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Te Ao Māramatanga
New Zealand College of Mental Health Nurses Inc.
Partnership, Voice, Excellence in Mental Health Nursing

PO Box 77-080, Mt Albert, Auckland, 1350, New Zealand

7 April 2021

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Principal Policy Analyst l Strategy & Policy l Mental Health and Addiction- Ministry of Health
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Re: Submission on Mental Health and Wellbeing Long-Term Pathway - New Zealand Ministry of Health

Tēnā Koe Emma

Please find a brief outline about Te Ao Māramatanga - New Zealand College of Mental Health Nurses followed by our submission on Mental Health and Wellbeing Long-Term Pathway - New Zealand Ministry of Health.

About Us

Te Ao Māramatanga is the professional body and voice for Registered Nurses with specialist mental health knowledge and skills in New Zealand. Our growing membership includes a number of nurses who have been awarded Fellowship or Whetū Kanapa status in recognition of their contribution to mental health nursing. Members include nurse practitioners, registered nurses, enrolled nurses, nurses who hold a mental health and addiction credential, retired nurses and student nurses. We have nurses with expertise in a range of settings-clinical practice, education, research, workforce development, policy, primary health services, secondary services, district health boards, non-government organisations and specialty areas including disability and addiction. Our members are spread in both urban and rural areas nationwide and link into local College branches. Te Ao Māramatanga now includes national branches for addiction nurses and disability nurses.

The College board brings a wealth of knowledge which we draw from to advance the care of people with mental health problems through the expertise and the professionalism of mental health nursing in New Zealand. Our governance structure is internationally recognised for its bi-cultural constitution and ways of working which includes a president and kaiwhakahaere and a Māori caucus that supports our board. We are very privilaged to have Dame Margaret Bazley as our patron for a number of years.

As an organisation we have set, promoted, and maintained the standards for the practice of mental health nursing in Aotearoa New Zealand - Standards of Practice for Mental Health Nurses (2012). These standards are used widely to inform nurses, employers and organisations concerned with the development and expectations of the mental health nursing workforce.

Te Ao Māramatanga strives to work in partnership; will be the voice of mental health nursing in Aotearoa and will always promote excellence in mental health, addiction, and disability nursing. We have the passion, committment and expertise to do so. Providing nursing professional leadership on workforce matters is vital at this point and time to continue to develop and expand supportive services for people with disabilities, people with mental health needs and people with addiction needs. Moreover, nurses play a role in supporting whānau and communities with their health and wellbeing.

SUBMISSION

Our submission on Mental Health and Wellbeing Long-Term Pathway - New Zealand Ministry of Health

What is your name?

Te Ao Māramatanga- New Zealand College of MH Nurses
Suzette Poole- President and Chrissy Kake- Kaiwhakahaere

What is your email address?

President@nzcmhn.org.nz

What is your organisation?

Te Ao Māramatanga- New Zealand College of Mental Health Nurses

What is your ethnicity?

N/A

If you selected Māori, please feel free to share Iwi.

N/A

What is your age?

N/A

Is there a community or sector area you relate to, or are representing with your submission?

Mental Health, Addiction and Disability Nursing

Do you work for a mental health and/or addiction provider?

