Workforce Development and Leadership for the Addiction Treatment Sector

An Environmental Scan and Future Commissioning Priorities

June 2023

Contents

Abstract

There can be no addiction treatment sector without a workforce.

This environmental scan was informed by contributions from the sector and identifies issues that influence service delivery models and workforce planning and development.

These will inform future planning and purchasing priorities for Te Whatu Ora.

The views expressed in this document do not necessarily represent the views or policy of Te Whatu Ora.

4. Findings from the environmental scan (Continued)

1. Executive summary

There can be no addiction treatment sector without a workforce.

If there is to be a workforce with sufficient capability and capacity, there are significant challenges to be addressed in transitioning to the Oranga Hinengaro System and Service Framework (the Framework).[1]

If there is to be effective workforce development to support the sector, there needs to be planning for and delivery of effective workforce initiatives.

Te Whatu Ora has commissioned Atamira Platform to prepare a report on the features and challenges for the addiction treatment sector in Aotearoa New Zealand and their impact on the workforce.

Workforce issues within the sector are not new – they have been identified as a challenge for decades. There has been expansion in some areas of the workforce, including:

- methamphetamine funding
- youth alcohol and other drug (AOD) and co-existing problems (CEP) service development
- an increase in placements and therefore workforce for some residential services
- through programmes such as Te Ara Oranga in Northland
- expanded pregnancy and parenting support services for women with substance use issues.

The present and future addiction treatment workforce is required to deliver the Framework, and a variety of responses are required to ensure there are staff with sufficient capability and capacity.

Implementing the system and service framework will need to occur in coordination with a specific addiction workforce strategy and the provision of ongoing training and development opportunities.

However, there needs to be a realisation that, if the aspirations of the Framework are to be achieved, this will mean commissioning a range of services informed by tangata whai ora wrapped around a small clinical workforce.

There is a risk of looking only to fill shortages and not asking what workforce might be required in the longer term.

Without new funding, there is likely to be some dis-investment in current services to allow investment in new or different services and investment in new or different workforces.

1 Ministry of Health. (2023). Oranga Hinengaro System and Service Framework. Ministry of Health. www.health.govt.nz/system/files/documents/publications/oranga-hinengaro-system-and-service-framework-apr23-v2.pdf

Funding shortfalls should not compromise existing positions over new. New investment will be necessary.

The sector needs to agree priorities and an action plan to direct efforts towards delivering the Framework. This approach needs to be closely aligned with the education sector to develop, deliver and sustain relevant qualifications to attract people to work in the sector and to develop career pathways. The linkage between increasing placements in services before there can be more tertiary training places and more tertiary lecturers and sustainable courses needs to be emphasised and strengthened.

Four approaches are proposed to meet these challenges:

- Commissioning to be with tangata whai ora so that every pathway successfully connects them to a range of response options that they choose from to develop their lived experience wisdom, which enables tangata whai ora to navigate their journey and meet their needs, restoring tangata whai ora to greater mental wellbeing, as defined by them, now and into the future.
- Drive clinical service improvement by addressing staff capacity and capabilities.
- Boost the representation of the community in the addiction treatment workforce, including those with lived experience.
- Improve the collection and coordination of workforce data and information on the addiction workforce.

These approaches will require leadership and coordination across the entire sector.

Priorities were determined by ranking those making the most impact, the effort required and the financial cost to implement in the short term, medium term and longer term.

The priorities are grouped around the following categories:

- **Supporting the existing workforce** by addressing pay equity in NGOs and scale creep, filling vacancies, providing supportive workplace environments and developing a specific addiction treatment workforce development strategy.
- **Addressing how the Māori workforce in the addiction treatment sector can express their tino rangatiratanga and mana motuhake** if the sector is to actively deliver on Te Tiriti o Waitangi.
- **Addressing the pipeline of new entrants**, most importantly by working with the education sector to develop a 10-year approach aligned with the Framework.
- **Promoting leadership and professionalism** at district, regional and national levels to drive system transformation.
- **Promoting a workforce that looks like the communities that services work in** by involving the lived experience workforce at every level of the system and promoting greater diversity through deliberate recruitment strategies.

There will likely be a range of views and expectations of what tino rangatiratanga and mana motuhake mean for the sector, and achieving some kind of agreement early on and applying this will be crucial for long-term success.

Addressing these issues will take great commitment and resources, but their success will transform the way the sector operates and will restore recovery to those it serves.

2. Introduction

2.1 Purpose of the report

Te Whatu Ora is seeking insights through an environmental scan to identify the issues that might influence improved delivery models and workforce initiatives that can deliver the skills and expertise required. This will inform future planning and purchasing priorities.

To do this, Te Whatu Ora is seeking ways that will provide it with relevant and informed perspectives to guide its commissioning. This includes coordinating the leadership within the sector to promote informed views to support improved models of care, service delivery and workforce planning and development initiatives.

For the purposes of this report:

- short term means by 1 July 2024
- medium term means by 1 July 2027
- long term means after 1 July 2027.

The report has been prepared by the Atamira Platform Trust. Platform works with non-governmental organisations (NGOs), including NGO addiction treatment services, that support people and their whānau directly impacted by mental health and addiction.

2.2 Limitations of the report

This report is not a stocktake of current addiction treatment workforce numbers by occupational class or a forecast of how many of each are needed or a demand analysis of service users – but all of these should be considered as part of a future workplan.

People interviewed were asked for their personal opinion/insights rather than as an organisational position. It was not possible to authenticate every subjective opinion expressed in this report, although every view was considered to be held sincerely and sometimes strongly.

It was not possible to interview everyone with a view on workforce issues for the addiction treatment sector. It is strongly recommended that, once Te Whatu Ora has considered the issues and challenges identified through this environmental scan, the report be made available to the sector.

The important intersections and interactions between the addiction treatment sector with primary care (in a very broad sense, not only general practice), mental health and public health and with other government agencies, including the Department of Corrections (both Community Probation and Correctional Services), Oranga Tamariki, Ministry of Housing and Urban Development and Ministry of Education, are acknowledged.

This report did not examine the workforce planning and development of those areas nor the problem gambling sector, addiction research sector or commissioning services themselves. Rather, the report focused on what might be considered specialist or core addiction treatment services such as withdrawal management, opioid substitution, assessment and triage, intervention and residential treatment.

2.3 Definition of workforce development

Workforce planning and development are vital to ensuring the workforce is best able to deliver future services.

A distinction is made between workforce planning and workforce development:[2]

> Workforce planning is the systematic identification, analysis and planning of future workforce needs, based on future population needs and health strategy and policy.
>
> Workforce development is the set of activities that ensure the workforce is best able to deliver future services. These activities are most effective when underpinned by robust workforce planning processes, informed by health strategy and policy.

Te Pou – the national workforce centre for mental health, addiction and disability in Aotearoa New Zealand – has developed a series of resources that are available to support organisations to undertake future-focused, people-centred workforce planning and development activities as part of its *Getting it right* framework. These resources support services to make effective workforce decisions so they are well placed to deliver on health strategy and policy intentions or directions.

The definition used in this project goes beyond the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development and worker wellbeing. In line with recent policy approaches, the project accepts that workforce development should have a systems focus. A systems approach considers targeting individual, organisational and structural factors rather than just addressing education and training of individual mainstream workers.

This approach includes consideration of those factors that enhance supportive working environments and how training is provided in a multidisciplinary setting. Without addressing these underpinning and contextual factors, the ultimate aim of increasing the workforce's effectiveness is unlikely to be achieved.

2 Te Pou. (2023). *Workforce planning and development*. www.tepou.co.nz/initiatives/workforce-planning-and-development

2.4 Methodology

Te Whatu Ora has commissioned Atamira Platform to prepare a report on the features and challenges for the addiction treatment sector in Aotearoa New Zealand and their impact on the workforce. Please note that the views expressed in this document do not necessarily represent the views or policy of Te Whatu Ora.

A desk-top review was undertaken of various national policy documents to provide context on issues affecting the delivery of addiction treatment and workforce development. A questionnaire was developed based on particular themes for respondents. This was then sent to 36 individuals with direct experience of the addiction treatment sector, with many involved in commissioning or delivering addiction treatment services or workforce development services.

Interviews used a semi-structured approach to elicit views and perspectives from the contributors, with interviews being around 60–90 minutes. Some people were interviewed more than once where further information was sought. Statistical data and information were sought from published sources.

Data, information and material from the interviews was collated into a draft report. Priorities were identified and assessed against impact/effort/cost, benefit for who and how many, and short-term, medium term and long-term recommendations. This draft was peer reviewed by internal and external sources before final editing and presenting to Te Whatu Ora.

The main contributors to the report were 33 individuals through 23 interviews.

Note that this report refers to contributors who make contributions rather than submitters making submissions.

As the report has been prepared for Te Whatu Ora, it is assumed that the audience has a reasonable working knowledge of the addiction treatment sector. The report has tried to keep the use of acronyms to a minimum. It is expected that the intended audience understands NGOs to be non-governmental organisations, CEP to be co-existing problems, OST to be opioid substitution treatment and DHBs to be District Health Boards.

The acronym DAPAANZ used throughout this report reflects the original name for the Addiction Practitioners Association Aotearoa New Zealand. The original acronym still widely used in the sector stands for the Drug and Alcohol Practitioners Association of Aotearoa New Zealand.

2.5 Kaupapa Māori services

From 1 July 2022, Te Aka Whai Ora became responsible for commissioning kaupapa Māori services, while Te Whatu Ora commissions mainstream services. It is acknowledged, however, that many Māori service users and their whānau, many Māori working in mainstream services and many kaupapa Māori services will face the same challenges identified in this environmental scan of workforce issues.

2.6 Acknowledgements

The willingness to participate and the insights offered from all of the contributors are gratefully acknowledged. Assistance from the staff of Te Whatu Ora in providing guidance and data and the team at Atamira Platform are also acknowledged and appreciated. A special thanks also to the three external peer reviewers for your useful guidance.

3. Policy context and emerging workforce issues

3.1 Policy context

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction[3] placed an emphasis on service users. The addiction treatment sector needs to have the capability and capacity to respond to the diverse needs of a diverse range of service users now and in the future. Addressing this involves expanding existing services, growing new types of services and supports and developing a diverse and resilient workforce that reflects the community.

He Ara Oranga made it clear that historical systemic issues and resource constraints needed to be addressed and that this will be a significant undertaking that will take many years.

The restructured Health sector (from 1 July 2022) disestablished the DHBs and created new entities responsible for the commissioning and delivery of health services, including publicly funded addiction treatment services and workforce development. The new commissioning agencies – Te Whatu Ora | New Zealand Health Agency and

3 Paterson, R., Durie, M., Disley, B., Rangihuna, D., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Government Inquiry into Mental Health and Addiction. mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Te Aka Whai Ora | Māori Health Authority – are responsible for the delivery of those services in a way that supports the aspirations espoused in *He Ara Oranga*.

Following *He Ara Oranga*, *Kia Manawanui Aotearoa*[4] set out the pathway for growing and supporting a sustainable, diverse, competent and confident mental health and addiction workforce through:

- expanding the mental health, addiction and mental wellbeing workforce across sectors
- transforming the mental health, addiction and mental wellbeing workforce to enable it to respond to people's mental wellbeing needs and to intervene early
- valuing, retaining and supporting strong leadership across mental health, addiction and mental wellbeing.

Kia Manawanui Aotearoa identified the key system enablers – leadership, , workforce, information, policy and technology.

The *Health and Disability System Review – Final Report | Pūrongo Whakamutunga*,[5] which led to the establishment of Te Whatu Ora and Te Aka Whai Ora, stated that workforce development is a key constraint in our current health and disability system. In line with worldwide trends, New Zealand also is experiencing growing clinical workforce shortages. Our system will not be sustainable unless we change models of care and use the workforce differently. While the Review did not recommend immediate changes to workforce regulatory structures, it noted that there are large numbers of different bodies involved in workforce training and regulation. Unless they work effectively together to promote and achieve relevant workforce plans, some tighter oversight may be required in future.

On 28 April 2023, the *Oranga Hinengaro System and Service Framework*[6] was published, setting direction for the future mental health and addiction system and services over the next 10 years. The Framework represents the next step in the transformation to support better mental wellbeing outcomes for all in Aotearoa.[7] It is intended to provide guidance to the health sector on how to commission, design and deliver services so that everyone can strengthen their own mental wellbeing, and when needed, there is a range of quality support grounded in equity, te ao Māori values and what tangata whai ora, whānau and communities tell us they need.

4 Ministry of Health. (2021). *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Ministry of Health. www.health.govt.nz/system/files/documents/publications/web3-kia-manawanui-aotearoa-v9_0.pdf

5 Health and Disability System Review. (2020). *Health and Disability System Review – Final Report | Pūrongo Whakamutunga*. Health and Disability System Review. www.health.govt.nz/system/files/documents/publications/health-disability-system-review-final-report.pdf

6 See note 1.

7 Ministry of Health. (2023, April 28). *New guidance for mental health and addiction system and services*. www.health.govt.nz/news-media/news-items/new-guidance-mental-health-and-addiction-system-and-services

Box 1: Summary of strategies and reports relevant to the project

He Ara Oranga and ***Kia Manawanui Aotearoa*** outline the outcomes sought for people experiencing mental health and substance use issues in a transformed sector.

The ***Oranga Hinengaro System and Service Framework*** drives the structure to deliver the outcomes desired in a transformed sector.

Te Whatu Ora will support this by:

- identifying short-term, medium-term and long-term priorities for addiction treatment sector workforce development
- identifying the funding that is required to deliver those goals
- developing leadership within the sector to inform Te Whatu Ora of opportunities and priorities
- identifying improved channels for Te Whatu Ora to seek and receive advice to inform its commissioning of services.

At the core is an absolute commitment to a mental health and addiction system and all support and services that will recognise and elevate the voices of Māori and tangata whai ora.

Bringing this framework to life will require collective action by the Ministry of Health, Te Aka Whai Ora, Te Whatu Ora and mental health and addiction service providers including hauora Māori partners, lived experience leaders, NGOs and primary health organisations.

Te Whatu Ora and Te Aka Whai Ora will lead the implementation of the framework, beginning with:

- a detailed stocktake/equity map to validate the current landscape
- work on an equitable funding model for various population groups around the country and to identify funding gaps
- a review of which services should be delivered nationally, regionally and locally
- development of an innovation hub and/or national service networks to assist with consistency nationally.

The Ministry of Health will develop a monitoring and accountability framework to track progress towards the future system.

The Framework identifies the core components of a contemporary mental health and addiction system with a 10-year view. It provides guidance for those responsible for publicly funded health system policy, design, service commissioning and delivery. It sets out:

- core principles identified by Māori and people with lived experience that should underpin the system and services
- critical shifts required to move towards a future system that supports pae ora – healthy futures
- the types of services that should be accessible and available to individuals, whānau and communities.

