Midland Regional Mental Health and Addiction Workforce Stocktake

FINAL: April 2019

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1. Executive Summary:

At the September 2018 combined Clinical Governance and Portfolio Managers Leadership Network, the Midland Regional Mental Health and Addiction (MRMH&A) team agreed to undertake a Workforce Stocktake across the region. The aim of the Stocktake was to highlight and share examples of good practice to identify and respond to Workforce issues in the Midland region.

A questionnaire was developed in consultation with relevant stakeholders. The intention was not to place the burden onto Service Providers. Clinical Governance and Portfolio Managers selected local respondents for their respective area. The Questionnaire was sent out via Survey Monkey for completion by 31 January 2019.

There were eight responses from the Midland DHBs. The following document provides a summary of the information received. Responses were received from Clinical Leads, Portfolio Managers and Human Resources.

Findings:

There were clearly some examples of good practice being undertaken across the region. Further follow-up will be conducted in some instances to further explore issues raised in some of the responses.

Recommendations:

Many of the recommendations from the Stocktake mirror those of the recent Single Session Family Consultation Workshops Evaluation, the Review in the Reduction of Section 29 project report and the He Ara Oranga report, not to mention a number of other projects. It is however worthwhile revisiting those here as a reminder of the direction of travel that we need to continue to work towards.

- Māori specific strategies for the recruitment and retention of Māori staff need to be determined locally in partnership with GMs Māori and more explicitly shared across the region.

- Opportunities for a greater level of collaboration between the Provider Arm and NGOs be actively sought and utilised. Representation on Recruitment Panels, shared Training Programmes and opportunities for cross-sector placements are ideal opportunities for such collaboration.

- Clinical Governance Leads and Portfolio Managers work to ensure that Supporting Parents Healthy Children implementation forms part of their local recruitment, retention and development strategies.

- DHB areas look into and share resources such as Trauma 101 course development, Intentional Peer Support, Youth oriented community education sessions and Suicide Identification and Prevention programmes. Where there is an identified need for provision across multiple DHB areas, MRMH&A will look into providing a Regional response.

MRMH&A wishes to thank everyone who took the time to reply to the Stocktake.

2. Findings:

There were clearly some examples of good practice being undertaken throughout the region. Further follow-up will be conducted in some instances to further explore issues raised in some of the responses.

It is hoped that DHB areas might share such initiatives across the region to improve workforce capability.

2.1: Examples of Good Practice:

It was positive to see one DHB area describing the "Supporting Parents Healthy Children (SPHC) Self-Assessment Tool-kit and Guidelines" as supportive to the Mental Health and Addiction workforce development. Whilst we know that other DHB areas are also working towards embedding SPHC, weaving this kaupapa through recruitment, retention and workforce development shows commendable joined-up activity.

Some other examples of good practice include "Trauma 101 course development, Intentional Peer Support and SORTED community education sessions for the wider youth sector". The MRMH&A Team will circulate briefings about some of these programmes in the near future.

It was also positive to note from Question 7 that most DHB areas open trainings to other DHB areas. However it appears that some NGOs may not have received invitations to training opportunities within their own DHB area as highlighted in Question 4. The recent Inquiry into Mental Health and Addiction clearly found that there is room to improve relationships between the Provider Arm and NGOs and shared access to training certainly provides an opportunity to support that.

2.2: Issues for Further Investigation:

Whilst it is positive that "Training Programmes, Culture development activities and Innovative recruitment / retention approaches" are in place in some DHB areas according to Question 2, further information will be sought in order to support the work across the region.

Question 3 identified that all DHB areas reported they had Māori specific strategies for the recruitment and retention of Māori staff. Whilst there are clearly some examples of good practice within the responses, there was a degree of ambiguity in some. Once again clarity on each area's work in this area shall be collated and shared.

There has been ongoing debate regarding developing KPIs for recruitment of Māori Staff within some DHB areas. Question 3 shows one of our DHBs advising us that they have a KPI of 11% in this area. We understand that other DHBs in the region are considering setting targets to improve the recruitment of Māori staff and information regarding the positive and negative factors of doing so can only inform the decision making process. There is also a wider conversation to be had concerning whether services are configured appropriately to accommodate the needs of Tangata Whenua and this issue needs to inform any conversation relating to Māori staffing levels.

It was positive to note from Question 4 that Suicide Prevention Training from Te Rau Matatini is being undertaken. There have been requests for information regarding Suicide Assessment and Prevention for those who have had training previously and this matter is being looked into.

HealthShare's Data and Information Team is currently working with MRMH&A, looking into the "Qlik-sense workforce development and forecasting tool" issue that was raised. Further exploration of exactly what is needed is being determined with the respondent.

The MRMH&A Team will certainly seek further information regarding the information provided by some respondents and findings will be described in a follow-up briefing.

3. Recommendations:

Many of the recommendations from the Stocktake mirror those of the recent Single Session Family Consultation Workshops Evaluation, the Review in the Reduction of Section 29 project report and the He Ara Oranga report, not to mention a number of other projects. It is however worthwhile revisiting those here as a reminder of the direction of travel that we need to continue to work towards.