No

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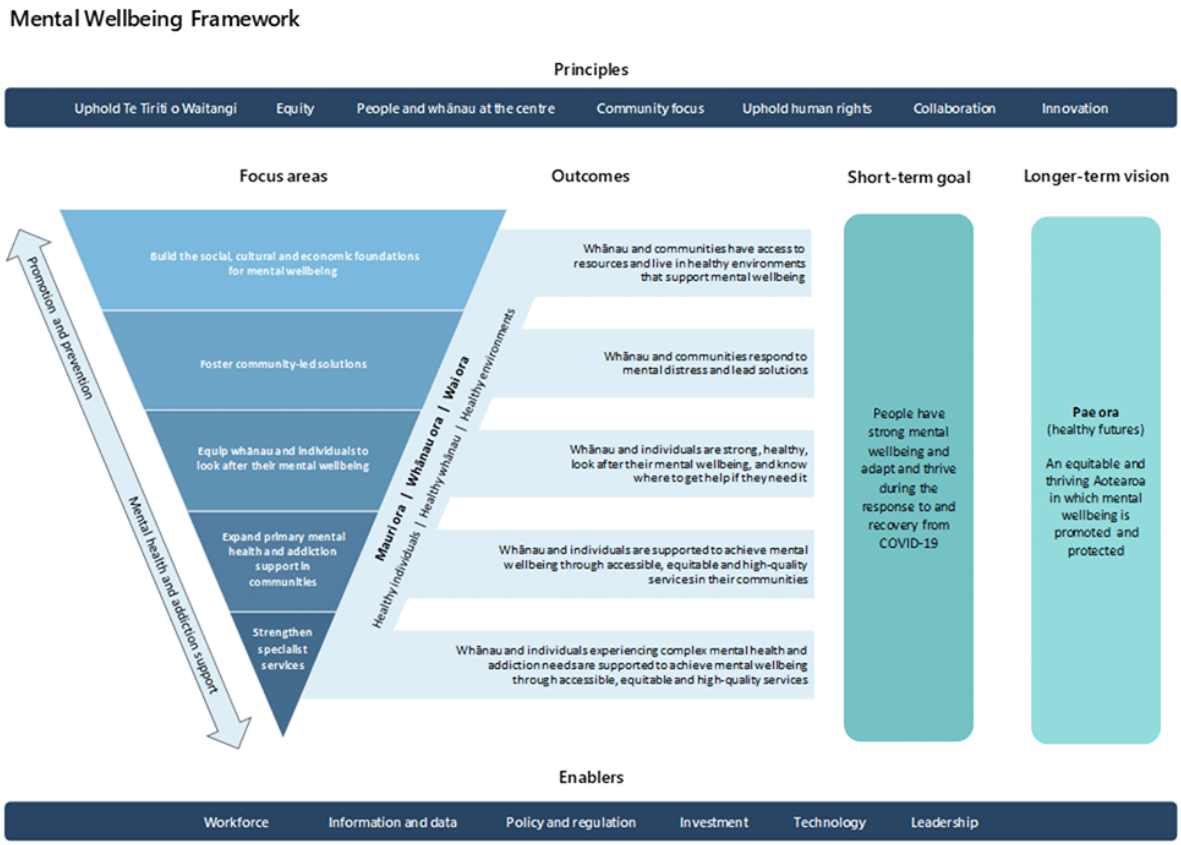

When Kia Kaha was developed, it was clear we needed common values to achieve collaborative success. These are articulated in the mental wellbeing framework included in Kia Kaha (above) through seven guiding principles, which will set out how we will work. These principles should be embedded across everything we do.

In relation to each of these principles, what specific actions would you like to emphasise that would ensure they are upheld within future work to support mental wellbeing? You are welcome to comment on all principles or can focus on those most relevant to you.

Uphold Te Tiriti o Waitangi – the principles of Te Tiriti underpin all actions in Kia Kaha.
The long- term plan must be firmly founded on Te Tiriti o Waitangi and a process in place to ensure that the principles are embedded in aspects of a new plan and accountability measures are in place to ensure that the principles are upheld. Consideration of HAUORA Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry Wai 2575 is needed in the design of a long- term plan.

The Standards of Practice for Mental Health Nursing in New Zealand developed by our College states in Standard One:

> *The Mental Health Nurse acknowledges Māori as tangata whenua of Aotearoa New Zealand. The Mental Health Nurse is knowledgeable of the place of Te Tiriti o Waitangi in nursing care and acknowledges the diversity of values, belief systems and practices of people and cultural groups within New Zealand society. (P, 6)*

These standards will be refreshed this year and will include tools to help nurses, educators, and leaders/managers of nurses to utilise to support the preparation and recruitment and retention of nurses. This project will include a focus on this standard.