It is not intended to determine how services are delivered at a regional or local level and does not provide detailed descriptions of services, as this will need to be informed by local communities' needs and aspirations.

Te Whatu Ora has also developed a stepped model of care (Table 1) based on three stages:

- Harm has not occurred yet – prevention and early intervention.
- Harm is occurring – addiction treatment intervention needed.
- Mitigating further harm – maintenance and aftercare.

This report focuses on the 'Harm is occurring' portion – not the entire stepped model of care.

The model is currently under development, and does not represent government policy. The model will demonstrate the Framework's proposed approach to treating substance use disorders and reducing harm caused by alcohol and other drugs in Aotearoa New Zealand.

3.2 Emerging workforce issues

During the course of interviewing people for this project, contributors have stated that the present system is not fit for purpose, it is broken and it needs to change. It was felt that there had been a lot written but now there needs to be action. As one contributor put it:

> [We need to have a system] founded on te Tiriti, delivered by peers, in the community and supported by clinical services.

There was a common view that those working in the addiction treatment workforce should be supported to develop their skills and expertise and to be able to deliver services in safe, supportive environments. Those seeking treatment should not feel more stressed by the experience.

The work people carry out in their roles can be physically, mentally and emotionally taxing. It was also evident that:

- there has been significant change in some areas
- the restructuring of service models is still going on
- different models of care for the same services are being implemented
- the intentions of new models of care are not what is being seen on the ground
- positions are being lost
- some services have high vacancy rates
- people are leaving the sector.

Several people commented that the strong focus on primary care and the creation of the health improvement practitioner role and ACC assessors for special claims have had a big impact on an already depleted workforce in secondary care. The benefits of that from an addiction standpoint are yet to be seen yet the cost is already clearly evident.

Concerns were raised that mental health nurses were being recruited to replace specialist addiction workers.

Contributors also commented that people need to feel valued. A priority for Te Whatu Ora is to communicate through various channels to the addiction sector how this change is happening and what it will mean for the services, the workforce and for those seeking help. This means explaining to the workforce how the intended changes will be of benefit

to the workforce to deliver the services. There is a risk that there is a perception of change being done *to* rather than *with* the workforce. There have been previous workforce plans, but it may not be clear to the sector just what has been achieved. To support further change, it will be necessary to demonstrate to the workforce just what the intended improvements will be and whether they are being achieved.

A recent report prepared by Te Pou[8] presents estimates for the 2022 Te Whatu Ora adult alcohol and drug, forensic and mental health workforce based on the Health Workforce Information Programme employee dataset. This report is about the workforce in Te Whatu Ora (formerly DHB) mental health and addiction services for adults (people aged 18 and over), which includes health workers delivering services to people in community or hospital inpatient settings and providing specialist consultation and liaison services to emergency departments, NGOs, general practices and primary health organisations.

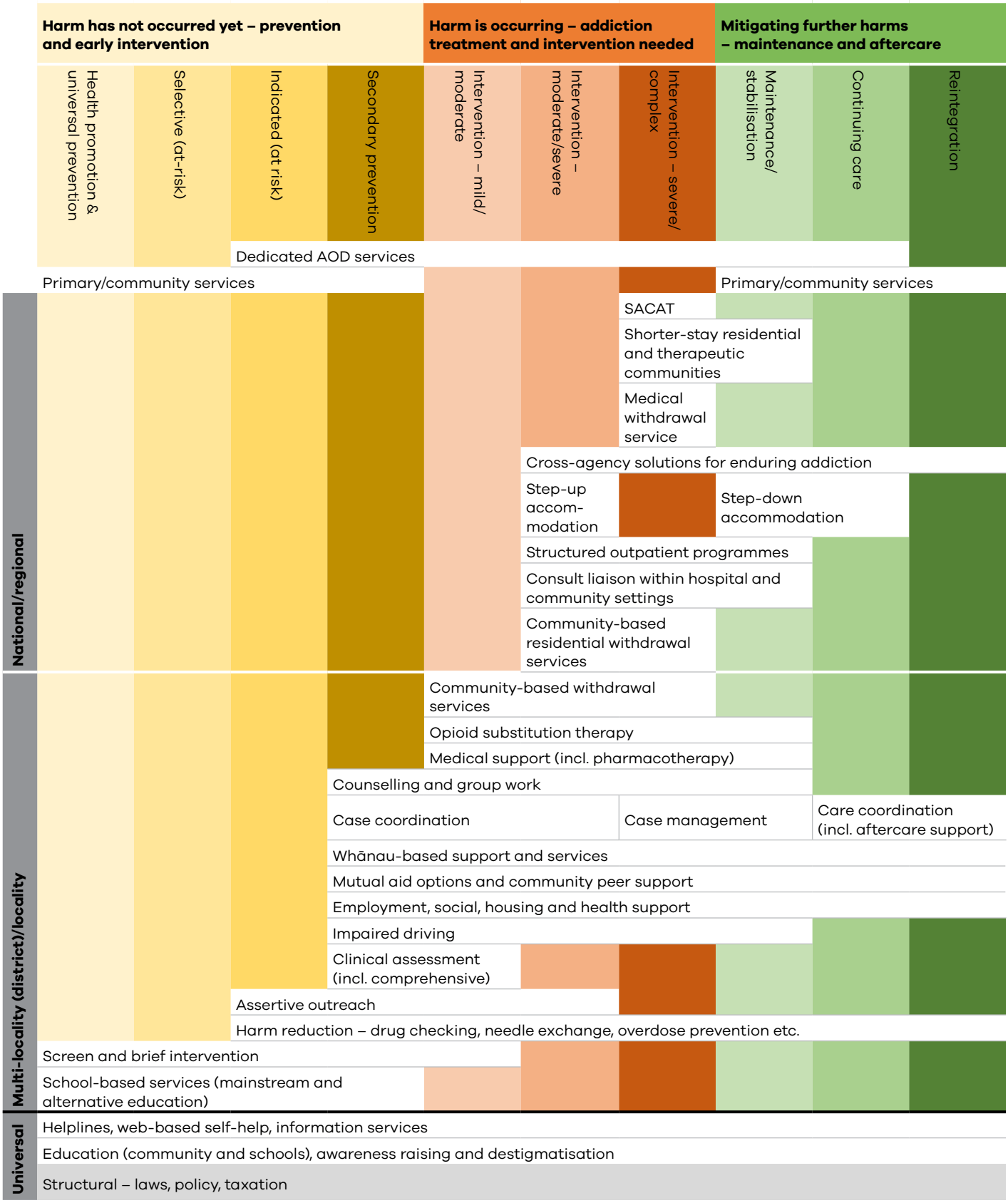
The report estimates the Te Whatu Ora adult alcohol and drug, forensic, and mental health full-time equivalent (FTE) workforce size, vacancies, composition and turnover. It also summarises the age, gender, ethnicity and length of service profile for Te Whatu Ora employees on 31 March 2022. Key findings are that:

- the workforce totals 7,311 FTE positions (employed and vacant) which includes mental health and forensic workforce
- the alcohol and other drug workforce is estimated as 645.0 FTE positions including 574.6 FTEs employed and 70.6 FTEs vacant (11 percent vacancy rate)
- the total workforce is comprised of support workers (15%), registered health professionals (71%) and advisors, managers and administrators (14%).

The report finds some progress towards health policy and strategy goals to grow the workforce size is being hampered by high vacancy rates and recruitment at replacement levels only. A workforce development plan is needed to build sustainable workforce pipelines, increase ethnic and gender diversity, reduce vacancies, increase recruitment and improve retention and address the challenges of an ageing workforce.

8 Te Pou. (2022). *Te Whatu Ora adult mental health and addiction workforce: 2022 alcohol and drug, forensic, and mental health services*. Te Pou. https://d2ew8vb2gktr0m.cloudfront.net/files/resources/Te-Whatu-Ora-workforce-report-2022.pdf

Table 1 Proposed stepped model of care for addiction treatment – draft not government policy



Box 2: Workforce challenges in the NGO addiction treatment sector

A recent Te Pou report on workforce development challenges in the NGO sector made the following conclusions:[9]

- NGOs funded through government health contracts to deliver adult alcohol and drug and mental health (including forensic) services are numerous and diverse.
- They have ongoing challenges that require focused national workforce planning and development.
- An NGO workforce development plan co-designed and co-produced with NGOs is urgently needed. Priorities for this plan include:
  - continuing to grow lived experience, Māori and Pasifika leadership and representation in the sector
  - addressing funding and contracting inequities
  - increasing access to NGO-focused training, supervision and mentoring options
  - addressing recruitment and retention challenges and competition for workforce.
- A planned and coordinated approach to NGO workforce development will support this sector to better meet health policy and strategy goals for a vibrant and growing NGO sector that delivers more of the services people need.[10]

There is some data on the infant, child and adolescent mental health and addiction sector from Whāraurau.[11] ICAMH/AOD workforce highlights for 2020/21 include:

- 66% employed in DHB services and 34% in non-DHB services
- 51% NZ European/Pākehā, 20% Māori, 16% other ethnicity, 7% Pacific and 5% Asian
- 73% in clinical roles and 17% in non-clinical (excluding administration and management)
- 8% vacancy rate (vacancies ranged from 0% to 32%) with vacancies largely for clinical roles
- 19% overall turnover rate (28% in non-DHBs, 14% in DHBs) for support workers, nurses, social workers and psychologists.

9 Te Pou. (2023). *NGO workforce development challenges: 2022 survey of adult alcohol and drug and mental health services*. Te Pou. https://d2ew8vb2gktr0m.cloudfront.net/files/resources/NGO-workforce-challenges-report-2022.pdf

10 Other Te Pou reports on workforce data can be found at www.tepou.co.nz/initiatives/more-than-numbers-workforce-data

11 wharaurau.org.nz

Turnover reasons included external job opportunities for better salaries, relocation to another city/town, internal job opportunities and pursuing further education/career development opportunities. In the survey, both DHB and non-DHB services identified key needs for this part of the sector as:

- recruitment of staff with ICAMH training and experience
- training in therapeutic interventions.

In light of the different needs of young people and how approaches to support young people to recover are different from adults, there need to be different approaches to developing the youth addiction treatment sector.

All this is not to undermine those initiatives already available to support the workforce nor to suggest that there are no new initiatives under way to attract new entrants to the sector.

3.3 An addiction treatment sector workforce strategy

Contributors to this project understood the connection between the Framework and this report on the features and challenges for the addiction treatment sector in Aotearoa New Zealand and their impact on the workforce.

When asked whether there needs to be a specific strategy for the addiction treatment workforce, a majority agreed. These were some common themes:

- Funding for addiction treatment needs to be separated from funding for mental health services.
- Addiction needs its own workforce planning and development in order to make strategy – otherwise we cannot see where we are going or what is expected without a strategy. Such a strategy could fall out of a wider workforce strategy.
- There need to be career pathways in the addiction sector.
- The strategy should be explicit about aspirations, address marginalised communities and require passion of the people in the workforce to drive it.
- The workforce strategy should be co-designed, bringing all the parties together.
- We need to understand where the addiction sector is going.
- Strategies can be too often developed by Wellington, and they can become obsolete.

Responses also said that strategy planning needs to include Treasury and other agencies as strategy is linked to funding, whether for scholarships, incentives or services. To be effective, there will need to be funding for the implementation of the workforce strategy.

Two measures that matter are the training pipeline and supporting the existing workforce. Commissioning needs to address these two issues in the short term as otherwise there is no medium to long term. If these measures are not addressed, in 10 years, everyone will be a generalist.

Contributors said that there are specialities within addiction treatment – for example, OST and withdrawal management. Having skills and competencies in addiction treatment is good, but there also needs to be acknowledgment of the finer skills in OST. A focus on younger people is needed so workforce development is not all adult focused.

Contributors suggested that the addiction treatment sector is sufficiently different from the mental health sector to have its own workforce strategy. A view was expressed that including addiction treatment in mental health has not done addiction treatment many

favours. The question was asked as to what was achieved by the *Mental Health and Addiction Workforce Action Plan 2017–2021*.[12] That question would be best answered by Te Whatu Ora.

Contributors were not averse to having a specific addiction workforce strategy sitting alongside wider workforce strategies – for example, for mental health and CEP. The strategy could be limited to addiction treatment sector only (specialist area) or could be embedded in other services. Not everyone wants to be a generalist, and the sector needs to increase the number of specialists. People can move between roles as part of their career pathway. The strategy could include CEP, but anyone working in addiction treatment should consider this anyway.

The idea that simply offering more graduate programmes and training opportunities will accordingly increase the workforce is not supported. There are so many competing options available (especially in the health professions), and the addiction treatment sector will simply be competing for a larger slice of a finite pool where other professions might be more attractive. Actively offering incentives designed to deliberately increase the workforce or promoting certain programmes of study was considered to be a good start.

There were also alternative views to having a specific addiction workforce strategy. Common themes were that:

- a range of roles/professions will encounter addiction so we need an addiction and CEP workforce strategy to work at a number of levels
- the strategy should include CEP
- alcohol-related health issues, especially physical health issues, also need to be considered
- we need a more balanced approach
- maybe take a behavioural approach rather than mental health and/or addiction
- service users recognise that a behavioral change is needed – one contributor said of service users "it's about learning to change what I do, not changing me" – which would be the same for gaming, gambling or other addictions
- addiction treatment skills/understanding should be embedded in other workforces such as Corrections and other health professions such as nursing.

Some contributors thought there needs to be something specific for some workforce groups in the sector.

One contributor said that, through having had close relationship with some addiction providers, the view that addiction is special feeds into a narrative that addiction treatment is different, but addiction treatment needs to be considered as part of a broader sector.

Another suggested that there is a balance between being the "stars" and being precious. Others thought there needs to be consideration wider than core addiction treatment only, as there is real risk of siloing ourselves, and there is a need to develop a set of skills/competencies that are transferable to a range of settings.

Another contributor said that an addiction workforce strategy would have to identify just

12 Ministry of Health. (2018). *Mental Health and Addiction Workforce Action Plan 2017–2021*. Ministry of Health. www.health.govt.nz/system/files/documents/publications/mental-health-addiction-workforce-action-plan-2017-2021-2nd-edn-apr18.pdf

what is the workforce that would be covered in such a strategy. If for core services only, this would be for approximately 1,500 people, so quite small. Also, if for core services only, the strategy should recognise that people will be upskilled over a career and may go back and forth out of the core – for example, by stepping away from the frontline to teaching roles or policy work but still use addiction treatment skills and expertise.

Based on views and information gathered for this report, it is proposed that the objectives of a workforce development strategy for the addiction sector over the next 10 years would have the objectives to:

- support those workers remaining in the adult and youth addiction treatment sector by addressing vacancies, gaps and shortages in the localities and districts as identified by the detailed stocktake/equity map and by providing training opportunities
- support Māori kaimahi to express their tino rangatiratanga and mana motuhake
- increase diversity
- develop professionalism and leadership in the sector
- address the pipeline of new entrants through closer alignment between commissioning agencies, employers, workforce centres and peak bodies with the education sector
- address the challenges of an ageing workforce
- collect, coordinate and apply workforce data and information.

