Te Ao Māramatanga- NZCMHNurses written submission 5 June 2018- Information for members only - 17 June 2018.

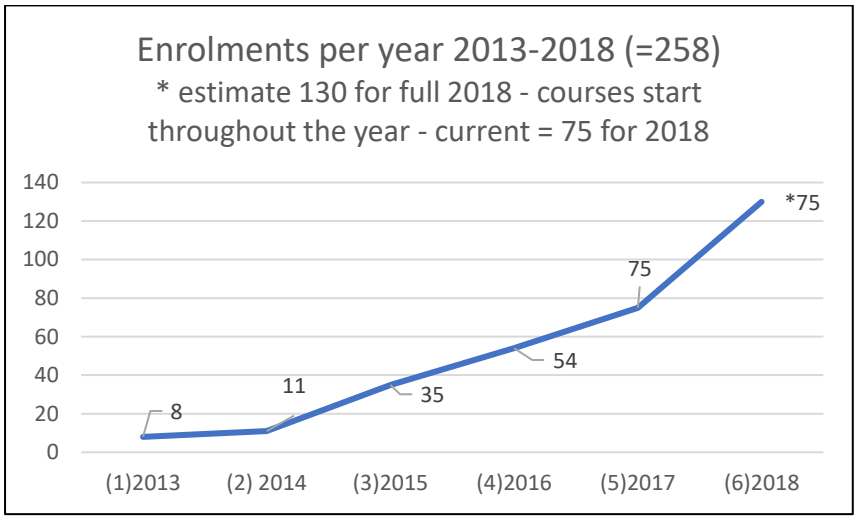
Written up by Suzette Poole – President

To be discussed further at face to face hui with Mental Health and Addiction Inquiry panel on 13 July 2018

Question 1: What's currently working well?

Mental health and addiction credentialing programme

Our Mental health and addiction credentialing programme is working well and is in high demand http://www.nzcmhn.org.nz/Credentialing.



This credentialing programme is available to any nurse working in primary health**,** who has the knowledge, skills enhancement and experience to apply mental health and addiction assessment, referral and interventions in a primary care setting. This programme is available to both individuals and primary healthcare organisations and district health boards who are prepared to facilitate a local group programme.

The programme is underpinned by a collaborative approach between; Primary health care organisation, DHB specialist mental health and addiction services and Te Ao Māramatanga-NZCMHNurses. DHB specialist mental health and addiction services provide some of the education and this helps build across sector relationships and increase the confidence of primary care nurses to contact a wide range of mental health and addiction services for support.

The inclusion of supervision by mental health nurses has enabled programme participants to grow their practice through a process of reflection as they integrate new knowledge and skills into practice. Nurses report a range of benefits from course attendance including increased confidence levels in their ability to be responsive to the needs of people presenting with mental health and/or addiction needs.

Reflections submitted as a part of their portfolio, document nurses actively involved in prevention and early intervention activity as well as developing ongoing supportive relationships with people

experiencing complex and longer-term illness, as a result of programme learning transitioning into the practice environment.

One collaborative delivering this programme in Auckland commissioned an independent evaluation of the programme in 2015. This evaluation and the results of the initial pilot programme, funded by Health Workforce New Zealand, is available on the following link:
http://www.nzcmhn.org.nz/Credentialing/Evaluation-and-Monitoring

The inquiry panel will have an opportunity to hear more about this programme when they meet with Te Ao Māramatanga- NZCMHNurses on 13 July 2018 as we see that this programme is clearly part of the solution.

Mental health and addiction nurses located in primary care settings

Mental health and addiction nurses are walking and working alongside other workforce groups to demonstrate how to support people with mental health or addiction problems. The presence of mental health and addiction nurses in some primary settings has had a positive impact on primary care practitioners in terms of reducing stigma and discrimination. More importantly people with mental health and addiction issues accessing primary care services have an opportunity to receive more support earlier.

Growth in some primary care services

There are an increasing number of services within communities, including earlier intervention within PHO's/brief intervention services. The stepped care approach is helping to ensure people get the right intervention at the right time by the right person.

Psychological therapies

Peoples ability to access psychological/talking therapies has improved in same areas however more is needed. More training in psychological/talking therapies needs to be funded for the health workforce who work in a range of settings. Nurses do need more access to funded brief intervention training and other talking therapies.

Primary Brief Intervention (PBI)

We see that these are only working well in some PHOs and are most effective when capability / capacity building is at core of service. PBI clinicians work in consult liaison model. Work well for enrolled populations.

Responsiveness and timeliness of access is essential to early intervention. A stepped care approach ensures people get the right intervention at the right time by the right person.

Mental health in schools

Mental health nurses are supporting teachers in schools in Christchurch which is a great initiative. This will be excellent if it could be rolled out to other areas.

Nurses in schools

The government is investing in putting nurses into schools which is a very positive move. We believe there is a need to ensure that these nurses are supported to develop their knowledge and skills to best support children their families and whānau who have mental health and addiction needs.

Increases in services for child and youth services

Local initiatives such as a PHO and a DHB working together with the adolescent group offering help with addiction in Nelson & Marlborough District Health Board is working well.

Child and Youth Services, including family interventions are growing to meet the needs of clients/families and young people – they are community based and therefore don't have the 'mental health hospital stigma' – this improves access and engagement.

