The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Mental Health and Addiction Workforce Action Plan
Health Workforce New Zealand
Ministry of Health
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To the Workforce Action Plan Team,

Mental Health and Addiction Workforce Action Plan 2016-2020

Thank you for providing the Royal New Zealand College of General Practitioners (the College) the opportunity to comment on the *Mental Health and Addiction Workforce Action Plan 2016-2020* (the Action Plan).

Introduction to general practice and the College

General practice is the specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical College in the country. The College provides training and ongoing professional development for general GPs and rural hospital generalists, and sets standards for general practice. The College is committed to achieving health equity in New Zealand. To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education and housing).
- A greater focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Health services that are better integrated with other community services.
- A review of the funding model for primary care to ensure that funding is targeted towards the most disadvantaged.
- Free primary health care for low-income families, because health inequities begin early and compound over the life course.

Submission

The College welcomes the Ministry's focus on the primary and community care workforce as being fundamental to mental health and addiction care now and in the future. It is notable that the mental health and addiction workforce is atypical in that it also includes many workers in the criminal justice system due to the Misuse of Drugs Act. This is an important intersection of sectors both in terms of skillsets and competencies, and in terms of philosophy (health rehabilitation vs societal rehabilitation).

We support action to increase the capacity and capability of the whole workforce, and note that training and education programmes must be supported by infrastructure (e.g. to enable participation) and appropriate funding streams. There are several different Ministry work streams pertaining to mental health and addiction that are either under development or due for review (e.g. Commissioning Framework, Outcomes Framework,

'Like Minds, Like Mine', Suicide Prevention Action Plan, Improving the Lives of People with Dementia, Youth Mental Health Project, Te Puāwaiwhero, Te Kōkiri, Te Tahuhu) as well as initiatives underway at the provider and PHO level. The College implores that all of these pieces of work, their updates, and developments are carefully aligned to ensure best use of the workforce and the limited funding resources.

It is understood that the Action Plan is intended to focus solely on workforce issues, however the College notes that meaningful gains in mental health and addiction outcomes are underpinned by the socioeconomic determinants of health[1]. Consequently, the College's submission is founded on the expectation that there will be continued government strategy to improve these socioeconomic factors for the most vulnerable of the New Zealand population. This is crucial to improving access and equity; a significant focus of several of the action points.

Alcoholism and drug addiction are recognised as diseases and require a 'health response' rather than a punitive one.[2] The punitive system (refer to Misuse of Drugs Act) has resulted in many people (particularly low socioeconomic and Māori) being convicted for drug-related crime and missing out or having reduced access to treatment, while the evidence tells us that access to treatment is an important factor in reducing the likelihood of re-offending.[3] Furthermore, convictions affect the ability to get long-term employment and housing and so the cycle of destructive behaviour is perpetuated. The strong crossover between mental illness and addiction means that there are likely to be a high number of convicts with coexisting mental health and addiction issues. Those working with mental health and addiction patients in the justice system, require additional support to ensure that treatment initiated while the person is incarcerated is continued when they are released. Concern has been expressed in the past about the quality of mental health care being received by prisoners and recently released prisoners, and the College asserts that inequitable outcomes are unacceptable in any situation.

Consultation Process

The College is concerned about the consultation process for this workforce action plan. It appears that there was limited circulation of the consultation document and it was not publically listed on the Ministry's consultation webpage, with only a brief news item listed on 16 December 2015 that did not directly supply the consultation documents.

Part 1- Strategic Setting

It is noted that the definition of the mental health and addiction workforce in this plan is extremely broad and includes 'family and whānau'. The everyday surroundings of addicts, including whānau and friends play significant roles in supporting (or sabotaging) their recovery. The College agrees that the sector needs to view whānau as an essential part of the existing and future workforce and needs to change the way it works with whānau to provide better information and support (i.e. the whānau ora model). Furthermore, health literacy of the practitioner – especially with such a broad definition of 'workforce' - is just as important as the health literacy of the end user and their whanau.

It is noted that the Action Plan will 'align with' an Outcomes Framework and a Commissioning Framework. Some 'good' activities, such as providing care that is patient-centred, are very hard to measure and incentivise and these should not be overlooked when developing these frameworks. Additionally, it is unclear as to what order these frameworks are being developed; presumably the Outcomes Framework will be established prior to discussions about how to best to achieve it (via commissioning). The College looks forward to reviewing these frameworks when they are released later this year.