Aspects of these objectives are discussed in the next section of this report.

An addiction workforce strategy would be expected to drive the development of a capable workforce with the capacity to deliver the outcomes within the new system by explaining what is proposed to be done, how it is being done and what has been achieved. There should also be clear accountabilities.

Such a strategy could be aligned with a similar strategy for the mental health workforce.

It is clear that workforce issues in the addiction sector have been around for some time, and while people are hopeful of change, there is a feeling of resignation that nothing is about to change for the better.

There needs to be a single driving force or single point of accountability for ensuring the availability, capacity and capability of the addiction treatment workforce.

4. Findings from the environmental scan

4.1 Environmental context

An environmental scan of the sector informed by interviews with sector representatives has identified several features of the addiction treatment sector and some of the challenges that are impacting on the workforce. These are discussed in this section.

The features and issues are not presented in priority order – many are interrelated and should be considered as a whole to give a wide perspective.

4.2 Snapshot of the addiction sector

Box 3 gives a high-level overview of the addiction treatment sector in Aotearoa New Zealand.[13]

13 Sources: Ministry of Health, Te Whatu Ora, Te Pou, Whāraurau.

Box 3: The addiction treatment sector in Aotearoa New Zealand

The understanding of current prevalence of mental health and addiction issues is limited, but self-reported levels of distress are increasing.

Mental health issues and substance-related harm start early in the life course and have lasting impacts.

Over the past 5 years, an average of 49,370 people were treated each year by publicly funded addiction treatment services – 16% of those people received treatment from more than one service

The FTE workforce in adult services is approximately 1,594 FTE positions employed with a vacancy rate of 10%, and the vacancy rate for youth services is over 8%. The national average vacancy rate obscures very high vacancy rates in some services.

Since 2018, the FTE workforce size grew by 6%, which is about the same as the population.

Investment in alcohol and other drug services is relatively low at 12% of investment in *Oranga Hinengaro* services.

Peer services and lived experience leadership investment remains low and inconsistent nationally.

$108.1 million was invested in NGO addiction services in 2021/22.

$105.2 million was invested in national provider arm services in 2021/22.

In 2023, Te Whatu Ora will be managing addiction treatment-related contracts, involving more than $213 million.

4.3 Features and challenges of the current addiction treatment sector in Aotearoa New Zealand

Why people work in the addiction treatment sector

Contributors were asked why people choose to work in and to remain in a sector that, on the face of it, does not always look that attractive.

Common themes among the responses were that:

- some people have some connection to the sector, either through their own issues or a family member, and are wanting to help others
- some may have a strong service ethic, wanting to give back
- for some, it may be a religious vocation
- for others, there may be a strong sense of social justice and wanting political change
- some people, especially overseas applicants, may be looking for a supportive employer to enter the workforce

- people may like the intellectual challenge of working in the addiction treatment sector as it requires good clinical skills and it is about what is real in someone's life – the work is dynamic, not boring
- there are more people working in the addiction sector with lived experience of addiction than people working in other sectors with experience of that condition.

One contributor said that it was where they could study towards a university degree. However, this is now much more limited as training institutions offering addiction-related degrees are in fewer locations and not always in the main cities.

Another contributor could not get a job after university and fell into the sector, saying people learn how to be part of it and have a love for it.

One contributor observed that mental health nurses often realised that the people they were working with had substance use issues and migrated into addiction treatment.

Another contributor noted that it was not for money, prestige or status.

One contributor noted that people do fall into the sector, but there are lots that leave again. This depends on leadership within the service. Little NGOs cannot compete salarywise but can emphasise cultural practice, be values based and have whānau-based approaches. These are big motivators.

The addiction sector is born out of experience, one contributor commented, and so people often come into the sector later in life, bringing a degree of maturity. Some come in intentionally and some unintentionally but become passionate about the work and the people.

People who stay in the sector in some instances may not have been able to move if they wanted to, and those who leave are in demand due to their expertise and quality.

Discussion around what makes the sector attractive led to views about what makes supportive workplaces.

Supportive workplaces were seen as not only about supporting people to access training and education opportunities but also whether people had opportunities to develop themselves and would, for example, allow people to reflect on their practice and how they can improve. The opposite to this was being risk averse and to just go through the functions. For Māori staff, it might mean appreciating that they are often called on to step outside of their work role and being allowed to do this in a meaningful way. It was also reported that some new graduates feel supported for the first year or so but not after that, which can lead to them being discouraged and leaving.

One contributor mentioned a survey of why people leave their service (in a large DHB). Retirement was the main reason (over 50% of leavers), some because of personality conflicts and some because of COVID-19. For some staff, especially those coming from residential treatment, harm reduction rather than abstinence could be an issue. Also, some people left because service users were becoming more complex.[14]

Contributors said that people need to be paid properly. The sector is losing people who become health improvement practitioners and to private practices. Some services cannot get psychologists, allied health workers and others.

Contributors said that part of being a supportive workplace involves supervisors and team leaders who are aware of someone's workload – if the person is good, they can

14 The point about increasing complexity of cases raises whether addiction services use any tools to measure this. There are tools used in hospitals to measure this, for example, by nursing staff. For workforce planning purposes, this could be a useful development.

get all the difficult cases, There should be a mix of complexity in the cases to avoid "compassion fatigue" and to keep the work rewarding.

Taking up study while working can be incredibly hard on individuals and their home life. There are academic support services such as Te Rau Puawai[15] – a partnership between Health Workforce NZ and Massey University. Over the last 20 years, it has helped more than 400 health workers into the Māori mental health workforce. It gives bursaries and learning support to students who want to begin or complete a Massey University qualification. Te Rau Puawai does not deliver any courses – instead, it provides a scholarship and learning support including an academic mentor, an academic support tutor, individual learning and personal support, help with course planning, an essay writing and study skills workshop, access to Māori community and student networks, visits from its team to a student's home or workplace and access to Te Rau Puawai whānau – a network of students from Kaitaia to Invercargill at all levels in Māori mental health-related areas.

Contributors suggested that addressing pay inequities across the country and across services, including between former DHB services now part of the national addiction treatment providers network and NGOs, would be expected to make working in the sector more attractive. Returning to previous staffing levels that have been lost to cost cutting was suggested by one contributor.

As well as providing leadership and supervision training, three practices involving education that might be useful to retain staff[16] are:

- providing a challenging project
- checking that managers/supervisors can teach
- provide training – but always follow-up and support.

If commissioning is to be different and to be innovative, there may well be opportunities for staff to be involved in challenging projects. DAPAANZ is working to improve training for supervisors, so this should help how they relate to those being supervised. Training either for individuals or teams should be considered in the context of their present work. An example was given where a team wanted advanced cognitive behavioural therapy training but this was not relevant to their role.

Preparation before training and being able to apply learning post-training help cement that learning into practice. What will be important for future consideration is to enhance the ways that individuals working in the sector can feel that they are valued, they are making a difference and they are being of service.

Some substance use patterns change, some stay the same

Shifts have occurred in patterns of consumption and the types of substances consumed such as new psychoactive substances, while alcohol, methamphetamine and cannabis remain the main drugs of choice. Aotearoa New Zealand experiences the problematic use of alcohol and other drugs across the whole life span – it is not only a youth issue. There is greater awareness of trauma and co-existing substance use with mental health disorders

15 Massey University. (2023). *About Te Rai Puawai.* www.massey.ac.nz/student-life/m%C4%81ori-at-massey/he-ringa-%C4%81whina-tauira-m%C4%81ori/te-rau-puawai-m%C4%81ori-mental-health-workforce-development-programme/about-te-rau-puawai

16 Horrobin, C. (2023, April 19). *Should I stay? Only if I grow: Three tips for using learning to retain your people.* www.stuff.co.nz/business/opinion-analysis/300845839/should-i-stay-only-if-i-grow-three-tips-for-using-learning-to-retain-your-people

and greater awareness of foetal alcohol spectrum disorder, child protection and family-sensitive practice issues. New effective preventive measures such as drug checking have been introduced, while the importance to public health of needle exchange services is ongoing. Initiatives such as Access and Choice[17] recognise the wide variety of sectors and workers involved in identifying and reducing alcohol and other drug-related harm.

Advice from the New Zealand Drug Foundation is that there are new drug variants arriving all the time. In 2023, cocaine use is surging. Routes of administration are also changing. New potent opioids and overdoses are an issue. Patterns of use over COVID-19 lockdowns and since were more 'dissociate' types of drugs, often benzodiazepines, and some of these have higher potency than previously with limited ability for someone to taper off use.

This quickly changing scene means addiction treatment services need to be alert and agile – people with novel drug-use patterns may not be able to quickly access services or may not fit easily within current treatment options even if they do approach services.

These patterns of use and the broader settings will require different workforce requirements in a new model of care. There is a need to consider what are core addiction treatment services and to strengthen these to avoid creating more pathways leading to a dead end as treatment services are unable to cope with the increased demand, exacerbating wait times and increasing staff dissatisfaction. Treatment may begin in primary and community settings, with specialist services receiving the more urgent, acute and complex cases. Having training in managing addiction issues for other workforces should help.

Inequity and reducing discrimination need to be addressed

In Aotearoa New Zealand, people have differences in health that are not only avoidable but are unfair and unjust. Māori men and women do not live as long as others and have poorer health in general, and there are 'postcode' lotteries regarding the availability and accessibility of particular services. Data over the past 20 years from the Youth2000 survey series has found rangatahi Māori consistently have poorer health outcomes when compared to Pākehā youth.[18] Communities such as Māori, Pacific, people with disabilities, and refugee and migrant communities experience greater inequities to accessing addiction treatment.

Through their commissioning roles, both Te Whatu Ora and Te Aka Whai Ora will seek to address such inequities. This may require considerable effort, time and investment.

Any approach that places the service user and their whānau at the centre will need to address the issues of stigma and discrimination. While this may be uncomfortable for some, it needs to be addressed.

Stigma can be experienced in three broad categories:[19] personal stigma, structural stigma and societal stigma. These forms can all simultaneously exist or may occur at different times and in different settings.

17 www.wellbeingsupport.health.nz

18 University of Auckland. (2022, August 26). *Health inequities at large for rangatahi Māori*. www.auckland.ac.nz/en/news/2022/08/26/health-inequities-at-large-for-rangatahi.html

19 New Zealand Drug Foundation. (2015). *Scoping of a destigmatisation programme on drug use and drug dependence: A report for the Ministry of Health by the New Zealand Drug Foundation*. New Zealand Drug Foundation.

Suggestions that can be incorporated into the development of models of care as part of a specific programme to reduce stigma and discrimination include:

- education and training around stigma and discrimination for clinical workers and administrators delivered by consumers – for example, Addictions 101 training
- stories of change from people in recovery
- supervision and support for clinicians provided by consumers to help them have a better understanding of recovery
- a stronger focus on recovery that includes assistance with finding employment and housing
- auditing and monitoring to include measures based on reducing stigma and discrimination
- auditing of treatment workers' competence against stigma and discrimination
- workplaces utilising employee support services to better understand stigma and discrimination.

The impact of such approaches is through understanding stereotypes and bias. People challenge their own stereotypes and become more reflective and more critical of discrimination.

Central to the vison of a transformed treatment system and the services that make up that system is expanding access and choice across the range of addiction treatment services so that all New Zealanders can obtain the care and support they need, when and where they need it.

Te Tiriti as the foundation of service

A central aspect of the *Oranga Hinengaro System and Service Framework* is the Crown's obligation to uphold Te Tiriti o Waitangi. Meeting the collective obligations under te Tiriti is necessary to achieve pae ora – healthy futures. The Crown has a responsibility to enable Māori to exercise authority over their health and wellbeing (under article 2 of te Tiriti) and achieve equitable health outcomes for Māori (under article 3) in ways that enable Māori to live, thrive and flourish as Māori (Ritenga Māori declaration, commonly referred to as the fourth article).

Section 7 of the Pae Ora (Healthy Futures) Act 2022 outlines the principles that apply to the health sector and describes key outcomes and actions intended to meet our responsibilities under the articles of te Tiriti as articulated by the courts and the Waitangi Tribunal. The Waitangi Tribunal's *Hauora* report[20] recommends a series of principles applicable to the health system, which will therefore be key to implementing the Framework. Those principles are:

- tino rangatiratanga
- equity
- active protection
- options
- partnership.

20 Waitangi Tribunal. (2023). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575). Waitangi Tribunal. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_195476216/Hauora%202023%20W.pdf

Contributors were asked what honouring te Tiriti looks like in the addiction treatment sector.

Comments from contributors included that the establishment of Te Aka Whai Ora was something to be celebrated rather than being seen as a threat. Māori are more than a "special interest" group. A Māori cultural perspective needed to be in everything, with the application of Māori tikanga and mātauranga Māori.

It was also evident from the discussions that there are concerns and tensions to how Māori staff working in mainstream services can express their tino rangatiratanga and nana motuhake. There are those with aspirations to form their own professional organisation and to develop the Māori Addiction Centre, Te Whare Tukutuku. However, this may be viewed by some as "separatist".

It is critical and urgent that the leadership in Te Whatu Ora and Te Aka Whai Ora address these views and develop a way forward where the strengths of many improve outcomes rather than dividing the sector.

There will likely be a range of views and expectations of what tino rangatiratanga and mana motuhake mean for the sector. Achieving some kind of agreement early on and applying this will be crucial for long-term success.

For some contributors, honouring te Tiriti as the foundation for service should be the starting point for any organisation. There should be an expectation that people are demonstrating their commitment. Contributors said that supporting Māori supports wider aspirations for equity at individual and collective level, there should be a basic expectation for services to have bicultural capacity and showing their commitment could include Te Whatu Ora looking at the populations accessing their service and prioritising those that demonstrate commitment. Priority should be to kaupapa Māori services first, then those services demonstrating cultural commitment. However, several also said that they needed to be better.

Notable in seeking how services are committing themselves to te Tiriti is the approach being taken by HealthCERT with the updated Ngā Paerewa – Health and Disability Services Standard (NZS 8134:2021) for use under the Health and Disability Services

(Safety) Act 2001. HealthCERT worked with Te Apārangi: Māori Partnership Alliance[21] to ensure Māori participation and decision making span across HealthCERT and Regulatory Assurance teams' work programmes. Section 1.1.4 of the old standard was replaced by the new section 1.1 Pae ora healthy futures, which outlines service providers' responsibilities under te Tiriti in the context of the services they are providing. This is a new part of the standard designed to empower Māori to know what outcome or experience of service provision each section entitles them to as tangata whenua. Te Apārangi additionally authored 34 criteria throughout Ngā Paerewa, which further embed the principles of te Tiriti in how services are provided. These criteria are underpinned by sector guidance, which Te Apārangi drafted, and includes links to te Tiriti training, tools and resources to support providers as they begin to implement these updated requirements.