Community approaches

Innovation and new ways of delivering services to people who experience mental health and addiction issues in community services is working in some areas.

Effective Home-Based Treatment (HBT) models are generally working well- if they don't get swallowed by crisis services. HBT tends to work well for the service user and their whānau as they all get the required support and psychoeducation in their own environment, or in a respite facility (if their own environment is not helpful at that time).

We see community or iwi initiatives to improve wellbeing happening– example are communities who are trying to address methamphetamine abuse.

Regional Work plans and Cooperation

Some real gains being made in developing regional work plans and cooperation to implement these plans. We are too small of a country to be developing the same thing in different ways. Education and training in South Island is a good example as this has helped to reduce duplication, increase consistency and improve networking / relationships.

Collaborative initiatives that focus on physical health of people who experience mental health and or addiction issues

Strategies to improve the physical health of people who experience mental health and addiction issues has been a positive across-sector initiative and work must continue in this area. This project is a good example of New Zealand research driving the need to pay attention to this critical area. The collaborative across-sector model of this initiative is a great example of collective impact. Te Ao Maramatanga- NZCMHNurses have supported this initiative and contributed to the design of the Equally Well Prescribing Toolkit https://www.tepou.co.nz/initiatives/equally-well-prescribing-toolkit/224

Crisis services

Single point of entry services (SPOE) have received good feedback from the community in at least one service.
Early intervention services are working well in at least one service.
Homecare national triage services is working well to help improve delivery of services

Clinical Governance

Clinical governance works well where it exists however it appears to vary up and down the country. Mental health and addiction nurse leaders should have a seat at the executive and senior management table to provide clinical and professional expertise in decision making around clinical health services. This is vital if managers have little or no experience of working in the mental and addiction sector- they maybe more likely to focus on financial imperatives with little thought to clinical needs or impact on people using services.

Least restrictive practice

There is continued work on reduction of seclusion and restraint in inpatient services and the rates are decreasing. Initiatives so far have seen significant reductions however further reduction needs a planned approach. National Safe Practice Effective Communication (SPEC) training programme is making a positive difference.

Growth of peer support workforce and in support worker workforce

Nurses are learning to work alongside the growing peer support and support worker workforce more and more in community settings.

Mental Health and addiction nurses – recruitment and retention

Since 1996 there has been a focus on recruitment and retention of mental health nurses. This has been successful in addressing some workforce issues and must be continued.

Strategies to increase the number of mental health and addiction nurses appear to be working as Nursing Council stats show an increase. However, although numbers are growing anecdotal evidence suggests that there is still a shortage. This may be due to the development of new roles for mental health and addiction nurses outside of specialist mental health and addiction services, for example in NGOs or primary care setting or in corrections setting- probation onsite in prisons.

Standards of practice for Mental Health Nursing Practice are available in NZ

The standards of mental health nursing were first published in 1995, updated in 2004 and then again in **2012** by Te Ao Māramatanga – New Zealand College of Mental Health Nurses (NZCMHN).
Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (Te Ao Māramatanga-NZCMHN, 2012). http://www.nzcmhn.org.nz/Publications/Standards-of-Practice-for-Mental-Health-Nursing

The Standards of Practice for Mental Health Nursing in New Zealand (herein referred to as Standards of Practice') are applicable to all mental health nurses practising in mental health and addiction services, in any practice setting. New graduate nurses, with support of a preceptor, will be expected to meet the Standards of Practice on completion of a New Entry to Specialist Practice mental health and addiction programme leading to the award of a post graduate certificate in the specialty, in their first year of practice.

The Standards of Practice are concerned with the performance of mental health nurses in Aotearoa New Zealand, and include practice outcomes and attributes of knowledge, skills and attitudes. The values, attitudes and seven Real Skills identified in *Let's get real* (Ministry of Health, 2008) which underpin the provision of effective mental health and addiction services in Aotearoa New Zealand, are reflected in these standards.

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.

Standard Two

The mental health nurse establishes collaborative partnerships as the basis for therapeutic relationships. This involves building on strengths, holding hope and enhancing resilience to promote recovery and wellbeing.

Standard Three

The mental health nurse provides nursing care that reflects contemporary mental health care and standards.

Standard Four

The mental health nurse promotes mental health and wellbeing in the context of their practice.

Standard Five

The mental health nurse is committed to their own professional development and to the development of the profession of mental health nursing.

Standard Six

The mental health nurse's practice reflects relevant policies, legislation, ethical standards and codes of conduct.

These standards are now due for a review once funding to do so is secured. The standards are underpinned by *Let's get real* which is currently being refreshed and therefore we hope to have the standards reviewed by 2019. A funded implementation process to promote and fully embed these standards into practice, education and service delivery will be needed.

Nursing education

Some nursing training programmes for students and new graduates are providing positive clinical placements for students. "As a preceptor I have fantastic feedback from students going through Whitireia". However further research is required to understand more about the experiences of students and new graduate nurses.

More people with lived experience of mental health or addiction issues are involved with education of health professionals. An example is Debra Lampshire- consumer advisor- The University of Auckland.

