip the generalists who are working in the health and social sector to identify and appropriately respond to mental health and addiction issues (see action 3.1 in the national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017)).

7.2 Consumer focus

The needs, expectations and goals of the consumer and their family/whānau are central—a strengths-based approach. They have the right to culturally appropriate effective services, and to be informed of choices and participate in decision-making about their support and/or treatment. Population data is used to identify health trends ***(www.workforceinaction.org.nz)***.

7.2.1 Individual choice and increased expectations

In the future, consumers and their families/whānau will have greater choice and control over the community MH&A support services that they receive. New Zealand already has an example of how personalised support services could operate in the MH&A sector in the form of the individualised funding model that has been introduced into the disability sector. The development of this model has been informed by the learnings from the *Enabling Good Lives* demonstration projects[5].

Implications:

- Consider a future whereby consumers could hire, manage, pay, train and make their own contracts with their community support workers, or choose to manage aspects of this process themselves.
- Consider the risks and opportunities associated with this scenario - including the possibility that the majority of the community MH&A support workforce could end up being self-employed and working as independent contractors.
- Consider how to help prepare the workforce for this scenario - as consumers gain more choice and control over their personal supports, CSWs might need to become more marketable by being able to respond to a wider range of needs. They will also need to be able to work alone and have a highly developed sense of judgement about when to intervene or when to seek specialist advice. These advanced skills lie further up the specialisation continuum (Biala, 2008) and are beyond the current scope of practice for a community support worker. They are also skills that are not reflected in the wages that are currently being paid to support workers in the sector.

7.3 Workforce intelligence

Comprehensive workforce data captures community support worker numbers, demographics, qualifications and roles. Role descriptions and job titles are included in standard NZ workforce data. Plans are developed to ensure sufficient community support workers are available to meet future workforce demands and models of service delivery ***(www.workforceinaction.org.nz)***.

It is important to be in a position to estimate the numbers of CSW staff coming on stream over the next few years. The level 4 Certificate in Mental Health Support Work is seen as the entry level qualification for CSWs working in MH&A services. Whilst we have some information about the number of people who have successfully completed a NZQA approved qualification (see table 3), this information includes students who have accessed a wide range of level 4 to 6 courses, including counselling, psychology and social services, many of whom may not have ended up working in MH&A NGO services.

[5]http://www.enablinggoodlives.co.nz/

Table 3: Domestic students completing qualifications by region of provider[6]

Region	2010	2011	2012	2013
Auckland Region	252	206	192	155
Bay of Plenty Region	33	36	34	3
Canterbury Region	41	44	46	52
Hawkes Bay Region	27	32	40	28
Manawatu-Wanganui Region	26	35	25	22
Nelson Region	30	22	22	18
Northland Region	47	86	80	96
Otago Region	34	26	0	0
Southland Region	12	23	33	21
Taranaki Region	0	8	8	6
Waikato Region	109	91	106	69
Wellington Region	198	264	279	160
Total	**809**	**873**	**865**	**630**

Data source: Tertiary Education Commission (2015)

It is not enough to know the total number of successful graduates across the board. Account should be taken of whether specific courses are full when they start, and of their attrition rates. Given that the *More than numbers* survey (Te Pou o te Whakaaro Nui, 2015a) predicted shortages in addiction practitioners and community support workers, it is also critical to know the numbers of students who are completing their qualification and intend working in MH&A NGO services in each district. This district level information is important (ie, age, gender and ethnicity) in order to establish if the education sector is able to supply a workforce that matches the current and projected population demographics for each district.

Implications

- Increase the amount of available data on students who are enrolling and completing relevant non-regulated MH&A qualifications.
- Investigate methods to increase available data on the CSW and peer support workers who are employed in the MH&A sector.

Note: The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017) signals a clear intention to collect better MH&A workforce data. Refer to action 4.1 in Appendix one.

[6]**Note:** The region is the administrative headquarters of the provider, so it will not necessarily reflect where the student was actually studying. In addition, the data for 2013 was provisional and subject to revision.

7.4 Career development

An easily navigated career pathway helps current and future Kaiāwhina make choices about training and roles to pursue. The pathway enables new workers to enter the sector, progress to leadership roles and to the regulated workforce. Skills and knowledge will be transferable and recognised within the NZ qualifications framework ***(www.workforceinaction.org.nz)***.

7.4.1 Career pathways

NGO services continue to face challenges in recruiting and retaining experienced and qualified community support staff. In general, there is little data available to track recruitment and retention in NGOs. However, anecdotally, poor staff retention has been linked to limited scope for career development. Whilst a career pathway does exist in some organisations, it is not clear how a CSW goes from being a support worker to an advanced support worker, or even a team leader. In some instances, promotion would appear to be a rather random combination of personal interest, aptitude and opportunity (personal communication).