Other contributors discussed the issue of equity for Māori. For mainstream services, this means bringing a Tiriti lens to their work. It is about giving Māori staff opportunities, but also Board composition needs to include Māori representation as well as senior management teams. There needs to be a long-term approach to meeting the needs of everyone, including Māori. This strategic approach has to start with how we are approaching equity. Other contributors said it is easy for mainstream to think it is just about getting more Māori staff, that this doesn't appreciate attitudes or bias and there is a need to get equity to the core of activity.

What mattered in the past, still matters – involving kaumātua, helping people when they are out of treatment, nurturing people and providing necessities like kai.

Two contributors noted that, as the sector has become more qualified, it has lost its "Māoriness" in a professionalised workforce. Much of this professionalisation was considered to be influenced by American approaches. The question was asked, "Where is the care, compassion and heart?" Both thought the present addiction treatment system was too constrained and cannot be fixed as it is not fit for purpose. They felt that a whole new way is required driven by tangata whenua. There needs to be a change in the narrative (away from deficits and moralising), taking a wider perspective to include community, housing and mana motuhake.

Concerns were also raised that Māori staff are not paid as well as others. At the same time, there were expectations put on them because they are Māori – for example, performing opening and closing karakia and arranging pōwhiri. Māori leaders in the sector have been called "separatists". There are concerns that people are being invited to be on committees and advisory groups because they are brown. It is tough on Māori staff who are not allowed to be who they are. Contributors would like to see the Pākehā workforce have confidence to work with Māori and whānau.

In response to what a good addiction treatment service looks like for Māori, it was suggested that this involves care and trust and that the workers are like service users. For example, in a new space for someone, it might take 6 months for them to trust the service. Services need to take the time to learn the person's whanaungatanga and whakapapa. This should be done in a way that is mana enhancing – we need to hold people until they can hold themselves. For some contributors, it is about what the person needs, not what suits the service. It's about kanohi ki kanohi, not moralising.

21 www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standard/resources-nga-paerewa-health-and-disability-services-standard/te-aparangi-maori-partnership-alliance

Other contributors said that Māori will be the judges as to how well services are doing. Creating culturally competent services can be challenging because it should be seen in the context of working with others, not because someone has to be culturally competent. Mainstream services should not expect Māori to step in, as Māori services have their own work to do.

For youth services, one contributor noted that services are seeing a growing population of mixed heritage who have different experiences. This allows for young people to stand between two cultures, not having to pick one, so they can be authentic in both. Services need to be responsive to this. In Māori for Māori, culture can be protective, and with partnered approaches, it is OK to be of both cultures.

An example was provided for how workplaces can be more supportive of Māori staff. In this case, Māori staff were granted up to 5 days' paid tangi leave. While it took a while, eventually the executive team of that service accepted why it was important for Māori to be able to attend tangi for a number of days.

It was appreciated that there are a small number of Māori staff who are often called on to step outside of their work role but the question was how are we building expertise if we keep calling on the same people? We seem to call on a small group to help deliver/develop initiatives.

One service noted that it had progressed from having one cultural advisor to having developed a wider Māori team, wider tikanga. There are now Māori and Pasifika clinical leads and whānau advisor roles. This has required significant investment. However, treatment is still a very Western model. In some cases, voices of te mātauranga Māori are not coming through loudly and consistently.

It must be acknowledged that there are service models of bicultural practice that are effective and where Māori are respected and valued and where there is collective responsibility in tikanga and kawa.

A contributor said that, to attract more Māori to work in the addiction treatment sector, there needs to be an identifiable pathway from school – there needs to be greater recognition of 'social service' roles, not just the business ones, and for Māori to be valued. To be retained means providing hope and having succession planning with someone to pass the knowledge on to.

Delivering mana-enhancing services

Mana holds a special place in the culture of Aotearoa New Zealand.

The concept of mana-enhancing services is now legislated for in the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and is being considered wider than only Māori provider services.

Mana-enhancing services involve:[22]

- providing care that is respectful and includes traditional models and practices relating to wellness and healing – Māori concepts of health and wellbeing can be described using the holistic Te Whare Tapa Whā model, and supports such as mirimiri, rongoā Māori and karakia may be helpful to improve general wellbeing and reduce distress

22 Huriwai, T., & Baker, M. (2016). *Manaaki: Mana enhancing and mana protecting practice*. Te Rau Matatini. terauora.com/wp-content/uploads/2022/04/Manaaki-Mana-Enhancing-and-Mana-Protecting.pdf

- recognising family and the importance of family as core cultural considerations
- recognising the role of history and past trauma in shaping people's health and experiences of health care services
- working towards a workforce that mirrors the ethnicity of those receiving care
- personnel reflecting on their own assumptions and positions of power in the health care system and taking a position of continuous learning in relation to understanding other people's experiences, recognising each individual as an expert in their own experience.

There needs to be more help available to inform and guide mainstream services as to how to implement mana-enhancing approaches and a framework for services to show how they can demonstrate they are delivering mana-enhancing services.

Improving the patchwork of service coverage

There is a wide range of substance use/addiction-related services available in Aotearoa New Zealand, including:

- self-help – for example, through helplines, web-based and e-mental health and substance use information and services
- public health – health literacy and awareness, drug checking, needle exchange
- primary care – brief intervention in community settings and frontline services, pharmacies
- assessment and intervention – community-based outreach and inpatient services
- crisis and acute support/intervention
- emergency and general hospital/hospice and palliative care/pain management
- secondary/hospital-based services
- a range of managed withdrawal options, including medical inpatient, social and community-based withdrawal
- residential care including therapeutic communities
- opioid substitution treatment
- pregnancy and parenting support for women with alcohol and other drug issues
- Alcohol and Other Drug Treatment Courts
- impaired driver treatment services
- recovery/community support and related integrated support and care
- services for those people with physical or cognitive impairment associated with substance use, which may be chronic, permanent or acute (symptomatic of intoxication)
- respite and relapse prevention services (staying well).

While this appears to be comprehensive (and there may be more to add – for example, specific services working with older people and services solely focused on addiction service audits), the availability and accessibility to such services across the country is highly variable.

An important aspect of the *Oranga Hinengaro System and Service Framework* and the commissioning of services will be to acknowledge this patchwork of services. This includes determining which services to prioritise and which workforces to grow without undermining other services – for example, introducing a service that has previously been unavailable may attract staff to apply from other local services with consequential impacts.

However, there needs to be a realisation that, if the aspirations of the system and services framework are to be achieved, this will mean commissioning a range of services informed by tangata whai ora wrapped around a small clinical workforce. There is a risk of looking only to fill shortages and not asking what workforce might be required. There may be some dis-investment in current services to allow investment in new or different services and investment in new or different workforces.

Addressing internal and external competition for a limited workforce

It has long been a complaint from the NGO sector that it is a training and development ground for staff, only to lose them to national provider arm services for better pay and conditions.[23] It was also suggested that the NGO sector is able to provide rewards and incentives that are unavailable to public sector services.

There is also competition for the addiction workforce from other agencies – for example, the Department of Corrections, ACC and private practice. At the Addiction Leadership Day held in Wellington in March 2023, concerns were raised by some participants that the roll-out of the Access and Choice initiative, with more attractive pay rates, had resulted in staff transferring to the new services.

There has also been international competition when various Australian states have boosted investment in more mental health and addiction services. Much has been made recently of Kiwis living in Australia being able to gain citizenship after 4 years. The potential impact of overseas recruitment is hard to quantify. It is also worth noting that Aotearoa New Zealand has recently developed initiatives to attract overseas workers to the mental health and addiction sector here. This brings concerns about how overseas workers might not accept or understand cultural practices here. However, the big question remains not only for the addiction sector but across the health system as to how to address the attrition rate as workers retire or leave the sector for other reasons.

Making the addiction treatment sector more visible

Funding for addiction treatment services, the size of the workforce and the number of people seen for substance use are blurred because of the various service configurations, because service coding is not used uniformly around the country, limiting the reliability of the analysis, and because addiction treatment data is gathered into other categories with adult and youth mental health services, co-existing problem services and other workforces. Funding for addiction can also be blurred with other services, and how that funding is being used may not be transparent.

The Te Whatu Ora financial reporting system does not have addiction practitioner/addiction counsellor as part of its occupational database. Instead, there is one account code (2454) shared with social workers. In the financial reporting system, the addiction treatment workers are invisible – this also inflates the numbers of social workers and indicates there are unregistered social workers in the system. It is hard to identify gaps, training needs, registration issues and so on. There is a youth addiction account code but not one for those working in adult services, which is likely to be most national addiction treatment provider arm staff.

23 See note 9.

In the *Workforce Taskforce Update #3*, the Allied Health, Technical & Scientific Working Group advised that it had established:

> 20 profession steering groups that will feed into the National Workforce Development Plan and make recommendations to the National Workforce Taskforce for a more sustainable workforce pipeline to support the local growth of these professions as well as collective recommendations across Allied Health professions to increase the visibility of and interest in these professional pathways. Each of the steering groups will engage with a range of relevant stakeholders, including unions and key sector groups throughout their mahi.
>
> The initial profession steering groups are anaesthetic technicians, sonographers, cardiac & clinical physiologists, medical imaging technologists, radiation therapists, oral health therapists, laboratory technicians and scientists, physiotherapists, speech language therapists, occupational therapists, dietitians, paramedics, optometrists, pharmacists, podiatrists & orthotists, psychologist, audiologists, and social workers.[24]

It is hardly surprising then that addiction practitioners are not even in the first 20 allied professionals to be considered if there is no recognition of them or addiction peer and consumer roles. It should be a matter of concern for Te Whatu Ora to address this. Similarly, there is no code for peer and consumer roles as they sit in the code for community support workers. Again, these are not service specific so it is hard to quantify any gaps in addiction specifically as the code will be used in other settings too such as mental health.

A further example relates to psychiatry. Through additional 2-year+ accredited placement and training (either before or after Fellowship with the College), psychiatrists can obtain a Certificate of Advanced Training in Addiction Psychiatry. This addiction

24 Te Whatu Ora & Te Aka Whai Ora. (2023, March 10). *Workforce Taskforce Update: Issue no. 3.* (p. 7) www.tewhatuora.govt.nz/assets/Whats-happening/Work-underway/Taskforces/Workforce-Taskforce-Update-10-March-2023.pdf

scope is recognised by the Royal Australian and New Zealand College of Psychiatrists.[25] Trainees come through this pathway now – so much so that provider arm services can afford to employ those psychiatrists willing to undertake addiction training. Other (non-psychiatrist) specialists (such as general practitioners, physicians, gastroenterologists who are all Fellows of various Colleges) can apply to the Royal Australasian College of Physicians to undertake a 2-year addiction training programme and, if passed, are awarded a Fellowship of the Australasian Chapter of Addiction Medicine (FAChAM).[26]

While FAChAM is recognised in Australia as a specific vocational scope and doctors can call themselves addiction specialists (and are remunerated accordingly), it is not recognised as a scope of practice in Aotearoa New Zealand.

Because it is not recognised as such by the New Zealand Medical Council, it is not attractive as a career pathway, and doctors must have oversight and supervision by an addiction psychiatrist. This is very challenging for trainees and is a further disincentive to commence training in addiction medicine. Other advanced specialities such as pain medicine, public health and sexual health have registrar positions.

This is something for Te Whatu Ora to address that could make a meaningful difference and would likely promote a career in addiction medicine as being more attractive.

It should also be stressed that Te Whatu Ora's support should extend beyond this – for example, by supporting placements for trainee registrars in psychiatry and general practice into addiction treatment services.

Contributors also recommended that careers in addiction treatment need to be widely promoted as a viable option for school leavers and undergraduates – "If you can't see it, you can't be it." If people, especially young people in education, are not aware of what careers in addiction treatment can offer, they will not likely consider this as an option.

Addiction treatment involves many occupational groups

The addiction treatment sector involves many disciplines and occupational groups sometimes working in multidisciplinary teams, which can include peer support workers, case managers, substance use counsellors, social workers, psychologists, psychiatrists, nurses, doctors, pharmacists and others.

The are several benefits of working in such multidisciplinary teams:[27]

- Various services and resources can be offered to a range of service users with different backgrounds, experiences and issues.
- A multidisciplinary team takes a holistic approach that looks at and cares for the whole person rather than only the substance use.
- Multidisciplinary approaches can be efficient for service users as the point of contact is usually one team or organisation that might offer a variety of services. If a service user needs to be referred to professionals for specific services, they are already given access to a range of other services within the multidisciplinary team itself. If the service does not directly offer the service, it can refer the service user to other trusted

25 www.ranzcp.org/pre-fellowship/about-the-training-program/certificates-of-advanced-training/addiction-psychiatry

26 www.racp.edu.au/about/college-structure/adult-medicine-division/australasian-chapter-of-addiction-medicine

27 Willingness. (2021, March 16). *5 benefits of a multidisciplinary approach*. https://willingness.com.mt/5-benefits-of-a-multidisciplinary-approach

professionals or organisations that work alongside them. This contributes to a speedy referral process and leads to minimised delays and less time searching for the right professional, planning, scheduling and driving around.

- It assists with continuity of care whereby care is offered and given from different perspectives, progress is monitored, access to needed services or professionals is facilitated and any transitions needed can be facilitated too.
- In a multidisciplinary approach, service users are given the opportunity to create goals for themselves, which motivate them to work towards achieving their desired outcomes.
- Different professionals who actively collaborate and work together with the aim of clearly addressing the needs of service users and the community not only strengthen health systems but also enhance clinical and health-related outcomes.
- With improved outcomes, service users gain increased satisfaction as they are being treated and cared for holistically and effectively.
- Professionals may experience more satisfaction working together instead of alone and may learn more about how their own speciality can interact with those of others.

To ensure optimum functioning of the team and effective outcomes for service users, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined.[28] This requires:

- establishing an inclusive and responsive team culture
- the best use of the skill mix within the team
- agreed clinical governance structures
- agreed systems and protocols for communication and interaction between team members.

However, there can be challenges and barriers to working this way,[29] including:

- conflicting or unclear roles and responsibilities
- lack of trust or respect between team members
- differences in communication styles, expectations or cultures
- a lack of resources, time or training to support effective teamwork
- ethical dilemmas or confidentiality issues related to sharing information or making decisions
- burnout or stress due to high workloads, emotional demands or vicarious trauma.

While many occupational groups contributing to aspects of assessment, treatment and recovery can be a strength, there are also many different models of care operating in Aotearoa New Zealand, so it is not easy to determine if this multidisciplinary approach is being optimised. It is also not an easy task to provide coordinated and joined-up workforce planning and development for such a multidisciplinary sector, whether for occupational groups or collectively as a system.