The New Entry to Speciality Practice – Nursing programme for nurses in DHBs and NGOs are making a significant and positive contribution to growing the workforce. However more funded placements are needed. https://www.tepou.co.nz/initiatives/new-entry-to-specialist-practice-mental-health-and-addiction-nursing/47

The Skills Matter funded programmes are supporting mental health and addiction nurses to develop their knowledge and skills in practice and in leadership. These programmes are supporting nurses to undertake research. Nurse Practitioner pathways are supported by these programmes. https://www.tepou.co.nz/initiatives/clinical-leadership-in-nursing-practice/50

Recent changes in legislation have enabled some nurses to do more

Nurse practitioners and registered nurses with prescribing rights who support people with mental health and addiction problems can offer timely access to health services in a range of settings- hospital to home that provides a whole person approach, person centred care and family and whānau centred care.

Growth of Nurse practitioners

The nurse practitioner- mental health, addiction, disability workforce is growing very slowly. It has been just over a decade and a half since the first nurse practitioner (NP) in mental health was endorsed. In 2001, the first NP was endorsed by the Nursing Council of New Zealand followed by the first NP - mental health in 2002. Sixteen years later, in 2018 we have around 17 NPs endorsed to practice with people experiencing mental health problems, addiction or people with disabilities people. Most NPs have NP positions but not all.

NPs are highly skilled, able to meet the needs of many and are cost effective. A NP can work in a variety of settings - they blend the physical health and mental health and addiction skills. However, this workforce needs to be grown but in a way that is not seen as a replacement for current workforces -- it must be in addition to.

Growth of Enrolled Nurses

The new scope of practice for enrolled nurses includes training in mental health. This workforce in mental health and addiction services that supports registered nurses is growing.

Growth of Māori Mental Health Nursing workforce

There are targets set by the Chief Nurses Office- MOH for employment of Māori registered nurses. This requires consistent and diligent efforts with pipeline support for interested students. In 2015, we- Te Ao Māramatanga-NZCMHN's Māori Caucus partnered with Te Rau Matatini to develop a strategy 'Māori Mental Health Nursing Growing our Workforce - Every whānau should have a Māori nurse' http://teraumatatini.com/publications-and-resources/m%C4%81ori-mental-health-nursing-growing-our-workforce.

The inquiry panel will have an opportunity to hear more from Māori Caucus when they meet with Te Ao Māramatanga- NZCMHNurses on 13 July 2018 as we see that this programme is clearly part of the solution but further investment to meet demand.

Other comments

Strategies to encourage people to access mental health and addiction services appear to be working based on the Mental Health Commissioners report that noted an increased demand in specialist services. It also notes that males are accessing more specialist services than females. This may mean males are not engaging in services to support them when they are in the early stages of becoming unwell. We also don't know how many people are accessing primary health services or NGO services.

We see increased inclusion of people with lived experience and their families being involved in service design in some areas however do not always appear to be well supported or resourced

We see increased inclusion of tangata whenua, Māori leaders involved in service planning and delivery however it does not always appear to be well supported or resourced.

We see increased inclusion of Pasifika leaders involved in service planning and delivery however it does not always appear to be well supported or resourced.

We see more people with lived experience of mental health or addiction issues being involved in government departments and national workforce centres.

Question 2: What isn't working well at the moment?

Wellbeing of the mental health, addiction and disability nursing workforce

We are deeply concerned about the wellbeing of the mental health and addiction nursing workforce. It appears many nurses are stressed, burnt out and tired which can have direct impact on the quality of care they are able to provide. We know a growing number of nurses are being assaulted at work. People accessing services and people providing services should be able to feel safe in mental health. addiction and disability services. Trauma informed care applies to both people accessing and providing services and yet is not fully embedded into all services.

Link between mental health and addiction

The two sectors -- Addiction and Mental Health are still only casual friends -- they need to become life partners. The difference in funding models, practice models and training can be vastly improved to be enablers to a joined-up system. People who need care are still finding that despite the rhetoric **-- every door is not always the right door.**

There are high admission rates of people with co-existing- mental health and addiction needs and they need support from a workforce that have the right values, attitudes, knowledge and skills. Acute services must ensure that models of care are developed to best support people with co-existing problems and designs of physical environments support recovery and well-being. There must be sufficient skilled staffing in place to support people who are acutely unwell.

Young people and their families are facing long wait times

Young people and their families are facing long wait times - and assessment is often the only response. There is a need to build community resources to meet the needs for families who are struggling with parenting, managing challenging behaviours with youngsters with learning needs, and defining the best approach to meeting a learning need is morphing into the mental health arena. Behavioural psychology is a huge unmet need.

There is lack of respite services for children and youth.

Physical health of people with mental health and addiction needs

Physical health care for people with long term mental health conditions deserves more focused attention. Funding models currently indicate there is no incentive for service users to seek their physical health care from a GP.

People with mental health and addiction needs deserve top end physical care - as mental health services often compel many to take psychotropic medication that ultimately causes detrimental side effects. This may be particularly complex for those who have pre-existing, co-morbid or indeed undiagnosed physical health needs and/or disabilities.

Community support for people in distress

Communities should have prompt first line effective responses when they are worried about a person. Community drop in facilities where social care can be offered to support people when acute environment crisis occurs- sudden homelessness, family violence, sudden bereavement. Access to psychosocial support is paramount at these times.

