



Whakamārama te Huarahi To Light the Pathways

A Strategic Framework for Child and Adolescent Mental
Health Workforce Development 2006 – 2016



2006

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The Werry Centre for Child and Adolescent Mental Health
Workforce Development

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Foreword

The mental health and wellbeing of our children and young people is a priority for New Zealand. The mental health of all New Zealanders will be influenced by the delivery of the services provided to children and young people both now and in the future. Addressing the needs of the workforce required to deliver future services is key to successful outcomes for those who access services. We need a workforce that provides the right care and treatment for those who need it – in the right place, at the right time.

Whakamārama te Huarahi builds on priorities set by the Ministry of Health in *Tauawhitia te Wero: The national mental health and addiction workforce development plan, 2006–2009*, and our second national mental health plan *Te Tāhuhu: Improving mental health, 2005–2015*, where there is a strong emphasis on increasing services for children and young people and building a workforce to deliver those services. There is also a focus on working together nationally, regionally and locally, across DHB and NGO sectors, with a whole of health approach that includes other government-funded social services.

There is a need to have a framework that considers a ten year timeframe to allow time to plan for a future workforce to deliver future services. It challenges us on how we might consider the quality and delivery of our services and ways of working ten years from now.

Sometimes it is hard to imagine the future – but this framework sets in motion the possibility of providing the best children & young people services we can with one of our greatest assets, our workforce. One thing that is at the heart of this work is remembering why we need to consider our future – our children and young people – and who better to tell us what services and workforce will meet the needs of children and young people than those who use them?

Robyn Shearer
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Acknowledgements

When researching and writing the strategic framework it was very apparent that a large body of work has been undertaken over the last decade to identify the needs of the child and adolescent mental health sector and its workforce, and that of the wider mental health sector.

To acknowledge this, the document has been named ***Whakamārama te Huarahi**: To Light the Pathways*. The whakatauki is: *Ā o tūpuna i whakamārama te huarahi mo tātou: The experience and guidance of our elders will give us a brightness of hope and direction for future developments.*

Throughout the development of ***Whakamārama te Huarahi***, the project team has encountered the energy and commitment of those who work with infants, children and adolescents to support their mental health and wellbeing. Building on both the previous work and the commitment evident in the workforce, it is our hope that this strategy highlights the pathways for focussed and innovative workforce development.

I would particularly like to acknowledge and thank the people who attended the symposium in Auckland, the regional consultation meetings, and those who have provided written feedback. I would also like to acknowledge and thank those who gave of their time and expertise to inform the direction of the project, including Basia Arnold, Colin Hamlin and Anna Long of the Ministry of Health, the Regional Workforce Development Coordinators and a large group of sector leaders: clinicians, managers, and educators. This collective input informed and improved the end product.

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Executive Summary

The mental health of New Zealand's infants, children and young people is central to building a healthy future for all New Zealanders. When children and young people have mental health and substance problems, they and their families and whānau require a highly skilled, well-supported and effective mental health and addictions workforce.

This framework describes a way forward to engage all those involved with supporting and developing this workforce in a partnership approach. The framework outlines a national approach to tackle systemic obstacles currently limiting workforce development and a process to support regional, inter-district and local planning processes.

Child and adolescent mental health specialists are needed across a range of settings to respond to the level of need for specialist interventions for moderate to severe mental health and/or substance problems. This workforce is also responsible for providing specialist consultation and liaison services to other professionals working with infants, children and young people. Experienced professionals are also needed to participate in the training of the future workforce.

We must support these specialist workers, increase their numbers and their diversity and enhance their capacity to meet these broad and important responsibilities.

A key issue facing the child and adolescent mental health sector is workforce shortages. These shortages need to be seen in the context of health sector workforce shortages generally. They are compounded for the child and adolescent mental health workforce however due to the relatively small size and low sector profile of infant, child and adolescent mental health, and underdeveloped pathways into the field.

We must also build and sustain the level of knowledge and skills of the other workforces responding to infants, children and young people and their families and whānau; the primary healthcare workforce, other government service workforces and related community sector workforces, to deliver a comprehensive response across the tiers of service delivery.

Intra-sectoral and inter-sectoral engagement to address workforce issues has many benefits beyond addressing workforce issues specific to child and adolescent mental health. Drawing on the passion and commitment of all the workforces involved with infant, child and adolescent wellbeing will strengthen provider relationships and benefit accessible, timely and effective service provision to infants, children, young people and their families/whānau across the spectrum of settings.

Part One: Introduction and Background

Vision and Principles

Infants, children, young people and their families/whānau have access to a **highly skilled, well supported and effective** mental health and addictions workforce.

Across a range of settings, from specialist services to community and primary health services, achieving this vision will require a workforce for child and adolescent mental health and wellbeing that:

- is committed to building strengths and resilience in the community, family/whānau, children/tamariki and youth/taitamariki;
- is committed to working with children and young people in the context of their family, their community and the people and systems they interact with;
- is committed to the detection of early indicators of mental health problems and is skilled in early intervention and prevention;
- is trained and competent to work with the appropriate level of assessment and intervention in the context within which they operate;
- is multi-disciplinary with clear competencies and scopes of practice;
- is both clinically and culturally competent (dual competence) to maximise outcomes for Māori in both mainstream and kaupapa Māori settings;
- is diverse in cultural backgrounds and ethnicity and has cultural competence to provide services to a culturally diverse community;
- collaborates between providers within and beyond the health sector to strengthen and support each other's work;
- utilises sector stakeholder partnerships to lead future workforce and service planning; and
- undertakes workforce planning processes so that the sector is responsive to future opportunities.

Whakamārama te Huarahi includes recommendations for national, regional and local workforce development planning to address the challenges and issues facing the specialist mental health and addictions workforce and related workforces.

Scope of the Strategic Framework

This national strategic framework relates to workforce development in organisations which deliver services to infants, children and young people with moderate to severe mental health problems, including alcohol and other drug problems and early psychosis. These organisations consist of DHB child and adolescent mental health services (CAMHS) and services and agencies contracted by District Health Boards to provide services to infants, children and young people with mental health and substance problems.

A strategic framework for workforce development for the specialist funded spectrum of services must also give reference to the full range of services provided to infants, children, young people and their families. This requires that workforce development planning is undertaken with reference to intersectoral capacity and capability and with input from the wide range of stakeholders involved with child and adolescent mental health and wellbeing.

Strategic Goals for the Child and Adolescent Mental Health Workforce 2006 – 2016

Goal One

Retain and develop the existing child and adolescent mental health workforce.

Goal Two

Increase the numbers of the child and adolescent mental health workforce through training and enhanced career pathways.

Goal Three

Increase the diversity of the child and adolescent mental health workforce through the development of core competencies, new roles and new ways of working.

Goal Four

Increase Māori workforce numbers across all roles and parts of the sector.

Goal Five

Increase Pacific workforce numbers across all roles and parts of the sector.

Goal Six

Increase clinical/cultural competencies throughout the child and adolescent mental health workforce.

Goal Seven

Increase capacity of related sector workforces to provide mental health screening and, where appropriate, assessment and therapeutic intervention.

Goal Eight

Increase organisational capacity and sector leadership to develop and plan future workforce needs for the child and adolescent mental health sector.

Key Stakeholders

Planning and progressing workforce development in the child and adolescent mental health service sector will require greater system connectedness with stakeholders impacting on, and impacted by, developments in this sector. Key stakeholders are:

- the public of New Zealand and the consumers/tangata whaiora¹ and families/whānau who access mental health and addiction services;²
- consumer advisory, advocacy and support organisations;
- providers of mental health and addiction services to infants, children, adolescents and their families, across the primary, secondary and tertiary health sector;
- providers of paediatric health services, child and family services, child disability support services, and maternal mental health services;
- providers of other services which infants, children, adolescents and their families access, such as schools and education centres, marae, church based agencies, youth transition services, family counselling services, and the Department of Child, Youth and Family;
- District Health Boards of New Zealand (DHBNZ), DHB funding and planning managers, Regional Mental Health Workforce Development Coordinators, regional mental health networks, clinical directors, service managers, human resource managers, cultural advisors and consumer advisors;
- The Werry Centre for Child and Adolescent Mental Health Workforce Development, established by the Ministry of Health in 2003, and the other Ministry of Health funded mental health and addictions workforce development programmes: the Mental Health Workforce Development Programme; Te Rau Matatini for Māori workforce development; and Matua Rāki for addiction treatment workforce development (for a list of other agencies refer to Tauawhitia te Wero: National Mental Health and Addiction Workforce Development Plan, Ministry of Health, 2005a);
- professional boards and associations of relevant professional groups, in particular nursing, occupational therapy, psychiatry, psychology and social work;
- training providers, in particular university and polytechnic teaching and research departments providing courses and supporting research in the field;
- workforce associations supporting workers in the sector, in particular the non-government, community-based workforce;
- the Tertiary Education Commission, responsible for facilitating collaboration and cooperation in the tertiary education system;

¹ the terms ‘service users’ or ‘consumer’ should be taken to include the family, whānau and significant others of the child and young person, although this should not always be assumed with the older adolescent age group.

² the term ‘addiction’ should be taken to include substance abuse/misuse/dependence.

- the Clinical Training Agency (CTA), providing funding for post entry clinical training programmes that are vocational, clinical, of more than six months duration and leading to a formal, nationally recognised qualification;
- unions; and
- groups and organisations with a focus on specific mental health and addiction issues affecting infants, children, adolescents and their families/whānau.

Preparation of this strategic framework has included discussions with a wide range of key stakeholders, including sector and intersectoral input. The implementation of recommendations in this document will require further engagement and collaboration between the above stakeholders.

Strategic Drivers

Strategies for Service Delivery - Child and Adolescent Mental Health

Over the last decade, various strategy documents have identified mental health services for children and adolescents as a priority area (refer Appendix C). Intersectoral collaboration, early intervention strategies and improving outcomes for Māori have been central themes.

There has been progress: growth of specialist services delivered in the community; rapid growth in the non-government organisation (NGO) sector; and growth in the number of Māori mental health providers (Minister of Health, 2005). However, a comprehensive report reviewing changes in the sector, *Specialist Mental Health Services for Children and Youth* (Mental Health Commission, 1999), concluded: “Workforce shortages remain the most significant barrier to the expansion and development of specialist child and youth mental health services in New Zealand” (p. 5).

Workforce Development Strategies

A number of strategies have been developed to address mental health workforce capacity and capability issues (refer Appendix C). The most current of these are:

- The *Mental Health (Alcohol and Other Drug) Workforce Development Framework* (Ministry of Health, 2002b). This document describes a whole of system approach based on five strategic imperatives: workforce development infrastructure; organisational development; recruitment and retention; training and development; and research and evaluation. *Whakamārama te Huarahi* is structured within this approach.
- *Te Tāhuhu, Improving Mental Health: The second national mental health and addiction plan 2005 – 2015* (Minister of Health, 2005). This plan confirms mental health services for children and young people as a priority area.

- *Future Workforce 2005 – 2010* (DHBNZ, 2005). This document outlines a health and disability sector-wide approach to support workforce activity at the local, regional and national levels. The wider sector strategic priorities and actions described in *Future Workforce* align well to the goals of *Whakamārama te Huarahi*.

Whakamārama te Huarahi is one of a suite of workforce development strategies developed by the Ministry of Health funded mental health workforce development programmes. The ‘umbrella’ plan for current workforce planning in the mental health and addiction sector is *Tauāwhitia te Wero, Embracing the Challenge: National mental health and addiction workforce development plan 2006 – 2009* (Ministry of Health, 2005a).

The Child and Adolescent Mental Health Service Context

Child and adolescent mental health services are specialist mental health services provided by District Health Board providers (DHBs) and Non-Government Organisations (NGOs) for children, young people and their families/whānau. Most are community based providing specialist assessment and treatment, respite, crisis services and residential care on an outpatient basis, with smaller numbers of services providing inpatient and day-patient care.

Child and adolescent mental health services are funded to treat infants, children and young people up to and including age 19 years with moderate to severe mental health issues. Broadly, these include:

- emotional disorders including anxiety, depressive and post-traumatic stress disorders;
- behavioural and developmental disorders including attention deficit hyperactivity disorder and autistic spectrum disorders;
- eating disorders;
- psychotic disorders including first episode psychosis, schizophrenia and bipolar disorders;
- alcohol and other drug disorders including substance abuse and dependence; and
- Tourette syndrome.

Services for first episode psychosis intervention are funded across the youth/adult age range. DHB child and adolescent mental health services (CAMHS) are not contracted to provide services for conduct disorder as a sole presenting problem. Youth Horizons Trust and other providers have this contract (Ramage et al., 2005).

As well as assessment, diagnosis and treatment of mental health disorders, service specifications for CAMHS include education, prevention and early intervention activities, and specialist consultation/liaison support to other professionals including those in other mental health services, primary health, child health, education, child protection, and youth justice (Ministry of Health, 2003).

Current State Analysis

In New Zealand, there are approximately 1.3 million infants, children and young people under nineteen years, equating to 30% of the total population. Child and adolescent mental health services receive 10.5% of the overall mental health expenditure (Gaudin, 2004).

Service provision and workforce capacity falls far short of the benchmarks for children and adolescents set out in the *Blueprint (Mental Health Commission, 1998)*: access being only 1.1% of young people, compared to 2% of adults and a 3% target overall (Ramage et al., 2005).

Child and Adolescent Mental Health Providers

Child and adolescent mental health services are delivered by all twenty one DHBs and a number of DHB funded NGOs in diverse and complex arrangements.

There is an increasing focus on intersectoral collaborative programmes.

There was a 6% increase in funding (DHBs & NGOs) from 2003/2004 to 2004/2005.

Some DHBs were under-spent for the 2003/2004 year. This underspend may be related to vacancies.

Kaupapa Māori services are provided by nineteen NGOs and three DHBs.

Ten Pacific services are provided by NGOs and DHBs.

Stocktake of Child and Adolescent Mental Health Services in New Zealand (Ramage et al., 2005 pp. 6 & 10)

Access to Child and Adolescent Mental Health Services

The *Blueprint* (Mental Health Commission, 1998) benchmark targets for access to services for children and adolescents over a six month period are as follows:

0 – 9 years	1%
10 – 14 years	3.9%
15 – 19 years	5.5%

The *Stocktake of Child and Adolescent Mental Health Services in New Zealand* (Ramage et al., 2005) identified that access rates in the majority of child and adolescent mental health services remain significantly less than *Blueprint* targets.