The College gave significant feedback about cultural competency as well as mental health, addiction, and disability content in the NZ Nursing Councils' *Review of the Nursing education standards for programmes leading to registration as a registered nurse* and are awaiting the outcome as we firmly believe more is needed to improve the training of RNs across both the primary and secondary sectors to work effectively with this population group.

Equity – people have different levels of advantage and experience and require different approaches and resources to get equitable outcomes.

The College absolutely agrees that we must address inequity and design services to ensure equitable outcomes that are determined in consultation with the person and their family. A purposeful approach must be taken to ensure all staff working in MH&A services are equipped with the required knowledge and skills that result in behaviour changes that address institutional racism and unconscious bias.

Measures to monitor how the equity gaps are being closed should include quantitative and qualitative approaches.

Our collaborative publication on the future of Mental Health, Addiction and Disability nursing due to be published later this year will discuss Equity.

Our College is developing a series of webinars and at least one topic will be Equity.

Our Credentialing programme content is being reviewed this year and content to support equity in practice prioritised.

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People and whānau at the centre – whānau are a crucial part of the support network for individuals experiencing challenges. This principle seeks to strengthen the capacity of people and whānau to lead their own pathways to wellbeing.

The College absolutely agrees that we must have the person and whānau at the centre of care. We also acknowledge that the person may be supported by a group of people that they determine are important to them. We are aware that some people for a variety of reasons are not connected to their families and sometimes this is not their choice. The refresh of our College Mental Health Nursing Standards of Practice this year will further emphasize this principle again.

Focusing on a strengths-based approach will be needed. Services offered will need to include a workforce that understand what trauma informed care and specialist workers to support the person and their family with their recovery from traumatic past and ongoing experiences.

Community focus – strong communities provide a foundation of support and connection which is vital for mental wellbeing.

The College absolutely agrees that we must have a community focus and continue to support people to feel connected to their communities, and a closer connection of the secondary MH&A services to the communities in which people live, including stronger links with primary care providers. Reducing stigma and discrimination both within MH&A services staff and in our communities will be key.

We would comment that it may be relevant to include Community as a key enabler in the diagram. In our experience, particularly in relation to the Primary care Credentialing Programme, a key support for people and whānau is often a wide variety of community-based initiatives that range from a wellbeing focus through to crisis and services to assist people in distress. There are large numbers of services, not necessarily connected with recognised health services, that provide both formal and informal support and assistance, within communities.

Uphold human rights – human rights are central to implementing an effective, equitable and balanced future mental health and addiction system.
The College absolutely agrees that human rights are central to implementing an effective, equitable and balanced future mental health and addiction system.

Continuing to design and deliver services that use the least restrictive approach and reducing the use of restraint and seclusion should remain a key part of the plan. This will require purpose-built facilities that are staffed with people with a skill mix that that matches the needs of the population. As well as protecting rights, it is also important that users of services are provided with greater access, choices, and resources to 'live' their rights as part of their recovery journeys.

Collaboration – working together is vital to create stability, efficiency, and enhanced support for New Zealanders.
The College absolutely agrees that collaboration on many levels will be vital. Power balancing will need to address the risk of dominant organisations, work forces, groups and contractual agreements for service delivery which take power at the expense of others. Respected and skilled facilitators alongside agreed principles of working collaboratively will be needed and essential that we draw on the current and increasing peer leadership workforce into the future service delivery approaches and models.

Our Credentialing programme is a good example of collaboration influencing workplace culture change and encouraging collaborative relationships between secondary and primary services. By working together to deliver local credential programmes, different services develop an appreciation of the "others" working lives and this helps break down barriers, assumptions, and siloed thinking both in individual staff members and professions. We have noticed this in our own membership with Mental Health and Addiction Nurses, providing the assessment of Primary Healthcare Nurses reflective writing about their roles and workplace scenario's. Our members have commented on the assumptions made before reading about the diverse and complex work of these nurses and their newfound respect for the wide range of prevention, early intervention and at times crisis work they are engaged in.