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[1] World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014. Available at: http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf?ua=1

[2] Global Commission on Drug Policy. On Drugs; Report of the Global Commission on Drug policy, June 2011.Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf

[3] Ibid.

Part One discusses the shift of services towards 'care closer to home' with a greater role for primary health and community care settings, along with new skills and technologies. Mental health is central to the values and principles of the Alma Ata Declaration (1978) and a core component of general practice. GPs and other members of the primary care team (particularly practice nurses) are ideally placed to undertake preventive measures because of their ongoing contact with a number of high risk groups in the community, the bereaved, the chronically ill, carers, postnatal women and mothers with young children.[4] The College supports the shift towards community and primary based care but reminds the Ministry that the GP workforce is also facing considerable capacity issues – particularly in rural and provincial areas.[5] As part of the team of mental health and addiction service providers, the GP workforce requires continued support for its development from Health Workforce New Zealand.

It is highlighted that there has been a shift in mental health and addiction care towards prevention, early intervention and a culture of recovery. We recognise that these are important goals, however full recovery may not be an achievable goal for all people and we would not want these people to be excluded under the outcomes framework - this is particularly relevant for the ageing population due to the higher incidence of degenerative mental health conditions such as dementia. With regards to addiction, abstinence should not be the sole focus of care and definition of 'recovery'. It is crucial that primary and community care supports people to live well on a day to day basis with a mental health condition and places equal priority on ensuring the right support is in place to enable people to manage their condition effectively.

A key issue identified in part one is the inequitable physical health status of those with mental health and addiction issues. This issue is well described in the 'Equally Well' consensus paper published by Te Pou in late 2014, and is an area in which general practice has the potential to contribute substantially.[6] For effective holistic care, there needs to be true integration of services and healthcare teams, where a shared Patient Management System (PMS) enables the primary carer to ensure that physical health problems are not overlooked or undertreated.

Māori and Pacific people are disproportionately affected by mental health and addiction issues and the College agrees that workforce development should reflect this through targeted investment, recruitment, training, support, and retention of Māori and Pacific healthcare provers. At present, the majority of the Māori and Pasifika health workforce is at the lower paid, community health worker end, while the need to recruit Māori and Pasifika lies across all levels of healthcare. To this end, the College has recently set the aspirational goal if recruiting 22% Māori registrars into its programme in 2016. However, most Māori/Pasifika do not see Māori/Pasifika providers and so the provision of treatment must be appropriate and effective regardless of the practitioner's ethnicity/culture. This is a key reason why there needs to be more research and resource placed into developing the cultural competence of all health and social carers.

The inequitable mental health and addiction outcomes faced by Māori and Pasifika require more than just a health workforce response. These population groups are more likely to be criminally convicted for drug use, while the justice system is less likely to offer treatment or diversion, creating a situation of institutionalised racism. We reiterate the addiction is a disease and should be first and foremost treated as such.

It is notable that addiction workers are often recovered addicts themselves (and that recovery can be lifelong battle). This unique feature should be considered as part of the support and development plan for the addiction-recovery workforce and specific consultation with this group is encouraged. Their approach to treating and supporting an addict may not follow a traditional pathway and is another reason to ensure funding streams are sufficiently flexible with clear communication lines between providers.

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[4] Corney R. Developing mental health services in the community: current evidence of the role of general practice. J R Soc Med. 1994;87:408–10

[5] RNZCGP. 2015 Workforce Survey Report. Wellington: Royal New Zealand College of General Practitioners, Dec 2015. Available at: https://www.rnzcgp.org.nz/2015-workforce-survey-report/?stage=Live

[6] The Equally Well consensus position paper is available at: http://www.tepou.co.nz/resources/equally-well-consensus-position-paper/546

Part 2 – Action Plan

Priority One – Workforce development in primary health and community care

Action 2(a) - We agree that there needs to be greater training of GPs in screening for mental health and addiction across the board and support the move to increase training opportunities for the workforce engaging as the first point of contact. A recent study showed that only 24% of primary care doctors in New Zealand think their practice is well prepared to manage the care of patients with severe mental health problems and only 20% to manage the care of patients with substance abuse related issues.[7] Lack of primary care workforce capability means that specialist services are not readily able to transfer care back to general practice. As models of care evolve and more mental health and addiction care is provided in the community, it will be important to enable GPs to develop the necessary skills to support these patients. We know that this is particularly important for patients with addiction issues, many of whom currently can only access treatment via secondary care settings. The College is exploring an Advanced Competency Module in Mental Health and Addiction to allow GPs with an interest in mental health to develop advanced skills. This module will also need to be supported by GP career structures and funding.