Table 1. Six monthly access rates compared to Blueprint benchmarks for child and adolescent mental health services (2004)

Age Group (yrs)	0–9	10–14	15–19
Strategic Blueprint Benchmarks	1.0%	3.9%	5.5%
Access Rate 1st 6 Months of 2004	0.4%	1.3%	2.0%

These are, in turn, significantly less than the actual need suggested by prevalence rates of approximately 15% for mental health problems with clinical impairment in children and adolescents, particularly in the 15-18 years age group (Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2003).

Prevalence is higher for Māori youth and, therefore, “the Commission suggests that the target for access to mental health services for Māori should be double that for the general population” (Mental Health Commission, 1998 p. 57).

In 2003, more males (59%) accessed and attended services than females (41%). Fifty-four percent of clients attending services were 15–19 year olds, with females accessing services slightly more than males in this age group only.

In 2003, one in five clients that accessed child and adolescent mental health services were Māori with nearly twice as many males accessing services than females. The *Stocktake* survey of referring GPs and educational professionals reported the main barriers to accessing services for Māori clients were:

- cultural barriers, including lack of Māori health professionals and lack of Māori health services or knowledge of them;
- family barriers (culturally sanctioned or stigma associated with mental health problems); and
- financial and waiting time barriers.

The Pacific access rate was 0.56% for 2003. This rate was the lowest rate by ethnicity. Consistent with other population groups, access increased with age so that the 15–19 year old clients were the largest age group of Pacific clients accessing mental health services.

The Northern region has the largest numbers of Asian clients in child and adolescent mental health services, again with higher access rates in the 15–19 years age group.

Stocktake of Child and Adolescent Mental Health Services in New Zealand
(Ramage et al., 2005)

This access summary highlights that older teens are particularly vulnerable to mental health problems (Ramage et al., 2005). The summary also indicates that a higher target is needed to meet higher levels of need in the Māori population and that barriers to access issues need to be addressed. *Kia Puāwai Te Ararau* (Te Rau Matatini, 2006) highlights this as a priority action point in Pathway Two by stating the need to “raise awareness amongst hapu, iwi and Māori communities about factors that affect the mental wellbeing of tamariki and rangatahi, early recognition of mental illness and how to access services” (p.23).

Infants, children and young people with high mental health needs (i.e. those with severe mental health disorders and co-morbidity) and their families are also likely to be high users of other services in the health sector as well as services from state agencies (refer Appendix C). Severity and complexity of problems means this group have an increased risk of self harm and suicide (Mental Health Group, 2000) and require an intersectoral approach, particularly with CYF and the youth justice and education sectors.

The dedicated clinical and non-clinical workforce providing mental health services for children and adolescents, at just over 1100 full time equivalents (budgeted FTEs), comprises approximately one seventh of the overall mental health workforce (Ramage et al., 2005). The Ministry of Health contracted child and adolescent mental health sector vacancy rate for 2004 was 12 per cent (Ramage et al., 2005).

Given the 2004 community clinical FTE figures, the growth required to meet *Blueprint* targets is a daunting 74 per cent increase (Ramage et al., 2005).

Table 2. DHB & NGO community clinical FTEs compared to Blueprint benchmarks (2004)

Actual DHB & NGO Community Clinical FTEs 2004	Community FTEs as per Blueprint Benchmark for 2004	Increase of FTEs needed to meet Benchmark	% Increase
667	1163	496	74%

Source: Table 83, Stocktake of Child and Adolescent Mental Health Services in New Zealand (Ramage et al., 2005)

Workforce shortages result in a range of negative pressures on the workforce. Already stretched services tend to restrict recruitment to those who already have knowledge, skills and experience in the field. Shortages at the senior staff level limit, or prevent, a service’s capacity to take clinical placements or internships, or to provide a safe level of supervised practice for the less experienced worker.

These shortages impact not only on recruitment but also on retention, on the workplace culture and systems, on the capacity of the organisation for cross-sectoral liaison and consultation, on capacity to release staff for training and development, and potentially affect both the access to, and the quality of, services to consumers.

The Child and Adolescent Mental Health Workforce

DHB Child and Adolescent Mental Health Services (CAMHS) Workforce

The specialist CAMHS workforce draws primarily on a health qualified workforce. The five key workforce groups are, in order of volume; nursing, psychology, social work, occupational therapy and psychiatry. In addition, the workforce includes support, cultural, liaison and consumer roles, clerical staff and management (Ramage et al., 2005).

The CAMHS clinical workforce has specialist training in child development, child and adolescent psychopathology and age/developmentally appropriate assessment and treatment interventions, both pharmacological and therapeutic. Working with the child and the adolescent in the context of their family and social setting requires skills in family therapy, case management and multi-agency working.

The typical CAMHS worker is a female Pakeha between 30 and 50 years of age (Khin, 2002). There is an under-representation of Māori, Pacific and Asian staff (Ramage et al., 2005).

A 2002 survey by Te Rau Matatini of Māori working in CAMHS³ reported that males and young people are under-represented. Māori are under-represented in CAMHS clinical roles with most Māori taking up non-clinical support or community roles. Job duration for most respondents was two years or less (Tassell & Hirini, 2004 as cited in Te Rau Matatini, 2006). Māori CAMHS staff identified cultural training as a priority workforce training need (Te Rau Matatini, 2006).

Chronic high vacancy levels in the DHB provider sector impacts on both service provision and workforce development. In 2004, there was an inpatient workforce vacancy rate of 18% and a community workforce vacancy rate of 14% (Ramage et al., 2005). Workforce shortages limit both current access to services as well as the sector's ability to access *Blueprint* funding to increase the workforce. Capacity issues are a key challenge for CAMHS.

NGO Child and Adolescent Mental Health Services Workforce

The NGO workforce draws on a wider workforce to deliver a diverse range of child and adolescent mental health services. The *Stocktake* (Ramage et al., 2005) identified this workforce, in order of volume, as made up primarily of mental health support workers, social workers, counsellors and alcohol and other drug workers. It should be noted, however, that the categories used in the *Stocktake* did not reflect the diversity of roles and qualifications used within the NGO settings.

The NGO services have a lower workforce vacancy rate (around 6 %) than CAMHS and have a workforce demographic that is more diverse in ethnicity and age range (Ramage et al., 2005). The challenges for both the mainstream and the kaupapa Māori NGO services relates more to the inability to compete with DHBs for the restricted pool of the clinically trained child and adolescent mental health workforce than recruitment to vacancies in general. Short-term funding contracts can constrain NGOs from establishing permanent positions, offering career pathways and undertaking longer-term planning for training and development (Ramage et al.,

³ In this survey the term 'CAMHS' was inclusive of DHB and NGO providers, including kaupapa Māori providers.

2005). Funding and workforce capability issues are, therefore, a key challenge for NGO and kaupapa Māori services.

NGO Kaupapa Māori Services Workforce

A kaupapa Māori service can be defined as one that operates from a tikanga Māori philosophical base, uses a holistic health model (for example, Te Whare Tapa Whā) and a whanaungatanga approach (Ramage et al., 2005). Currently, the kaupapa Māori workforce is a small workforce of 51 FTEs, however many are part of larger organisations working from a whānau ora perspective (Ramage et al., 2005).

The kaupapa Māori contracted child and adolescent mental health workforce is made up of approximately equal numbers of clinical and non-clinical staff, with the reported clinical workforce being, in order of volume; counsellors (including alcohol and drug counsellors), social workers and mental health nurses. The non-clinical workforce largely consists of mental health support workers as well as support roles such as kaumātua (koroua and kuia) (Ramage et al., 2005).

Geographical isolation and the attendant impact on recruitment and retention are issues identified by kaupapa Māori services. Services reported gaps in clinical expertise in child and adolescent mental health and unfilled vacancies remain high (Te Rau Matatini, 2006). As with other NGO services, kaupapa Māori services report being unable to compete with DHB salaries and conditions (Ramage et al., 2005).

The need for dual (cultural and clinical) competency is noted as a key training area. Also noted is the impact of the Health Practitioners Competency Assurance (HPCA) Act (New Zealand Government, 2003) in that roles doing clinical work, such as counsellors, are not being recognised as ‘clinical’ by funders.

For a comprehensive description of issues for the Māori mental health workforce and workforce strategy, refer to *Kia Puāwai Te Ararau: National Māori Mental Health Workforce Development Strategic Plan, 2006-2010* (Te Rau Matatini, 2006).

The Alcohol and Other Drug Specialist Workforce

Funding for mental health services for young people includes funding for substance problems. Service provision occurs within CAMHS and NGO services, in specialist alcohol and other drug services, in specialist dual diagnosis services, and kaupapa Māori community treatment services.

The alcohol and other drugs (AOD) workforce is small however, totalling approximately 53 FTEs in 2004 with a further 3 vacant FTEs across the range of services. The DHB alcohol and other drug workforce consisted of 29 FTEs in 2004 with a further 3 vacancies whilst the NGO AOD workforce was 24 FTEs with no vacancies (Ramage et al., 2005).

Competence with co-morbidity of mental health and substance problems (dual diagnosis) is a key issue for both the alcohol and other drug specialist workforce and the child and adolescent mental health workforce.

The Child, Youth and Family, Education and Health Collaborative Services Workforce

A number of services and programmes are provided by the Department of Child, Youth and Family (CYF) for children and young people with high and complex needs. These programmes involve collaboration between Health, CYF and Education and involve both NGO and DHB child and adolescent mental health service providers. Not all FTE are clinical, some of this workforce holds administrative support roles to fund and monitor service coordination.

In the 2004 *Stocktake* (Ramage et al., 2005), a total of 34 actual FTEs were reported with a further 11.1 FTEs reported vacant. This workforce is small, consisting of, in order of volume; mental health support workers, mental health nurses, social workers, counsellors, occupational therapists and registered psychologists.

Pacific Workforce

* This section has been developed by discussions between Pacific mental health and addictions professionals:

Foliaki, S., Kingi, D., Cook, N., Solomon, M., Siataga, P., Annandale, M., et al. (2005). Pacific perspectives on child and adolescent mental health workforce development (draft): Publication pending.

The *Stocktake* (Ramage et al., 2005) identified that ten services, both DHB and NGO, are contracted to provide Pacific child and adolescent mental health services. However, identifying Pacific services was problematic as there is no specific purchase code for these.

A total of 64 Pacific staff were identified although it is possible a larger number may also identify as working with child and adolescent mental health as a component of family-based services. Of these Pacific staff, 27 were employed by DHBs, predominantly in the roles of mental health nurse, social worker and cultural appointments. The NGO Pacific workforce is made up of predominantly non-clinical roles. Roles, in order of volume, are; mental health support workers, social workers and cultural workers.

Although limited information exists regarding Pacific child and adolescent mental health, it is known that Pacific children and young people, like Māori, have low access rates to mental health services. The lack of culturally appropriate services and a shortage of Pacific mental health workers in child and adolescent mental health are critical issues contributing to this low access rate (Ramage et al., 2005).

Pacific self-identity and cultural preservation are key issues for Pacific youth. Pacific young people usually have to develop their own identity out of at least two cultures. Pacific culture, values and practices are strong in New Zealand and are usually centred on the church. As such, a lot of youth development activities take place within churches (Annandale & Instone, 2005).

In the health and mental health sector it is important to recognise young Pacific people in the context of their culture and family, acknowledging that each Pacific culture is different (Minister of Health, 2002). Youth consumers have challenged the assumption that culture is specifically ethnic. Culture also includes recognising young Pacific people in the context of youth cultures. Competency in ethnic language was considered to be secondary as most New Zealand-born youth populations are more fluent in English than in the Pacific language/s of their parents and grandparents (Agnew et al., 2004).

The Pacific mental health workforce is extremely small and so is struggling to meet the needs of Pacific communities. Key issues for this workforce include the difficulty of spreading a limited resource across service delivery. There is also a need for strategic policies to further develop appropriate models of care for Pacific children and young people and to develop cultural and clinical competencies for Pacific teams and to provide relevant and accessible training opportunities to grow the Pacific mental health workforce.

Dual competency may not take into account the diversity of Pacific peoples (ethnicities, languages, age, Pacific born versus New Zealand born etc). It is suggested that, rather than focusing on individual cultural competency, a more realistic and preferred approach would be collective cultural competency. Having a team of multi-skilled workers with a range of cultural skills and experience who are clinically and culturally competent works best.

Cultural competency is often guided by traditional views of Pacific culture. Pacific young people and their parents come from diverse backgrounds, therefore, it is vital that cultural competencies encompass contemporary as well as traditional views of Pacific cultures.

There are a number of initiatives already utilised in supporting Pacific recruitment. These include offering work experience to students within their service and the apprenticeship/mentor model for Pacific nursing and psychology students.

It has also been noted that for any Pacific workforce development initiatives to be effective the community must be involved, whether it be churches, schools, or sports groups, for example. Involving various Pacific communities will also help with raising their awareness of mental health and reducing the stigma and shame associated with mental illness, essential to early intervention.

Asian Workforce

The numbers of people of Asian origin in New Zealand is growing rapidly, particularly in the Northern region. According to recent population projections, the 0–19 years Asian population is predicted to increase by 53,000 over the next ten years (The Werry Centre, 2005). Yet the number of Asian people in the workforce remains small. A total of 23 Asian staff are identified in the 2005 Stocktake (Ramage et al., 2005) of which all but two were clinical staff. Currently there are no Ministry of Health contracted Asian child and adolescent mental health services.

A key workforce need is to increase the numbers of Asian people in the workforce so as to deliver culturally concordant services to the New Zealand Asian population. As the category ‘Asian’ includes a highly diverse grouping of ethnicity and inter-ethnic variations, achieving cultural concordance would require a considerable increase in critical mass in this workforce. Acknowledging this, strategic direction needs to focus on increasing cultural awareness and competence across the workforces that provide mental health services to the Asian population (Tse, Bhui, Thapliyal, Choy, & Bray, 2005).

Consumer Workforce

There are a small number of people involved in the workforce in a variety of paid and unpaid roles as youth or family/whānau consumer representatives, advocates, advisors, and participants in service focus groups.