Innovation – innovative and original approaches to mental and social wellbeing support will facilitate transformation of the mental health and addiction system.
The College absolutely agrees innovation is needed and acknowledges that some parts of the system may be working well and provide ideal places to build from as transformation takes a stronger hold.

Innovation can come from engaging users of services and promoting the consumer-clinician alliance to partner in service delivery. Valuing MH&A staff who wish to work differently will

be crucial to innovative change. In the past, innovation to implement in the care and recovery of people with psychosis, such as Soteria house, has stalled however this approach remains an evidence-based approach overseas.

Ministry support to help services design and deliver new approaches will be needed,
A research and evaluation – strategy to grow the evidence of new service models is needed. Evidenced based practice is needed but also practice based evidence. Services will need support to develop measures/outcomes that show a persons' wellbeing has improved as assessed by them and their whānau for example.

Investment in approaches that may not have traditionally been viewed as related to health, but which support wellbeing in communities, can support prevention and early intervention efforts by health practitioners in their local communities.

What support is most needed to build the ability of communities to initiate and lead mental wellbeing initiatives?
Firstly, acknowledgment of existing community-based services that already provide a range of wellbeing initiatives and who would benefit from further investment.

Support and expertise to help community services shape up ideas and take the lead to develop services from a community perspective, that support access and choice goals and promote prevention and early intervention from a wellbeing perspective. Start-up type funding. Building stronger and enduring partnerships across the MH&A and social sector agencies is essential to support the psychosocial factors that can easily be pathologized as psychiatric disorders when working in a closed system of care.

What examples of mental health and addiction services are working well, and what makes these successful?
The examples in the Initial Mental Health and Wellbeing Commission's (Initial Commission)- *Mā Te Rongo Ake* highlight innovative examples of teams working together.

During the Covid- 19 pandemic and since then the College has noted that barriers to community approaches were broken down and enabled services to be quickly mobilised. Nurses have been involved and contributed to making the breakthroughs needed. An example of this was in Kirikiriroa Addiction services where cross sector barriers were

removed to enable DHB staff to work in NGOs where NGO staffing became a critical issue, and the NGO service was at risk of not being able to deliver their service.

During the first Covid lock down, Waitemata DHB, specialist staff, their in-house peer services and partner NGO's set up the 'one stop shop' – walk in for people requiring assistance at the 'front door' of the community teams. For the first time all key players were on the same page as the person and their whānau. This also had an impact on how MH&A staff were able to increase their knowledge and experience the valued contribution of NGO and peers as part of specialist care planning.

Our college primary mental health and addiction credentialling programme received additional funding from the 2019 Wellbeing Budget and is contributing to the development and support of Access and Choice initiatives. Interest in this programme continues to grow, with enrolments for 2021 increased and new programmes pending. Stories from nurses are included in our quarterly reports to Te Pou and some will be published soon. A formal evaluation programme is in place to report on the impact and outcomes.

What are the key medium-term shifts (i.e., in the next 3-5 years) you think are needed to transform mental wellbeing supports?

Key medium-term shifts (i.e., in the next 3-5 years) needed to transform mental wellbeing supports in the view of the College in brief are:

- Ensuring the transformation is shaped and founded on partnership with Māori and authentically honours and respects the Treaty of Waitangi in word and in visible actions amongst the leaders charged with transformation inclusive of mental health, addiction, and disability nurse leaders.
- Ensuring the transformation is shaped and founded on partnership with people with lived experience in an authentic way that truly honours and respects their expertise and is evident in the visible actions of other leaders also charged with transformation.
- Ensuring the transformation is shaped and founded on partnership with whānau and families of people with lived experience in an authentic way that truly honours and respects their expertise and is evident in the visible actions of other leaders also charged with transformation.
- Increasing the input of the family advisor roles across the sector to inform future care delivery. For example, Waitemata DHB has further bolstered the family advisor role through development of an MOU to work with family members – namely a Family Advisory Council, which partners with consumer representatives in the DHB to advise broadly on changes to service delivery.
- Strong shared leadership, collaborative approach with focus on upskilling leaders in the transformational leadership style and appreciative inquiry approach that reduces barriers to working across organisations, professions, and communities.