Services for people with disabilities who also have mental health and addiction needs or who require secure mental health care requires a review

New Zealand relies heavily on a significant number of overseas trained learning and disability trained nurses to provide specialist services as this formalised training, currently, is largely absent from undergraduate and post graduate nursing education. Nurses who support people with disabilities in a range of in-patient and community settings are often professionally isolated. There is no national strategy to develop and grow this workforce.

Te Ao Māramatanga has offered one solution to this and will be supporting this group of nurses by way of establishing a disability nurses branch. This will be announced formally in July. As a College we will support this branch to continue to advocate for improved services for people with disabilities inclusive of the need to developing a disability nursing workforce plan - a pipeline from school student to Nurse practitioner.

Education for the wider nursing workforce, medical and allied health professionals throughout the health system is needed to ensure that when people with disabilities access health services they are respected, listened to receive timely quality, equitable and accessible services to support them with their wellbeing: This can be achieved in establishing and researching interprofessional learning and clinical opportunities to reduce the risk of diagnostic overshadowing (changes in wellbeing being attributed to the disability rather than an established, undiagnosed or unmet physical or mental health need).

The need to support people with disabilities, their family and whānau or carers to improve their physical health, mental health and health literacy is an imperative.

The restraint and seclusion on people with disabilities is another area of concern that we will be seeking to address.

Nursing undergraduate programmes should include integrated theory, practice and clinical learning opportunities that enable students and graduates to understand how to best support people with disabilities with their wellbeing.

The inquiry panel will have an opportunity to hear more about our concerns regarding services providing to people with disabilities when they meet with Te Ao Māramatanga- NZCMHNurses on 13 July 2018.

More services to support people who have an addiction are needed

More services to support people who have an addiction are needed. Addiction issues affect individuals, families and whānau. Responses should be person and family and whānau centred (not a one size fits all approach.
To enable this approach and decrease stigma associated with addiction issues (commonly co-occurring mental health issues) increased resources are required.

As a first response, substance use and other compulsive behavioural issues should be addressed via local accessible family and whānau and youth services that are health and wellbeing orientated, identify barriers to wellbeing and have a preventative focus.

All front-line health and related sector workers should receive training (knowledge, skills and attitudes) in addiction and ongoing supervision to increase the scope of service response. The Mental Health and Addiction Credentialing Programme is one example of a training approach that is particularly focussed on skills and attitudes.

Increased accessible community- based services are required to meet the needs of people (individuals and families and whanau) who require specialist assistance and should be staffed by qualified addiction practitioners.

People with addiction needs are not always able to access care and residential treatment programmes and follow-up support close to home.

There is an urgent need to provide increased supportive accommodation options (recovery and wellbeing focussed) for people discharged from residential addiction treatment services to support recovery journeys and limit early relapse.

The role of peer support should be increased with consideration of role boundaries, role clarity and defined training and supervision systems.

The impact of methamphetamine and other substances on families and whānau is of concern with children being removed from homes. Earlier intervention strategies including through schools are needed that focus on the wellbeing of children and support of families and whānau and, for those families with established addictions greater support for their recovery journeys is required. New life needs to be addressed.

Accessible naloxone should be available to opioid substance users and their families as an overdose prevention strategy.

Greater emphasis should be placed on increasing the proportion of people receiving opioid substitution treatment being treated in a primary care setting to reduce stigma and promote holistic care

Nurse Practitioners and registered nurse prescribers should have a significant role utilising a nursing model of care to support people with addiction.

Te Ao Māramatanga will be supporting New Zealand addiction nurses by way of establishing an addiction nurses branch this will be announced formally in July.

The inquiry panel will have an opportunity to hear more about our concerns regarding addiction services when they meet with Te Ao Māramatanga- NZCMHNurses on 13 July 2018.

The ring fencing of mental health money has not been consistently upheld

The 1996 Mason Inquiry we understand set up a ring fencing approach for mental health money however we are unconvinced that this still occurs and, in some services may not have been in place for many years. We are under the impression that some DHB services may have redirected mental health funding to cover costs in other health care services. Clarity about the “ring fenced money’ would help to understand what has really happened and how any funding is ‘protected’ in the current fiscal environment.

We argue for transparency and public accountability for any funding of services for people with mental health or addiction needs and for people with disabilities. This may be a role for the newly established Mental Health Commission.

Mental Health Nursing Framework has delivered on only some of the recommendations

Mental Health Nursing and its Future: A Discussion Framework – Report from the Expert Reference Group to the Deputy Director-General, Mental Health Dr Janice Wilson, (here on in referred to as 'the framework') was published in 2006 by the Ministry of Health.
http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/12CBFAC7FCA3C1F0CC2576DF007B1AC2/$file/mental-health-nursing.pdf

The framework provided a strategic direction for the future of mental health nursing to strengthen both nursing leadership and practice within the multidisciplinary clinical environment. The overall goal was to provide strategies to move the profession of mental health nursing forward. Several recommendations were made about leadership, mental health nurse practitioners, standards, skill mix, clinical career pathways, professional supervision, education, research, and recruitment and retention.

In the conclusion it was noted that "adherence to the recommendations made in this framework will facilitate the implementation of the Government's strategy for mental health, including the Blueprint. It will enhance the quality of mental health care provided by district health boards and non-government organisations, and result in improved health outcomes for service users. It is imperative that stakeholders work together to develop creative recruitment and retention strategies, and new ways of working. This is particularly pertinent given New Zealand is facing increasing demands for mental health services, an alarming shortfall in mental health nurses, and increasing global nursing shortages. (MOH, 2006, p.70).

