Addiction Workforce Development in New Zealand

Raine Berry
Cutting Edge 2011
Addiction Workforce Development in New Zealand

- Current workforce development activity
- Findings from 2011 addiction workforce snapshot survey
- Predictions for the future of addiction workforce development activity
What is Addiction Workforce Development

- “a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather that just addressing education and training of individual mainstream workers” (NCETA 2002)
Addiction Workforce Development Components

- Legislation, policy, resources
- Organisational structure, systems and culture
- Recruitment and retention
- Knowledge, skills and attitudes
- Training and education
Why is addiction workforce development needed?

- Increasing demand for treatment
- Influx of referrals from Corrections and Justice
- Increasing complexity of addiction-related issues
- More focussed approach on evidence-based practice
- Ageing population and workforce
Matua Raki

Task:
To develop the capacity and capability of the addiction workforce

Guiding Principle:
Workforce development must support tangata whaiora/client centred service delivery

Vision:
A highly skilled, confident and competent workforce which, supported by a sound infrastructure, will provide accessible and effective service to minimise addiction-related harm
Current Addiction Workforce Development Activities

- Focus on initiatives that both support the **systems** that sustain the addiction workforce and that ensure relevant workforces have the complexity **capability** to deliver effective interventions to people experiencing addiction-related problems.
- **Supporting Leadership**
  - Leadership Days
  - Regional Leadership Seminars with NCAT

- **Developing the Consumer and Peer Workforce**
  - Regional consumer forums
  - Consumer Leadership group
  - Framework for consumer participation in addiction education
  - Education opportunities for people in peer roles

- **Addiction Nursing Workforce**
  - Addiction speciality nursing knowledge and skills competency framework
  - Supporting Nurse Practitioner pathway
  - Seminars with DANA

- **Takarangi Competency Framework**
  - Training and resources
● **Training Providers**
  - Network meetings
  - Involvement with a range of tertiary providers

● **Guidelines and Resources**
  - Screening, Assessment and Evaluation
  - Interventions and Treatment for Problematic Use of Methamphetamine and other ATS
  - P’d Off
  - Making Visible
  - Think Parent Think Family
  - Consumer and Peer Roles in the Addiction Sector
  - Working with people in the Criminal Justice Sector Reflective Workbook
  - Substance Withdrawal Management Guidelines for Medical and Nursing Practitioners
  - Substance Withdrawal Guidelines for Addiction and Allied Practitioners
- Recruitment and Retention Strategies
  - Mana Arahi
  - Orientation Framework
- Working with Young People
  - Tools and Resources kit
  - Mentoring framework
  - Smashed and Stoned
- Pacific Addiction Workforce Strategy
  - Implementation with Le Va
- Research
  - Snapshots, surveys, evaluation
  - Workforce Forecasting Tool
- Coexisting Problems (CEP)
  - Managers, Funders and Planners – Organisational Change workshops
  - CEP Formulation workshops
  - CEP Skill Set
  - Enhanced practitioners group
- **Compulsory Treatment Orders**
  - Scoping resources for new roles
  - Maori focussed responses to changes in the ADA Act

- **Primary and Allied Workforce Initiatives**
  - Addiction web based decision support tool for GP’s with Best Practice
  - Development of training resource on decision support tool
  - BI training – PC, Corrections Police, Youth Workers