One contributor offered that, with many disciplines in the addiction sector, there can be multiplicity of roles and also a hierarchy that can alienate other views. The view was

28 NSW Health. (2014, January 28). *Multidisciplinary team care.* www.health.nsw.gov.au/healthone/Pages/multidisciplinary-team-care.aspx

29 LinkedIn. (2023). *What are the challenges and benefits of working in a multidisciplinary team for case management?* www.linkedin.com/advice/3/what-challenges-benefits-working-multidisciplinary

expressed that addiction treatment can be hampered by a medical model. Instead, it needs to operate as a health and social justice model, recognising wider parameters. For example, if a person is frequently seen in a service, staff need to understand what else is required to address basic life necessities. However, it was considered that a big issue is that services are not funded for pre- and post-treatment services. People with lived experience can support this.

Workforce planning and development involves many agencies

Multiple agencies, providers and professional regulators are involved in workforce planning and development for a small addiction treatment workforce of approximately 1,500 FTEs. It is less obvious how there is any comprehensive, integrated plan to bring all these perspectives into one view of a workforce strategy for the addiction treatment sector. There is a risk that, without a single coordinated plan, these multiple approaches will result in mixed messages to frontline workers, overlaps, gaps and competition for funding.

One contributor felt there was a distinction to be made between workforce development and professional development. Workforce development means addressing staff/skills shortages to get people qualified, while professional development means people already qualified remaining skilled and competent. In this distinction, professional development is a subset of workforce development. There are areas of the workforce that need to be upskilled, and baseline qualifications may not cover specific areas adequately. Cognitive impairment, cultural competence and working with minority or marginalised people/groups are some examples.

Contributors considered that addressing workforce needs also means identifying and applying resourcing and funding to support workforce planning and development. It will be important to identify what funding is available at present and what might be needed to bridge gaps in funding in the medium to longer term.

The *Oranga Hinengaro System and Service Framework* looks forward to a 10-year horizon. The sector needs to agree priorities and an action plan across the same timeframe to direct efforts towards delivering the Framework. This approach needs to be closely aligned with the education sector to develop, deliver and sustain relevant qualifications to attract people to work in the sector and to develop career pathways. The linkage between increasing placements in services before there can be more tertiary training places and more tertiary lecturers and sustainable courses needs to be emphasised and strengthened.

One contributor commented that a distinction needs to be made between work placements required as an undergraduate programme (for example, Weltec, Te Taketake) that are integrated with the degree as an academic unit (and assessed as such) and work experience or a paid internship that is additional to a postgraduate certificate or postgraduate diploma but not necessarily part of the postgraduate programme. Most students undertaking a postgraduate qualification are working in an addiction service and are undertaking the qualification to upskill, while internships allow those not working in the sector to gain the necessary experience to get employment in the sector. In both cases, the workplace carries the cost.

Box 4: The relationship between work placements and places in tertiary education

Throughout this project, a number of contributors raised the links between the number of work placements available in the addiction treatment sector driving the number of places that tertiary education organisations can make for students in the following year. If there are not sufficient placements, the size of the class and even the availability of lecturers or the course itself may be limited.

The Workforce Development team in Te Whatu Ora is developing a digital tool to improve student placement information. This digital system will help organise student placements and keep track of progress, tracking 183,000 weeks of placements.

Te Whatu Ora has also been undertaking a sector engagement process to gain a detailed understanding of how student placements are currently organised and future requirements.

Contributors felt that, if there is to be an increase in the numbers of people working in the sector, attracting new entrants will be a critical part of this. To attract new entrants is to provide them with jobs while they study – "learn while you earn" – and security that there will be jobs available post completion of their diploma or degree. Students themselves need support – for example, while they are managing jobs, family and study – and they may be older students.

While people may struggle to find paid employment, there seems to be little incentive for services to provide clinical placements. Some of the larger NGOs have invested in their own training programmes and appointed people to specific roles to develop internal training. Providing supervision can be limited if senior staff already have busy caseloads.

A similar situation also applies to medical students who could be attracted to work in the addiction treatment sector. Medical students have their own placement process. It was suggested that creating more training spaces for medical doctors in addiction treatment services would be very useful. There are only two to three medical placements currently available in the country (Auckland and Wellington). This would be an important pipeline to increasing the numbers of medical students and doctors on graduation staying in the sector.

Supporting Pasifika providers to take on interns was also identified as a major way to increase the Pasifika workforce. There can be a number of barriers to overcome to support Pasifika students – for example, contributors said that often scholarships are for 1 year only, limited to around $5,000 and not for the full term of the degree or diploma. Many students may start the course but cannot finish.

Leadership guides the operational environment to enable student placements to function effectively. Leadership can provide the kind of supportive workplace environment for student placements. This can also be through providing mentoring and role models. Good leaders bridge the gap between the learning and work environments and ensure students get a good overview of the breadth of addiction care.

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Provisional registration helps students to develop practical skills and experience and build valuable working relationships that can support students to secure a job to support them while studying and after graduation with a qualification.

Mention was made of a good initiative in the former Counties Manukau DHB where three services supported internships for students who then moved around the different services.

Funding and supporting such innovations across the country and generally increasing the number of internships and placements in a way planned with the education sector would provide a lot of benefits. Further investigation of this issue would need to consider the financial costs, the availability of supervisors, prioritising some professional groups and any other constraints.

As one contributor noted, fundamentally, if we are serious about attracting new people to the sector, we need to implement a variety of initiatives to support people to complete undergraduate qualifications (work placements) and postgraduate qualifications (internships).

Improving the collection and distribution of workforce data

Te Pou has reported that a wide range of stakeholders use the workforce information it provides, including Atamira Platform Trust, Te Hiringa Mahara | Mental Health and Wellbeing Commission, Manatū Hauora | Ministry of Health, workforce centres, Te Aka Whai Ora and Te Whatu Ora regional and national agencies, planners and funders, local providers, Toitū te Waiora | Community, Health, Education and Social Services Workforce Development Council, Kaiāwhina Action Plan groups and various students and academics.

Contributors proposed ways this data and information could be used better:

- Information is collected to answer specific health policy and strategy questions like are we growing the workforce to deliver more services to the population?
- There is a lack of dedicated health system response to recommendations emerging from the data collected. Attention to the data occurs when it coincides with specific projects or knowledge needs. This means there is a lack of accountability to providers in the form of a dedicated workforce plan to respond to their data.
- Data collection from NGOs is expensive for them – hence Te Pou collects information in 4-year cycles and is currently exploring ways to estimate the NGO workforce in between.
- In the health sector generally, there are problems with:
  - duplication – people seeking to reproduce data that is already available, especially for Te Whatu Ora providers
  - opacity – people don't know where to find the data they need
  - specificity – the available data lacks relevance to health policy and strategy goals
  - boundaries – people want data over which the health sector has no authority such as workforce funded by Corrections.

In response to what decision makers and the sector need to know but might not know now, the following was suggested:

- There is not a good picture of the challenges faced by Te Whatu Ora provider alcohol and drug services.
- There is a lack of clarity about alcohol and drug workforce in funding information that is relied on for estimates – for example, some workforce is funded using mental health purchase units.
- There appear to be multiple factors influencing low growth in the adult alcohol and drug workforce, including very low investment in Te Whatu Ora services (funding increased by 12% between 2018 and 2022 compared to 24% for the NGO workforce), diminished education pipelines for addiction practitioners and competition with mental health and integrated primary mental health and addiction services.
- Developing a centralised database relating to the addiction workforce would also assist with planning. Data and information on the addiction workforce is dispersed and not easily accessible. Regular (annual) reporting by tertiary institutions involved in the pipeline would assist with planning.
- One body (workforce centre or organisation) could be commissioned to gather and hold this information. Surveys of the addiction workforce can be sporadic and by their nature retrospective. Using forecasting and modelling techniques could help improve planning for future needs.
- Collecting data and information from across all the tertiary providers on the addiction pipeline would be essential to workforce planning. A priority must be to work with tertiary providers to improve the availability of addiction-related degrees.
- Information on the pipeline needs to be readily available and made transparent to decision makers for planning purposes and for potential employers. The work already under way by the Workforce Development team in Te Whatu Ora is acknowledged, and this will take time to develop and to be implemented.

Data issues are not only related to workforce. The lack of prevalence data and research on substance use is a real issue that needs to be highlighted. Support for an update to *Te Rau Hinengaro: The New Zealand Mental Health Survey*[30] and other types of related (and focused) studies will be important. It is difficult to address what is not completely understood.

Building a coherent qualifications framework between the addiction treatment and education sectors

The number of university and polytechnic courses offering tertiary education regarding addiction and substance use[31] indicates there appears to be sufficient training institutions available given the limited number of people seeking tertiary-level qualifications.

However, during this project, several contributors raised concerns about the lack of tertiary degrees in some of the main centres. Specifically, it was reported that there are no undergraduate courses in addiction in Auckland and Christchurch and no postgraduate courses available in Wellington. Dissatisfaction was also expressed regarding decision

30 Oakley Browne, M., Wells, J., Scott. K. (Eds). (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Ministry of Health. www.health.govt.nz/system/files/documents/publications/mental-health-survey.pdf

31 Te Pou. (2023). *Addiction education pathways tool*. www.tepou.co.nz/initiatives/addiction-education-pathways-tool

making by Te Pūkenga, the principal polytechnic body, without consultation or regard to service providers. One contributor noted that qualifications in addiction are inextricably linked to the education sector. Another noted that the pipeline of graduates coming out of tertiary training is largely invisible to employers, who may have unrealistic expectations of just how many there may be.

Some contributors felt that requiring people with qualifications and experience from other sectors to be DAPAANZ registered was a barrier. For example, nurses and social workers could be employed without having to study towards an addiction qualification.

Building a coherent qualifications network will require formal and informal relationships between the addiction treatment (health) and education sectors at a national and local level. This will also include coordinating data and information on the addiction workforce training pipeline and applying this to workforce planning. The linkage between increasing placements in services before there can be more tertiary training places and more tertiary lecturers and sustainable courses needs to be emphasised and strengthened. More workplace internships and innovative ways to attract and maintain new entrants through such internships will grow the future sector.

Participation by consumers, peer support and lived experience

It has long been a feature of the addiction treatment sector in Aotearoa New Zealand and overseas that consumers, peer support and people with lived experience (CPSLE) have important roles to play in addiction recovery. As one contributor said:

> Lived experience is about using one's own experience to change the experience for someone else.

As far back as 2014,[32] it was noted that human resources policies are usually flexible enough to respond to the diversity of the staff in any organisation. In employing peers, the learning from challenging life experiences can be an asset in the workplace, but they may normally be excluded due to past experiences – for example, people with interrupted education and employment or a criminal record may be valuable when working with others with similar life experiences. It may be helpful to develop human resources policies to reflect this. Service policies and delivery guidelines need to be checked to see if they are consistent with peer values – organisations may need to create a new policy, change an existing policy or make exclusions for peer workers in a policy. The most likely areas are those that deal with risk management, restraint, restrictions on freedom and documentation. New policies could include collaborative note taking, sharing risk and being alongside people in difficult situations while still fulfilling legal obligations around safety. This could become an opportunity for an organisation to review all its service policies to become more aligned with recovery ways of working.

The service user, consumer and peer workforce includes all people with openly identified lived experience of mental distress or addiction and recovery. They can be in paid or unpaid employment and use their experience to benefit others with mental distress or addiction in the work they do. Most work in mainstream agencies in the mental health and addiction sector, but some work in peer-led networks or agencies outside the sector such as primary health organisations or social services.

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32 Midland District Health Boards, Te Pou, & Northern Regional Alliance. (2016). *Service user, consumer and peer workforce: A guide for managers and employees*. https://d2ew8vb2gktr0m.cloudfront.net/files/resources/service-user-consumer-and-peer-support-workforce-a-guide-for-managers-and-employers.pdf

Contributors suggested that how some services hold peer support is stigmatising and discriminatory. It was felt that peer support workers are not always respected. It can be difficult if they raise issues or concerns on behalf of service users. This is possibly related to the criminality issues associated with drug use. One contributor commented that there needs to be greater mutual respect between peer support workers and clinical staff. It should be noted that this may not be everyone's experience and it can be hard to know how general this might be across the sector. Another said that, to have lived experience and clinical working together, it's not "either/or" but "and/and". One person said that having others speaking for people with lived experience is like colonisation.

Workforce surveys[33] conducted in 2018 and 2020 estimated the CPSLE workforce was around 481 FTE positions. Nearly all (96%) are employed in adult mental health and addiction services. Peer support workers are the largest role group. In 2020, the child and youth workforce included consumer advisors (4 FTEs) as well as 17 FTE peer support workers.

Across services for all age groups, NGOs employed 87% of the workforce and DHBs 13%.

Alcohol and drug services employ around 17% of the adult mental health and addiction CPSLE workforce and mental health services 83%.

People in recovery may well choose to become qualified counsellors and to seek a variety of qualifications in addiction treatment. There may be additional barriers and pressures on them by doing so. For someone working as a peer support worker, the main career pathway seems to be out of being a peer support worker – for example, by taking up social worker training/qualifications rather than remaining within peer support. This is an area that could benefit from some specific research. Contributors felt there was a need to allow for maturity of practice for people to remain as peer support workers and being able to take on more tasks as appropriate to progressive levels of experience.

The good news is that, from Semester Two 2023, AUT will be providing a course for peer support lived experience training. Participants with lived experience will automatically gain 15 credits. There is also a peer support lived experience 101 course run under the auspices of Odyssey House in Auckland that is meeting a huge demand for this type of training.

There were calls for consumer advisors and peer support workers to join the national multi-employer collective agreement (MECA) in the mental health and addiction sector. At present, most would be covered under a single-employer collective agreement.

Equal pay for work of equal value or worth has been attempted through various campaigns and changes to the law over many years. The MECA is also commonly referred to as a national or regional contract and has more than one employer party. A collective employment agreement is where a number of employees are party to an identical agreement – meaning they are bound by the same terms and conditions and are equally entitled to the same contractual rights.

Being on the MECA could mean recognition in monetary terms for the skill and expertise required for CPLSE work that will help to secure the future of this workforce and attract people into addiction work. This would benefit all workers covered by the MECA and also for everyone who depends on the skill and care of staff in their most vulnerable moments and for continued recovery.

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33 Te Pou. (2022). *Consumer, peer support and lived experience workforce stocktake of available information.* www.tepou.co.nz/consumer-peer-support-lived-experience-workforce-stocktake-of-available-information

While there is growing appreciation of having people with lived experience involved in a greater variety of ways in planning and delivering services, no assessment has formally been made to how well and how widely people with lived experience are being included in all aspects of the addiction treatment system.