We believe that Framework needs to be dusted off, updated in respect of understanding what the current situation is and informed by current evidence.

The inquiry panel will have an opportunity to hear more about the progress made on the recommendations in this framework when they meet with Te Ao Māramatanga- NZCMHNurses on 13 July 2018.

Refocus of Specialist Services is needed

We fully support the early intervention approach, also addressing wider social determinants of health, however these interventions will take time to be reflected in current needs. We still need to provide adequate services to the people presenting with needs now. Specialist services are under huge demand and require significant input until demand for services eases. In Auckland there is a rapidly growing population and services need to keep pace with population needs.

Investment in both specialist and early intervention services is needed.

There is a huge gap between the amount of beds available in some in-patient units, and the number of people needing to use them. Having to discharge unwell people to admit someone else is risky and unfair- to the person and their whānau. This is especially relevant if there are no crisis or home-based treatment teams to continue to assess and support. However, admissions could be reduced if there was more effective community follow up, and options for a more rapid response and good robust psychoeducation.

Raising awareness about mental health and encouraging people to seek help is a good strategy but when they do need support there simply aren't enough services available, and expectations are great. Because of high caseloads, lots of mainstream services are generally running as a crisis service- which means that a person needs to become unwell to obtain the service that would have stopped them from becoming unwell in the first place.

People with Head Injury

There is a need to improve services for the ageing population of people with head injury who are often accommodated in services that can manage behaviours rather than having specialist knowledge to support their wellbeing.

Nursing education programmes need more mental health and addiction content

The mental health and addiction content in undergraduate nursing education needs to be increased so it makes up around 50 % of the content. Mental health, addiction and disability should be every nurses' business.

A planned approach to mental health nursing knowledge and skill development is required

The absence of a mental health and addiction nursing workforce strategy to ensure there is sufficient nurses with the right values, attitude, knowledge and skills to support people with mental health or addiction problems is a real concern.

More information is required about the mental health, addiction and disability nursing workforce to inform workforce planning.

As 31 March 2015 there were 47, 488 Registered Nurses (RNs) with current practising certificates. Registered Nurses reported working in the following practice settings:

- Mental Health Community 2183 RNs
- Mental Health inpatient 2065 RNs
- Addiction 234 RNs
- Intellectual Disability 214 RNs

(NCNZ, 2015, p. 35)

However, the mental health and addiction nursing is ageing at a faster rate than the general nursing workforce. Over half are aged 50 years or older and around a quarter are eligible to retire in five years, time.

Stigma and discrimination remain headline issues for people with mental health and addiction problems.

These issues are societal and are also evident in health and mental health and addiction services.

Courtesy stigma or 'stigma by association' for students choosing a career in mental health is a problem. Even when a student nurse decides to pursue a career in mental health nursing support from peers, family, other nurses and nurse educators is not always forthcoming and stigma and discrimination towards people experiencing mental problems is often voiced.

Strategies to increase the popularity of mental health nursing should include support for nurses choosing a career in mental health nursing and actions to address negative attitudes towards mental health nursing and people with mental health problems expressed by nurses in other practice areas.

Societal issues impact greatly on the mental health of individuals/families and communities.

Poverty, discrimination, domestic violence, child abuse, incarceration, unemployment, minimum wage and benefits not equalling a 'liveable wage'; contributes greatly to a lack of dignity and self-

respect (not being able to pay bills/feed your family/give children the opportunities they deserve – music lessons/swimming lessons/sporting opportunities – due to the cost barriers).

Lack of educational opportunities, reducing aspirations and goals of children from poorer families. Having to be given an accommodation supplement and/or tax credits to make ends meet – taking away a person's self-respect and reducing their self-esteem.

Physical chronic illness; unpaid care-giving (of a family member/child with a disability). Loss of hope for the future and society increasingly unequal. As the rich get richer, the poor become poorer = an unhealthy society of 'haves' (too much) and 'have nots' (too little), and with all the associated stressors, impacting on a person's ability to cope and compromising their mental health.

However, all the above is not just about mental health and addiction services – they exist to try to help people pick up the pieces of their lives, but they don't have magic wands. We need to approach these issues from multiple perspectives and promote collaboration between services, organisations and across sectors. Health, Education, Early Childhood, MSD and Ministry of Justice all need to be working together.