Implications

- Consider how to develop the community support worker role. For example - build better understanding of the role and create more opportunities for progression into senior support worker roles, etc.
- Improve the retention of all staff by promoting career pathways/planning and utilising service models that facilitate flexible working arrangements (eg job sharing).

7.4.2 The NZ Qualifications Framework

The NZ Qualifications Framework (NZQF) is divided into ten levels, and covers a range of qualifications from certificates to doctoral degrees. The levels are based on the complexity of the learning, with a level 1 certificate being the least complex. The entry level qualification for a community support worker is deemed to be a Certificate in Mental Health (Mental Health Support Work) (Level 4), which is a competency based programme. The mechanism in place to ensure ongoing competencies is generally through the contractual process of employment agreements (Hennessy et al, 2017).

Table 4 captures the current list of NZQA approved qualifications (as per the Careerforce website) with the addition of the level 7 qualification - the Bachelor of Social Health and Wellbeing.

The bachelor degree was developed by the Open Polytechnic to help fill a gap in the educational pathway for the non-regulated MH&A workforce. Whilst the development of this level 7 course is a positive move, it cannot be assumed that it completely fills the gap in the educational pathway, nor can it be assumed that any of the other qualifications continue to meet the requirements of a rapidly evolving MH&A sector.

Table 4: NZQA approved qualifications for the non-regulated MH&A workforce

Level	Qualification	Description
4	NZ Certificate in Health and Wellbeing (Peer Support)	This is a new qualification targeted at people who have gained strength and resilience from their lived experience of MH&A problems and wish to support others with similar experiences. This new qualification replaced Mind and Body's old qualification - the Certificate in Peer Support (Mental Health) (Level 4) in 2017.
	NZ Certificate in Health and Wellbeing (Mental Health and Addiction Support)	This Certificate is an 18 month apprenticeship in health, disability and social services, which is a fully on-the-job training programme that has fours strands – one of which is mental health.
6	NZ Diploma in Addiction Studies (Applied)	The New Zealand Diploma in Addiction Studies (Applied) (Level 6) programme is designed to provide the addiction sector with qualified workers who have specialist knowledge and skills required to contribute to, and where appropriate carry out assessment, planning and intervention for people with addiction-related conditions.
7	Bachelor of Social Health and Wellbeing	This degree focuses on innovative and future orientated health and wellbeing practices that improve the quality of life for the people who use MH&A services and their family/whānau. After the completion of level 5, students have the opportunity to choose which major they wish to complete; Mental Health and Addictions, or Disability.

Source: Careerforce te toi pūkenga (https://www.careerforce.org.nz/) and Open Polytechnic Kuratini Tuwhera (https://www.openpolytechnic.ac.nz/qualifications-and-courses/op7800-bachelor-of-social-health-and-wellbeing/)

The New Zealand Qualifications Authority (NZQA) is the organisation responsible for developing, accrediting and approving national qualifications. Therefore, NZQA is the lead organisation with responsibility for the development of qualifications required by the MH&A sector for community support workers.

Given the increased emphasis on the role of the community support workforce in the future, it might be time to review the national curriculum so that it is more closely aligned with the future requirements of the MH&A sector.

Implications

- Engage with HWNZ and NZQA about initiating a process to revise the current curriculum for the non-regulated MH&A workforce.
- Create a clear educational pathway that is aligned with a career pathway.
- Foster multiple entry points into the workforce.

7.4.3 Core tasks of a community support worker

It is important that each professional group is able to define those areas where its particular skills can add value to the skills of other groups (Ivey et al., 1998). This is particularly important if the NGO part of the MH&A sector wants to go down the track of compensating certain roles at different points on the career path, according to people's experience, skills, knowledge and qualifications.

In the course of developing this paper, over 25 different CSW job descriptions (including five for peer support workers) were reviewed to determine if there was a core set of tasks that was common to all. Apart from standard requirements, such as having a driving license, keeping accurate records and adhering to legislative requirements, the only common theme was one of person-centric recovery, whereby CSWs were tasked with supporting consumers to enhance and improve their lives.

At its core, the concept of recovery is both individual and community focused - with an aspiration for a fullness of life (Adeponle et al., 2012). Historically, the role of community support workers has been to support people to take an active role in their recovery and offer a listening ear, advice and practical assistance (Health & Disability Commissioner, 2017). However, from the review of job descriptions, it is clear that the tasks and responsibilities of the CSW role range from the basic to the advanced. In addition, although some job descriptions stipulate that it is desirable to hold one of the recognised qualifications (ie, level 4 NZ Certificate in Health and Wellbeing), all organisations accept job applicants who can offer life experience, but who have either lesser or no qualifications.