Youth Consumer Roles

The Werry Centre Youth Consumer Advisor has made contact with approximately twenty five youth consumers in these roles around New Zealand. Issues include: concerns regarding the appropriateness of young consumers taking on roles within services they have used and may still require; type of role and scope; status within the team; degree of representation; and resourcing and funding issues.

Whilst adult mental health consumer roles have increased in number and exposure, and established best practice guidelines, this is not yet the case for the child and adolescent mental health consumer workforce. Specific to young people in these roles are issues such as developmental level, limited work experience, qualifications, knowledge of the sector, stigma and less developed communication skills. There is also currently no training or resources for youth consumer advisors that would assist them in their roles within child and adolescent mental health services in New Zealand.

Both the literature (E.g. Street & Herts, 2005) and young people themselves (information gained from a Werry Centre hosted forum) articulate that participation is beneficial for both themselves and services as they assist in developing a youth-focussed service that meets young people's needs and allows them to have a voice and feel valued. Guidelines are currently under development by the Werry Centre informed by the literature, other youth participation models, and more importantly, the advice and experiences of young people already in these roles.

Family/Whānau Consumer Roles

The Werry Centre Family/Whānau Consumer Advisor is currently making contact with individuals and organisations to obtain a clearer picture of family/whānau support and advisory roles within the child and adolescent mental health consumer workforce.

Family/whānau advisory roles vary widely. They can be individual positions or an advisory group and they may become involved with service improvements and also individual consumer advocacy.

As with the youth consumer roles, there is currently no training or resources that relate to child and adolescent mental health services. Guidelines are currently being developed by The Werry Centre.

Related Workforces

The mental health of children and young people does not exist in isolation from the family, whānau and social context. Many professionals and workers in community and government agencies play an important role in supporting the mental health of infants, children and young people and their carers.

In general health, these include general practitioners, paediatricians, Plunket nurses, public health nurses, sexual and reproductive health nurses, school nurses, child development therapists and registered and counselling psychologists, among others.

In education, these include early childhood, primary, secondary and tertiary teachers, Resource Teachers for Learning and Behaviour (RTLBs) and school guidance counselling services. Additionally there are health and counselling services provided by tertiary institutions.

Within government agencies, there are significant workforces involved in child care and protection, youth justice, youth policing and youth transition services.

There is also a large array of non-government organisations providing services to children, young people and their families in family social services, marae, and church based services.

All these workforces come into contact with infants, children and young people with moderate to severe mental health and substance problems. They require the capability to identify and, where appropriate, refer to specialist services and be part of an integrated response.

Primary Health Organisations (PHOs) are a key resource in supporting child and adolescent mental health. A key role of the PHOs is to build linkages with other providers of mental health and addictions services to ensure integration occurs between primary, secondary and tertiary services (Minister of Health, 2005).

It is not known how many of the staff in these related workforces have child and adolescent mental health and addiction training. Some, such as paediatricians and paediatric nurses, may have specific training in infant, child and adolescent mental health. Others, such as school guidance counsellors, have knowledge in adolescent development. Some basic competencies in infant, child and adolescent mental health and brief intervention training for alcohol and other drug problems is highly desirable.

Part Two: Strategic Direction

Preamble

This section describes a wide range of challenges and issues for the future workforce and provides strategic direction and recommendations for action at the national, regional and local levels.

Child and adolescent mental health has been a priority area for a decade however it has been difficult to get the necessary focus to attend to current workforce challenges and to plan future capacity and capability.

The Ministry of Health Mental Health Directorate (MeHD) has created a national and regional workforce development infrastructure (refer Appendix B) to address mental health workforce development. The establishment of both national and regional infrastructure has created new possibilities in the sector for effective and efficient workforce planning and action within the context of national strategy and regional and local needs.

This section is framed within the five strategic imperatives outlined in the *Mental Health (Alcohol and Other Drugs) Workforce Development Framework (Ministry of Health, 2002b)*:

- Workforce Development Infrastructure;
- Organisational Development;
- Recruitment and Retention;
- Training and Development; and
- Research and Evaluation.

Structure of Recommendations:

National Workforce Infrastructure Recommendations

National projects to address systemic obstacles, coordinate relationships and create sustainable workforce development for this sector.

Regional Workforce Infrastructure Recommendation

To establish a regional/inter-district strategic taskforce process to assess capacity and capability, identify regional priorities, and oversee and resource implementation plans.

Recommendations to Support Regional Taskforces and Local Plans

Further recommendations under the remaining four strategic imperatives are offered to support regional and local prioritisation, planning and implementation of workforce development strategies.

Workforce Infrastructure

Challenges and Issues

District Health Boards are charged with the responsibility to lead in improving health for their populations and have responsibility for health workforce development planning. However, many of the workforce challenges are complex, involving multiple stakeholders and requiring a multi-agency and intersectoral approach.

To achieve the goals of this strategic framework, the following is required:

- national leadership to address systemic obstacles, coordinate relationships and create sustainable workforce development;
- regional leadership to facilitate intra-sectoral and inter-sectoral communication, planning and response to workforce challenges and issues that can be addressed at a regional or inter-district level; and
- local leadership by funders and planners, general managers, service managers, clinical leaders and human resource managers to support workforce planning and respond to workforce challenges and issues that can be addressed at a local and service level.

No single agency or organisation can deliver workforce development and workforce development cannot be achieved in isolation from service development. A partnership between the national workforce development programmes, the Regional Workforce Development Coordinators and the District Health Boards is needed to implement this strategic framework.

National Strategic Direction

To address deficits in workforce numbers and increase diversity we need to develop training and career pathways to, and within, the sector. This will require a national approach and strong engagement between providers of education and clinical training with providers of services.

Recommendation 1 describes a cluster of related tasks. The first task is to develop a national competency framework for the sector, from primary to tertiary provision, and to investigate the creation of new roles to expand and complement current recruitment and professional groups. This, in essence, provides the training sector with the ‘industry specifications’ to deliver training that supports a ‘job-ready’ child and adolescent mental health and addiction workforce and creates a basis to map training and career pathways into the sector.

Recommendation 2 will establish a sustainable approach to service level workforce planning. It involves developing and piloting a New Zealand model for workforce development in specialist child and adolescent mental health services. Once piloted, this model will be made widely available.

Among models available and suitable for adapting to the New Zealand context is a version of the Sainsbury Centre’s workforce development planning model (Philip, Brewis, Durcan,

Knowles, & Lindley, 2003) adapted for use in child and adolescent mental health services by the Workforce Lead of the Greater Manchester Strategic Health Authority (Nixon, 2005, for further details please refer to the workforce development planning models resource on the Werry Centre website, www.werrycentre.org.nz). This model ensures workforce planning reflects local service configuration, workforce composition and distribution, and the ‘client care group’ that responds to children and adolescents with mental health needs.

Regular and standardised data collection is essential for workforce planning. **Recommendation 3** aligns the need to enhance child and adolescent mental health and addictions workforce data collection with the implementation of national health information strategies. It will also focus on working with professional bodies to enhance the utilisation of annual survey data for workforce planning.

Recommendation 4 relates to the provision of sector development and training. Due to the small size of the child and adolescent mental health sector, and the isolation of many small teams, *Whakamārama te Huarahi* recommends coordination of the planning and provision of key training to the sector: dual competency for those working with Māori (as described by Turia, Te Rau Tipu Conference, February 2004); dual diagnosis; and evidence based best practice. This will involve the workforce development programmes, employers, and those who commission and provide training working together to match training needs to delivery.

National Recommendations:

1. The Werry Centre for Child and Adolescent Mental Health Workforce Development and other national workforce development programmes to work with all stakeholders to:

- develop a competency framework for the child and adolescent mental health and addiction sector;
- investigate and pilot innovation in roles and ways of working;
- engage clinical training providers to deliver competency-based training to the sector through a range of delivery options, including distance options, modularised (stand-alone or build to degree level) generic competency training, under-graduate and post-graduate training, through to bridging courses for re-entry workers; and
- map and promote training and career pathways within the child and adolescent mental health and addiction field and related sectors working with child and adolescent wellbeing.

Who: Workforce development programmes and Regional Workforce Development Coordinators; regional support agencies; District Health Boards; DHBNZ; tertiary training providers; professional bodies; consumers; and other stakeholders.

2. A child and adolescent mental health workforce planning model to be developed and piloted as a joint initiative between a District Health Board and the workforce development programmes.

Who: The Werry Centre for Child and Adolescent Mental Health Workforce Development and other workforce development programmes; District Health Boards/CAMHS.

3. Integrate collection of nationally consistent child and adolescent mental health workforce data with the national Health Workforce Information Project (HWIP) and existing professional workforce surveys.

Who: Workforce development programmes; Regional Workforce Development Coordinators; HWIP; regional support agencies; District Health Boards; and professional bodies.

4. National provision of training to the sector to increase skills in key areas of dual (clinical and cultural) competency training, dual diagnosis training and evidence based psychosocial interventions.

Who: Workforce development programmes; Regional Workforce Development Coordinators; training and education providers; and professional bodies.

Regional and Local Strategic Direction

Each of the four health regions, Northern, Midland, Central and Southern, have developed regional strategies for mental health workforce development. Each of the twenty-one DHBs develop strategic plans (five to ten years) and district annual plans. These plans relate to workforces employed by DHBs and NGO provider services, and they may also relate to those contributing in an unpaid capacity. These plans are developed with input from the regional mental health and addiction networks which include service providers, consumers and, in some cases, voluntary sector input.

Whilst child and adolescent mental health and addiction services/workforces are included in these plans, there has not been sufficient detail to address the specific challenges and issues for this sector.

This framework recommends the establishment of regional child and adolescent mental health service taskforces (or inter-district processes with regional support) to create a sector-specific workforce focus. The structure and nature of this process is not prescribed and will differ from region to region. However, any such planning process should align with existing structures and planning cycles, be task-focused and be time-framed. This should be undertaken at either the regional level or at the inter-district level to inform regional plans, to support inter-district consistency and to engage larger NGO and inter-sectoral stakeholders efficiently.

The purpose of these regional/inter-district taskforces is to:

- assess regional workforce capacity and capability;
- prioritise issues for immediate planning and action;
- devise and implement a sector-specific child and adolescent mental health and addictions workforce development plan for the region, both short and long term; and
- make further recommendations for national action as identified.

Leadership for these processes will come from a partnership between The Werry Centre and the other national workforce development programmes, the Regional Mental Health Workforce Development Coordinators, and sector leadership.

Regional Recommendation:

- 5. Establishment of regional taskforces for child and adolescent mental health and addiction workforce planning and action.** In each region, The Werry Centre will work in partnership with the Regional Workforce Development Coordinators to engage key sector stakeholders to assess capacity, identify priorities, and plan and implement regional/inter-district child and adolescent mental health workforce development strategies.

Who: The Werry Centre; other workforce development programmes; Regional Workforce Development Coordinators; regional support agencies; District Health Boards; specialist services and other relevant providers; training providers; professional bodies; consumers; and other stakeholders.

Key stakeholder input should reflect the regional context, with input from:

- relevant primary through to tertiary service DHB and NGO health providers;
- agencies and organisations with collaborative contracts such as CYF, and Group Special Education (GSE);
- other related workforces in education, counselling, and youth transition services; and
- tertiary training and education providers.

Local and Service Level Strategic Direction

The final infrastructure recommendation is that the resources of the national programme for child and adolescent mental health workforce development, The Werry Centre, are used to support providers to implement service level workforce planning processes (as piloted in recommendation 3).

Local and Service Level Recommendation:

6. Implementation by child and adolescent mental health service providers of the piloted workforce planning model at service level.

Who: The Werry Centre for Child and Adolescent Mental Health Workforce Development and other workforce development programmes; and District Health Boards/CAMHS/NGO providers.

Further recommendations are contained within this strategy under the remaining four strategic imperatives. The descriptions and recommendations are intended as guidance to District Health Boards and all contracted providers of child and adolescent mental health and addiction services to undertake workforce development planning. Activities recommended under each of these strategic imperatives overlap and reinforce each other. However, local DHB service plans and NGO plans will reflect their own priority areas and will refine recommendations for their own implementation.

Organisational Development

Challenges and Issues

A key challenge is for sector leadership – the funders and planners, managers, clinical leaders and team members themselves – to work together to produce organisations where the workforce is highly skilled, well supported and effective in bringing about the best possible outcomes for clients.

New Zealand health organisations have undergone important shifts in the last decade: de-institutionalisation of mental health; re-structuring of the health sector and devolution of planning to regions with an emphasis on local responses to local need; a shift from competition to expectations of cooperation; significant growth in the NGO sector; establishment of primary health organisations; and growth in kaupapa Māori providers focusing on whānau ora. These shifts have occurred in the context of workforce shortages throughout the health sector.

Historical demarcations within organisations can create barriers to effective workforce development planning. For example, between the alcohol and other drug treatment sector and mental health sector there is a history of “misunderstandings, and separation of services administratively and geographically” (Matthews, 2004, p.30). These demarcations have also affected child and adolescent mental health provider teams.

The Mental Health Workforce Development Programme notes that whilst a system can promote goals such as the development of a sustainable workforce, “to ensure both the protection of funding and occupational integrity, mental health providers in New Zealand remain essentially competitive” (2006, p. 37). In two recent reports (Hatcher et al., 2005; Mental Health Workforce Development Programme, 2006) involving stakeholder interviews in New Zealand, a strong sense of demarcation is described between the DHB and NGO service sectors, at both the structural and relationship levels.

As a sub-specialty within mental health, child and adolescent mental health services are most often managed and administered within the adult mental health infrastructure. This can mean that service design, structures, processes and resources are determined by adult mental health service models with reduced proximity in funding, operational, and human resource management from the child and adolescent team(s).

Such organisational constraints stifle innovation in the sector. The challenge is to mandate sector leaders to step across demarcation lines and work in partnerships; “a sector that can respond positively to change, embrace new technologies and practices and re-embrace traditional ways of working will be better equipped...to work together in delivering integrated services” (Te Rau Matatini, 2006, p. 17).