The following vignette highlights these issues

> Mary is a single mother of two children- a two-year-old son and five-year-old daughter. She lives in a South Island city in rented accommodation. She receives an accommodation supplement and family tax credits. Mary works 20 hours per week. Her ex-partner disappeared a year ago, possibly overseas and therefore is not contributing to any financial child support or helping with raising the children. During their eight-year relationship, he was emotionally and physically violent towards her and at times towards the children.
>
> Her two-year-old son attends early child-hood play centre but contracted an infection- bronchiolitis. and has been recently discharged from the paediatric ward. Mary has had to find alternative care for five-year-old daughter with a friend as all her family live in the North Island. Mary stayed with her son in hospital for four days.
>
> Mary has also had to take time off from her part-time employment as her son was unwell for a week prior to admission to hospital, and whilst now he is discharged it will be up to another week before he will be ready to return to day-care.
> Mary is entitled to five days sick leave per year however she has none left. She is now faced with un-paid leave for three or more days as she has been looking after her son while he recovers. Mary is aware that there may be a provision for discretionary sick leave, but her employer is not the most approachable, so she has not yet enquired about this.
>
> Her five-year-old daughter recently started school. Costs associated with the school uniform ($120 for a pinafore; $90 for a school sweater; $60 for a fleece jacket; $100 for shoes; $40 for a blouse (x2) + stationary, swimming lessons).
>
> Mary is now facing the prospects of not being paid and has become increasingly stressed and anxious.
>
> Whilst she drives a car, this is due for a warrant. Mary knows at the least she needs to replace two tyres – her car is 15 years old and she is frightened that it won't pass, and she will be car-less. The bus service would not allow for her to drop her children at both day-care and school and allow her to be in work on time, she is worried that this could cost her, her job.
>
> Mary has been having difficulty sleeping, she is aware that she is becoming increasingly irritable with both children at a time when they both need her to be at her best. The 5-year-old daughter is struggling with the transition to school. She had cried herself to sleep for the four nights that her mother was away at the hospital. Marys son is still recovering from his illness.

> More than anything else Mary is worried that if anything else goes wrong then all the accumulated stress will come crashing down on her. She has been to see her GP, who offered her anti-depressants but nothing else. She has a prescription but is worried that the medication will make her feel sedated and nauseas – as she previously experienced when she was put on medication as a teenager.
>
> Mary needs to find out how much money she may loose from her wages and then make an appointment at WINZ – an experience she is not looking forward to, due to previous negative experiences and feeling like she was worthless the last time she had to an appointment.
>
> Mary has asked about some counselling, so she can have someone to talk to. She was told that there is a three-month waiting list. She is worried that if anything else goes wrong then she will crack under the pressure, everywhere she looks, there feels like more barriers and obstacles, and as always more out-goings and not a lot of money to cover her basics costs of living.

The above vignette is to illustrate how so many stressors impact on people's mental health and wellbeing.

We believe that there needs to be earlier interventions/access to talking therapies/a more equal society/ free education/access to assistance for uniforms – in such a way that people keep their dignity and respect.

Values and attitudes training for some staff at WINZ staff would be useful to ensure people like Mary receive the support they need.

A greater awareness amongst society/communities regarding the struggles some people experience is needed. **We need a kinder compassionate society.** This young mum could go on to have increasingly more difficulties that lower her resilience, putting her mental health at further risk which may in turn impact of her ability to be the best parent she can be.

If Mary's situation continues to deteriorate and she loses her job, then what would be the personal costs and the societal costs. Mary may end up in hospital, children may end up in care.

We think the solutions lie in improved responses from the local community, social services, education and primary health care. Mary may benefit from having support from someone help her to navigate her way through these services to ensure she receives timely support for her and her young family.

Question 3: What could be done better?

Mental health and addiction are everyone's' business not an optional extra

The line of sight must be towards making mental health, addiction and disability being every nurses' business.
- All clinicians need adequate undergraduate knowledge and skills.
- All clinicians should be expected to utilise and evaluate the above knowledge, skills and attitudes in practice

Making mental health and addiction the business of every nurse, in every setting. This would support the Inquiry focus on making it easier for people to access mental health care. People in every health care setting experience mental health and addiction issues. All health staff need to be able to respond.

More placements of mental health staff in primary health organisations

Expanded access to psychological services

This would support development of mental health skills in the primary care nursing workforce.

Ensure Mental Health Commission can monitor services and fulfils a 'watch dog function' to ensure money allocated to improving mental health, addiction and disability services is wisely and effectively used and makes a difference in peoples' lives.

The Mental Health Commission staff should include nurses with mental health, addiction and disability expertise.

Investment in mental health, addiction and disability workforce development is needed

Alongside of the implementation of new and existing initiatives, ensure there is robust, ethical and longitudinal research to provide baseline and comparative evaluations across the country: This then provides a basis upon which to inform, recommend and build future service delivery.

Health Workforce New Zealand- Nursing Advisory group should include nurses with mental health, addiction and disability expertise

The College has made two requests to be included in this group but has had no response from Health Workforce New Zealand

More whānau inclusion, and less focus on the individual (where appropriate) is needed

Reinstate the MH directorate within Ministry of Health

Invest in systems and process' to enable people with mental health and addiction problems to provide feedback about services

Client centred outcomes are needed. Gauge feedback from Tangata Whaiora on all changes. Services do not do this well. We need to invest more time and energy into finding out what people in services are saying they need to support them with their recovery. What we could be doing better. What works and what does not work.

Invest in early intervention initiatives to redress impact of trauma on people, their families and whānau

Well we need to intervene earlier with young people and young families; we need to work so much harder at reducing abuse and neglect.

We need a public awareness campaign about what abuse and neglect does to the developing brain, particularly new-born to 3-year olds (and in-utero).

We need a public awareness campaign of the impact of trauma on individuals, families, and generations.

The perpetuating cycles of abuse and neglect in families – we need to get alongside and support these families, including perpetrators of violence. Trauma informed interventions, starting with education for the public, for schools, for early childhood; for health (general and MH); the MOH; MSD; Minister of Justice, - across different organisations', departments, policies and processes that will work across ministries to address these fundamentally important issues.

