the Australia and New Zealand School of Government

CASE PROGRAM 2009-95.1

"Real skills" for New Zealand's mental health workforce

When Robyn Shearer, chief executive of New Zealand's mental health workforce development and research agency Te Pou, "fell" into psychiatric nursing in the late 1980s, she found herself working night shifts at Auckland's Oakley and Carrington hospitals. The role of these Victorian-era mental institutions was by then declining, and patient numbers were vastly reduced from their heyday. But their original custodial character remained, affecting patients and staff alike: "You were there in an authoritarian, containment role. Patient files were often scant, and you weren't encouraged to look into their backgrounds... There was little rehab focus: there really wasn't any talk of people leaving."[1] For a young nursing student, Oakley and Carrington were daunting and sometimes violent places that did little to present psychiatric nursing as a rewarding career. Some staff simply sat in the staffroom reading the paper; a few pursued their own business interests, such as real estate, while on duty. Unsurprisingly, "their engagement with patients was not always good." In Carrington's infamous back wards, "[long-term residents] weren't really focused on anything other than getting up, getting showered, eating. There were minimal activities for them. And it smelled. Rather than taking patients to the toilet at night, the staff just put down sheets on the floor."

Nonetheless, as a psychiatric assistant, Robyn Shearer saw glimpses of the positive impact that mental health workers could make. She remembered teaching a 16-year old Pacific Islands boy with developmental difficulties to read: he had been charged with attempted rape,

---

This case was written by Margot Schwass under the supervision of Professor John Alford, ANZSOG, as a basis for class discussion rather than to illustrate either effective or ineffective management. The support and assistance of the Ministry of Health in the development of this case is gratefully acknowledged. The contributions of Robyn Shearer, Ana Sokratov and Janice Wilson are appreciated, but responsibility for the content lies with the author.

[1] Robyn Shearer, interview with author 7 November 2008. Unless stated otherwise, all comments are from this interview.

and was sent to Oakley because there was nowhere else for him to go. She helped take selected patients on outings to swimming pools or to play golf. She observed nurses who genuinely cared about patients. "I could see that if you worked well with someone with a mental health illness, their potential could be realised."[2]

But opportunities to work well were scarce. At the time Robyn Shearer was beginning her nursing career, the mental health workforce — and the sector as a whole — was in crisis. Conditions in the country's psychiatric hospitals were described as Dickensian, with patients routinely over-medicated and unnecessarily subjected to practices such as seclusion and restraint.[3] There were critical shortages of psychiatrists, nurses, psychologists, social workers, Māori mental health workers and other staff. Those working in hospitals faced mounting stress; burnout was common, and morale low. One consultant psychiatrist said staff were "in siege mentality and … sick of not being able to provide a quality service." He pointed to a colleague who was leaving because "it looks bad on his CV to be associated with our unit — so badly is it viewed outside. He also worries that something terrible will happen soon and he does not wish to be associated with that." [4]

While realising that the mental health system was failing many who depended on its services, as well as the workers who cared for them, Robyn Shearer was convinced that it was where her long-term career lay. She qualified as a registered comprehensive nurse and worked in a variety of clinical roles and as a mental health manager for two DHBs.[5] Her interest in workforce issues saw her appointed to set up a national workforce development programme at the Health Research Council, before moving to the Ministry of Health to lead its mental health workforce development programme. In 2008, she became chief executive of Te Pou, the government-funded National Centre of Mental Health Research, Information and Workforce Development, where she has continued the challenge of "establishing good relationships with stakeholders, enabling others to become great leaders, focus[ing] on delivering quality services and keeping the needs of service users at the heart of my actions."[6]

Trying to transform such a depleted and demoralised workforce has been a huge challenge. How did the crisis situation of the 1980s and 1990s develop? And what approaches were used to turn that situation around, and build a workforce equipped for the 21st century?

Background: deinstitutionalisation and its legacy

The desperate state of the mental health system in the late 1980s was the result of the well-intentioned, but hopelessly unplanned, process of deinstitutionalisation that had been underway since the 1950s. Prompted by new therapies and a growing conviction that the mentally ill were best cared for in community settings, the role of the large mental

---

[2] 'Introducing Robyn Shearer, our new chief executive,' www.tepou.co.nz, accessed 6 November 2008
[3] Dr Max Abbott in *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, H. Haines & M. Abbott (eds), Auckland: Mental Health Foundation, 1986, p vi
[4] ibid, p127
[5] District Health Boards. Since their establishment in 2001, New Zealand's 21 DHBs have been responsible for providing, or funding the provision of, health and disability services in their geographical area.
[6] 'Introducing Robyn Shearer, our new chief executive,' www.tepou.co.nz, accessed 6 November 2008

institutions and their in-patient populations declined dramatically. Between the late 1940s and 1980, the rate of New Zealanders in mental institutions fell from an all-time high of 500 patients per 100,000 to 225 per 100,000.[7] While hospital care was still provided for the most acutely ill and those considered dangerous, the number of beds was limited and typical hospital stays were much shorter than in the past.

For the thousands of patients discharged into the community, the services available to them were few in number, limited in scope and operating on shoestring budgets. Former patients struggled to access medical care and therapies, welfare services, jobs, suitable housing and much more. Many became trapped in a cycle of discharge and readmission to hospitals that — thanks largely to more than five years of radical health sector reform — were under-resourced, over-crowded and under constant pressure to discharge those who were least ill. Lurid headlines about murders, rapes and suicides involving mentally ill people in the community appeared regularly, fuelling mounting fears among the public, outrage among politicians, and a mix of defensiveness and despair among those working in the sector.