From the literature, the following factors appear central to creating attractive child and adolescent mental health organisations:

- a focus on sector cooperation and organisational harmony based around the best possible outcomes for clients (Mental Health Workforce Development Programme, 2006);

- good people management practice: job design, skills development and a climate of regular, systematic involvement (Rudman, 2003 as cited in Mental Health Workforce Development Programme, 2006);
- the role of managers and clinical leaders in creating a culture that centres on teamwork and a learning environment (Curran, 2003 as cited in Mental Health Workforce Development Programme, 2006); and
- the opportunity to work with high calibre colleagues in a multi-disciplinary setting (Sainsbury Centre for Mental Health, 2000 as cited in Hatcher et al., 2005).

A frustration for mental health workers is the perception that clinical practice, training requirements and organisational culture are compliance-driven via legal and bureaucratic requirements, quality audits and risk-aversion. Mental health as a vocation is based on a ‘public good’ paradigm, therefore, it is essential that the demands of legislation and bureaucracy are connected to the desired outcomes for clients and not perceived as disconnected activities. This is more likely to occur when teams drive their own continuous quality improvement (CQI) processes as in a clinical governance model.

Functional teams are essential to the retention and efficacy of the workforce. Organisations need to intervene where there is tension or dysfunction. Understanding the problem is critical, for example; systems problems (e.g. poor role clarity), process problems (e.g. poor referral pathways) or individual issues (e.g. poor team participation), and addressing the problem at the correct level is important.

Managers and leaders (clinical, cultural and consumer) themselves need professional development to enable them to support high functioning team cultures, innovation and internal continuous improvement processes.

A recent PricewaterhouseCoopers report (Mental Health Workforce Development Programme, 2006) found that leadership and management of people was the most frequently identified training need across the mental health sector. This report also noted that manager training and development is “often not linked to performance management” (p30). Within this report are the results of a survey of NGOs. NGOs indicated that funding constraints on training and development budgets meant little training for new managers. Human resource capability was too often required to step in and “fight fires” (p27). Collaborative leadership training arrangements between DHBs and NGOs would strengthen leadership in the sector, build relationships, and promote the breakdown of barriers between providers.

According to the PricewaterhouseCoopers report (Mental Health Workforce Development Programme, 2006), HR managers play a crucial role in providing guidance in workforce management and development. Their role in workforce planning could be further developed. It is important that HR specialists “be fully aware of the nature of the departments that they are advising” (p. 32) but this requires sufficient HR capacity and proximity. In some organisations the HR specialist is somewhat removed from the manager-staff interface.

Supporting a high calibre workforce requires investment in the continuing development of clinical skills and recognition of staff achievements. Salary remuneration is not the only element in rewarding people, and cannot be in environments driven by collective agreements such as DHBs. However, flexibility in opportunities and support (release time and funding) for training,

access to high quality supervision, access to collegial support and review, and career pathways within and between service settings all contribute to attracting and retaining a high calibre workforce.

Attracting and retaining increased numbers of Māori in mainstream service settings will require organisational support for dual competence, access to cultural supervision, mentoring of new graduates and kaumatua leadership roles. This is available in kaupapa Māori organisations: “what attracted many to the Māori mental health workforce and what has kept them there was their ability to ‘practise in a Māori way’ without having to justify it to non-Māori managers or practitioners” (Te Rau Matatini, 2006, p.45). Most child and adolescent mental health services are mainstream and most Māori are seen in mainstream organisations (refer Table 59, Ramage et al., 2005). As such, mainstream services have a significant responsibility for recognising and responding to the needs of Māori staff, whaiora and whānau.

Similarly, attracting and retaining Pacific, Asian and other groups currently under-represented in the workforce will require organisational support for ‘culturally concordant practice’ (National Institute of Mental Health, 2003 as cited in Tse et al., 2005) and cross-cultural awareness and competence within teams and organisations.

Consumer roles in services are relatively new. Too often roles have been established without being well defined and without training and resources. This workforce is “a small, underdeveloped, and neglected arm of the mental health workforce” (Mental Health Commission, 2005, p. 9). Whether in a paid or unpaid role, organisations should ensure youth consumer advisors and family consumer advisors have access to peer and/or mentor support (from within or outside the team), favourable work conditions, and opportunities for skill development. Regular evaluation opportunities and the sharing of good practice through consumer networks will support the development of these roles within organisations.

Strategic Direction

Sector-specific regional and local leadership is required for participation in national workforce development planning processes and projects. Sector leaders require a mandate to foster intra-sectoral and inter-sectoral collaboration and to be innovative. Utilisation of existing networks throughout the sector, such as the regional mental health networks, ensures consistency in planning processes and implementation.

At the local level, managers, team leaders, clinical leaders, consumers and kaumatua require support to take leadership roles in regional planning, sector and intersectoral networking and service improvement processes. Consumer and Māori participation is integral to planning, implementation and evaluation processes.

Mainstream workforce planning requires a dual competency focus on:

- organisational response to the principles of the Treaty of Waitangi;
- internal processes which enable Māori participation, and recruitment and retention of Māori at all levels of service delivery for Māori tamariki, taitamariki and whānau;

- training and development to support non-Māori teams in working with Māori in mainstream settings; and
- opportunities to provide research and evaluation by Māori for Māori using kaupapa Māori and western research methodologies.

At the team level, there is a commitment to participatory processes for workforce and service delivery planning. Models include:

- clinical governance models;
- Knowing the People Planning process (as referred to in Ministry of Health, 2005a);
- service improvement models (such as the model used by the National Resource Group, Mental Health Workforce Development Programme); and
- 7 Habits of Effective CAMHS (York & Kingsbury, 2005).

These models are inclusive and enable positive change management (Ministry of Health, 2005a). Where workforce planning involves change processes, input from human resource managers, unions and professional bodies may be required.

Regional and Local Planning Recommendations

7. **Promote service leadership development (management, clinical, cultural and consumer) and processes** which develop an individual service's capacity to inform workforce planning, service operation and service delivery.
8. **Promote participatory service improvement processes**, including cultural and consumer specific opportunities for participation in workforce and service development.
9. **Intervene actively in team dysfunction:** identify workforce indicators, e.g. high turnover, recruitment difficulties, and negative feedback from clinical placements; develop the means to gather the information; and a process to respond.

Example of Strategy in Action:

A CAMHS or NGO team with a strong clinical governance process, including consumer and Māori participation, uses service improvement and service evaluation tools to assess demand, capacity and capability. This group feeds information and recommendations to those responsible for higher level planning. Local and regional plans are therefore informed by local needs as well as guided by national strategy.

Recruitment and Retention

Challenges and Issues

Recruitment and retention issues should be seen in the context of skilled labour shortages generally and specialist health workforce shortages in particular. Issues include: national and international employment competition for health professionals within and between sectors; complex pay issues between professions and between providers; increased regulation of professions; and changing patterns and expectations of work, work-life balance, training, and career paths.

Workforce supply issues are further compounded for the child and adolescent mental health sector as a specialist area within mental health by: low sector profile; lack of child and adolescent mental health content in training; low levels of clinical placements; and limited career pathways into and within the field.

A range of other issues impact on recruitment and retention in this sector:

- services, particularly DHB services, tend to budget and operate along historic staffing lines, tending to maintain the status quo rather than be innovative;
- professional identity is an important factor in recruitment and retention yet teams generally work from a multi-disciplinary, generic competencies base;
- professional bodies can be protective and the increasing pressure to specialise scopes of practice may further limit movement into and between professions;
- line by line monitoring of progress by providers and overly literal translation of the guidelines not aligned to local need can be an unintended consequence of *Blueprint* guidelines (Mental Health Commission, 2004);
- the impact of the Health Practitioners Competency Assurance Act (2003) on DHB providers, reinforcing the reliance on employing particular qualifications rather than a competency based approach and narrowing employment opportunities to health-registered professionals;
- the impact of the Health Practitioners Competency Assurance Act (2003) on NGO providers in employing and supporting sufficient numbers of ‘clinical’ roles, given that the bulk of their workforce are not registered health professionals.
- NGOs struggle to provide parity in pay and conditions (particularly training and development opportunities) with DHBs, contributing to shortages in the clinical NGO workforce;
- the shortages of a dually competent Māori workforce impacts on both mainstream and kaupapa Māori settings; and
- homogeneity of the workforce impacts on the capacity of the sector to develop culturally responsive services.

Rural areas face particular challenges in attracting and retaining a specialist workforce. Issues include difficulties in professional and career development, restricted access to training and collegial support, remuneration and workload. This is particularly true of the medical workforce where proximity to teaching hospitals and thus to research and professional development are highly valued.

NGO employers in isolated regions have additional challenges when attracting staff, particularly senior staff. Some providers report that Multi-Employer Collective Agreements (MECA) have compounded these difficulties, “MECA salary rates for Registered Nurses are on average twenty percent higher than those offered in the NGO sector” (Platform, 2005, p. 11).

In many regions there is limited alignment between the paediatric workforce (in both child health and child disability support) and child and adolescent mental health. Stronger alignment with paediatric services could support both service delivery and workforce expansion. For example, the child psychiatry workforce is unlikely to increase to the recommended numbers, however the paediatric medical workforce could be better aligned to support infant and child mental health services.

Increase Numbers

Growing the existing workforce will require a focus on three key groups:

- first-career professionals entering the sector following training;
- mature workers re-training; and
- those returning to the sector following a break in a career in child and adolescent mental health or a related field.

School leavers and graduates are not exposed to the child and adolescent mental health sector as a possible career route. Long lead times for training and restricted entry to clinical training (such as clinical psychology and child psychiatry) affect the attractiveness of this area. Once trained, there is a further obstacle in that many services require candidates to already have experience in child and adolescent mental health. This creates a significant barrier to entry to the child and adolescent mental health sector workforce.

As an example, a newly qualified nurse will not have received child and adolescent training by graduation and therefore may not be an attractive candidate for a child and adolescent mental health service, particularly where that service has senior staff vacancies. The nurse is not eligible for CTA funding for post-entry clinical training (PECT) and could not self-fund the study without a position and a caseload.

Newly trained workers have higher levels of debt than the previous generation of workers and may expect higher entry to pay scales, continued support for training, and lifestyle balance. Mature workers, in particular, may expect flexible and inclusive workplaces which acknowledge their skills, knowledge and experience and support a work-life balance to sustain their personal health and goals. The 30 – 50 years demographic, sometimes referred to as ‘the sandwich generation’, commonly have care-giving responsibilities to younger and older family members and may desire flexible work options. The bulk of this workforce is female: employers who are creative about family-centred policies will retain and recruit successfully. There is a trend for

older workers to tail off their careers, seeking part-time and casual work arrangements. These workers have valuable experience to offer in teaching, supervisory and mentoring roles.

Increasing the number of professionals entering the sector upon completion of training will depend upon promotion of, and increasing the attractiveness of, the sector. An attractive sector is one in which workplace environments are well-resourced, well accommodated and where staff feel valued, supported and developed. Functional teams provide students with positive placement experiences which encourage their commitment to child and adolescent mental health.

Retention of skilled and experienced professionals in this sector is essential. There is an insufficient labour supply to replace highly trained professionals, in specialist areas in particular. One immediate workforce source for the sector is to attract back into provider settings those professionals working in private practice. Flexible conditions and remuneration packages, including training and development packages, the opportunity to work as a senior team member, supervisory roles and the opportunity to undertake research, can support re-entry of this workforce.

The existing workforce includes a number of therapy roles with no health registration, specific scope of practice or pay scale. These include psychotherapists, family therapists, counselling psychologists and counsellors. There is considerable variation between employers as to the employment of these professionals. Such uncertainty is undesirable, particularly where these workers are already highly experienced in the sector.

Discussions are needed between employers and the relevant professional bodies to investigate health registration under the HPCA Act. The development of a competency framework for the sector (refer Recommendation 1) will have relevance to these discussions.

Staff satisfaction surveys and exit interviews are an under-utilised source of essential information regarding retention. Such initiatives can be difficult to sustain on a continuous basis, however a series of coordinated snapshots in key areas could be considered (for example, in regions with chronic workforce shortages, high attrition rates or distinctive demographics).

Create New Roles and Ways of Working

Workforce shortages will not be addressed in this sector simply through a ‘more of the same’ approach to team design and recruitment: “opportunities now exist for new disciplines and roles to emerge and for established, professional boundaries to continue to evolve...” (Minister of Health, 2005, p. 12).

This does not involve a ‘dumbing down’ of the workforce. The sector has historically employed people with a professional qualification (now health registered) who have not received specific training in child and adolescent mental health. Investigation of new roles and ways of working should be based on the premise that the practitioner holds the necessary competencies (not simply relying on a health registered qualification).

One possibility to investigate is the development of a generic child and adolescent practitioner role. This role would develop the non-clinical workforce, particularly in settings such as NGOs where there are few clinically trained roles. Such a role would complement, not replace, existing roles. A competency based training programme would support the capacity of the non-clinically trained workforce to undertake the work and to relate closely to the specialist trained clinical

workforce. Any role innovation requires an evidence base for effectiveness and piloting and evaluation within service settings would, therefore, be required.

Other possibilities include designing/instituting child and adolescent mental health roles which provide low intensity interventions. For example, roles utilising graduates in health, psychology, education and social work to undertake group psycho-education, befriending, guided self-help and referral facilitation (Nixon & Nixon, 2004) or roles supporting access to mental health treatment such as the use of ‘cultural brokers’ to support engagement (Health Canada, 2002 as cited in Mental Health Workforce Development Programme, 2006). Parent management training, an intervention with a promising evidence base (e.g. Webster-Stratton, 1996), could be delivered via a dedicated FTE. Where interventions are most efficacious through an inter-agency approach, joint appointments could be considered.

These roles have the potential for high contact numbers for receive specific interventions, such as parent management training groups or anxiety management psychosocial group processes. There can be flows in efficiency for the service, improving waiting times for the more specialised team members, reducing re-presentations by the same family, and improved access to the service generally.

Other new roles which could be considered are ‘gateway’ roles such as the specialist primary care mental health nurse. Such roles are currently being developed by primary health organisations in adult mental health. The DHBNZ *Future Workforce* strategy states that the future workforce will need to be more “integrated team based and multi-disciplinary” (DHBNZ, 2005, p. 18) and recommends the development of teams integrated with the secondary sector through, for example, joint appointments and developing roles for allied health professionals as part of the primary health care team.