- **Smoking Cessation Workforce**
  - Training on working with pregnant smokers

- **Short Courses**
Matua Raki courses

- CEP Formulation: 27
- Brief Cognitive Intervention: 18
- Contingency Management: 7
- Smoking Cessation: 4
- Workshops/Seminars: 8
- Smashed and Stoned: 5
- Leadership Seminars: 6
- Takarangi Competency Framework: 4
- Screening and Brief Intervention: 8
- Workshops/Seminars: 5
- CEP Managers, Funders and Planners: 14
Course Participants (N = 2132)
<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td><strong>Service Type</strong></td>
<td></td>
</tr>
<tr>
<td>DHB</td>
<td>56</td>
</tr>
<tr>
<td>NGO</td>
<td>44</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>29</td>
</tr>
<tr>
<td>Female</td>
<td>71</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>06</td>
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<tr>
<td>30-39</td>
<td>17</td>
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<td>40-49</td>
<td>32</td>
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<td>&gt;50</td>
<td>45</td>
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<tr>
<td><strong>Ethnicity</strong></td>
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<tr>
<td>NZ Euro</td>
<td>63</td>
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<tr>
<td>Maori</td>
<td>23</td>
</tr>
<tr>
<td>Pacific</td>
<td>3.5</td>
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<tr>
<td>Other</td>
<td>10.5</td>
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<tr>
<td><strong>Professional Body Members</strong></td>
<td></td>
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<tr>
<td></td>
<td>83</td>
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Workshop Participants Job Roles (n=945)
CEP follow up survey

- **Methodology:**
  - Online survey sent to registered participants
  - Likert scales re workshop satisfaction, perceived attitudinal and knowledge changes
  - Qualitative responses re barriers, relationships, specific things learnt etc
  - Approx 3 months post workshop

- **Sample:**
  - All registered participants with correct email addresses
  - 14/27 workshops surveyed to date

- **Response rate:**
  - 37% response rate to date
Practice Changes

- Better and increased use of formulation in case presentations and at initial assessment
- Using to guide interventions with more complex clients, rather than more vague notions of what might help
- Working differently as acknowledging and including the effects coexisting problems have on clients
- Now identify strengths rather than exacerbating the problems
- More effective when summarising clinical findings to clients and families
- Not really changed, but my attitude towards working with people with CEP has changed
Service changes

- We are now working on CEP in a wider team so that all can work in the same way

- Networking, developing in house resources and critical thinking from the CEP view to engage all people who wish to use our services

- There are still blocks within our service that need working through but we do have some plans in place

- Now looking at our services and relationships from a CEP view rather than "just" mental health
Increased Confidence or Awareness

- More knowledge and confidence working with CEP clients
- Seem to have more clients with CEP these days (maybe just more aware when assessing?)
- More confident discussing CEP with CMH staff and advocating strongly for predominantly AoD clients with CEP
- Become more CEP focused, supported confidence to develop two new groups (community and ward based), and liaise with peer support groups
- Working in close proximity with experienced practitioners has assisted me in advancing my practice
Relationship Changes

- As CEP is more in the 'spot light' there is increased awareness that something needs to happen across/between services
- Now sharing the knowledge with other services, and have built good relationships with other services
- Attending training with members of the MH team has increased the depth of relationships with that team
- I am more aware of the other services that are available to help our clients with co existing problems
- Implemented regular in-services with other services
- Awareness of how to contact relevant clinicians when requiring further clinical input
- have more knowledge of the CADs services owing to talking with some of the staff that work there on the course. This has allowed me to more appropriately refer to that service
No change but…

- I find with a lot of workshops that the enthusiasm is there, and then it goes as we get back into the swing of work and those pressures, and are unlikely to try.
- Intended to review all my clients using this framework but sadly have been too busy but will get onto it.
- Workshops not extending enough for advanced clinicians.
- I would like more training focused on marae based ideas.
- It has not changed overall. I have been doing all of this for years and am adept at accessing and communicating with services/clients/professionals at all levels.
- Lack of time, increased workloads including documentation compliance/review projects overload due to health service changes, management of A&D services more and more assimilated into the Mental Health service that the A&D focus and specialist work has been is being eroded away ………...
Other insights

- This whole issue needs to be better promoted, working group established, and some momentum in place to debate and train people from DHB and NGO land
- Can someone do CEP supervision online?
- It is the culture that has to change. Some times it feels like one step forward three steps backwards
- Don’t underestimate the networking aspect of the workshops you do – culture change often has roots in listening to what others are doing
Identified supports and barriers to implementing relationships and CEP capability

Barriers
- Lack of Resources
- Time constraints
- Poor relationships with management
- Bullying
- High workloads
- Different understandings of key concepts
- Having to negotiate across services for referrals, time, staff etc.