In 1996, a ministerial inquiry into mental health services (the Mason Inquiry) lambasted the system and its leadership. "Mental health services are in disarray…New Zealand must wake up to the fact that, for decades, mental health services have been delivered 'on the cheap'," the report concluded. Not only had the "gradual disintegration of systems" been damaging for the mentally ill, their families and the community; it had also damaged the workforce. The Mason Report identified "a flight of expertise [and] a loss of morale by those who remain within the system,"[8] and warned that "unless people with skills, ability and an empathy towards the mentally ill are available in sufficient numbers, then the mental health service runs the real risk of disintegrating."[9]

The report's findings echoed those of the National Working Party on Mental Health Workforce Development, released earlier in 1996. The Working Party pointed to surveys showing widespread national shortages of qualified, experienced mental health professionals.[10] (See *Appendix A* for a summary of staff then working in adult mental health services). Their report said training deficiencies were partly to blame. Firstly, not enough people were graduating from training programmes. More worryingly, those programmes did not reflect the changing requirements of a mental health system increasingly focused on community care and the recovery philosophy.[11] Also contributing to the staffing crisis, said the Working Party, were numerous "employment factors" — the difficulty of attracting people into mental health because of its negative image, staff morale, uncertainty created by health sector restructuring, a lack of on-the-job support.

---

[7] Hilary Haines & Max Abbott, 'Deinstitutionalisation and Social Policy in New Zealand,' *Community Mental Health in New Zealand,* Vol 1 No 2, Feb 1985, p46

[8] *Ministerial inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services* (the 'Mason Report'), Wellington: May 1996, p169

[9] ibid, p120

[10] National Working Party on Mental Health Workforce Development, *Towards Better Mental Health Services*, Ministry of Health: Wellington, 1996, p10

[11] In the mental health context, 'recovery' (more detail to follow) happens when people can live well in the presence or absence of mental illness.

The workforce problems highlighted by the Working Party were proof of the ad hoc nature of deinstitutionalisation and its legacy. With no guiding policy framework or strategy, deinstitutionalisation had simply been allowed to happen, driven largely by the convictions of clinicians, international evidence of the effectiveness of community-based care and a misguided perception by some administrators that it was cheaper than in-patient care. Unfortunately, with the devolution of purchasing powers to health boards and the fiscal austerity that accompanied the health reforms of the 1990s, any money saved by winding down hospital-based services was not necessarily put into community care.

The unplanned, chaotic drift to deinstitutionalisation created a new mental health landscape. For existing staff to work effectively in it, and to attract a pool of suitable new recruits, some long-overlooked fundamentals were urgently needed — the funding, strategy and infrastructure for workforce development.

The platform for workforce development: funding, strategy, infrastructure

The release of the Mason Report in 1996 prompted some swift responses. The Government immediately agreed to increase core mental health funding by $142.2 million over the next five years (from $419.2 million in 1995/96). A national action plan for mental health, *Moving Forward*, was released in 1997. The Mental Health Commission was established and, in 1998, released its landmark *Blueprint for Mental Health Services*, detailing the services required to meet the needs of the 3 percent of New Zealanders affected by serious mental disorders.

The *Blueprint* provided a firm foundation from which to tackle the workforce issues highlighted by the Mason Inquiry and the Working Party, setting out very clearly the number of full-time equivalent staff needed to deliver mental health services by 2010 (see Appendix B). A National Mental Health Workforce Development Co-ordinating Committee was established to give national co-ordination and leadership to workforce development initiatives. When the Government agreed to provide substantial extra funding to ensure the *Blueprint* targets were met within ten years, there was a specific allocation for national workforce development. Between 2002/03 and 2004/05, the 'Blueprint funding' for workforce development grew from $22.32 to $25.77 million.[12] This kind of dedicated workforce funding was a rarity: "We were the envy of other parts of the health sector," said Robyn Shearer.

But funding was only part of what was needed. Mental health nurse Dr Frances Hughes, invited by the Mason Inquiry to comment on workforce issues, identified an urgent need for national strategy and coordination: "How can you plan for a work force without a strategic plan? How can sectors work together when there is no requirement to work together?"[13] These questions were addressed with the first national workforce development plan,

---

[12] Ministry of Health, *Tauawhitia te Wero: Embracing the challenge, National Mental Health and Addiction Workforce Development Plan 2006-2009*, Ministry of Health: Wellington, 2005, p6. This funding was distributed via the Ministry of Health's Mental Health Directorate and the Clinical Training Agency, a business unit of the Ministry which funds post-entry clinical training.

[13] Mason Report, p129

Tuutahitia te Wero: Meeting the Challenges (2000) which outlined detailed goals for the next five years. The plan focused particularly on building specific workforces for areas where needs were emerging rapidly — including Māori, Pacific, alcohol and drugs, and child and youth workers. It was followed in 2005 by a second national plan, *Tauawhitia te Wero: Embracing the Challenge*, developed by the Ministry of Health under the leadership of Robyn Shearer.

An important infrastructure development was the establishment of five national workforce development centres/programmes between 2000 and 2008. All were funded by the Ministry of Health to undertake a mix of training, research and advocacy, and to develop strategic plans to guide the development of specific workforces. Te Pou was established in 2006 to continue the national workforce development programmes set up by the Ministry of Health and other agencies since 1997. The other centres were Te Rau Matatini, the Māori workforce development organisation; the Werry Centre for Child and Adolescent Mental Health Workforce Development; Matua Raki, the programme for addiction treatment workforce development; and Le Va, the Pacific workforce development programme (located within Te Pou).

The centres were designed to complement the training and development work of existing professional associations and colleges, such as those representing psychiatrists and nurses. They also supported the training and other workforce activities undertaken by the 21 DHBs and hundreds of non-governmental organisations that directly employed the country's mental health workers. Unlike these other agencies, the work of the national centres cut across occupational, regional and employer boundaries; their brief was strategic and long-term, and they managed an increasingly significant proportion of public funds allocated to national workforce development.

Over the same period, four regional mental health workforce coordinators were appointed, three in the North Island and one in the South. Their role was to align national workforce development efforts with the activities of DHBs and other employers in their regions. Various other mechanisms were developed to bring together the many agencies involved, including the Ministry of Health's Mental Health Workforce Development Committee (which included representatives from employers, as well as mental health service users, families and communities) and the Ministry of Health-DHB Workforce Development Steering Committee.