Development of roles for infant, child and adolescent mental health and substance interventions in the less stigmatising environment of the primary health care setting would:

- improve access for those who would not ordinarily seek help from mental health agencies;
- support early identification and intervention of infant, child and young people’s mental health problems;
- support families with information and access to parent management support;
- work across boundaries to develop a coordinated response to child and adolescent mental health between agencies; and
- act as an interface between universal first contact services and specialist services.

(Gale, Dover, Edwards, & Flemming, 2003)

Additionally, there are some established specialist roles which have the potential for broadening into child and adolescent mental health work, such as medical and allied professionals in child health, child disability, maternal and adult mental health.

Some systemic challenges exist, however, as actual or potential constraints to the creation of

new roles or broadening scopes of practice. The Platform (2005) report on the implications of the HPCA Act in the disability, mental health and addiction sector, notes that services will need to clearly define the role of health professionals, clearly define roles that do not require them to be undertaken by a health professional or rely on previous knowledge gained as a health professional, and clearly define roles that require a health background but are not required to hold a current annual practising certificate (such as team leader roles).

The development of a range of competencies for the child and adolescent mental health sector will aid this process of clarification of scopes of practice and increase new roles and ways of working.

Increase Diversity

Population projections over the next decade show that New Zealand will continue to be an ethnically diverse population and, in some regions, there will be increases in the proportions of Māori, Pacific and Asian populations within the general 0-19 years population (The Werry Centre, 2005).

There is a need to improve the diversity of the child and adolescent mental health workforce to address:

- an imbalance between the level of need within the Māori population compared with the numbers of Māori in the workforce;
- low numbers of Māori in the workforce in clinical roles;
- an imbalance between the level of need within the Pacific population compared with the numbers of Pacific in the workforce;
- low numbers of Pacific in the workforce in clinical roles;
- an imbalance between the level of need within the Asian communities compared with the numbers of Asian people in the workforce; and
- an imbalance in the male:female numbers in the workforce.

A more diverse workforce will improve the capacity of the child and adolescent mental health team, contribute to a wider set of competencies, knowledge and skills and support cultural concordance in service delivery.

It is imperative that we develop the Māori workforce: to improve the balance of Māori in the workforce proportional to the representation of Māori in the client group; to deliver services within kaupapa models of practice; and to train and develop Māori workers to contribute to the full range of roles and settings.

Te Rau Matatini (2006) sets a Māori mental health workforce target of 20% of the dedicated mental health workforce and the primary health care workforce. This target is conservative when applied to the rates of prevalence and access by Māori in the child and adolescent population (refer to Appendix D) and workforce shortages of Māori in the registered professions, “particularly in specialist areas such as CAMHS...” (p. 52).

Increasing numbers of Māori are participating in tertiary education (Te Rau Matatini, 2006). Similarly, for Pacific and Asian, the pool of students is available. The challenge is to attract them towards mental health, and child and adolescent mental health in particular (Faleafa, 2004).

The challenge is twofold. Firstly, to develop training and career pathways to encourage and support people into clinical training and from training into child and adolescent mental health; and secondly, career pathways to support the mature and experienced worker from elsewhere in the sector to be part of the specialist workforce, either in registered professions or new roles.

Sector promotion and targeted recruitment drives benefit from clear training and career pathways. Training and career pathway development will be mapped as part of a national project (refer Recommendation 1).

Strategic Direction

National leadership and national projects are established to address the issues of competency development, training pathways and career pathways.

Working in partnership, District Health Board providers, along with The Werry Centre, other workforce development programmes and the Regional Mental Health Workforce Development Coordinators, engage with key stakeholders to map current capability and capacity. Regional and local plans, guided by national strategy, determine local solutions to grow workforce numbers, create new roles and increase diversity in the child and adolescent mental health workforce.

Innovative solutions to specialist shortages are applied, e.g. transfer of skills and expansion of scopes of practice, utilising peer and distance supervision and clinical support via video conferencing and other technologies.

Regional and Local Recommendations

Increase the Workforce

10. Promotion of careers in child and adolescent mental health in schools and in tertiary education provider settings by:

- encouraging the child and adolescent mental health workforce to promote the sector to school leavers and graduates in their own disciplines;
- offering internships/support packages to those with baseline clinical training to undertake post-graduate study in child and adolescent mental health; and
- consider ways of supporting universities delivering child and adolescent mental health post-entry clinical training (PECT), such as formalising clinical supervision and internship capacity.

11. **Participate in a national project to create career pathways, to align training opportunities** within the mental health sector and across the wider sector for child and adolescent wellbeing, and look for opportunities to improve career movement:
 - between adult, and child and adolescent mental health;
 - between health professionals in the wider child and adolescent sector through secondments, shared training opportunities, and bridging courses;
 - between the NGO and the DHB child and adolescent mental health workforces through secondments, shared training opportunities, and bridging courses;
 - for non-health registered workforces including; alcohol and other drug clinicians, school guidance counsellors, counselling psychologists, family therapists and others who currently work with children and young people;
 - for mental health support workers to move from the foundation certificate to other qualifications in child and adolescent mental health; and
 - for graduates of nursing, social work, occupational therapy, psychology, and psychiatry.
12. **Develop a service level recruitment strategy** based on the goals identified in this strategic framework.
13. **Develop a service level retention strategy** where indicators such as staff satisfaction and staff interviews at exit suggest this is needed.
14. **Participate in the investigation of the issues involved in HPCA Act registration** of key non-health registered disciplines employed in the organisation.
15. **Diversification of clinical placements:** service providers engaged with a wide number of training providers to support good experiences in placements for a range of disciplines.
16. **Joint funding of ‘hard to find’ roles** between agencies such as senior supervising roles within disciplines for colleagues isolated by low numbers or distance.

Example of Strategy in Action:

Services and local tertiary education providers support graduates to return to their training programmes each year to promote the child and adolescent mental health sector and to support clinical placements.

Create New Roles

17. **Participate in the national project to investigate new roles and develop competencies;**
 - in primary care for specialist infant, child and adolescent mental health and substance interventions; and
 - for non-health registered/non-clinical roles.
18. **Review employer responses** to the HPCA Act (2003) and identify implications for workforce planning.
19. **Utilise technology such as video conferencing and distance learning programmes** to support the transfer of skills and extended scopes of practice.

Examples of Strategy in Action:

Providers get together to develop combinations of joint training, joint clinical placements, work exchanges and secondment initiatives.

Scholarships are offered by an employer for development of individuals already working in the sector to undertake specialist training.

DHBs investigate local solutions to local shortages, such as utilisation of Medical Officer Specialist Scale (MOSS) positions under the supervision of a child psychiatrist or utilisation of paediatric workforce capacity to support infant and child mental health capacity.

Increase Workforce Diversity

20. **Increase entry of Māori** into clinical positions and throughout the workforce through promotion of the sector to Māori school leavers and graduates, and through scholarships and internships.
21. **Increase entry of Pacific people** into clinical positions and throughout the workforce through promotion of the sector to Pacific school leavers and graduates, and through scholarships and internships.
22. **Increase entry of Asian people** into clinical positions throughout the workforce through promotion of the sector to Asian school leavers and graduates, and through scholarships and internships.
23. **Ensure provision of cultural support** for Māori, Pacific and Asian staff working in mainstream child and adolescent mental health services.
24. **Establish employer scholarships** to target key gaps in the workforce, utilising apprenticeship, internship and bonded training arrangements for supporting entry into the workforce.
25. **Support and share innovative HR practice** with a range of options available to staff across their working lives as part of a retention strategy.

Example of Strategy in Action:

A human resource manager works with service managers to implement family-friendly practices such as flexitime. For example, allowing parents to work full time during school terms on a 0.8FTE salary, thus having paid (time in lieu) leave during school holidays.

Training and Development

Challenges and Issues

Some of the key challenges and issues impacting on training and development in child and adolescent mental health are:

- the low profile of the child and adolescent mental health sector;
- long lead times required to train the specialist child and adolescent mental health workforce;
- the low priority and lack of mental health content, child and adolescent mental health in particular, in clinical or undergraduate training programmes;
- low numbers undertaking clinical placements in the sector;
- restricted local arrangements for clinical placements between providers of training and service settings;
- lack of nationally approved ‘bridging’ programmes for the returning/retraining workforce to up-skill in child and adolescent mental health;
- sector size impacts on the year to year viability of the small number of post-entry clinical training programmes in child and adolescent mental health;
- Clinical Training Agency funding criteria restricted to registered health professionals affecting the non-clinical health workforce, for example, many alcohol and other drug clinicians;
- the impact of full-time training packages in child and adolescent mental health on mature workers and issues of accreditation by the registering bodies;
- restricted ability of services to provide release time from clinical work to attend training and development opportunities;
- issues of accessibility of training at a local and regional level;
- tensions in the sector between maintaining professional identity versus generic competencies;
- a lack of career pathways within child and adolescent mental health; and
- a lack of child and adolescent mental health training for related workforces: CYF, school guidance counsellors, school nurses, GPs and practice nurses, and the child disability sector.

Competency Development

Competencies describe the knowledge, skills and attitudes that a practitioner needs. A competency framework has yet to be developed for the New Zealand child and adolescent mental health sector.

Competency development needs to include:

- generic (core) and discipline-specific competencies for those working in dedicated infant, child and adolescent mental health roles;
- core competencies for primary healthcare practitioners and related workforces responding to infants, children and young people with mental health and substance problems;
- dual (cultural and clinical) competencies;
- cross-cultural competencies; and
- dual diagnosis competencies.

The development of competencies will support teams to:

- identify the range of competencies currently available and identify gaps for recruitment, role development, and training and development needs;
- function effectively as multi-disciplinary teams by identifying the competencies generic to the service setting and support role clarity for each discipline operating within the team; and
- have a common understanding by identifying the competencies generic across the sectors working with child and adolescent mental health and wellbeing.

Development of competencies supports alignment between tertiary education, clinical training and the work setting, and provides the necessary framework for on-going partnerships to support collaboration in course development, supervision and clinical placements, research, and teaching.

A competency framework should incorporate primary, secondary and tertiary services to facilitate an integrated approach across the health sector: “evidence tells us that early interventions in a number of mental health conditions for children and young people can result in better outcomes” (Minister of Health, 2005, p. 9). There is a need to build the capacity of primary health care practitioners to recognise mental health and substance problems in the infant, child and youth population, to support referrals and provide management and continuity of care.

Additionally, competencies support other professionals, such as school guidance counsellors, community support workers and mental health support workers to identify training needs for referral, management and appropriate levels of intervention as they work with infants, children and young people with moderate to severe mental health issues. Competencies will support those involved in training programmes for these workforces and the identification of career pathways.

Dual clinical/cultural competency is needed for all those working with Māori. Dual competency has been described as “culturally appropriate best practice, which incorporates an understanding of the importance of whānau and traditional healing, represents a synthesis between indigenous values and the highest international clinical standards” (Turia, 2004, p. 9). Education and training programmes should incorporate an integrated dual competency approach to content and, wherever possible, training delivery.

The New Zealand population is forecast to become more diverse, and cross-cultural competence is essential: “The most compelling reason is the unfavourable outcomes and under-utilisation of mental health services of ethnic groups in comparison with the general New Zealand population” (Tse et al., 2005, p. 20). Cross-cultural competencies will need to include recognition of migrant issues, including refugee migrant needs, and inter-generational issues for migrants.

A project to develop a whole of sector (primary, secondary and tertiary) competency framework is recommended as a national project (refer Recommendation 1).

Training System Design

The ad hoc nature of education and training in mental health contributes to barriers for both training and career progression.

At the undergraduate level, a number of certificate and diploma courses in mental health are available which may not be on the qualifications framework and, therefore, may not be nationally recognised. These courses are generally adult focussed, to the extent that even basic competencies in infant, child and adolescent mental health and addiction are absent.

Where courses are child and adolescent focussed, there is no national curriculum supporting skills and knowledge in mental health or substance problems/addiction: “Very few training programmes include child and adolescent mental health as part of their curriculum. Those that do generally focus on developmental issues, adolescent suicide and child protection/abuse issues” (Peters, 2003, p. 1).

One possibility is to establish a foundation degree for child and adolescent mental health and wellbeing. The essential features of foundation degrees are; employer involvement in their development, work-based learning, and the potential to progress to an honours degree level. This has been promoted in the UK since 2000 as a way to address labour market skill shortages. It provides a training pathway in to the sector resulting in greater workforce diversity.

Mental health specialist training commences at the post-graduate level but, even here, for most professional disciplines, infant, child and adolescent content is minimal, sometimes absent. This is a contributing factor to the limited number of those opting to specialise in child and adolescent mental health. One exception is psychiatry training, however FTE budget constraints impact on the number of basic and advanced trainees undertaking training placements in child and adolescent mental health.

A small number of specialist child and adolescent mental health post-graduate courses are delivered. There is a need to strengthen access to these through innovative course design, promotion, mode of delivery and support for inter-departmental studies.

Enhancing existing specialist training and expanding training possibilities will require discussions with tertiary training providers, professional bodies who recognise qualifications, and employers to ensure support.

Training Provision

Ensuring that training programmes are available in smaller centres may have economic benefits for recruitment and retention of isolated and rural workforces: “provision of education and training in rural and remote areas may ... be a more cost-effective way of improving workforce numbers than seeking to entice ‘unwilling’ practitioners away from the major population centres...” (Australian Government Productivity Commission, 2005, pp. 178-179).

All training and development should apply the best available evidence base to treatment therapies and interventions. In the absence of a strong evidence base, training and development content should be rigorously monitored and evaluated with input from consumers, clinicians and professional bodies.

Successful education and training programmes transfer attitudes and values as well as knowledge and skills. Effective training providers include consumer voices to support consumer focussed service provision and continuous improvement: “young people want to participate more in all aspects of mental health services including projects, planning, recruitment, training and quality monitoring” (Te Rau Matatini, 2006, p. 20).

Clinical placements require coordination to support students interested in or preparing to move into child and adolescent mental health as a career. Variations between services in who they will accept for clinical placements and poor communication between services and training providers contribute to low entry numbers into the workforce. Shortages of senior staff and thus clinical capacity to supervise further limit opportunities for clinical placements. Creative placement options include: joint service placements; having more than one student from different disciplines; formalisation of clinical placement arrangements across the year and across disciplines. These need to be explored regionally as well as locally.