Supports
- Increased knowledge
- Relationships with other services
- Management support
- Supervision including peer
- Access to Te Ariari
- Training
- Support from the Ministry to get DHB's to build CEP into the district plan
- MDT supportive of comprehensive assessment and treatment planning
Which of the following factors have facilitated your ability to implement strategies or initiatives in becoming more CEP capable?

- Having upper management/planning/funding support
- Having planners, funders, upper management...
- Having local context discussions about what...
- Having CEP capable clinicians
- Having manageable workloads
- Having proximity to other service
- Having existing relationships with other agencies
- Having access to additional training
- Having clear deadlines
- Having guidance/coaching around implementation
- All Other Responses
Findings from 2011 Addiction Workforce Snapshot
Who are our workforce?

<table>
<thead>
<tr>
<th></th>
<th>NGO</th>
<th>DHB</th>
<th>NGO and DHB June 2011</th>
<th>2008 Phone Survey</th>
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<tbody>
<tr>
<td>No of Responding Services</td>
<td>31</td>
<td>17</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>FTE's</td>
<td>301</td>
<td>480</td>
<td>781</td>
<td></td>
</tr>
<tr>
<td>Addiction Practitioner/ Counsellor</td>
<td>175 (58%)</td>
<td>184 (38%)</td>
<td>359 (46%)</td>
<td>58%</td>
</tr>
<tr>
<td>Others e.g. consumer &amp; peer support, OTs, cultural advisors, youth workers</td>
<td>73 (24%)</td>
<td>33 (7%)</td>
<td>106 (14%)</td>
<td></td>
</tr>
<tr>
<td>Medical Officers</td>
<td>1 (.03%)</td>
<td>38 (8%)</td>
<td>39 (5%)</td>
<td>2%</td>
</tr>
<tr>
<td>Nurses</td>
<td>11 (4%)</td>
<td>156 (32.5%)</td>
<td>167 (21%)</td>
<td>15%</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1 (.03%)</td>
<td>8.5 (1.8%)</td>
<td>9.5 (1.2%)</td>
<td>5%</td>
</tr>
<tr>
<td>Social Workers</td>
<td>22 (7%)</td>
<td>16 (3%)</td>
<td>38 (5%)</td>
<td>16%</td>
</tr>
<tr>
<td>Admin</td>
<td>18 (6%)</td>
<td>45 (9%)</td>
<td>63 (8%)</td>
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</table>
## Who are the Workforce?

<table>
<thead>
<tr>
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<th>NGO</th>
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<tr>
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<tr>
<td><strong>FTE’s</strong></td>
<td>301</td>
<td>480</td>
<td>781</td>
</tr>
<tr>
<td><strong>Vacant Positions</strong></td>
<td>13 (4%)</td>
<td>20 (4%)</td>
<td>33 (4%)</td>
</tr>
<tr>
<td><strong>HPCA</strong></td>
<td>26 (09%)</td>
<td>227 (47%)</td>
<td>253 (32%)</td>
</tr>
<tr>
<td><strong>DAPAANZ Registered Practitioners</strong></td>
<td>125 (42%)</td>
<td>189 (39%)</td>
<td>314 (40%)</td>
</tr>
<tr>
<td><strong>Another Reg Body</strong></td>
<td>26 (09%)</td>
<td>61 (13%)</td>
<td>87 (11%)</td>
</tr>
<tr>
<td><strong>No Reg Body</strong></td>
<td>72 (24%)</td>
<td>58 (13%)</td>
<td>130 (17%)</td>
</tr>
</tbody>
</table>
Hard to fill positions

- NGO & DHB
  - CEP Positions
  - Addiction Qualified

- DHB
  - OST
  - Medical Officers

- NGO
  - Youth Roles
  - Full dapaanz registered practitioners
  - Nurses
## Service Demand – Last 12 months