The problem with the lack of clarity about the tasks and responsibilities of the CSW, is that it creates friction with other health professionals who do not understand what it is that a CSW can offer people. The lack of clarity also makes it difficult for both funders and providers to benchmark services and for DHB planners to determine the size and composition of the MH&A workforce relative to the need and demand for services in each district.

Implications

- Identify and clarify the core set of tasks of a community support worker (including peer support workers).

7.5 Workforce recognition – a valued workforce

The community support worker's contribution to health and disability teams is valued by employers, other professionals, consumers and the community. This will also be reflected in fair and equitable policies and practices ***(www.workforceinaction.org.nz)***.

The April 2017 pay equity settlement in the aged care sector in New Zealand has highlighted the issue of low pay for predominately female occupations in New Zealand[7]. In a broader sense, this settlement is about much more than whether or not women are paid the same rate as men. Some of the workers who will benefit from the settlement are paid just $15.75 per hour, which represents the statutory minimum wage, despite years of experience.

Many MH&A community support workers are in a similar position, with some staff being paid less than the living wage ($20.20 per hour). NGOs would argue that they would like to be in a position to pay their staff higher wages, but that they cannot afford to do so because of the low level of funding that they receive from the DHBs. In some instances MH&A NGOs have not received a cost-of-living increase from their local DHB for a number of years[8].

In June 2017 a pay equity claim on behalf of mental health support workers was lodged with the Employment Relations Authority[9].

Implications

- Monitor the pay equity issue, particularly with regard to the living wage for community support workers.
- Consider the development of an agreed national salary scale.
- Consider the development of pay bands to distinguish the level of compensation given to certain roles at different points on a career path.
- Consider the development of a multi-employer collective agreement (MECA) to enable a national approach to the pay rates, training and conditions of employment for community MH&A support workers.

[7] http://www.stuff.co.nz/the-press/opinion/91658929/editorial-aged-care-settlement-an-important-pay-equity-milestone.
[8] https://www.fairfunding.org.nz/ccp
[9] http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=11878800

7.6 Quality and safety

Consumers have the right to receive services from a skilled, integrated team. Community support workers are competent, adaptable and work to the required standards. They reflect on their and the wider team's practice. This workforce is trained to enhance personal and consumer safety. Management/infrastructures support this ***(www.workforceinaction.org.nz)***.

Professionalism and being professional is important to both the workforce and to consumers. The Health Practitioners Competence Assurance (HPCA) Act (2003) determines the scopes of practice in New Zealand for many health occupations. The Health and Disability Commissioner Act (1994) provides some protection for those health practitioners who are not regulated under the HPCA Act (2003), but this is a legislative safety net for consumers and does not address the workforce development needs of CSWs.

For health occupations that are not covered by this Act (eg community support workers), there is the ability for groups of practitioners to self-regulate. The Addiction Practitioner's Association, Aotearoa New Zealand (known as Dapaanz) is an example of self-regulation. Dapaanz was set up as a national body in 2002 to implement and oversee the *Practitioner Competencies for Alcohol & Drug Workers in Aotearoa-New Zealand* (Alcohol Advisory Council of New Zealand, 2001). This Association fosters and maintains good, ethical practice in addiction treatment through their code of ethics, the *Addiction Intervention Competency Framework*, (Addiction Practitioners Association Aotearoa New Zealand, 2011) and their registration process.

Health Workforce NZ could take the lead role in developing a national body for mental health CSWs, similar to Dapaanz. The indications from Hennessy's (2015) study were that CSWs were anxious to establish some form of professional identity and protection. Given that a further two years has passed since that study was undertaken perhaps it is time to consider some form of professionalisation for CSWs, which would give the general public some confidence about the standard of care and would also give CSWs some legitimacy as a professional occupational group.

Implications

- Investigate if the community support workforce wants to develop a distinct professional identity.
- Consider the advantages and disadvantages of self-regulation, credentialing or professional registration for the mental health community support workforce.
- Consider the role of *Let's get real* (Ministry of Health, 2008) in a professionalised community support workforce.
- Engage with Health Workforce NZ about the possibility of establishing a national body for community support workers.

Peer support

The growth and development of the peer support workforce has been signalled as a significant area of workforce development in order to increase capacity and capability across a spectrum of self-care support.