Training should be supported by accreditation to an appropriate academic institution and be recognised by the relevant professional associations, colleges and registration boards.

Training Funding

There has been an increase in the number of one-off workshops and trainings available to the sector. However, national, regional and local training plans are needed and should be based on regional and local workforce planning processes.

Eligibility for CTA funding has been restricted to registered health professionals. This has severe limitations on small providers, particularly NGOs, having the ability to support staff through post-entry clinical training. Where regional priorities for training are identified, regional taskforces should consider agreements between employers/regions to advance priority areas.

Regions could consider ways to collectively fund a number of places for non-health registered employees (e.g. some alcohol and other drug clinicians, cultural support workers and mental health support workers). Such an initiative would also support course sustainability from year

to year and therefore support capacity to encourage the few training providers still providing specialist child and adolescent mental health and addictions papers. Loss of specialist post-entry clinical training would be a severe blow to future workforce development.

Where employers fully or part fund and provide paid release time, bonding agreements could be considered to support retention. Hatcher et al (2005) provide a strong statement about student loans: “New Zealand has designed a scheme which is a model of how *not* to increase recruitment of young professionals into the health service” (p. 65) and promotes ‘forgivable student loans’ for people working in mental health. The authors also recommend that we “facilitate a culture of expectation that support workers will train to become clinicians” (p. 69).

Funding is necessary to support the innovation required to break down some of the obstacles to sub-specialty training. Examples of possible innovation include joint funding of ‘hard to find’ clinical or cultural supervision; shared clinical placements; establishment of supernumerary FTE to support clinical training for psychiatric registrars; and the identification of a service to take a ‘lead provider in training’ role.

Strategic Direction

At the national level, the development of a competency framework will establish the core training needs of the sector. Engagement between the providers of education and training and the ‘end user’, the health sector, is essential to align competencies to training provision. This engagement will be supported by a national project (refer Recommendation 1).

A competency framework supports a stepped competency approach from core competency development for all those working with infants, children, young people and their families/whānau, through to specialist competency development in bridging courses and in post-graduate training. Inclusion of child and adolescent mental health competencies supports clearer training and career pathways.

At the regional level, as part of a regional partnership process, analysis of training needs should occur and inform regional action for knowledge and skills development. Agreements between DHB and NGO providers, including top-slicing agreements, help to generate innovation in supporting capacity across provider workforces.

At the service level, there is support for joint trainings, secondments and shared supervisory arrangements.

At the team level, training and development should facilitate the development of a cohesive culture, promoting and enhancing skills in multi-disciplinary teamwork, inter-agency working, dual competency development, and, wherever possible, shared learning between teams and between providers.

At the individual level, training and development should create a pathway that is adaptable to the needs and experience of the individual and be linked to continuing performance development processes and career paths. Employers use a variety of ways to encourage career progression such as apprenticeships for support workers to move to clinician level and support for experienced clinicians to take on research and teaching roles.

Regional and Local Recommendations

Core Competencies

26. **Participate in the development of a competency framework in child and adolescent mental health** and promoting its inclusion into a mental health national training plan.
27. **Promote the development of core competency content** in child and adolescent mental health within undergraduate and graduate training courses accessed by related workforces.
28. **Support the competency development of related workforces, particularly adult mental health and addiction services**, in identifying and responding to infants, children and young people with parents/caregivers with mental illness.

Examples of Strategy in Action:

Development of competencies provides the tertiary education sector with clear guidelines for the learning needs of the sector.

Core competencies for child and adolescent mental health and substance problems are available so that training providers can incorporate these into training programmes.

Training System Design

29. **Participate in the national project for the development of a range of education and training delivery options.**
30. **Focus on provision of education and training in isolated areas in the region** to support retention in rural areas.

Examples of Strategy in Action:

Funds are allocated to deliver some of the training available in rural and isolated areas.

Training Provision

31. **Consider provision of cross-agency training**, for example between DHB and NGO providers, to improve capacity across the workforce.
32. **Support training for managers, team leaders and clinical leaders** in management competencies which will support a systemic approach to management, including: clinical governance models for continuous improvement; participatory action models of research; and effective skills for inter-agency partnerships.
33. **Support staff to deliver education programmes in prevention and early intervention** that support access of traditionally low access populations and reduce the need for secondary mental health services, e.g. parent management training programmes.

Examples of Strategy in Action:

Where a specific training need is identified regionally, regional stakeholders collaborate to devise and deliver training to relevant workforces. For example, an identified regional need for training on infant mental health would involve a number of providers across primary, secondary and tertiary health and utilise clinical and cultural expertise.

Senior practitioners are expected to complete training to masters level and there is an expectation that they will participate in workforce development initiatives supporting increased capacity and capability in the sector e.g. through training, research, supervision or mentoring in the sector.

Video conferencing technology is used to support teams receiving distance learning and viewing conferences and workshops.

Training Funding

34. **Consider regional and inter-district training provision agreements** between service providers/employers and the tertiary institutions to support continuity of training and alignment with needs across the whole of the sector workforce.
35. **Review provision of the training and development budget** to child and adolescent mental health staff to ensure that staff are supported to develop their own competency and to participate in the competency development of others in the field.

Example of Strategy in Action:

Intersectoral collaboration (CAMHS, CYF, GSE and the education sector) to fund training for a joint initiative to implement parent management training programmes regionally.

Research and Evaluation

Challenges and Issues

The relatively small size of the child and adolescent mental health sector contributes to reduced capacity for teaching, research and evaluation. Current capacity to provide training, to research, and to evaluate the sector relies on a small number of people in an aging workforce. Development of sustainable future capacity is essential.

Research in the sector is not coordinated and this may result in inefficiencies, with research gaps, overlaps or duplications due to a lack of dissemination of findings.

There is little well-established evidence for the interventions upon which child and adolescent mental health practice is based. The child and adolescent mental health sector needs to generate research which will provide an evidence base for current and future practice in the New Zealand context.

Regional and local research and evaluation initiatives are important to support contextualised workforce and service delivery planning. Even within regions, there may be differences in epidemiology, service provision and workforce.

Research and evaluation to support workforce planning is hindered by difficulties in collecting workforce data. The recent *Stocktake* of child and adolescent mental health services (Ramage et al., 2005) included the following limitations:

- considerable follow up of providers was required;
- the quality of the data provided was variable;
- there was a lack of NGO data captured in MHINC;
- the primary care and private professional workforces were not included; and
- there was difficulty in determining the number of unique clients when clients are seen by a number of agencies, and this data is not collected centrally.

Regular standardised data collection on workforce composition is needed centrally. Regional planning would benefit from collection and analysis of access rates in relation to the workforce numbers, workforce distribution, workload in various clinical settings, and allocation of time to various disorders.

The *Stocktake* (Ramage et al., 2005) found a lack of workforce data by discipline. One exception was the survey of the Psychiatric workforce initiated by the Royal Australia and New Zealand College of Psychiatry and conducted by The Werry Centre in 2004 (Ramage et al., 2005) which has provided valuable data.

Where annual surveys are undertaken by professional bodies, data is not typically collected in a way that can be made available for analysis of the child and adolescent mental health workforce. This data collection and analysis would ideally be available and repeated bi-annually. The national project on data collection will support this (refer recommendation 3).

Where workforce development research has been undertaken, it has tended to focus on only one discipline or on only one part of the child and adolescent mental health workforce. A notable exception is the recent report *Improving Recruitment to the Mental Health Workforce in New Zealand* (Hatcher et al., 2005).

The sector needs clinical information and epidemiological data on client access and barriers to access. Clinical information in New Zealand is currently stored in a range of non-compatible data systems which limits its utility and has contributed to a culture of poor investment in data capture.

The implementation of MH Smart (utilisation of HONOSCA) is a move in the direction of outcome data that can be utilised locally and regionally as well as nationally. However this will require systems, training and support for services to collect, collate and aggregate data in a timely way to support service delivery and service planning.

In an environment of workforce shortages there is limited support and release time for practitioners to write up their practice and unique perspectives on New Zealand based models of intervention.

The sector cannot afford to divide the specialist workforce into academic researchers and clinical practitioners. This is particularly true where a very small number of people in the sector hold highly specialised competencies, such as dual competencies or rare expertise in a sub-speciality area. Such clinicians are highly sought after in clinical, teaching and research roles and can feel conflicted as to how best to develop the needs of their specialist area as well as look after their own development.

In such a small sector, employers should consider development of teaching and research as a retention strategy:

- support for dual roles such as joint clinical and academic (teaching/research) positions, and joint clinical and mentoring positions (supervision/clinical placement);
- an expectation that senior staff will undertake post-graduate training to a research level; and
- support for specialists in the workforce to participate in training other areas of the sector with fewer clinical resources.

Strategic Direction

Research and evaluation is undertaken to identify training and development needs in the workforce, to adapt international best practice to the New Zealand context and to understand and plan workforce needs.

Research by clinicians supports skill development for individual clinicians, supports team practice with an empirical base and develops an evidence base for clinical practice in the New Zealand context. Support for innovative practice and the development of Māori and other culturally linked models of practice needs to occur.

Research links support institutional links between the tertiary education sector and the health sector, with mutual benefit. Both tertiary education and service providers contribute to joint

clinical and academic (both teaching and research) positions.

A strong research ethic nationally improves quality of care by ensuring international best practice is adapted for the New Zealand context with appropriate evaluation. Incorporation of research within clinical services supports innovation and rigour in clinical practice and improved outcomes for service users.

An intra-sectoral and inter-sectoral approach to research and evaluation supports evidence based practice across a range of settings. Consumers of child and adolescent mental health services, and their families, are involved in determining what research and evaluation should occur, how it should be carried out, and what the results mean for future planning.

A network of researchers is maintained to ensure: research planning; high quality academic standards; and to support clinical services to carry out research. A national research network supports local research and attracts high quality input from overseas.

To create continuous learning organisations, research is complemented by evaluation of outcomes. Models which support this include action research, action learning sets, continuous quality improvement and outcomes evaluation processes.

As a sector, we need to understand the workforce to grow and retain the workforce. This means targeted workforce research, by academics, teams and individual practitioners. This knowledge, in turn, informs workforce development planning and has mutual benefits for the tertiary sector/ health provider interface.

Regional and Local Recommendations

36. **Support the development of a national research network** to facilitate links between academics and service providers and to support workforce planning.
37. **Consider supporting/commissioning regional/sub-regional needs assessment and development research:** identifying specific local challenges and issues and innovative practices to overcome these.
38. **Enable research** by child and adolescent mental health practitioners, such as: joint positions between training institutions and services, use of study leave as a retention strategy; use of bonding; and the availability of scholarships for senior staff to undertake higher level study.

Examples of Strategy in Action:

Via the clinical governance process in place in a team, the analysis of outcome measures to support service evaluation is promoted and team members are encouraged to undertake this research, either as a project for a senior team member (for example, for a PDRP portfolio) or as part of seeking a formal qualification.

A research forum meets two monthly via video conferencing to plan and support research and evaluation initiatives and to develop collaborative research ideas.

Implementation of the Framework

2006

2016

2006–2009

2009–2011

2011–2016

<p>Develop initial regional/ sub-regional taskforces to:</p> <ul style="list-style-type: none"> • assess demand, capacity and capability; • prioritise; and • oversee implementation of plan. 	<p>Review of regional/sub-regional/local plans.</p> <p>Priority issues are addressed and further priorities identified.</p>	<p>Review of regional/sub-regional/local plans.</p> <p>Priority issues are addressed and further priorities identified.</p>
<p>Development of a whole sector competency framework.</p>	<p>Competencies reflected in graduate clinical training curriculum.</p> <p>New staff are 'work-ready' and competent.</p>	<p>Priority issues are addressed and further priorities identified.</p> <p>Competencies reflected in under-graduate education and training curriculum.</p> <p>Positions filled.</p>
<p>Investigate new roles and ways of working.</p>	<p>Pilot new roles and ways of working.</p>	<p>Competencies reflected in under-graduate education and training curriculum.</p> <p>Positions filled.</p> <p>Evaluate new roles and ways of working.</p>
<p>Build relationships between tertiary education and service providers to maximise up-take of existing clinical training.</p>	<p>Increased engagement to plan curriculum, course delivery and clinical placements.</p>	<p>Evaluate new roles and ways of working.</p>
<p>Promotion of the sector, especially to Māori, Pacific, Asian, males, and target graduates of nursing, social work, occupational therapy, psychology and psychiatry.</p>	<p>Increased up-take of people undertaking child and adolescent mental health and addictions training.</p> <p>Mentoring of graduates.</p>	<p>On-going engagement to plan curriculum, course delivery and clinical placements.</p>
<p>Investigate support for health registration of key non-health registered disciplines.</p>	<p>Increased use of bonding, scholarships, and internships.</p>	<p>Increased numbers of Māori, Pacific, Asian and males in the workforce.</p>
<p>Pilot a child and adolescent mental health workforce planning model in a DHB and make this available as a national resource.</p>	<p>Workforce planning model available as a national resource.</p>	<p>Increased numbers of non-health registered workers with child and adolescent mental health training.</p>
<p>Planning and provision of national training in key competency areas: dual competency; dual diagnosis; and evidence based practice.</p>	<p>Ongoing provision of training.</p>	<p>On-going workforce planning.</p>
<p>Improve data collection.</p>	<p>Consistent data collection.</p>	<p>On-going provision of training.</p>
<p>Support and share innovative and flexible HR and 'learning organisation' practice.</p>	<p>Continued dissemination of best practice.</p>	<p>Consistent data collection.</p>
<p>Continue clinical placement pilots in the Northern and Midland regions and extend to other areas and NGOs, including cultural specific models.</p>	<p>Resources and systems available to support high quality placements in all regions.</p>	<p>Employment practices in this sector are 'cutting edge'.</p>
<p>Investigation of training models.</p>	<p>Piloting of new training models eg for child psychiatry.</p>	<p>Investigation of sustainable training models for future implementation.</p>
<p>Development of a national research network.</p>	<p>Increased planning of, and collaboration in, research and evaluation activities.</p>	<p>Development of a body of evidence-based best practice for the New Zealand context.</p>

The Future of Child and Adolescent Mental Health – How Will the Sector Look in 2016?