There are several ways service users and people with lived experience could participate at a treatment system level, including:

- instituting lived experience advisory groups with diverse backgrounds and experiences and whose representatives are compensated for their contributions
- demonstrating a commitment to lived experience and whānau roles being employed across policy, strategy and quality programmes
- improving mechanisms to ensure real-time feedback from service users/tangata whai ora and by having consumer evaluators involved in analysing the responses
- designing systems and services that can absorb the variety of demands from service users/tangata whai ora
- implementing reporting systems that assess whether services are showing that they are working to understand and improve the work they do
- improving physical and oral health outcomes by supporting access to low-cost/no-cost community resources and implementing equally well and green prescription initiatives
- reviewing policies and practices to remove stigmatising or discriminatory practices and applying this lens to new and proposed policies
- continuing to deliver Supporting Parents Healthy Children initiatives
- managing the transitions between services within the system so care is coordinated
- implementing programmes that identify and support the development of leaders in the communities where the services are to be delivered
- ensuring young people and women feel safe and supported to discuss substance use-related issues wherever they encounter the health system.

Te Pou has recently published a guide[34] written for anyone involved with the consumer, peer support and lived experience workforce in mental health and addiction services in Aotearoa New Zealand. This includes employers, managers, colleagues, commissioners, government agencies, organisations and services that include lived experience roles or are intending to employ or work with lived experience roles.

There is also a small but growing workforce of people with lived experience of addiction and prison. A contributor with this experience spoke of the "express connection" that can be made when working with a group of prisoners in the prison environment. To find someone who has been where they are is to give them hope. This connection can also continue on release back into the community.

There is a major challenge for the addiction treatment sector to consider whether it is prepared to employ people as peer support workers who are still using alcohol and other drugs. It was suggested that, in contrast with the mental health and the health promotion sector (such as needle exchange, drug testing), which seemed more comfortable with enduring conditions, the addiction treatment sector required abstinence. In some circumstances, there may be benefit for the service user to have a support worker

34 Te Pou. (2023). *He arataki ki ngā kaimahi mātau ā-wheako: A guide to the consumer, peer support, and lived experience workforce in mental health and addiction settings*. Te Pou. https://d2ew8vb2gktr0m.cloudfront.net/files/resources/CPSLE-guide.pdf

who is a substance user. However, it would need to be acknowledged that staff may be uncomfortable working alongside someone who is drinking or using illegal drugs.

Developing the residential treatment workforce

Residential treatment for addiction is provided by NGOs in Aotearoa New Zealand. However, there is no formal training for people to work in residential treatment services.

A specific training course for therapeutic communities has been developed and has most recently been hosted at Higher Ground.

By the nature of being in close proximity to residents, residential treatment can be intense. Treatment can be driven by group processes so it can be draining. There are also on-call aspects, and the time and energy involved being tiring.

Workforce development for people working in residential treatment needs to prepare them for the complexity of the work as people in residential treatment often need the most work, with complex presentations. A contributor said that it is not enough to be able to talk to someone and that staff need to multitask, saying it was great to have social worker or nursing qualifications but they also need to be able to wash the dishes. The work is not an hour's appointment.

There was a sentiment expressed that funding for residential treatment has been treated differently based on bed night rates, which can be limiting. The pricing structure used in former Ministry of Health contracts (and Corrections) is quite different from pricing structures used by former DHBs.

One contributor remarked that the *Let's get real* training provided through Te Pou[35] was useful, particularly the youth module. Training available through the Access and Choice initiative was also helpful to develop new staff. This was readily available, a good model to come alongside and provided online options.

Other issues raised by contributors included that finding work placements for residential treatment can be difficult. Interns need to get up to speed with their skillset without constant need for supervision. Having such placements was considered to be good for staff to reflect their own skills and helps drive benefits across the whole team. Leadership tends to be grown in house.

35 www.tepou.co.nz/initiatives/lets-get-real

Developing the withdrawal management workforce

There is no consistent nationwide model of care for withdrawal management. People may be seen in various settings – home, community or hospital wards. Withdrawal management nurses are trained mental health nurses.

One workforce centre commissioned two researchers to study withdrawal management nationwide. However, it was reported that they struggled to understand the various pathways. It was also said that, even if someone can navigate the pathway, there is no guarantee of access.

There were concerns raised as to how withdrawal management works in rural and remote areas. There is a good model working in Northland based at Dargaville. New premises have opened in metro-Auckland. The proposed approach to addressing the patchwork of services across localities and districts is likely to highlight the differences in the ways withdrawal management is delivered.

Another area that could be examined further is the availability of withdrawal management at home. All options in various settings should be considered to improve access to this service.

One contributor said that often people are seen for mental health issues first, then if acute withdrawal is needed, they may be discharged and told to keep drinking. Withdrawal can do more harm than good if not managed.

It was felt that there needs to be consistency of approaches to withdrawal management across the sector. Also, the sector needs to think about how services work with people so acute withdrawal is not the starting point to engage with people. It is possible to help people change behaviour and we need to understand what has got them to where they are today.

Developing the opioid substitution treatment (OST) workforce

A significant feature of the OST sector is the regulatory framework that requires the appointment under legislation of officers to carry out certain functions for the treatment of dependence. However, there are currently significant challenges in appointing and retaining sufficient numbers of officers (lead clinicians) to ensure nationwide coverage.

Specialist OST services and lead clinicians are specified by the Minister of Health under section 24A of the Misuse of Drugs Act 1975 and notified in the *New Zealand Gazette*. OST services in Aotearoa are expected to provide a standardised approach underpinned by concepts of centring the person, family and whānau at the heart of treatment, recovery, wellbeing and citizenship. To help services take this approach, the *New Zealand Practice Guidelines for Opioid Substitution Treatment*[36] provides clinical and procedural guidance for specialist services and primary health care providers who deliver OST. These services are also subject to a Ministry audit every 3 years through the *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool*.[37]

36 Ministry of Health. (2014). *New Zealand Practice Guidelines for Opioid Substitution Treatment*. Ministry of Health. www.health.govt.nz/system/files/documents/publications/nz-practice-guidelines-opioid-substitution-treatment-apr14-v2.pdf

37 Ministry of Health. (2014). *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool*. Ministry of Health. www.health.govt.nz/system/files/documents/publications/specialist-opioid-substitution-treatment-service-audit-review-tool-dec14-v2_0.pdf

All specialist services are required to employ a lead clinician approved by the Director of Mental Health. To be approved as a lead clinician under section 24(7)(a) of the Misuse of Drugs Act, a person must be a senior specialist service medical practitioner involved in the treatment of addiction with controlled drugs and at a minimum must demonstrate the qualities and skills expected of a leadership role for the breadth of service delivery that supports a marginalised and often vulnerable population.

The number of appropriately skilled and qualified lead clinicians available to provide regulatory oversight of specialist services, general practices prescribing OST and pharmacies has decreased over the years, with a diminishing number of medical officers providing broader regional coverage and often on a declining number of FTEs.

A low priority appears to be placed on the role and functions of the lead clinician specifically and the OST service in general. While the apparent demand for OST provision has remained fairly static (at approximately 5,500 service users nationwide), it is not clear if this is reflective of the real demand or of service accessibility. Furthermore, service users are regionally dispersed and ageing – both features that require increased resources to support.

Themes from contributors were that some former DHBs allocated limited lead clinician resource. This is often in the smaller regions where there is an expectation to cover several lead roles across mental health and/or addiction services, there is limited cover and there are fewer prescribers/GPs to share the prescribing or clinical oversight responsibility. Creative solutions have been implemented to ensure that the requirements are met. This includes the sharing of lead clinicians across regions, the appointment of a local lead clinician but with oversight from another out-of-area medical officer, the appointment of lead clinicians under short *Gazette* periods, the appointment of locums at significant cost to the service and the aggressive advocating of an increase in FTEs to cover the functions. However, the allocated FTEs do not reflect the workload or rather the workload can be carried out within the FTEs but only if it is limited to prescription provision. This is not and never has been the purpose or intent of OST services in New Zealand.

Contributors considered that, to be attractive for applicants, the role needs to be full-time or close to it. To remain in the role, a lead clinician may have to accumulate enough FTEs across several localities or take on other duties as well as the statutory role.

Statutory roles are not optional. The solution appears to be funding for statutory positions to ensure there are sufficient personnel to cover those statutory duties. The roles can be actively recruited for and filled with suitably qualified practitioners confident that the roles are full-time or close to it.

Concurrent to the lack of attractiveness in terms of FTEs to the appointment of a lead clinician role, there is also a lack of direct training and skill development to support emerging medical practitioners into this role. A medical officer must show commitment and dedication to working in the addiction sector without a clear training or specialism pathway. While there is some work being done to address this, it has been a long-neglected area that currently places considerable pressure (mentoring and oversight) on the limited lead clinician resource available.

Developing the youth workforce

There are distinctions between what works for young people and what works in adult services. For example, for youth, differences can involve:

- assessment, formulation and interventions
- youth experiencing additional components such as being expelled from school or having family issues
- medications available for youth not being the same as for adults.

Youth workers need to be able to engage with young people and also navigate issues with schools and families. They may be peers with their own life experiences but not expecting people to make changes.

There has been an increase in FTEs for the youth addiction treatment sector and efforts to reconfigure services into youth-focused teams. Although this has not been achieved nationwide, there is some evidence of progress.

Contributors remarked that, unlike adult services, change in someone is not always obvious, so the work may seem less rewarding, and even frustrating. Workers need to see a young person coming back as a success, ready to make change.

Youth workers are trained in using screening, and brief interventions with a substance use perspective can be done by anyone in the youth sector. A trained worker can identify issues and act on this to minimise harm. Tools includes Substances and Choices Scale (SACS) screening and the HEEADSSS tool. HEEADSSS stands for Home, Education/ Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety. HEEADSSS assessment allows for early identification of mental health, alcohol and other drug issues as well as other information to assist young people in their development, Such tools could be used more widely, although uptake is very good. Contributors thought that there are great resources available for HEEADSSS.

Contributors proposed that there is a need to include youth issues in tertiary addiction training. At present, it is too focused on adults. It should be noted that AUT offers a specific paper on youth addiction and co-existing problems.[38]

38 https://courseoutline.auckland.ac.nz/dco/course/PSYCHIAT/766

A contributor said that there is a need to avoid an influx of youth to adult services. Not every young person who leaves a youth service goes into adult service. Adults entering adult services might do so because of relationship issues or being directed by a court or employer, but there are different incentives for a young person entering an adult service. They may be identified as someone in and out of services, and there may be a perception that they still have issues. Different approaches from what works for adults are needed to keep a young person engaged in treatment. An examination of existing evidence regarding what happens for young people after leaving youth services might provide insights of what works best in Aotearoa New Zealand.

For a young person with a chronic condition, there needs to be a longer transition between services, not a service handover. There can be a risk of a youth service hanging on too long or dropping the youth person off if issues become complex. Young people need supportive environments, and there is a general move away from institutional types of services. Residential programmes can be too long. In one contributor's opinion, they should not be longer than a school term so the young person can co-enrol with their home school. For some, 1–3 weeks on a smaller youth programme might be sufficient. If the young person requires intensive monitoring (a youth justice issue), they are not suitable for a youth AOD programme.

The Whāraurau ICAMH/AOD workforce survey highlights for 2020/21 showed:

- 73% in clinical roles and 17% in non-clinical (excluding administration and management)
- 8% vacancy rate (vacancies ranged from 0% to 32%) with vacancies largely for clinical roles.
- 19% overall turnover rate (28% in non-DHBs, 14% in DHBs) for support workers, nurses, social workers and psychologists.

Whāraurau advise that 2021/22 data will be available shortly, but the vacancy rate has increased above 8%.

Someone cannot be a youth advisor past the age of 25 years old. Youth services need to hold/maintain that maturity of practice and ensure succession planning without losing the experience of a seasoned worker. A contributor felt that workers will often know when they are no longer relevant.

While there have been specific Māori youth addiction services in the past, contributors said there are no longer such services, and contributors considered that there is a huge need for this type of service. This is why Oranga Tamariki approached Whāraurau as there are high numbers of young people getting into the justice system. There are only a few day programmes – for example, the Mirror Youth Day Programme in Dunedin, and PACT in Wellington has an 8-day programme but this is not kaupapa Māori.

Developing the Pasifika workforce

Developing the Pasifika workforce depends on developing Pasifika services. Such services reflect how Pasifika live their lives. For example, contracting may demand a certain caseload of 20 service users per worker. This does not work for Pasifika as the workers will spend hours with the family to get them engaged before agreeing for a person to even enter the service. This pre-treatment part of a service is not built into contracts.

Two-thirds of Pasifika people in Aotearoa are now born here. There are eight different Pasifika ethnicities, so one person can't be expected to be culturally competent for all of these.

Contributors felt that there is plenty of research on the barriers for Pasifika people seeking treatment. Stigma is a major barrier to people accessing services – people might be ashamed for having an illness (addiction).

Contributors felt that Pasifika clinicians work quite differently from mainstream and that they are not paid the same. Procurement of services is for one size fits all.

An example was provided of how one Pasifika service employs clinicians in dual roles. This service has both a health promotion and a clinical contract so sets clinicians in the community working in both services. They provide information, brief interventions and conversation before putting people on the pathway into clinical interventions. Those conversations all happen before consent forms have to be signed and other compliance matters. This creates le va (space) to have conversations with the person and their aiga.

There was strong support for Pasifika providers to be paid to take on interns as a major way to increase the workforce. Often scholarships are for 1 year only, not for the full term of the degree or diploma. Many students may start but cannot finish the courses. Leadership helps. Gaining provisional registration also helps students to get work in the sector.

Contributors also thought that workshops for Pasifika should be designed and delivered by Pasifika as they can then be delivered in a culturally relevant way.

Mention was made of a good initiative in the former Counties Manukau DHB where three services supported internships for students who then moved around the different services.

Overseas development was also promoted by sending Pasifika people from Aotearoa to services in Samoa, Tonga, Fiji and across the Pacific. There were also examples of webinars that connect Pasifika workers.

Contributors commented that there is a Māori indigenous data group but no equivalent for Pasifika. Having such a resource would more accurately identify and define issues for a relatively small population that would not necessarily be detected in the larger general population research.

Mention was made of Te Taketake course, which allows undergraduates to get DAPAANZ registration. Contributors thought that it can be difficult to get people into universities.

If potential Pasifika students are not aware of what an addiction treatment service does, they will not know to apply – "If you can't see it, you can't be it." Recruitment for Pasifika (and others) needs to make a career in the sector attractive and to explain what the sector is about.

It was also suggested that the younger generation born in Aotearoa may not always be connected to earlier generations. An example was given of a young person who was eligible to study law but preferred to be a plumber because money was available from the start.

As well as recruitment, the sector should think about how to retain staff and also recruit people who have left the sector to come back.

Pasifika services spend a lot of time developing the staff member by getting them to understand the Pasifika world and to have aligned values. The person can then grow into being an addiction practitioner.