As these initiatives demonstrated, by the beginning of the 21st century, workforce development was increasingly seen as a strategic, national and ongoing exercise requiring a "whole system" approach. Traditionally, workforce initiatives had been fragmented across a wide range of agencies; the individual hospitals or health boards who recruited and employed staff, the institutions and programmes which trained them, the professional bodies which supported them and set standards for training, assessment and registration. Employers and agencies dealing with workforce issues thus tended to see "workforce development" as comprising a number of discrete elements — education, training, recruitment, retention, organisational culture, leadership — that could be tackled independently as needed. However, a whole system approach saw all these elements as part of an integrated, indivisible whole. As Robyn Shearer explained:

> "The whole system approach is not just about training. It deals with all the infrastructure an organisation needs, not just to deliver services, but to develop its workforce and to enable workers to do their job well. And it deals with the fact that workforce development goes hand in hand with service development. They are often seen as very separate things. But it's the people that deliver the service, so I don't see how they can be different."

Responding to the new mental health landscape

The resource guidelines provided in the *Blueprint* were undoubtedly valuable, said Robyn Shearer: "It's been fantastic having the *Blueprint* as an argument for why we need to invest in growing particular workforces, such as child and youth." However, its full-time equivalent (FTE) guidelines did not always keep pace with developments in services, and were far from definitive. Accurately quantifying the workforce has remained problematic, especially with the increasing diversification of service providers: data is generally collected only from DHBs, meaning the sizeable non-governmental organisation (NGO) workforce is seldom counted.[14] Some working in the field say that the lack of reliable data has hampered the development of national strategies.[15]

Accordingly, workforce development efforts have focused less on simply growing the size of the mental health workforce to meet nominal targets (apart from certain niches where needs were growing rapidly, such as the child and adolescent workforce, and Māori and Pacific workers) than on developing workforce capabilities. According to *Te Tāhuhu*, the second national mental health strategy (2005), the mental health workforce in the twenty-first century needed to "support recovery, [be] person centered, [be] culturally capable and deliver an ongoing commitment to assure and improve the quality of services for people." What did these attributes mean, and how have they been developed?

Real skills for a recovery-focused workforce

In 1998, the *Blueprint* said the concept of recovery and a focus on service users should guide all aspects of the mental health system. These principles were subsequently incorporated into all national strategies and policies, as well as the National Mental Health Standards that service providers must meet in order to qualify for government funding.

Defined as what happens when people "live well in the presence or absence of mental illness," the recovery concept represented a profound attitudinal shift. It placed people with mental illness at the centre of the mental health system: recovery was a journey that they had the power to define and to participate in fully. It implied that the role of mental health workers was to support people's recovery, not to incarcerate, manage or cure them. Among other things, this meant being willing to be guided and led by service users themselves, and to recognise that medical competencies alone were not enough to support recovery.

---

[14] *Appendix C* gives a partial picture of the number of FTE workers in 2003-2004, but data collection problems are apparent — note the wide variations in the number of psychiatrists assessed by different sources. Likewise, *Appendix D* estimates how many more mental health workers were required in order to meet the *Blueprint* service targets, but also notes discrepancies in data and definitions.

[15] For example, the authors of *Improving Recruitment to the Mental Health Workforce in New Zealand,* Health Research Council, Wellington: 2005, p29

Improving training and professional development were seen as key to developing a recovery-focused workforce. Yet in 2001, the Mental Health Commission said the training and curricula provided to many mental health workers did not adequately address recovery and related issues such as service user participation, family perspectives, discrimination and stigma. The Commission proposed a set of "recovery competencies" for all workers, regardless of their occupation or role within an organisation (see *Appendix E).* The competencies must not be treated simply as "add-ons" to current curricula or training standards, it said: "They signal a fundamental change to all aspects of the education of mental health workers. They require that some new material be taught. But they also require that some existing material be taught differently."[16]

Over the next few years, competency frameworks continued to be developed and refined, culminating in 2008 with the release of the Ministry of Health's *Let's get real: Real Skills for people working in mental health and addiction*. The seven core "Real Skills" it required of mental health workers (see *Appendix F*) would not replace the competency frameworks of individual professions, nor create a "one size fits all" workforce, said Robyn Shearer, who led the *Real Skills* project. Rather, they expressed common understandings about how mental health workers – from entry level workers. to practitioners and leaders – should work with and for service users in the interests of recovery. From 2008 onwards, Te Pou was working to gradually embed *Real Skills* as a training and organisational development tool across DHB and NGO services, and in all courses available to mental health workers.

Robyn Shearer acknowledged it was hard to measure the impact of such initiatives. In 2006, the Mental Health Commission recommended "robust audits" to find out the extent to which recovery had been incorporated in the training of mental health workers.[17] As at the beginning of 2009, these had not yet occurred. Anecdotal evidence was encouraging: the Commission reported that service users were encountering better attitudes among workers, suggesting a growing understanding of recovery. It appeared that the most substantial progress was being made by newer workforce groups, such as community support workers.[18] Meanwhile, Te Pou was working to develop and pilot an evaluation tool that services could use to measure how well they implemented recovery practices. Te Pou was also introducing patient outcome measurement tools such as HONOs (health of the nation outcome scale) in clinical services, and providing training for staff in their use. Such tools allowed clinicians to work with patients and families/whānau on measuring the individual's progress over time, said Robyn Shearer.

Robyn Shearer identified a number of issues still to be tackled. Among them was the need for mental health workers to be trained to work better with the families of the mentally ill. In part, she conceded this was the result of the emphasis on the needs of service users, who did not always want family members to be involved in their recovery. There was room for clinicians to have a better understanding of the Privacy Act (which had sometimes been

---

[16] Mental Health Commission, *Recovery Competencies for New Zealand Mental Health Workers,* Mental Health Commission, Wellington: 2001, p3

[17] Mental Health Commission, *Te Haererenga mo te Whakaōranga*: *The Journey of Recovery for the New Zealand mental health sector,* Mental Health Commission, Wellington: 2007, p 104

[18] ibid, p105

misinterpreted to prevent information from being disclosed to family members), and also to recognise when "someone's problems are systemic and can be family-oriented… Many workers wouldn't feel comfortable running a family meeting or confronting family issues. We're trained to work with individuals and their problems. So I think in that sense, we don't always do families justice. It could be better." She identified training for mental health workers in talking therapies (such as cognitive behavioural therapy and motivational interviewing) as another important priority which Te Pou will be driving.