The following vision is put forward to stimulate discussion and planning by all those working with infant, child and adolescent mental health and substance problems and by those with responsibility for workforce development.

By 2016 infant, child and adolescent mental health and wellbeing is the concern of all health, education and social service workers. Training and resources for these workforces means better recognition and better outcomes for consumers.

A wide range of people are drawn to work in the sector because they are passionate about children and young people having the best outcomes possible. They have the skills to **build on strengths and develop resiliency** in the community, family/whanau and in individuals. They care about people.

They work in systems that value them. Workplaces and workforce policies are **family friendly and flexible**, adapting to the needs of individuals as they train, gain experience, seek further development, and move through life stages. The sector is seen as an attractive career option.

The sectors work closely to devise **integrated systems of care** across the primary, secondary and tertiary continuum.

There is a common understanding through **generic core competencies** as the basis for multi-disciplinary and inter-agency working. **Role-specific competencies** clarify the roles of specific disciplines. Development of cultural competencies supports **culturally appropriate and clinically competent practice**.

Workforce planning and workforce development occurs around the **care group** with strong intra-sectoral and intersectoral participation ensuring capacity and continuity of care between different parts of the sector.

Employers use the vision of *Whakamārama te Huarahi* to review their performance in planning and developing the workforce, that is, **ensuring that infants, children, young people and their families/whanau have access to a highly skilled, well supported and effective workforce**.

Glossary of Terms

Blueprint	The 1998 Mental Health Commission document ' <i>Blueprint for Mental Health Services in New Zealand: How Things Need To Be</i> '.
CAMHS	Child and Adolescent Mental Health Services. This term refers to DHB Provider Arm services for child and adolescent mental health and addiction.
Children/tamariki and adolescents/taitamariki	People aged 0-19 years (inclusive).
Clinical governance	A framework for health service continuous improvement based on; clinical effectiveness, risk management effectiveness, patient experience, communication effectiveness, response effectiveness, strategic effectiveness and learning effectiveness.
Co-morbidity	Co-occurring mental health and substance misuse or abuse issues.
Competencies	The attitudes, skills, knowledge and behaviours of health practitioners and support workers that enable them to perform particular functions.
Consumer/Whaiora	A person who experiences or has experienced mental illness and/or substance misuse or abuse and who uses or has used mental health and addiction services.
CYF	Department of Child, Youth and Family. A government statutory agency for the protection of children and young people.
CTA	Clinical Training Agency, funded by the Ministry of Health.
DHB	District Health Board.
Dual competency	Best practice based on the highest international clinical standards underpinned by indigenous values and concepts of healing.
Cultural competency	The appropriate skills, knowledge and attitudes to provide services to those of cultures other than your own.
Dual diagnosis	Co-existing mental health and addiction disorders.

FTE	Full-Time Equivalent.
HONOSCA	Health of the Nation Outcome Scales for Children and Adolescents.
Inter-district	Two or more districts within a region working collaboratively.
Intersectoral	Relationships between those sectors working for the wellbeing of children and adolescents, and their families.
Kaumatua (koroua and kuia)	Māori elder.
Kaupapa Māori	Māori theme.
Kaupapa Māori Services	Provided by primarily Māori workers for Māori clients.
Local	Refers to District Health Board areas.
Marae	Meeting area for families and communities.
MHINC	Mental Health Information National Collection.
MH Smart	Mental Health Standard Measures of Assessment and Recovery Initiative. Established to assist District Health Boards in outcome collection processes.
NGO	Non Government Organisation. These organisations may or may not be in receipt of government funding.
PECT	Post Entry Clinical Training.
PDRP	Professional Development and Recognition Programmes.
Rangatiratanga	Sovereignty.
Regional	Refers to the four health regions; Northern, Midland, Central & Southern.
Te ao Māori	World of Māori.
Tikanga	Values and principles.
Wānanga	Traditional learning.
Whānau Ora	Family wellbeing.
Whanaungatanga	Building relationships.

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Appendices

- Appendix A** **Summary of Recommendations**
- Appendix B** **The National Infrastructure for Workforce Development Planning**
- Appendix C** **Strategic Drivers**
- Appendix D** **Prevalence of Child and Adolescent Mental Health and Substance Disorders**
- Appendix E** **A 2004 Stocktake of the Child and Adolescent Mental Health Services' Workforce**
- Appendix F** **Resources**

Appendix A — Summary of Recommendations

Goal One Retain and develop the existing child and adolescent mental health workforce.	Goal Two Increase the numbers of the child and adolescent mental health workforce through training and enhanced career pathways.	Goal Three Increase the diversity of the child and adolescent mental health workforce through the development of core competencies, new roles and new ways of working.	Goal Four Increase Māori workforce numbers across all roles and parts of the sector.	Goal Five Increase Pacific workforce numbers across all roles and parts of the sector.	Goal Six Increase clinical/cultural competencies throughout the child and adolescent mental health workforce.	Goal Seven Increase capacity of related sector workforces to provide mental health screening and, where appropriate, assessment and therapeutic intervention.	Goal Eight Increase organisational capacity and sector leadership to develop and plan future workforce needs for the child and adolescent mental health sector.
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Workforce Infrastructure

Recommendation 1.							National
<p>The Werry Centre for Child and Adolescent Mental Health Workforce Development and other national workforce development programmes to work with all stakeholders to:</p> <ul style="list-style-type: none"> • develop a competency framework for the child and adolescent mental health and addiction sector; • investigate and pilot innovation in roles and ways of working; • engage clinical training providers to deliver competency-based training to the sector through a range of delivery options, including distance options, modularised (stand-alone or build to degree level) generic competency training, under-graduate and post-graduate training, through to bridging courses for re-entry workers; and • map and promote training and career pathways within the child and adolescent mental health and addiction field and related sectors working with child and adolescent wellbeing. 							
Recommendation 2.							National
<p>A child and adolescent mental health workforce planning model to be developed and piloted as a joint initiative between a District Health Board and the workforce development programmes.</p>							
Recommendation 3.							National
<p>Integrate collection of nationally consistent child and adolescent mental health workforce data with the national Health Workforce Information Project (HWIP) and existing professional workforce surveys.</p>							
Recommendation 4.							National
<p>National provision of training to the sector to increase skills in key areas of dual (clinical and cultural) competency training, dual diagnosis training and evidence based psychosocial interventions.</p>							

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Workforce Infrastructure

Recommendation 5.							Regional
Establishment of regional taskforces for child and adolescent mental health and addition workforce planning and action. In each region, The Werry Centre will work in partnership with the Regional Workforce Development Coordinators to engage key sector stakeholders to assess capacity, identify priorities, and plan and implement regional/inter-district child and adolescent mental health workforce development strategies.							
Recommendation 6							Local
Implementation by child and adolescent mental health service providers of the piloted workforce planning model at service level.							

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Organisational Development

Recommendation 7.							Local
Promote service leadership development (management, clinical, cultural and consumer) and processes which develop an individual service's capacity to inform workforce planning, service operation and service delivery.							
Recommendation 8.							Regional/Local
Promote participatory service improvement processes, including cultural and consumer specific opportunities for participation in workforce and service development.							
Recommendation 9.							Local
Intervene actively in team dysfunction: identify workforce indicators, e.g. high turnover, recruitment difficulties, and negative feedback from clinical placements; develop the means to gather the information; and a process to respond.							

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Recruitment and Retention

Recommendation 10.							Regional/Local
<p>Promotion of careers in child and adolescent mental health in schools and in tertiary education provider settings by:</p> <ul style="list-style-type: none"> encouraging the child and adolescent mental health workforce to promote the sector to school leavers and graduates in their own disciplines; offering internships/support packages to those with baseline clinical training to undertake post-graduate study in child and adolescent mental health; and consider ways of supporting universities delivering child and adolescent mental health post-entry clinical training (PECT), such as formalising clinical supervision and internship capacity. 							Regional/Local
Recommendation 11.							Regional/Local
<p>Participate in a national project to create career pathways, to align training opportunities within the mental health sector and across the wider sector for child and adolescent wellbeing, and look for opportunities to improve career movement:</p> <ul style="list-style-type: none"> between adult, and child and adolescent mental health; between health professionals in the wider child and adolescent sector through secondments, shared training opportunities, and bridging courses; between the NGO and the DHB child and adolescent mental health workforces through secondments, shared training opportunities, and bridging courses; for non-health registered workforces including; alcohol and other drug clinicians, school guidance counsellors, counselling psychologists, family therapists and others who currently work with children and young people; for mental health support workers to move from the foundation certificate to other qualifications in child and adolescent mental health; and for graduates of nursing, social work, occupational therapy, psychology and psychiatry. 							Local
Recommendation 12.							Local
Develop a service level recruitment strategy based on the goals identified in this strategic framework.							

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Recruitment and Retention

Recommendation 13.							Local
Develop a service level retention strategy where indicators such as staff satisfaction and staff interviews at exit suggest this is needed.							
Recommendation 14.							Regional/Local
Participate in the investigation of the issues involved in HPCA Act registration of key non-health registered disciplines employed in the organisation.							
Recommendation 15.							Regional/Local
Diversification of clinical placements: service providers engaged with a wide number of training providers to support good experiences in placements from a range of disciplines.							
Recommendation 16.							Regional/Local
Joint funding of 'hard to find' roles between agencies such as senior supervising roles within disciplines for colleagues isolated by low numbers or distance.							
Recommendation 17.							Regional/Local
Participate in the national project to investigate new roles and develop competencies: <ul style="list-style-type: none"> • in primary care for specialist infant, child and adolescent mental health and substance interventions; and • for non-health registered/non-clinical roles. 							

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Recruitment and Retention

Recommendation 18.							Regional/Local
Review employer responses to the HPCA Act and identify implications for workforce planning.							
Recommendation 19.							Regional/Local
Utilise technology such as video conferencing and distance learning programmes to support the transfer of skills and extended scopes of practice.							
Recommendation 20.							Regional/Local
Increase entry of Māori into clinical positions and throughout the workforce through promotion of the sector to Māori school leavers and graduates, and through scholarships and internships.							
Recommendation 21.							Regional/Local
Increase entry of Pacific people into clinical positions and throughout the workforce through promotion of the sector to Pacific school leavers and graduates, and through scholarships and internships.							
Recommendation 22.							Regional/Local
Increase entry of Asian people into clinical positions and throughout the workforce through promotion of the sector to Asian school leavers and graduates, and through scholarships and internships.							

Goal One Retain and develop the existing child and adolescent mental health workforce.	Goal Two Increase the numbers of the child and adolescent mental health workforce through training and enhanced career pathways.	Goal Three Increase the diversity of the child and adolescent mental health workforce through the development of core competencies, new roles and new ways of working.	Goal Four Increase Māori workforce numbers across all roles and parts of the sector.	Goal Five Increase Pacific workforce numbers across all roles and parts of the sector.	Goal Six Increase clinical/cultural competencies throughout the child and adolescent mental health workforce.	Goal Seven Increase capacity of related sector workforces to provide mental health screening and, where appropriate, assessment and therapeutic intervention.	Goal Eight Increase organisational capacity and sector leadership to develop and plan future workforce needs for the child and adolescent mental health sector.
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Training and Development

Recommendation 26.							Regional/Local
Participate in the development of a competency framework in child and adolescent mental health and promote its inclusion into a mental health national training plan.							
Recommendation 27.							Regional/Local
Promote the development of core competency content in child and adolescent mental health within undergraduate and graduate training courses accessed by related workforces.							
Recommendation 28.							Regional/Local
Support the competency development of related workforces, particularly adult mental health and addiction services, in identifying and responding to infants, children and young people with parents/caregivers with mental illness.							
Recommendation 29.							Regional/Local
Participate in the national project for the development of a range of education and training delivery options.							
Recommendation 30.							Regional/Local
Focus on provision of education and training in isolated areas in the region to support retention in rural areas.							

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Training and Development

Recommendation 31.							Regional/Local
Consider provision of cross-agency training, for example between DHB and NGO providers, to improve capacity across the workforce.							
Recommendation 32.							Regional/Local
Support training for managers, team leaders and clinical leaders in management competencies which will support a systemic approach to management, including: clinical governance models for continuous improvement; participatory action models of research; and effective skills for inter-agency partnerships.							
Recommendation 33.							Regional/Local
Support staff to deliver education programmes in prevention and early intervention that support access of traditionally low access populations and reduce the need for secondary mental health services, e.g. parent management training programmes.							
Recommendation 34.							Regional/Local
Consider regional and inter-district training provision agreements between service providers/employers and the tertiary institutions to support continuity of training and alignment with needs across the whole of the sector workforce.							
Recommendation 35.							Local
Review provision of the training and development budget to child and adolescent mental health service staff to ensure that staff are supported to develop their own competency and to participate in the competency development of others in the field.							

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Research and Evaluation

Recommendation 36.							Regional/Local
Support the development of a national research network to facilitate links between academics and service providers and to support workforce planning.							
Recommendation 37.							Regional/Local
Consider supporting/commissioning regional/sub-regional needs assessment and development research: identifying specific local challenges and issues and innovative practices to overcome these.							
Recommendation 38.							Regional/Local
Enable research by child and adolescent mental health practitioners, such as: joint positions between training institutions and services; use of study leave as a retention strategy; use of bonding; and the availability of scholarships for senior staff to undertake higher level study.							

Appendix B.

The National Infrastructure for Mental Health Workforce Development Planning

The establishment of a national and regional infrastructure for workforce development has created new possibilities in the sector for effective and efficient workforce planning within the context of national strategy, current policy initiatives, projected demographic data and identified local needs.

The Werry Centre for Child and Adolescent Mental Health Workforce Development

- Undertakes research, consultation and needs analysis to support workforce planning.
- Undertakes projects to increase the capacity and capability of the workforce.
- Supports the delivery of education and training to the sector.

Te Rau Matatini

- Ensures that Māori mental health service users – tangata whaiora – have access to a well prepared and well qualified Māori mental health workforce.
- Contributes to Māori mental health workforce policy development at a national and regional level.
- Expands the Māori mental health workforce.
- Promotes rewarding career opportunities in mental health for Māori.

Matua Raki – Addiction Treatment Sector Workforce Development Programme (National Addiction Centre)

- Aims to provide the encouragement, resources and rewards for excellence in the practice of addiction treatment.
- Delivers a range of training and also collaborates to run the New Zealand School of Addiction.