We also need to stop pathologizing a person's 'normal response' to abnormal or overwhelming experiences. In MH & A we look for symptoms to assist with a diagnosis. What if the symptoms are in fact 'adaptations' – how the person has adapted to survive, but not thrive. Time to start asking people 'what has happened to them?' As opposed to 'what is wrong with them?

Invest in services for the ageing population

We have an ageing population many of whom will have co-existing physical, mental health or addiction issues. There is a lack of workforce planning to ensure we have a skilled workforce to support older people in their homes, aged care facilities- rest-homes or in hospitals.

Provide more drop-in services

More drop-in services, where people could just swing by and be welcomed by skilled and experienced clinicians. It would be a casual and warm environment for teens and adults. These would be nationwide- in town and cities, and late night. This is one initiative and a way to be the 'ambulance at the top of the cliff' for many people.

Initiatives to raise awareness about mental health and addiction for families and whānau

This is needed for families and whānau to enable them to best support family members who experience mental health or addiction problems Staff in MH&A sectors need to be more skilled to be able to better support the clients and their whanau. There needs to be more whanau inclusion, and less focus on the individual (where appropriate).

Keep investing in initiatives that redress poor physical health of people with mental illness. Current health disparities for people with mental illness need to be addressed by improving access to primary care, and by ensuring mental health services are responding to the physical health needs of people with mental illness.

Continue with addressing social determinants that impact on wellbeing

Iwi based solutions
Whānau based solutions
More free community health services
More support post prison release for people
More funding to support parents to spend time at home with new-borns and toddlers i.e. up to one year

Supporting development of capacity in primary care.

Most people with mental health and addiction issues see their primary care provider first. Most don't need a specialist mental health service, so it is important that primary care is able to provide assessment, treatment and support.
Introduce health targets around Primary Health- a bit like smoking cessation - they weren't reflected until it became a target and there was financial incentive.
Review and change funding model for GP practices.
Cost of accessing support with mental health or addiction problems from non-specialist services is a barrier

Focus on children and youth via schools

We need to be starting in schools by teaching a stress/vulnerability model to our young people and showing them ways of coping with stress. It needs to go right the way back to their 1st year at school. Ensuring there are skilled people onsite at schools to be a safe person for troubled and stressed young people as well as children who have identified learning, mental health, addiction or disability needs.

Children need more hope for their future, and encouragement and expectation to achieve. They need to know how drugs and addiction affect their brain at different stages.
They need to know that when life does not go well, that they can deal with it and it will pass. If they are taught how to cope at a young age, feeling overwhelmed will be more manageable and less catastrophic.

The increase in school nurses is a great start however these nurses must be also skilled in mental health and addiction to best serve the children and their families and whānau.

Supporting initiatives on suicide reduction

This needs an intersectoral approach involving all government agencies but needs to be community focussed and community driven.

Investment in initiatives to reduce the high rates of suicide among Māori and Pasifika young people must be scaled up.

Take strong action on alcohol: Evidence shows that when countries take strong action on alcohol, suicides are reduced. Suicide rates among young males significantly are decreased.

The book 'Sorrows of a century – NZ Suicides from 1900-2000' gives some insight in that it says suicide is not necessarily mental health's responsibility – as a society we all must be responsible. Give society the support, dignity, respect, equality and education through future polices and decision making – then we will see a healthier society, a recovering society, and a reduction in suicide.

Question 4: From your point of view, what sort of society would be best for the mental health of all our people?

A compassionate and caring society

A greater awareness amongst society/communities regarding the struggles some people experience is needed.

A new system would be one where people can access free primary care services and receive a whole of health and wellbeing response. Where they have access to someone trained to co-create a health plan with them and are offered a health coach to support them with their recovery. This service would also be available for families or communities seeking to improve their wellbeing. People would feel listened to and not judged, they would understand the range of options and be able to choose what suited them.

Question 5: Anything else you want to tell us

Nurses are part of the solution

– if every nurse had the right values, attitudes knowledge and skills to best support people with mental health, addiction and disabilities then just over 50,000 nurses could make a huge positive impact on the lives of many New Zealanders.

Review of mental health act in line with UNCRPD is needed.

The current Mental Health Act is almost 30 years old. It addresses the needs of the 1980s but not the needs of the 21st century. Review needs to be a priority recommendation for the Inquiry.
We need a major rethink about how to reduce the number of people on community treatment orders
We need investment in resources to support people with high needs and only use MH Act as a very last resort.

Forensic Mental Health Services

We need investment in resources to support people with high needs to support them to return and live in their community of choice
Investment in the forensic mental health workforce is needed

A major re-think of the physical inpatient units – design and bed numbers and staffing mix is required to support people with their recovery

More units for women only
More units for rainbow people

The impact of alcohol misuse in New Zealand

While we accept that this is legitimate, alcohol related health and social impact will continue. We have a problem
- reducing access could assist.
- increasing prices will assist.

Needs to be same as smoking cessation.

Strong action is needed to address the harm from alcohol including mental health harm: (Increasing the price, reducing availability, restricting alcohol advertising and sponsorship and including mental health warnings on all alcoholic drinks – to delay the onset of drinking amongst youth and reduce the development of alcohol addiction). In addition, early identification of Fetal Alcohol Spectrum disorder.