The national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017) has identified a strategic approach to growing the peer support workforce nationally, including identifying training needs based on the national competencies (Te Pou o te Whakaaro Nui, 2014b) for the mental health and addiction service user, consumer and peer workforce.

Addiction peer support workers are currently considering the advantages and disadvantages of peer workers being permitted to apply for one of three categories of 'endorsed practitioner' status under Dapaanz - ie, peer support, advanced peer support and peer supervisor. No decision on this proposal has been reached as yet.

7.7 Access – opportunity to participate in training and learning

Community support workers have the opportunity to participate in training and learning to develop their knowledge and skills and advance their careers. Choices regarding the range of jobs are available. Career information, workplace development and progression can be accessed by all. Support workers have access to and use technology in the workplace. ***(www.workforceinaction.org.nz)***.

Any training and development investment needs to be seen in the context of workforce development so that the necessary supports are in place to bring about practice change. Without this level of support, any investment in additional training is unlikely to bring about much change in practice.

Access to training and professional development opportunities are also limited by the amount of funding that NGOs receive. Rather than every NGO trying to replicate very similar training programmes there may be advantages in adopting a more collaborative approach that involves other NGOs, primary health care organisations and district health boards.

Implications

- Develop innovative solutions to help staff advance their careers (eg secondments).
- Collaborate with other MH&A providers on training.

7.8 Sector leadership

The scale of the transformation represents a significant workforce development challenge for a number of different agencies including NGO employers, DHB funders, educational institutions, Health Workforce New Zealand, Careerforce and the Ministry of Health.

The model of care proposed for the future will require a new form of sector leadership that is prepared to work together to test and evaluate innovative and radical solutions. These solutions range from changing job roles through to the creation of new teams that are prepared to deliver a service to consumers and their families/whānau in different ways.

A planned approach to a transformative process will need some form of system leadership at a senior level and will include a combination of top-down policies and bottom-up activities, which are focused on implementing a shared vision. In order to make any real progress, the systemic issues will need to be addressed by Health Workforce New Zealand and the Ministry of Health. Without this level of top-down support, the bottom-up activity is not likely to result in any substantive change.

Implication

- Investigate establishing a cross-agency governance structure, which includes all key stakeholders, to provide oversight of the growth and development of the MH&A community support workforce.

8. SUMMARY OF KEY QUESTIONS FOR CSW FORUMS

Te Pou and Platform Trust are intending to host a number of forums over 2017 for community support workers to discuss the issues that have been raised in this paper. The following questions offer possible areas to focus on at these forums.

Table 5: Developing the community support workforce - 5 focus areas

Developing the community support workforce – 5 focus areas	
	**1. Retention & recruitment** • What do we know about the breadth and diversity of roles that constitute 'community support work'? • How do we grow and strengthen the peer support workforce?
	**2. Training and development** • What do community support workers perceive to be their training and development needs, both now and in the future? • What do peer workers perceive to be their training and development needs, both now and in the future?
	**3. Professionalism** • To what extent does the community support workforce want to develop a distinct professional identity? • What are the advantages and disadvantages of self-regulation, credentialing or professional registration for the mental health community support workforce?
	**4. Eduction and career pathways** • What do we already know about the educational and career pathways of the community support workforce? • What else do we need to know? • What is the impact of MH&A workforce redesign?
	**5. Role clarification** • What are the similarities and the differences between what community support workers do and what peer support workers do? • What tasks and functions are considered to be in-scope for community support work and what is out-of-scope?

9. GETTING FROM HERE TO THERE

There is a great, and growing, risk to the entire mental health and addiction system if the NGO part of the MH&A sector is not properly equipped to meet the projected increase in demand for MH&A community support services. Failure in the community/primary part of the health system will only serve to place even more pressure on the acute end of the specialist MH&A system.

Acute MH&A services are struggling to cope with the current level of demand, let alone a projected increase in demand (refer to a recent media report at http://www.stuff.co.nz/taranaki-daily-news/news/national/90759959/Families-despair-as-hospitals-face-severe-shortages-for-acute-mental-health-treatment). The current situation is untenable and unsustainable in the medium to longer term.

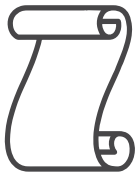
With the growing emphasis on primary mental health solutions, there is also a risk that the health sector simply shifts the emphasis from secondary MH&A specialist services to a predominantly GP led model of care and mistakenly assumes that GPs will be able to cope with the increased demand for services and that the shift will be transformative. What is actually required is a more blended approach amongst a wide range of health and social sector professionals who are prepared to collaborate with one another, and to partner with consumers and their families/whānau.