The College further notes that 'increasing opportunities for training' must also address the health practitioners' ability to attend the training. Ability to attend training can be impaired by lack of funding[8], inability to find cover, or difficulty in finding training at the appropriate (e.g. advanced psychiatry versus screening and basic intervention). Therefore, the College recommends that this action is supported by funding structures (e.g. funding to allow practice nurses to attend training days), locum provision services, and use of Information and Communication Technology (ICT) to provide training in geographically hard to reach areas (e.g. online modules, videoconferencing).

Action 2(b) - the College recommends that workforces working with rural populations – which have higher rates of suicide compared to urban[9] – are added to the list of early intervention training to be prioritised.

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

Action 5(a) - The College supports the 'one team' approach, in the context of collaborative multidisciplinary teams, and notes that this must be underpinned by appropriate communication mechanisms (e.g. shared Patient Management System for regulated healthcare workers) to ensure continuity of care both within a primary care setting and between primary and secondary care. The interface and relationship between primary and secondary care is particularly important - GPs and general practice teams need ready access to advice and information from secondary and specialist services in order to provide effective care for mental health and addiction patients in the primary care setting.

Action 5(b-c) - We support the action to increase supervision and mentoring programmes across primary and secondary teams and note that many alcohol and other drug (AOD) doctors are GPs who do not wish to become specialists in AOD, but need specialists in the field to mentor them and lead the field in terms of research, clinical leadership and advocacy. General practitioners and other non-AOD specialists appreciate the expertise and support that the few current Addiction Medicine specialists can provide. A challenge for these programmes will be the current shortage of specialists and experienced healthcare workers to provide the supervision. To help address this challenge, the College recommends the use of clinical/professional networks that are led by an AOD specialist. Additionally, the College supports the enhancement of PHO support services to enable virtual and co-located assessment, coordination, and navigation pathway support.

Action 5(f) – For national principles for models of care to be 'embedded' into local and regional service and workforce development, there need to be funding structures and infrastructure that support the model. For

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[7] Osborn R, Moulds D, et al. Primary Care Physicians in ten Countries Report Challenges Caring for Patients with Complex Health Needs. Health Affairs, 2015; 34(12): 2104-2112.

[8] GPs often fund their own continuing medical education (CME) activities, while nursing and allied health workers CME is often underfunded or not funded at all.

[9] Ministry of Health. Suicide Facts: Deaths and intentional self-harm hospitalisations 2012. Retrieved Dec 2015 from: http://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2012

example, if a patient receiving treatment in a psychiatric facility is moved into primary care. Another example would be nurse-specific benefits and practice incentive payments for care coordination which has been effective in Australia in encouraging the use of teams.

Action 5(g) - In terms of new technologies, the College supports the use of telehealth services (e.g. videoconferencing, ePortals, and self-management apps) that comply with privacy standards, that have had clinical input throughout their design, and that have been developed to integrate with existing systems. ICT in the health sector already face extreme challenges with multiple systems across hospitals and primary healthcare providers. For providers to make better use of telehealth, interface with existing PMS must be considered. Additionally, it is crucial to consider the access that mental health and addiction patients have to telehealth service in terms of health and IT literacy and in terms of their ability to own/physically access the required technology. Without consideration of patient access, the Action Plan and related strategies risk widening health inequities.

Action 6(b) - An example of a new model of care for those with co-existing mental health and addiction issues is the Te Rawhiti community mental health centre[10] (East Auckland). Every member of the Te Rawhiti team received training in dual diagnosis competencies which required considerable goodwill by staff and strong leadership and support from management. The College supports this type of model where specialists, GPs, nurses and other allied health workers are working together, using shared information, with appropriate training, to provide patient-centred care.