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- Transformational change to fully enable access and choice at a local level and from a wellbeing/prevention and early intervention perspective requires sustained and collaborative effort to meet demand and reduce the need for secondary services. From our perspective, there are pockets of this change making a big difference in some communities but there are still significant barriers to making this happen in others.
- Ensuring that every nurse can recognise if a person:
    - has a mental health need, can provide an initial response and if needed can refer on and provide a soft handover to ensure person connects with another service.
    - has an addiction need, can provide an initial response and if needed can refer on and provide a soft handover to ensure person connects with another service ,
    - has a disability, can adapt their care to ensure the person can effectively receive the service they need, can provide an initial response.

- Further work is needed to understand the responsibility of regulated health professional workforce in terms of accountability of care when working in a range of settings with a range of health team members. Te Pou has resources on the regulated and non-regulated workforce and top of scope direction for service development.
- All staff in specialist services are required to have the skill set of consult liaison to work more effectively with the primary care and social sector to support the range of needs on service users.

Workforce – growing and supporting a sustainable, diverse, competent, and confident mental health and addiction workforce.

The College urges rapid action be taken on growing and supporting a sustainable, diverse, competent, and confident mental health and addiction workforce. A workforce plan is long overdue.

The skill mix must match the needs of the population.

There is a serious shortage of mental health, addiction, and disability nurses. Demand is high and experienced nurses are sought after in primary care and by the Department of Corrections. Their knowledge and experience also mean that this skilled workforce move in careers managing and leading services and into Ministry positions. Their breadth of knowledge and skills will continue to inform future services. Many of these leaders are College members.

Whilst investment in growing the Nurse Practitioner and Enrolled Nursing workforce groups has occurred it is now time to invest in growing the registered nurse workforce. The College advocates for scholarship funding for student nurses to complete a pathway into mental health, addiction, or disability. RN training programmes fees sit at around 8 k per year and many students work. Freeing students up to focus on their study by way of supporting their living costs could help attract students. Providing scholarships for student nurses in their second and or third year of RN training who indicate an interest in mental health, addiction or disability nursing would be one solution. Dedicated funding for 200 student nurses annually could result in an uplift within the next 2 years to help solve the RN shortage. Initiatives to attract Māori people into the mental health, addiction or disability sectors need urgent and significant upscaling. Fully funded scholarships with a funded supported network system would help reduce attrition rates of Māori nursing students.

The College supports the Auckland University with the NP- TP, NP and EN supported practice initiatives in primary care which focus on mental health and addiction as well as growing Māori NPs. Further work is needed to ensure the Enrolled Nursing workforce is well supported in primary care settings and the College will continue to have high input.

A framework and investment in coaching, mentoring, supervision, professional and clinical supervision, cultural supervision, and Kaupapa Māori supervision is needed to support all the workforce groups. Investment in training people to provide these types of structured support is needed. Workloads for all staff must allow for time to receive these types of supports- reflection in practice and on practice is needed. Creating learning cultures will help turn the tide on risk adverse type cultures that may prevail and often permeate services following serious incidents.

Investment in a range of non- pharmacological approaches is needed. Whilst the College continues to advocate for nurses to be trained on brief interventions and talking therapies, we also need to consider how nurses who are skilled in these approaches are valued for their skills and recognised as making a significant contribution by delivering these interventions. Designing services to enable nurses to fully utilise their skills in brief interventions and talking therapies is needed and will be addressed in the College's Future of Mental health, addiction, and disability nursing document. This collaborative publication

is due to be published later this year will discuss broader workforce – education and training.

A suite of funded education, training and professional development options should be available to nurses once they qualify. Investment in developing skills and knowledge to support the health and wellbeing of people is needed and this could be achieved by a scholarship approach. The College are available to support such an approach.

The workforce now and in the future must know how to weave clinical and cultural practice together and understand how Rongoa healing practices and other interventions can work together to best support the person on care and their whānau.