Contributors noted that Te Whatu Ora separates out issues rather than dealing holistically with a person's issues in one service. People may be referred to an 0800 number, but this does not work for Pasifika. When it comes to commissioning, Pasifika

services need to stand their ground about how they deliver the service in a way that is appropriate for them. Not all funders understand the cultural framework.

Developing the Asian workforce

At the 2018 Census, the majority of New Zealand's population is of European descent (70%, often referred to as Pākehā), with indigenous Māori being the largest minority (16.5%) followed by Asians (15.3%).[39]

The same source noted Auckland is the most ethnically diverse region in New Zealand with 53.5% identifying as Europeans, 28.2% Asian, 11.5% Māori, 15.5% Pasifika and 2.3% Middle Eastern, Latin American or African (MELAA).

The proportion of Asian people in the population is not reflected in the workforce at present. To be more equitable, the sector should consider how to attract more Asian people to work in it.

It was also suggested that drug use is increasing among young Asians. Asian service users are not getting good outcomes. It was proposed that, for prison services, if a person does not speak English well, they cannot get onto drug treatment programmes. Workers will know of the problems but do not know what to do about it. Agencies and services might think that all Asians are successful and doing well, but they can struggle.

It was proposed that there needs to be an Asian focus in the workforce covering clinical, cultural supervision, practical, choice and cultural competence aspects, including linguistically.

One contributor recommended that the sector needs to recognise the unique expertise that Asian workers bring, but the sector should not rely on only a few Asian staff to work with Asian people – for example, if someone approaching a service appears Asian. There can be large (false) assumptions made as to whether someone is appropriate to see an Asian service user. All staff should be culturally competent so they can grow and share experiences and wisdom. Employing more ethnicities is not about ticking the box. Cultural training is not a one-off event and needs to be ongoing.

There are no specific workforce initiatives for Asian workers. Networks could be set up to make connections, share knowledge of challenges and share culturally driven initiatives.

Developing a diverse workforce

Throughout the interviews, people have commented that the composition of the addiction treatment workforce needs to reflect the communities they are working in.

It may be necessary for Te Whatu Ora to commission research on the diversity of service users and the current addiction treatment workforce with a view to developing strategies to attracting people with diverse abilities into the workforce.

Attracting and developing the rainbow workforce, people with neurodiversity, refugee and migrant populations and people with disabilities are ways services can reflect the communities they live and work in.

Contributors speaking on employing people with lived experience said that consumer advisors appreciated being on interview panels. However, they believe this needs to go further and they should be involved with the shortlisting process. The implication is that,

39 en.wikipedia.org/wiki/Demographics_of_New_Zealand

through the shortlisting process, people that may not fit mainstream can be filtered out, either intentionally or unintentionally.

Youth services are probably at the forefront of diversity. Youth training delivered by Whāraurau shows great diversity, and youth services are employing young youth workers with wide backgrounds.

To develop a diverse workforce is for those who are employing people to have an open mind to employing people with a much greater range of diversity than may be there at present. One contributor made an important point that promoting diversity involves teaching really good reflective practices and understanding personal biases and limitations to how we think.

Commissioning is to be different

Commissioning of services by Te Whatu Ora in this new environment is expected to be done differently. This could include:

- designing services in partnership with people, whānau and communities, including Māori and people with lived experience
- fostering a culture of innovation and flexible implementation approaches to adjust for learnings
- national coordination and support for the sector to change
- support for a strong national level of voices to give advice to commissioning agencies.

The *Oranga Hinengaro System and Service Framework* identifies the core components of a contemporary mental health and addiction system with a 10-year view. It provides guidance for those responsible for publicly funded health system policy, design, service commissioning and delivery. It sets out:

- core principles identified by Māori and people with lived experience that should underpin the system and services
- critical shifts required to move towards a future system that supports pae ora – healthy futures
- the types of services that should be accessible and available to individuals, whānau and communities.

The Framework will need to have identified performance measures that show how effective addiction treatment services and the overall system are in delivering outcomes and is to be developed by the Ministry of Health. How well services are performing is of interest to the very people who may want to access those services or have a loved one needing to access those services and to those who are accountable for the expenditure of public funding.

This raises how performance against the measures will be assessed. Previous mention regarding HealthCERT and the Health and Disability Services Standard has been identified as one way. A possible future workforce of addiction treatment-specific auditors could be recruited as one other way. This would be similar to the OST audits where a team comprising a lead auditor and experienced OST lead from another service and a consumer advisor visit the service and provide an overall assessment of service delivery. Such a team should include a cultural advisor as well.

The service models need in turn to be supported by ongoing planned and sustainable workforce development initiatives. Identifying and responding to where there are identified shortages of specific workers in the addiction treatment sector is critical.

It is essential that the many voices of service users and those involved in delivering services are heard and listened to when developing service models.

One contributor commented that they agreed for the need to have a workforce that looks like the community but also that the commissioning itself should be for services that reflect the community. There is a need to craft commissioning informed by lived experience and have networks that extend into the community to recognise the kinds of services needed.

There is a risk that, without careful consideration of future and evolving service models and the workforce planning and development required to support those models, funding will be invested in supporting what has always been done with the same results. Without changes to planning frameworks, investment strategies will be meaningless. If there is to be a move to having a greater proportion of contracts for 3 years or longer (to give services and staff greater certainty of employment and to improve return on investment in workforce development) and avoiding the constant churn of renewing short-term contracts, there is even greater urgency to apply the system and services model.

There is also the risk of becoming so system focused that it looks to only filling existing shortages and not asking if these are the right services and what workforce might be required to staff those services.

Te Whatu Ora has a difficult challenge to balance short-term action with planning for longer-term improvements in outcomes through better service delivery and workforce development.

In its role in commissioning services Te Whatu Ora has a significant number of addiction treatment-related contracts involving more than $213 millions. The contracts may have been negotiated by a DHB, a regional collection of DHBs or by the Ministry of Health. They may not be consistent with the Nationwide Service Framework service specifications

or may be for services not covered in that framework. A majority of all the addiction-related contracts are to be renewed over the next 2 years.

Current contracts contain little in specific terms relating to workforce development. Immediate consideration could be given to more explicit workforce requirements – for example, to specifying in new contracts a proportion of the FTE payment to cover workforce development investment. Contracts could also include the minimum staffing numbers and the experience/qualifications of staff to be contracted for services.

Contracts need to be flexible enough to manage service delivery subtleties – for example, recognising the pre-treatment work those goes into engaging with people and whānau even before the person enters treatment, cultural aspects for Māori and Pasifika service users where hours may be spent engaging people and for youth transitioning between services.

Contributors raised that, in some localities where the same or similar services will be commissioned by both Te Whatu Ora and Te Aka Whai Ora, there is a question of how consistency of service specification, terms and conditions and staffing capacity and capability will be established. For example, if in one locality there are three or more districts delivering community withdrawal management, some services may be delivered by kaupapa Māori services contracted with Te Aka Whai Ora while mainstream services may be contracted by Te Whatu Ora.

It was also mentioned that, working with Te Aka Whai Ora, Māori providers did not have to explain why they work the way they do. This implies that, with mainstream contracts, they are questioned about the way they engage with service users and whānau.

For the workforce centres, some contributors felt there may be little scope to vary the contract or to add new items. Some contributors felt frustrated that they have raised topics with the workforce centres but cannot get traction for new courses of training. Some considered a contestable workforce development innovation fund could allow service providers to develop specific training programmes. Various forms of scholarships and grants are provided by the workforce development centres, and these should be reviewed to ensure there is a consistent policy approach for how these are developed or applied. Data on how many scholarships and internships result in permanent placement should be examined regularly to ensure their effectiveness.

Long-term planning as well as shorter-term planning (3–5 years) needs to be well coordinated across the treatment system. Strengthening national coordination functions and the development of leaders through specific programmes should be part of an organised workforce strategy. However, this needs to be informed by the sector and well articulated to the workforce if it is to gain acceptance and participation.

If Te Whatu Ora is to commission the most appropriate services to deliver the performance and outcomes sought in the *Oranga Hinengaro System and Service Framework*, *He Ara Oranga* and *Kia Manawanui Aotearoa*, it needs to seek the best available advice from sector leaders, supported by evidence. Consideration needs to be given as to how this essential advice is channelled through to Te Whatu Ora, bringing together diverse opinions and perspectives.

Leadership as a system enabler

Several contributors commented on how the leadership in the sector has moved away from the academics, and this leadership role has not really been replaced. It was felt by these contributors that it does not serve the sector well not having academic perspectives. Those who have helped create the sector are moving on or have left but may have inadvertently cut off the development of the next level of leaders if there is no succession planning. There can be a continuous call that there is no leadership. Leadership can be strong in some regions, but there is a need for greater leadership at national level.

Without succession planning, people can fall into leadership roles if there are not appropriate appointment processes. With succession planning, people would get promoted by making sure they are suitably qualified and experienced.

Contributors thought that, in some services, there may be little career development (for example, if senior managers are not likely to be moving on any time soon) so there must be opportunities for people "to shine in other ways". As an example, a contributor welcomed the new faces on the DAPAANZ Board.

New graduates look to the leaders, so leaders need to be mindful of what they say and should lead by example. For one contributor, Addiction Leadership Day meetings are an indicator where the barometer is at for leadership, but this person comes away feeling depressed because some of the attitudes expressed are not particularly helpful. On a more positive note, a contributor suggested that there is an opportunity to create a culture where people want to come into the sector and want to be leaders.

It was suggested that some people may feel they are not good enough to be leaders, they might not be able to live up to expectations placed on them to be leaders or they have yet to reach the top of their own service. Opportunities should be provided to allow people to work outside of their current service.

One contributor said that the leadership structure in the sector is not clear. Certain professions will take on leadership by virtue of their qualifications. However, it was proposed that leaders need to be appointed based on personal qualities, not because of their profession.

The peak bodies provide a vital leadership relationship conduit with the sector. This will be vital for two-way sector communication and partnership while also giving Te Whatu Ora a mechanism to achieve the service transformation set out in *He Ara Oranga*. The peak bodies provide a place to hold articulated industry standards and support the delivery of the Framework. Peak bodies should be involved in sector development and training and contributing to informing the policy and monitoring functions.

Contributors definitely felt there needed to be a specific leadership development programme within the addiction treatment sector. Currently, it was felt that there was nowhere to send staff to train to be a manager in the addiction sector. New managers particularly in the addiction sector need training in human resources issues – for example, investigating complaints (someone's dealing drugs, someone's using and so on) and responding to risks of personal grievances.

In this respect, consideration should be given to a leadership academy that would identify and develop the leadership potential of individuals through a dedicated programme.

The International Initiative for Mental Health Leadership (IIMHL),[40] which brings together and connect mental health leaders to spread innovation and best practice, could be promoted widely to the addiction sector.

It was suggested that, currently, there are no clearly defined pathways to leadership that graduates and new staff in the workforce can aspire to. This can be done in collaboration with individuals and organisations who hold strategic roles in the addiction sector.

It was recommended that leadership programmes in the addiction treatment sector need to be intentional, purposeful leadership development, exposed to a range of service models such as services for Māori, Pasifika and housing – not about "what is your leadership style". There is a need to optimise the ability/opportunity for staff to lead – "submerged leadership" – with those leaders at various organisational levels. It also needs to be designated and made obvious who the leaders are.

Other contributors thought that people need to be exposed to different services and different work environments, even if it is to learn that is what they do not want to do. There is a risk that, the further up the hierarchy goes, the further the decision makers know how the service works.

One considered that the quality of "intel" given to policy makers is too filtered. When Te Whatu Ora puts out consultation documents, staff are told they do not represent the organisation and to feed comments up through the hierarchy. "Gatekeepers" then sanitise the advice. It is believed that this can be where addiction treatment can get lost in mental health. Again, the extent to which this happens around the country is not clear.

For youth services, one contributor felt the need to promote "communities of leadership". (Note that this term has been co-opted by the Education sector and means something else in that sector.) This would involve a core group of people deepening their knowledge and sharing experience to support youth. This would consolidate learnings/competencies and promote engagement.

On a positive note, Te Pou has launched an online leadership development directory,[41] which provides a list of leadership programmes currently available to the sector and includes programmes for emergent and established leaders as well as those specifically for Māori, Pasifika, women and the lived experience workforce.

Promoting professionalism

Part of providing supportive work environments is to demonstrate and promote professional ways of working.

The *Health and Disability System Review – Final Report | Pūrongo Whakamutunga*[42] noted that there are large numbers of different bodies involved in workforce training and regulation. Unless they work effectively together to promote and achieve relevant workforce plans, in future, some tighter oversight may be required.

However, it may be difficult to legislate higher levels of professionalism, particularly in the addiction treatment sector where there are multiple bodies involved in the regulation of the various professions.

40 www.iimhl.com

41 www.tepou.co.nz/mental-health-addiction-leadership-programmes

42 See note 5.

The existing set of competencies for the sector in the *Addiction Intervention Competency Framework*[43] is managed on behalf of the sector by DAPAANZ. This framework was produced in 2011, and DAPAANZ recognises it is overdue for review. As well as being explicit about the expectations required for working in the sector, the competencies also set the curricula for the tertiary training institutions.

One contributor proposed that before competencies comes values, and such values need to be made explicit. Then the values would drive competencies that in turn drive workforce strategy that drives an action plan. If there is to be an equity framework, there needs to be a competency framework as well. It was suggested that, having considered each profession's own competencies, an overall competency framework can be developed and any gaps addressed. By building upwards, there is no need to introduce another set of competencies that cuts across what already exists.

Professionalism also includes how services relate to other services and even other sectors. One set of contributors noted that it can be difficult to collaborate across sectors/services. An initiative such as Waypoint in Auckland (part of the Access and Choice programme) is an exemplar for how this could work.

Two contributors said that ethics are hugely related to professionalism and leadership, especially in residential treatment services. With so many people from various professions, training in ethics needed to be done early on so people understood boundaries and ways of working with service users.

Two contributors also raised the safety and security of staff. When dealing with difficult situations, staff should be trained well so as to deal professionally in such situations, and there need to be leaders able to front the issues. In their view, this really depends on workplace culture and structure.

Improving clinical performance

All of the workforce centres commission training to improve clinical performance and non-clinical performance and in some instances directly provide training. Te Pou provides the most addiction treatment-related services, including online resources and online training. The substance withdrawal management guidelines[44] are the most accessed online resource.

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43 Addiction Practitioners Association Aotearoa New Zealand. (2011). *Addiction Intervention Competency Framework: A competency framework for professionals specialising in problem gambling, alcohol and other drug and smoking cessation intervention.* DAPAANZ. https://dapaanz.org.nz/wp-content/uploads/dapaanz_addiction_intervention_competency_framework.pdf

44 Te Pou. (2021). *Substance withdrawal management: Guidelines for medical and nursing practitioners.* Te Pou. https://d2ew8vb2gktr0m.cloudfront.net/files/resources/Substance-withdrawl-management_updated_2022-06-08-213700_vohp.pdf

Contributors were asked what workforce initiatives had worked and what initiatives they would want to see.