Mental Health Workforce Development Programme

- Promotes a nationally coordinated approach that builds mental health workforce capacity and capability so services meet the recovery needs of adult mental health service users.
- Informs evidence-based workforce development policy and implements workforce development initiatives.
- Provides a transparent workforce development initiative administration mechanism.

PAVA, an NGO Pacific health strategy organisation, contracted by the Mental Health Directorate (Ministry of Health). Their work includes:

- community support workers training programme for Pacific and non-Pacific workers on Pacific models of care and treatment;
- set of cultural and clinical competency standards in Pacific mental health to guide Pacific mental health professionals in the treatment and management of mental illness within Pacific models of care; and

- a feasibility study on the workforce development infrastructure needs for the Pacific mental health workforce.

Regional Mental Health Workforce Development Co-ordinators

- Build strong relationships within and across the mental health sector.
- Facilitate uptake of national mental health workforce development opportunities.
- Increase regional feedback and participation in national, regional and district mental health workforce development planning.
- Ensure national workforce centres and programmes are responsive to the needs of the mental health sector.

In addition, these roles:

- support DHB funders and planners and DHB and NGO managers to collect and analyse required data;
- write regional workforce development plans; and
- support the implementation of these plans.

Appendix C.

Strategic Drivers

Strategies for Service Delivery - Child and Adolescent Mental Health

Key strategy documents for the child and adolescent mental health sector include:

- *Looking Forward*, the national mental health strategy (Ministry of Health, 1994) and *Moving Forward* (Ministry of Health, 1997), its implementation plan;
- the report on *Child, Adolescent and Family Mental Health Services* (McGeorge, 1995);
- the *Mason Report* (Mason, Johnston, & Crowe, 1996);
- *New Futures: A strategic framework for specialist mental health services for children and young people in New Zealand* (Ministry of Health, 1998b);
- *Te Tāhuhu, Improving Mental Health 2005-2015: The second New Zealand mental health and addiction plan* (Minister of Health, 2005).

These strategies are referenced to targets for access to services formulated in the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998). *Blueprint* targets were not initially established for the child and adolescent population; however, they were subsequently established as follows: 0-9 years 1%, 10 – 14 years 3.9%, and 15 – 19 years 5.5% (see Table 2, p. 13).

New Futures, (Ministry of Health, 1998b, p. 3-4), identified several key targets:

- to expand specialist mental health services for children and young people in order to meet the needs of those with the most severe mental health problems;
- major developments in meeting the needs of Māori: that is, to improve Māori health and the further development of the Māori workforce in mainstream services and kaupapa Māori mental health services;
- to strengthen training for child and adolescent mental health clinicians in working with coexisting mental health and alcohol and other drug abuse and dependence; and
- inter-sectoral coordination which allows the needs of the child or young person to be responded to effectively by all the agencies involved.

In 1998, a national *Child Health Strategy* (Ministry of Health, 1998a) was launched which reinforced the strategic direction for inter-sectoral coordination in child health and disability support services to improve child health outcomes. This strategy had as its aims: “a greater focus on health promotion, prevention and early intervention; better co-ordination; develop a national child health information strategy; child health workforce development; improve child health evaluation and research; leadership in child health” (p. viii).

Several other significant strategy documents and developments also apply to this sector.

These include:

- the *New Zealand Health Strategy* (Ministry of Health, 2000) which lists children and young peoples' health as a priority area;
- the *New Zealand Disability Strategy* (Minister for Disability Issues, 2001);
- the *Primary Healthcare Strategy* (Ministry of Health, 2001);
- *He Korowai Oranga*, the Māori Health Strategy (Ministry of Health, 2002a); and
- the *Pacific Health and Disability Action Plan* (Minister of Health, 2002).

The Ministry of Social Development has developed *Family Start* and *Strengthening Families* initiatives and the Ministry of Justice and Ministry of Social Development led the development of the *Youth Offending Strategy* (Ministry of Justice & Ministry of Social Development, 2002). These also have intersectoral capacity goals.

In *He Korowai Oranga* (Ministry of Health, 2002a) the three principles of the Treaty of Waitangi — partnership, participation and protection — are articulated in line with Māori expectations of their relationship with the Crown in the health and disability sector. The overall aim of *He Korowai Oranga* is whānau ora — Māori families supported to achieve their maximum health and wellbeing.

Three key threads are woven through the *He Korowai Oranga* strategy (Ministry of Health, 2002a) and the Māori Health Action Plan (Ministry of Health, 2002c):

- acknowledging Māori aspirations for rangatiratangā (sovereignty) over their own lives;
- maintaining and building on the gains already made in Māori health; and
- reducing the inequalities that currently exist between the health and wellbeing of Māori and other population groups.

Various strategic documents, for example the *Youth Health Action Plan* (2002), and the work of the Office of the Children's Commissioner, stress the importance of opportunities for children and young people to participate in the development of services. Consumer participation, important in shaping service design, also has implications for mental health workforce development, both in shaping the workforce and, specifically, in developing the consumer workforce.

Workforce Development Strategies

A number of strategies have been developed to address the key issues of mental health workforce capacity and capability:

- *Developing the Mental Health Workforce: A report of the National Mental Health Workforce Development Coordinating Committee* (National Mental Health Workforce Development Co-ordinating Committee, 1999);
- *Tuutahitia te Wero: Meeting the Challenges* (Health Funding Authority, 2000b) identified child/tamaiti and youth/rangatahi mental health as one of five priority areas for mental health workforce development;

- *He Nuka Mō Ngā Taitamariki: A National Workplan for Child and Youth Mental Health Services* (Health Funding Authority, 2000a), focused on the workforce challenges specific to the child and adolescent mental health sector and the funding required to increase services to meet benchmark targets;
- the *Mental Health (Alcohol and Other Drug) Workforce Development Framework* (Ministry of Health, 2002b) asserted a whole of system approach based on five strategic imperatives: workforce development infrastructure; organisational development; recruitment and retention; training and development; and research and evaluation;
- *the Pacific Health and Disability Workforce Development Plan* (Ministry of Health, 2004), provided goals and an action plan for Pacific workforce development and improving health outcomes for Pacific people;
- *Te Tāhuhu, Improving Mental Health: The second national mental health and addiction plan 2005 – 2015* (Minister of Health, 2005) confirmed mental health services for children and young people as a priority area. There is a strong emphasis on strengthening cross-agency working to promote the optimal use of resources, minimise clinical risk and maximise in-demand workforce capabilities. This strategy describes the following key focus areas for services to children and young people: acknowledge the wider environment; recognise the need for government services to work together to effectively address need; and early intervention can result in better outcomes.
- *Future Workforce 2005 – 2010* (DHBNZ, 2005), provides a health and disability sector-wide approach to support workforce activity at the local, regional and national levels. The key priorities are nurturing and sustaining the workforce and developing workforce/sector capability across the tiers of service provision.
- *Tauāwhitia te Wero, Embracing the Challenge: National mental health and addiction workforce development plan 2006 – 2009* (Ministry of Health, 2005a) is a national strategic plan which sets the vision for a diverse mental health and addiction workforce that is:
 - responsive to the needs of service users, their families, whānau and significant others; and
 - confident in their positive and unique contribution to the journey of recovery.

A national infrastructure to support mental health and addictions sector workforce development in the form of four national programmes is now in place (refer Appendix B). A number of strategic documents have been developed:

- *Kia Puāwai te Ararau: Te Rau Matatini's Māori Mental Health Workforce Development Strategic Plan* (Te Rau Matatini, 2006) for the Māori workforce – child, adolescent and whānau mental health workforce development is one of the six workforce priorities in this plan. The objectives and recommendations of *Kia Puāwai Te Ararau* (Te Rau Matatini, 2006) are supported by *Whakamārama te Huarahi* and extended to the mainstream child and adolescent mental health workforce;
- *Matua Raki National Addiction Treatment Sector Workforce Development Programme Plan 2005-2015* (Matua Raki, 2005) includes a commitment to workforce development

for people delivering treatment services for youth and their family/whānau;

- *National Non Government Organisations (NGO) Mental Health and Addictions Workforce Development Plan 2006 – 2009* (Draft) (Blueprint Centre for Learning, 2005) for development of the non-government sector workforce and for this to be aligned to, guided by and supported by national and regional infrastructure; and
- the *Asian Mental Health Workforce Development Feasibility Project* (Tse et al., 2005) commissioned by the Mental Health Workforce Development Programme, proposes “an educational programme to improve the appropriate skills, knowledge and cultural competence of the mental health workforce that provides services for the well-being of the Asian population” (p. 1).

Additionally, there is a Pacific Workforce Development Feasibility project currently being undertaken by PAVA, a Pacific advisory group. The goals, objectives and recommendations of the *Pacific Health and Disability Workforce Development Plan* (Ministry of Health, 2004) are supported by *Whakamārama te Huarahi*.

Appendix D.

Prevalence of Child and Adolescent Mental Health and Substance Disorders

The conjoint findings of the two New Zealand prevalence studies (Fergusson, 2003) showed that the prevalence of mental health problems in children and adolescents is significantly higher than the existing *Blueprint* targets. At 11 years of age, 18% were found to have met the criteria for at least one mental health disorder over the preceding twelve months (Fergusson, Horwood & Lynskey, 1997 as cited in Ramage et al., 2005), increasing to approximately 25% at age 15 (Fergusson & Harwood, 2001 as cited in Ramage et al., 2005) and 42% at age 18 (Fergusson et al., 2003). Fergusson and Horwood (2001 as cited in Ramage et al., 2005) also found that at ages 15 and 18 years, females had higher rates of disorders than males due largely to greater rates of anxiety and depression. However, it was also noted that at age 18 years males had higher rates of alcohol abuse and dependence than females.

This finding is consistent with research conducted overseas which suggests that the rate of disorders with clinically significant impairment in functioning associated with a mental health diagnosis in children and adolescents is 15% (Waddell & Shepherd, 2002). Furthermore, “New Zealand literature suggests that the prevalence of mental health problems among Māori is 1.5 – 2.0 times higher than that among non-Māori. This difference appears to be related to disadvantage” (Ramage et al., 2005 p. 9). Māori comprise nearly 25% of young people and one in five clients that accessed child and adolescent mental health services in 2003 were Māori (Ramage et al., 2005).

It is known that there is high prevalence of mental health disorders for children and young people in care and protection services and those who come into contact with the justice system. Additionally, many young people with mental health disorders also have substance misuse and dependency issues (Health Funding Authority, 2000a).

In 2001, 40% of Pacific people were less than 15 years old and most were born in New Zealand. There is limited research on the mental health of Pacific children and young people, however it is estimated that over a six-month period, 23% of Pacific people in New Zealand could expect to experience a mental illness (including alcohol and other drug use disorders) (Ministry of Health, 2005b).

A 2004 prevalence survey (Green, McGinnity, Meltzer, Ford, & Goodman, 2005) conducted in Great Britain of children and young people aged 5 – 16 living in private households, found that children with mental disorders were much more likely than other children to have had time off school (both authorised and unauthorised), tended to have poorer general health, much lower scores on ability to empathise with others, and about half scored in the bottom quartile on a scale measuring the extent of the network of family and friends to whom the child felt close. Most parents had sought some form of advice from a professional, usually a teacher, although a number had sought specialist advice (mental health specialist or from special educational service staff such as educational psychologists). Furthermore, the parents of these children were significantly more likely themselves to have an emotional disorder.

Young people with mental health disorders (excepting children with an autism spectrum disorder) have also found to be more likely than other young people to smoke, drink and take drugs (Green et al., 2005).

Appendix E.

A 2004 Stocktake of the Child and Adolescent Mental Health Services' Workforce: A summary

The child and adolescent mental health workforce is significantly less than that required to meet *Blueprint* targets. Community clinical FTEs across 21 DHBs and contracted NGOs totalled 667 FTEs. This is compared with the 2004 population *Blueprint* resource guideline of 1163.37 FTEs.

Workforce vacancies in DHB in-patient and community settings were significant across all regions.

Workforce shortages in the NGO contracted services were significantly lower than in DHB CAMHS.

DHB psychiatrist FTEs were half that recommended in the World Health Organization guidelines (58.73 compared with 119.02 FTEs) (World Health Organization, 2003).

There were low numbers of Māori and Pacific workers in relation to the composition of the under 20 years population, particularly in the clinical workforce.

The DHB inpatient workforce totalled 124.7 actual FTEs with a further 27.4 FTEs reported vacant.

The DHB community child and adolescent mental health workforce totalled 614.04 actual FTEs (excluding 98.77 vacant positions). The three largest occupational groups were psychologists, social workers and mental health nurses.

Forty-three NGOs, from 66 NGOs surveyed (excluding kaupapa Māori services) reported a total of 301 actual FTEs with 18 FTEs that were vacant. The NGO workforce was largely comprised of mental health support workers, social workers and counsellors.

NGO kaupapa Māori services reported a total workforce of 37 FTEs which was mainly comprised of mental health support workers, counsellors and social workers.

A total of 64 Pacific staff were identified in the child and adolescent mental health workforce, across the range of services, the majority of which are working in the Northern region. This workforce is predominantly made up of mental health support workers, social workers, mental health nurses and cultural appointments.

The programmes coordinated by the Department of Child, Youth and Family reported a total of 34 actual FTEs with a further 12.1 FTEs that were reported vacant. The workforce was mainly comprised of mental health support workers, mental health nurses and social workers.

The total workforce equated to 1130 actual FTEs with a further 158 vacant FTEs.

Stocktake of Child and Adolescent Mental Health Services in New Zealand
(Ramage et al., 2005)

Appendix F.

Resources

The following resources are available on the Werry Centre website: www.werrycentre.org.nz :

- Strategic Framework for Child and Adolescent Mental Health Workforce Development Bibliography of Key Documents.
- Stocktake of Child and Adolescent Mental Health Services in New Zealand 2005: A Workforce Development Summary.
- New Zealand Population Projection Statistics 2006, 2011, 2016.
- Strategic Framework for Child and Adolescent Mental Health Workforce Development: Labour Literature Review.
- Practice Models of Workforce Development.
- The Nixon Model of Workforce Development.
- Child and Adolescent Mental Health Services: A Qualitative Study on Staff Retention.

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