It is time for key stakeholders to make a decision. Is the country happy with maintaining the status quo with regard to the MH&A community support workforce? If not, then the relevant actions outlined in this paper, and reflected in the national *Mental Health and Addiction Workforce Action Plan* (Ministry of Health,2017), need to be prioritised and then implemented with some sense of urgency.

10. RECOMMENDED NEXT STEPS

In anticipation of the final version of this discussion document being made available to a wider audience, the following steps will be undertaken:

Table 6: Recommended next steps

	Task	Description of activity
	Continue to explore the issues in more depth	This initiative will continue to test assumptions and explore the main issues in more depth, and will add a greater level of detail should further information come to light that adds to the sector's understanding of these issues.
	Consult with stakeholders	Input will be sought from a wide range of stakeholders in order to arrive at a general level of agreement about the workforce development actions that are urgently required to help know, grow and develop the community support workforce.
	Analyse the feedback	Stakeholder feedback will be collated and analysed with a view to revising the material that has been presented in this discussion paper.
	Enhance the approach	The discussion paper will be refined to reflect closer alignment between the vision of future MH&A service delivery and the priority actions that are required to help realise that vision from the perspective of the community support workforce.
	Disseminate a final paper	A concise paper for online publication will be developed. It will profile, from NGO perspectives, how the capacity and capability of the community support workforce can be increased.
	Establish both a NGO workforce governance group & a support worker advisory group	Platform Trust and Te Pou will engage with relevant stakeholders to establish and convene a NGO workforce governance group that receives advice from a community support worker advisory group.

APPENDIX 1: SUMMARY OF ACTIONS FROM NATIONAL MH&A WORKFORCE ACTION PLAN

The following table summarises those actions from the *Mental Health and Addiction Workforce Action Plan 2017-2021* (Ministry of Health,2017) that are relevant to the development of the community support workforce (including the peer support workforce). Please note that the respective roles and responsibilities of all key stakeholders have yet to be established. It is hoped that this paper will go some way towards helping to clarify which agency is responsible for what activities with regard to achieving the objectives of the national plan.

Table 7: Summary of actions from *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017)

#	Action	Phased activity	HWNZ	Other agencies
1.1	Implement an outcomes approach	Work with workforce centres and education providers to align training and competency requirements with national policy directions.		
1.2	Develop strong leadership	Identify CSWs and peer workers with leadership potential - particularly Māori, Pacific and under-represented workforce groups.		
		Develop professional development programmes for existing CSWs and peer support workers.		
2.1	Enable a more responsive workforce	Provide opportunities for CSWs and the peer workforce to co-design new roles and lead change processes.		
2.2	Strengthen collaborative ways of working	Facilitate the Pacific allied health and community support workforce to engage with and develop Pacific integrated approaches for MH&A.		
		Increase training opportunities in broader community-based services (eg schools, general practice, prisons).		
2.3	Facilitate agencies to address the social determinants of health	Develop training and development programmes in collaboration with other health and social agencies to increase the level of understanding of how the social determinants of health interact with, and impact on, mental health and wellbeing.		
3.1	Build capability across the health and disability workforce	Develop programmes for CSWs and peers employed in other related sectors (eg disability, social sector) to increase their capacity to identify and appropriately respond to MH&A issues.		
		Develop mental health literacy programmes that are culturally appropriate.		
3.2	Support the development of the community workforce to respond effectively	Refer to the list of activities in the Workforce Plan.		

#	Action	Phased activity	HWNZ	Other agencies
3.3	Strengthen and sustain the capability and competence of the mental health and addiction workforce	Refer to the list of activities in the Workforce Plan.		
3.4	Strengthen the workforce's capability to work in multidisciplinary ways	Strengthen training pathways to develop an integrated workforce and meet people's changing mental health and addiction needs.		
4.1	Use workforce data to understand the current and future size and skill mix of the workforce	Investigate methods to increase available data on the CSW and peer support workforce.		
		Use data to inform workforce planning and to adapt workforce development initiatives.		
4.2	Grow and develop the Māori workforce	Implement strategies to recruit, train and retain Māori CSW and peer support staff.		
		Improve the skills of the Māori community health and disability workforce – in relation to MH&A.		
4.3	Grow the Pacific CSW, peer and consumer workforce	Implement targeted strategies to recruit, train and retain Pacific CSW and peer support staff.		
		Strengthen the infrastructure for the recruitment and retention of the peer and consumer workforce by providing effective leadership, management and supervision.		
		Strengthen Pacific peer workforce networks at regional and national levels.		

Source: Adapted from Ministry of Health (2017).

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