The practice settings must fully enable Māori nurses and other nurses trained in Te Ao Māori and Māori health models and approaches to practice and care for people coming into wellbeing services, mental health, addiction, or disability services. Barriers must be identified and removed.

Our collaborative publication on the future of Mental Health, Addiction and Disability nursing due to be published later this year will discuss workforce – education and training.

Information and data – timely, accurate and comprehensive information and data will be crucial for longer-term success.

The long- term plan must result in services that lead to tangible changes as experienced by the person and their whānau- data must be collected about how receiving a service has helped them achieve their wellbeing goals. High input from people with lived experience into the design of data collection, analysis and utilisation is needed.

Further exploration of use of the Hua Oranga, an Indigenous mental health outcome measurement tool for use with Māori is needed as the use of this tool was expected to improve the care and treatment of tangata whaiora (consumers) in partnership with whānau (family) and clinicians.

A system must be designed where the person tells their story once and this unfolds overtime. Electronic clinical systems need to be contemporary, nimble and connect more efficiently with a primary care partner, and adherence to all informed consent requirements

removes barriers to current concerns about sharing information outside of the DHB system, thus reducing integrated care ability. Users of services have also wished for some time now to have a collaborative note writing approach within clinical services. A review of the large number of required reporting to the MOH on service delivery activity is exceptionally large and takes valuable clinical time to complete at the expense of face-to-face care.

The Feedback Informed Treatment model could be considered and or inform the development of similar tool unique to New Zealand.

Policy and regulation – policy decisions and legislative changes set the framework within which on-the-ground services operate.
A review of Policy, regulation and legislation that are barriers to change is needed to enable the sector fully to understand what needs to change. This should include legislation and regulations related to workforce groups.

Resources to support people and their families should be available to ensure that involuntary treatment is minimal.

Investment – ongoing investments and enhancements to existing funding arrangements will be critical for ensuring people in Aotearoa New Zealand have free and easy access to a range of mental wellbeing support.

Yes, the long-term plan will need to ensure that funding mechanisms are designed and protected from being lost in wider DHB costs and enable the needs of the people in the local/regional communities to be met. Easy- free access in community services will be essential. The College supports the growth of Nurse Practitioners and see these roles as being critical to working with people in a range of settings. Growing Māori NPs is essential. Reducing barriers to people in the community accessing nurses could be enhanced by supporting and funding more nurse-led clinics and increase of non-pharmacological interventions.

It would be beneficial to develop communications that socialise the public to the changing nature of nursing scope and what a nurse practitioner and/or nurse prescriber could provide to them and their family. In our experience, many people are unaware that nurses have a higher level of training than previously and can autonomously manage most aspects of healthcare and wellbeing.

Technology – ensuring resources reach people with limited access to digital technology is a priority.
Enabling people on low incomes to access technology to support their wellbeing is needed. Access to people living in rural communities will need to be assured.

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Digital technology that ensures people with disabilities can access is needed.

Digital technology for families and communities to use would be valuable.
People, families, and communities should have other choices as well so there is not an over reliance on Digital technology and face to face meetings/sessions are still valued and supported.

Resources designed with high input from people with lived experience and their families is needed. A way to enable a person to also pull together information electronically from multiple sources would be good.

Ensuring the workforce is trained in the range of technologies available will be needed. Support from a trained worker for a person using digital support tools should be acknowledged.

Need to ensure older people digital technology is designed to suit their needs.
The different patient management systems in NZ are a barrier and national system is needed.

Protection on a persons' health information must be assured as must be consent.

Investment in Digital Technology support experts is needed if system fails.

With the number of Digital Technology – e- MH and apps etc. being developed guidance on what is approved for use in NZ is needed so people and families know the best practice options available. Clinicians must feel confident be able to use technology e.g., texts, to have digital conversations with service users; some current DHB policies do not support this direct and convenient approach for service users.