Service-user involvement

"I am in no doubt that attitudes and ways of practice among mental health workers have changed significantly by the very active participation and involvement of consumers," said Deputy Director-General of Health and psychiatrist Dr Janice Wilson in 2008. "They have challenged the traditional medical paradigm, and mental health professionals have responded and shifted."[19]

One of the key ways in which service users — people with current or past experience of mental health services — could influence the mental health system was by becoming part of the workforce. Many argued that "recovery must be led by service users and informed by their unique lived experience of mental illness.[20] Over time, growing opportunities were created for service users to enter the workforce and advisory roles. It was envisaged that they would eventually become "a skilled, powerful, pervasive and openly identified part of the mental health workforce."[21]

Some service users entered the workforce as mental health support workers, a new occupational group with its own tertiary certificate-level qualification offered nationwide since 1999. The development of this new, non-clinical, recovery-focused occupation has been described as "a great workforce achievement of the decade."[22] By 2004, 1,176 people had graduated with the National Certificate in Support Work and, by 2008, support workers were the second largest occupational group (after nurses) in the mental health workforce. [23] In addition, a sub-category of peer support workers had developed, also with its own training framework. Service users were specifically recruited for these roles, which Robyn Shearer described as "using your own experience to support someone through their mental health journey."

But service users can be found working in all capacities throughout the mental health system, including in decision-making and governance roles. One was Ana Sokratov, consumer consultant to the Waitemata DHB (which has the largest mental health services group of any DHB in the country). A trained lawyer, she is also a company director of Te Rau Matatini (the national Māori mental health workforce development organisation) and an advisor to the

---

[19] Interview with author, 10 Nov 2008.
[20] Mental Health Commission, *Te Haererenga mo te Whakaōranga*, p120
[21] Mental Health Commission, *Service-user Workforce Development Strategy for the Mental Health Sector 2005-2010*, Mental Health Commission, Wellington: 2005, p1
[22] ibid
[23] Mental Health Commission, *Te Haererenga mo te Whakaōranga*, p 108

Mental Health Commission, the Families Commission and the Health and Disability Commissioner. Her team of eight consumer advisors at Waitemata DHB — all of whom are also service users — work across mental health and alcohol and drugs services (in-patient and community, for all ages), as well as forensic services. Their role is to embed consumer perspectives at every level of the DHB's mental health services, working alongside staff and managers in areas including service development, quality improvement, staff recruitment and training. They also provide recovery training, using a module developed by Ana that has since become mandatory for all staff. "We've talked about definitions of recovery, hope, about collaboration with consumers, about working with families, about breaking down attitudinal barriers, stigma and discrimination. The feedback we get shows the training has helped bring about a change of culture in our services."[24] In 2008, Ana helped develop online training for overseas doctors wanting to work in mental health in New Zealand, also giving consumer, Māori, Pacific and family perspectives on recovery.

As at 2009, the number of service users working in mental health was still unknown, and the Mental Health Commission said they remained "a significant unrealised potential."[25] For Robyn Shearer, the way to realise that potential was by ensuring they received high-quality training, support and supervision to equip them for a demanding role in which they often had to challenge the ways clinical staff and systems worked. Ana Sokratov agreed that training, as well as high levels of management support, were key to enabling service users to work to their full potential. Experience of mental illness was not in itself a sufficient qualification:

> "Not everyone who has a mental illness can do this sort of work. It's about how you understand that experience, and your ability to use it positively in working with either consumers or staff. If you've got a huge chip on your shoulder, you're not going to be successful. But if you've got a sense of survival, if you've experienced recovery and understood how you got there, all the ups and downs, and if you can articulate that in a way that creates improvements and persuades people to change — those are the qualities and attributes we need."

Developing the NGO workforce

The expansion of non-governmental organisations (NGOs), many of them run and/or staffed by service users, was also central to the transformation of the mental health system. While in the mid-1990s the sector was small and received only 10 percent of public mental health funds, by 2008, approximately a third of all funds was distributed to around 400 NGOs. Most provided housing, employment support, skills development and advocacy services, with some offering clinical services as well. They ranged from neighbourhood drop-in centres to large providers of residential and home-based support, but the majority had fewer than 10 full-time equivalent employees. Most community support workers were employed by NGOs and comprised the majority of the NGO workforce, which also included many volunteers.

Key workforce issues for NGOs included a lack of funding certainty (which could affect training and development plans), lower wages, a lack of career pathways, and professional isolation for some staff (especially clinical) compared with their colleagues in DHBs. The

---

[24] Ana Sokratov, interview with author, 7 November 2008. Unless stated otherwise, all comments are from this interview.
[25] Mental Health Commission, *Te Haererenga mo te Whakaōranga*, p120

lack of data about the NGO workforce was also a problem, although Platform (a sector organisation representing many mental health NGOs) undertook a workforce survey in 2007. Coordinating a strategic national approach to NGO workforce development was also challenging. In 2006, the Ministry of Health's Mental Health Workforce Development Programme commissioned *Te Awhiti*, an NGO workforce development plan, and in 2009, Te Pou appointed an NGO lead to work directly with the sector and organisations such as Platform.

Robyn Shearer said that Te Pou was committed to developing the potential of the NGO workforce, as the services they provided were often more innovative, flexible and attuned to recovery. As one psychiatrist commented in 2001: "NGOs and consumer groups bring an expertise and experience that's not available or understood in conventional services, which can be blinded by their day-to-day workload and frustrations."[26]

Multidisciplinary teamwork

The role of multi-disciplinary teams was another defining feature of mental health services in the early twenty-first century. Traditionally, the psychiatrist was the key decision-maker in the mental health hierarchy: others such as social workers, nurses or occupational therapists contributed, but it was the psychiatrist's view that prevailed when deciding treatment, discharge and admission.