Set targets for reducing hazardous drinking by New Zealanders across the age span and monitor.

Invest in services to support people in the prison and post release to support them with their wellbeing and recovery.

Need for public health (population based) approaches to issues such as substance use and addiction, and suicide.
Health services generally only respond to individuals, and often only once a problem has developed.

Health Insurance companies, for those that can afford health insurance, should make available to their customers a health and wellbeing coach to support people.

Fund more mental health and addiction nurses to work alongside Police teams

Non-pharmacological treatments
More understanding about non-pharmacological treatments
Improve access to funding more non-pharmacological treatments

Improve access to funded Māori and Pasifika healers and healing practices

Person centred care and whanau centred care appears to be only an aspiration in a fiscally constrained environment.

Address models of funding and the issue of discrepancy in funding (particularly salaries) between NGO and DHB services – evident for many years in the addiction sector.
In addition, precarious short-term funding cycles are stressful to established providers and add to multiple reporting requirements.

Change the business model operating in primary care

Nurses are trying to do their best with very limited resources
The mental health and addiction sector is an incredibly challenging sector at times and media reports are often negative. It is often only the goodwill of staff that keep services running. We have gone the extra mile repeatedly.

"*Most of us are doing our best. We have little access to funded training, little support, and are expected to get on with it without making mistakes. Lots of us have been assaulted- physically and verbally. We don't get recognized for extra qualifications we obtain. Our wages are not keeping up with inflation. Many of us are stressed, tired, sad, and burned out. We want to give more, but we have no more to give. Help us to give more"*

Appendix: About Te Ao Māramatanga- New Zealand College of Mental Health Nurses

Te Ao Māramatanga-New Zealand College of Mental Health Nurses is the professional body and voice for Registered Nurses with specialist mental health knowledge and skills in New Zealand. http://www.nzcmhn.org.nz/.

Our growing membership includes several 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, cultural services and specialty areas including disability and addiction. Our members are spread in both urban and rural areas nationwide and link into local College branches.

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 have been very privileged to have Dame Margaret Bazley as our patron for several years. http://www.nzcmhn.org.nz/About-Us/Meet-the-National-Committee

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.http://www.nzcmhn.org.nz/Publications/Standards-of-Practice-for-Mental-Health-Nursing

Key contributions of Te Ao Māramatanga to the mental health, disability and addiction sector include:

Professional support of our membership – We provide a range of professional development activities that promote contemporary best practice to members including local, regional and national forums for mental health, addiction and disability nurses. Recent conferences include:

- National conference held in Hamilton held on 10 -11 October 2017- *Surfing the Waves* conference http://www.nzcmhn.org.nz/News-Events/2017-Conference
- Wellington Branch Regional Event held on 1 February 2018 and focused on 'Quality'
- A biennial Wānanga 'What is the future for Māori Mental Health Nursing?" held in Porirua, on 7-9 March 2018. http://www.nzcmhn.org.nz/Maori-Caucus/Upcoming-Wananga

- Our board and Māori caucus actively support and promote the development of Māori mental health nursing and work with key partners such as Te Rau Matatini – National Workforce Centre for Māori Workforce development to promote best practice with Māori people.

- Te Ao Māramatanga supports members pursuing a Nurse Practitioner scope of practice by providing mentoring and a small financial contribution via our Rita McEwan fund. We recognise and support the key contribution Nurse Practitioners can make in the sector to improve outcomes and access to services.

- **Professional support to the wider health sector – Primary Mental Health and Addiction Nurse Credential Programme –** Since 2013 we have offered nurses working in primary care settings, a programme of study and assessment, to increase their knowledge, skills, experience and confidence responding to the needs of people presenting with mental health and addictions concerns. This programme has been independently evaluated and delivered with very positive outcomes and demand for additional programmes is growing as word of positive programme outcomes spreads. As funding permits we plan to further develop this programme in partnership with the wider sector. Building the capability and capacity of the primary sector to respond to the mental health and addiction needs of their communities is key to future health care strategy. http://www.nzcmhn.org.nz/Credentialing

- **Professional advisory relationships and links with key stakeholders nationally and internationally** – Our board and membership maintain a diverse range of key sector relationships and are utilised to provide a range of professional advice and representation to both Government departments, professional, workforce and non-governmental organisations. Te Ao Māramatanga will continue to build and sustain relationships with key stakeholders to provide professional nursing expertise such as:
  - Office of the Chief Nursing Officer- Ministry of Health
  - National Directors of Mental Health Nurses
  - Nursing Council of New Zealand
  - New Zealand College of Nurses
  - Royal Australian and New Zealand College of Psychiatrists
  - Health and Safety Quality Commission
  - Te Pou o te Whakaaro Nui- National Mental Health, Addiction and Disability Workforce Centre
  - Matua Raki- National addiction workforce centre
  - Te Rau Matatini – National Workforce Centre for Māori Workforce development
  - Le Va – National workforce centre for Pasifika peoples
  - New Zealand Nurses Organisation
  - Kites Trust
  - Australian College of Mental Health Nurses
  - DANA- Drug and Alcohol Nurses Association
  - PSA- Public Services Association.