<table>
<thead>
<tr>
<th>Category</th>
<th>% More</th>
<th>% Same</th>
<th>% Less</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NGO</td>
<td>DHB</td>
<td>NGO</td>
</tr>
<tr>
<td>Overall</td>
<td>62</td>
<td>47</td>
<td>31</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>30</td>
<td>34</td>
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<tr>
<td>CEP</td>
<td>44</td>
<td>60</td>
<td>52</td>
</tr>
<tr>
<td>Justice, Courts, Corrections</td>
<td>66</td>
<td>71</td>
<td>31</td>
</tr>
<tr>
<td>Family/whanau involvement</td>
<td>30</td>
<td>40</td>
<td>67</td>
</tr>
</tbody>
</table>
Percentage of staff attending Matua Raki training in last 12 months

- DHB  60%
- NGO  58%
Rating of Matua Raki Events

![Graph showing ratings of Matua Raki events]

- **% Very Good**: 50
- **% Good**: 30
- **% Neutral**: 20
- **% Poor**: 10
- **% Very Poor**: 0

**Categories**:
- Increasing Knowledge
- Networking Opportunities
- Impact on Clinical Practice
- Improving Client Outcomes
# Matua Raki Resource Uptake

<table>
<thead>
<tr>
<th>Resource</th>
<th>% of services with a copy</th>
<th>% rating useful – very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer and Peer Roles</td>
<td>53</td>
<td>44</td>
</tr>
<tr>
<td>FIP Supervisors Guide</td>
<td>43</td>
<td>93</td>
</tr>
<tr>
<td>He Tete Kura</td>
<td>47</td>
<td>83</td>
</tr>
<tr>
<td>Making Visible</td>
<td>55</td>
<td>86</td>
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<tr>
<td>MR Newsletters</td>
<td>93</td>
<td>81</td>
</tr>
<tr>
<td>ATS Guidelines</td>
<td>80</td>
<td>84</td>
</tr>
<tr>
<td>Screening and Assessment Guidelines</td>
<td>77</td>
<td>100</td>
</tr>
<tr>
<td>Takarangi Competency Framework</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>Talking Therapies</td>
<td>53</td>
<td>90</td>
</tr>
<tr>
<td>Nursing Knowledge and Skills Framework</td>
<td>46</td>
<td>88</td>
</tr>
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</table>
Predictions for the future of addiction workforce activity
Key Influences

By mid 2020s NZ population estimates are:

- Over 5 million in total
- One in five will be over 65 yrs (compared with one on 8 now)
- Working age population will be 58% (67% now) & will be older (average age 42yrs in 2011)
- NZ Maori, Asian and Pacific populations will continue to grow

www.stats.govt.nz
3 key documents

- **HWNZ - Service MHA Workforce Review**
  - Strengthening the primary care workforce, earlier interventions
  - Continuing to support addiction specialist workforce
  - Integration of addiction and mental health?

- **MoH - National MHA Service Development Plan**
  - Increased primary and community care
  - Addiction expertise used strategically

- **MHC – Mental Health and Addiction Blueprint**
  - Driving sector improvements
  - Support addiction workforce at all levels,
Other key influences

- Review of the A&D Act
- Drivers of crime
- HPCA Act
Workforce responses

- Long term planning
- National approach with regional responses
- Widening the scope of addiction workforce development
- Focus on primary/community care workforce development
- Early intervention
- Relooking at treatment provided to people with moderate to severe addiction
Workforce responses

● Lead the way re further integration with mental health

● Training and Education
  – Multidisciplinary and multi-service training
  – Support a culture of learning and development
  – Less investment in training
  – more investment at service level to ensuring practice standards are met

● Continued funding of addiction workforce development
Summary

- Maintenance of a sustainable, responsive and effective addiction workforce requires a multi-faceted approach focusing on:
  - influencing high-level systems that shape the workforce
  - addressing systems and structures that affect performance and outcomes
  - strategies and supports to improve individual performance
  - Recruitment and retention
  - Influencing organisational culture
  - Research and evaluation