In some senses, little has changed. Robyn Shearer said that psychiatrists mostly retained ultimate responsibility for treatment, especially when people were assessed or treated compulsorily under the Mental Health Act "and rightly so. The buck stops with them if things go wrong; they are deemed the responsible clinicians for treatment outcomes." However, on a day-to-day level, care was generally delivered by teams drawn from multiple occupational groups with complementary areas of expertise. As the recovery approach required, they included both medical staff (chiefly psychiatrists and nurses) and non-medical staff (psychologists, support workers, social workers and others). Roles were changing and expanding. Nurse practitioners were becoming increasingly common and undertaking some of the traditional medical roles. Others – such as occupational therapists, support workers, peer support roles and psychologists – could be utilised more, Robyn Shearer said.

The challenge of the multi-disciplinary environment, she believed, was that workers tended to have been trained individualistically within their own profession. "Then suddenly, you have to work in this environment where you're part of a team. You have to decide who fits where in the hierarchy, and who is going to provide what level of service." She said Te Pou was planning to provide more post-entry group training opportunities to help workers function better in multi-disciplinary teams.

Another important focus was developing the leadership skills of psychiatrists. "They are trained to be doctors, but leading a team or service requires a whole lot of other skills they may not get taught in the workplace setting or at medical school." At present, she said their

---

[26] Dr Frank Rawlinson in Mental Health Commission, *Awhi, Tautoko, Aroha: Celebrating recovery-focused mental health workers who assist people on their journeys*, Mental Health Commission,Wgtn: 2001, p17

ability to lead often depended on the leadership models they had encountered while working in hospitals as medical students or interns, where they were "under the wing" of the psychiatrist in charge. The involvement of the College of Psychiatrists in the development of the *Let's Get Real* framework acknowledged the importance of leadership skills for psychiatrists.

Working better with Māori and Pacific people

The Mason Report highlighted not only a disproportionately high number of Māori with mental health disorders, but also a lack of culturally appropriate services, a high rate of Māori hospital admissions and readmissions, and a shortage of Māori mental health workers. Ten years later, with the Māori population having grown steadily to become 14.6 percent of all New Zealanders[27], many of these problems remained. The prevalence of mental disorders over a 12-month period was significantly higher among Māori (29.5 percent) than the non-Māori population (19.3 percent).[28] Māori tended to be more seriously ill before they came into contact with mental health services; the majority with mental health problems did not receive any form of health care.[29] Young Māori were experiencing higher rates of mental illness than earlier generations.[30] Yet the country had fewer than ten Māori psychiatrists, accounting for less than 2 percent of all psychiatrists.[31]

Nonetheless, some important things had changed in Māori mental health. Māori concepts of health and wellbeing were firmly embedded in national mental health policy and plans, including *Te Puāwaitanga*, the first Māori mental health strategic plan (2002). There was considerable growth in kaupapa Māori mental health services (those run by Māori and founded on Māori cultural philosophies). In mainstream services, too, there was increasing understanding of the link between cultural identity and mental wellbeing. By 2006, psychiatrist and long-standing Māori health champion Professor Mason Durie could write that "the foundations for building a mental health care system that encompasses Māori world views and Māori models of treatment and care … have been significantly developed and are now integral to services in DHBs and NGOs."[32]

The Ministry of Health sought to build more effective services for Māori through several strategies. Te Rau Matatini, the Māori workforce development centre, was established in 2002 to develop the cultural and clinical excellence of Māori mental health workers. The centre set a target to increase the number of Māori mental health workers from 15 percent of

---

[27] Between 1991 and 2006, the Māori population increased by 30 percent to reach 565,329 in 2006. Statistics New Zealand projects the Māori population will grow by another 20 percent between 2006 and 2021.
[28]MA Oakley Browne, JE Wells, KM Scott (eds), *Te Rau Hinengaro: The New Zealand Mental Health Survey*, Ministry of Health, Wellington 2006
[29] Ministry of Health, *Te Puawaiwhero: The second Māori mental health and addiction national strategic framework, 2008-2015*, Ministry of Health, Wellington: 2008, p9
[30] ibid, p6
[31] Mental Health Commission, *Te Haererenga mo te Whakaōranga*, p31/ Te Rau Matatini, *Kia Puāwai Te Ararau: National Maori Mental Health Workforce Development Strategic Plan 2006-2010*, Ministry of Health: Wellington, 2006, p 41
[32] Mental Health Commission, *Te Haererenga mo te Whakaōranga*, p30

the workforce in 2002 to 20 percent by 2011.[33] There was also a commitment to broadening the occupations in which Māori worked; traditionally, most were support workers or nurses, with very few psychiatrists and psychologists. Other Ministry of Health initiatives included the formation of Te Rau Puawai, a joint initiative with Massey University to fund university students working in disciplines related to Māori mental health, and the Henry Rongomau Bennett scholarships, fostering Maori leadership skills and clinical excellence among Māori mental health practitioners.

Approaches to training and skills development for those working in both kaupapa Māori and mainstream services continued to evolve. While *Tauawhitia te Wero* (the 2006-09 national workforce development plan) had contained a framework of dual competencies for workers — cultural and clinical — *Real Skills* approached the issue differently. Explained Robyn Shearer: "One of the core skills is 'working with Māori', but in fact the ability to work responsively and effectively with Māori is threaded through all the other skills. We didn't want workers to see it as a separate thing, an add-on — although, if you were working in a kaupapa Māori service, there might be some extra specialist te reo [Māori language] or other skills that would be different from a mainstream service."

Despite these promising developments, Māori voices continued to raise concerns about how well Māori concepts of mental health were put into practice by mainstream services, and the level of support for kaupapa Māori services. According to the Mental Health Commission, "there was a shortage of funders who understood and valued kaupapa Māori service provision, and lack of funding for the establishment of sustainable infrastructures."[34] There were also concerns about the appropriateness of evaluating the performance of kaupapa Māori services using "Eurocentric paradigms."[35]

With the establishment of Le Va, Te Pou was tackling the need to grow the Pacific mental health workforce. As at 2009, Pacific people remained over- represented in mental health and addiction services, yet tended to access services at a late stage. Le Va aimed to grow numbers and capability of the Pacific workforce via scholarships, leadership development programmes, tools and training.