- Māori specific strategies for the recruitment and retention of Māori staff need to be determined locally in partnership with GMs Māori and more explicitly shared across the region.

- Opportunities for a greater level of collaboration between the Provider Arm and NGOs be actively sought and utilised. Representation on Recruitment Panels, shared Training Programmes and opportunities for cross-sector placements are ideal opportunities for such collaboration.

- Clinical Governance Leads and Portfolio Managers work to ensure that Supporting Parents Healthy Children implementation forms part of their local recruitment, retention and development strategies.

- DHB areas look into and share resources such as Trauma 101 course development, Intentional Peer Support, Youth oriented community education sessions and Suicide Identification and Prevention programmes. Where there is an identified need for provision across multiple DHB areas, MRMH&A will look into providing a Regional response.

Appendix 1 Responses:

Q1. Which is your DHB area?

- Overall there were seven responses
- All Midland DHBs responded to the Questionnaire (The table below shows the responses by DHB area):

DHB Area	Responses
Bay of Plenty	01
Hauora Tairāwhiti	02
Lakes	03
Taranaki	01
Waikato	01
Midlands TOTAL	08

The following responses have been anonymised.

Q2. What strands of Mental Health and Addictions Workforce Development activity are underway within your DHB area?

- Staff surveys (3)
- Training programmes (6)
- Scholarships (1)
- Culture development activities (4)
- Innovative recruitment / retention approaches (1)
- Internship / Apprenticeships (1)
- Rolling recruitment campaign (1)
- Use of International Recruits contacts (1)
- No response (1)

Q3. Does your DHB have any Māori specific strategies (for the recruitment and retention of Māori staff)?

- Yes (1)
- We have ring-fenced positions for Māori new-grad Nurses (1)
- We employ Māori and local as a preference (1)
- Māori representations on all panels (1)
- Specific questions around the Treaty and its application (1)
- Underway (1)
- Yes - Kuwatawata, Mahi Atua (1)
- Monitoring of KPI – 11% of workforce target (1)
- Don't know / not that I am aware of (2)
- Currently working with [local Kaupapa organisation] to ensure MHAS has visibility in their Te Tomokanga Māori Gateway Programme for rangatahi. This is a long term commitment to develop a Māori focused recruitment pipeline (1)

Q4. What strands of wider DHB activities that support Mental Health and Addictions Workforce Development are underway within your DHB area?

- As above (1)
- Annual planning for 2019/20 require all of the DHB and key providers to outline how they will contribute to the implementation of our new Model of Care for Mental Health
- Family Violence Training (1)

- Closer engagement with nursing schools to promote MH&AS (1)
- Promotion of existing health pathways / programmes / scholarships (1)
- Not sure with the Provider Arms to what courses staff have access to (1)
- Suicide Prevention Training from Te Rau Matatini (1)
- Rolling out Supporting Parents Healthy Children Self-Assessment Tool-kit and Guidelines (1)
- Equally Well Self-Assessment Tool (1)

Q5. Does your DHB area have any relevant Mental Health and Addictions specific Workforce Campaigns currently/recently underway?

- Short-listing weighting reflects Maori recruitment (1)
- Development of Mataora roles (1)
- Ongoing rolling CMH recruitment… is starting to pay off… need to be actively changing our advertisement so it has a fresh look and feel and still attracts interest (1)
- No / Not that I am aware of / Nil (6)

Q6. Are there any Mental Health and Addictions Workforce Development activity that your DHB area have undertaken in the past that you feel have been successful?

- Mental Health Credentialing for Primary Care Nurses
- Trauma 101 course development / Intentional Peer Support / SORTED community education sessions for the wider youth sector (e.g. school guidance counsellors, Oranga Tamariki etc.)
- Restructuring of vacant Community Nurse positions to accommodate 2nd year entry to Specialist Nurses
- No / Not that I am aware of / no comment (4)
- No response (1)

Q7. Are there opportunities for Mental Health and Addictions Staff from other DHB areas to attend trainings within your DHB area?

- Question 2 we are doing points 1, 3, 5 and 7
- Yes / when there are spaces / Often involves an international type speaker, where the seminar / training is opened to others / possibilities are there (4)
- Not often, as we are very regional. We tend to be invited to other areas for training opportunities (1)
- Don't know (1)

Q8. Any further comments?

- Workforce Development is hampered by the lack of a specific budget in [respondent's] Mental Health & Addiction portfolio
- We need the Qlik-sense workforce development and forecasting tool, developed by [Name i] and [Name ii] to be fully populated to present a regional picture of all health professional groups, then the ability to extract that at a local level.
- Working with HWINZ [to] understand what the volumes and pathways for Psychiatric training so we can generate better scholarships (bonding) for these trainees into our vacant positions
- Most of the training needs are identified within each of the contract holders rather than at the Portfolio Manager's level
- N/A (3)