Leadership – effective communication, collaboration and guidance from leaders will help ensure responses are coordinated, mental wellbeing needs are met, and individuals and whānau feel supported.
The health system must be redesigned to fully enable services to work in partnership with Māori at all levels. Establishing and supporting Māori Nursing roles to work in partnership

with nurse leaders of MH and A services to provide nursing leadership across the health sector is needed.

The College has a sole focus of professional leadership of mental health, addiction, and disability nursing. Our board members as well as members work in a range or practice settings across the health sector. We provide professional leadership and will continue to do so as the health system changes over the coming years. This will be important as more and more mental health nurses are being employed in roles outside of provider arm secondary services. Providing professional leadership for Māori Nurses supporting people with mental health and addiction needs in NGOs as well as other practice settings is offered by our College board that includes a Kaiwhakahaere and Māori Caucus.

As the Māori Nursing workforce grows, we anticipate that our support will increase over the coming years and we are preparing for this.

A strong shared leadership approach is needed.

Bespoke Leadership development programmes will need to be developed to build critical mass of leaders who are culturally effective, excel in communication and collaboration and provide clear guidance in a way that is trustworthy, cohesive, and coordinated to ensure mental wellbeing needs are met, and individuals and whānau feel supported. A national framework for this programme could be developed that can be regionalized or localized. A team leadership approach will be needed to transform services and to sustain the change. A mix of leadership styles will be needed to ensure the long- term plan is actualized and makes a difference.
The leaders of the long- term plan will need to work in partnership with leaders who are people with lived experience. Our College has established links with peer leaders and work will continue to grow in this area. The refresh of our College Mental Health Nursing Standards of Practice this year will further emphasis this as will our collaborative publication on the future of Mental Health, Addiction and Disability nursing due to be published later this year.

Nursing leaders that focus on holistic wellbeing will be critical to mobilize the nursing workforces in a range of settings and to also address the stigma and discrimination which we know is a barrier to accessing health care.

Nursing leaders responsible for actualizing the ‘long term plan’ will need to role model the ability to weave cultural and clinical practice together including how Rongoa healing and pharmacological interventions interact. This year our College is investing in developing a resource about weaving clinical and cultural practices together.

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Our collaborative publication on the future of Mental Health, Addiction and Disability nursing due to be published later this year will have a section dedicated to nursing leadership.

Our College sees the role of nurse to support a person and their whānau to lead their own journey to wellbeing. The refresh of our College Mental Health Nursing Standards of Practice this year will further emphasis this.

Consideration of dedicated DHB board members or regional leadership groups that represent the communities of people with experience of mental health and or addiction, disability is needed to ensure their voice is clearly heard to inform service delivery.

Our College would also like to see a dedicated Ministry of Health appointed role on the New Zealand Nursing Council to ensure the profession of Nursing and future thereof consistently is informed by Mental Health and Addiction Nursing. The College will follow-up on this with the Minister of Health.

What are the key longer-term shifts (i.e., in the next 6-10 years) you think are needed to support system transformation?

Longer terms shifts needed to support system transformation are like those noted in the short-term shifts. Additional shifts are:

- Developing a long- term plan framework that also enables regional and local solutions, family, and whanau solutions.
- People managing how they can purchase or choose their own support and help.
- Stronger working relationships across both Health & Social sector agencies to support a collaborative approach to the care of the person and their family.
- Agencies collaborating to support a person and their family.
- A significant reduction of people in prison with unmet mental health and addiction needs
- Further and sustained reduction in stigma and discrimination towards a more equitable societal wellbeing focus
- Reduction of stigma, discrimination and socially exclusive practices and the goal of elimination of institutional racism within the system

- A skilled and flexible nursing workforce that is enabled to work across and within a range of practice settings.
- Regional solutions to SA(CAT) where whānau can be included and access local treatment and barriers to inclusion are removed. (FYI the current beds for AOD Act are in Christchurch)

Please share any other thoughts in the text box provided below.

Whilst the rapidly developed *Kia Kaha* plan provided direction to take NZ through the pandemic and resulted in breakthroughs in developing peoples and community responses to health and wellbeing the co-creation of a 10-year plan approach to mental health and addiction must be person and whānau centred and have a wellbeing- holistic health focus.