Promoting careers in mental health

While DHBs and NGOs were responsible for recruiting and retaining the mental health workers their organisations needed, Robyn Shearer was convinced a national career promotion campaign was also needed to address long-standing shortages. The shortage of psychiatrists was a particular concern. In 2003, there were 288 specialist psychiatrists working in New Zealand, providing a ratio of approximately 1:14,000 population. The World Health Organization recommended 1:10,000, meaning New Zealand was short of at least 118 psychiatrists.[36] While numbers were gradually increasing, this was often through the short-term recruitment of doctors from overseas, who did not always have the cultural knowledge

[33] Te Rau Matatini, *Kia Puāwai Te Ararau,* p41and p11
[34] Mental Health Commission*, Te Haererenga mo te Whakaōranga*, p167
[35] ibid, p169
[36] ibid, p 113

to work in a recovery-focused way. Meanwhile, the number of local trainees entering programmes remained low, and failure and dropout rates were high. “We need to do something quite different with the way we promote psychiatry as a career,” she said.

For all occupational groups, negative perceptions of mental health were a barrier to recruitment, said Robyn Shearer. These were symptomatic of wider community attitudes towards mental illness — fears of violence, a belief that mentally ill people were hopeless cases — and also fuelled by negative publicity about apparent failures by services and individual professionals. When headline-grabbing sentinel events occurred, she said, “I think people start to wonder why on earth they’re working in mental health.”

She said the *Real Skills* document was proving useful as a promotional and recruitment tool, giving prospective mental health workers a clear sense of the different roles and ways of working in the sector. But she also called for a national advertising campaign which would promote in a realistic way the challenges and rewards of working in mental health. “It needs to present the complexities. There are some very conflicting aspects to this work that require very careful thought and judgement from workers. They have to balance an individual’s freedom of choice against the fact that their judgment may be impaired, and deal with much that is unpredictable.”

Progress and challenges

In 2006, the Minister of Health announced that the number of psychiatrists and mental health nurses had grown by 26 percent since his government came to power in 2000. This was proof, he said, of the administration’s commitment to redressing the mistakes of the past: “A failure to invest in the mental health workforce in the 1990s led to increased pressure on services and a failure to deliver quality care for New Zealanders in need.”[37] Through reinvestment, the workforce was growing again.

However, there were still some significant gaps between the number of staff that the *Blueprint* said were needed to deliver a quality mental health system, and the actual workforce. Progress against the *Blueprint* targets (see *Appendix B*) was variable: the Mental Health Commission said that while the number of community-based, non-clinical support workers was only 10 percent less than *Blueprint* guidelines, the number of community-based clinical workers was 27 percent below the target.[38] There were particularly high vacancy rates in service areas that had experienced rapid growth and high demand, especially child and youth, and addiction services. The number of Māori and Pacific workers still did not reflect the high prevalence of mental illness among these groups. Service users themselves represented a valuable workforce whose potential remained untapped. There was still much room for improvement in the way the mainstream workforce worked with Māori and Pacific service users and their families.

Although Robyn Shearer believed workforce policy, strategy and infrastructure had developed strongly since the 1990s, there was a need to consolidate the gains. The workforce

---

[37] Hon. Pete Hodgson, press release, 3 Aug 2006. Available at www.beehive.govt.nz, accessed 10 Nov 2008
[38] Mental Health Commission, *Te Haererenga mo te Whakaōranga*, p103

development centres needed to produce more evidence of how their programmes were benefiting the workforce and service users. What constituted valid evidence also needed re-thinking: "sharing stories and knowledge is sometimes under-rated." She was confident that the centres were making a difference, although change would not be rapid. "In ten years time, we should have a different-looking workforce doing different things" as a result of the centres' efforts.

A real test of progress, she said, would be the success of efforts to build the primary health workforce, a new area of work that recognised that for most New Zealanders, their mental health needs were best met by primary health providers (GPs, medical centres etc). Robyn Shearer was concerned that the workforce implications may not be adequately planned for. "Although there have been funded initiatives that have worked well, the workforce side of it has been based on local good practice with little consistency nationally or attention to the competencies required. We don't want to set the primary care sector up to fail, so it's important we plan across primary and secondary services about how they can work together, and share resources when possible." The development of the primary mental health workforce would, she said, demonstrate how well the mental health sector had learned from the mistakes of deinstitutionalisation and its aftermath.

> "In health, things are often done in response to a crisis and without the luxury of planning. Something looks like a good idea, it's funded, and expectations are set. But it often happens without really considering what we want this service to look like, what we want our workers to deliver, what competencies they need to do so. More importantly – will this meet the needs of our population and what evidence do we have to ensure this is the correct approach? We've had lots of experience with the 'let's see if this works' approach: now it's time for a systematic, planned approach. We need to acknowledge that it takes ten years from planning a change in workforce, to having that change embedded in the system fully with the right training, recruitment, organisational development, information and research. Its as simple as having the right people in the right place at the right time doing the right thing!"

Appendix A: Staff working in adult mental health services, 1995

Figure 13: Staff in adult mental health inpatient facilities (FTEs) — 1995

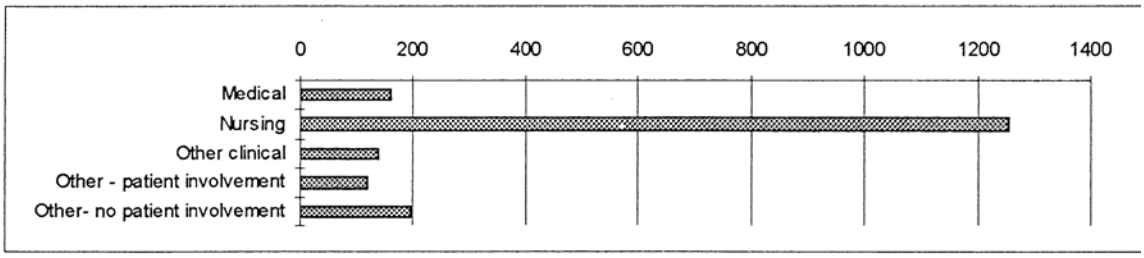


Figure 14: Staff in mental health community residential facilities (FTEs) —- 1995