Action 6(c) – The College supports the removal of barriers to integration and agrees that there need to be more "flexible approaches to service delivery", as alluded to in the introduction to priority two. To support better integration, the College suggests that more commissioning of access to specialists and non-specialist funded mental health and addiction support be made available at the point of support in primary care. The flexibility provided by this model would enable and empower the primary carer to work with the patient to develop a care and support plan that will work for them. It is also vital that DHB funding streams support integrated care in primary care settings. For example, separate budgets currently exist for patients with severe needs and patients with high prevalence and episodic (mild to moderate) needs, creating a disincentive for service integration.

Priority Three – Specialist workforce capacity and training pathways

It is noted that the goals of priority three are aspirational but unattainable in a five year time frame i.e. "*The specialist mental health and addiction workforce shortages are addressed and the specialist workforce can meet the demand for mental health and addiction services".* It takes a minimum of 60 FTE months (5 years) to complete the Royal Australia and New Zealand College of Psychiatrists (RANZCP) training programme therefore, to address psychiatrist shortages within 5 years, the trainee intake of the RANZCP would need to increase dramatically now with a high trainee success rate. Training also involves considerable resource from existing specialists which may be difficult to provide given the current workforce shortage.

The proposed actions to achieve Priority Three goals suggest that the Ministry is looking to explore how other roles could expand or adapt to provide services that do not require expert (psychiatrist)-level attention. The College is not opposed to utilising alternative workforces to address shortages however notes that this is only appropriate when the substitute practitioner has appropriate skills, knowledge and expertise and when continuity of care is maintained (i.e. the relevant information about the patient is passed to the primary caregiver).

One concept that the RNZCGP is considering exploring with the RANZCP, is the placement of GP trainees in unfilled psychiatry training placements (with strong clinical support to ensure practice safety). Psychiatry trainees provide substantial capacity and currently, where these placements have been unfilled, the service provider suffers.

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[10] Te Pou. Webpage: Te Rawhiti community mental health centre, a one stop shop for people with co-existing mental health and addiction issues. Available (Jan 2016) at: http://www.tepou.co.nz/news/te-rawhiti-community-mental-health-centre-a-one-stop-shop-for-people-with-co-existing-mental-health-and-addiction-issues/59 -

Putting GP trainees into these positions will alleviate workforce pressures and also provide GPs with a better understanding and competency in mental health.

Action 8(a) - In terms of recruitment and retention strategies, it is noted that remuneration and CPD allowance are key aspects of ensuring a workforce feels valued. This is particularly important for non-medical and kaiāwhina workers that frequently have little-to-no CPD support.

Priority Four – Addiction treatment and recovery training pathways

Action 10 - At present, addiction medicine is not recognised as a vocational scope of practice in New Zealand. In 2013, the Medical Council of New Zealand undertook a consultation on whether it should be recognised which the College supported with the additional recommendation that it does not prevent other specialists from working in this area. The MCNZ consultation did not result in the recognition of this scope in New Zealand (and the College is aware that this is outside of the Ministry's mandate) however reconsideration of this scope may be worthwhile.

Overarching priority areas for mental health and addiction workforce development

Action 14 - The College notes that the Council of Medical Colleges in New Zealand undertook stocktake of the Medical Colleges' cultural competency training resources in 2014/15. This may be a useful resource for the Ministry's review. Building sector capability to be responsive – particularly to Māori – requires the ongoing development of tools and resources to assist people to benchmark, measure progress, and achieve cultural and clinical competencies in their day-to-day practice.[11] The College has developed a Māori Health Strategy and continues to promote cultural competence in its training programme and among its Fellows/Members.

Action 15 – The College notes that 'children and youth' are lacking from the list of targeted populations for workforce development in cultural competency improvement.

Additional Comments

There are two further areas of importance that are touched on in the Action Plan that the College would support greater emphasis on:

- National and regional system-level leadership of mental health and addiction in terms of service-delivery development and shared ownership of outcomes (i.e. multi-agency coordination, workforce development).
- Greater resource for monitoring, evaluation, and research into mental health and addiction services and their effectiveness. In particular, the College advocates for the development of a clear addiction research agenda.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely

Helen Morgan-Banda
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[11] Ministry of Health. Te Puāwaiwhero – the Second Māori and mental Health and Addiction National Strategic Framework 2008 – 2015. Available at:
http://www.health.govt.nz/system/files/documents/publications/tepuawaiwhero.pdf