The concept of finding balance in wellbeing of physical, mental/emotional, family, spiritual along with a connection to the environment needs to prevail. Adoption of a holistic wellbeing approach that incorporates mental, physical, spiritual, whānau and environmental wellbeing. This will take a fundamental change in developing a consistently common approach to discovering what is happening for a person and their family and whānau and does not rely solely on a medical diagnosis framed system.

In the inverted triangle the part named- Specialist mental health and addiction service we know provides services for 1000s of people each year and around 90% of that work happens in the community. People with a range of needs access Specialist mental health and addiction services including people with high needs. However, some people may benefit from this level of service do not access services voluntarily and some choose not to.
We know that demand is high and even prior to Covid-19 there had been a 40% increase in demand which services met but with no additional resource. Since Covid-19 happened demand for services has grown. We also know that there has been an increase in people requiring specialist forensic MH services and the need is high in prisons as well. We know that many people have co-existing mental health and addiction needs and during withdrawal or under the influence of substances require support if admitted.

Whilst investment in primary care has been high, investment in supporting people with high and complex needs appears to be lacking. Nurses as the largest clinical workforce are at the forefront of working with this group of people and we know that their own safety and wellbeing can suffer. The long-term plan must include actions to support the wellbeing of the workforce.

This Specialist mental health and addiction service grouping would benefit from a rethink and may have one of sub-groups which require a model of care – most have Co-existing problems and a workforce is needed to best meet the needs of people requiring this level of

service. Within this group Māori are likely to be high in numbers as will the use of community treatment orders and antipsychotic medications and people with trauma histories- both personal, historical, and intergenerational. Resourcing to work with the whānau, communities and other services is needed. The challenge will be to ensure the population currently requiring Specialist mental health and addiction services receive intense support to enable them to receive care in NGOs or primary care settings.

Going forward the safety and wellbeing of the workforce inclusive of nurses who provide Specialist mental health and addiction services must be well considered. The welcome growth of the peer workforce to lead or be part of this level of service must be supported by workplace safety and wellbeing.

Mental Health, Addiction and Disability Nurses are more that capable of taking a holistic health approach. Workload allocation must give nurses time to care and support and respond.

A review of the 'case manager' approach to care, versus a specialist clinician delivering interventions for people with moderate to severe presentations is required. The CM/KW model is outdated and has been in place since deinstitutionalization. No one person can be totally responsible for both the health and social needs of a person in their care. Aligning the current MH&A workforce with the notion of being specialists offering episodes of specialist care in a 'sharing the care' approach with GP & practice nurse will transform the system. Increasing the role of the CSW and peer support specialist to work alongside the specialist MH clinician will help this transition, and more likely to deal effectively with the social issues that contribute a large proportion of people's distress. This will increase the peer esteem between both specialist MH and GP through these shared care activities, which is the public health approach with other health delivery approaches. The impact of long-Covid symptoms on peoples mental and physical wellbeing will increase as we move through the pandemic and see an increase of the latter health challenges when more people with these challenges choose to live in Aotearoa. We need to be ready for this population with a shared care approach.

Covid- 19 provides more impetus for nursing as a profession to provide holistic health care. *"People who are immunocompromised, older people, and those with pre-existing health conditions are susceptible to worsened health effects from COVID-19, including poor mental health and addiction outcomes. Other groups with potentially greater vulnerability include*

those with existing mental health or addiction issues, rainbow communities, people experiencing homelessness, disabled people, and people with histories of trauma". We are skilled to help address inequity and are and will be integral health team members to support the wellbeing of all New Zealanders.

Thank you for the opportunity to comment, please feel to contact us if you have any queries about our submission.

Te Ao Māramatanga- New Zealand College of Mental Health Nurses looks forward to providing professional nursing leadership on the health system transformation journey ahead.

Ngā Mihi Nui

Suzette Poole (President) and Chrissy Kake (Kaiwhakahaere)

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