Some said that, over the past 3 years, there has been a real struggle to get more dedicated addiction workforce initiatives under way. Reasons for this included lots of priorities but no links to an overall addiction workforce strategy. One person felt strongly that there has been significant underinvestment in workforce development for decades, which was unprofessional and showed a lack of focus. Another view expressed was that there was not enough training and what is available seems to be the "same old, same old". It was felt that there needs to be a constant provision of training as people keep changing. Some people felt that they had suggested training for some topics but there was no room in Te Pou's workplan for any new or additional items. Some thought that there seems to be a lot of Te Pou publications rather than actual training for practice work.

Some NGOs have developed their own training courses. This meant staff giving their time to develop these and in some cases employing specific roles. This could be expensive, and NGOs did not always have the funding to develop and run courses. One DHB CADS service has prepared robust, renewed orientation modules. The orientation programme is for all staff, from frontdesk to doctors.

Growing the peer support workforce needs to be supported by an education campaign so workers can understand what peer support is and isn't before they apply.

Contributors gave examples of specific training they liked and wanted included:

- Previous work on formulations was considered to have worked well to develop a particular skillset. Contributors said that formulation training needs to be continued and reinforced in contracts with updates to be provided if it is to move from a niche skill to being embedded as a core skill. This could be coordinated across the sector, including using continuing professional development (CPD) points for registration as an incentive to attend training.

- Assessment and formulation for youth – outside of postgraduate study, this training can be hard to get. At a youth training conference in Dunedin a few years back, there was great interest in this. Such training needs to be for clinical and non-clinical staff, tailored for the respective roles. Some formulation training could be extended to be online, could include case studies and can be broad for a wider audience.
- Several contributors spoke highly of Te Taketake training organised through the Moana House training institution and the way it incorporates cultural aspects.
- Lived Experience Peer Support 101 at Odyssey House Auckland was recommended by contributors as it helps people to decide if they want to be a peer support worker.
- A motivational interviewing course run at Canterbury was mentioned by several contributors.
- Brief intervention training for workforces outside of the core specialist services was recommended to increase knowledge outside of specialist services.
- *Let's get real* was mentioned several times for having some useful courses, and training opportunities emerging from the Access and Choice initiative were also welcomed.

One contributor described how the Te Ara Oranga initiative to prevent the harm from methamphetamine in Northland had worked well despite some shortcomings. In their opinion, what was good was that it:

- improved relationships with NGOs
- improved referral pathways including from Police
- created an addiction position in emergency departments (EDs) where someone could be referred from, and this also facilitated a change in culture towards people that use substances by the ED staff – "positive ripples from small changes".

What was not so good was that:

- when originally set up, it advertised to have a doctor supervising the clinical approach but could not recruit
- pou navigators at grass roots were key positions providing assertive outreach but they lacked professional supervision, especially in more remote districts.

Mention was made of a very good online programme developed by Te Pou for OST. However, this relied on one person managing it, marking answers and responding. This made the tool chunky and took ages before a person received a response and could move on to the next stage. One contributor would definitely support reinstating this, but the training would need to be properly resourced.

One person said that experience from Adverse Childhood Event (ACE) training indicated that about 70% of a workforce needs to be trained for a particular approach or treatment for it to become embedded.

Another contributor thought that barriers to training need to be addressed – for example, online training is promoted, and for Careerforce, there is only online training. Careerforce also requires people to be in work. There is an assumption that someone being able to use a computer makes a good worker. However, this contributor felt that not everyone is comfortable or able to use online resources and their job is to work with people, not with computers.

When considering its detailed stocktake of services, there is a strong priority for Te Whatu Ora to identify the specific training gaps and, informed by this, to commission a nationwide programme to address those gaps. This may require some reprioritisation of existing workforce plans and contracts held by the workforce centres and some new investment.

Investing in structural support for the sector

Contributors were asked whether investment in structural support is required across the addiction sector. This is specifically related to how advice is provided to Te Whatu Ora concerning what services are needed and what workforce initiatives should be provided.

The term 'infrastructure' here is taken to mean advice from peak bodies and the regulatory bodies and the provision of data and information. The topic of data and information is covered in an earlier section.

The sector itself has constantly signalled in recent years that the loss or lack of resource for the structural foundations of addiction treatment leadership and workforce (for example, a dedicated addiction workforce centre and resourced leadership groups) is making it difficult to attract, retain and build the capability and capacity of the addiction workforce.

Contributors thought that the National Committee for Addiction Treatment (NCAT) is not adequately resourced and that having a peak body is really important. DAPAANZ, the New Zealand Drug Foundation, and NCAT are all involved with aspects of representing the sector. The workforce centres are also involved, but with the demise of Matua Raki (the former National Addiction Workforce Development Centre), there is a lot to be done and significant investment required.

Contributors observed that national-level organisations such as NCAT rely on the goodwill of their members and are basically funded by those members or the generosity of previous DHBs. Funding can be lost due to cost-saving reductions. It was also acknowledged that it can be hard for people to get time off to attend meetings or paid travel to meetings. People already in full-time work are being asked to volunteer their time to not only participate in meetings but to prepare submissions, provide responses to enquiries and generally represent the sector.

One contributor suggested a peak body for the addiction treatment sector would be similar to overseas models such as the Network of Alcohol and other Drugs Agencies (NADA) in New South Wales. Other examples could be Turning Point in Victoria and the Canadian Centre on Substance Use and Addiction.

NADA represents 80 organisational NGO members in the alcohol and other drugs sector in New South Wales. The NGOs provide a broad range of services, including health promotion and harm reduction, early intervention, treatment and continuing care programmes. NADA itself provides a range of programmes and services that focus on sector and workforce development, data management, governance and management support, research and evaluation, sector representation and advocacy as well actively contributing to public health policy.

NADA is governed by a Board of Directors elected from the NADA membership and is primarily funded by the New South Wales Ministry of Health.

One contributor suggested that, if peak bodies are not directly funded (by Te Whatu Ora), they can be independent but they will still need support. This person suggested that Te Whatu Ora could seek new initiatives then fund for that work. It is about creating space for this to happen and creating diversity that reflects the community.

Having the channels for the sector to communicate its voice to Te Whatu Ora and decision makers will need support from Te Whatu Ora. Important in this is how the sector represents substance use-related issues to the wider public, particularly issues regarding treatment options. Whether this is one group or several groups, it appears that dedicated resourcing, including funding and staffing, will be critical.

5. Priorities for commissioning

The previous section has attempted to bring together an environmental scan covering a wide range of issues that are currently impacting service delivery and workforce development in the addiction treatment sector and that will continue to have an impact as the new framework is implemented.

While there was a small sample group of people interviewed (33 out of a workforce of 1,500 FTEs), it will be up to Te Whatu Ora to ultimately decide and act on the issues and priorities. A theme that came through from this process is that people do want positive change and for action, not words.

Priorities have been considered using criteria of impact, effort and cost for implementation in the short term, medium term and longer term.

5.1 Supporting the existing workforce

This will be advanced by addressing pay equity in NGOs and scale creep, filling vacancies, providing supportive workplace environments and developing a specific addiction treatment workforce development strategy.

There are necessary precursor steps to achieving this such as the work already under way involving:

- a detailed stocktake/equity map to validate the current landscape
- work on an equitable funding model for various population groups around the country and to identify funding gaps
- a review of which services should be delivered nationally, regionally and locally
- development of an innovation hub and/or national service networks to assist with consistency nationally.

As part of the stocktake of the current landscape, there should be an assessment of training needs to inform training initiatives commissioned from the workforce development centres.

Providing training opportunities, improving the work environment, identifying career pathways, allowing time for engagement through improved management of the workflow, improving attitudes towards service users and improving the recruitment and retention of staff will all contribute to improved workforce capability and capacity. Identifying opportunities and barriers to implementing and maintaining these issues (and other issues that may be identified through consulting with stakeholders) need urgent consideration.

Active recruitment will be important to fill existing vacancies. The limitation, however, will be the pool to draw upon and competition from other sectors. For many, the levels of remuneration and therefore funding will be the primary driver.

Reviewing Te Rau Puawai as an example of what pragmatic opportunities there might be to develop and grow the workforce and how to support people while they are studying towards addiction-specific qualifications should be considered.

This priority is likely to be the most expensive. Without new funding, there is likely to be some dis-investment in current services to allow investment in new or different services and investment in new or different workforces. Funding shortfalls should not compromise existing positions over new. New investment will be necessary.

Short-term priorities are to complete the stocktake, including identifying skill shortages, and commissioning training to fill those gaps. Adding specific workforce development requirements to contracts beginning 1 July 2024 is also a short-term priority. Te Whatu Ora addressing the issue related to Fellowship of the Australasian Chapter of Addiction Medicine and the appointment of statutory officers for OST would make a meaningful difference and promote a career in addiction treatment.

A significant short-term priority is to commence development of a 10-year addiction treatment sector workforce strategy and implementation plan.

Medium-term priorities are to develop and implement service improvement measures, including workforce development measures to demonstrate value for money from the investment as this will be important to ensure support from government.

In the longer term, it will take time to fill vacancies once they are identified. However, the impact on service provision and meeting existing demand for services from people with substance issues are likely to be substantial.

5.2 Addressing how the Māori workforce in the addiction treatment sector can express their tino rangatiratanga and mana motuhake

If the sector is to actively deliver on Te Tiriti o Waitangi as the *Oranga Hinengaro System and Services Framework* intends, there needs to be dialogue with the Māori workforce on how these concepts are expressed in the sector. It is also clear from mainstream services that they are aware they need to do better and cannot rely on kaupapa Māori services to show them how to work with Māori service users and whānau.

In the longer term, it will take time to fill vacancies once they are identified. However, the impact on service provision and meeting existing demand for services from people with substance issues are likely to be substantial.

There is an urgent priority for Te Whatu Ora and Te Aka Whai Ora to begin these conversations in the sector if the foundation for the system is to be right from the beginning.

This conversation with Māori, the Māori workforce and Māori service users will need to be ongoing **over the medium to long term**, not a one-off event. The effort required to have such open and ongoing conversations followed by action will have a significant effect and avoid the impression that, despite all the good intentions, the system remains the same.

5.3 Addressing the pipeline of new entrants

This will be delivered most importantly by working with the education sector to develop a 10-year approach aligned with the *Oranga Hinengaro System and Service Framework*.

However, it is not likely to be achieved quickly given the disruptions occurring in the education sector.

There are a number of challenges here – availability, staffing and credentialling within the education sector. However, the greatest challenge and opportunity will be to consider how these workforce and training opportunities can be promoted and incentivised as a career option. If resources could be ring-fenced to provide support to enter the specialist professions and training programmes, this would significantly help.

Given the challenges identified here, addressing the pipeline of new entrants is likely to begin **in the short term** – for example, by considering incentives to working and training in the addiction sector – but will not be resolved until **the medium or even long term**.

5.4 Promoting leadership and professionalism

Leadership has been identified in *Kia Manawanui Aotearoa* as an enabler for change. Promoting leadership and professionalism needs to be at district, regional and national levels to drive the system transformation that will deliver safe and effective services for people with substance use issues.

The addiction treatment sector is multidisciplinary, and there are people from diverse professional fields. Not all workers belong to a formally regulated, publicly accredited profession or have credentials from a professional licensing and accrediting body.[45] However, all should be expected to perform professionally and competently.

At present, there are several peak bodies that bring together national views from across the addiction treatment sector and have a strong interest in developing a strong, effective workforce. In addition, there are established regional forums that bring together local networks of service providers, funders, planners and service users such as in metro Auckland, Bay of Plenty and the South Island. Communities of practice have also evolved for specific issues such as the effects of new synthetic drugs.

These existing structures provide a good place to start to further develop networks to promote leadership and professionalism.

In the transformed health sector, there will be the opportunity to grow informal and formal networks to inform regional and national commissioning priorities. Regional collaboratives would focus on implementing and locally adapting national models of care to improve outcomes.

Involvement in these networks would allow the development of leaders. The development of sector leadership groups or communities of practice would focus on governance and leadership as well as clinical practice processes to improve quality, share practices and identify priorities to recommend to Te Whatu Ora at relatively low cost. However, resourcing for leadership development programmes and supporting coordination functions will be required.

In the short term, Te Whatu Ora should seek to establish and extend those existing local, regional and national forums to inform future commissioning and sector dialogue.

Other short-term priorities include updating the set of competencies expected across the addiction sector. Consideration should be given to developing a leadership programme and promotion of existing initiatives such as the IIMHL. Ensuring the conditions for scholarships and internships are consistent across the workforce centres should also be a short-term priority ahead of the next round of applications for grants at the end of 2023.

In the medium to longer term, there should be an evaluation of leadership development programmes and commissioning of workforce initiatives to ensure these are meeting the needs of the workforce. Consideration should be given to a workforce innovation fund that organisations can apply for to develop specific initiatives.

45 Canadian Centre on Substance Use and Addiction. (2017). *Professionalism and ethics*. CCSA. www.ccsa.ca/sites/default/files/2019-04/CCSA-Professionalism-Ethics-Summary-2017-en.pdf

5.5 Promoting a workforce that looks like the communities that services work in

This involves the lived experience workforce at every level of the system and promoting greater diversity through deliberate recruitment strategies.

The *Oranga Hinengaro System and Service Framework* spells out the services to be accessible and available for people experiencing substance-related harm. This lists a wide range of actual and potential service users. Where population size is not sufficient for local specific services, national virtual consultation and advisory services might be required.

There is then a priority for a workforce that is both clinically and culturally attuned to the communities they are working with. A first step would be for Te Whatu Ora to commission research on the diversity of service users and the current addiction treatment workforce with a view to developing strategies to attracting people with diverse abilities into the workforce. All clinical and non-clinical roles should have competencies to engage with diverse communities. Te Whatu Ora funds some training for cultural competency, and consideration should be given to identifying any gaps in such training.

Attracting and developing the rainbow workforce, people with neurodiversity, refugee and migrant populations and people with disabilities are ways services can reflect the communities they live and work in.

Again, this would hinge on the availability of people to be recruited into the workforce. This does not necessarily need to be expensive as it could be part of a wider recruitment strategy, and it would have impact for those people wanting to access services.

In the short term, Te Whatu Ora should commission research on the diversity of service users and the current addiction treatment workforce. Services should be reminded of the benefits of including a wide range of applicants and appointments to promote diversity in the workforce.

In the medium to long term, strategies to attract people with diverse abilities into the workforce would be developed and implemented. Training programmes should be extended to ensure competency in working with diverse communities. Such competency should be core to the addiction treatment sector.

In closing, addressing each of these priorities would have a positive impact, but the potential to benefit from their collective impact would drive enormous improvements in the recruitment, capability and capacity not only for the addiction treatment sector but across the whole health sector.

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