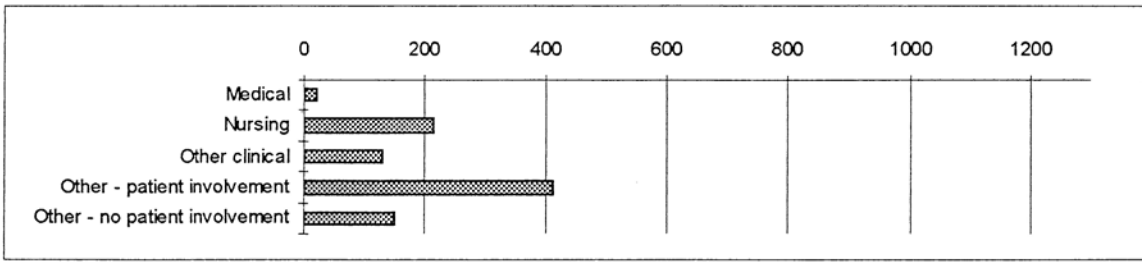
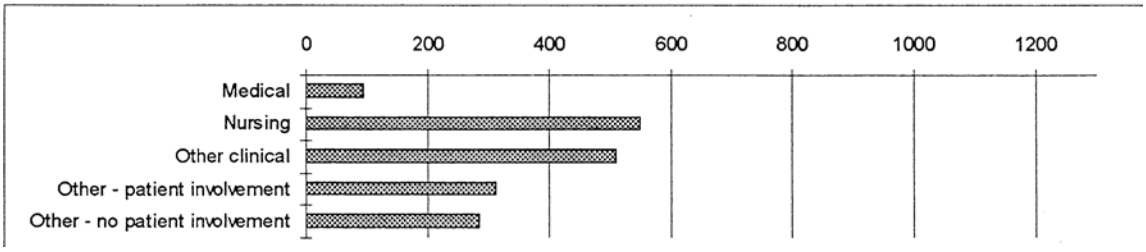


Figure 15: Staff in mental health community services (FTEs) — 1995



Source: Ministry of Health, *Towards Better Mental Health Services: The report of the National Working Party on Mental Health Workforce Development,* Wellington: Ministry of Health, 1996, p102. Note that the graphs exclude staff working in forensic psychiatric services.

Appendix B: The *Blueprint*'s workforce requirements

The Mental Health Commission's *Blueprint for Mental Health Services in New Zealand: How things need to be* (1998) set out the resources required to create a "high quality, well integrated mental health service" capable of meeting the needs of the three percent of New Zealanders affected by severe mental disorders. It included resource guidelines for the number of treatment places, bed or 'care' packages, and full time equivalent staff (FTEs) required. The following table shows only the FTEs required for services provided to various age groups.

Type of service		Current resources: total NZ	Resource guideline: total NZ	Resource guideline per 100,000 total population	Age group			
ADULT SERVICES					**0-14**	**15-19**	**20-64**	**65+**
Mental health and alcohol & drug services - specialist expertise	FTEs	2.3	68.1	2.00		0.30	1.30	0.20
Mental health and alcohol & drug – community teams	FTEs	0.0	56.7	1.50		0.20	1.20	0.10
Mental health & intellectual disability – specialist expertise	FTEs	18.4	37.8	1.00		0.60	0.40	
Total clinical FTEs		1,634.1	2,748.7	56.90	0.70	6.90	44.90	4.40
Total non-clinical FTEs		451.2	1,529.7	40.50		2.60	36.10	18.10
SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES					**0-14**	**15-19**	**20-64**	**65+**
Community mental health teams – child, youth & their families	FTEs	300.2	1,080.2	28.6	15.6	13.0		
Total FTEs		300.2	1,080.2	28.6	15.6	13.0		
SERVICES FOR OLDER PEOPLE					**0-14**	**15-19**	**20-64**	**65+**
Older people – community teams	FTEs	49.3	321.0	8.5				8.5
Total FTEs		49.3	321.0	8.5				8.5
REGIONAL SPECIALIST SERVICES - FORENSIC					**0-14**	**15-19**	**20-64**	**65+**
Forensic – court liaison	FTEs	19.5	30.2	0.80			0.80	
Forensic – prison liaison	FTEs	9.2	25.4	0.67			0.67	
Forensic – community liaison services	FTEs	35.6	18.9	0.50			0.50	
Mental illness and alcohol & drug disorders – specialist expertise	FTEs	0.0	7.4	0.20			0.20	

Type of service		Current resources: total NZ	Resource guideline: total NZ	Resource guideline per 100,000 total population	Age group			
Total FTEs		64.3	81.9	2.17			2.17	
REGIONAL SPECIALIST SERVICES					**0-14**	**15-19**	**20-64**	**65+**
'Mothers & babies' – community staff	FTEs	22.8	66.1	1.75		0.25	1.50	
Head injury or neurological disorder with behavioural problems – community teams	FTEs	0.0	7.6	0.20			0.20	
Eating disorders – community teams	FTEs	15.4	90.6	2.40		0.40	2.00	
Services for profoundly deaf people who have a mental illness – community consultation/ liaison	FTEs	1.5	4.5	0.12			0.12	
Services for refugees who have mental health disorders – community staff	FTEs	2.8	7.6	0.20			0.20	
Services for people with disabling personality disorders – community teams	FTEs	10.2	11.3	0.30			0.30	
Services for people with severe anxiety disorders – community teams	FTEs	8.0	11.3	0.30			0.30	
Mental illness prevention services – community staff	FTEs	0.0	377.7	10.00	3.30	2.80	3.90	
Total clinical FTEs		60.7	576.7	15.27	3.30	3.45	8.52	

Source: **Blueprint for Mental Health Services in New Zealand: How Things Need to Be,** ***Mental Health Commission, Wellington: 1998, pp 99-102***

Appendix C – Estimated size of the workforce (as at Oct 2005)

Clinician	Number	% Maori	Source
Alcohol and drug workers	+/- 850		National Addiction Centre
Mental health nurses[1]	2,871 registered nurses (1,722 in DHB inpatient units; 739 in community posts)	13% of registered mental health nurses	Nursing Council of New Zealand Annual Report 2003
	253 enrolled nurses	19% of enrolled mental health nurses	
Mental health support workers	974	27%	NZQA graduates of the National Certificate in Mental Health Support Work[2]
Psychiatrists	415	1%	Medical Council annual report 2003[3]
	269		NZHIS active specialists 2002[4]
	302		CTA strategic intentions 2004-2013[5]
Psychologists	1,305[6] (28% work in DHBs) 486 spend some time as clinical psychologists	4.7%	NZHIS 2003 Annual workforce survey
Social workers	311		ANZASW[7]

1. 71 percent of registered nurses in mental health are female and that the median age is between 40 and 44. For enrolled mental health nurses 77 percent are female with a median age of 45 to 49.

2. Not all mental health support workers completed the National Certificate and not everyone who has done the certificate is working in mental health. NZQA is the New Zealand Qualifications Authority.

3. Based on doctors who are vocationally registered to practice Psychological Medicine or Psychiatry as of March 31, 2003, however, some of these are inactive and do not hold an APC.

4. Active here is defined as holding an APC and practicing for more than four hours a week. NZHIS is the New Zealand Health Information Service.

5. Quoted in the 'Clinical Training Agency Strategic Intentions: 2004-2013' (Ministry of Health, 2004) as the number of psychiatrists holding an APC in June 2003 based on the New Zealand medical register.

6. 1,305 is the number of psychologists sent an invoice for their APC in 2003. 889 psychologists responded to the workforce survey of which 486 stated that they spent some time as Clinical Psychologists. 121 of these worked in private practice and 211 in DHBs.

7. ANZASW is the Aotearoa New Zealand Association of Social Workers.

S

Source: Mental Health Workforce Development Programme,* Improving Recruitment to the Mental Health Workforce in New Zealand, *Health Research Council, Auckland, 2005, p25

Appendix D – Future workforce requirements (as at Oct 2005)

Table 5. Current FTE's in post compared to the 'Blueprint' targets.

	Current FTE's in Post[1]	Implement 'Blueprint' Fully (FTE's)[2]	FTE Needed	Percentage Increase
Community clinical FTE's	2721	4723	2002	74%
Inpatient clinical FTE's	2363	2472	109	5%
Total clinical FTE's	5084	7195	2111	42%

1. From DHB third quarter returns to the Mental Health Commission 2003-2004.

2. From Mental Health Commission 'Report on Progress 2002-2003 towards implementing the Blueprint for mental health services in New Zealand' (Mental Health Commission, 2004).

In Table 5 it appears that only a small increase in inpatient clinical FTE's is needed, whereas from the survey of advertised vacant posts these are the staff most in demand.

Note: the source document draws attention to the discrepancy between this data — which indicates that only a small increase in inpatient clinical FTEs is needed — and a survey of mental health jobs advertised on DHB websites on a certain day (July 4 2004). That survey indicated that inpatient clinical staff were those most in demand. The difficulty of defining the term 'clinical' (which, to some individuals and organisations, meant staff with direct contact with consumers, while others used it to refer to professionally qualified workers) was also noted.

Source: Mental Health Workforce Development Programme,* Improving Recruitment to the Mental Health Workforce in New Zealand*, Health Research Council, Auckland: 2005, p29

Appendix E: Recovery competencies for mental health workers (2001)

A competent mental health worker:

1. understands recovery principles and experiences in the Aotearoa/NZ and international contexts

2. recognises and supports the personal resourcefulness of people with mental illness

3. understands and accommodates the diverse views on mental illness, treatments, services and recovery

4. has the self-awareness and skills to communicate respectfully and develop good relationships with service users

5. understands and actively protects service users rights

6. understands discrimination and social exclusion, its impact on service users and how to reduce it

7. acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them

8. has comprehensive knowledge of community services and resources and actively supports service users to use them

9. has knowledge of the service user movement and is able to support their participation in services

10. has knowledge of family/whānau perspectives and is able to support their participation in services.

Source: Mental Health Commission,* Recovery Competencies for New Zealand Mental Health Workers*, Mental Health Commission, Wellington: 2001, p7

Appendix F: The Ministry of Health's Real Skills from *Let's Get Real*

The seven Real Skills are shared by everyone working in mental health and addiction treatment services, whether administrative staff, psychiatrists or team leaders. Each Real Skill cannot be read in isolation. It is important to read across all of the Real Skills to see how they inter-relate and connect with one another. Work in mental health and addiction treatment services is complex and involves using more than one Real Skill at any one time.

Working with service users
Every person working in a mental health and addiction treatment service utilises strategies to engage meaningfully and work in partnership with service users, and focuses on service users' strengths to support recovery.

Working with Māori
Every person working in a mental health and addiction treatment service contributes to whānau ora for Māori.

Working with families/whānau
Every person working in a mental health and addiction treatment service encourages and supports families/whānau to participate in the recovery of service users and ensures that families/whānau, including the children of service users, have access to information, education and support.

Working within communities
Every person working in a mental health and addiction treatment service recognises that service users and their families/whānau are part of a wider community.

Challenging stigma and discrimination
Every person working in a mental health and addiction treatment service uses strategies to challenge stigma and discrimination, and provides and promotes a valued place for service users.

Law, policy and practice
Every person working in a mental health and addiction treatment service implements legislation, regulations, standards, codes and policies relevant to their role in a way that supports service users and their families/whānau.

Professional and personal development
Every person working in a mental health and addiction treatment service actively reflects on their work and practice and works in ways that enhance the team to support the recovery of service users.

Source: Ministry of Health,* Let's Get Real: Real skills for people working in mental health and addiction, *Ministry of Health, Wellington, 2008, p4